

Evaluation of Better Access

MAIN REPORT

Jane Pirkis, Dianne Currier, Meredith Harris, Cathy Mihalopoulos

Vikas Arya, Michelle Banfield, Bridget Bassilios, Ben Buchanan, Peter Butterworth, Lisa Brophy, Philip Burgess, Mary Lou Chatterton, Miranda Chilver, Kathy Eagar, Jan Faller, Ellie Fossey, Maria Ftanou, Jane Gunn, Ariel Kruger, Long Le, Danielle Newton, Leo Roberts, Katrina Scurrah, Roman Scheurer, Matthew Spittal, Caley Tapp, Tim van Gelder, Michelle Williamson

8 December 2022

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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
 - o Study 1a: An analysis of MBS data
 - Study 1b: Analysis of data from the Multi-Agency Data Integration Project (MADIP)
 - o 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
 - o 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).

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 non-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 beforeand-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.

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 associated with a certificate/diploma qualification had lower odds of significant improvement in 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 associated with a certificate/diploma qualification had to be aged 56 years and over had higher odds of significant deterioration in anxiety symptom severity.

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, 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 (<u>https://novopsych.com.au/</u>) 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 later 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 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.

1. Background

The Better Access initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative (Better Access) was introduced in November 2006 in response to low treatment rates for mental disorders. The ultimate aim of Better Access is to encourage more people to seek support for their mental ill-health. It works to improve 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

Better Access 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. Key features of these items are summarised in Table 1.1 below. Note that the focus is on how the Better Access MBS items interface with each other. The complete list of Better Access MBS items is provided in Appendix 1.

ITEM GROUP	PROVIDER(S)	DESCRIPTION
Preparation of a	GP/other	• For consumers with a mental disorder ^b for who would benefit from a structured
mental health	medical	approach to management of their treatment needs.
treatment plan	practitioners ^a	• Consumers with a plan can be referred for a course of psychological therapy services
		or focussed psychological strategies (see below). ^c
		• A new plan is needed only if clinically required, and usually not within 12 months of a previous plan.
Review of a	GP/other	• For assessing and managing the consumer's progress under a mental health
mental health	medical	treatment plan or a psychiatrist assessment and management plan (see below).
treatment plan	practitioners	• Should be conducted at least once, initially four weeks to six months after the plan is
		prepared and, if required, at least three months after the first review.
Mental health	GP/other	• For providing extended consultations to a consumer whose primary treating problem
treatment	medical	is a mental disorder. Consultations must involve: taking a relevant history or
consultation	practitioners	identifying a presenting problem; providing treatment, advice or referral; and
		documenting consultation outcomes.
		• Can be provided to consumers with a mental health treatment plan or psychiatrist
		assessment and management plan, but a plan is not required to claim this item.
		Can be used to provide ongoing management if the consumer has reached the
		maximum yearly number of treatment sessions (see below).
Psychological	Clinical	• To provide psychological assessment and therapy for a mental disorder, where an
therapy services	psychologists	appropriate referral has been made.
		Consumer can access up to 10 individual sessions per calendar year (temporarily
		increased to 20 until 31 December 2022), and a further 10 group sessions.
Focussed	Psychologists,	• To provide focussed psychological strategies for a mental disorder, where an
psychological	GP/other	appropriate referral has been made. Approved strategies include: psycho-education,
strategies	medical	cognitive-behavioural therapy, relaxation strategies, skills training, interpersonal
	practitioners,	therapy and eye-movement desensitisation reprocessing.
		Consumer can access up to 10 individual sessions per calendar year (temporarily
		increased to 20 until 31 December 2022), and a further 10 group sessions.

Table 1.1: Summary of Better Access MBS items

ITEM GROUP	PROVIDER(S)	DESCRIPTION
	social workers, occupational therapists	
Preparation of a psychiatrist assessment and management plan	Psychiatrists	 Upon referral from a GP/other medical professional or nurse practitioner, to develop a treatment plan to be implemented by the referring practitioner. Treatment may be via focussed psychological strategies items delivered by GPs/other medical practitioners (see above). A psychiatrist can recommend treatment by an allied health provider. When a psychiatrist assessment and management plan is in place, the GP/other medical practitioner can make the referral to the allied health provider without needing to complete a separate mental health treatment plan.
Review of a psychiatrist assessment and management plan	Psychiatrists	 Initiated by the referring practitioner, usually where the current psychiatrist assessment and management plan is not achieving the anticipated outcome. From this item, the consumer can be referred to an allied health professional for psychological therapy services or focussed psychological strategies (see above). A psychiatrist assessment and management plan can also be reviewed by a GP/other medical practitioner using the dedicated items for review of a mental health treatment plan (see above).
Initial patient consultation	Psychiatrists	 To encourage an increase in the number of new patients seen by a psychiatrist, upon referral from a nurse practitioner, medical practitioner practising in general practice, a specialist or another consultant physician. From this item, the consumer can be referred to an allied health professional for psychological therapy services or focussed psychological strategies (see above).

Source: Australian Government Department of Health and Aged Care¹⁰

^a Other medical practitioners became eligible to provide services under Better Access in July 2018. Other medical practitioners are medical practitioners who are not vocationally recognised as general practitioners, specialists or consultant physicians. They are granted access to Medicare provider numbers due to practicing within a rural and remote areas or currently undertaking an approved training program and working towards attaining a fellowship.

^b Dementia, delirium, tobacco use disorder and mental retardation are not regarded as mental disorders for the purposes of the mental health treatment items.

^c Other MBS items (not regarded as Better Access items) can also be used to refer consumers to Better Access psychological treatment (see Appendix 1 footnote b).

Over time, the "rules" around Better Access have changed (see Appendix 2). Most of the changes relate to the permissible number of sessions of psychological therapy or focussed psychological strategies that any individual can access in a given year, but new item numbers have been added at different stages to enable people who might otherwise be disadvantaged (e.g., people in rural and remote areas) to preferentially access care (e.g., via videoconferencing).

The most recent set of changes, which were progressively introduced from March 2020, relate to COVID-19 and recognise the mental health impacts of the pandemic. These changes have culminated in the current arrangements where individuals can now access up to 20 individual face-to-face, phone or telehealth sessions per calendar year (i.e., 10 additional sessions over and above the previous arrangement), irrespective of where they live. Consumers living in residential aged care facilities (RACFs) can also access up to 20 individual sessions via dedicated item numbers, either in their RACF or in the provider's rooms, and again face-to-face, via phone or telehealth. In both cases, the arrangements were in place until 31 December 2022 when we began the evaluation.

Better Access in context

Better Access represents the bulk of Medicare funding for mental health services, although there are some Medicare funded services that fall outside Better Access (e.g., the majority of services provided by psychiatrists). In turn, Medicare-funded services represent one component of all Australian Government-funded mental health services. Others include mental health services commissioned by Primary Health Networks (PHNs), headspace services and the new Adult Mental Health Services. In addition, there are two other major funders of mental health services in Australia: state and territory governments and private health and other third party insurers.

In 2019-20, the latest year for which data are publicly available from the Australian Institute of Health and Welfare,¹¹ total expenditure from these three sources was just over \$11 billion. \$1.4 billion of this (12%) was for Medicare-funded services. As noted, the majority of this expenditure will have been for Better Access services.



Figure 1.1: Expenditure (\$ million) on mental health-related services, by source of funding, 2019-20

Source: Australian Institute of Health and Welfare¹¹

Previous evaluation and review of Better Access

A multi-component evaluation of Better Access was commissioned by the then Department of Health and Ageing in late 2008, after the scheme had been in place for around two years. Our team undertook several of the components of that evaluation, including a study of consumer outcomes,^{12,13} a consumer experiences study,^{14,15} and an analysis of MBS and Pharmaceutical Benefits Scheme (PBS) data.¹⁶ We brought all of the components together in a summative evaluation which concluded that:

"Better Access has increased access to mental health care for significant numbers of Australians. This includes many people who have been traditionally disadvantaged in the past. It has achieved good clinical outcomes for many of these consumers. These achievements should not be underestimated. Good mental health is important to the capacity of individuals to lead a fulfilling life (e.g., by studying, working, pursuing leisure interests, making housing choices, having meaningful relationships with family and friends, and participating in social and community activities). This major mental health reform seems to have improved access to and outcomes from primary mental health care for people with moderate to severe common mental disorders."¹⁷

More recently, four major reviews and inquiries have considered Better Access. The MBS Review Taskforce reviewed all 5,700+ items on the MBS, examining the extent to which the items are meeting the goal of providing affordable and universal access, best practice healthcare, and value for individual consumers and the overall healthcare system. It examined issues relating to incremental changes to the scope of the MBS, many of which were directly relevant to Better Access (e.g., the addition of allied

health professionals as eligible providers). It recommended that a continuous MBS review mechanism be implemented, and that systems be put in place to measure outcomes of care, rather than just the services delivered. It also recommended that the relative values of individual MBS rebates should be considered, and that funding models that complement fee-for-service delivery should be explored.¹⁸

The Productivity Commission Inquiry into Mental Health considered Better Access in the context of a broader inquiry into the roles and responsibilities of different levels of government in improving mental health to support economic participation and enhance productivity and economic growth. The Productivity Commission Inquiry noted that certain sessions (e.g., group sessions) are underutilised, and that improved access to telehealth should be a matter of priority. It also noted that GP referrals do not always match consumer need to the most appropriate level of intensity of care, and that these referral pathways could be improved. In addition, it noted issues relating to the mental health workforce, wait times, out-of-pocket costs, and affordability. Like the MBS Review, the Productivity Commission Inquiry recommended that consumer outcomes should be measured, specifically suggesting that this should be done in such a way as to inform practice (i.e., by providing feedback to providers on consumers' progress). It also recommended that an evaluation of Better Access was urgently needed.¹⁹

The House of Representatives Select Committee on Mental Health and Suicide Prevention also considered Better Access within its broader remit. The Committee identified a number of barriers to use of Better Access, most notably affordability and workforce composition, supply and distribution. The Committee recommended that future reforms to Better Access focus on the viability of bulk-billing incentives for allied health professionals, varying rebate levels for different providers and different activities, the cap on the number of sessions, and the referral process.²⁰

The Royal Commission into Aged Care Quality and Safety also considered Better Access, specifically doing so in the context of looking at the impact of COVID-19 on aged care. It recommended that Medicare items should be created to "increase the provision of allied health and mental health services to people living in residential aged care during the pandemic to prevent deterioration in their physical and mental health."²¹ This recommendation led to the creation of the RACF items mentioned above.

Most recently, the Strengthening Medicare Taskforce has been established to provide concrete recommendations to the Australian Government on improving affordability of and access to primary care (including access to multidisciplinary team care involving GPs and allied health professionals). It has a particular focus on improving prevention and management of ongoing and chronic conditions, including mental health conditions.²²

The current evaluation of Better Access

The Australian Government Department of Health commissioned a new evaluation of Better Access in 2021, recognising that the program had been running for almost 15 years. Our team was commissioned to conduct the evaluation. A brief summary of the evaluation is provided here; more detail is provided in Section 2.

Our evaluation built on and made reference to the findings of the previous evaluation and review activities that have occurred in relation to Better Access. However, it collected data from multiple new sources, doing so in a more systematic way than had been possible in the past. It therefore provides insights that have not been available from the previous evaluations, reviews and inquiries.

The evaluation involved a mixed-methods approach, with quantitative and qualitative data drawn from multiple sources via 10 separate studies. Some of the studies were purpose-designed and others relied on existing data. We used some of these methods in our previous evaluation, but most were new. The approach was designed to give the evaluation breadth and depth and to maximise the utility of our findings, updating previous results and offering new insights. Using data from multiple studies meant that the strengths of one study could potentially address the limitations of another and vice versa. It also

meant that we could triangulate our findings in a way that allowed us to draw conclusions with greater confidence.

We conducted the evaluation over two stages. Stage 1 considered the effectiveness of Better Access in improving consumer outcomes and increasing access to mental health care. Stage 2 examined the issues identified under Stage 1 that impacted access to services, clinical efficacy and effectiveness of referral pathways and considered potential solutions to address these.

The evaluation involves 10 separate studies, seven in Stage 1 and two in Stage 2. The studies are listed in Table 1.2.

STAGE	STUDY
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

Table 1.2: Stages and studies in the evaluation

The current report

This Final Report presents findings from all of the 10 studies. Section 1 has described the broad context and scope of the evaluation. Section 2 provides a detailed overview of the evaluation, outlining its governance, its terms of reference, and the research questions it is designed to answer. Sections 3-12 describe in detail the methods we used in each of studies and present their findings. Section 13 summarises and synthesises the findings from each study, organising them around the evaluation's research questions. Section 14 offers conclusions and recommendations.

2. Evaluation overview

Governance

Throughout the evaluation, we worked closely with the Department of Health and Aged Care and the two evaluation advisory groups established by the Department: The Clinical Advisory Group (CAG) and the Stakeholder Engagement Group (SEG).

The CAG comprised individual mental health care specialists from the key provider types delivering Better Access services (i.e., clinical psychologists, psychologists, social workers, occupational therapists, GPs and psychiatrists). Members who were affiliated with a professional body or organisation participated in their individual capacity only and not as a representative of that professional body or organisation. The role of the CAG was to provide advice and guidance on clinical matters relevant to the evaluation.

The SEG comprised representatives from the broader mental health sector, including from mental health care provider groups who currently do and do not provide services under Better Access, consumer and carer representatives, and representatives from various population subgroups (e.g., First Nations people, older Australians, and people from cultural and linguistically diverse backgrounds). Members who were nominated by an organisation participated as a representative of that organisation and not in their individual capacity. Consumer and carer representatives contributed in their individual capacities. The role of the SEG was to provide advice and input on issues related to Better Access from across the full gamut of stakeholders.

We sought input and feedback from both groups at key points in the evaluation through formal meetings and out-of-session consultation. Appendix 3 provides lists of the CAG and SEG memberships.

Terms of reference

The evaluation's Terms of Reference are outlined below.

The key objective of the evaluation was to consider the effectiveness of Better Access in achieving its overall aims of improving consumer outcomes and increasing access to mental health care. It also set out to consider the effectiveness of the current Better Access model and recommend potential changes to enhance its ability to achieve its aims.²³

The evaluation findings will be used to inform future reforms to the Better Access initiative and/or other measures to improve access to mental health treatment and consumer outcomes.²³

The evaluation began in August 2021 and was completed in December 2022. As noted in Section 1, it comprised two stages:

- Stage 1 considered the effectiveness of Better Access in improving consumer outcomes and increasing access to mental health care, including:
 - a. the clinical efficacy of treatment provided, including individual consumer outcomes and population level outcomes;
 - the optimum number of sessions or course of treatment required, on average, to improve consumer outcomes, and the relative benefit of the additional 10 sessions on patient outcomes;
 - c. the appropriateness and effectiveness of current treatment planning mechanisms and referral pathways; and
 - d. factors impacting access to and uptake of services, including appropriateness of treatment and population demographics.

- Stage 2 considered the issues identified in Stage 1 that impact access to services, clinical efficacy and effectiveness of referral pathways and identify potential solutions to address these. In assessing potential solutions, consideration may be given to:
 - a. specific matters raised in the report from the MBS Review Taskforce, such as eligible providers and rebates under Better Access; and
 - b. specific matters raised by the Productivity Commission in its inquiry into mental health, such as availability of the mental health workforce, wait times, out-of-pocket costs and affordability.²³

Research questions

We took the above Terms of Reference and distilled them into the following research questions, organising them around issues of accessibility, responsiveness, appropriateness, effectiveness and sustainability as per the National Health Performance Framework.²⁴ In doing this, we also referred back to our original evaluation of Better Access,¹⁷ looking at whether research questions that were asked then are applicable for the current evaluation:

Accessibility

- 1. What is the overall level of uptake of Better Access services, and how has this changed over time (and in response to program refinements)?
- 2. Do patterns of uptake vary by different groups of item numbers (e.g., plans, treatment services, treatment services by provider type)?
- 3. Do patterns of utilisation vary by levels of co-payment?
- 4. What is the relationship between use of Better Access treatment services and use of other mental health services?
- 5. Who are the main users of Better Access?
- 6. Has Better Access reached groups in the population who are traditionally disadvantaged in terms of access to access to mental health care?

Responsiveness

1. What are the barriers and facilitators to consumers accessing Better Access?

Appropriateness

- 1. Is Better Access reaching consumers with mild to moderate mental health conditions?
- 2. What are the typical trajectories of care under Better Access (e.g., what proportion of plans are followed by treatment services, how many episodes of care involve a review)?
- 3. Do the treatment planning and referral pathways in Better Access work optimally?
- 4. Is the care provided through Better Access consistent with best practice?
- 5. Are mental health workforce issues impacting upon provision of Better Access?

Effectiveness

- 1. Does the mental health of consumers who receive care under Better Access improve?
- 2. Are outcomes better for some consumers than others?
- 3. Do certain treatment-based factors influence outcomes (e.g., the total number of sessions, the mode of service delivery)?

Sustainability

1. What might future reforms to Better Access look like?

2. What is the feasibility and acceptability of principles for routinely monitoring outcomes for consumers seen by psychologists and other allied health professionals delivering care through Better Access, and providing feedback to those providers?

Stage 1 studies

The first eight studies in the evaluation comprised Stage 1. These studies are described briefly below.

Study 1a: An analysis of MBS data

Study 1a involved a comprehensive analysis of MBS data, similar to the one we undertook in our previous evaluation of Better Access.¹⁶ More specifically, Study 1a involved an analysis of the uptake, utilisation, costs and patterns of services delivered under Better Access. With the Department of Health's help, we sourced aggregated, de-identified MBS and Pharmaceutical Benefits Scheme (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).

The findings from Study 1a are reported in Section 3.

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

We worked with colleagues from the Australian National University to analyse data from the Multi-Agency Data Integration Project (MADIP). MADIP is a secure data asset that links data on health, education, government payments, income and taxation, employment, and population demographics over time. It contains data on use of MBS item numbers, and by linking this information with information from various other sources we were able to answer questions that we were unable to answer through the other Stage 1 studies. For example, using MBS data that had been linked to data from the National Health Survey, were able to examine patterns of Better Access use and non-use in relation to need (as defined by scores on the Kessler-10, or K-10²⁵). Similarly, examining individual-level MBS data over time allowed us to look at the proportion of Better Access users who were "new" users and to look at Better Access service pathways. In addition, using linked MBS and Census data, we were able to look at the uptake of Better Access by First Nations people, children and young people and people with varying levels of income.

The findings from Study 1b are reported in Section 4.

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

Study 2 involved before-and-after study in which consumers' outcomes were assessed in terms of change on a variety of measures over the course of their episodes of care. We had initially planned to use data from a single large dataset held by NovoPsych (a subscription-based platform for collecting outcome data in a way that provides psychologists and other mental health professionals with feedback on their consumers' progress), but on the advice of the CAG and the SEG we also drew on data from three large psychology practices. We worked with the custodians of three of these datasets; we provided them with code to organise and analyse their data in a purpose-designed, consistent way, and they returned the outputs to our team. The custodian of the remaining dataset provided us with pre-existing outputs.

The findings from Study 2 are reported in Section 5.

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

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 eligible consumers for us and mailed them an invitation on our behalf. Interested consumers then completed the survey online. The survey focussed on participating consumers' experiences with receiving treatment through Better Access, and on their perceptions of the outcomes of this treatment. Survey data were linked to MBS claims data for consenting participants.

The results from Study 3 are reported in Section 6.

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 4 involved the re-analysis of data from two large-scale randomised controlled trials of tailored approaches to providing primary mental health care that were previously conducted by our team (Target-D³ and Link-me⁴). In each trial, participants with depression and/or anxiety were classified according to their baseline severity (minimal/mild or moderate, and severe) and followed for 12 months. Baseline severity was determined prognostically in the original trials using an algorithm that predicted the likely severity of symptoms in three months' time. Participants' service use was gauged via a Resource Use Questionnaire (RUQ), and mental health-related symptoms, level of functioning and quality of life were assessed using standardised measures. We re-analysed data from the control group participants in both trials. We used the RUQ to identify a subset of individuals who received Better Access treatment as part of their "usual care" and to see whether they differed from those who consulted other health professionals or services for mental health. We examined participants' patterns of use of Better Access treatment and other mental health care, and the extent to which they paid out-of-pocket costs for these services. We also examined factors associated with changes in their symptoms, quality of life and functioning at two points in time during the 12 months over which they were followed up.

The findings from Study 4 are reported in Section 7.

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 collect data on whether participants were diagnosed with a mental health condition in the past year and provided a means of capturing participants' self-rated mental health using standardised measures. Both studies also linked participants' data to their Medicare records, making it possible to determine whether they had received Better Access services. Because both studies have been conducted longitudinally, we were able to determine whether there was a change in individuals' mental health from one wave of data collection to the next if they had received services through Better Access. In addition, we were able to establish whether observed changes varied as a function of prognostic severity, the number or type of services received, or other factors. We used modified versions of the Target-D and Link-me algorithms to gauge prognostic severity.

The findings from Study 5 are presented in Section 8.

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

Study 6 involved in-depth qualitative interviews with people with lived experience of mental health conditions who had and had not used Better Access services in 2021. We recruited interview participants through Beyond Blue's Blue Voices network and through Lived Experience Australia's membership, using

an expression of interest (EOI) process. We deliberately sought a diverse sample of participants. We asked those who had used Better Access services why they had, what their experiences were, and whether they would change anything. We asked those who hadn't used them why they hadn't, what the barriers were, and what might make them likely to use them in the future.

The findings from Study 6 are presented in Section 9.

Study 7: A survey of providers and referrers

Study 7 involved a survey of providers and referrers from the main professional groups whose services are eligible for rebates under Better Access: clinical psychologists; psychologists; social workers; occupational therapists; general practitioners (GPs); and psychiatrists. Participants were recruited through provider organisations, which circulated an invitation notice to their respective memberships for us. Participants completed the survey online, offering their views on how well the Better Access program works, what the barriers and facilitators are to its use, and what modifications might be desirable.

The findings from Study 7 are presented in Section 10.

Intended augmentations to Studies 3 and 6: A focus on consumers in residential aged care facilities

We attempted to augment Studies 3 and 6 to give special attention to consumers in RACFs, in response to recommendations from the CAG and the SEG. In doing this, we grappled with a number of issues. The first was that the absolute number of people in residential aged care who have received services under the dedicated RACF Better Access item numbers is low. The RACF item numbers were introduced on 10 December 2020 and between that date and 31 May 2022, a total of 4,363 services were delivered to 2,595 individuals. The second issue was that we anticipated that there would be a lower response to invitations to complete the Study 3 survey or take part in the Study 6 interviews for this age cohort than for other groups. This might be due to a number of factors. For example, the stress in the sector due to the ongoing COVID-19 pandemic would have an impact on the capacity of staff to support residents to participate. In addition, digital access, literacy issues and poor health might act as barriers. We discussed these issues with the SEG representative from the Older Persons Advocacy Network and others to try to identify the best solution.

On the basis of these discussions, we asked Services Australia to approach <u>all</u> individuals who had received services via the RACF item numbers in 2021 (rather than a stratified random sample) and invite them to participate in the Study 3 survey (via a paper-based or an online version). For consistency with the main survey in Study 3, we focussed on the item numbers relating to treatment from psychologists, social workers and occupational therapists, and did not include other item numbers (e.g., GP-related item numbers). The total number of people approached by Services Australia was 301.

There was a final question on the survey that invited participants to take part in the Study 6 interview. Services Australia initiated the mail-out on 29 April 2022, and the survey was open until 17 June 2022.

The total number of participants who took part in the survey and the interviews was low (16 and two, respectively). We felt that these numbers were too low to generate meaningful data, and we held further discussions with the Older Persons Advocacy Network's representative on the SEG. Ultimately, the decision was made to not present any of the findings from the surveys or interviews with RACF residents.

Stage 2 studies

The last two studies in the evaluation were conducted in Stage 2. These are described below.

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

Study 8 involved consultations with a broad range key stakeholders about future reforms to Better Access. We used a novel online approach to seeking stakeholders' views and our aim was to identify a collective view of the most salient issues and priorities for future reform. We acknowledged that universal consensus could not be expected across the diversity of standpoints and interests stakeholders represented, but our goal was to identify those areas where consensus was strongest, as well as to capture the range of differences. The consultation process involved stakeholders nominating their priorities, taking part in a wide-ranging and inclusive discussion about the nominated priorities, and then participating in a rating and ranking exercise to assess levels of agreement and dissent.

The findings from Study 8 are presented in Section 11.

Study 9: Piloting a routine outcome measurement and feedback system

Study 9 piloted a routine outcome measurement and feedback system using the NovoPsych platform in a proof-of-concept way. More specifically, Study 9 explored the feasibility and acceptability of principles for routinely monitoring outcomes for consumers seen by allied health providers delivering care through Better Access. It considered both the feasibility and acceptability of routine outcome monitoring for supporting clinical care and to provide data for program-level quality improvement. NovoPsych already does the former and we adapted it so that it could be used for the latter, trialling the feasibility and acceptability of establishing a publicly reportable outcomes dataset.

The findings from Study 9 are presented in Section 12.

Relationship between the research questions and the studies

Table 2.1 shows the relationship between the research questions and the studies. Many research questions were addressed by several studies, and most studies answered more than one research question.

DOMAIN	RESEARCH QUESTION				STUDY ^a						
_		1a	1b	2	3	4	5	6	7	8	9
Accessibility	What is the overall level of uptake of Better Access services, and how has this changed over time (and in response to program refinements)?	~	~								
	Do patterns of uptake vary by different groups of item numbers (e.g., plans, treatment services, treatment services by provider type)?	~									
	Do patterns of utilisation vary by levels of co-payment?	✓									
	What is the relationship between use of Better Access treatment services and use of other mental health services?	~	~			~					
	Who are the main users of Better Access?	✓									
	Has Better Access reached groups in the population who are traditionally disadvantaged in terms of access to access to mental health care?	~	~								
Responsiveness	What are the barriers and facilitators to consumers accessing Better Access?		~		~			~	~		
Appropriateness	Is Better Access reaching consumers with mild to moderate mental health conditions?		~	~	~	~	~				
	What are the typical trajectories of care under Better Access (e.g., what proportion of plans are followed by treatment services, how many episodes of care involve a review)?	~	~								
	Do the treatment planning and referral pathways in Better Access work optimally?				~			~	~		
	Is the care provided through Better Access consistent with best practice?				~			~	~	~	
	Are mental health workforce issues impacting upon provision of Better Access?				~			~	~	~	
Effectiveness	Does the mental health of consumers who receive care under Better Access improve?			~	~	~	~				
	Are outcomes better for some consumers than others?			\checkmark	\checkmark	\checkmark	\checkmark				
	Do certain treatment-based factors influence outcomes (e.g., the total number of sessions, the mode of service delivery)?			~	~	~	~				
Sustainability	What might future reforms to Better Access look like?							✓		✓	
	What is the feasibility and acceptability of principles for routinely monitoring outcomes for consumers seen by psychologists and other allied health professionals delivering care through Better Access, and providing feedback to those providers?										~

Table 2.1: Research question(s) answered by each study

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 || Study 8: A consultative virtual forum on future reforms to Better Access 1 || Study 9: Piloting a routine outcome measurement and feedback system

Assessing outcomes

As noted in Table 2.1, Studies 1b, 2, 3, 4 and 5 examined the effectiveness of Better Access. These studies examined outcomes for consumers using a range of measures combined with a consistent approach to classifying change. For brevity and to avoid repetition across sections, the measures are summarised here as is the approach to classifying change.

