



Evaluation of Better Access

EXECUTIVE SUMMARY

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Executive summary

Introduction

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access) has been running since November 2006 and takes the form of a series of item numbers on the Medicare Benefits Schedule (MBS). The MBS lists the services for which the Australian Government provides a rebate to consumers to assist them in meeting the costs. Each service is associated with a schedule fee, and the rebate is paid as a percentage of the schedule fee. In the case of Better Access, rebates are available for the following services by eligible providers: (1) preparation and review of mental health treatment plans and provision of mental health care consultations by general practitioners (GPs) and other medical practitioners; (2) delivery of psychological therapy services by clinical psychologists; and (3) delivery of focussed psychological strategies by GPs, other medical practitioners, psychologists, social workers and occupational therapists. Several additional item numbers provide rebates for initial consultations with new consumers and preparation and review of psychiatrist assessment and management plans by psychiatrists.

We were commissioned to evaluate Better Access and did so in two stages via 10 inter-related studies. These were:

- Stage 1
 - Study 1a: An analysis of MBS data
 - Study 1b: Analysis of data from the Multi-Agency Data Integration Project (MADIP)
 - Study 2: A study of consumer outcomes using routinely collected clinical data
 - Study 3: A survey of the experiences and outcomes of consumers recruited through Medicare
 - Study 4: Consumer characteristics, treatment patterns, and clinical change associated with Better Access treatment services: Re-analysis of data from two randomised controlled trials
 - Study 5: Examining the outcomes of Better Access at a population level using data from two longitudinal studies (Ten to Men and the Australian Longitudinal Study on Women's Health)
 - Study 6: Qualitative interviews with people with lived experience of mental health conditions
 - Study 7: A survey of providers and referrers
- Stage 2
 - Study 8: A consultative virtual forum on future reforms to Better Access
 - Study 9: Piloting a routine outcome measurement and feedback system

Collectively, the studies were designed to inform questions about Better Access across the following domains:

- Accessibility
- Responsiveness
- Appropriateness
- Effectiveness
- Sustainability

Overview of study findings

Study 1a: An analysis of MBS data

Study 1a involved an analysis of the uptake, utilisation, costs and patterns of services delivered under Better Access, drawing on MBS and Pharmaceutical Benefits Scheme (PBS) data. With the Department of Health's assistance, we sourced aggregated, de-identified MBS and PBS data from Services Australia for the period 1 January 2018 to 30 June 2022. From this, we developed profiles of use of Better Access services overall and for key item groups (e.g., mental health treatment plans, psychological treatment sessions), for all Australians and according to key consumer characteristics (e.g., age group, sex, and geographic area group).

Results from Study 1a indicate that the reach of Better Access has continued to expand as the program has matured. In 2021, one in every 10 Australians received any least one Better Access service and one in 20 received at least one session of psychological treatment^a through Better Access. In recent years, the number of treatment services delivered has increased more than the number of people treated. For every person who received treatment through Better Access in 2021, 5.4 sessions were used (up from 4.5 in 2018).

Rates of uptake and utilisation varied across population subgroups, tending to be relatively higher among females, people aged 15-24 and 25-44 years, and people living in major cities (regardless of area socioeconomic status) and inner regional areas in 2021. Between 2018 and 2021 increases in utilisation were particularly apparent for many of these same groups (females, people aged 15-24 and 25-44 years, people in major cities in areas with high or medium socioeconomic status). Rates of uptake and utilisation of Better Access treatment services also increased for people in remote areas due to their uptake of telehealth or phone services, although they remained lower than those for people living in other areas despite this increase. People aged 65 and over, and males, and people living in major cities in lower socioeconomic status areas and in regional areas experienced relatively lower (or sometimes negative) growth in rates of uptake and utilisation compared to their counterparts.

Increases in uptake and utilisation have translated into increases in the costs of Better Access services over time. The total cost to government of Better Access services, in terms of benefits paid, was \$1,213 million in 2021 (an annual average increase of 4% since 2018). This equates to \$458 per Better Access user and \$46 per capita in 2021. For Better Access treatment services, benefits paid amounted to \$827 million in 2021 (an annual increase of 7% since 2018). This equates to \$618 per person treated and \$31 per capita in 2021.

Costs have also increased for consumers. Co-payment rates increased across most types of Better Access services with the biggest jump occurring in 2021. In 2021, 47% of all Better Access services involved a co-payment by the consumer (up from 36% in 2018) and 65% of Better Access treatment services involved a co-payment (up from 53% in 2018). For services where the consumer paid a co-payment, the median out-of-pocket cost for any Better Access service was \$74 in 2021 (the same as in 2018); it was also \$74 for any Better Access treatment session (again the same as in 2018). In the first half of 2022, median co-payments showed strong increases compared to 2021 (\$87 for any Better Access service and \$90 for any Better Access treatment session). Increases in median out-of-pocket costs were greatest for all allied health professional services and initial patient consultations by psychiatrists. These patterns mirror trends in allied health and specialist MBS services more generally.

