Evaluation of Better Access

CONCLUSIONS AND RECOMMENDATIONS

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Conclusions and recommendations

This report provides a summary of the key findings from the evaluation of Better Access and draws some broad conclusions. It then provides some interpretation of these findings, considering what they mean for Better Access in the context of the broader mental health system. It then shifts focus to specific issues raised by the evaluation, making recommendations for how they might be addressed. In doing this, it refers back to recent relevant inquiries and reviews.

Summary and conclusions

The evaluation points to some consistent findings about Better Access in terms of outcomes and access. Those who receive treatment through Better Access tend to have positive outcomes, irrespective of how outcomes are measured. These outcomes are not related to sociodemographic factors like where people live or how much money they earn, which is positive. Instead, they appear to be associated with levels of need, with those who receive care when they are experiencing relatively severe symptoms of depression or anxiety, high levels of psychological distress, low levels of functioning and/or poor quality of life showing the greatest levels of improvement over episodes of Better Access care. There are also indications that a relatively greater number of sessions may lead to better outcomes, but this is not quite so clear-cut.[a]

The findings with respect to access are somewhat less positive. The reach of Better Access has continued to expand, with more than 10% of the Australian population receiving any Better Access service in 2021 and around 5% receiving at least one session of psychological treatment through the program. This should be considered in the context of 21% of the adult population experiencing a mental disorder in 2021.[1] Not all of these people would have needed formal care, and some may have sought care through other avenues, but there are certainly people who would benefit from Better Access who are not accessing it. At the same time, Better Access appears to be providing services to some people with relatively low levels of need who could potentially be helped by information or support through other means.

The evaluation suggests that particular groups are differentially affected by issues of access. Better Access is certainly serving some groups better than others, and these gaps are widening. Of most concern, increases in utilisation over time disproportionately favour people on relatively higher incomes in major cities. Affordability was consistently raised as an issue by the consumers and providers who contributed to the various studies in the evaluation. In 2021, 65% of Better Access treatment services attracted a co-payment compared with 53% in 2018. The median co-payment for these services was relatively stable at around $74 per session between 2018 and 2021 but increased significantly in the first half of 2022 to $90.

Moving forward, it will be important to maintain positive outcomes for those who use Better Access while increasing access for those who are currently missing out. Improved targeting of the program will be important here, as will consideration of how Better Access interfaces with other elements of the mental health system. Maximising the affordability of the program to reduce inequities will also be critical.

[a] Most of the studies that considered outcomes showed that higher numbers of sessions were predictive of improvement in outcomes as assessed by a range of measures. However, because session numbers were, by necessity, aggregated in different ways in different studies and because the relationship between session numbers and improvement was not linear, it is not possible to determine whether there is an "ideal" or "optimal" number of sessions.

Better Access in the context of the broader mental health system

Better Access is one element in the broader system of mental health care, representing a significant investment by the Australian Government. It is complemented by a range of other Australian Government-funded services (e.g., mental health services commissioned by Primary Health Networks [PHNs]; headspace services). Better Access also sits alongside public hospital and community mental health services funded by state/territory governments. Private hospitals also form part of the mix.

In this context, Better Access was originally designed to improve clinical treatment and management for people who have mild to moderate mental health conditions, for whom short-term evidence-based interventions are most likely to be useful.[2] This is still its stated aim but the evaluation has shown it is not only serving this group but also people with more complex needs – the so-called the "missing middle" – who may require more treatment and support than is available through 10 or even 20 Better Access sessions, but who are unlikely to be seen by state/territory-funded mental health services (which are at capacity and serving consumers with the greatest levels of symptom severity and the highest levels of risk) and may not be able to afford private sector options.[3] It is also providing services to those with relatively lower levels of need for whom less intensive service options (e.g., digital services) may be beneficial.

Consideration should be given to how best to serve the needs of these different consumer groups, and whether Better Access is the ideal avenue for all of them. It would be useful to revisit the objectives of Better Access to tailor the program towards those with mild, moderate and severe mental illness, noting that several of the studies in the evaluation indicated that the greatest gains in terms of outcomes were made for those with relatively high levels of baseline severity. People with lower levels of need might then be channelled to alternatives that do not necessarily involve psychological therapy from Better Access providers.