These measures are outlined in Table 2.2. Most are standardised measures of symptoms, functioning and quality of life. One is measure of self-rated mental health that was purpose-designed for the evaluation. Drawing on such a broad range of measures allowed us to examine outcomes on a variety of different dimensions for a substantial number of consumers.

Table 2.2: Measures used in studies that examined the effectiveness of Better Access

MEASURE	DESCRIPTION		STL	JDY	
		2	3	4	5
Assessment of	Consumer-rated measure that assesses guality of life. Comprises 35 items that ask the			\checkmark	
Quality of Life	consumer to rate their quality of life on 8 dimensions (independent living, pain,				
instrument (AQoL-	senses, mental health, happiness, coping, relationships and self-worth). Ratings can				
8D) ²⁶	be converted to a utility weight with anchors of 1 for 'perfect health' and 0 for 'dead'.				
Center for	Consumer-rated measure of depressive symptoms in the past week. Comprises 20				✓
Epidemiological	items relating to symptoms such as restless sleep, poor appetite and feeling lonely.				
Studies – Depression	Each item is scored 0 (Rarely or none of the time, 1 (Some or little of the time), 2				
scale (CES-D)27	(Moderately or much of the time), or 3 (Most or almost all the time). Scores range				
	from 0 to 60, with high scores indicating greater depressive symptoms. A score of 16				
	is regarded as indicative of clinical depression.				
Clinical Outcomes in	Consumer-rated measure of psychological distress. Consists of 34 items relating to	✓			
Routine Evaluation	four domains (subjective wellbeing, problems/symptoms, life functioning, risk/harm).				
(CORE-OM) ^{28,29}	The items are phrased as statements about how the consumer has been over the last				
	week. Each item is scored on a 5-point scale ranging from 0 (Not at all) to 4 (Most or				
	all the time). Scores are presented as a total raw score (range 0-136) and a mean				
	score from 0-4. A mean score of 1 or more indicates that the consumer is likely to				
	reach a clinical threshold.				
Clinical Outcomes in	Abbreviated version of the CORE-OM, also designed to measure psychological	~			
Routine Evaluation	distress. Consists of 10 items from the original CORE-OM. Each item is scored the				
(CORE-10) ³⁰	same way as the parent instrument (i.e., on a scale of U-4). Scores are presented as a				
	total raw score (range 0-40) and a mean score from 0-4. Total scores of 0-10 suggest				
	the consumer is in the non-clinical range, whereas scores of 11-14 indicate mild				
	psychological distress, scores of 15-19 indicate moderate psychological distress,				
	scores of 20-24 indicate moderate to severe psychological distress, and scores of 25				
Doprossion Aprioty	Consumer rated measure that assesses the negative emotional states of depression	\checkmark			
and Stress Scale	anyiety and stress. The longer form (DASS-12) consists of 42 items, and the shorter				
(DASS-21/42) ^{7,8}	form (DASS-21) consists of 21 items. Each item takes the form of a statement relating				
(0/00 21/42)	to a symptom of depression anxiety or stress. The consumer is asked to consider how				
	much each statement applied to them in the past week. Each item is scored from 0				
	('Did not apply to me at all') to 3 (Applied to me very much, or most of the time'). The				
	total score on the DASS-42 ranges from 0 to 126; the raw total score on the DASS-21				
	ranges from 0 to 0-63 but is then doubled so that it also ranges from 0 to 126. There				
	are three sub-scales – depression, anxiety, and stress – each of which has a score				
	ranging from 0-42. The cut-offs for the depression sub-scale is as follows: ≤9 – normal,				
	10-13 – mild, 14-20 – moderate, 21-27 – severe, ≥28 extremely severe. The equivalent				
	cut-offs for the anxiety and stress sub-scales are ≤7, 8-9, 10-14, 15-19 and ≥20, and				
	≤14, 15-18, 19-25, 26-33 and ≥34, respectively.				
Depression Anxiety	Abbreviated version of the DASS-42 and DASS-21, also designed to assess depression,	✓			
and Stress Scale	anxiety and stress. Consists of 8 items from the original DASS, and 2 additional items				
(DASS-10) ³¹	relating to substance use and suicidality. As with the original measure, the consumer				
	rates each item on a scale of 0-3 to indicate now much it applied to them in the past				
	week. This yields a total score of U-30. Severity of depression, anxiety and stress is				
- FureOal F	Classified as follows: 0-0 – sub-clinical of fillid sevenity, 7-12 moderate, 13-30 sevene.			1	
dimonsion quality of	consumer-rated measure that assesses quality of life on five domains (mobility, solf care, pain			•	
life questionnaire	usual activities and nsychological status). Ratings can be converted to a utility weight				
(FO-5D-5L) ³²	with anchors of 1 for "nerfect health" and 0 for "dead"				
Generalised Anxiety	Consumer-rated measure that assesses anxiety symptoms. Consists of seven	\checkmark		✓	
Disorder scale (GAD-	questions about how often the consumer been bothered by selected anxiety				
7) ³³	symptoms over the past two weeks. Each item is scored 0 (Not at all), 1 (Several				
- /	days), 2 (More than half the days) or 3 (Nearly every day). The total score ranges from				
	0-21. A score of 10 or more indicates the likely presence of Generalised Anxiety				
	Disorder.				
Global Assessment	Clinician-rated measure of functioning which seeks a single rating. Ratings range from	✓			
of Functioning Scale	1 (Persistent danger of severely hurting self or others OR persistent inability to				
(GAF) ³⁴	maintain minimal personal hygiene OR serious suicidal act with clear expectation of				
	death) to 100 (Superior functioning in a wide range of activities, life's problems never				

MEASURE	DESCRIPTION		STU	JDY	
		2	3	4	5
	seem to get out of hand, is sought out by others because of his/her many positive				
	qualities. No symptoms).				
Kessler-10 (K-10) ²⁵	Consumer-rated measure developed to assess non-specific psychological distress.	\checkmark			
	Comprises 10 items which ask the consumer about symptoms of depression and				
	anxiety in the past four weeks. Each item is rated from 1 (None of the time) to 5 (All				
	of the time), resulting in a total score that ranges from 10 to 50. Scores of 10-15				
	indicate little or no psychological distress, scores of 16-21 indicate moderate				
	psychological distress, scores of 22-29 indicate high psychological distress, and scores				
	of 30-50 indicate very high psychological distress.				
Kessler-10+ (K-	Four-item extension to K-10 that asks about total days out of role due to			\checkmark	
10+)35,36	psychological distress. Two items ask consumers about the number of days in the past				
	28 days they were unable to perform, or had to cut down on, their day-to-day				
	activities because of psychological distress. Only asked of respondents who report any				
	psychological distress on the first 10 K-10 items.				
Outcome Rating	Consumer-rated measure that measures consumers' perceptions of their	✓			
Scale (ORS) ³⁷	improvement over the course of treatment. Consumers use visual analogue scales to				
	indicate how well they have been faring in three domains (individually.				
	interpersonally and socially) and overall over the past week. In each case, the visual				
	analogue scale is 10cm long. Marks to the left indicate low levels and marks to the				
	right indicate high levels, vielding scores on each scale range from 0-10 and the total				
	score ranges from 0-40. The clinical cut-off for adults is 28.				
Patient Health	Consumer-rated measure that assesses depressive symptoms. Consists of nine items	✓		√	✓
Questionnaire (PHO-	relating to how often the consumer has been bothered by depressive symptoms				
QUESTIONNUNC (111Q	during the past two weeks. Each item is scored 0 (Not at all) 1 (Several days) 2 (More				
5)	than half the days) or 3 (Nearly every day). Total scores range from 0.27 . Scores of 0.4				
	indicate no depression, scores of 5.9 indicate mild depression, scores of 10.14				
	indicate no depression, scores of 5-9 indicate find depression, scores of 10-14				
	depression, and scores of 20.27 indicate source depression				
Dationt Lloalth	Consumer rated measure that assesses the frequency of depression.	<u> </u>			1
Questionnaire 2	consumer-rated measure that assesses the frequency of depressed mode and				•
	can be used to screep for depression as a "first stop" approach. These who screep				
(PHQ-2)**	call be used to screen for depression as a first step approach. Those who screen				
	individual items is the same as for the DHO 0, and the total score ranges from 0.6. A				
	individual items is the same as for the PHQ-9, and the total score ranges from 0-6. A				
Desitive and	Score of 3 is regarded as the cut-point for further screening.				
Positive and	Consumer-rated measure of positive and negative affect. Consists of 20 items, 10	v			
Negative Affect	relating to positive affect and 10 relating to negative affect. Each item relates to a				
Schedule (PANAS)	specific feeling, and the consumer is asked to indicate the extent to which they have				
	reit this way over the past week. Each item is scored on a scale of 1 (very slightly or				
	not at all) to 5 (Extremely). This results in total scores for positive and negative affect				
	that each range from 10-50.				
Satisfaction With	Consumer-rated measure of global life satisfaction. Consists of 5 items that are	v			
LITE Scale (SWLS)**	phrased as statements about the consumer's satisfaction with life. They are asked to				
	rate their agreement with each of these statements. Each item is scored on a scale of				
	1 (Strongly disagree) to 7 (Strongly agree). This yields a total score of 5-35. The scores				
	can be interpreted in the following way: 5-9 – extremely dissatisfied; 10-14 –				
	dissatisfied; 15-19 – slightly dissatisfied; 20-24 – slightly satisfied; 25-29 – satisfied;				
	30-35 – extremely satisfied.	<u> </u>			
Self-rated mental	Purpose-designed consumer-rated measure of mental health before and after receipt		~		
health	of Better Access care. Comprises two questions. The first question asks, "On a scale of				
	1 to 10, where 1 is the worst possible mental health and 10 is the best possible				
	mental health, how would you rate your mental health before your first session with				
	the mental health professional?" The second question asks, "On a scale of 1 to 10,				
	where 1 is the worst possible mental health and 10 is the best possible mental health,				
	how would you rate your mental health after your last session with the mental health				
	professional?" These questions are based on standard questions about self-rated				
	mental health used in large-scale population surveys like the Australian Health				
	Survey. ⁴²				

Across all four studies, we used an effect size methodology to classify change over time on the standardised measures of symptoms, functioning and quality of life. An effect size of 0.3 (small-to-

medium, as per Cohen's⁴³ classification) of a standard deviation of the first or "baseline" score on any measure for all eligible episodes or participants in a given study was used to calculate an absolute threshold for change score on each measure. Changes were then classified as "significant improvement", "no significant change" or "significant deterioration".

We chose 0.3 as the effect size by considering studies of the Minimum Clinically Important Difference (MCID) on two commonly used measures (the PHQ-9 and GAD-7) in broadly similar populations^{44,45} and other guidance regarding the range of effect sizes likely to be minimally clinically/subjectively important.⁴⁶ The MCID represents the smallest difference perceived by the consumer to be beneficial. An effect size of 0.3 is at lower end of the reported ranges, but we considered this appropriate because samples in all of the studies included everyone in the datasets, not just those who used a minimum number of sessions or completed treatment.

3. Study 1a: An analysis of Medicare Benefits (MBS) data

Introduction

Study 1a involved an analysis of the uptake, utilisation, costs and patterns of use of Better Access services, drawing on Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) data. With the Department of Health's help, we sourced aggregated, de-identified MBS 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). This enabled us to address research questions relating to accessibility (e.g., the extent to which access and patterns of use are impacted by where people live), changing patterns of use (e.g., the extent to which the additional 10 treatment sessions have been taken up), affordability (e.g., bulk-billing rates and consumer co-payments), and typical trajectories of care under Better Access (e.g., the proportion of mental health treatment plans that are followed by treatment services). Study 1a provides context for other studies in the evaluation as it reports on all claims for Better Access services nationally.

Methods

Preparatory steps

Organising Better Access MBS items into item groups

An initial step was to compile a complete list of Better Access MBS items. The list was based on materials supplied by the Department of Health, and classified each item on the following characteristics:

- program phase a classification that indicated if the item was introduced as part of a specific initiative. The categories were: original (i.e., not a specific initiative), rural and remote (telehealth), COVID-19, and Residential Aged Care Facility (RACF) mental health support;
- item category and item sub-category broad groupings of items according to their clinical purpose. The item categories were: associated MBS items (including the sub-categories of preparation of mental health treatment plan, review of a mental health treatment plan, mental health treatment consultation, preparation of a psychiatrist assessment and management plan, and initial patient consultation), initial 10 individual treatment sessions (including the sub-categories of focussed psychological strategies and psychological therapy services), additional 10 individual treatment sessions (including the sub-categories of group focussed psychological strategies and psychological therapy services);
- provider type GPs, other medical practitioners, clinical psychologists, psychologists, social workers, occupational therapists, or consultant psychiatrists; and
- mode of delivery face-to-face, telehealth, or phone.

The list of Better Access MBS items is provided in Appendix 1.

Documenting changes to the Better Access program

Over time, significant refinements have been made to the Better Access program. To facilitate our analyses of changing patterns of use following these program refinements, we compiled a list of changes

to the Better Access program. This is summarised in Figure 3.1, with more detailed information provided in Appendix 2, Table A2.1.

Data supply

The data presented in this report were supplied by Services Australia in de-identified, aggregated form according to a set of specifications developed by our evaluation team. The scope of data was as follows.

Summary data on MBS items focused on the Better Access items (as listed Appendix 1). Additional summary data were provided on non-Better Access MBS psychiatrist items. The summaries included all services rendered from 1 January 2018 to 30 June 2022 and processed up to and including 7 August 2022. The date of first service was set at 1 January 2018 because Services Australia only holds five years of data at the time of extraction. For the most part, the data were organised into reference periods defined by calendar years because Better Access program rules regarding the permissible number of treatment sessions are based on calendar year. To facilitate analyses of time trends, some data were organised into quarterly reference periods.

Summary data were provided on prescriptions for antidepressant and anxiolytic medications funded through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS) from 1 January 2018 to 30 June 2022 and processed up to and including 7 August 2022. Medications included in the PBS/RPBS are classified according to the Anatomical Therapeutic Classification (ATC) system developed by the World Health Organization.^{47c} The anxiolytic medications (ATC Level 3 category N05B) included Alprazolam, Bromazepam, Buspirone, Chlordiazepoxide, Clorazepate Dipotassium, Diazepam, Lorazepam, and Oxazepam. The antidepressant medications (category N06A) included Amitriptyline, Citalopram, Clomipramine, Desipramine Hydrochloride, Desvenlafaxine, Dosulepin (Dothiepin), Doxepin, Duloxetine, Escitalopram, Fluoxetine, Fluvoxamine, Imipramine, Lithium Carbonate, Mianserin, Mirtazapine, Moclobemide, Nefazodone Hydrochloride, Nortriptyline, Paroxetine, Phenelzine, Reboxetine, Sertraline, Tranylcypromine, Trimipramine, and Venlafaxine. PBS/RPBS data includes subsidised and under co-payment threshold prescriptions. It does not include data on medications not listed in the PBS, medications that were paid for privately, over-thecounter medications, or medications supplied to public hospital inpatients.⁴⁸

Services Australia also provided population counts, based on the number of people enrolled in Medicare at the end of each calendar year or at the end of each quarter, as relevant.

Measures

The supplied data included summary statistics for various groupings of Better Access MBS items (based on the item characteristics described earlier). The summary statistics included: counts of persons and services; the sum of provider fees charged and sum of MBS benefits paid; and out-of-pocket costs for services where a co-payment was made (median and interquartile range).

These summary statistics were stratified by age group (0-14 years, 15-24 years, 25-44 years, 45-64 years and 65 years and over), sex (male, female), and geographic area group or area level (Statistical Areas Level 3 or SA3). Geographic area group was based on a classification used by the Australian Institute of Health and Welfare (AIHW),⁴⁹ which utilises information about remoteness based on the Australian Bureau of Statistics (ABS) Australian Statistical Geography Standard (ASGS)^{50,51} and socioeconomic status based on the ABS Index of Relative Socioeconomic Disadvantage (IRSD):⁵² It comprised six categories - major cities (higher socioeconomic areas defined as IRSD quintile 5); major cities (medium socioeconomic areas defined as IRSD quintiles 3 and 4); major cities (lower socioeconomic areas defined as IRSD quintiles 1 and 2), inner regional areas, outer regional areas, and remote (including very remote) areas. Because a

^c There are occasional differences. Notably, lithium carbonate is classified as an antipsychotic in the ATC but as an antidepressant in the PBS/RPBS.

consumer's age or address may change during the reference period, their characteristics at the last date of service in the reference period were applied to all services for that consumer in the reference period.

Out-of-pocket costs to consumers were calculated as the provider fee charged minus the MBS benefit paid. Virtually all services are bulk-billed or have a non-zero co-payment, however for a small percentage of services the patient is billed but with a zero co-payment. For Study 1a, only services for which the consumer contributed a co-payment are included in out-of-pocket cost estimates. Therefore, the percentages of bulk-billed services and services with out-of-pocket costs may not sum to exactly 100%.

Services Australia applied cell suppression to the summary statistics when the number of consumers was between 1 and 5. For this report, cell sizes of 10 or fewer are not reported. Where necessary, we applied consequential suppression so that the suppressed cell values cannot be calculated.

Statistical analyses

We converted counts of persons and services to crude rates per 1,000 population, to enable comparisons in uptake (i.e., the number of persons using services) and utilisation (i.e., the number of services used) over time adjusted for population growth. We converted provider fees charged, MBS benefits paid, and out-of-pocket costs to 2021-22 values using the ABS Consumer Price Index for medical and hospital services.^{53,54} For out-of-pocket costs, we reported median values (rather than the average or mean) as this is the preferred option in cases where data may be skewed, for example where the majority of people have low out-of-pocket costs, but a small number of people have high costs. This is a frequently used approach to reporting out-of-pocket costs, so there is an equal probability of an out-of-pocket cost falling above or below the median cost. Note that, because the median reflects the distribution of all included values for a particular group, there can be greater variation in out-of-pocket costs for population subgroups than for the overall population. We also reported medians for other count measures (e.g., numbers of services following a mental health treatment plan, and days elapsed between mental health treatment plan and first treatment session).

In most cases, we present descriptive profiles of counts, rates, percentages, medians (and inter-quartile ranges), and average annual change in those statistics. We conducted analyses to examine the relationship between uptake of Better Access treatment and rates of use of other Commonwealth-funded mental health services, namely the use of antidepressant and anxiolytic medications and the use of non-Better Access psychiatrist services provided in the community. For these analyses, the unit of analysis was area (SA3) level. We grouped SA3s into quintiles of Better Access uptake, where quintile 1 comprised SA3s with the lowest uptake and quintile 5 comprised SA3s with the highest uptake. The relationships were quantified using Spearman's rho correlation coefficients, which are appropriate when comparing ordinal and continuous variables). We used the thresholds suggested by Dancey and Reidy⁵⁷ to interpret the strength of the relationships - correlations of .07 to 0.9 are considered "strong", 0.4 to 0.6 "moderate", and 0.1 to 0.3 "weak". A correlation of 1 is "perfect" and 0 is "zero".

Approvals

The University of Melbourne Human Research Ethics Committee approved the study (HREC 2021-22771-22273-2). The Services Australia External Requests Evaluation Committee approved the data request (EREC RMS2103).

Acknowledgements

All data reported in Study 1a were supplied by Services Australia.

Figure 3.1: Key changes to the Better Access program



F2F, face-to-face. Note: This figure shows changes relating to the addition or retirement of MBS item numbers and changes to treatment session limits. The figure provides key dates relating to the introduction of these changes; other changes may also have occurred (see Appendix 2 Table A2.1 for a more detailed list of changes).

Results

Uptake of Better Access services

In 2021, more than 2.6 million Australians received at least one Better Access service of any kind (Table 3.1). This equates to one in every 9.9 Australians in 2021 (the most recent year for which a full 12 months of data were available). When adjusted for population growth, there was a 1.8% average increase per year in the number of people using Better Access services since 2018.

In 2021, more than 1.3 million people (one in every 19.6 Australians) received at least one Better Access treatment service (i.e., a service claimed using the psychological therapy service or focussed psychological strategies MBS items). Adjusted for population growth, the number of persons treated through Better Access increased by an average of 0.9% per year since 2018.

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Any Better Access service	Persons	2,431,330	2,541,216	2,589,944	2,649,355	2.9	1,645,247
	Rate (per 1,000)	95.6	98.7	99.7	100.8	1.8	62.4
	% of BA users	100.0	100.0	100.0	100.0	0	100.0
Any Better Access	Persons	1,260,559	1,321,194	1,342,890	1,338,424	2.0	879,939
treatment service	Rate (per 1,000)	49.6	51.3	51.7	50.9	0.9	33.4
	% of BA users	51.8	52.0	51.9	50.5	-0.9	53.5

Table 3.1: Uptake of any Better Access service and any Better Access treatment service, 2018 to 2022

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population. The denominator for '% of BA users' is the number of people who received any Better Access service. 'Any Better Access service' refers to a service provided under any of the Better Access MBS items in Appendix 1. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

Levels of uptake varied across key item groups as defined by provider type and clinical purpose. In 2021, GPs and other medical practitioners^d prepared a mental health treatment plan for more than 1.4 million Australians and reviewed a mental health treatment plan for more than 500,000 Australians (Table 3.2). The rate of persons receiving a mental health treatment plan increased modestly between 2018 and 2020, but decreased between 2020 and 2021 by 3.2%. In contrast, the rate of persons receiving a review of a mental health treatment 2018 and 2021 (5.4% per year, on average) with the main increase between 2020 and 2021.

GPs and other medical practitioners provided mental health treatment consultations to more than 1 million Australians in 2021, or 37.8% of all people who received any Better Access service. In contrast, GPs and other medical practitioners provided focussed psychological strategies to approximately 12,500 Australians or 0.5% of all people who received any Better Access service. Growth in the rate of persons receiving focussed psychological strategies was 5.6% per year, on average, compared to a decrease of 0.6% per year in persons receiving a mental health treatment consultation.

^d The vast majority of people who receive Better Access services from a GP or other medical practitioner receive them from a GP (see Appendix 2, Table 2.1).
		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Preparation of a mental	Persons	1,332,633	1,416,351	1,468,297	1,421,494	2.2	661,998
health treatment plan	Rate (per 1,000)	52.4	55.0	56.5	54.1	1.1	25.1
	% of BA users	54.8	55.7	56.7	53.7	-0.7	40.2
Review of a mental health	Persons	441,152	471,323	523,173	533,449	6.5	272,725
treatment plan	Rate (per 1,000)	17.3	18.3	20.1	20.3	5.4	10.3
	% of BA users	18.1	18.5	20.2	20.1	3.5	16.6
Mental health treatment	Persons	986,806	989,591	992,758	1,000,284	0.5	510,427
consultation	Rate (per 1,000)	38.8	38.4	38.2	38.1	-0.6	19.4
	% of BA users	40.6	38.9	38.3	37.8	-2.4	31.0
Focussed psychological	Persons	10,343	10,161	12,114	12,572	6.7	7,675
strategies	Rate (per 1,000)	0.4	0.4	0.5	0.5	5.6	0.3
	% of BA users	0.4	0.4	0.5	0.5	3.7	0.5

Table 3.2: Uptake of Better Access services delivered by GPsand other medical practitioners, 2018 to 2022

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population. The denominator for '% of BA users' is the number of people who received any Better Access service (see Table 3.1).

In 2021, uptake of Better Access treatment services was highest for focussed psychological strategies delivered by psychologists (approximately 730,000 persons or 28.0 per 1,000 population) and psychological therapy services delivered by clinical psychologists (approximately 530,000 persons or 20.5 p er 1,000 population) (Table 3.3). Uptake of these services was steady between 2018 and 2021, although there was a drop-off in the uptake of psychological therapy services between 2020 and 2021 (-3.8%).

Uptake was comparatively much lower for focussed psychological strategies delivered by social workers (approximately 100,000 people or 3.9 per 1,000 population) and occupational therapists (12,000 people or 0.5 per 1,000 population) in 2021. Uptake increased by 5.6% per year on average for focussed psychological strategies delivered by social workers and decreased by 9.4% for focussed psychological strategies delivered by occupational therapists, with the decrease accelerating after 2019.

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Psychological therapy	Persons	517,309	544,826	558,310	537,367	1.3	359,734
services (clinical	Rate (per 1,000)	20.3	21.2	21.5	20.5	0.2	13.6
psychologists)	% of BA users	21.3	21.4	21.6	20.3	-1.6	21.9
Focussed psychological	Persons	690,703	717,358	723,172	734,792	2.1	464,072
strategies (psychologists)	Rate (per 1,000)	27.2	27.9	27.9	28.0	1.0	17.6
	% of BA users	28.4	28.2	27.9	27.7	-0.8	28.2
Focussed psychological	Persons	84,516	93,124	97,032	102,851	6.8	62,640
strategies (social workers)	Rate (per 1,000)	3.3	3.6	3.7	3.9	5.6	2.4
	% of BA users	3.5	3.7	3.7	3.9	3.8	3.8
Focussed psychological	Persons	15,720	15,632	13,434	12,097	-8.4	7,003
strategies (occupational	Rate (per 1,000)	0.6	0.6	0.5	0.5	-9.4	0.3
therapists)	% of BA users	0.6	0.6	0.5	0.5	-10.9	0.4

Table 3.3: Uptake of Better Access services delivered by allied health professionals, 2018 to 2022

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population. The denominator for '% of BA users' is the number of people who received any Better Access service (see Table 3.1).

Services delivered by consultant psychiatrists made up a relatively small share of total Better Access services (Table 3.4), noting that the Better Access psychiatrist items are limited to initial patient consultation and preparation and review of a psychiatrist management plan, and do not include any items for treatment. In 2021, consultant psychiatrists conducted an initial patient consultation for approximately 150,000 Australians (5.7 per 1,000), prepared a psychiatrist assessment and management plan for 42,000 (1.6 per 1,000), and a review of a psychiatrist assessment and management plan for 7,500 (0.3 per 1,000). The rate of reviews decreased by 6.3% per year, on average, since 2018 (from 0.4 per 1,000 to 0.3 per 1,000). The rate of plans and initial patient consultations has remained fairly steady.