^a In this report, "treatment" provided through Better Access refers specifically to services claimed under the dedicated MBS items for psychological therapy services delivered by clinical psychologists and focussed psychological therapy services delivered by psychologists, social workers, occupational therapists and GPs or other medical practitioners.

Changes to the Better Access program rules have influenced the ways people receive psychological treatment through the program. Face-to-face remains the dominant mode of delivery, however uptake of telehealth and phone services has been substantial accounting for about one third (33%) of Better Access treatment services used in 2021. The additional 10 sessions of treatment for people experiencing difficulties due to COVID-19 accounted for 15% of all individual treatment sessions used in 2021. Uptake of these new services by different population groups tended to mirror overall patterns. An exception was that uptake of the COVID-19 phone treatment services was highest among people in lower socioeconomic status areas within major cities. Through the expansion of Better Access services to residents in aged care facilities (RACFs) in late 2020, approximately 400 RACF residents received 1,600 Better Access treatment sessions. Together these program changes contributed to a sustained level of uptake of Better Access treatment (average annual growth of just under 1% in persons treated per 1,000 population) and higher levels of utilisation (average annual growth of 7% in services used per 1,000).

Study 1a also explored typical patterns of Better Access treatment, using data describing the services received following a mental health treatment plan. Approximately two thirds of mental health treatment plans were followed by one or more treatment sessions, although there was some suggestion of a decline in this proportion in 2021. Approximately two thirds of the plans that were followed by treatment sessions involved between one and six sessions, one fifth involved between seven and 10 sessions, and a further one eighth involved 11-20 sessions. Few people (no more than 5%) received 21 or more sessions and <1% received 31 or more. There was an uptick in the percentage of episodes with 11-20 and 21-30 sessions in 2020, corresponding to the introduction of the additional 10 sessions in response to COVID-19.

More than one third of plans that were followed by treatment sessions involved a formal review using the dedicated MBS items. However, as the number of reviews completed each year actually increased over time, this could suggest that the people who are receiving more sessions are also receiving more reviews. The median number of treatment sessions when a review was involved was nine or 10, compared to three when a review was not involved. The median time between a mental health treatment plan and the first treatment session increased from 18 days in 2018 to 22 days in 2021. This is consistent with reports from psychologists. As with rates of uptake and utilisation, people living in more urban and affluent areas tended to receive a greater quantum of treatment, to receive reviews of their treatment, and to wait a shorter time between their mental health treatment plan and first treatment session.

Analyses of co-payment patterns for treatment sessions following a mental health plan showed that, as the number of sessions received increased, so too did the likelihood of making a co-payment at a given session or at any previous session. This could suggest that people who are able to afford co-payments are more likely to receive more treatment.

Study 1a also examined patterns of use of some other types of Better Access services, namely mental health treatment consultations and psychiatrist services. More than one third (38%) of Better Access users received mental health treatment consultations in 2021. The average number of mental health treatment consultations per user of these consultations was 1.8, which suggests that GPs are not usually using them to provide substantial amounts of care to an individual consumer (although they may be for some individuals). Use of the mental health treatment consultations items has declined somewhat since 2018, which may reflect reduced reliance on these items as alternatives or supplements to the treatment items following the introduction of telehealth and phone treatment services and the additional 10 sessions. Psychiatrists provided a plan and/or initial patient consultation for 7.2% of Better Access users in 2021, and the majority of these consumers also received treatment sessions or mental health treatment consultations. However, over time, proportionally more people received psychiatrist services and a mental health treatment plan or review but no treatment or mental health treatment consultations which could reflect worsening access and affordability barriers to Better Access treatment services.

In an analysis of area-level data, Study 1a showed that uptake of Better Access treatment was positively associated with use of antidepressant medications, but only in lower socioeconomic status areas within major cities and in outer regional/remote areas, and only in 2021 and 2022. This may reflect a relatively greater reliance on treatment by GPs in these areas – via the mental health treatment consultation, focussed psychological strategies items and (potentially) other MBS items outside the scope of the current evaluation. GPs are able to prescribe antidepressants which could mean this is more likely to be a treatment avenue in these areas. In contrast, there was a positive relationship of uptake of Better Access treatment with use of anxiolytic medications and with use of non-Better Access psychiatrist services in all geographic area groups and in all years between 2018 and 2022. The latter finding likely reflects the greater supply of psychiatrists in areas with higher levels of clinical psychologists and psychologists who provide the majority of Better Access treatment.

Study 1b: Analysis of data from the Multi-Agency Data Integration Project (MADIP)

Study 1b complemented Study 1a by linking Medicare Benefits Schedule (MBS) data to other administrative and survey data available through the Multi-Agency Data Integration Project (MADIP).¹ These linked data were available from 2016 to 2021 and provided insights into the use and uptake of Better Access. More specifically, Study 1b used MADIP data to explore six broad themes: (1) patterns of use and non-use of Better Access in relation to need; (2) the proportion of Better Access users who are “new”; (3) use of Better Access by First Nations people; (4) use of Better Access by children and young people; (5) socioeconomic differences in Better Access use; and (6) Better Access service pathways.