Positioning Better Access in the context of the broader mental health system is consistent with the National Mental Health and Suicide Prevention Agreement which commits the Australian Government and all state/territory governments to *"collaborate on systemic, whole-of-government reform to deliver a comprehensive, coordinated, consumer focused and compassionate mental health and suicide prevention system to benefit all Australians."*[4] Of particular relevance, the National Agreement commits all governments to address gaps in the mental health system by reviewing existing models of care and developing new ones where necessary.[4] It also binds them jointly deliver accessible and affordable treatment, support better integration across disciplines and services, and prioritise the delivery of whole-of-person care.[4]

Recommendations

Complementary service delivery models

Studies 1b, 2, 3, 4 and 5 clearly showed that Better Access is delivering care to people with a range of needs, providing treatment to consumers with varying levels of depression and anxiety symptoms, psychological distress, functioning and quality of life. For example, Study 1b indicated that, over a two-year period, 6% of Australian adults with low levels of psychological distress received Better Access treatment, and 11%, 21% and 25% of those with moderate, high and very high levels of distress respectively, also did so. Consideration should be given to whether Better Access – as a program that is designed to deliver session-based clinical care – is ideally positioned to serve people with such a diverse range of needs, or whether complementary models of service delivery might also be warranted.

Meeting the needs of people with severe and complex mental health conditions: Multidisciplinary, holistic care

The evaluation provided clear evidence that people with severe and complex mental health conditions benefit from Better Access. Studies 2, 3, 4 and 5 showed that reductions in symptoms and improvements in levels of functioning and quality of life were greatest for those with the highest levels of need (e.g., Study 3 found that high self-rated mental health at the beginning of an episode of care associated with 47% lower odds of showing improvement).

Having said this, there are suggestions that Better Access does not always serve people with complex needs optimally. Participants in Studies 6, 7 and 8 suggested that many of these people require more multidisciplinary, holistic care than Better Access can deliver. They indicated that this sort of care would ideally involve seamless delivery of clinical treatment and non-clinical support and care from private and public health, mental health, and social support services. Over 90% of the Study 8 participants agreed that multidisciplinary, holistic care is required, and over 75% indicated that the Medicare-funded service model that underpins Better Access would not be able to accommodate such an approach without a fundamental restructure.

Better Access should continue to provide foundational clinical care for people with complex needs, and this group should be able to readily access the additional 10 sessions of care (see Recommendation 12). However, additional clinical care might also desirably come from other sources, delivered in a coordinated, integrated fashion by a broader range of providers. Non-clinical support and care that may be necessary to “round out” clinical treatment and provide more holistic care for people with complex needs (e.g., help with navigating housing or financial support services, or peer support services) might also come from elsewhere. For example, Primary Health Networks (PHNs) might be supported to commission additional primary mental health care services in their local areas to meet some of these unmet clinical and non-clinical needs.

Greater coordination between Better Access and these complementary services could allow people with complex needs to draw on both in ways that lead to improvements not only in clinical outcomes but also in their overall quality of life.

Meeting the needs of people who may benefit from less intensive services

Better Access may not be ideal for people who have lower levels of need. As noted, Studies 2, 3, 4 and 5 suggested that this group is likely to show the least benefit in terms of improvement in symptoms, levels of functioning and quality of life. They have less room to improve because their mental health and wellbeing is relatively good when they enter episodes of care. Some of those with lower levels of need – e.g., those are experiencing relatively low levels of psychological distress – might be well served by services that sit outside Better Access. Digital options should be explored here. The Head to Health website acts as an ideal starting point for this, because it assists people to find a range of low intensity options to match their needs. Some people may only require digital services, whereas others may benefit from a small number of tailored Better Access sessions to support their use of digital services.