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Preparation of a	Persons	42,882	41,931	41,593	42,351	-0.4	29,109
psychiatrist assessment	Rate (per 1,000)	1.7	1.6	1.6	1.6	-1.5	1.1
and management plan	% of BA users	1.8	1.7	1.6	1.6	-3.2	1.8
Review of a psychiatrist	Persons	9,045	8,909	8,908	7,684	-5.3	5,510
assessment and	Rate (per 1,000)	0.4	0.3	0.3	0.3	-6.3	0.2
management plan	% of BA users	0.4	0.4	0.3	0.3	-8.0	0.3
Initial patient	Persons	131,384	133,539	137,533	149,816	4.5	78,300
consultation	Rate (per 1,000)	5.2	5.2	5.3	5.7	3.3	3.0
	% of BA users	5.4	5.3	5.3	5.7	1.5	4.8

Table 3.4: Uptake of Better Access services delivered by consultant psychiatrists, 2018 to 2022

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population. The denominator for '% of BA users' is the number of people who received any Better Access service (see Table 3.1).

Utilisation of Better Access services

In 2021, approximately 11.3 million Better Access services were delivered. Adjusted for population growth, this represents an average annual increase of 4.5% from approximately 9.5 million services in 2018 (Table 3.5).

In 2021, approximately 7.3 million Better Access treatment services were delivered, an average annual increase of 7.1% from 5.7 million in 2018. Treatment services made up nearly two thirds (64.4%) of total Better Access services in 2021. This percentage has remained fairly steady, increasing only slightly from 59.9% in 2018.

Table 3.5: Utilisation of any Better Access service and any Better Accesstreatment service, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Any Better Access	Services	9,567,533	9,873,074	10,647,956	11,295,485	5.7	5,172,960
service	Rate (per 1,000)	376.2	383.4	410.1	429.9	4.5	196.1
	% of BA services	100.0	100.0	100.0	100.0	0.0	100.0
Any Better Access	Services	5,733,018	5,975,389	6,569,630	7,275,153	8.3	3,352,832
treatment service	Rate (per 1,000)	225.4	232.0	253.0	276.9	7.1	127.1
	% of BA services	59.9	60.5	61.7	64.4	2.4	64.8
	Ratio (sessions/persons treated)	4.5	4.5	4.9	5.4	6.1	3.8

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population. 'Any Better Access service' refers to a service provided under any of the Better Access MBS items in Appendix 1. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

Tables 3.6-3.8 summarise the utilisation of Better Access services for key item groups. The largest relative increases in utilisation rates were for items relating to: review of a mental health treatment plan (annual increase of 7.0% from 2018 to 2021); focussed psychological strategies delivered by GPs/other medical practitioners (9.9%), psychologists (6.5%) and social workers (10.0%); and psychological therapy services delivered by clinical psychologists (7.6%). The largest decreases were for items relating to review of a psychiatrist assessment and management plan (-6.3%).

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Preparation of a	Services	1,334,869	1,418,974	1,473,480	1,425,356	2.2	662,552
mental health	Rate (per 1,000)	52.5	55.1	56.7	54.2	1.1	25.1
treatment plan	% of BA services	14.0	14.4	13.8	12.6	-3.3	12.8
Review of a	Services	494,123	527,938	618,470	624,547	8.1	288,031
mental health	Rate (per 1,000)	19.4	20.5	23.8	23.8	7.0	10.9
treatment plan	% of BA services	5.2	5.3	5.8	5.5	2.3	5.6
Mental health	Services	1,809,232	1,753,947	1,787,109	1,759,821	-0.9	753,460
treatment	Rate (per 1,000)	71.1	68.1	68.8	67.0	-2.0	28.6
consultation	% of BA services	18.9	17.8	16.8	15.6	-6.3	14.6
Focussed	Services	32,160	32,325	42,669	44,143	11.1	21,994
psychological	Rate (per 1,000)	1.3	1.3	1.6	1.7	9.9	0.8
strategies	% of BA services	0.3	0.3	0.4	0.4	5.2	0.4

Table 3.6: Utilisation of Better Access services delivered by GPs and other medical practitioners, 2018 to 2022 year to date

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population.

Table 3.7: Utilisation of Better Access services delivered by allied health professionals, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Psychological	Services	2,358,867	2,479,293	2,797,843	3,037,179	8.8	1,409,629
therapy services	Rate (per 1,000)	92.7	96.3	107.8	115.6	7.6	53.4
(clinical psychologists)	% of BA services	24.7	25.1	26.3	26.9	2.9	27.2
Focussed	Services	2,913,026	3,007,372	3,240,295	3,637,688	7.7	1,664,914
psychological	Rate (per 1,000)	114.5	116.8	124.8	138.4	6.5	63.1
strategies	% of BA services	30.4	30.5	30.4	32.2	1.9	32.2
(psychologists)							
Focussed	Services	357,727	386,133	428,297	492,153	11.2	228,301
psychological	Rate (per 1,000)	14.1	15.0	16.5	18.7	10.0	8.7
strategies (social workers)	% of BA services	3.7	3.9	4.0	4.4	5.2	4.4
Focussed	Services	71,238	70,266	60,526	63,990	-3.5	27,994
psychological	Rate (per 1,000)	2.8	2.7	2.3	2.4	-4.6	1.1
strategies (occupational	% of BA services	0.7	0.7	0.6	0.6	-8.7	0.5
therapists)							

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population.

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Preparation of a	Services	42,870	41,799	41,515	42,267	-0.5	29,125
psychiatrist	Rate (per 1,000)	1.7	1.6	1.6	1.6	-1.5	1.1
assessment and	% of BA services	0.4	0.4	0.4	0.4	-5.8	0.6
management plan							
Review of a	Services	9,033	8,691	8,875	7,681	-5.3	5,541
psychiatrist	Rate (per 1,000)	0.4	0.3	0.3	0.3	-6.3	0.2
assessment and	% of BA services	0.1	0.1	0.1	0.1	-10.4	0.1
management plan							
Initial patient	Services	144,388	146,336	148,877	160,660	3.6	81,419
consultation	Rate (per 1,000)	5.7	5.7	5.7	6.1	2.5	3.1
	% of BA services	1.5	1.5	1.4	1.4	-2.0	1.6

Table 3.8: Utilisation of Better Access services delivered byconsultant psychiatrists, 2018 to 2022 year to date

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population.

The ratio of <u>treatment sessions</u> delivered (Table 3.5) to <u>persons treated</u> (Table 3.1) provides an approximation of the average number of Better Access treatment sessions used per person each year. In 2021 the ratio was 1:5.4 (Table 3.9). That is, 5.4 sessions were used for every one person who received Better Access treatment in 2021. The ratio has increased over time (by 6% per year) from 1:4.5 in 2018.

The ratio of treatment sessions to persons treated varied considerably across provider types. In all years between 2018 and 2021, the ratio was highest for psychological therapy services delivered by clinical psychologists (1:5.7 in 2021) and lowest for focussed psychological strategies delivered by GPs/other medical practitioners (1:3.5 in 2021). Ratios increased between 2018 to 2021 for all providers, however these two groups also experienced the greatest and least change (7.4% and 4.1%, respectively).

The ratio of persons to services for mental health treatment consultations was lower than for the treatment sessions, at 1:1.8 in all years from 2018 to 2021.

	2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Any Better Access treatment service	4.5	4.5	4.9	5.4	6.1	3.8
Psychological therapy services (clinical psychologists)	4.6	4.6	5.0	5.7	7.4	3.9
Focussed psychological strategies (psychologists)	4.2	4.2	4.5	5.0	5.5	3.6
Focussed psychological strategies (social workers)	4.2	4.1	4.4	4.8	4.2	3.6
Focussed psychological strategies (occupational therapists)	4.5	4.5	4.5	5.3	5.3	4.0
Focussed psychological strategies (GPs/other medical						
practitioners)	3.1	3.2	3.5	3.5	4.1	2.9
Mental health treatment consultations	1.8	1.8	1.8	1.8	-1.4	1.5

Table 3.9: Services per person for selected item groups, 2018 to 2022 year to date

Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

Uptake and utilisation according to consumer characteristics

Figures 3.2 through 3.5 show patterns of uptake and utilisation of Better Access services according to consumers' age group, sex, and where they live, and how these patterns have changed over time. In all years 2018 to 2021, rates of uptake and utilisation were highest among females (compared to males), people aged 15-24 and 25-44 years (compared to those aged 0-14, 45-64 or 65 and over), and people living in major cities and inner regional areas (compared to people living in outer regional and remote areas).

Levels of uptake and utilisation have changed over time, with increases particularly apparent for some of these same groups (females, people aged 15-24 and 25-44 years, people in major cities in high socioeconomic status areas). Rates of uptake and utilisation of Better Access treatment services also increased for people in remote areas., although they remained lower than for people living in other areas despite this increase. Notably, increases in uptake and utilisation of treatment services in remote areas were on par with those in major cities in high socioeconomic status areas. In contrast, people aged 65 and over, and males, experienced relatively lower (or sometimes negative) rates of growth in uptake and utilisation compared to their counterparts.



Figure 3.2: Rates of uptake and utilisation of any Better Access service and any Better Access treatment service, by sociodemographic factors, 2018 to 2021

Note: ' Δ ', average annual percentage change 2018-21. Red text, change for the total population. 'SES', socioeconomic status. 'Any Better Access service' refers to a service provided under any of the Better Access MBS items in Appendix 1. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

Figures 3.3 through 3.5 show corresponding patterns across different item groups. With respect to age and sex, these tended to show similar patterns to the overall Better Access patterns in Figure 3.2. For example, for most item groups, uptake and utilisation was highest among those aged 15-24. However, there were some exceptions. For example, focussed psychological strategies delivered by GPs/other medical practitioners were used relatively more often by people in older age groups (45-64 and 65 and over) than focussed psychological strategies delivered by allied health providers, compared to their younger counterparts. Focussed psychological strategies delivered by occupational therapists were used relatively more often by people aged 0-14 than focussed psychological strategies delivered by other allied health providers, compared to their older counterparts.

Most noticeable were the variable patterns according to geographic area. For example, people in major cities (higher and medium socioeconomic status areas) were most likely to utilise treatment sessions delivered by a clinical psychologist or psychologist, whereas people in inner regional areas were most likely to receive treatment sessions from a social worker. With respect to services delivered by GPs/other medical practitioners, people in major cities (lower socioeconomic status areas) were the most likely to receive mental health treatment consultations. With respect to treatment services delivered by allied health professionals, people in major cities and inner regional areas were more likely to receive these

from a clinical psychologist or psychologist. With respect to psychiatrist services, people in major cities (lower socioeconomic status areas) were the most likely to receive a psychiatrist assessment and management plan, whereas people in major cities (higher socioeconomic status areas) were the most likely to receive an initial patient consultation.

Rates of uptake and utilisation also changed over time in different ways across different item groups. For example, for many item groups the strongest increases in uptake and utilisation were among people in major cities (higher socioeconomic status areas). However, people in remote areas also experienced considerable increases, particularly in the use of mental health treatment plans and reviews delivered by GPs/other medical practitioners, treatment sessions delivered by clinical psychologists, psychologist and social workers, and initial patient consultations with psychiatrists. However, they experienced negative changes in use of other item groups, namely the use of focussed psychological services delivered by GPs/other medical practitioners, and psychiatrist assessment and management plans and reviews. Uptake and utilisation of focussed psychological strategies delivered by occupational therapists decreased for most groups, but particularly for those aged 0-14, males, and people in outer regional and remote areas.



Figure 3.3: Rates of uptake and utilisation of Better Access services delivered by GPs and other medical practitioners, by sociodemographic factors, 2018 to 2021

Note: '% Δ ', average annual percentage change 2018-21. Red text, change for total population. 'SES', socioeconomic status.



Figure 3.4: Rates of uptake and utilisation of Better Access services delivered by allied health professionals, by sociodemographic factors, 2018 to 2021

Note: '% △', average annual percentage change 2018-21. Red text, change for total population. 'SES', socioeconomic status.



Figure 3.5: Rates of uptake and utilisation of Better Access services delivered by consultant psychiatrists, by sociodemographic factors, 2018 to 2021

Note: '% Δ ', average annual percentage change 2018-21. Red text, change for total population. 'SES', socioeconomic status.

Affordability to consumers

In 2021, approximately half (52.8%) of all Better Access services were bulk-billed, an average annual decrease of 6.0% per year from 63.5% in 2018 (Table 3.10). Conversely, 46.6% of services in 2021 involved a co-payment by the consumer, an increase of 9.3% each year from 35.7% in 2018.^e If a co-payment was made, the median out-of-pocket cost per service was constant between 2018 and 2021 at \$74 per service. In the first half of 2022, the percentage of services for which the consumer made a co-payment increased to 50.5% and the median out-of-pocket cost per service increased to \$87.

In 2021, approximately one third (34.4%) of Better Access treatment services were bulk-billed, down from 46.2% in 2018, while 64.8% involved a consumer co-payment, up from 52.7% in 2018. These trends continued into the first half of 2022. The median co-payment was stable at \$74 from 2018 to 2021 and increased to \$90 in the first half of 2022.

Table 3.10: Bulk-billing and out-of-pocket costs paid by consumers, for any Better Access servicesand any Better Access treatment services, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Any Better Access	Services	9,567,533	9,873,074	10,647,956	11,295,485	5.7	5,172,960
service	Services bulk-billed (%)	63.5	60.7	61.4	52.8	-6.0	49.0
	Services with OOP (%)	35.7	38.5	38.0	46.6	9.3	50.5
	Median OOP (\$)	74	72	77	74	-0.2	87
	OOP 25 th percentile (\$)	46	48	47	43	-1.8	60
	OOP 75 th percentile (\$)	97	98	99	99	0.8	109
Any Better Access	Services	5,733,018	5,975,389	6,569,630	7,275,153	8.3	3,352,832
treatment service	Services bulk-billed (%)	46.2	42.7	44.2	34.4	-9.4	30.5
	Services with OOP (%)	52.7	56.3	55.0	64.8	7.2	68.9
	Median OOP (\$)	74	75	77	74	0.0	90
	OOP 25 th percentile (\$)	49	50	50	48	-0.7	65
	OOP 75 th percentile (\$)	97	97	99	99	0.8	109

OOP, out-of-pocket. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Fees charged, benefits paid, and out-of-pocket costs are expressed in 2021-22 dollars. Estimates of out-of-pocket costs are based on services for which a co-payment was charged. 'Any Better Access service' refers to a service provided under any of the Better Access MBS items in Appendix 1. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

Tables 3.11-3.13 profile bulk-billing rates and out-of-pocket costs for key Better Access item groups. These show that the percentage of services which were bulk-billed or, conversely, for which a copayment was made by the consumer varied depending on the type of provider and service the consumer received. Notably:

• The item groups with the highest rates of bulk-billing were mental health treatment plans and reviews, mental health treatment consultations, and reviews of a psychiatrist assessment and management plan (all had bulk-billing rates of 80% or higher in all years 2018 to 2022 year to date). These rates declined modestly between 2018 and 2021. The item groups with the lowest rates of bulk-billing were initial patient consultations delivered by psychiatrists (16.0% in 2021), psychological therapy services delivered by clinical psychologists (30.5% in 2021) and focussed psychological strategies delivered by psychologists (34.7% in 2021). These item groups also had

^e Virtually all services are either bulk-billed or have a non-zero co-payment (other than a small percentage of services where the patient is billed but with a zero co-payment). That is, bulk-billing and co-payment rates are effectively the complement of each other.

large decreases in bulk-billing rates between 2018 and 2021 (-12.5%, -8.4% and -10.9%, respectively).

- In 2021, for GPs and other medical practitioners, services relating to the delivery of focussed psychological strategies involved a co-payment more frequently (32.3% of services) than services for the preparation or review of a mental health treatment plan (14.6%-15.6%) or for mental health treatment consultation (5.4%) (Table 3.11).
- Approximately two thirds of the treatment services delivered by clinical psychologists, psychologists and occupations therapists in 2021 involved a co-payment (61.2%-68.8%), compared to less than half (46.2%) of services delivered by social workers (Table 3.12).
- For consultant psychiatrists, the majority of services for initial patient consultation involved a copayment (83.8%), compared to one third of services for preparing a psychiatrist assessment and management plan (33.8%) or reviewing a psychiatrist assessment and management plan (15.5%) (Table 3.13).
- Between 2018 and 2021, the percentage of services for which a co-payment was made increased for all item groups except focussed psychological strategies delivered by GPs/other medical practitioners and occupational therapists. The increase was highest for services relating to review of a mental health treatment plan and mental health treatment consultations delivered by GPs/other medical practitioners (11.5% and 11.3% average annual increase, respectively), preparation of a psychiatrist assessment and management plan (17.9%), and focussed psychological strategies delivered by social workers (11.1%). In the first half of 2022, the percentage of services for which the consumer paid a co-payment increased across all providers and item groups.

For services at which a co-payment was paid, the out-of-pocket cost varied depended on the type of provider that the consumer saw:

- For services delivered by GPs/other medical practitioners, the median co-payment varied between \$41 (interquartile range [IQR] \$24-\$56) for mental health treatment consultations and \$62 (IQR \$39-\$92) for focussed psychological strategies. For services delivered by allied health professionals, the median co-payment varied between \$72 (IQR \$46-\$93) for psychological therapy services (clinical psychologists) and \$83 (IQR \$53-\$104) for focussed psychological strategies (psychologists). For consultant psychiatrist services, the median co-payment varied between \$100 (IQR \$51-\$149) for review of a psychiatrist assessment and management plan and \$171 (IQR \$118-\$222) for initial patient consultation.
- Between 2018 and 2021, average annual change in median out-of-pocket costs was modest across all providers and items groups (change of no more than +/- 5%), with the exception of focussed psychological strategies delivered by occupational therapists which increased by 8.8% annually. In the first half of 2022, however, median co-payments for all allied health professional services and initial patient consultations by psychiatrists showed strong increases compared to 2021.

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Preparation of a	Services	1,334,869	1,418,974	1,473,480	1,425,356	2.2	662,552
mental health	Services bulk-billed (%)	88.3	87.4	88.6	85.1	-1.2	82.3
treatment plan	Services with OOP (%)	11.2	12.2	11.1	14.6	9.1	17.4
	Median OOP (\$)	46	46	46	46	0.1	45
	OOP 25 th percentile (\$)	33	32	32	31	-2.5	32
	OOP 75 th percentile (\$)	66	63	62	60	-3.3	62
Review of a	Services	494,123	527,938	618,470	624,547	8.1	288,031
mental health	Services bulk-billed (%)	88.3	87.1	88.7	84.0	-1.6	80.6
treatment plan	Services with OOP (%)	11.3	12.4	11.0	15.6	11.5	18.9
	Median OOP (\$)	44	43	44	42	-1.4	45
	OOP 25 th percentile (\$)	27	27	27	23	-4.0	30
	OOP 75 th percentile (\$)	61	58	59	56	-2.4	60
Mental health	Services	1,809,232	1,753,947	1,787,109	1,759,821	-0.9	753,460
treatment	Services bulk-billed (%)	95.9	95.5	95.8	94.4	-0.5	93.2
consultation	Services with OOP (%)	3.9	4.3	4.0	5.4	11.3	6.6
	Median OOP (\$)	41	42	43	41	-0.2	45
	OOP 25 th percentile (\$)	26	26	27	24	-1.7	30
	OOP 75 th percentile (\$)	57	56	57	56	-0.3	63
Focussed	Services	32,160	32,325	42,669	44,143	11.1	21,994
psychological	Services bulk-billed (%)	66.7	63.9	73.1	67.5	0.4	65.3
strategies	Services with OOP (%)	33.0	35.7	26.5	32.3	-0.7	34.5
-	Median OOP (\$)	59	61	65	62	1.5	63
	OOP 25 th percentile (\$)	42	44	42	39	-2.7	45
	OOP 75 th percentile (\$)	77	88	91	92	6.4	99

Table 3.11: Bulk-billing and out-of-pocket costs paid by consumers, for Better Access servicesdelivered by GPs and other medical practitioners, 2018 to 2022 year to date

OOP, out-of-pocket. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Fees charged, benefits paid, and out-of-pocket costs are expressed in 2021-22 dollars. Estimates of out-of-pocket costs are based on services for which a co-payment was charged.

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Psychological	Services	2,358,867	2,479,293	2,797,843	3,037,179	8.8	1,409,629
therapy services	Services bulk-billed (%)	39.8	36.4	39.8	30.5	-8.4	26.9
(clinical	Services with OOP (%)	59.1	62.6	59.4	68.8	5.2	72.5
psychologists)	Median OOP (\$)	75	72	74	72	-1.3	82
	OOP 25 th percentile (\$)	48	50	50	46	-1.1	60
	OOP 75 th percentile (\$)	86	92	95	93	2.8	99
Focussed	Services	2,913,026	3,007,372	3,240,295	3,637,688	7.7	1,664,914
psychological	Services bulk-billed (%)	49.1	45.1	45.2	34.7	-10.9	30.5
strategies	Services with OOP (%)	49.8	54.0	54.1	64.5	9.0	68.9
(psychologists)	Median OOP (\$)	74	81	79	83	3.9	91
	OOP 25 th percentile (\$)	51	50	54	53	0.8	71
	OOP 75 th percentile (\$)	97	103	101	104	2.2	111
Focussed	Services	357,727	386,133	428,297	492,153	11.2	228,301
psychological	Services bulk-billed (%)	64.8	62.8	62.9	52.6	-6.7	48.4
strategies (social	Services with OOP (%)	33.7	35.6	35.8	46.2	11.1	50.7
workers)	Median OOP (\$)	69	70	73	74	2.4	81
	OOP 25 th percentile (\$)	40	44	46	43	2.4	62
	OOP 75 th percentile (\$)	88	92	90	95	2.5	101
Focussed	Services	71,238	70,266	60,526	63,990	-3.5	27,994
psychological	Services bulk-billed (%)	37.7	41.3	47.2	38.0	0.3	35.1
strategies	Services with OOP (%)	61.4	57.9	51.7	61.2	-0.1	64.4
(occupational	Median OOP (\$)	57	61	69	74	8.8	81
therapists)	OOP 25 th percentile (\$)	25	27	27	26	1.0	54
	OOP 75 th percentile (\$)	88	92	100	99	4.0	111

Table 3.12: Bulk-billing and out-of-pocket costs paid by consumers, for Better Access services delivered by allied health professionals, 2018 to 2022 year to date

OOP, out-of-pocket. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Fees charged, benefits paid, and out-of-pocket costs are expressed in 2021-22 dollars. Estimates of out-of-pocket costs are based on services for which a co-payment was charged.

Table 3.13: Bulk-billing and out-of-pocket costs paid by consumers, for Better Access servicesdelivered by consultant psychiatrists, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Preparation of a	Services	42,870	41,799	41,515	42,267	-0.5	29,125
psychiatrist	Services bulk-billed (%)	79.0	75.1	74.5	65.6	-6.0	60.4
assessment and	Services with OOP (%)	20.6	24.5	25.0	33.8	17.9	38.9
management plan	Median OOP (\$)	120	120	118	146	6.9	201
	OOP 25 th percentile (\$)	68	65	75	81	6.4	142
	OOP 75 th percentile (\$)	182	175	197	204	3.9	270
Review of a	Services	9,033	8,691	8,875	7,681	-5.3	5,541
psychiatrist	Services bulk-billed (%)	87.5	87.8	87.0	84.3	-1.3	73.8
assessment and	Services with OOP (%)	12.3	12.0	12.9	15.5	8.0	25.6
management plan	Median OOP (\$)	90	83	86	100	3.4	144
	OOP 25 th percentile (\$)	57	44	52	51	-3.7	99
	OOP 75 th percentile (\$)	136	160	147	149	3.0	149
Initial patient	Services	144,388	146,336	148,877	160,660	3.6	81,419
consultation	Services bulk-billed (%)	23.8	20.7	19.7	16.0	-12.5	15.4
	Services with OOP (%)	76.0	79.0	80.1	83.8	3.3	84.4
	Median OOP (\$)	158	158	170	171	2.8	204
	OOP 25 th percentile (\$)	118	118	122	118	0.1	135
	OOP 75 th percentile (\$)	205	209	213	222	2.7	264

OOP, out-of-pocket. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Fees charged, benefits paid, and out-of-pocket costs are expressed in 2021-22 dollars. Estimates of out-of-pocket costs are based on services for which a co-payment was charged. Rates are crude rates per 1,000 total population.

Figures 3.6 to 3.9 profile differences in co-payment rates and median out-of-pocket costs between sociodemographic groups and over time. These show that:

- Overall, co-payment rates tended to be higher for people aged 0-14, 15-24 and 25-44 compared to those aged 45-64 and 65 and over. Median out-of-pocket costs were lower for people aged 65 and over, compared to all other age groups. This was the case for most item groups, except for services provided by GPs/other medical practitioners. These tended to have lower co-payment rates for people aged 0-14, 15-24 and 65 and over, compared to those aged 25-44 and 45-64.
- Co-payment rates and median out-of-pocket costs tended to be similar for males and females, except that co-payment rates were somewhat higher for females than males who received focussed psychological strategies from GPs/other medical practitioners, and for males than females among those who received focussed psychological strategies from occupational therapists.
- For people living in major cities, there was a gradient in co-payment rates and median out-ofpocket costs whereby those living in areas of greatest disadvantage were the least likely to make a co-payment and, if a co-payment was made, to pay lower out-of-pocket costs while people in higher socioeconomic areas were the most likely to make a co-payment and to pay a higher amount. This was generally true across all provider and item groups, although there tended to be more variation between socioeconomic areas for allied health professional services than for GP/OMP services.
- For people living in inner regional, outer regional and remote areas, the percentage of services with a co-payment was generally similar. Median co-payments overall were higher for people in remote compared to inner regional and outer regional areas, although these patterns varied across providers and item groups.



Figure 3.6: Out-of-pocket costs for any Better Access service and any Better Access treatment service, by sociodemographic factors, 2018 to 2022

Note: SES, socioeconomic status. 'Any Better Access service' refers to a service provided under any of the Better Access MBS items in Appendix 1. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

Figure 3.7: Out-of-pocket costs for Better Access services delivered by GPs and other medical practitioners, by sociodemographic factors, 2018 to 2022



Note: SES, socioeconomic status.