Study 1b provides population-level evidence that Better Access is reaching those with comparatively high levels of need in the Australian community. The coverage is high, with almost a half of those with very high levels of distress using some form of Better Access service, and 25% accessing psychological treatment. That said, people with relatively lower levels of need are also accessing Better Access, albeit at lower rates. In absolute terms, this means that significant numbers of people with lower levels of psychological distress are accessing the program.

In recent times, there has been a reduction in new users of Better Access (i.e., users who did not access Better Access services in the previous year). This reduction is particularly apparent for those using Better Access treatment services. Between 2018 and 2021, the proportion of those who accessed any Better Access treatment service who were new users declined from 56% to 50%, with the steepest drop occurring between 2020 and 2021. This reduction in new users has coincided with an increase in the provision of additional services to continuing users. The number of continuing users of Better Access services has increased over time, as has the number of sessions of treatment provided to them; continuing users of Better Access treatment services were more likely to have received additional sessions than new users in 2020 and 2021. Telehealth options may also help to explain the findings with respect to new users; in both 2020 and 2021, new users were more likely than continuing users to receive face-to-face treatment only, suggesting that providers may have found it easier to provide telehealth services to consumers with whom they had existing relationships.

First Nations people use Better Access services at a higher rate than non-First Nations people, however rates of use for First Nations people are declining whereas rates of use for non-First Nations people are increasing. For example, in 2018 15.2% of non-First Nations people used any Better Access service compared with 10.4% of First Nations people, but by 2021 the figure for the former group had decreased to 14.8% whereas the figure for the latter group had increased to 11.0%. In addition, the relatively greater levels of use for First Nations people may not be commensurate with their significantly greater levels of need. In 2017/18, for example, 24.2% of First Nations people experienced high or very high psychological distress compared with 13.3% of non-First Nations people.

For children and young people, patterns of Better Access use vary with age and sex. Rates of use increase with age from five to 17, but then show a decline that does not fully adjust until the early 20s. Rates are similar for boys and girls until about the age of 15, but girls become much more likely to use Better

Access as they enter mid-adolescence and their early 20s. Changes in patterns of use between 2018 and 2021 are most marked for this group, with rates of use increasing over time for these girls and young women.

The data from Study 1b highlight a number of equity issues in relation to use of Better Access services and suggest that these may be worsening. The profile of use of Better Access treatment services across income groups is not consistent with the profile of their levels of psychological distress. Those on the lowest incomes are least likely to access services. For example, 5.1% of those in the lowest socioeconomic quintile used any Better Access treatment services in 2021 compared with 6.6% in the highest quintile. In the same year, only 56.5% of those in the lowest quintile proceeded to treatment from a plan compared with 69.3% of their high income counterparts. The wait times to treatment for those who did progress from a plan to treatment were also longer for those in the lowest income quintile; their median wait time was 22 days whereas the median wait time for those in the highest quintile was 17 days. All of these indicators have worsened over time.

Study 2: A study of consumer outcomes, using routinely collected clinical data

Study 2 was one of the studies that considered the effectiveness of Better Access. It involved a before-and-after study in which consumers' outcomes were assessed in terms of change on a variety of standardised measures over the course of their episodes of care. These measures captured information on changes in severity of symptoms and levels of functioning. We used data on outcomes from 83,346 episodes of care in a purpose-designed analysis and reported on pre-existing outputs from a further 2,775 episodes (86,121 episodes in total).

Irrespective of the measure used, consumers began their episodes of care with varying levels of severity. Some presented for treatment with high levels of baseline severity, while others presented with more mild or moderate levels. In the case of some of the symptom-based measures, some consumers presented in the "normal range". Overall, this suggests that Better Access is not only reaching consumers with mild to moderate mental health conditions as it was originally intended to do,² but that it is also providing services for those with more severe mental illness. The finding that some consumers presented in the "normal range" warrants further exploration. In some cases, it may be that the particular measure was not capturing the consumers' presenting issue (e.g., a measure of anxiety being used for a person who presented for care with depression). However, in others it may suggest issues relating to the threshold and appropriateness of referral.

In terms of outcomes, the picture was largely positive. In general, there was evidence of consumers' experiencing significant improvements in their symptoms and functioning in over half of the episodes of care that we examined.

For the most part, the proportions of consumers showing positive outcomes was similar, irrespective of their sex or age. There was, however, some evidence that relatively fewer older consumers showed improvement.

In determining levels of improvement, we only considered change in severity of symptoms and levels of functioning between the first and last outcome assessment in any given episode. However, in an effort to glean proxy information on the number of sessions in a given episode, we also captured information on the total number of outcome assessments that were done. This method was imperfect because sessions in which measures were not administered would not have been captured, and there were suggestions that the number may have varied depending on the outcome measure used. The number of outcome assessments was not usually associated with differential levels of outcome, but where it was there was a tendency for proportionally greater improvement in episodes with more outcome assessments. This hints at there being a greater likelihood of improvement with a greater number of sessions, although there may be other explanations, for the reasons mentioned above. The notion is supported to some extent,

however, by the fact that inactive clients (i.e., those who had completed treatment) showed greater levels of improvement than active clients.