Considering the implications of complementing Better Access with other service delivery models

If there is an appetite for exploring how relevant service delivery models could complement Better Access, this should be done carefully. Appropriate funding would be required. The benefits and disadvantages should be considered, and any unintended consequences thought through. The aim of any complementary models would be that they should add to, rather than duplicate, what is being provided through Better Access. The incentives for providers to deliver services through one model or another would need to be examined, as would the interface between the different models. Any new or modified model should be trialled alongside Better Access, with the processes, outcomes and costs carefully monitored before any broader roll-out.

Recommendation 1: Models of service delivery that complement Better Access are warranted. For those with severe and complex needs, Better Access should be supplemented by other multidisciplinary models that not only provide more intensive, longer-term clinical care but also offer holistic support for dealing with life's complexities. For those with lower levels of need, less intensive options (e.g., digital services) should be explored. The way in which combinations of these models might work for consumers, providers and funders should be carefully evaluated.

Workforce capacity, composition and distribution

Many Better Access providers are currently at capacity. A 2022 survey of psychologists showed that one third of them were unable to see new consumers. This figure represented an increase from one fifth in 2021 and one in 100 before the pandemic.[5] Study 1b suggested that these capacity issues have translated into new consumers either not being able to get into care or having to wait for longer periods in order to do so. Although the number of consumers and the number of sessions provided to them increased between 2018 and 2021, the increase was primarily accounted for by existing users. The median wait time to receive an initial session of Better Access treatment following receipt of a mental health plan increased from 14 days in 2017-18 to 19 days in 2020-21.

In addition to capacity issues, there are questions about the composition of the workforce, and whether additional or alternative providers might be brought in to meet demand. And there are issues with distribution, with the location of providers' practices contributing to relatively poorer access for consumers in rural areas and areas of lower socioeconomic status. In Study 8 there was considerable discussion about whether expanding the range of eligible providers could help to address capacity issues, particularly in under-served areas.

These issues should be considered in the context of the models that might run alongside Better Access in order to address gaps in the system of care (see Recommendation 1). As noted above, addressing these sorts of gaps is the crux of the National Mental Health and Suicide Prevention Agreement.[4] Under the proposed arrangements, greater emphasis would be placed on low intensity digital services for people with relatively low levels of need. Better Access would be then focus on people with mild and moderate mental health conditions, as well as those with higher levels of need for whom other service delivery models might be required too.

This improved program targeting would have implications for workforce capacity and composition issues. Better tailoring of Better Access would be likely to reduce the overall demand on the program, easing some of the capacity issues within it. But it is likely that demand might increase in other settings, so sufficient funding would be required to ensure that people were equally well served by all parts of the system. As an MBS-funded scheme, Better Access would deliver clinical services only, and the workforce would need to reflect this. Elements elsewhere in the system would also provide clinical care, and others would provide non-clinical care; these might require a broader workforce. Consideration of the training, levels of experience and scopes of practice of different Better Access and non-Better Access provider groups will be important here and are part of the remit of the National Mental Health Workforce Strategy.[6]

Workforce distribution issues were raised by the MBS Review Taskforce, particularly in relation to the lack of providers in rural and remote areas,[7] and are also being picked up by the National Mental Health Workforce Strategy.[6] The widespread adoption of telehealth services under Better Access will undoubtedly have helped to some extent, but there are broader issues around attracting and retaining providers in rural and remote areas. It may be easier to recruit and retain providers in rural and remote areas if they are salaried than if they work within a fee-for-service model. Different options may be required to attract Better Access providers to rural and remote areas. Similar issues apply in areas of lower socioeconomic status.

Recommendation 2: Means of addressing workforce capacity and composition issues should be considered in the context of the National Mental Health Workforce Strategy and the complementary service delivery models noted above. Improved tailoring of the program would be likely to reduce overall demand and allow consumers' needs to be better matched to providers' training, levels of experience and scopes of practice.

Recommendation 3: Workforce distribution issues – particularly the lack of providers in rural and remote areas – should also be considered in the context of the National Mental Health Workforce Strategy. Broad measures to recruit and retain providers in rural and remote areas are likely to be more successful than ones that are tied to the MBS.