Figure 3.8: Out-of-pocket costs for Better Access services delivered by allied health professionals, by sociodemographic factors, 2018 to 2022



Note: SES, socioeconomic status.

Figure 3.9: Out-of-pocket costs for Better Access services delivered by consultant psychiatrists, by sociodemographic factors, 2018 to 2022



Note: SES, socioeconomic status.

Costs of Better Access services

The overall increases in uptake and utilisation have translated into increases in the costs of Better Access services over time. The total cost of these services to government, in terms of benefits paid, increased in from \$1,078.6 million in 2018 to \$1,213.3 million in 2021 (an annual increase of 4.0%). These represent real increases as all estimates of cost are expressed in 2021-22 dollars. Over the same period, total provider fees charged increased by 6.5%. This indicates that, across all Better Access services, consumer co-payments had increased at a relatively greater rate than benefits paid (Table 3.14). Out-of-pocket costs are explored later in this section.

In 2021, Better Access treatment services totalled \$827.1 million in MBS benefits paid. Provider fees charged (\$1,180.6 million in 2021) increased at a higher rate than MBS benefits paid (9.3% vs. 6.7% average annual change since 2018), indicating that out-of-pocket costs for consumers have increased relatively more than MBS benefits paid for treatment sessions.

Table 3.14: Fees charged and MBS benefits paid for any Better Access serviceand any Better Access treatment service, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%)	2022 YEAR TO DATE
						2018-2021	
Any Better Access	Fees charged (\$m)	1,333.1	1,372.1	1,478.3	1,612.1	6.5	762.3
service	Benefits paid (\$m)	1,078.6	1,083.6	1,168.9	1,213.3	4.0	535.0
	% of total fees charged	100.0	100.0	100.0	100.0	0.0	100.0
	% of total benefits paid	100.0	100.0	100.0	100.0	0.0	100.0
Any Better Access	Fees charged (\$m)	903.3	944.6	1,035.3	1,180.6	9.3	558.8
treatment service	Benefits paid (\$m)	681.7	691.9	763.2	827.1	6.7	359.6
	% of total fees charged	67.8	68.8	70.0	73.2	2.6	73.3
	% of total benefits paid	63.2	63.9	65.3	68.2	2.6	67.2

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Fees charged and benefits paid are expressed in 2021-22 dollars. 'Any Better Access service' refers to a service provided under any of the Better Access MBS items in Appendix 1. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

At a service user level, in 2021, the cost of Better Access services <u>per user</u> was \$458 in benefits paid and \$608 in fees charged per user of Better Access. The cost of Better Access treatment sessions <u>per person</u> treated was \$618 in benefits paid and \$882 in fees charged. Between 2018 and 2021, the costs per person treated increased at a greater rate than the cost per Better Access user, reflecting the increased utilisation of treatment sessions during this time (Table 3.15).

At a population level, in 2021, this amounted to \$61 per capita in fees paid and \$46 per capita in benefits paid for any Better Access service, and \$45 per capita in fees paid and \$31 per capita in benefits paid for any Better Access treatment service.

Table 3.15: Costs per user and per capita for any Better Access service andany Better Access treatment service, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Any Better Access service	Cost per BA user - Fees charged (\$)	548.30	539.94	570.78	608.49	3.5	463.33
	Cost per BA user - Benefits paid (\$)	443.63	426.41	451.32	457.96	1.1	325.18
	Cost per capita - Fees charged (\$)	52.41	53.28	56.93	61.35	5.4	28.90
	Cost per capita - Benefits paid (\$)	42.41	42.08	45.02	46.17	2.9	20.28
Any Better Access treatment service	Cost per person treated - Fees charged (\$)	716.59	714.96	770.95	882.08	7.2	635.04
	Cost per person treated - Benefits paid (\$)	540.79	523.69	568.33	617.97	4.5	408.66
	Cost per capita - Fees charged (\$)	35.51	36.68	39.87	44.93	8.2	21.19
	Cost per capita - Benefits paid (\$)	26.80	26.87	29.39	31.48	5.5	13.63

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Fees charged and benefits paid are expressed in 2021-22 dollars. 'Any Better Access service' refers to a service provided under any of the Better Access MBS items in Appendix 1. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists. Persons treated refers to the number of people who used any Better Access treatment service in a given year.

Tables 3.16-3.18 summarise fees charged and benefits paid across key item groups. In general, across the years, the items which made up the largest percentage of fees charged and benefits paid were psychological therapy services delivered by clinical psychologists and focussed psychological strategies services delivered by psychologists (34.8% and 29.0% in 2021, respectively). Between 2018 and 2021, the treatment service items typically increased as a percentage of total fees charged and benefits paid, with the exception of focussed psychological strategies provided by occupational therapists. In contrast, mental health treatment plans, mental health treatment consultations, and psychiatrist plans and reviews decreased over time in terms of percentage of total fees charged and benefits paid. These patterns primarily reflected changes in utilisation.

Table 3.16: Fees charged and MBS benefits paid for Better Access services delivered by GPs and other medical practitioners, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Preparation of a	Fees charged (\$m)	157.6	162.3	166.8	156.4	-0.3	72.1
mental health	Benefits paid (\$m)	150.1	153.8	158.7	146.6	-0.8	66.4
treatment plan	% of total fees charged	11.8	11.8	11.3	9.7	-6.4	9.5
	% of total benefits paid	13.9	14.2	13.6	12.1	-4.6	12.4
Review of a	Fees charged (\$m)	43.1	45.0	52.1	51.8	6.3	23.9
mental health	Benefits paid (\$m)	40.5	42.0	49.0	47.7	5.6	21.3
treatment plan	% of total fees charged	3.2	3.3	3.5	3.2	-0.2	3.1
	% of total benefits paid	3.8	3.9	4.2	3.9	1.5	4.0
Mental health	Fees charged (\$m)	150.6	141.7	143.2	136.7	-3.2	57.8
treatment	Benefits paid (\$m)	147.4	138.2	139.8	132.4	-3.5	55.3
consultation	% of total fees charged	11.3	10.3	9.7	8.5	-9.1	7.6
	% of total benefits paid	13.7	12.8	12.0	10.9	-7.2	10.3
Focussed	Fees charged (\$m)	5.5	5.3	6.8	7.1	9.0	3.6
psychological	Benefits paid (\$m)	4.8	4.5	6.0	6.1	8.5	2.9
strategies	% of total fees charged	0.4	0.4	0.5	0.4	2.2	0.5
	% of total benefits paid	0.4	0.4	0.5	0.5	4.2	0.5

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Fees charged and benefits paid are expressed in 2021-22 dollars.

Table 3.17: Fees charged and MBS benefits paid for Better Access services delivered by allied health professionals, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Psychological	Fees charged (\$m)	442.7	464.8	517.5	570.5	8.8	269.1
therapy services	Benefits paid (\$m)	343.6	351.9	396.9	421.8	7.1	185.3
(clinical	% of total fees charged	33.2	33.9	35.0	35.4	2.1	35.3
psychologists)	% of total benefits paid	31.9	32.5	34.0	34.8	3.0	34.6
Focussed	Fees charged (\$m)	404.8	421.6	455.0	536.3	9.8	254.4
psychological	Benefits paid (\$m)	294.1	295.1	317.4	351.5	6.1	150.6
strategies	% of total fees charged	30.4	30.7	30.8	33.3	3.1	33.4
(psychologists)	% of total benefits paid	27.3	27.2	27.2	29.0	2.0	28.1
Focussed	Fees charged (\$m)	40.9	43.7	48.4	58.2	12.5	27.9
psychological	Benefits paid (\$m)	32.5	34.0	37.4	42.0	8.9	18.5
strategies (social	% of total fees charged	3.1	3.2	3.3	3.6	5.6	3.7
workers)	% of total benefits paid	3.0	3.1	3.2	3.5	4.7	3.5
Focussed	Fees charged (\$m)	9.5	9.1	7.7	8.4	-3.9	3.8
psychological	Benefits paid (\$m)	6.8	6.5	5.5	5.7	-5.5	2.3
strategies	% of total fees charged	0.7	0.7	0.5	0.5	-9.9	0.5
(occupational	% of total benefits paid	0.6	0.6	0.5	0.5	-9.3	0.4
therapists)							

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Fees charged and benefits paid are expressed in 2021-22 dollars.

Table 3.18: Fees charged and MBS benefits paid for Better Access services delivered by consultant psychiatrists, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Preparation of a	Fees charged (\$m)	20.2	19.7	19.5	20.1	-0.3	14.4
psychiatrist	Benefits paid (\$m)	19.0	18.2	18.0	17.7	-2.3	11.8
assessment and	% of total fees charged	1.5	1.4	1.3	1.2	-6.3	1.9
management plan	% of total benefits paid	1.8	1.7	1.5	1.5	-6.1	2.2
Review of a	Fees charged (\$m)	2.6	2.5	2.5	2.1	-6.8	1.6
psychiatrist	Benefits paid (\$m)	2.5	2.4	2.4	2.0	-7.3	1.4
assessment and	% of total fees charged	1.5	1.4	1.3	1.2	-6.3	1.9
management plan	% of total benefits paid	1.8	1.7	1.5	1.5	-6.1	2.2
Initial patient	Fees charged (\$m)	55.6	56.5	58.9	64.5	5.1	33.7
consultation	Benefits paid (\$m)	37.4	37.1	37.8	39.8	2.1	19.1
	% of total fees charged	4.2	4.1	4.0	4.0	-1.4	4.4
	% of total benefits paid	3.5	3.4	3.2	3.3	-1.8	3.6

BA, Better Access. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Fees charged and benefits paid are expressed in 2021-22 dollars.

Changes in uptake and utilisation in response to program refinements

As shown in Figure 3.1 and Appendix 2, there have been several changes to the Better Access program since 2018. Most of these changes relate to the permissible number of sessions of psychological therapy or focussed psychological strategies that any individual can access in a given year, or to new item numbers that have been added at different stages to enable people who might otherwise be disadvantaged to preferentially access care (e.g., people in rural and remote areas, people residing in aged care facilities).

The following analyses explore time trends in the uptake and utilisation of Better Access treatment in response to three key changes, noting that these changes are not independent of each other:

- the introduction of items for treatment services delivered via telehealth and phone;
- changes to the permitted number of individual treatment sessions in a calendar year; and
- mental health support for aged care residents during the COVID-19 pandemic.

Introduction of items for services delivered via telehealth and phone

One major change to Better Access has been the introduction of telehealth and phone treatment services. These have been introduced at different stages for different purposes:

- As shown in Figure 3.1, at the inception of the Better Access program, treatment services could only be delivered face-to-face. This requirement remained in place until November 2017.
- From 1 November 2017, a series of changes to Better Access were introduced to allow services to be delivered via telehealth to people in rural, remote and very remote locations, on the proviso that the consumer was located at least 15 kilometres by road from the provider at the time of the consultation. On 1 November 2017, new items were introduced to allow allied health professionals to deliver up to seven of the permitted 10 sessions of individual treatment via telehealth, and to allow group services to be delivered via telehealth. On 1 September 2018, the requirement for some individual sessions to be delivered face-to-face was removed. On 1 November 2018, additional items were added to allow GPs and other medical practitioners to deliver focussed psychological strategies via telehealth.

- Between 13 March and 6 April 2020, new telehealth and phone items were introduced in response to the COVID-19 pandemic. These items replicated the existing face-to-face treatment, consultation, plan and review items, and were available to all eligible consumers without geographical restriction.
- On 7 August 2020, an additional 10 individual treatment sessions were introduced for people subject to public health orders due to COVID-19 (either because movements within the state/territory were restricted or because they were required to isolate or quarantine). People in eligible areas who had used their 10 sessions were able to receive up to 10 additional sessions in a calendar year delivered face-to-face, or via telehealth or phone.
- Shortly thereafter, from 9 October 2020, the additional 10 sessions (previously available only to people subject to public health orders due to COVID-19) were extended to all eligible consumers. This brought the permitted number of individual treatment sessions to 20 per calendar year across all modes of delivery (face-to-face, telehealth and phone). These limits are scheduled to remain in place until 31 December 2022.

We divided the period between 1 January 2018 to 30 June 2022 into four epochs (corresponding to the dates described above) and described quarterly time trends in the uptake and utilisation of Better Access treatment services, according to mode of delivery (Figure 3.10). Results are also summarised by calendar year to facilitate comparisons (Table 3.19). These show that:

- Following the introduction in March/April 2020 of the new telehealth and phone items for all eligible consumers, the use of face-to-face treatment services initially declined sharply, then increased again although levels were generally below those in the pre-pandemic period. This lower level of use of face-to-face treatment services continued through to 2022, even after the introduction of the additional 10 sessions in late 2020 (Figure 3.10). The decrease in use of face-to-face services was more than offset by use of the COVID-19 telehealth and phone services as well as a substantial relative increase in use of the rural and remote telehealth items. As a result, overall levels of Better Access treatment use increased between 2020 and 2021 (Table 3.19).
- Face-to-face remained the most common mode of delivery of Better Access treatment, even after the introduction of equivalent telehealth and phone services. In 2021, face-to-face treatment services were used by 1,123,823 persons (84.0% of Better Access treatment users). That said, telehealth and phone services were, collectively, taken up by a substantial number of people in 2021, COVID-19 telehealth services were taken up by 365,000 people (27.3% of all Better Access treatment users), COVID-19 phone services were taken up by 191,000 people (14.3% of all Better Access treatment users), and rural and remote telehealth services by 36,000 people (2.7% of all Better Access treatment users). Note that these percentages sum to more 100% because some people used more than one modality of service. These patterns were broadly similar in the first half of 2022, although the proportion of people using face-to-face treatment services was lower than in 2021 (76.8% vs. 84.0%).
- In terms of the number of treatment services used in 2021, COVID-19 telehealth services accounted for 1.5 million services (20.6% of all Better Access treatment services), COVID-19 phone services accounted for 580,000 services (8.0% of all Better Access treatment services), and rural and remote (telehealth) services accounted for 106,000 (4.0% all Better Access treatment services). These patterns were similar in the first half of 2022, although there was somewhat less use of face-to-face services and more use of the telehealth and phone services.



Figure 3.10: Uptake and utilisation of Better Access treatment services, by mode of delivery, 2018 Q1 to 2022 Q2

Note: 'Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists. 'Q', quarter.

Table 3.19: Uptake and utilisation of sessions of Better Access treatment,by mode of delivery, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Any Better	Persons (n)	1,260,559	1,321,194	1,342,890	1,338,424	2.0	879,939
Access	Rate (per 1,000)	49.6	51.3	51.7	50.9	0.9	33.4
treatment	% of BA treatment users	100.0	100.0	100.0	100.0	0.0	100.0
service	Services (n)	5,733,018	5,975,389	6,569,630	7,275,153	8.3	3,352,832
	Rate (per 1,000)	225.4	232.0	253.0	276.9	7.1	127.1
	% of BA treatment sessions	100.0	100.0	100.0	100.0	0.0	100.0
Any face-to-	Persons (n)	1,260,033	1,319,198	1,179,855	1,123,823	-3.7	676,187
face	Rate (per 1,000)	49.5	51.2	45.4	42.8	-4.8	25.6
treatment	% of BA treatment users	100.0	99.8	87.9	84.0	-5.6	76.8
sessions	Services (n)	5,727,543	5,961,516	4,616,974	5,087,608	-3.9	2,229,026
	Rate (per 1,000)	225.2	231.5	177.8	193.6	-4.9	84.5
	% of BA treatment sessions	99.9	99.8	70.3	69.9	-11.2	66.5
COVID-19	Persons (n)	n.a.	n.a.	334,580	365,378	n.a.	252,518
telehealth	Rate (per 1,000)	n.a.	n.a.	12.9	13.9	n.a.	9.6
treatment	% of BA treatment users	n.a.	n.a.	24.9	27.3	n.a.	28.7
service	Services (n)	n.a.	n.a.	1,230,868	1,496,643	n.a.	786,078
	Rate (per 1,000)	n.a.	n.a.	47.4	57.0	n.a.	29.8
	% of BA treatment sessions	n.a.	n.a.	18.7	20.6	n.a.	23.4
COVID-19	Persons (n)	n.a.	n.a.	224,515	191,003	n.a.	108,752
phone	Rate (per 1,000)	n.a.	n.a.	8.6	7.3	n.a.	4.1
treatment	% of BA treatment users	n.a.	n.a.	16.7	14.3	n.a.	12.4
service	Services (n)	n.a.	n.a.	641,538	584,488	n.a.	272,005
	Rate (per 1,000)	n.a.	n.a.	24.7	22.2	n.a.	10.3
	% of BA treatment sessions	n.a.	n.a.	9.8	8.0	n.a.	8.1
Rural and	Persons (n)	2,313	4,752	28,744	36,084	149.9	24,984
remote	Rate (per 1,000)	0.1	0.2	1.1	1.4	147.2	0.9
(telehealth)	% of BA treatment users	0.2	0.4	2.1	2.7	144.9	2.8
	Services (n)	5,475	13,873	80,250	106,414	168.9	65,723
	Rate (per 1,000)	0.2	0.5	3.1	4.0	166.0	2.5
	% of BA treatment sessions	0.1	0.2	1.2	1.5	148.3	2.0

BA, Better Access. n.a., not applicable. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

We examined the extent to which different population groups made use of the COVID-19 telehealth and phone treatment sessions (Table 3.20). Patterns of uptake across groups defined by age and sex were similar for telehealth and phone treatment sessions. In terms of age, people aged 15-24 and 25-44 had the highest rates of uptake, while those aged 0-14 and 65 and older had the lowest. Uptake rates for females were more than double the rates for males. For COVID-19 telehealth treatment services, uptake was highest among people in major cities (higher socioeconomic status areas) whereas for COVID-19 phone treatment services, uptake was highest among people in major cities (lower socioeconomic status areas). People outer regional and remote areas had the lowest rates of both telehealth and phone treatment services, compared to the other demographic area groups.

As noted earlier, however, rates of uptake and utilisation of Better Access treatment services have increased over time for people in remote areas as much as they have for people in higher socioeconomic areas in major cities. Further analysis showed that this is because both these areas, the decline in uptake of face-to-face treatment was lower than in other areas (Table 3.20), but relatively more people took up

only telehealth and/or phone treatment options in remote areas than in other areas (18% vs 12% in 2020, and 21% vs. 14%-17%).

Table 3.20: Rates of uptake of sessions of COVID-19 telehealth and phone treatment services and face-to-face services by sociodemographic groups, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
COVID-19	0-14 years	n.a.	n.a.	7.4	6.3	n.a.	3.5
telehealth	15-24 years	n.a.	n.a.	22.7	25.5	n.a.	17.0
treatment	25-44 years	n.a.	n.a.	20.7	23.7	n.a.	17.2
service	45-64 years	n.a.	n.a.	10.4	10.8	n.a.	7.4
	65 years and over	n.a.	n.a.	3.0	2.9	n.a.	1.9
	Female	n.a.	n.a.	17.7	19.6	n.a.	13.8
	Male	n.a.	n.a.	8.0	8.1	n.a.	5.3
	Major cities (higher SES)	n.a.	n.a.	18.1	21.8	n.a.	14.7
	Major cities (medium SES)	n.a.	n.a.	15.3	16.6	n.a.	11.4
	Major cities (lower SES)	n.a.	n.a.	10.7	11.4	n.a.	7.7
	Inner regional	n.a.	n.a.	10.7	9.6	n.a.	6.8
	Outer regional	n.a.	n.a.	5.3	5.1	n.a.	4.1
	Remote	n.a.	n.a.	2.8	3.5	n.a.	2.9
COVID-19	0-14 years	n.a.	n.a.	2.3	1.5	n.a.	0.7
phone	15-24 years	n.a.	n.a.	14.1	11.5	n.a.	6.1
treatment	25-44 years	n.a.	n.a.	12.1	10.7	n.a.	6.1
service	45-64 years	n.a.	n.a.	9.9	8.5	n.a.	5.0
	65 years and over	n.a.	n.a.	4.2	3.2	n.a.	1.9
	Female	n.a.	n.a.	11.6	9.9	n.a.	5.7
	Male	n.a.	n.a.	5.7	4.6	n.a.	2.5
	Major cities (higher SES)	n.a.	n.a.	6.7	6.0	n.a.	3.2
	Major cities (medium SES)	n.a.	n.a.	8.8	7.5	n.a.	4.1
	Major cities (lower SES)	n.a.	n.a.	11.0	10.0	n.a.	5.7
	Inner regional	n.a.	n.a.	9.4	6.8	n.a.	4.1
	Outer regional	n.a.	n.a.	5.5	3.8	n.a.	2.6
	Remote	n.a.	n.a.	2.1	1.8	n.a.	1.3

n.a., not applicable. SES, socioeconomic status. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

Changes to the permitted number of individual treatment sessions per calendar year

Another major change to the program has been to allow people with an approved treatment plan who are experiencing severe or enduring mental health impacts from COVID-19 and restrictions to access an additional 10 sessions of individual treatment per calendar year:^{58,59}

- As shown in Figure 3.1, the permitted number of individual treatment sessions was capped at 10 in 2013 and this limit remained in place until 2020.
- On 7 August 2020, the existing face-to-face, phone and telehealth individual session limit increased to 20 individual sessions/year for people subject to public health orders due to COVID-19.
- From 9 October 2020 (as described in (a) above), the existing face-to-face, phone and telehealth individual session limit was increased to 20 individual sessions/year for all eligible consumers. These limits are scheduled to remain in place until 31 December 2022.

We divided the period between 1 January 2018 and 30 June 2022 into three epochs, capturing the changes to the permissible number of individual Better Access treatment sessions. We described time trends in the uptake and utilisation of individual Better Access treatment services, according to whether they were initial or additional services (Figure 3.11). Results are also summarised by calendar year (Table 3.21). These show that:

- Following the introduction of the additional 10 sessions without geographical restriction, utilisation of Better Access individual treatment services increased by an average of 8.4% per year. This was mostly due to utilisation of the additional sessions by existing users, as the number of people receiving individual treatment increased only modestly (0.9%).
- The percentage of Better Access treatment users who received at least one additional treatment session was 17.0% in 2021 and 13.6% in the first half of 2022. That is, only about one in every six people who received Better Access treatment in 2021 received any additional sessions.
- The share of treatment services accounted for by the additional 10 sessions was 14.8% in 2021 and 11.8% in the first half of 2022.



Figure 3.11: Uptake and utilisation individual Better Access treatment services, by whether the sessions were individual or additional, 2018 Q1 to 2022 Q2

Note: Q, quarter. 'Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

 Table 3.21: Uptake and utilisation of initial and additional individual treatment services, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Any	Persons (n)	1,259,570	1,320,338	1,342,399	1,337,834	2.0	879,595
individual	Rate (per 1,000)	49.5	51.3	51.7	50.9	0.9	33.4
treatment	% of individual session users	100.0	100.0	100.0	100.0	0.0	100.0
service	Services (n)	5,695,521	5,945,081	6,556,073	7,258,098	8.4	3,345,533
	Rate (per 1,000)	223.9	230.9	252.5	276.2	7.2	126.8
	% of individual sessions	100.0	100.0	100.0	100.0	0.0	100.0
Initial	Persons (n)	1,259,570	1,320,338	1,341,526	1,318,705	1.5	839,580
individual	Rate (per 1,000)	49.5	51.3	51.7	50.2	0.4	31.8
treatment	% of individual session users	100.0	100.0	99.9	98.6	-0.5	95.5
service	Services (n)	5,695,521	5,945,081	6,227,773	6,186,813	2.8	2,949,681
	Rate (per 1,000)	223.9	230.9	239.9	235.5	1.7	111.8
	% of individual sessions	100.0	100.0	95.0	85.2	-5.2	88.2
Additional	Persons (n)	n.a.	n.a.	100,652	226,845	n.a.	119,588
individual	Rate (per 1,000)	n.a.	n.a.	3.9	8.6	n.a.	4.5
treatment	% of individual session users	n.a.	n.a.	7.5	17.0	n.a.	13.6
service	Services (n)	n.a.	n.a.	328,300	1,071,285	n.a.	395,852
	Rate (per 1,000)	n.a.	n.a.	12.6	40.8	n.a.	15.0
	% of individual sessions	n.a.	n.a.	5.0	14.8	n.a.	11.8

n.a., not applicable. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population.

We examined the extent to which different population groups were making use of the initial individual and additional treatment sessions (Table 3.22). The patterns of uptake were similar for initial individual and additional individual treatment sessions. The age group with the highest rate of uptake was those aged 15-24 years, followed by those 25-44 years. Lowest rates of uptake were among those aged 65+ and 0-14 years, compared to the other age groups. Females had approximately double the rates of uptake compared to males. People living in major cities (higher and medium socioeconomic status areas) had the highest rates of uptake. Lowest rates of uptake were in outer regional and remote areas.

Table 3.22: Uptake of initial and additional individual treatment sessions,by sociodemographic groups, 2018 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Initial	0-14 years	35.2	34.8	32.2	29.5	-5.7	17.7
individual	15-24 years	74.9	80.5	86.6	88.2	5.6	55.7
treatment	25-44 years	66.3	69.8	72.6	72.1	2.8	46.9
service	45-64 years	48.8	49.7	48.4	45.6	-2.2	28.6
	65 years and over	19.5	20.1	19.1	17.8	-3.0	11.3
	Female	60.7	63.1	65.3	65.1	2.4	42.1
	Male	38.2	39.3	37.9	35.1	-2.8	21.4
	Major cities (higher SES)	54.4	57.3	59.1	59.5	3.0	38.9
	Major cities (medium SES)	53.6	55.7	56.2	54.8	0.7	35.0
	Major cities (lower SES)	49.5	50.8	50.3	47.5	-1.4	29.4
	Inner regional	49.2	50.4	50.1	47.6	-1.1	29.7
	Outer regional	32.7	32.9	33.4	32.8	0.1	20.4
	Remote	14.4	15.3	16.6	16.0	3.6	9.8
Additional	0-14 years	n.a.	n.a.	1.5	3.5	n.a.	1.7
individual	15-24 years	n.a.	n.a.	6.6	16.0	n.a.	8.4
treatment	25-44 years	n.a.	n.a.	6.1	13.2	n.a.	7.1
service	45-64 years	n.a.	n.a.	3.7	8.0	n.a.	4.1
	65 years and over	n.a.	n.a.	1.3	2.7	n.a.	1.4
	Female	n.a.	n.a.	5.5	12.2	n.a.	6.5
	Male	n.a.	n.a.	2.2	5.0	n.a.	2.5
	Major cities (higher SES)	n.a.	n.a.	5.6	12.4	n.a.	6.6
	Major cities (medium SES)	n.a.	n.a.	4.7	10.2	n.a.	5.4
	Major cities (lower SES)	n.a.	n.a.	3.4	7.6	n.a.	3.8
	Inner regional	n.a.	n.a.	2.8	6.3	n.a.	3.4
	Outer regional	n.a.	n.a.	1.4	3.7	n.a.	2.0
	Remote	n.a.	n.a.	0.7	1.9	n.a.	1.1

n.a., not applicable. SES, socioeconomic status. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population. 'Any Better Access treatment service' refers to a service provided under any of the following Better Access MBS items in Appendix 1: psychological therapy services delivered by clinical psychologists or focussed psychological strategies services delivered by GPs/other medical practitioners, psychologists, social workers and occupational therapists.