The only consistent difference in terms of outcomes was related to baseline severity (i.e., consumers' levels of symptoms or functioning when they began the episode of care). Episodes of care were delivered to consumers with varying levels of baseline severity. Irrespective of the measure used, those with more severe baseline scores had a greater probability of showing improvement over the course of the episode. Conversely, those with the least severe baseline scores were the most likely to deteriorate over the course of the episode.

These findings require careful interpretation. Overall, it is positive that, irrespective of the measure used, consumers' mental health improves during a majority of episodes of care. It is also positive that this improvement is related more to indicators of clinical need (i.e., baseline severity) than to demographic factors (e.g., age and sex). However, it is worrying that consumers experience deterioration in their mental health in not insignificant numbers of episodes, and that some show no change. These consumers are most likely to be people who began their episode with relatively mild symptoms or high levels of functioning or satisfaction with life.

Study 3: A survey of the experiences and outcomes of consumers recruited through Medicare

Like Study 2, Study 3 examined the effectiveness of Better Access. It also considered the program's responsiveness and appropriateness. More specifically, it captured the experiences and outcomes of a large group of consumers who had used Better Access.

Study 3 involved a cross-sectional survey of consumers who had received treatment from clinical psychologists, psychologists, social workers and occupational therapists via Better Access during 2021. Services Australia identified a stratified random sample of 27,167 eligible consumers for us and mailed them an invitation on our behalf. Interested consumers then completed the survey online. The survey was ultimately completed by 2,013 consumers. Of these, 1,317 (65%) consented to their survey data being linked to their MBS claims data.

The Study 3 survey presents a positive picture of Better Access from the perspective of consumers. Our survey participants saw a range of providers, usually because they were feeling depressed, anxious or stressed and recognised that they needed some help with their problems. Two thirds were still receiving care at the time of the survey, and around half had attended, or were likely to attend, more than 10 sessions. The majority had received at least some sessions face-to-face, but half had also received some via telehealth, presumably indicating the popularity of the latter types of sessions during the COVID-19 pandemic. Almost all participants had received their sessions individually, rather than in a group. Most participants paid some out-of-pocket costs for their care.

One third of our participants were new to Better Access and two thirds had received care through the program previously. The proportion of new users is lower than the proportion we identified in Study 1b (50%) which is likely to reflect differences due to our sampling strategy and the treatment period of interest.

Over half of our participants were given a diagnosis at time of seeking care through Better Access. The most common diagnoses were anxiety disorders and depression, but a broad range of other diagnoses were endorsed as well. Around one third said that they were not given a diagnosis, however. This warrants further exploration, given that having a diagnosed mental disorder is one of the eligibility requirements for Better Access. It is possible that some of these consumers were given a diagnosis but did not recall this happening or were not made aware of the specific diagnosis. There may also be other issues at play, including inappropriate referrals, inadequate communication between providers and referrers, or stigma.

The experience of care was positive for most participants. They valued their relationship with the mental health professional and felt that the strategies that the mental health professional equipped them with met their needs. The vast majority said that they were satisfied or very satisfied with their care. A much smaller minority provided indications about some aspects of their care that could be improved. For example, some found that the out-of-pocket costs were too high, and some felt that they had to wait too long for an appointment. Some also ceased their sessions early because they didn't find the sessions helpful, or because they didn't like the mental health professional's manner or approach.

Overwhelmingly, participants experienced good outcomes from their Better Access care. The self-rated mental health of 91% of all participants improved. A majority attributed this improvement – at least in part – to the treatment they received from the mental health professional. Baseline self-rated mental health and the number of sessions were associated with improvement.

When we analysed data from the subgroup of participants who gave us permission to link their survey data to their MBS claims data, we found that they were similar to the total sample in terms of their sociodemographic characteristics. They also reported similar patterns of care. About two thirds of this subgroup paid a median co-payment of \$71.60 per session for their care. The median was lower (\$61.75) for those who thought their care was affordable and higher (\$77.55) for those who thought that it was too expensive. As with the total sample, the vast majority of this subgroup indicated that their self-rated mental health improved over the course of their episode of Better Access care. Again, the strongest predictors of improvement and deterioration was baseline self-rated mental health. For the subsample, paying a co-payment was also associated with improvement.

Study 4: Consumer characteristics, treatment patterns, and clinical change associated with Better Access treatment services: Re-analysis of data from two randomised controlled trials

In Study 4, we used data from participants who made up the control groups of two randomised controlled trials (Target-D³ conducted in 2016-2019 and Link-me⁴ conducted in 2017-2019) in an effort to provide further insights into the accessibility, appropriateness and effectiveness of Better Access.