Therapies available through Better Access

There are suggestions that the list of therapies available through Better Access is too restrictive. In Study 8, 92% of participants supported expanding the range of therapies to better meet consumers' mental health needs. Eighty seven percent suggested that any new therapies must have evidence of effectiveness from scientific studies, and 78% said that they must have support from people with lived experience.

The list of available therapies through Better Access could potentially be expanded in order to enable the program to be better targeted. Different therapies of varying levels of intensity (e.g., session numbers) might be more suitable for different groups of consumers, raising questions about whether the current list of available psychological therapies is ideal for all. The Productivity Commission recommended that the treatment options available under Better Access should be updated.[3] More specifically, it suggested that a number of additional psychological therapies should be added to the list of approved therapies under Better Access, following review by the Medical Services Advisory Committee (MSAC) and MBS Review Advisory Committee (MRAC) and assuming that they meet National Health and Medical Research Council (NHMRC) Level 1 or 2 evidence standards.

Recommendation 4: Additional psychological therapies could be added to the list of approved therapies under Better Access, providing that they meet National Health and Medical Research Council (NHMRC) Level 1 or 2 evidence standards.

Referring people to the most appropriate care

As noted above, Studies 1b, 2, 3, 4 and 5 clearly showed that Better Access is delivering care to people with varying needs, ranging from relatively low level to severe and complex. Studies 1b showed that there are inequities in access to care, and that although people with higher levels of need are more likely to receive treatment through Better Access, the absolute numbers of those with relatively lower levels of need are substantial. In addition, although Studies 2, 3, 4 and 5 showed that those with severe and complex mental health conditions benefit from Better Access treatment, Studies 6, 7 and 8 suggested that this group may require additional care, beyond what Better Access offers.

Differentiating people on the basis of their initial level of need in order to direct them to the most appropriate care would be helpful here. One way of doing this, as recommended in the Productivity Commission Inquiry into Mental Health, would be to make use of more rigorous and consistent assessment and referral processes.[3] Appropriate triage tools could be used to assist GPs in this regard. These would need to simplify the processes, not add to the "red tape" concerns articulated by providers in Study 7.

Primary mental health care triage tools already exist, with the Initial Assessment and Referral Decision Support Tool (IAR-DST)[8] being one example. The IAR-DST offers a standardised, evidence-based approach to assist GPs and mental health care providers to make recommendations about the most appropriate

care based on a consumer's level of need. It is designed to complement clinical judgement by assessing consumers on eight objective domains (symptom severity and distress; risk of harm; impact on functioning; impact of co-existing conditions; treatment and recovery history; social and environmental stressors; family and other supports; and engagement and motivation). The IAR-DST then uses this assessment to match consumers to one of five levels of care (self-management; low intensity; moderate intensity; high intensity; and acute and specialist). Psychological services provided through Better Access would typically be regarded as moderate to high intensity. The IAR-DST is currently being rolled out across a number of primary mental health care settings, including in GPs' practices and Primary Health Networks (PHNs) which use it to guide a stepped care approach.

If a tool like the IAR-DST was incorporated into practice management software used by GPs it could potentially be used to inform and better target the mental health treatment plan (see Recommendation 7). Appropriate training and support for GPs would also be required. There was funding allocated in the 2021-22 Budget to integrate the IAR-DST into practice management software, and the current initiative to provide Training Support Officers to promote the IAR-DST could be extended to align with Better Access. Consideration would also need to be given to how GPs would be recompensed for appropriate triage and referral (e.g., replacing the item numbers that currently relate to the preparation of a mental health treatment plan with broader mental health assessment, planning and referral items).

In addition to boosting the infrastructure and providing training and support for the IAR-DST, GPs (and other referrers) would need to be supported to refer to the most appropriate provider or service, perhaps with the assistance of up-to-date service directories. Allied health professionals providing services within Better Access could be listed by their profession, scopes of practice and specialist skills. This would potentially raise the profile of social workers and occupational therapists, noted as an issue by providers in Study 7. Outside Better Access, special consideration should be given to listing low intensity services here, with digital services that meet the National Safety and Quality Digital Mental Health Standards[9] being given preference and promoted.