Mental health support for aged care residents during the COVID-19 pandemic

From 10 December 2020, the eligibility requirements for Better Access were expanded to allow residents of aged care facilities whose mental health is impacted by the COVID-19 pandemic to access Medicare-subsidised psychological treatment.^{58,60} This expansion involved the creation of new dedicated MBS item numbers available only to residents in aged care facilities (see Appendix 1 for details of the item numbers). This expansion is scheduled to end on 31 December 2022.^{58,61}

The items function as per the existing Better Access items, allowing residents of aged care facilities to receive services for: preparation of a mental health treatment plan; review of a mental health treatment plan after an initial 6 treatment sessions; and up to 20 individual sessions of Better Access treatment from GPs/other medical practitioners and allied health professionals in a calendar year. The individual treatment sessions are delivered face-to-face. The preparation or review of a mental health treatment plan services can be delivered face-to-face or via telehealth or phone (noting that the phone items for mental health treatment plans were discontinued on 6 August 2021). The dedicated MBS items do not include services from consultant psychiatrists or mental health treatment consultation services from GPs/other medical practitioners.

We described time trends in the uptake and utilisation of the RACF COVID-19 mental health support items (Figure 3.15). Results are also summarised by calendar year (Table 3.23). These show that:

- In 2021, approximately 2,000 persons received at least one service via the dedicated RACF items. Of these people, approximately 1,600 (82.6%) received services for the preparation or review of a mental health treatment plan and approximately 400 (20.0%) received individual treatment sessions. These 2000 people received approximately 3,200 services, half of which were individual treatment services (approximately 1,600 services or 49.0% of services). Among those who received treatment sessions, the ratio of persons to sessions was approximately 1:4.
- In the first half of 2022, 883 people received these services. Compared to 2021, relatively fewer received plans or reviews (78.1%) and more (24.1%) received individual treatment services.



Figure 3.12: Uptake and utilisation of the RACF COVID-19 Mental Health Support items available only to residents in aged care facilities, 2020 Q4 to 2022 Q2

Notes: Q, quarter. RACF, residential aged care facility.

Table 3.23: Uptake and utilisation of the RACF COVID-19 mental health support services available only to residents in aged care facilities, 2020 to 2022 year to date

		2020	2021	2022 YEAR TO DATE
Any RACF COVID-	Persons (n)	27	2,005	883
19 mental health	Rate (per 1,000)	0.001	0.076	0.033
support service	% of RACF users	100.0	100.0	100.0
	Services (n)	39	3,228	1,310
	Rate (per 1,000)	0.002	0.127	0.050
	% RACF services	100.0	100.0	100.0
Preparation or	Persons (n)	n.p.	1,656	690
review of a	Rate (per 1,000)		0.063	0.026
mental health	% of RACF users		82.6	78.1
treatment plan	Services (n)	n.p.	1,697	692
	Rate (per 1,000)		0.065	0.026
	% RACF services		51.0	52.8
Individual	Persons (n)	n.p.	402	213
treatment service	Rate (per 1,000)		0.015	0.008
	% of RACF users		20.0	24.1
	Services (n)	n.p.	1,631	618
	Rate (per 1,000)		0.062	0.023
	% RACF services		49.0	47.2

n.p., not provided due to small counts. RACF, residential aged care facility. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population.

Relationship between use of Better Access services and other mental health services

We explored patterns of use of mental health medications, and use of non-Better Access psychiatrist services, across areas where the uptake of Better Access treatment has been relatively higher or lower. We also examined whether these patterns have changed over time. With respect to mental health medications, we focused on antidepressant and anxiolytic medications as these are the principal pharmacological agents used in the treatment of affective and anxiety disorders, which are the key disorders targeted by Better Access. For these analyses, the unit of analysis is SA3, with each SA3 contributes equally regardless of population size.

Antidepressant and anxiolytic medications

Figure 3.13 shows the rates of persons using antidepressant (chart a) and anxiolytic (chart b) in areas grouped into quintiles of Better Access treatment uptake in 2021. Tables 3.24 and 3.25 show equivalent estimates for all years 2018 through 2022. We excluded the 0-14 year group from these analyses because many SA3s had low counts of antidepressants and anxiolytic use among this age group which may be statistically unreliable.



Figure 3.13: Rates of antidepressant and anxiolytic use among persons 15 years and older, by quintiles of Better Access treatment uptake, SA3s, 2021

Note: SA3, Statistical Areas Level 3. Dashed line shows trend in medians.

Overall, there was a weak but statistically significant negative correlation between use of antidepressants and level of Better Access treatment uptake at an area level in more recent years (2021 and 2022). There was a (usually) monotonic *decrease* in antidepressant use as level of Better Access uptake increased. That is, areas with the lowest Better Access treatment uptake had the *highest* rates of antidepressant use, and areas with the highest Better Access treatment uptake had the *lowest* rates of antidepressant use. Rates of antidepressant use increased between 2018 and 2021 across all levels of Better Access treatment uptake^f. However, the correlations did not differ significantly between 2018 and 2021 (z=1.17, p=0.24) indicating that the associations with Better Access uptake remained fairly stable over this time.

The picture was different for anxiolytics. Overall, there was a statistically significant, moderate positive correlation between area-level rates of anxiolytic use and level of Better Access treatment uptake in all years examined. There was a monotonic *increase* in anxiolytic use as level of Better Access uptake increased. That is, people areas with lowest Better Access uptake had the *lowest* rates of anxiolytic use. Rates of anxiolytic use decreased between 2018 and 2021 in all groups. However, the correlations did not differ significantly between 2018 and 2021 (z=1.50, p=0.13) indicating that the associations with Better Access uptake remained fairly stable.

^f 2022 data are reported but cannot be compared to earlier years because only six months of data were available (giving less opportunity to accrue medication use compared to a full 12 months).

Table 3.24: Rates of antidepressant use among persons 15 years and older, by quintiles of Better Access treatment uptake, SA3s, 2018 to 2022 year to date

RATES OF ANTIDEPRESSANT USE IN QUINTILES OF BETTER ACCESS UPTAKE								
	N 1	Q1 (LOWEST) MEDIAN (IQR)	Q2 MEDIAN (IQR)	Q3 MEDIAN (IQR)	Q4 MEDIAN (IQR)	Q5 (HIGHEST) MEDIAN (IQR)	ρ²	
2018	334	167.2 (111.8, 188.7)	158.9 (102.3, 194.8)	157.8 (131.5, 195.2)	155.3 (132.8, 190.9)	148.0 (129.7, 169.1)	-0.02	
2019	333	174.6 (116.5, 192.9)	166.2 (104.6, 199.9)	158.6 (134.6, 195.0)	162.3 (136.6, 194.1)	149.2 (132.8, 171.7)	-0.05	
2020	334	179.2 (131.1, 198.7)	179.9 (106.1, 210.1)	162.7 (140.7, 197.9)	167.1 (142.4, 196.6)	154.2 (139.7, 175.3)	-0.08	
2021	334	184.5 (129.0, 203.0)	185.8 (115.6, 211.8)	174.8 (149.7, 205.9)	168.7 (142.8, 192.8)	156.7 (144.5, 178.8)	-0.11*	
2022	334	160.2 (119.0, 183.9)	171.2 (118.0, 187.2)	150.7 (123.3, 175.1)	147.3 (124.1, 163.6)	137.0 (127.4, 154.2)	-0.15**	

* p<0.05, ** p<0.01. IQR, interquartile range. SA3, Statistical Areas Level 3. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 population.

¹ Total number of SA3s for analysis was 340 (non-spatial SA3s were excluded). SA3s were excluded from analysis for a given year if cells for any subgroups were suppressed due to small counts.

 $^{2}\rho$, Spearman's correlation coefficient.

Table 3.25: Rates of anxiolytic use among persons 15 years and older, by quintiles of Better Access treatment uptake, SA3s, 2018 to 2022 year to date

	RATES OF ANXIOLYTIC USE IN QUINTILES OF BETTER ACCESS UPTAKE								
	N ¹	Q1 (LOWEST) MEDIAN (IQR)	Q2 MEDIAN (IQR)	Q3 MEDIAN (IQR)	Q4 MEDIAN (IQR)	Q5 (HIGHEST) MEDIAN (IQR)	ρ²		
2018	333	39.5 (28.7 <i>,</i> 46.4)	40.0 (31.1, 50.3)	46.6 (40.2 <i>,</i> 56.3)	53.2 (45.5 <i>,</i> 61.7)	57.0 (51.1 <i>,</i> 66.4)	0.54***		
2019	333	37.0 (28.8, 45.6)	40.3 (30.3, 48.7)	44.3 (37.5, 53.3)	51.4 (43.7 <i>,</i> 58.8)	56.8 (51.1, 64.9)	0.56***		
2020	334	36.7 (28.9 <i>,</i> 45.4)	39.7 (27.9, 47.4)	41.7 (34.4, 50.0)	48.9 (40.1 <i>,</i> 58.6)	52.2 (47.3 <i>,</i> 60.5)	0.49***		
2021	334	34.1 (24.8, 42.6)	36.8 (27.8, 45.2)	40.6 (33.0, 48.8)	44.8 (36.0, 53.2)	48.5 (43.4, 54.1)	0.45***		
2022	331	21.8 (17.4, 26.4)	25.1 (19.8, 30.8)	24.5 (19.6, 30.3)	28.5 (22.7, 34.1)	32.1 (27.6, 35.3)	0.43***		

*** p<0.001. IQR, interquartile range. SA3, Statistical Areas Level 3. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 population.

¹ Total number of SA3s for analysis was 340 (non-spatial SA3s were excluded). SA3s were excluded from analysis for a given year if cells for any subgroups were suppressed due to small counts.

 $^{2}\rho$, Spearman's correlation coefficient.

We then examined whether these patterns persisted when we took where people live into account. Tables 3.28 and 3.29 show the correlations between antidepressant and anxiolytic use with Better Access treatment uptake, stratified by geographic area. Note that the outer regional and remote groups were combined because the number of SA3s in the remote group was too small for analysis (<25). Notably, the patterns differed for antidepressant and anxiolytic use:

- In areas of lower socioeconomic status in major cities and in outer regional/remote areas, higher levels of Better Access use were associated with higher levels of antidepressant use. This was also the case in major cities (medium socioeconomic status areas) in 2018-2020, but the association was no longer statistically significant in 2021 or 2022. For all other geographic groups, there was no significant association.
- In contrast, there was a positive association between anxiolytic use and Better Access treatment uptake in all geographic area groups, but the association was highest for major cities (higher socioeconomic status areas) and lowest for outer regional/remote groups.

Table 3.26: Correlations between antidepressant use and Better Access treatment uptake amongpersons 15 years and older, within geographic area groups, 2018 to 2022 year to date

	MAJOR CITIES (HIGHER SES)		GE MAJOR CITIES (MEDIUM SES)		OGRAPHIC AREA GROUP MAJOR CITIES (LOWER SES)		PS INNER REGIONAL		OUTER REGIONAL/REMOTE	
	n¹	ρ²	n¹	ρ²	n¹	ρ²	n¹	ρ²	n1	ρ²
2018	49	0.05	93	0.30*	48	0.51***	82	-0.14	62	0.32*
2019	49	0.05	93	0.32**	48	0.47***	81	-0.12	62	0.34**
2020	49	0.15	93	0.29**	48	0.50***	81	-0.15	63	0.29*
2021	49	0.19	93	0.17	48	0.43**	81	-0.12	63	0.32*
2022	49	0.26	93	0.08	48	0.33*	81	-0.15	62	0.30*

* p<0.05, ** p<0.01, *** p<0.001. IQR, interquartile range. SES, socioeconomic status. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Geographic area groups are based on Statistical Areas Level 3 (SA3). Total number of SA3s for analysis was 340 (non-spatial SA3s were excluded). SA3s were excluded from analysis for a given year if cells for any subgroups were suppressed due to small counts. ² ρ, Spearman's correlation coefficient.

Table 3.27: Correlations between anxiolytic use and Better Access treatment uptake among persons 15 years and older, within geographic area groups, 2018 to 2022 year to date

	GEOGRAPHIC AREA GROUPS										
	MAJOR CITIES (HIGHER SES)		MAJOR CITIES (MEDIUM SES)		MAJOR CITIES (LOWER SES)		INNER REGIONAL		OUTER REGIONAL/REMOTE		
	n¹	ρ²	n¹	ρ²	n¹	ρ²	n¹	ρ²	n¹	ρ²	
2018	49	0.75***	93	0.69***	48	0.69***	81	0.56***	62	0.57***	
2019	49	0.80***	93	0.72***	48	0.70***	81	0.60***	62	0.50***	
2020	49	0.75***	93	0.68***	48	0.66***	81	0.52***	63	0.44***	
2021	49	0.70***	93	0.63***	48	0.57***	81	0.50***	63	0.47***	
2022	49	0.75***	93	0.57***	48	0.42**	81	0.45***	60	0.52***	

* p<0.05, ** p<0.01, *** p<0.001. IQR, interquartile range. SES, socioeconomic status. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Geographic area groups are based on Statistical Areas Level 3 (SA3). Total number of SA3s for analysis was 340 (non-spatial SA3s were excluded). SA3s were excluded from analysis for a given year if cells for any subgroups were suppressed due to small counts. ² ρ , Spearman's correlation coefficient.
Non-Better Access psychiatrist MBS services

Figure 3.14 shows the rates of persons using non-Better Access psychiatrist MBS services (out of hospital) in areas grouped into quintiles of Better Access treatment uptake in 2021. Table 3.25 shows equivalent estimates for all years 2018 through 2022.



Figure 3.14: Rates of use of non-Better Access psychiatrist MBS services, by quintiles of Better Access treatment uptake, SA3s, 2021

Note: SA3, Statistical Areas Level 3 (SA3).

Overall, there was a moderate-to-strong positive correlation between the use of non-Better Access psychiatrist MBS services and level of Better Access treatment uptake in all years examined. That is, people living in areas with lowest Better Access uptake had the *lowest* rates of psychiatrist service use. There was a monotonic *increase* in use as level of Better Access uptake increased. Rates of psychiatrist use increased between 2018 and 2021 in all groups. However, the correlations did not differ significantly between 2018 and 2021 (z=-1.05, p=0.29) indicating that the associations with Better Access uptake remained fairly stable over this time.

		RATES OF USE OF NO	N-BETTER ACCESS PSY	CHIATRIST MBS SERVIC	ES IN QUINTILES OF BE	TTER ACCESS UPTAKE	
	N 1	Q1 (LOWEST)	Q2	Q3	Q4	Q5 (HIGHEST)	ρ²
		MEDIAN (IQR)	MEDIAN (IQR)	MEDIAN (IQR)	MEDIAN (IQR)	MEDIAN (IQR)	
2018	329	7.9 (5.3, 10.3)	10.5 (8.7 <i>,</i> 11.9)	12.3 (10.5, 15.2)	14.5 (11.9, 17.9)	17.4 (13.4, 20.8)	0.65***
2019	329	8.3 (6.2, 10.6)	10.6 (8.9, 13.0)	13.0 (10.7, 15.3)	14.5 (12.0, 18.0)	18.0 (13.6, 22.1)	0.65***
2020	330	9.8 (7.1, 11.7)	11.7 (9.9, 14.2)	12.8 (11.7, 16.7)	16.5 (13.5, 19.6)	19.0 (14.8, 23.4)	0.65***
2021	331	10.2 (8.0, 12.5)	12.3 (10.8, 14.8)	13.8 (12.0, 16.9)	18.1 (14.5, 20.5)	20.4 (17.3, 26.2)	0.69***
2022	328	5.7 (4.3, 6.8)	7.6 (6.1, 9.0)	10.2 (8.8, 12.0)	12.8 (10.4, 16.0)	17.5 (13.0, 21.3)	0.79***

Table 3.28: Rates of use of non-Better Access psychiatrist MBS services, by quintiles of Better Accesstreatment uptake, SA3s, 2018 to 2022 year to date

* p<0.05, ** p<0.01. IQR, interquartile range. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 population.

¹ Geographic area groups are based on Statistical Areas Level 3 (SA3). Total number of SA3s for analysis was 340 (non-spatial SA3s were excluded). SA3s were excluded from analysis for a given year if cells for any subgroups were suppressed due to small counts. ² ρ, Spearman's correlation coefficient.

We then examined whether these patterns persisted when we took where people live into account. Table 3.26 shows the correlations between use of non-Better Access psychiatrist MBS services with Better Access treatment uptake, stratified by geographic area.

Notably, there was a positive association between anxiolytic use and Better Access treatment uptake in all geographic area groups in 2021 and in all except the outer regional/remote group in 2018-2020. However, the association was highest for major cities (higher socioeconomic areas) and lowest for outer regional/remote groups.

	MAJOR CITIES (HIGHER SES)		GEOGRAPHIC AREA GROUPS MAJOR CITIES MAJOR CITIES (HIGHER SES) (MEDIUM SES) (LOWER SES)				S INNER	REGIONAL	OL REGIONA	JTER L/REMOTE
	n¹	ρ²	n¹	ρ²	n¹	ρ²	n¹	ρ²	n¹	ρ²
2018	49	0.59***	93	0.40***	47	0.58***	80	0.49***	60	0.19
2019	49	0.66***	93	0.39***	47	0.54***	80	0.37***	60	0.16
2020	49	0.62***	93	0.47***	47	0.63***	80	0.25*	61	0.19
2021	49	0.72***	93	0.52***	47	0.72***	81	0.28*	61	0.26*
2022	49	0.74***	93	0.58***	47	0.66***	80	0.50***	59	0.30*

Table 3.29: Correlations between use of non-Better Access psychiatrist MBS services and Better Access treatment uptake, within geographic area groups, 2018 to 2022 year to date

* p<0.05, ** p<0.01, *** p<0.001. IQR, interquartile range. SES, socioeconomic status. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Geographic area groups are based on Statistical Areas Level 3 (SA3). Total number of SA3s for analysis was 340 (non-spatial SA3s were excluded). SA3s were excluded from analysis for a given year if cells for any subgroups were suppressed due to small counts. ² ρ , Spearman's correlation coefficient.

Typical patterns of Better Access treatment

The next few analyses explore patterns of treatment following a mental health treatment plan. For these analyses, the year refers to the year in which the mental health treatment plan was prepared, however the services that followed may have been used in the same year as the plan or in later years (up to 30 June 2022). This means, however, that for plans completed in later years, there will have been less time for treatment sessions to have been received. For example, for a plan completed in 2021, there will have been 6 to 18 months, depending on the date the plan was completed.

Note also that a consumer can continue on the same mental health treatment plan indefinitely, with the plan being updated as clinically required.⁶² This means that a person may have many courses of treatment under the same plan.

Analyses focused on treatment services received following a mental health treatment plan provided by GPs/other medical practitioners, although some data are reported about treatment services received after either a mental health treatment plan or a psychiatrist assessment and management plan.

Number of treatment sessions following a mental health treatment plan

Table 3.30 summarises information about (i) the extent to which mental health treatment plans were followed by treatment sessions and (ii) if so, the number of treatment sessions received. The findings are organised according to the year the mental health treatment plan was completed. From 2018 to 2020, approximately two thirds (64.7%-66.9%) of mental health treatment plans were followed by one or more treatment sessions. The proportion decreased to 58.8% in 2021, however as noted earlier this will, to some extent, reflect there being less time for treatment sessions to have been received compared to people with a plan completed in earlier years. In interpreting these data, it is important to bear in mind that some consumers who did not received psychological treatment via Better Access may have received psychological treatment services under other MBS items (the mental health treatment consultation or standard GP items) or other funding arrangements (e.g., privately paid, PHN-commissioned psychological treatment services) or may have received other types of mental health care.

In 2018-2021, approximately two thirds of the plans that were followed by treatment sessions involved between 1 and 6 sessions, one fifth involved between 7 and 10 sessions, and a further one eighth

involved 11-20 sessions. Few people (no more than 5%) received more than 21 or more sessions and <1% received 31 or more.

The distribution of sessions used was relatively stable over time, the median number being 5 regardless of the year in which the plan was prepared. There was, however, an uptick in the percentage of episodes with 11-20 and 21-30 sessions in 2020. Similarly, the 75th percentile increased in 2020 (from 9 in 2018 and 2019 to 10 in 2020). These patterns are consistent with the introduction of the additional 10 sessions in 2020.

	MENTAL HEALTH TREATMENT PLANS FOLLOWED BY ONE OR MORE TREATMENT SESSIONS (%) ¹	NUMBE	NUMBER OF TREATMENT SESSIONS FOLLOWING A MENTAL HEALTH TREATMENT PLAN (%) ¹							
		1-2	3-4	5-6	7-10	11-20	21-30	31+	MEDIAN (IQR) ²	
2018	66.9	25.4	20.0	17.7	21.1	13.8	1.5	0.6	5 (2, 9)	
2019	65.7	25.8	20.1	17.5	20.0	13.2	2.5	0.8	5 (2 <i>,</i> 9)	
2020	64.7	24.4	18.8	16.8	18.3	16.8	4.0	0.9	5 (3, 10)	
2021	58.8	26.9	21.1	18.4	18.5	13.3	1.6	0.1	5 (2, 8)	
2022	47.1	48.1	28.2	14.9	7.6	1.3	0.0	0.0	3 (1,4)	

Table 3.30: Treatment sessions following a mental health treatment plan, 20	018 to 2022 year to date
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IQR, interquartile range. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Takes into account all individual treatment sessions received following a mental health treatment plan up until either the last session received, or a new plan was completed.

Table 3.31 presents equivalent results by demographic group. Generally, the proportion of plans followed by one or more treatment sessions was fairly similar across age groups and sexes. There was a gradient in which people in major cities (higher socioeconomic areas) had the highest proportions (ranging from 66.8% to 73.5% in 2018-2021 depending on year) and people in remote areas had the lowest proportions (41.3% to 45.2% in 2018-2021 depending on year).

In all years from 2018 to 2021, the median number of treatment sessions was 5 for most age groups, with the exception of 2019 and 2021 where the median was 4 for those aged 65 and over, and 2020 where the median was 6 for those aged 15-24. Males and females also had similar median number of sessions in 2018 and 2019, but in 2020 and 2021 the median number was higher for females than males. People in major cities (higher and medium socioeconomic status areas) typically had the highest median number of treatment episodes (5 or 6), while those in outer regional and remote areas typically had the lowest (usually 4).

Table 3.31: Treatment sessions following a mental health treatment plan,by demographic factors, 2018 to 2022 year to date

	MENTAL HEALTH TREATMENT PLANS FOLLOWED BY ONE OR MORE TREATMENT SESSIONS (%) ¹				NUMBER OF TREATMENT SESSIONS FOLLOWING A MENTAL HEALTH TREATMENT PLAN (MEDIAN, IQR) ¹					
	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022
Age group										
0-14	70.4	67.8	64.0	56.6	43.0	5 (3, 9)	5 (3 <i>,</i> 9)	5 (3, 9)	5 (2, 8)	3 (1, 4)
15-24	64.5	63.5	63.2	56.8	43.7	5 (2 <i>,</i> 9)	5 (2 <i>,</i> 9)	6 (3 <i>,</i> 10)	5 (2 <i>,</i> 9)	3 (1, 5)
25-44	66.4	65.2	65.2	59.7	48.5	5 (2, 9)	5 (2, 9)	5 (3, 10)	5 (2 <i>,</i> 8)	3 (1, 4)
45-64	68.2	67.1	65.7	60.3	49.4	5 (3, 9)	5 (2, 9)	5 (3, 10)	5 (2 <i>,</i> 8)	3 (1, 4)
65 and over	66.2	66.1	63.8	59.1	50.1	5 (2, 9)	4 (2, 9)	5 (2, 9)	4 (2, 7)	2 (1, 4)
Sex										
Female	67.9	66.9	66.3	60.5	48.5	5 (3, 10)	5 (3, 10)	6 (3, 10)	5 (2 <i>,</i> 9)	3 (1, 4)
Male	65.4	63.8	61.9	56.0	44.8	5 (2, 9)	5 (2, 8)	5 (2, 9)	4 (2, 8)	3 (1, 4)
Geographic area group										
Major cities (higher SES)	73.5	72.7	71.8	66.8	54.8	6 (3, 10)	5 (3, 10)	6 (3, 11)	5 (3 <i>,</i> 9)	3 (2, 5)
Major cities (medium SES)	70.3	69.0	67.8	61.8	50.2	5 (3, 9)	5 (3 <i>,</i> 9)	6 (3, 10)	5 (2 <i>,</i> 8)	3 (1, 4)
Major cities (lower SES)	64.2	62.8	61.3	54.8	43.5	5 (2, 9)	5 (2, 9)	5 (2, 10)	5 (2 <i>,</i> 8)	2 (1, 4)
Inner regional	63.4	62.0	60.9	54.8	42.0	5 (2, 9)	5 (2 <i>,</i> 9)	5 (2, 9)	4 (2, 7)	2 (1, 4)
Outer regional	56.2	54.0	53.8	49.2	37.5	4 (2, 8)	4 (2, 8)	5 (2, 9)	4 (2, 7)	2 (1, 4)
Remote	45.2	44.1	46.0	41.3	33.2	4 (2, 7)	4 (2, 8)	4 (2, 8)	4 (2, 8)	2 (1, 4)

IQR, interquartile range. SES, socioeconomic status. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Takes into account all individual treatment sessions received following a mental health treatment plan up until either the last session received, or a new plan was completed.

We also explored the patterns of treatment following either a mental health treatment plan or a psychiatrist assessment and management plan. Results were nearly identical (see Appendix 4, Tables A4.2 and A4.3).

Proportion of mental health treatment plans followed by a review

Table 3.32 summarises information about the extent to which services for the review of a mental health treatment plan were used. In all years 2018 to 2021, of plans that *were not* followed by treatment sessions, approximately 10% were followed by a review. This suggests that at least some people who did not receive Better Access treatment sessions were receiving other care and that this care was being reviewed. Of plans that *were* followed by treatment sessions, more than one third involved a review. Between 2018 and 2021, the median number of treatment sessions when a review was involved was nine or then, compared to three when a review was not involved.