The Target-D participants had depression, and the Link-me participants had depression or anxiety. Using self-reported service use information collected in the trials, we classified participants who reported visits to a psychologist, social worker or occupational therapist in a private practice setting as users of Better Access treatment services. We also identified consumers who reported use of other mental health professionals/services (including visits to GPs, other mental health specialists, other health professionals, emergency department visits, overnight hospital admissions, and taking mental health-related medications). Across the two trials, 314 consumers were classified as having used Better Access treatment services delivered by allied health professionals (with or without other mental health professionals/services) over a 12-month follow-up period, 420 who used other mental health professionals/services only, and 207 who used none of these mental health professionals/services.

We found evidence that participants classified as users of Better Access had worse mental health symptoms and functioning at baseline than those who used other forms of mental health care only, who in turn had worse mental health than those who did not use mental health care. In contrast, they had similar baseline levels of general health and quality of life, and mental health-related medication use, compared to those who used other forms of mental health care. Our results suggested that those aged 56 years and over may be less likely to use Better Access treatment services than other forms of mental health care. This finding is consistent with other studies, and may reflect attitudes and beliefs of both consumers and practitioners about the benefits of psychological therapy for this group.^{5,6} We also found that consumers classified as users of Better Access treatment services were more likely to report difficulty managing on their income at baseline. Otherwise, the sociodemographic characteristics of Better Access treatment users were generally similar to those who used other forms of mental health care.

We explored the mental health service use patterns of participants classified as users of Better Access treatment services, noting that both trials were completed prior to the introduction in October 2020 of an additional 10 treatment sessions in response to the COVID-19 pandemic. We estimated that, over the 12-month period they were followed up, they used an average of seven Better Access treatment sessions. Half to two thirds had made out-of-pocket payments for these sessions. Those predicted to have moderate or severe depression or anxiety in the next three months used more Better Access treatment services and other mental health services than those predicted to have minimal/mild depression or anxiety. They also paid more in total out-of-pocket costs for their care because they used more services.

We were able to explore changes over time in depression and anxiety symptoms, quality of life and functioning among participants classified as users of Better Access treatment services. Approximately half reported significant improvements in their mental health symptoms and functioning and quality of life over 12 months (43-55%, depending on the measure). This was despite the fact that the measures were collected at set points in time in the original Link-me and Target-D trials, and that these were not designed to correspond with the start and end of a Better Access treatment episode. Approximately one quarter to one third experienced significant deterioration over the same period (22-32%, depending on the measure). Significant improvement was most consistently associated with poorer baseline levels of mental health and poorer short-term prognosis. People aged 36-55 years or 56 years and over tended to have lower odds of significant improvement in anxiety symptom severity, while females and those with a certificate/diploma qualification had lower odds of significant improvement in functioning, as measured by days out of role. Conversely, significant deterioration was most consistently associated with better baseline levels of mental health, people aged 56 years and over had higher odds of significant deterioration in anxiety symptom severity, while females and those with a certificate/diploma qualification had higher odds of significant deterioration in functioning.

We found some evidence that, over the 12 months of follow-up, using five or more sessions of Better Access treatment increased the odds of significant improvement, or reduced the odds of significant deterioration, in anxiety and depression symptoms among those with a more severe prognosis.

Study 5: Examining the outcomes of Better Access at a population level using data from two longitudinal studies (Ten to Men and the Australian Longitudinal Study on Women's Health)

Study 5 involved analysis of data from two large-scale Australian longitudinal studies, Ten to Men (the Australian Longitudinal Study on Men's Health) and the Australian Longitudinal Study on Women's Health (ALSWH). Both Ten to Men and ALSWH have followed participants over multiple waves of data collection. By using data from Ten to Men and ALSWH, we were able to identify groups of participants with "mental health need" at baseline. Using linked MBS data, we were then able to identify a sub-group who used Better Access treatment services between waves of data collection.

There was considerable variability in Better Access use across cohorts and over time. When we compared those who had used Better Access treatment services in any given analysis with those who had not done so, certain characteristics stood out. For the most part, these characteristics related to clinical need, which would appear to be appropriate. For example, when we used adapted versions of the Target-D and Link-me algorithm from Study 4 to classify participants' likely severity of depression and/or anxiety in three months' time, Better Access users were more likely to fall into the "severe" prognostic severity group. They were also more likely to have a history of depression or anxiety, and to be taking medication for their mental health. However, likelihood of using Better Access treatment services also differed as a function of where people lived, with those in rural areas being less likely to use these services.

Those who did use Better Access treatment services typically accessed a median of 5-6 sessions over the given analysis periods, usually from clinical psychologists and/or psychologists. The results should be considered in the context of the analysis periods in the Study 5 which ranged from 1.87 years to 5.65 years. Half to three quarters of participants paid at least some out-of-pocket costs, with those who did so

typically paying between \$80 and \$100 per session. There was a relationship between prognostic severity and these patterns of service use: those in the “severe” group tended to use more sessions, and those in the “minimal/mild” group were generally more likely to pay out-of-pocket costs. This suggests that those with the greatest levels of need were not only more likely to access Better Access treatment services (as noted above), but also that they were likely to access a greater number of sessions and to pay less for doing so.