Recommendation 5: A tool like the Initial Assessment and Referral Decision Support Tool (IAR-DST) could be used to inform and better target the mental health treatment plan, in order to direct people towards (or potentially away from) Better Access services based on their level of need. Appropriate training and support for GPs would be required, as would suitable mechanisms for recompensing GPs for appropriate triage and referral.

Recommendation 6: GPs should be supported to refer to the most appropriate providers within Better Access and to a broader range of services (particularly low intensity services) outside it. Up-to-date service directories that list allied health professionals providing services within Better Access and point to high quality digital services might be one means of doing this.

Fostering communication and collaboration between providers

The evaluation suggested that good communication between providers is key to optimal care. Allied health professionals in Study 7 commonly cited barriers related to communication and collaboration. Around 70% of all allied health professionals noted that good communication with referrers was a facilitator to provision of quality care. GPs also commonly noted that good communication with relevant allied health professionals and good documentation from these professionals were key facilitators.

Fostering good communication between GPs and allied health professionals operating within Better Access and other providers delivering services outside Better Access is critical for holistic, person-centred care (see Recommendation 1). The mental health treatment plan is a key way of ensuring that all providers and the consumer themselves are "on the same page". The benefits of the mental health treatment plan should be retained but it should be standardised, simplified and used to help GPs understand the needs of individual consumers and work collaboratively with other providers to meet

these needs, rather than just as a requirement for referring them to Better Access. Appropriate funding mechanisms would need to be in place to achieve this.

The case conferencing item numbers announced in the 2022-23 October Federal Budget are also likely to be helpful in promoting good communication and shared care between providers. These new item numbers will enable the various providers who are involved in a consumer's treatment to provide more collaborative care. It will be important to consider how these item numbers might operate relative to existing chronic disease management case conferencing item numbers. Once they are introduced, the uptake and impact of these item numbers for providers and consumers should be monitored.

Recommendation 7: The mental health treatment plan should be retained but should be standardised, simplified and used to help GPs understand the needs of individual consumers and work collaboratively with other providers to meet these needs, rather than just being a requirement for referring consumers to Better Access. Appropriate funding mechanisms will need to be in place to achieve this.

Recommendation 8: The case conferencing item numbers announced in the 2022-23 October Federal Budget should also be used as a way of fostering more collaborative care. The uptake and impact of these item numbers should be monitored.

Affordability

A key finding from the evaluation was that although Better Access has enabled many people to access mental health care who otherwise may not have been able to do so, affordability is an issue. Studies 1a and 1b showed that those on low incomes are less likely to use Better Access, with Study 1b indicating that this is despite their relatively higher levels of need. Study 1b also showed that people on low incomes are less likely to receive treatment following a mental health plan than their wealthier counterparts, and to wait longer for their first treatment session if the mental health plan is followed by treatment. This poorer access to treatment is likely to have been exacerbated recently by increases in the out-of-pocket costs that are borne by consumers (with Study 1a demonstrating that the median co-payment for any Better Access treatment service increased from $74 per session in 2021 to $90 per session in 2022). Participants in Studies 3, 6, 7 and 8 all indicated that the affordability of Better Access was a major concern, with Study 8 participants ranking improvements to affordability as the single highest priority for future reforms to the program.