	SERVICE I	PATTERNS FOLLO TREATME	L HEALTH	NUMBER OF SESS A MENTAL HEA PLAN (MEI	SIONS FOLLOWING LTH TREATMENT DIAN, IQR) ¹	
	PLAN ONLY (%)	PLAN AND REVIEW ONLY (%)	TREATMENT SESSIONS WITHOUT REVIEW (%)	TREATMENT SESSIONS WITH REVIEW (%)	WITHOUT REVIEW	WITH REVIEW
2018	29.3	3.8	42.0	24.9	3 (2, 6)	10 (6, 12)
2019	30.7	3.6	40.7	25.0	3 (2, 5)	10 (6, 13)
2020	31.7	3.7	38.0	26.6	3 (2, 6)	10 (7, 16)
2021	37.8	3.3	38.6	20.2	3 (2, 5)	9 (6, 13)
2022	52.1	0.8	42.7	4.4	2 (1,4)	7 (6, 9)

Table 3.32: Treatment sessions and reviews following a mental health treatment plan, 2018 to 2022 year to date

IQR, interquartile range. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Takes into account all individual treatment sessions and review of a mental health treatment plan services received following a mental health treatment plan up until either the last session received, or a new plan was completed.

Tables 3.33 and 3.34 provide equivalent data by demographic group, for selected years 2018 and 2021. Patterns were generally similar by age group and sex. However, of plans that *were* followed by treatment sessions, there was a gradient whereby reviews were most often conducted for consumers living in major cities (higher socioeconomic status areas) and least often for consumers living in outer regional and remote areas (Table 3.33). The median number of treatment sessions, with and without a review, was generally similar across age groups and sexes but tended to be highest for consumers in major cities (higher socioeconomic status areas) (Table 3.34).

	SERVIC	E PATTERNS F TREATM	OLLOWING A ME IENT PLAN (2018)	ENTAL HEALTH	SERVICE PATTERNS FOLLOWING A MENTAL HEALTH TREATMENT PLAN (2021) ¹				
	PLAN ONLY (%)	PLAN AND REVIEW ONLY (%)	TREATMENT SESSIONS WITHOUT REVIEW (%)	TREATMENT SESSIONS WITH REVIEW (%)	PLAN ONLY (%)	PLAN AND REVIEW ONLY (%)	TREATMENT SESSIONS WITHOUT REVIEW (%)	TREATMENT SESSIONS WITH REVIEW (%)	
Age group									
0-14	27.5	2.6	45.9	24.1	40.9	2.7	38.3	18.1	
15-24	32.4	4.3	37.9	25.4	40.2	3.9	34.7	21.2	
25-44	30.9	4.1	40.8	24.3	37.9	3.4	38.1	20.5	
45-64	29.0	4.3	42.1	24.6	37.2	3.8	39.9	19.2	
65 and over	30.3	5.5	43.1	21.1	37.6	4.7	41.3	16.4	
Sex									
Female	29.1	4.1	40.8	26.1	36.8	3.5	38.0	21.7	
Male	32.0	4.1	42.1	21.8	41.5	3.7	37.9	16.8	
Geographic area group									
Major cities (higher SES)	24.9	2.6	44.1	28.4	31.7	2.4	41.0	25.0	
Major cities (medium SES)	27.6	3.4	42.5	26.5	36.1	3.1	38.9	21.8	
Major cities (lower SES)	32.3	5.0	44.1	23.3	42.0	4.4	35.7	17.8	
Inner regional	33.1	4.7	40.8	21.4	42.0	4.1	37.3	16.6	
Outer regional	39.0	5.7	38.1	17.2	46.5	4.9	34.9	13.6	
Remote	49.0	6.5	32.2	12.3	54.0	5.2	31.2	9.5	

Table 3.33: Service patterns following a mental health treatment plan,by demographic group, 2018 and 2021

SES, socioeconomic status. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Takes into account all individual treatment sessions and review of a mental health treatment plan services received following a mental health treatment plan up until either the last session received, or a new plan was completed.

	NUMBER OF SESSIONS FOLLOWING A MENTAL HEALTH TREATMENT PLAN (MEDIAN, IQR) ¹										
		WIT	HOUT REV	IEW			۱	NITH REVIEV	V		
	2018	2019	2020	2021	2022	2018	2019	2020	2021	2022	
Age group											
0-14	4 (2, 6)	4 (2 <i>,</i> 6)	4 (2, 6)	3 (2 <i>,</i> 5)	2 (1, 4)	10 (7, 12)	10 (7, 12)	10 (7, 14)	9 (6, 12)	7 (6, 8)	
15-24	3 (2, 6)	3 (2 <i>,</i> 5)	3 (2, 6)	3 (2 <i>,</i> 5)	2 (1, 4)	9 (6, 12)	10 (6, 13)	10 (6, 16)	9 (6, 13)	7 (6, 9)	
25-44	3 (2, 6)	3 (2 <i>,</i> 5)	3 (2, 6)	3 (2 <i>,</i> 5)	2 (1, 4)	9 (6, 12)	10 (6, 13)	10 (7, 16)	9 (6, 13)	7 (6, 9)	
45-64	4 (2, 6)	3 (2 <i>,</i> 6)	3 (2, 6)	3 (2 <i>,</i> 5)	2 (1, 4)	10 (6, 13)	10 (6, 13)	10 (7, 16)	9 (6, 13)	7 (6, 9)	
65 and over	3 (2, 6)	3 (2, 5)	3 (2, 5)	3 (2, 5)	2 (1, 4)	10 (6, 13)	10 (6, 13)	10 (7, 16)	9 (6, 12)	7 (5, 9)	
Sex											
Female	3 (2, 6)	3 (2 <i>,</i> 6)	3 (2, 6)	3 (2 <i>,</i> 5)	2 (1, 4)	10 (6, 13)	10 (6, 14)	10 (7, 16)	9 (6, 13)	7 (6, 9)	
Male	3 (2, 6)	3 (2, 5)	3 (2, 5)	3 (2, 5)	2 (1, 4)	9 (6, 12)	9 (6, 12)	10 (6, 14)	9 (6, 12)	7 (6, 9)	
Geographic area											
group											
Major cities (higher SES)	4 (2, 6)	4 (2, 6)	4 (2, 6)	4 (2, 5)	3 (1, 4)	10 (7, 13)	10 (7, 14)	11 (7, 17)	10 (7, 14)	7 (6, 9)	
Major cities (medium SES)	4 (2, 6)	3 (2, 5)	3 (2, 6)	3 (2, 5)	2 (1, 4)	10 (6, 13)	10 (6, 13)	10 (7, 16)	9 (6, 13)	7 (6, 9)	
Major cities (lower SES)	3 (2, 6)	3 (2, 6)	3 (2, 6)	3 (2, 5)	2 (1, 4)	9 (6, 12)	9 (6, 12)	10 (6, 15)	9 (6, 12)	7 (5, 9)	
Inner regional	3 (2, 6)	3 (2 <i>,</i> 5)	3 (2, 6)	3 (2 <i>,</i> 5)	2 (1, 4)	9 (6, 12)	9 (6, 13)	10 (6, 14)	9 (6, 12)	7 (5, 8)	
Outer regional	3 (2, 6)	3 (2, 5)	3 (2, 6)	3 (2, 5)	2 (1, 4)	9 (5 <i>,</i> 12)	9 (5, 12)	9 (6, 14)	8 (6, 12)	7 (5, 8)	
Remote	3 (2 <i>,</i> 5)	3 (2 <i>,</i> 5)	3 (2 <i>,</i> 5)	3 (2 <i>,</i> 5)	2 (1, 4)	8 (4, 11)	9 (5, 12)	9 (5, 14)	8 (5, 12)	7 (5, 9)	

Table 3.34: Treatment sessions, by review status anddemographic group 2018 to 2022 year to date

IQR, interquartile range. SES, socioeconomic status. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Takes into account all individual treatment sessions and review of a mental health treatment plan services received following a mental health treatment plan up until either the last session received, or a new plan was completed.

Time elapsed between a mental health treatment plan and first treatment session

We estimated the number of days elapsed between a mental health treatment plan and the first treatment session following the plan – an indicator of wait time. Note that these estimates include both individual and group sessions.^g Also, the estimates are based on all sessions following a mental health treatment plan, regardless of when the first session occurred. Plans that were not followed by any treatment sessions were excluded from these analyses.

The median number of days elapsed between a mental health treatment plan and the first treatment session increased from 18 days in 2018 to 22 days in 2021 (an average change of 6.9% each year) (Table 3.35). There was a greater increase over time at the 75th percentile compared to the 25th percentile. That is, in 2018, for 25% of plans, the median number of days elapsed was 47 (just under 7 weeks) or more; in 2021, for 25% of plans, the median number of days elapsed was 56 (8 weeks) or more.

The median number of days elapsed was much shorter in the first half of 2022, however it is likely that this will be longer when the full year of data becomes available given that (as shown in Table 3.30) relatively fewer people in the 2022 cohort had yet received any treatment services.

^g Additional analyses (not shown) considering only individual sessions produced identical estimates.

Table 3.35: Days elapsed between mental health treatment plan and first treatment session (individual or group), 2018 to 2022

	DAYS ELAPSED BETWEEN MENTAL HEALTH TREATMENT PLAN AND FIRST TREATMENT SESSION ¹							
	MEDIAN	MEDIAN 25 TH PERCENTILE						
2018	18	7	47					
2019	20	7	50					
2020	21	7	53					
2021	22	8	56					
Average annual change 2018-2021 (%)	6.9	4.6	6.0					
2022	14	6	30					

Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022. ¹ Takes into account all individual and group treatment sessions received following a mental health treatment plan up until either the last session received, or a new plan was completed.

There was some variation across sociodemographic groups (Table 3.36). The median number of days elapsed was longer for those aged 0-14 and 15-24, compared to older age groups (26 vs. 20-22, respectively in 2021), and was shortest among people living in major cities (higher socioeconomic status areas) and longest among people living in inner regional and outer regional areas (19 vs. 27, respectively, in 2021).

DAYS ELAPSED BETWEEN MENTAL HEALTH TREATMENT PLAN AND FIRST TREATMENT SESSION (MEDIAN, IQR)¹ 2018 2019 2020 2021 2022 Age group 0-14 21 (7, 53) 22 (8, 56) 24 (8, 65) 26 (8, 67) 15 (6, 32) 15-24 21 (8, 55) 23 (8, 61) 24 (9, 63) 26 (9, 66) 15 (6, 32) 25-44 20 (7, 50) 14 (6, 29) 18 (7, 47) 20 (7, 50) 22 (8, 55) 45-64 17 (7, 42) 20 (7, 49) 18 (7, 44) 18 (7, 44) 14 (6, 29) 65 and over 15 (7, 36) 17 (7, 38) 17 (7, 39) 14 (6, 29) 20 (8, 43) Sex Female 19 (7, 48) 21 (7, 52) 21 (8, 55) 23 (8, 57) 14 (6, 30) Male 18 (7, 45) 19 (7, 48) 20 (7, 49) 22 (8, 54) 14 (6, 30) Geographic area group Major cities (higher SES) 15 (6, 40) 16 (6, 43) 17 (7, 46) 19 (7, 49) 13 (5, 28) Major cities (medium SES) 19 (7, 47) 14 (6, 29) 17 (7, 43) 19 (7, 49) 21 (8, 54)

Table 3.36: Days elapsed between mental health treatment plan and first treatment session (individual or group), 2018 to 2022

IQR, interquartile range. SES, socioeconomic status. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

21 (8, 54)

23 (9, 57)

24 (9, 59)

21 (8, 57)

22 (8, 55)

24 (9, 60)

24 (9 63)

20 (7, 54)

24 (8, 58)

27 (10, 63)

27 (10, 63)

23 (9, 58)

15 (6, 31)

16 (7, 34)

16 (7, 34)

14 (6, 31)

20 (7, 50)

22 (8, 54)

21 (8, 55)

20 (7, 53)

¹ Takes into account all individual and group treatment sessions received following a mental health treatment plan up until either the last session received, or a new plan was completed.

Co-payment patterns

Major cities (lower SES)

Inner regional

Outer regional

Remote

We examined whether co-payment patterns varied according to the number of treatment sessions received following a mental health treatment plan. For this, we analysed co-payment rates for up to the first 20 sessions of individual Better Access treatment following a mental health treatment plan. Note

that, as the number of sessions increases, the number of consumers who received that number of sessions decreases. As shown earlier in Table 3.30, few people (no more than 5%), received more than 20 sessions.

Figure 3.15 chart (a) shows the proportion of consumers who had made a co-payment *at each* session, from the first to the 20th. For consumers who had a mental health treatment plan prepared in 2018, just over half (52.9%) made a co-payment for their first session; this proportion increased over time, up to 65.7% in 2021 and 70.5% in 2022. The proportion of consumers who made a co-payment at each session increased slightly with each further session received. The largest increases were for consumers with plans prepared in 2019-2021, where the proportion increased by 10-15% between the first and 20th sessions. For consumers with plans prepared in the first half of 2022, the proportion increased up until the 12th session and decreased thereafter; in the absence of complete data for 2022, it is unclear whether represents a true change in the pattern or particular characteristics of consumers who required a higher number of sessions in a short time and/or the billing practices of their providers.

Chart (b) shows the proportion of consumers who had made a co-payment *at any previous session*. For consumers who had a mental health treatment plan prepared in 2018, just over half made a co-payment prior to their second session (55.1%); this proportion increased over time, up to 67.9% in 2021 and 72.2% in 2022. The proportion of consumers who had made a co-payment for *any previous session* increased with each additional session received. The largest increases were for consumers with plans prepared in 2018-2020, where the proportion increased by 21-23% between the second and 20th sessions. For plans prepared in 2021 the increase was more modest at 12.8%. Again, for plans prepared in 2022, the proportion increased up until the 12th session and decreased thereafter.



Figure 3.15: Co-payment patterns across treatment services following a mental health treatment plan, 2018 to 2022 year to date

> b) Proportion of sessions with a copayment at any previous session

Note: These data take into account all individual treatment sessions received following a mental health treatment plan up until either the last session received, or a new plan was completed.

Patterns involving other types of Better Access care

a) Proportion of sessions with a copayment

The next analyses focus on patterns of use of the mental health treatment consultation and psychiatry items; these foci were informed by discussions in the CAG and SEG meetings. We started by organising the Better Access services into six high-level item groups reflecting their clinical function and/or provider type:

- 1. Preparation of mental health treatment plan or Review of mental health treatment plan (GPs/other medical practitioners)
- 2. Mental health treatment consultation (GPs/other medical practitioners)
- 3. Preparation of psychiatrist assessment and management plan or Review of psychiatrist assessment and management plan (psychiatrists)
- 4. Initial patient consultation (psychiatrists)
- 5. Psychological therapy services (clinical psychologists)
- 6. Focussed psychological strategies (GPs/other medical practitioners, psychologists, social workers, occupational therapists)

We determined the percentage of Better Access users who used each possible combinations of these item groups, then profiled the combinations involving either mental health treatment consultation or psychiatrist services within a calendar year.

An important caveat to these analyses is that they are based on annual data. This means that, for people who used Better Access services across multiple years, the annual counts will underestimate the extent to which they used more complex combinations over the entire course of their care. Nonetheless, they will provide an indication of whether the types and combinations of care received each year have changed over time. Another caveat is that we do not know whether the different item types were used as part of the same episode or course of treatment, or separately.

The first focus was on *how often GPs provided treatment through items other than the focussed psychological strategies items.* We were unable to definitively answer this question for a couple of reasons. One reason was that although we were able to capture use of the mental health treatment consultation items in the combinations, we do not know whether these were used to supplement treatment delivered under a plan through the psychological therapy services and focussed psychological strategies or were used for other clinical reasons. The second reason was that although GPs may also use standard consultation items to provide mental health care, the MBS data do not tell us whether a particular consultation was used for mental health or other purposes, so we did not include these items in our analysis.

Overall, in 2021, 37.7% of Better Access users received one or more mental health treatment consultations (Table 3.38). This included 11.7% who received these in addition to psychological treatment and 26.1% who received them alone or in combination with a mental health treatment plan or review and/or psychiatrist services. Overall, there was modest decrease in uptake of the mental health treatment consultation items between 2018 and 2021 overall (-2.4% per annum) and for most of the combinations involving them, with the exception of the combination of mental health treatment consultations and a mental health treatment plan or review.

Table 3.37: Percentage of Better Access users who received GP/other medical practitioner mental
health treatment consultations, 2018 to 2022 year to date

COMBINATIONS INVOLVING MENTAL HEALTH TREATMENT CONSULTATION ITEMS (HIERARCHICAL) ¹	2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
MHTC + PTS/FPS + Psychiatrist	1.4	1.3	1.3	1.3	-3.7	0.6
MHTC + PTS/FPS	11.2	10.8	11.1	10.4	-2.4	7.1
MHTC + Psychiatrist	1.1	1.1	1.0	1.1	-2.8	0.8
MHTC + MHTP/Review ²	5.5	5.6	5.6	5.5	0.2	3.6
MHTC only ¹	21.3	20.2	19.2	19.5	-3.0	18.9
Any mental health treatment consultation	40.6	38.9	38.3	37.7	-2.4	31.0
Any Better Access service	100.0	100.0	100.0	100.0	-	100.0

BA, Better Access. FPS, focussed psychological strategies. MHTC, mental health treatment consultation. MTHP, mental health treatment plan. PTS, psychological therapy services. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Combinations are hierarchical and therefore mutually exclusive.

² These categories do not involve any other provider.

The second focus was on *how often psychiatrists were involved in care with other Better Access providers, through the provision of psychiatrist assessment and management plans and initial patient consultations.* Overall, in 2021, psychiatrists provided a plan and/or initial patient consultation for 7.2% of Better Access users (Table 3.39). This comprised 3.0% who also received Better Access psychological treatment and a further 1.1% who did not receive psychological treatment but did receive management through the mental health treatment consultation items. A further 0.5% did not receive psychological treatment or a mental health treatment consultation but did receive a mental health treatment plan or review and 2.6% received only psychiatrist services. Overall, the percentage of Better Access users who received psychiatrist services was quite stable between 2018 and 2021, however there was a 5.1% increase in the percentage of Better Access users who received psychiatrist services as well as a mental health treatment plan or review treatment or mental health treatment and 2.1% increase in the percentage of Better Access users who received psychiatrist services as well as a mental health treatment plan or review but did not receive treatment or mental health treatment consultations.

COMBINATIONS INVOLVING PSYCHIATRIST ITEMS (HIERARCHICAL) ¹	2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Psychiatrist + PTS	1.5	1.4	1.4	1.4	-1.8	0.9
Psychiatrist + FPS	1.6	1.5	1.5	1.6	0.2	1.2
Psychiatrist + MHTC	1.1	1.1	1.0	1.1	-2.8	0.8
Psychiatrists + MHTP/Review	0.5	0.5	0.5	0.5	5.1	0.4
Assessment and management plan ²	0.5	0.5	0.5	0.5	0.8	0.9
Initial patient consultation ²	1.9	1.9	1.9	2.1	2.6	2.4
Any Psychiatrist service	7.1	6.8	6.8	7.2	0.4	6.6
Any Better Access service	100.0	100.0	100.0	100.0	-	100.0

Table 3.38: Percentage of Better Access users seen by psychiatrists, 2018 to 2022 year to date

BA, Better Access. FPS, focussed psychological strategies. MHTC, mental health treatment consultation. MTHP, mental health treatment plan. PTS, psychological therapy services. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to 7 August 2022.

¹ Combinations are hierarchical and therefore mutually exclusive.

² These categories do not involve any other provider.

Discussion

Summary and interpretation of findings

Study 1a showed that Better Access has continued to grow 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 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).

In 2021, uptake and utilisation tended to be higher among females (compared to males), people aged 15-24 and 25-44 years (compared to those aged 0-14, 45-64 or 65 and over), and people living in major cities and inner regional areas (compared to people in outer regional and remote areas). 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 high socioeconomic status areas). However, increases were also seen among people in remote areas due to their uptake of telehealth or phone services. 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) rates of growth in uptake and utilisation.

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 4.0% 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 6.7% 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, 46.6% of all Better Access services involved a co-payment by the consumer (up by 9.3% per year from 35.7% in 2018) and 64.8% of Better Access treatment services involved a co-payment (up by 7.2% per year from 52.7% 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) but increased to \$87 in the first half of 2022. It was also \$74 for any Better Access treatment session (again the same as in 2018), but increased to \$90 in the first half of 2022. Increases in co-payment rates and median out-of-pocket costs were greatest for allied health professional and psychiatrist services, a finding that reflects increases for allied health and specialist MBS services generally over the same period.⁶³ These patterns are of concern as high treatment costs can result in consumers delaying or not using a service at all.⁶⁴

Changes to the Better Access program rules appear to have influenced the ways people receive psychological treatment through the program. Although face-to-face service provision remains the dominant mode of delivery, uptake of telehealth and phone treatment services has been substantial, together accounting for about one third (32.6%) of Better Access treatment services used in 2021. The additional 10 sessions of treatment for people experiencing difficulties due to COVID-19 were used by 17.0% of Better Access users and accounted for 14.8% of individual treatment sessions used in 2021. Through the expansion of Better Access services to residents in aged care facilities 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 sessions (average annual growth of 0.9% in persons treated per 1,000 population) and higher levels of treatment (average annual growth of 7.1% in the rate of services used per 1,000).

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. Of plans that were followed by treatment sessions, two thirds involved between one and six sessions, one fifth involved

between seven and 10 sessions, and a one eighth involved 11-20 sessions. Few people (no more than 5%) received more than 21 or more sessions and <1% received 31 or more. Broadly, this concurs with an earlier analysis of data from the Australian Longitudinal Study on Women's Health which showed that, among women, users of high levels of treatment sessions were the minority.⁶⁵ There was an uptick in the percentage of plan followed by 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 elapsed between a mental health treatment plan and the first treatment session – an indicator of wait times – increased from 18 days for plans completed in 2018 to 22 days for plans completed in 2021. This is consistent with recent Australian Psychological Society survey findings that most (88%) psychologists have experienced increased demand for services since the start of the COVID-19 pandemic, with one in three psychologists now unable to see new clients (up from one in five in June 2021 and one in 100 prior to the pandemic), and longer wait times for consumers (up to three months or longer).⁶⁶

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. The extent of these increases was lower in 2021 than in 2018-2020. Bearing in mind that co-payment rates for treatment services were relatively stable between 2018 and 2020, before increasing in 2021 and again in 2022, this could simply be because there was less scope in later years for the co-payment rates to increase with subsequent sessions.

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 (37.7%) of Better Access users received mental health treatment consultations in 2021, although we do not know the exact nature of the clinical content of the consultations. We estimated an average of 1.8 mental health treatment consultations per user of these consultations, 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). We could not examine the use of standard GP consultations because the MBS data do not describe the purpose of these consultations, however GPs report that they use standard MBS items for mental health consultations twice as often as the mental health consultation items, which in turn are used more than 10 times as often as the focussed psychological strategies items.^{67,68} Use of the mental health treatment consultations items has declined somewhat since 2018. Possible reasons for this decline may be that, for some consumers, improved access to treatment resulting from the introduction of telehealth and phone treatment services or the temporary increase in the number of available treatment sessions has reduced the need for the mental health treatment consultation items as an alternative or supplement to the treatment items. It could also reflect a shift over time in GP's preferences away from these items and towards the standard consultation items. With respect to psychiatrist services, we found that 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; again, this may reflect worsening access and affordability barriers to Better Access treatment services.

Analysis of the relationships between the uptake of Better Access treatment services and other Commonwealth-funded mental health services showed that these patterns are complex. There was a positive relationship of uptake of Better Access treatment 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.

Strengths and limitations

Study 1a drew on complete MBS data for the Better Access program covering a 4.5 year period, from 1 January 2018 up to 30 June 2022. This allowed us to examine how the significant changes made to the program rules during this period may have impacted on patterns of Better Access care. The start date for the supplied data was set at 1 January 2018 because Services Australia can only provide up to 5 years of the most recent available data, determined according to the date of extraction. This meant that we were not able to examine changes over a longer time period.

A limitation of MBS data is that information about the clinical characteristics of consumers (e.g., diagnosis, levels of psychological distress, or other measures of severity and psychosocial function) is not routinely collected by Medicare. The absence of this information meant that we were unable to draw conclusions about the levels of need of consumers using Better Access services and to examine whether need is associated with the types of Better Access care received. However, Studies 2, 3, 4 and 5 in the current evaluation were able to consider these issues, as did Study 1b which analysed the Multi-Agency Data Integration Project (MADIP) dataset.

Another limitation of MBS data is that information about the outcomes of people who receive these services is not routinely collected by Medicare. However, Studies 2, 3, 4 and 5 examined changes in mental health using several different types of samples and Study 9 explored whether routinely collecting outcome data is feasible and acceptable to providers.

Conclusions

The analysis of MBS data for Study 1a allowed us to develop a picture of Better Access service use based on complete, national data. Study 1a showed that the provision of Better Access services has continued to grow over time. This is in part because recent changes to the program, such as the introduction of telehealth and phone treatment services and the additional 10 sessions of treatment, have been well utilised. However, in recent years, the number of treatment services delivered has increased more than the number of people treated. For example, the estimated average number of treatment sessions used per year among those who received treatment rose from 4.5 in 2018 to 5.4 in 2021. At the same time, the data suggest that proportionally fewer people are accessing treatment following the completion of a mental health treatment plan and, of those that do access treatment, fewer receive their first treatment session in a timely way. The costs of treatment have also risen for consumers, with bulk-billing rates decreasing and out-of-pocket costs increasing in 2021 and 2022. Those consumers who used more sessions were more likely to be paying a co-payment for their services. Alongside these changes in the utilisation and costs to consumers of Better Access treatment, our analysis indicated that the program appears to be serving some groups better than others (such as people living in areas of medium or high socioeconomic status within major cities, females and young adults). Many of these gaps have widened in recent years, although other gaps (such as lower levels of use by people living in remote areas) have

narrowed. People living in more urban and affluent areas also tended to be more likely to access treatment following a mental health treatment plan, to wait a shorter time for their first session, to receive a greater quantum of treatment, and to have their treatment formally reviewed.

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

Introduction

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 that it was not possible to glean through Study 1a or through the subsequent studies in the evaluation.

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.

Methods

Data source

The MADIP dataset is a secure data asset combining administrative information on health, education, government payments, income and taxation and employment with other information such as population demographic characteristics from the Census.¹ MADIP provides an enduring (and regularly updated) data linkage of these Australian Government data sources. The integration and process of data access is managed by the Australian Bureau of Statistics. Deterministic and probabilistic linkage of the different data sources is based on a Person Linkage Spine developed from three sources: the Medicare Consumer Directory, the DOMINO Centrelink Administrative Dataset, and the Personal Income Tax dataset. Access to MADIP data is protected and only authorised researchers with approved projects have access to de-identified data.