Many participants who used Better Access treatment services experienced improvements in their mental health over the given analysis period. Typically, between around 45% and 55% of these participants had better mental health at the end of the analysis period than they did at the beginning. It would be drawing a long bow to attribute this improvement to their use of Better Access treatment services, particularly given the length of the analysis periods. Nonetheless, this degree of improvement is reasonably consistent with the findings from Studies 2 and 4 which used similar standardised measures of mental health to assess change over time.

Study 6: Qualitative interviews with people with lived experience of mental health conditions

Study 6 involved qualitative interviews with people with lived experience of mental health conditions who had and hadn’t received services from allied health professionals under Better Access throughout 2021. We recruited 23 users and 14 non-users of Better Access through Beyond Blue’s Blue Voices network and through Lived Experience Australia.

Overall, Study 6 paints a positive picture of Better Access from the perspective of users. Most users felt that the referral process was reasonably smooth and direct. With a few exceptions, most participants felt that their mental health treatment plans were accurate. Most participants had a mixture of face-to-face and telehealth or phone sessions. Face-to-face sessions were generally preferred as participants felt that it was easier to establish rapport and trust with the mental health professional in a face-to-face situation. Most participants felt that the number of sessions available to them through Better Access was too few, particularly for mental health conditions that were perceived to be more complex.

All Better Access users reported positive changes to their health and wellbeing since seeing a mental health professional. These positive changes included improved mood, improved sleep, increased social confidence, as well as feelings of hope and empowerment. Mental health professionals also assisted participants to get back into the workforce or to better manage their chronic pain. The manner and approach of the mental health professional was perceived to be the main reason for positive changes in participants’ health and wellbeing. Feeling safe and heard was particularly important, as was the willingness of mental health professional to provide unbiased, compassionate feedback. The provision of techniques and strategies for managing mental health conditions in day-to-day life was also highly valued by participants.

Most non-users of Better Access reported that they were aware of the program. Their primary reasons for not utilising Better Access were because they were receiving mental health support through other services and providers (e.g., GPs, hospital based psychiatric services) and other funding schemes (e.g., the NDIS, employment-sponsored arrangements).

For both users and non-users, barriers to accessing the program were mostly financial. For example, many felt that the gap payment was too high, or that taking time off work to visit a mental health professional and losing income was difficult. Other barriers related to the availability of providers, and to perceived mismatches based on providers’ approaches or skillsets and consumers’ needs. Difficulties with the GP referral process were also mentioned. Among Better Access users, enablers were mostly financial; the fact that services were subsidised was seen as a significant benefit. Among both groups, other primary enablers to accessing Better Access were GP factors (having a good relationship with the GP, the GP being aware of Better Access, and the GP knowing when to refer and who to refer to) and mental

health professional factors (having a good rapport and feeling safe and comfortable with the mental health professional, being offered flexible appointments).

Looking to the future of Better Access, both users and non-users expressed a desire for the number of sessions to be increased for all users or for those people with more complex mental health needs. In addition to this, some wished to see free sessions or greater subsidy of sessions. Both users and non-users suggested that the program could also be improved by modifying the referral process and undertaking community promotion. Non-users added to this list, suggesting that further improvements could be made by increasing the flexibility of service delivery, reducing the costs of care, and tailoring care to consumers' specific needs.

Study 7: A survey of providers and referrers

Study 7 also provided insights into the responsiveness and appropriateness of Better Access, this time from the perspective of providers and referrers. It involved an online survey of providers and referrers from the main professional groups whose services are eligible for rebates under Better Access. Participants were recruited through provider organisations, which circulated an invitation notice to their respective memberships for us. In total, 2,386 providers and referrers responded to the survey: 572 clinical psychologists; 1,140 psychologists; 398 social workers; 104 occupational therapists; 45 GPs; and 126 psychiatrists.

The majority of the survey participants had provided Better Access services in 2021. Over 95% of the clinical psychologists, psychologists and social workers had provided psychological therapy services or focussed psychological strategies, as had 79% of the occupational therapists. They most commonly provided these as individual sessions, typically because they felt that group sessions were hard to arrange and financially unviable. Ninety six percent of the GPs had prepared or reviewed mental health treatment plans, 74% had used the mental health treatment consultation items, and 23% had used the focussed psychological strategies items. Around half of the psychiatrists (54%) had prepared or reviewed a psychiatrist assessment and management plan or conducted an initial consultation with a new consumer. The majority of GPs and psychiatrists who had not used the relevant Better Access items had provided equivalent services but done so using other item numbers. Only a small minority of providers in any provider group had delivered the relevant Better Access services in residential aged care settings.