Providers in Study 8 noted that they have been forced to set their own fees above schedule fee levels because the schedule fees associated with Better Access treatment services are too low. They indicated that schedule fees have not always kept pace with indexation, and that the costs of running private practices as small businesses have risen. This has had an impact on out-of-pocket costs for consumers (because they pay a co-payment up to or beyond the schedule fee, depending on whether the provider charges more than the schedule fee). Schedule fees associated with Better Access item numbers should be reviewed in a manner that is consistent with the MBS Review Taskforce recommendation that the approach to setting (and re-setting) schedule fees be standardised and made more transparent.[7]

The MBS Review Taskforce also recommended a range of actions to address rising out-of-pocket costs,[7] many of which are now being considered by the Strengthening Medicare Taskforce.[10] These included, but were not limited to, further investigation of the Extended Medicare Safety Net (EMSN).[7] Under the EMSN arrangements, consumers who spend a threshold amount on visits to Medicare-subsidised providers in a calendar year are entitled to higher Medicare rebates for future visits. Modifying the rules around the EMSN would make Better Access care more affordable for some, particularly those who also need care from Medicare providers for other conditions. Potential options might include modifying the threshold, or quarantining a threshold for mental health-related item numbers.

Other options for increasing affordability that are tied to the MBS should also be explored, and again some of these were proposed by the MBS Review Taskforce and are being considered by the Strengthening Medicare Taskforce.[7,10] These options include bulk-billing incentives in some areas or loadings on specific item numbers. There are precedents for this; loadings for the delivery of bulk-billed telehealth services delivered by psychiatrists in rural and remote areas were reinstated in the October 2022-23 Budget. Additional models for minimising co-payments or complementing Better Access in other ways might include paying GPs and allied health professionals practice incentive payments (PIPs) or service incentive payments (SIPs) for maximising the quality of mental health care provided to consumers. Options that sit outside the MBS, like blended funding models, should also be considered.[7,10,11]

Recommendation 9: The appropriate level for schedule fees should be determined in a standardised, transparent way.

Recommendation 10: The rules around the Extended Medicare Safety Net (EMSN) should be modified to increase the affordability of Better Access services. Potential options might include modifying the threshold, or quarantining a threshold for mental health-related item numbers.

Recommendation 11: Other options to increase affordability that sit within or outside the MBS should also be explored (e.g., bulk-billing incentives, loadings on specific item numbers, practice incentive payments, service incentive payments, and blended funding models).

Number of sessions: Additional 10 sessions

The Productivity Commission and the House of Representatives Senate Select Committee on Mental Health and Suicide Prevention both recommended trialling an additional 10 sessions over and above the standard 10.[3,12] The provision of the additional 10 sessions during the COVID-19 pandemic effectively enabled the evaluation to incorporate such a trial.

To differing degrees, Studies 2, 3 and 4 suggested that levels of improvement were associated with the number of sessions consumers received. It is important to note, however, that the studies did not always explicitly test whether the additional sessions were associated with greater improvement and did not point to a threshold number of sessions required for improvement. Study 2 used the number of outcome assessments in each episode of care as a proxy for the number of sessions and showed that, as a general rule, those with five or more outcome assessments improved the most. Study 3 showed that consumers who received 3-4, 5-6, 7-10 or 11+ sessions were more likely to improve than those who received 1-2; there was some evidence of a dose-response effect but the 95% confidence intervals overlapped. Studies 4 and 5 used data that was not tied to specific episodes; Study 4 suggested that people who had five or more sessions had increased odds of significant improvement, but this was dependent on the measure used, and Study 5 produced results that contradicted Studies 2, 3 and 4, presumably because of the significant period (often of several years) between data collection waves.

Studies 1a showed that the uptake of the additional sessions has not been insubstantial but it has not been extensive either, with the percentage of Better Access treatment users who received at least one additional treatment session sitting at 17.0% in 2021 and 13.6% in the first half of 2022. However, Study 1b suggested that provision of additional services to existing consumers may have limited the capacity of providers to offer treatment to new users; the number of continuing users of Better Access services and the number of sessions provided for them increased markedly in 2020 and 2021, whereas the figures for new users remained stable.

The additional 10 sessions were welcomed by many of the consumers and providers who participated in the various studies that sought their views via surveys, interviews or other consultative methods. For example, three quarters of the participants in Study 8 felt that the additional 10 sessions should be

retained as a standard offering and close to 90% indicated that potentially even more sessions should be available for people with complex needs.

However, it does not appear to be the case that the additional sessions have always been specifically targeted to consumers with particularly complex needs. In Study 3, the patterns of self-reported baseline mental health were almost identical for those who did and didn't receive the additional sessions.