Analysis cohorts

The analyses were based on those who completed the 2016 Census (23.7 million respondents). After omitting visitors to Australia, those who died prior to the analysis period, and respondents who were unable to be linked or where there were not unique linkages to the Person Linkage Spine and other datasets, the final analysis sample comprised 20,263,132 individuals (in 2018). The analysis sample varied across the study years (2018 to 2021) based on age inclusion criteria and the exclusion of those identified each year in the National Death Index.

A subset of the analyses used data from those who completed the Kessler 10 (K-10) in the 2017/18 National Health Survey. The National Health Survey included 21,315 respondents. However, only respondents aged 18 years or older were invited to complete the K-10, some survey respondents did not complete the K-10, other respondents were unable to be uniquely linked to the MADIP Person Linkage Spine and/or other MADIP datasets, and some survey participants died prior to the analysis period. In addition to the K-10, the analysis using the National Health Survey data used the demographic and socioeconomic measures collected through the survey. It is also important to note that the design of the National Health Survey means it provides an estimate of the resident population living in private dwellings and not of those living in remote or very remote First Nations communities).

Using the 2016 Census and the 2017/18 National Health Survey (and the National Death Index) as our starting point allowed us to identify three cohorts for Study 1b.

- Cohort 1 (Adult population): This cohort included Australians identified in the 2016 Census who were aged 18 or over in each year of the analysis (2018, 2019, 2020 and 2021) and had a unique linkage to the Person Linkage Spine and specifically to the Medicare Consumer Directory (and therefore to the Better Access items). In 2018, this cohort included 16,084,885 individuals.
- Cohort 2 (Child and youth population): This cohort was based on the same Census-linked dataset as Cohort 1 but included individuals aged 5-24 in each analysis year (again, 2018, 2019, 2020 and 2021). In 2018, this youth cohort comprised 5,907,424 individuals.
- Cohort 3 (Adult sub-sample): This cohort was based on the MADIP linkage to the 2017/18
 National Health Survey. The National Health Survey dataset includes a set of population weights
 generated by the Australian Bureau of Statistics that can be used to generate estimates that
 better reflect the overall Australian population. Analyses using Cohort 3 were adjusted to correct
 for the non-linkage of the National Health Survey respondents in MADIP (based on age and sex).
 The final National Health Survey cohort comprised 14,340 individuals.

Data used for analysis

Service use

We used MBS data to identify use (and date of service) of Better Access and other relevant MBSsubsidised services, the National Death Index (to exclude people who died during each year of analysis or earlier), and Pharmaceutical Benefits Scheme (PBS) data to identify people who received antidepressant and anxiolytic medication (defined using the Anatomical Therapeutic Chemical [ATC] codes N05B and N06A, consistent with Study 1a).

We used MBS data to classify Better Access items into meaningful groups, as we did in Study 1a. For the purposes of Study 1b, the groups were:

- Any Better Access service: This included any service provided under any of the Better Access items listed in Appendix 1.
- Any Better Access treatment service: This included delivery of psychological therapy services by clinical psychologists and delivery of focussed psychological strategies by psychologists, social workers, occupational therapists and GPs.

Some analyses used more specific breakdowns of service use – e.g., provider type (clinical psychologist, psychologist, social worker, occupational therapist, GP) and session modality (face-to-face, telehealth). Some also considered the number of services received, and the wait time between receiving a mental health treatment plan and the first session of Better Access treatment. All of this information was based on the specific MBS item number used at each occasion of service.

In general, analyses were person-based (i.e., describing the number or percent of individuals who received a Better Access service each year). However, some analyses considered the number of services as the outcome.

Sociodemographic variables and indicator of need

We described people in terms of various sociodemographic characteristics (e.g., age, sex, equivalised household income) by using data collected in the 2016 Census and in the 2017/18 National Health Survey. We also used an indicator of First Nations people developed by the Australian Bureau of Statistics from information collected through a number of different data sources.

We used K-10 scores from the 2017/18 National Health Survey as an indicator of need. As noted in Section 2, the K-10 is a 10-item measure of psychological distress which asks consumers about their symptoms of depression and anxiety over the past four weeks.²⁵

Analyses

Most of the analyses in this section draw upon (near) population data. Therefore, we focus our presentation on descriptive statistics, reporting numbers and the percentages of the underlying population that are using any given services in a calendar year. We differentiate the results for key sub-populations (e.g., contrasting new Better Access users in a year vs those who are continuing to use Better Access services; considering key groups in the population based on age, gender, First Nations status, and household income). Although our main focus in the analysis is on the <u>users</u> of Better Access, we also consider the total number of treatment sessions delivered in a calendar year. To provide information on the number or nature of services used by consumers during a year, we use the MADIP data to calculate medians, interquartile range and means of services used, and contrast different service types (e.g., telehealth vs face-to-face). Although measures of statistical significance are not informative in the analysis of population-level data, we do report the results of statistical models (using generalised linear models with a log-link to evaluate binary outcome measures and report measures of relative risk) for some analyses with smaller denominators (e.g., those based on the National Health Survey [Cohort 3] and the subset of MADIP data in our final analysis of Better Access service pathways).

Approvals

The Australian National University Human Research Ethics Committee approved the ethical aspects of this project (Protocol 2022/611).

Results

Patterns of use and non-use of Better Access in relation to need

We examined patterns of use and non-use of Better Access in relation to need by using K-10 data from the 2017/18 National Health Survey and linked MBS data for the adults in Cohort 3. The levels of psychological distress that individuals report on the K-10 at different time points (i.e., two years or more apart) are relatively consistent,⁶⁹ and scores on the K-10 have been shown to correspond closely to diagnoses of mental disorders.⁷⁰ Therefore, it is likely that many of those identified with high or very high levels of distress in the National Health Survey experienced longer-term or chronic distress and poor mental health. For this reason, we examined Better Access service use during the 12 months before and after each National Health Survey participants' interview.^h Data from the National Health Survey were weighted to the general population.

Figure 4.1 shows that there was a strong association between psychological distress and Better Access use. There was a gradient of any Better Access use across levels of distress, with greater likelihood of use being associated with greater levels of psychological distress. In total, 46% of Australian adults with very high psychological distress used any Better Access service in the 12-months before or after their National Health Survey interview, and 33% of those with high levels of psychological distress did so. The equivalent figures for use of Better Access treatment services were 25% and 21%.

^h National Health Survey interviews were conducted between July 2017 and June 2018. A very small number of interviews conducted in July 2018 were classified as June 2018.





The above descriptive findings were confirmed in simple generalised linear models (using a log link). Table 4.1 shows how the likelihood of using any Better Access service and any Better Access treatment service increased as a function of severity of psychological distress.

Table 4.1: Association between psychological distress and use of
Better Access services in 24 months (Cohort 3: adults aged 18+)

	ANY BET	TTER ACCESS SE	RVICE	ANY BETTER A	CCESS TREATM	ENT SERVICE
Psychological distress	Coefficient (RR)	95%CI lo	95%Cl hi	Coefficient (RR)	95%CI lo	95%Cl hi
Low	1.00			1.00		
Moderate	2.04	1.89	2.27	1.91	1.65	2.22
High	3.52	3.12	3.98	3.84	3.28	4.50
Very high	4.72	4.09	5.46	4.54	3.72	5.53

The proportion of Better Access users who are new

The longitudinal nature of the MADIP data allowed us to follow individuals in Cohort 1 over time and document their use of Better Access. This meant that we could examine the proportion of adult Better Access users in any given year who were "new" (i.e., did not access Better Access services in the previous year). We considered consumers who were new to any Better Access service and any Better Access treatment service, as well as consumers who were new to any given type of provider.

Table 4.2 shows that although there was an increase over time in the percentage of the cohort who used Better Access services, the proportion of users who were "new" declined. In 2018, 53.0% of those who accessed any Better Access service were new users, but in 2021 this figure had dropped to 50.5%. Among those using a Better Access treatment service, the percentage of new users declined from 56.0% in 2018 to 49.9% in 2021, with the most marked decline evident between 2020 and 2021.

SERVICE		2018	2019	2020	2021
	N people	16,084,885	16,199,009	16,310,197	16,499,245
Any Better Access	N total service users	1,689,518	1,762,237	1,788,802	1,832,835
service	% of cohort using services	10.50%	10.88%	10.97%	11.11%
	N continuing users	794,393	840,827	871,127	908,143
	% of cohort: continuing users	4.94%	5.19%	5.34%	5.50%
	N new users	895,125	921,410	917,675	924,692
	% current users who are new	52.98%	52.29%	51.30%	50.45%
	% of cohort: new users	5.57%	5.69%	5.63%	5.60%
Any Better Access	N total service users	852,676	897,536	916,378	916,898
treatment service	% of cohort using services	5.30%	5.54%	5.62%	5.56%
	N continuing users	375,133	404,371	429,057	459,675
	% of cohort: continuing users	2.33%	2.50%	2.63%	2.79%
	N new users	477,543	493,165	487,321	457,223
	% current users who are new	56.01%	54.95%	53.18%	49.87%
	% non-users who started this year	2.97%	3.04%	2.99%	2.77%

Table 4.2: New and continuing Better Access users, by categoryof use, 2018 to 2021 (Cohort 1: adults aged 18+)

Table 4.3 presents these data in a different way, considering the annual percentage change in the rate of service use for new and continuing Better Access users (adjusting for change in the size of the cohort). Again, although the average annual percent change in the rate of any Better Access service use in the adult cohort was 1.9%, new users only showed a 0.3% increase each year whereas continuing users showed a 3.7% increase. The difference was even starker for the rates of use of any Better Access treatment service over time. There was an overall average increase of 1.6%, but this reflected a 6.1% increase for continuing users but a 2.2% decline in use for new users. This decline was driven by a large reduction in the rate of new users between 2020 and 2021.

SERVICE		2019 TO 2018	2019 TO 2020	2020 TO 2021	AVERAGE ANNUAL CHANGE (%)
Any Better	% change in rate of all service users	3.57%	0.82%	1.29%	1.89%
Access service	% change in rate of continuing users	5.10%	3.60%	4.25%	3.68%
	% change in rate of new users	2.21%	-1.08%	-0.39%	0.25%
Any Better	% change in rate of all service users	4.52%	1.40%	-1.09%	1.61%
Access treatment service	% change in rate of continuing users	7.03%	5.28%	5.91%	6.11%
	% change in rate of new users	2.54%	-1.19%	-7.25%	-2.19%

Table 4.3: Annual change in the rate of use of Better Access services by new and continuing users, by category of use, 2018 to 2021 (Cohort 1: adults aged 18+)

Table 4.4 drills down into use of any Better Access treatment service, presenting the percentage of new and continuing users for services provided by each of the five types of providers. The table show a decline in the percentage of new users over time for all providers apart from GPs (noting GPs deliver Better Access treatment services to relatively few consumers). The greatest declines in new users over the four years was for clinical psychologists and occupational therapists, with declines between 2018 and 2021 from 58% to 49% and from 62% to 52%, respectively. Again, the greatest annual decline was evident between 2020 and 2021.

Table 4.4: New and continuing Better Access users, by
provider type, 2018 to 2021 (Cohort 1: adults aged 18+)

SERVICE		2018	2019	2020	2021
Clinical	N total service users	362525	382957	392947	380414
(psychologists	% of cohort using services	2.25%	2.36%	2.41%	2.31%
therapy services)	N continuing users	151737	164670	176869	192313
	% of cohort: continuing users	0.94%	1.02%	1.08%	1.17%
	N new users	210788	218287	216078	188101
	% current users who are new	58.14%	57.00%	54.99%	49.45%
	% of cohort: new users	1.31%	1.35%	1.32%	1.14%
Psychologists	N total service users	457201	477111	483559	493003
(focussed	% of cohort using services	2.84%	2.95%	2.96%	2.99%
strategies)	N continuing users	167766	181441	190545	206157
	% of cohort: continuing users	1.04%	1.12%	1.17%	1.25%
	N new users	289435	295670	293014	286846
	% current users who are new	63.31%	61.97%	60.60%	58.18%
	% of cohort: new users	1.80%	1.83%	1.80%	1.74%
Social workers	N total service users	56305	62288	64136	68079
(focussed	% of cohort using services	0.35%	0.38%	0.39%	0.41%
strategies)	N continuing users	17514	19756	21576	23925
0,	% of cohort: continuing users	0.11%	0.12%	0.13%	0.15%
	N new users	38791	42532	42560	44154
	% current users who are new	68.89%	68.28%	66.36%	64.86%
	% of cohort: new users	0.24%	0.26%	0.26%	0.27%
Occupational therapists	N total service users	24428	26193	28204	32022
(focussed	% of cohort using services	0.15%	0.16%	0.17%	0.19%
psychological	N continuing users	9393	10303	11066	15398
strategies)	% of cohort: continuing users	0.06%	0.06%	0.07%	0.09%
	N new users	15035	15890	17138	16624
	% current users who are new	61.55%	60.67%	60.76%	51.91%
	% of cohort: new users	0.09%	0.10%	0.11%	0.10%
GPs (focussed	N total service users	8062	7768	9158	9444
strategies)	% of cohort using services	0.05%	0.05%	0.06%	0.06%
sti ategiesj	N continuing users	3053	2864	3000	3420
	% of cohort: continuing users	0.02%	0.02%	0.02%	0.02%
	N new users	5009	4904	6158	6024
	% current users who are new	62.13%	63.13%	67.24%	63.79%
	% of cohort: new users	0.03%	0.03%	0.04%	0.04%

Figure 4.2 and Table 4.5 provide some insights into possible explanations for the decrease in new users over time. One explanation is that the introduction of the additional 10 sessions in the latter part of 2020 may have resulted in existing consumers receiving more sessions and reduced providers' capacity to take on new consumers. Figure 4.2 suggests that this may have been the case; the number of continuing users of any Better Access service and the number of sessions provided for them increased markedly in 2020

and 2021, in parallel with much flatter lines for new users. The top panel of Table 4.5 confirms that continuing users of Better Access treatment services were more likely to have received the additional sessions than new users, and that this gap increased further in 2021.

Another potential explanation is that the widespread availability of telehealth options, also introduced during 2020, may have disproportionately benefited existing consumers. Providers may have found it more difficult to initiate treatment with new consumers by telehealth than to build on relationships that they may have already established face-to-face with existing consumers. The bottom panel of Table 4.5 shows that in both 2020 and 2021, new users were more likely to only receive their treatment services face-to-face compared to continuing users.





Table 4.5: Use of additional 10 sessions and face-to-face sessions only, by new and continuing users,2020 to 2021 (Cohort 1: adults aged 18+)

		2020	2021
Use of additional 10	New	4.78%	8.13%
sessions	Continuing	11.47%	26.77%
Use of face-to-face	New	63.56%	64.62%
sessions only	Continuing	55.53%	52.15%

Use of Better Access by First Nations people

We used MADIP data for the adults in Cohort 1 to examine use of Better Access by First Nations people. First Nations people were identified based on an indicator derived by the Australian Bureau of Statistics from the 2016 Census and other datasets. We also conducted sub-analyses using data for the adults in Cohort 3. This allowed us to consider levels of psychological distress alongside Better Access use for First Nations and non-First Nations people. We present national figures as well as estimates restricted to those living in major cities (to address potential confounding by lower levels of service availability in regional and remote areas that may have a greater impact on the estimates for First Nations people). Table 4.6 shows the annual rates of use of Better Access services by First Nations and non-First Nations people. In any given year, the proportion of First Nations people using Better Access services was higher than the proportion of non-First Nations people doing so. The pattern was more pronounced for the use of any Better Access service than any Better Access treatment service. It was also more pronounced when all Australian adults were considered than when the analysis was restricted to those living in major cities.

			2018	2019	2020	2021
All of Australia	Any Better Access	% Not First Nations people	10.39%	10.76%	10.86%	11.02%
	service	% First Nations people	15.21%	15.73%	15.21%	14.76%
	Any Better Access treatment service	% Not First Nations people	5.29%	5.53%	5.61%	5.57%
		% First Nations people	5.92%	5.95%	5.94%	5.38%
Major cities only	Any Better Access	% Not First Nations people	10.82%	11.23%	11.34%	11.53%
	service	% First Nations people	19.34%	19.80%	19.17%	18.52%
	Any Better Access treatment service	% Not First Nations people	5.64%	5.92%	6.00%	5.97%
		% First Nations people	8.10%	8.12%	8.06%	7.26%

Table 4.6: Annual rates of use of Better Access services by First Nations and non-First Nations people, by category of use, 2018 to 2021 (Cohort 1: adults aged 18+)

Although this finding might be regarded as positive, considerable caution should be exercised for two reasons. The first is that the proportion of First Nations people using Better Access services has declined over time, whereas the proportion of non-First Nations people doing so has increased. To illustrate this change over time, Table 4.7 presents side-by-side the results of generalised linear models (with log link) predicting the use of any Better Access service and any Better Access treatment service in 2018 and 2021. These models are based on the total Australian sample but control for remoteness (and a number of other covariates). Comparison of the relative risk ratios for each model over time shows that relatively higher levels of use of Better Access services by First Nations people in 2018 decreased substantially by 2021. In fact, in the case of any Better Access treatment service, First Nations people were less likely to use these services than their non-First Nations counterparts in 2021.

Table 4.7: Association between First Nations status and Better Access use, 2018 and 2021 (Cohort 1: adults aged 18+)

			2018			2021	
		Coefficient (RR)	95%CI lo	95%Cl hi	Coefficient (RR)	95%CI lo	95%Cl hi
Any Better Access	Not first Nations	1.00			1.00		
service	First Nations	1.35	1.34	1.37	1.20	1.19	1.21
Any Better Access	Not first Nations	1.00			1.00		
treatment service	First Nations	1.11	1.09	1.12	0.93	0.92	0.95

The second reason for interpreting the data in Table 4.6 with caution is that they do not take into account levels of need. Using data from the sub-sample of adults in Cohort 3 enabled us to consider Better Access use for First Nations and non-First Nations people in the context of their respective levels of need. Figure 4.3 provides data on levels of need as assessed by the K-10 (from the 2017/18 National Health Survey) for First Nations people and non-First Nations people next to the data on Better Access use (in 2018) from Cohort 1. It reiterates the point that, relatively speaking, higher proportions of First Nations people used any Better Access service and any Better Access treatment service in 2018. However, it suggests that this higher level of use may not be commensurate with their far greater levels of psychological distress. We also note that the K10 may not be the most appropriate way to measure psychological distress among First Nations people,⁷¹ and that a more culturally suitable scale has been developed and validated.⁷²



Figure 4.3: Psychological distress (2017/18) and rates of use of Better Access services (2018) by First Nations and non-First Nations people (Cohort 3: adults aged 18+)

Use of Better Access by children and young people

We used data from Cohort 2 to examine use of Better Access by children and young people. We focussed on people aged between five and 17, making reference to young adults as relevant.

Figure 4.4 shows how children and young people's use of different mental health services changes with increasing age (in years), and also demonstrates how rates of service use have changed over time (between 2018 and 2021). The figure presents data on any Better Access services (in orange) and any Better Access treatment service (in grey). The dotted and solid lines represent the proportion of the given age group using the relevant services in 2018 and 2021, respectively.

The general upward trend for all lines shows how Better Access service use increases with age. However, there is evidence of a dip in young people's use of Better Access treatment services at around 17 years, with this decline not fully adjusting until the early 20s. This decline may reflect a real change (e.g., growing independence may reduce the impact of parental/familial support in accessing services, or decreased financial support may act as a new barrier to service use). Alternatively, the decline could potentially reflect lower rates of data linkage in this age range as the different administrative records for young people may become less consistent as they experience various life transitions (e.g., changes of address, obtaining their own Medicare card, receipt of benefits in their own right).

The difference between the dotted and solid lines provides evidence of changes over time in patterns of use. Those aged 14 and over were more likely to use Better Access services in 2021 than they were in 2018, but for those aged under 14, the reverse was true.



Figure 4.4: Use of Better Access services by age and category of use, 2018 and 2021 (Cohort 2: children and young people aged 5-24)

Figure 4.5 shows the strong interaction between age and sex. Young boys (aged <10 years) are more likely to use Better Access treatment services than young girls. Rates of service use are similar for boys and girls aged between 10 and 14, and it is only from the age of 15 that the marked gender difference in the use of Better Access services observed among adults becomes evident. The other key feature of Figure 4.5 is the gendered nature of the time effect. There is little evidence (from the columns clustered within age groups) of any substantial increase in use of Better Access treatment services for boys over time, but from the age of 10 onwards girls and young women are increasingly likely to access services over time. For example, 10.4% of young women aged 15 to 17 used Better Access treatment services in 2018, whereas 13.3% did so in 2021. The corresponding figures for young men were 5.7% and 5.3%. The increase for young women was most marked between 2019 and 2020.







Socioeconomic differences in Better Access use

We used linked Census and MBS data to examine the relationship between individual-level indicators of socioeconomic status and use of Better Access services over time. By doing this, we were able to complement the analyses in Study 1a that considered area-level indicators of socioeconomic status. As a point of comparison, we also considered the relationship between individual-level socioeconomic status and access to psychotropic medication through the PBS. The majority of our analyses used data from Cohort 1 but we also conducted supplementary analyses with data from Cohort 3 in order to examine the relationship between socioeconomic status and levels of need.

Figure 4.6 shows the relationship between self-reported equivalised household income (taken from the 2016 Census) and use of Better Access treatment services and antidepressants/anxiolytics over time (considering those with any use in a calendar year). Income data are presented in quintiles, and data are presented for those in major cities only, to reduce the potential confounding effect of service availability.

The profile of users of any Better Access treatment services shows that between 2018 and 2021 those with comparatively higher levels of income were most likely to access these services. This gap has

widened over time as the percentage of those in the higher income groups using these services has increased and the percentage of those in the lower income groups doing so has decreased.

The profile of users of antidepressants/anxiolytics over the same period was quite different. Across all years, people on lower incomes were consistently more likely to have antidepressants/anxiolytics dispensed for them. Rates of use for all groups have increased slightly over time.

Figure 4.6: Use of Better Access treatment services and antidepressants/anxiolytics by equivalised household income (in quartiles), 2018-2021 (Cohort 1: adults aged 18+ living in major cities)



Use of any Better Access treatment services

The above findings should be interpreted in the context of levels of need of people in the different income groups. Using K-10 data for adults who participated in the 2017/18 National Health Survey, Figure 4.7 shows that psychological distress varies as a function of income level. Twenty two percent of people in the lowest income households had high or very high levels of distress, whereas the rate amongst those with the highest income was 9%.



Figure 4.7: Psychological distress by equivalised household income (in quartiles), 2017/18 (Cohort 3: adults aged 18+ living in major cities)

Taken together, these findings suggest that there are inequities in access to Better Access treatment services, with those with the lowest level of income missing out, despite their relatively higher levels of need. There are also suggestions that those on the lowest level of income may be preferentially offered pharmacological treatment instead of psychological therapies.

Better Access service pathways

We explored Better Access service use pathways, using data for subsets of the MADIP adult cohort. More specifically, we compared Better Access users who received a mental health treatment plan between January and March in 2017 with those who did so in the same three months of 2020. The analysis was restricted to those who had not used any Better Access services in the previous year, and anyone who died in the following two years was excluded. The two groups allowed us to investigate whether there were changes over time in the rates of access to Better Access treatment following the preparation of a mental health treatment plan and the wait time between receiving a plan and the first treatment session. We also examined whether the likelihood of receiving treatment following a plan and wait times varied by income and other sociodemographic factors.

Use of Better Access treatment following a mental health treatment plan

Figure 4.8 shows the steps in study design and sample selection, as well as the number in each group who went on to receive Better Access treatment following the preparation of a mental health treatment plan. Overall, one third (33.6%) of adults who received a mental health treatment plan in the first three months of the relevant year (and who had not received any Better Access services the previous year) had not received any Better Access treatment by the end of the following year. This figure was 31.4% for the 2017 group and 35.6% for the 2020 group.



Figure 4.8: 2017 and 2020 groups (Cohort 1: adults aged 18+)

We examined the relationship between equivalised household income and likelihood of using Better Access treatment services following a mental health treatment plan. Figure 4.9 shows that there was a clear socioeconomic gradient for both groups, with those in the two-highest income groups much more likely to access treatment than those with lower income. For the 2017 group, there was a 10 percentage point difference between those in the lowest quintile and those in the fourth quintile, and the difference plateaued for the highest quintile. The pattern was the same for those in the 2020 group, although overall percentages of people in each quintile accessing treatment was significantly lower.

Figure 4.9: Use of Better Access treatment services following receipt of a mental health plan by equivalised household income (in quartiles), 2017-2018 and 2020-2021 (Cohort 1: adults aged 18+)



We explored the factors that were associated with <u>not</u> receiving Better Access treatment services following a mental health treatment plan further in a generalised linear regression model (with log link). We found that the likelihood of <u>not</u> receiving treatment was greatest for those living in a low-income household, living in a more disadvantaged area, and with other sociodemographic factors, including being young (aged 18-24), being male; identifying as First Nations, living in an outer regional or remote location, and coming from New South Wales, the Northern Territory or the Australian Capital Territory.

We extended the linear regression model to examine the apparent difference in the proportion of people receiving no Better Access treatment in 2017-2018 versus 2020-2021. More specifically, we included an interaction between group and treatment. There was an absolute difference of -4.2% (95%CI = -4.51 to - 3.84) and a relative difference of 0.94 (95%CI = 0.93 to 0.95). In other words, the likelihood of people accessing treatment following a mental health treatment plan was 6% lower in 2020-2021 than it was in 2017-2018.

There was no evidence that people who received a mental health treatment plan but did not subsequently use Better Access treatment services were more likely to receive alternative Australian Government-funded treatment options. They were less likely to receive MBS-subsidised psychiatrist services and less likely to receive antidepressants and anxiolytics listed on the PBS. They may have received a range of other treatment options, however, including services provided through Primary Health Networks, via community health centres, in private hospital settings, or through public sector inpatient and community services. They may also have been receiving mental health care from GPs billing against non-Better Access item numbers. We have no way of knowing about their extent of the use of these other services through MADIP.

Wait times for Better Access treatment following a mental health treatment plan

We then focussed on those in each group who did receive Better Access treatment, and examined wait times between receiving a mental health treatment plan and accessing treatment. Table 4.8 shows the median, interquartile range and mean wait times for the 2017 group and the 2020 group.