Each provider group was extremely positive about the outcomes that Better Access achieves for consumers. Over 80% of the clinical psychologists, psychologists, social workers, and occupational therapists agreed or strongly agreed that Better Access enables them to provide consumers with mental health care that they can benefit from, that reduces their symptoms, that improves their levels of functioning, that addresses their presenting issues, and that improves their overall mental health and wellbeing. Around 70% of GPs also agreed or strongly agreed that by creating opportunities for them to refer to these allied health professionals and by enabling them to provide mental health care themselves, Better Access achieves these sorts of outcomes for consumers. Nearly 70% of psychiatrists also agreed or strongly agreed that Better Access has improved outcomes for consumers.

All provider groups were less positive about the processes underpinning Better Access. The most common concerns related to the cost and timeliness of Better Access care for consumers. Over 50% of participating psychologists and occupational therapists disagreed or strongly disagreed that Better Access enables them to provide consumers with mental health care that is affordable, as did over 30% of social workers and over 25% of clinical psychologists. GPs' responses were similarly weighted in this direction regarding the affordability of the scheme, and they also expressed concerns about timeliness, as did psychiatrists.

Other common themes emerged for the different provider and referrer groups through the various questions in the survey. Often these related to the interface between providers. Allied health professionals commonly cited barriers related to communication and collaboration. For example, 81% of

clinical psychologists cited difficulties with the process of referral and review as a barrier, and around 70% of all allied health professionals noted that good communication with referrers was a facilitator. GPs also commonly noted that good communication with relevant allied health professionals and good documentation from these professionals were key facilitators.

Other perceived barriers related to the administrative processes and “rules” around Better Access, and, in some cases, the funding arrangements. With respect to the latter, high proportions of psychologists, social workers and occupational therapists felt that the Medicare rebate doesn’t adequately recompense providers for their time.

Study 8: A consultative virtual forum on future reforms to Better Access

Study 8 involved consultations with a broad range of key stakeholders about future reforms to Better Access. We used a novel online approach that sought stakeholders’ views over three phases. Phase 1 involved an online survey designed to identify the most salient issues for Better Access going forward from the perspectives of participating stakeholders. The main topics raised in the survey were distilled into a set of “synthesis statements” that captured the general views expressed under each topic. In Phase 2, stakeholders discussed and debated these synthesis statements in an online discussion forum, and the statements were then further revised. In Phase 3, stakeholders completed a second online survey in which they were asked to rate their level of agreement with the revised synthesis statements and rank priorities for reform.

We invited 104 individuals representing different stakeholder groups to take part, most of whom were nominated by relevant professional and non-government organisations. In total, 90 (87%) participated. These comprised 35 current eligible service provider representatives, 18 current ineligible service provider representatives, one First Nations service provider representative, 23 consumers, people with lived experience, and carer representatives, four representatives from advocacy organisations, four health system experts, and five policy makers.

From the three-stage process a collective view emerged that people are finding it increasingly difficult to access Better Access, particularly for those with relatively fewer socioeconomic resources and those in regional, rural, and remote areas. There was consensus that addressing issues of affordability and geographic access was important to maintain the intent of the program and for reasons of equity. Affordability was particularly prominent, standing out in the ranking exercise. Two general approaches to addressing these issues were mooted. The first focussed on increasing funding to the program in its current form using levers like higher rebates and incentives for bulk-billing. The second centred around expanding the program parameters by increasing the range of eligible providers and expanding the types of therapy permissible through the program. There were dissenting views on both of these approaches. In the case of the first approach, although there was consensus that the rebate levels are currently too low and do not reflect the costs of running a private practice, there were concerns about providers benefiting from rebate increases rather than consumers. For the second approach, there were diverging views about the impact of expanding provider and therapy types on the quality and effectiveness of care.

There was a collective view that the scope of Better Access required expansion. This was seen to be driven, in large part, by the fact that consumers with increasingly complex needs are using Better Access. Participants felt that the original intent of Better Access as a means of providing short-term care for people experiencing mild to moderate mental illness did not accommodate the cohort with more complex needs. They noted that the therapies offered were too restrictive, and that multidisciplinary holistic models of care that address broader social determinants were required to adequately treat the broader group of consumers now using the program. There was a collective view that Better Access should be expanded to address this. However, there were dissenting views about the best way to do this. As noted above, some favoured expansions to the range of allied health professional providers and types of therapies offered. Some thought that the workforce should be expanded further still to include peer workers. Some suggested making Better Access care more integrated and multidisciplinary. Others

mentioned increasing the number of sessions available in order to provide longer-term care. And some suggested removing the requirement that consumers be given a diagnosis to access care. There was not universal agreement about any of these approaches, and various objections were raised (e.g., the suggestion that levels of funding required for some would be prohibitive). However, there was a general implicit acknowledgement that any reforms should recognise mental illness as a psycho-social phenomenon and that treatment should involve more than a brief stand-alone clinical intervention.