On balance, the evidence from the evaluation suggests that the additional 10 sessions should continue to be made available and should be targeted towards those with more complex mental health needs. If the additional 10 sessions are to be retained, it would make some sense for the review to occur after 10 initial sessions, rather than six. This would then act as the trigger for the additional 10. This is consistent with recommendations made by the Productivity Commission and the House of Representatives Senate Select Committee on Mental Health and Suicide Prevention.[3,12] However, this does assume that the majority of people will require at least 10 sessions, and Study 1a indicated that the mean number of sessions per person per calendar year is 5.4. A more nuanced, stepped approach might allow for reviews to occur at different time points, depending on consumers' levels of need and when the review might be most helpful/relevant. Alternatively, recommended reviews might occur after 10 sessions and others might occur at the discretion of the GP, allied health professional and consumer, as a means of collaborating and in line with best practice.

Recommendation 12: The additional 10 sessions should continue to be made available and should be targeted towards those with complex mental health needs. If the additional 10 sessions are retained, the review could occur after the initial 10 sessions. However, alternative review cadences might be recommended based on consumers' levels of need. Recommended reviews might also be complemented by reviews done at the discretion of the GP, allied health professional and consumer, as a means of collaborating and in line with best practice.

Session modality: Telehealth

The Productivity Commission and the House of Representatives Senate Select Committee on Mental Health and Suicide Prevention also commented on telehealth, noting that telehealth options should be made more widely available.[3,12] Again, the pandemic made this a reality, with the Better Access telehealth item numbers being introduced alongside a broader suite of around 280 temporary MBS telehealth item numbers. Prior to this they had been available to people in small and medium rural towns and remote and very remote communities. The widespread availability of telehealth arrangements has now been made permanent.

As noted, the telehealth sessions proved popular. Study 1a showed that although face-to-face remained the most common mode of delivery of Better Access treatment, telehealth services were taken up by almost one third of all Better Access treatment users. Importantly, the evaluation indicated that consumers who received telehealth care and consumers who received face-to-face care experienced similar improvements; session modality had no impact on outcomes for the consumers in Study 3.

Telehealth undoubtedly improved access to psychological care for people during the pandemic, just as it had done previously for people in rural and remote areas. People in other circumstances responded positively to it too (e.g., those whose mental health made it difficult for them to travel from home or visit a provider in their rooms). In summary, the telehealth item numbers appear to have improved access without jeopardising outcomes.

Now that telehealth options have become permanently available to all, consideration should be given to whether they are achieving maximum effect. For example, Study 1b showed that existing users were much more likely to receive services via telehealth than new users, suggesting that telehealth options may not have worked in their favour (and in fact may have made it more difficult for new users to access services). It would be worth considering whether further augmentation to the relevant item numbers

could further increases access (e.g., additional loadings for providers who use the relevant item numbers under particular circumstances, as discussed above). Consumers' preferences for face-to-face versus telehealth services (or a combination of the two) might also be explored further.

Recommendation 13: Telehealth options should continue to be monitored to ensure they are achieving their maximum effect.

Services for people in residential aged care facilities (RACFs)

The dedicated item numbers for people living in residential aged care facilities (RACFs) that were introduced during the COVID-19 pandemic[13,14] were not well taken up. Study 1a showed that in 2021 only 402 people received individual sessions through these item numbers. In the first half of 2022, 213 did so. This low uptake is unlikely to reflect low levels of need among this population group. Further investigation is required, but it is possible that alternative means of ensuring access to high quality mental health care for this group might better meet these needs.

Recommendation 14: Further investigation is required to determine whether the dedicated item numbers for people living in residential aged care facilities are the best means of ensuring access to high quality mental health care for this group.