In terms of the Better Access processes and requirements, collective views emerged regarding the GP referral and review processes, diagnosis requirements, and session number limits. There was a broad consensus that the Better Access referral and review processes could be improved, again with divergent views on how this might best be achieved. The collective view was that GPs had an important role to play in the program. However, there were different views on what the scope of that role should be, ranging from GPs providing a simple referral, to GPs continuing to complete mental health treatment plans, to GPs acting as *de facto* care coordinators. There were diverging views on the utility of mental health treatment plans and on suggestions for reform of the referral process, although there was general agreement that increasing awareness among GPs and consumers about what providers and treatments were available under Better Access was worthwhile. Collectively, it was acknowledged that there are many demands on GPs, and limitations regarding access to and the capacity of GPs need to be considered in any reform of the Better Access processes. There was also a collective view that the current GP review process is burdensome and adds little value, although having some mechanism for interaction between GPs and allied health professionals was seen as important. There was also a collective view that the requirement for one of a limited set of mental illness diagnoses was undesirable for a range of reasons (e.g., consumer need, clinical practice) and that fixed limits on session numbers was not compatible with best practice. No consensus was reached on the issue of different levels of rebate for current Better Access providers.

With respect to ongoing quality assessment and improvement of Better Access at a program level, there was a collective view that, in principle, routine outcome measurement could provide useful data. However, it was not endorsed across the board. Concerns were expressed about the practicalities of implementation, the relevance and utility for clinical practice, and the potential use of such data for compliance monitoring.

Finally, the collective view expressed across multiple areas was that consumers should be more involved in their own care and that the voice of people with lived experience be included in program reform initiatives. However, although participants expressed support for these general principles, they did not offer suggestions for how they might be achieved.

Study 9: Piloting a routine outcome measurement and feedback system

Study 9 was designed as a proof-of-concept exercise in the feasibility, acceptability, and utility of routine outcome data collection. Service providers were asked to enrol eligible consumers (new consumers who received treatment through Better Access) and assess them at each session using the Depression Anxiety Stress Scale (DASS-21).^{7,8} The NovoPsych digital platform (<https://novopsych.com.au/>) was used to manage the data. Participating providers were invited to complete an online survey about their experience with routine outcome measurement (feasibility) and their views on the acceptability and utility of routine outcome measurement for consumers, themselves, and their peers and profession as a whole.

Fifty six providers were enrolled in the study for its duration. Twelve of these providers collected outcome data from 35 consumers. The quality of the available data was relatively high, but there were issues with the comprehensiveness and consistency of data collection. There was data loss due to consumers declining to participate in the study, and no outcome measurement data being collected for some consumers who did agree to take part. There were also issues with adherence to the data collection

protocol, with signals that outcome data were not always collected at the first session, and with subsequent sessions also being missed.

The lower-than-expected number of providers who registered interest in piloting routine outcome measurement was disappointing, as was the fact that fewer still went on to participate. This may be due to a range of study related factors (e.g., the brief recruitment period, the fact that many providers are not accepting new consumers, evaluation fatigue), but it may also indicate a general wariness of routine outcome measurement on the part of providers.

The provider survey, completed by 25 providers, offers broader insights into the likelihood that providers would find routine outcome measurement acceptable and useful if it was rolled out at scale. Among survey participants, there was very strong acceptability of including routine outcome measurement to support clinical practice, albeit with some caveats. The majority of survey participants also supported the idea of providing deidentified outcome data for program-level monitoring and quality improvement but they had a number of reservations about doing so, particularly around how the data would be used, data security and privacy, and the logistics and burden of implementation. The former indicates the need for comprehensive and transparent communication to build trust and support, while the latter indicates that the financial and time burdens associated with program-wide outcome data collection need to be addressed. Survey participants indicated lower levels of likely acceptability from peers and their professions as a whole, although many were reluctant to speak on behalf of the profession.

Survey participants also considered the likely acceptability of routine outcome measurement to consumers. They noted that communication and information were key issues in terms of promoting the acceptability of routine outcome measurement to consumers. Communication about the purpose and benefit of outcome measurement and information and transparency about the uses of the data as well as privacy and data security issues were seen as important. The time taken during a session to do complete given measures was cited as a concern for consumers, however providers reported that there was substantial non-response when they tried to have consumers complete the measure prior to the session by following a link sent to them before the session. Increasing consumer buy-in would likely improve response. Addressing all of these issues is likely to involve upskilling and motivating providers who could then demonstrate the benefits convincingly to consumers, provide assurances about privacy data security, and seamlessly integrate measurement into their sessions as part of routine clinical practice to counter perceptions that it was something extra that was taking up treatment time.

Survey participants suggested that implementing routine outcome measurement at scale for a program as large as Better Access would need to be done carefully and systematically. They considered that it would likely require a purpose-built platform that was able to interface with a variety of practice-management software, be easy to use and secure, and have flexibility in terms of modes of administration of measures. In terms of the feasibility of collecting outcome data for program monitoring and quality improvement, providers considered that additional incentives and motivation-building for providers to participate would probably be required to bolster provider engagement over and above the benefits it might bring to their clinical practice.

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 depression, anxiety and/or psychological distress 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.^b

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 2021.⁹ 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 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.

^b 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.

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