Family/carer-inclusive practices

Several studies in the evaluation pointed to the importance of family/carer inclusive practices. In Study 8, for example, 95% percent of participants agreed or strongly agreed that *"Processes that encourage family and carer support for consumers and better sharing of information should be established where appropriate and safe for the consumer."*

Family/carer-inclusive practices should be embedded into Better Access going forward. The Productivity Commission recommended the introduction of dedicated MBS-rebated family/carer consultations, with separate item numbers depending on whether the consumer themselves is or isn't present.[3] The May 2021-22 Federal Budget included a measure to support the participation of family/carers in treatment provided under Better Access.

Recommendation 15: Dedicated family/carer item numbers should also be considered as a means of providing more holistic care. Again, if such item numbers were to be introduced their uptake and impact should be monitored.

Routinely assessing outcomes

Despite a disappointing response to Study 9, the evaluation highlighted the importance of capturing data on consumer outcomes in a routine way and at scale, in order to monitor the extent to which Better Access is achieving its goals, and to allow improvements to be made to the program as appropriate. Doing this would also allow providers to see what outcomes they might expect for similar consumers receiving similar treatment, and could provide immediate feedback to inform their practice. These sorts of benefits of routine outcome measurement were also noted by the Productivity Commission[3] and the MBS Review Taskforce.[7] There are no precedents for this in other Medicare-subsidised programs; the only data captured relate to activity and costs, not outcomes.

One of the difficulties with Study 9 was that it could not really put routine outcome measurement done at scale to the test. It examined whether providers found it acceptable to administer a particular assessment at each session, and the relatively small number who participated agreed that it was. They were less sure about how acceptable it might be to their peers but largely felt that it would be acceptable to consumers. Overall, the outcome data collected were relatively complete, suggesting that meaningful

data could be collected. Multiple other providers have used the platform used in Study 9 – NovoPsych – in their practices to track the progress of their own consumers and even to make comparisons with similar consumers, suggesting that this would be feasible in real-world circumstances. However, the NovoPsych system is not designed to capture information in a manner that would allow for program monitoring and quality assurance, so testing whether outcome measurement would be acceptable under these circumstances was beyond the scope of Study 9.

An alternative approach to laying the groundwork for routine outcome measurement is to look at systems that have been successfully developed and implemented in primary mental health care elsewhere. One example is *iaptus*,[15] the clinical software that supports routine outcome measurement for the Improving Access to Psychological Therapies (IAPT) program in the United Kingdom.[16] The IAPT program is different to Better Access but it does involve individual providers delivering psychological services to people with depression and anxiety. *iaptus* is a secure, flexible consumer management system that is built around the consumer pathway, capturing information on the consumer themselves and the treatment they receive from referral to the end of an episode of care. The collection of outcome data is a key element of this. Providers can use *iaptus* to make decisions about the specific treatment they offer particular consumers, based on typical outcomes for similar consumers. They can also monitor a consumer's progress over the course of an episode and use this feedback to make decisions about further sessions of care. Importantly, the system provides a bird's eye view of the overall IAPT program and the outcomes it is achieving. All of this is possible because *iaptus* has been deployed at scale and now contains data on more than five million consumers in the United Kingdom. The system already has a footprint in Australia and is being used by some PHNs.[15]

Steps should be taken to implement routine outcome measurement as a quality assurance tool for the Better Access program. It will be important to draw on lessons from the roll-out of *iaptus* in the United Kingdom,[15] and from the implementation of other outcome measurement systems used elsewhere in mental health in Australia (e.g., the Mental Health National Outcomes and Casemix Collection [MH-NOCC] and the Primary Mental Health Care Minimum Data Set [PMHC MDS]).[17,18] The Study 9 survey results suggested that implementing routine outcome measurement in the Better Access context would need to involve a flexible, easy-to-use, secure platform that could interface with various practice-management software systems, and that appropriate governance and transparency around data use would be required. They also indicated that providers would need to see the benefits to their own practice of contributing data to such a system, and that financial incentives would be likely to be required to guarantee provider engagement.

Recommendation 16: Steps should be taken to implement routine outcome measurement as a quality assurance tool for the Better Access program. This will require significant effort and investment in consultation and communication, system design and governance, technology, and ongoing administrative and financial support.

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