TIME TO TREATMENT	GROUP 1 (2017)	GROUP 2 (2020)
25 th percentile	7 days	7 days
Median	14 days	19 days
75 th percentile	39 days	54 days
Mean	58.3 days	67.8 days

Table 4.8: Wait times between receiving a mental health treatment plan and accessingBetter Access treatment, 2017-2018 and 2020-2021 (Cohort 1: adults aged 18+)

Half of those who received treatment following their plan in 2017 waited 14 days to receive treatment. In 2020, half waited 19 days. The distribution of wait time shows a long tail. The 75th percentile shows that the 25 percent of service users with the longest wait time had to wait at least 39 days in 2017 and at least 54 days in 2020. The tail of the distribution is also evident in the mean/average score, which was 58 days for the 2017 group and 68 days for the 2020 group. Quantile regression showed the difference between groups was significant at the median and the 75th percentile, with longer durations evident for the 2020 group.

An alternative way to think about wait times is to adopt a fixed time that represents a target goal for wait time between the mental health treatment plan and the first session of Better Access treatment. Using a target of 30 days, we found that 30.2% of consumers in the 2017 group and 36.7% of consumers in the 2020 group did not meet this threshold (IRR = 1.22, 1.20 to 1.23, p < .001).

We also used cumulative incidence plots to contrast the time between the mental health treatment plan and the first session of treatment for the two groups, with time represented by weeks and top-coded at 100 weeks (see Figure 4.10). The gap between the highest point of each line and the 100% line represents those with a plan who received no treatment (showing the higher rate of treatment in the 2017 group versus the 2020 group). The figures show a very steep increase (for both groups) over the first four weeks (at which point, 67% of those in the 2017 group who received treatment and 60% of those in the 2020 group who received treatment had done so). The figure also shows the long tail for both groups, with commencement of Better Access treatment continuing for up to 100 weeks following receipt of a mental health treatment plan.





We examined the relationship between income and wait times and the results are presented in Figures 4.11 and 4.12. Both figures show a clear socioeconomic gradient, with the wait times at the median and the 75th percentile greatest for those on the lowest incomes. The inequities described in these gradients were more pronounced for the 2020 group than the 2017 group.





Figure 4.12: Number of days at 75th percentile between receiving a mental health treatment plan and accessing Better Access treatment by equivalised household income (in quartiles), 2017-2018 and 2020-2021 (Cohort 1: adults aged 18+)



Discussion

Summary and interpretation of findings

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. 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 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 National 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 non-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.

Strengths and limitations

A major limitation of MADIP is its exclusive focus on MBS and PBS services. The results of Study 1b need to be considered in the context of programs that are the responsibility of other sectors. These include services that are commissioned by Primary Health Networks or delivered through community health centres, Aboriginal Community Controlled Health Organisations, private hospitals, or public sector inpatient and community services.

We used a single indicator of need, based on psychological distress assessed by the K-10. This assessment was made at a single point in time and we assumed that it represented levels of distress for any individual over a longer period, whereas in fact levels of distress may fluctuate.

In our analyses of use of Better Access services by First Nations people, we used an indicator of First Nations status developed by the Australian Bureau of Statistics. This classifies individuals who identify as

First Nations in any of the linked Australian Bureau of Statistics data collections. There may be inconsistencies in this indicator over time (as individuals move into and out of our adult cohort). As noted, there are also questions about how culturally appropriate the K-10 is for First Nations people,⁷¹ and an alternative scale has been developed.⁷² Understanding the context and implications of the current results requires engagement with and active participation from First Nations people.⁷³

The income measures that are core to many of the analyses in Study 1b are based on income reported in the 2016 Census. They do not capture any change in the income of individuals over time. It may be, for example, that the income of some of those with the highest incomes in 2016 declined over time, and this might partially explain increasing rates of service use within these groups. However, it might also be expected that a proportion of those on the lowest incomes would experience improved economic circumstances over time. More importantly, the general social patterning of use of Better Access was evident in the first year of observations.

Conclusions

The analysis of MADIP data in Study 1b allowed us to explore issues of access to Better Access that we were unable to examine in the other studies in the evaluation. The MADIP data show that although Better Access is reaching those with high levels of need and reaching people across the age spectrum, access is not equitable. It is harder for new users to access the program than it was in the past, as the number of continuing users and the number of treatment sessions provided to them has increased. First Nations people use Better Access at higher rates than non-First Nations people, but their rates of use are declining and are not commensurate with their significantly greater levels of need. People on low incomes are least likely to use Better Access services, despite having relatively greater levels of need than their high-income counterparts. Those people on low incomes who do use Better Access treatment services typically wait longer than people on high incomes to see a provider once they have a mental health treatment plan.

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

Introduction

Study 2 involved an analysis of outcomes for consumers that drew on data that were collected routinely by providers in the course of their clinical practice. We initially planned to source data exclusively from NovoPsych, which is a subscription-based platform that was explicitly mentioned in the Productivity Commission Mental Health Inquiry Report.¹⁹ NovoPsych was developed by our team member, Dr Ben Buchanan. Dr Buchanan is a practising psychologist, and developed NovoPsych as a purpose-built repository for outcome data that can support psychologists and other mental health professionals by providing feedback on consumers' progress.

The CAG and the SEG recommended that we consider other data sources as well, so we approached the custodians of data from three large psychology practices. These were Aaron Frost (Benchmark Psychology, Brisbane), Chris Mackey (Chris Mackey and Associates, Geelong) and Kaye Frankcom (Kaye Frankcom and Associates, Melbourne). Routinely collected outcome data were made available from each of these practices.

Study 2 complemented Studies 3, 4 and 5 by providing a different lens on consumer outcomes. Study 2 assessed outcomes via validated measures of symptoms, functioning and related concepts that were administered prospectively, and considered change over discrete episodes of care. Study 3 also considered outcomes over the course of an episode of care, but relied on consumers' retrospective reports of how their mental health changed over the course of the episode. Like Study 2, Studies 4 and 5 used prospectively administered measures, but assessed change over set periods of time rather than for specific episodes.

Methods

Study overview

Study 2 can be thought of as a before-and-after study, where consumers' outcomes were assessed in terms of change on a variety of measures over the course of their episodes of care.

Table 5.1 provides detail about the scope of the four datasets from which we sourced data. NovoPsych was the largest, currently holding data from around 3,000 providers. All four contained data from extensive periods, with the Mackey database going back to 2007 (when Better Access began), the NovoPsych and Benchmark databases housing data from early 2013, and the Frankcom database containing data from mid-2015.

DATASET	PROVIDERS	PERIOD OVER WHICH DATA
NovoPsych	≈3.000 (mostly psychologists	January 2013 to February 2022
	but also other providers)	
Benchmark	42 (all psychologists)	January 2013 to February 2022
Mackey	35 (all psychologists)	January 2007 to December 2018
Frankcom	14 (all psychologists)	May 2015 to October 2017

Table 5.1: Scope of the four datasets

We were not able to identify individual consumers or individual providers in any of the four datasets. To anonymise the data further, we do not refer to any of the datasets by name for the remainder of this report, and we report all findings by individual measure.

Outcome measurement

The four datasets include outcome data from 11 different measures (see Table 2.2 in Section 2 for more detail):

- Clinical Outcomes in Routine Evaluation (CORE-OM)^{28,29}
- Clinical Outcomes in Routine Evaluation (CORE-10)³⁰
- Depression Anxiety and Stress Scale (DASS-21/42)^{7,8}
- Depression Anxiety and Stress Scale (DASS-10)³¹
- Generalised Anxiety Disorder scale (GAD-7)³³
- Global Assessment of Functioning Scale (GAF)³⁴
- Kessler-10 (K-10)²⁵
- Outcome Rating Scale (ORS)³⁷
- Patient Health Questionnaire (PHQ-9)³⁸
- Positive and Negative Affect Schedule (PANAS)⁴⁰
- Satisfaction With Life Scale (SWLS)⁴¹

Purpose-designed analyses

For three of the four datasets, we were able to implement a consistent analysis strategy that employed purpose-designed analyses. These datasets included data on all of the above measures except the ORS.³⁷ Our approach is described below.

Data management

These three datasets were processed and analysed separately. For all three datasets the data custodian retained the raw data and provided dummy datasets to our team; we never saw the raw data. We developed data cleaning and organisation code and data analysis code based on the dummy datasets. The data custodians then used this code to conduct the analysis and provide our team with aggregate results. All code was written in R software (version 4.0.0).

Episodes of care

Wherever possible, we organised each dataset around episodes of care, aggregating these up from sessions at which outcomes were assessed. Where sessions were date-stamped, we were able to determine the time between consecutive sessions. We treated consecutive sessions as belonging to the same episode if the period between them was less than six months; if the gap between sessions was six months or more, the latter session was treated as the start of a new episode.

Inclusion and exclusion criteria

As far as possible, we tried to ensure that the sessions that made up episodes of care were delivered through Better Access. Our starting point involved ensuring that the providers who had delivered the care came from a professional group whose services were eligible for rebates under Better Access (psychologists, social workers and occupational therapists).

We were able to take one additional step with one of the datasets. This dataset "tagged" the sessions of care that were delivered under Better Access. We used these in the analysis and excluded all others in this dataset. In the other datasets, we made the assumption that all sessions and the episodes that they were aggregated to were delivered under Better Access. We did this based on the following rationale.
The overwhelming majority of episodes in our datasets were delivered by psychologists. We know that the vast majority of sessions of care that are delivered by psychologists in Australia are funded through Better Access. Other major sources of funding for private psychologists' services are Primary Health Networks,⁷⁴ private health insurance companies,⁷⁵ the Department of Veterans Affairs¹¹ and the Department of Defence.¹¹ Together, expenditure from these sources amounts to about \$125M annually, compared with \$720M which is provided through Better Access psychologists' services. We are confident, therefore, that the majority of sessions represented in the various datasets were Better Access sessions.

To be eligible for inclusion in the analysis, an episode of care had to include at least two sessions for which the same measure was completed. For some episodes, outcomes were assessed at more than two sessions. Where this was the case, we used the outcome scores from the first and last sessions on which the measure was administered to calculate change in on the given measure.

We also excluded some sessions that did not have valid data for analysis. We excluded sessions with outcome scores that fell outside the eligible scoring range for the given measure. We also excluded sessions with more than one administration of the same measure on the same day.

In addition to the above criteria, we had some rules about the consumers who received the episodes of care. Consumers were excluded from the analysis if they were not based in Australia. They were also excluded if there was evidence that they were aged less than 18; where date of birth data were missing we assumed that they were adults. Our reasoning here was that the vast majority of episodes of care would have been provided to adults.

Data analysis

We examined outcomes (i.e., the change in scores on a given measure between the first and last measurement occasions within an episode of care) using the effect size methodology described in Section 2. Using the effect size of 0.3, episodes were classified in terms of whether the consumer showed "significant improvement", "no significant change", or "significant deterioration" depending on whether the change score was greater than 0.3 times the standard deviation of the mean difference in outcome score for all episodes, between -0.3 and 0.3 times the standard deviation, or less than -0.3 times the standard deviation. For all estimates of change, we calculated 95% confidence intervals. Non-overlapping confidence intervals were used as a conservative method of determining whether differences in the proportions classified as "significant improvement", "no significant change" or "significant deterioration" were statistically significant.⁷⁶

We calculated effect sizes for each measure within a dataset, conducting a whole-sample analysis and then analyses stratified by sex (male, female and unspecified), age group (18-29, 30-39, 40-49, 50-59, 60-69, 70+), number of outcome assessment points in the episode (2, 3, 4, 5+) and baseline severity score on the given measure.

Baseline severity was calculated for each episode for each consumer. Outcome scale scores were categorised using either standard cut-off scores (see Table 5.2) or quartiles. Scores were rounded down for the purposes of categorisation.

MEASURE	CUT-OFFS USED TO INDICATE BASELINE SEVERITY
Clinical Outcomes in Routine Evaluation	Non-clinical: 0
(CORE-OM) ^{28,29}	Clinical: ≥1
Clinical Outcomes in Routine Evaluation	 Non-clinical range: ≤10
(CORE-10) ³⁰	• Mild: 11-14
	Moderate: 15-19
	Moderate to severe: 20-24
	• Severe: ≥25
Depression Anxiety and Stress Scale	Normal: ≤9
(DASS-21/42) – Depression ^{7,8}	• Mild: 10-13
	Moderate: 14-20
	• Severe: 21-27
	 Extremely severe: ≥28
Depression Anxiety and Stress Scale	Normal: ≤7
(DASS-21/42) - Anxiety ^{7,8}	• Mild: 8-9
	Moderate: 10-14
	• Severe: 15-19
	 Extremely severe: ≥20
Depression Anxiety and Stress Scale	Normal: ≤14
(DASS-21/42) - Stress ^{7,8}	• Mild: 15-18
	Moderate: 19-25
	• Severe: 26-33
	• Extremely severe: ≥34
Depression Anxiety and Stress Scale	 Sub-clinical or mild: ≤6
(DASS-10) ³¹	Moderate: 7-12
	• Severe: ≥13
Generalised Anxiety Disorder scale (GAD-	 No GAD: ≤9
7) ³³	● GAD: ≥10
Global Assessment of Functioning Scale	Quartile 1
(GAF) ³⁴	Quartile 2
	Quartile 3
	Quartile 4
Kessler-10 (K-10) ²⁵	Low psychological distress: 10-15
	 Moderate psychological distress: 16-21
	High psychological distress: 22-29
	 Very high psychological distress: ≥30
Patient Health Questionnaire (PHQ-9) ³⁸	 No depression: ≤4
	Mild depression: 5-9
	Moderate depression: 10-14
	 Moderately severe depression: 15-19
	 Severe depression: ≥20
Positive and Negative Affect Schedule	Quartile 1
(PANAS) ⁴⁰ – Negative	Quartile 2
	Quartile 3
	Quartile 4
Positive and Negative Affect Schedule	Quartile 1
(PANAS) ⁴⁰ – Negative	Quartile 2
	Quartile 3
	Quartile 4
Satisfaction With Life Scale (SWLS) ⁴¹	Quartile 1
	Quartile 2
	Quartile 3
	Quartile 4

Table 5.2: Baseline severity cut-offs used for measures in purpose-designed analyses

Pre-existing outputs

It was not possible to conduct purpose-designed analyses with the remaining dataset for logistical reasons, so we were provided with outputs from pre-existing analyses. This dataset included data on the ORS.³⁷

The specific outputs were organised around outcomes on the ORS at six points in time (May 2015, October 2015, April 2016, August 2016, May 2017 and October 2017) and contained data from the preceding six months or so. In each case, the key outcome metric was the effect size associated with change on the ORS from pre- to post-treatment. The effect size was different from the one that we used in the purpose-designed analyses, described above. This effect size was more complex and described the effect of treatment after correcting for number of sessions, regression to the mean, baseline severity and bias. It effectively reported the effect of treatment compared to no intervention. The creators of the software through which the outputs were generated indicate that an effect size of 0.8 can be translated as "clients reporting outcomes 80% better than those not receiving treatment".

Once again, we made the assumption that the vast majority of sessions represented in this dataset would have been delivered via Better Access.

Approvals

The University of Melbourne Human Research Ethics Committee approved the study (HREC 2021-22452-23859-4).

Acknowledgements

We would like to acknowledge the custodians of the four datasets for collaborating with us on Study 2.

Results

Purpose-designed analyses

In total, we had data on outcomes from 83,346 episodes of care in our purpose-designed analyses. Individual episodes could be represented in more than one analysis if multiple measures were used to assess outcomes in the same episode. The number of episodes represented in any given analysis varied from a low of 1,862 to a high of 53,216.

Table 5.3 profiles the episodes included in the analysis for each measure. Across all measures, around two thirds of episodes were delivered to females. Between 40% and 65% of episodes were provided to people under the age of 40. The number of outcome assessments that were administered in a given episode varied considerably by measure, with 2 assessments occurring for the majority of episodes when the CORE-OM, CORE-10, DASS-21/42, GAD-7, K-10 and PHQ-9 were used, and 5 or more assessments occurring for the majority when the DASS-10, GAF, PANAS and SWLS were used.

		CORE-OM	CORE-10	DASS-	DASS-10	GAD-7	GAF	K-10	PHQ-9	PANAS	SWLS
	_	_		21/42							
Sex	Male	32.6%	30.6%	35.7%	40.9%	35.5%	37.7%	32.5%	36.9%	37.5%	37.4%
	Female	67.4%	69.4%	64.3%	59.1%	64.5%	62.3%	67.5%	63.1%	62.5%	62.6%
Age	18-29	21.7%	26.8%	21.1%	39.6%	23.3%	31.7%	21.3%	22.1%	33.2%	33.2%
	30-39	20.4%	18.8%	18.5%	25.8%	18.8%	27.4%	18.5%	18.5%	27.6%	27.7%
	40-49	18.3%	16.3%	16.9%	18.1%	16.4%	20.4%	16.8%	16.6%	20.5%	20.4%
	50-59	15.7%	15.0%	15.7%	11.0%	15.3%	13.9%	16.1%	16.0%	12.5%	12.6%
	60-69	13.7%	12.2%	14.4%	4.1%	13.7%	5.5%	14.4%	14.1%	5.3%	5.2%
	70+	10.3%	10.9%	13.4%	1.4%	12.5%	1.2%	12.9%	12.8%	1.0%	1.0%
Number of	2	62%	46%	59%	15%	64%	8%	67%	60%	6%	6%
outcome assessments	3	20%	21%	21%	14%	20%	4%	21%	22%	4%	4%
	4	7%	10%	8%	14%	7%	6%	7%	7%	7%	7%
in episode	5+	11%	23%	13%	57%	9%	82%	6%	11%	83%	83%

Table 5.3: Breakdown of episodes included in analyses, by measure

Figure 5.1 shows the distribution of consumers' baseline severity across episodes for each measure. For all measures, episodes were distributed across baseline severity categories. There were sizeable proportions of episodes where the consumer began care with mild, moderate or severe symptoms or levels of functioning in all cases. There were also instances where the consumer began the episode in the "normal range". The precise patterns differed depending on the measure, and the number and nature of the cut-offs for the various levels of severity.



Figure 5.1: Baseline severity, by measure

Figures 5.2-5.14 present the findings from the purpose-designed analyses. The figures are organised around each measure, and, in each case, data are presented for all episodes, and then episodes stratified by sex, age group, number of outcome assessment points, and baseline severity score on the given measure. It is worth noting that for the baseline severity score, the lowest level of severity is always presented to the left of each figure.

The picture is largely consistent across measures. In most cases, there was improvement in around 50-60% of episodes. There were some outliers, with greater proportions of episodes showing improvement according to the GAF and PANAS, and lower proportions doing so when the DASS-10 was used as the assessment tool. There may be reasons for this that relate to the measures themselves, the constructs they assess (e.g., symptoms versus levels of functioning versus wellbeing), whose perspective they take (i.e., the consumer's or the provider's), and the way they were administered. There may also be differences in the way practices record data for consumers (e.g., how they take into account consumers who drop out of care early). In addition, the casemix of the consumer groups seen by different practices will have a bearing on outcomes,

In general, the outcomes differed little by the sex or age of the consumer, although there was some evidence that older consumers were less likely to show improvement. The number of outcome assessments in the given episode did not usually have a bearing on outcomes, but where it did there was a tendency for proportionally greater improvement in episodes with more outcome assessments.

The only consistent difference occurred for the baseline level of severity. For all measures, consumers entered the episode of care with varying levels of severity. Almost without exception, those with more severe baseline scores on the given measure were more likely to show improvement over the course of the episode. For these consumers, across most measures, there was improvement in around 60-75% of episodes. Exceptions were the GAF and the PANAS, where the percentages were higher. The differences associated with baseline severity reinforce the point above about differences in levels of improvement across measures. If some measures are more commonly used in particular practices than others, it might be anticipated that the greatest improvements are seen on measures that are used in practices that typically see consumers whose baseline levels of severity are high.

The picture for deterioration was the inverse of that for improvement. Again, the only consistent indicator of deterioration was baseline severity. For most measures, those who began their episode of care with the mildest level of symptoms or the highest level of functioning or satisfaction with life were the most likely to show deterioration.



Figure 5.2: Outcomes on the CORE-OM



Figure 5.3: Outcomes on the CORE-10

Significantly deteriorated 📰 No significant change 🗾 Significantly improved

4

5+

3

0-

2

Significantly deteriorated No significant change Significantly improved

46.3

35

1

60-69

42.7 38.3

70+

19.1





56.2

27

Male

16.8

60 -

Percentage .05

20

0.

Figure 5.4: Outcomes on the DASS-21/42 – Depression



Significantly deteriorated No significant change Significantly improved By number of outcome assessments in episode



Significantly deteriorated 📃 No significant change 🗾 Significantly improved

52.7

28.2

I

60-69

51.6

33.7

I

70+

14.7







49.9

34

Male

16.1

40

20

0.

Percentage

Figure 5.5: Outcomes on the DASS-21/42 – Anxiety

49.4

31.9

Female

18.7







Significantly deteriorated 📰 No significant change 🗾 Significantly improved





Figure 5.6: Outcomes on the DASS-21/42 – Stress

53.8

26.5

I

60-69

70.3

18.2

Severe

19.7

52.9

28.1

70+

77.5

17.8

Extremely

severe

4.

19 H 2

Figure 5.7: Outcomes on the DASS-10



Figure 5.8: Outcomes on the GAD-7





Significantly deteriorated No significant change Significantly improved





Significantly deteriorated No significant change Significantly improved

By baseline severity



80-

Figure 5.9: Outcomes on the GAF





Figure 5.10: Outcomes on the K-10



By age



27

Т

Female

19.6



Percentage

20-

0.

27.4

Male

16



By baseline severity



Figure 5.11: Outcomes on the PHQ-9





Significantly deteriorated 📰 No significant change 🗾 Significantly improved

Significantly deteriorated No significant change Significantly improved



Figure 5.12: Outcomes on the PANAS-NA

Figure 5.13: Outcomes on the PANAS-PA



Figure 5.14: Outcomes on the SWLS



Pre-existing outputs

The pre-existing outputs represented 2,775 episodes of care. Figure 5.15 presents the key results, describing outcomes at six cross-sectional time points as measured by the ORS.³⁷ It shows the effect size associated with change on the ORS over the course of an episode for active and inactive clients. Active clients are clients who are still receiving treatment, and inactive clients are clients whose episode has ended. Active clients may not yet have achieved optimal outcomes because they are still in treatment. Conversely, inactive clients might be expected to have better outcomes because many will have completed a full course of care (although some will have dropped out before they did so). The effect sizes for active clients sit at around 0.55 across all time points. The effect sizes for inactive clients range from 0.59 to 0.73.

Figure 5.15: Outcomes on the ORS



By active and inactive clients

Discussion

Summary and interpretation of findings

Study 2 tracked consumers' progress over the course of 86,121 episodes of care, assessing change via a variety of measures that tapped into different aspects of mental health.

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' mental health improving 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 between the first and last outcome assessment in any given episode, but we did capture information on the total number of outcome assessments that were done. We did this in an effort to glean proxy information on the number of sessions in a given episode. 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 suggests that there is 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. 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 some 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.

Strengths and limitations

The clear strength of Study 2 is that it examines outcomes for consumers over a very large number of episodes of care (n=86,121), using a variety of measures. It is rare for studies conducted in the primary mental health care context to capture outcome data on such a substantial number of episodes.

Study 2 had some limitations, however. Episodes did not necessarily equate to people; some consumers may have had more than one episode in a given dataset, meaning that the episodes would not have been entirely independent. We were able to investigate this in one of the datasets, and found that the mean number of episodes per consumer was \leq 1.1, suggesting that the vast majority of consumers did actually only have one episode of care.

More than one measure may have been used to assess outcomes across a single episode. We considered how to deal with this but decided that it was justifiable to include all measures for each episode, on the grounds that the different measures assessed different constructs.

Our purpose-designed analysis of three of the datasets relied on secondary analysis of data that were collected by providers in the course of their clinical practice, which meant that the data were not always perfect for the current purpose. We were only able to consider variables that were common across datasets, which meant that we were only able to look at the relationship between a small number of consumer-based and treatment-based variables and outcomes. This meant that we were not able to consider whether outcomes differed for particular priority populations (e.g., those younger than 18, First Nations people, people from culturally and linguistically diverse backgrounds, and lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually or gender diverse [LGBTIQA+) people]. We were not able to definitively determine the total number of sessions in any given episode. We used the number of outcome assessments conducted in the episode as a proxy for this, but there are likely to have

been many episodes with multiple sessions where outcome data were only collected at the first and last session.

The dataset from which we obtained pre-existing outputs captured outcome data in a different way, but we felt that it was important to include the additional information. We had less information on consumer and treatment-based characteristics, although we were able to report on whether consumers were still in treatment.

A final limitation was that we were only able to be certain that a given session was delivered through Better Access in one dataset. We are, however, confident that the majority of sessions in the other datasets were also delivered via Better Access.

Conclusions

Study 2 provides evidence that Better Access is achieving positive outcomes for many consumers, particularly those who seek care when they are experiencing relatively severe depression, anxiety and/or psychological distress.

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

Introduction

Study 3 took the form of a survey of consumers who had received treatment from psychologists, social workers and occupational therapists via Better Access during 2021. It focussed particularly on these consumers' experiences with receiving treatment through Better Access, and on their perceptions of the outcomes of this treatment. Survey data were linked to MBS claims data for consenting participants.

Study 3 was deliberately designed to explore experiences and outcomes for as large and representative a group of consumers as possible. In our previous evaluation of Better Access, we recruited 289 consumers through clinical psychologists, 317 through psychologists, and 277 through GPs. In addition to formally assessing outcomes for these consumers, we asked them and an additional 530 consumers (458 recruited by social workers and 72 recruited by occupational therapists) about their experiences of care.^{12,13,15,17,77} At the time, we acknowledged that recruiting through providers may have introduced some biases. This influenced our decision to recruit consumers directly in Study 3 for the current evaluation.

Study 3 complements several other consumer-focussed studies in the evaluation. Like Study 6, it provides information on consumers' experiences with Better Access care; Study 3 offers breadth by eliciting the views of a large number of consumers through surveys, whereas Study 6 offers depth by seeking more detailed views from a smaller number of consumers through qualitative interviews. Study 3 also complements Studies 2 and 4. Collectively, these studies provide different windows into the outcomes of Better Access care. Study 3 does this in a purpose-designed way, but does so retrospectively, whereas Studies 2 and 4 capitalise on outcome data that were collected for a different purpose but were collected prospectively.

Methods

Study design

Study 3 involved a cross-sectional survey of people who had received Better Access-funded treatment from a clinical psychologist, a psychologist, a social worker or an occupational therapist in 2021. The survey explored these consumers' experiences with and outcomes from Better Access.

Sampling and recruitment

Services Australia identified a stratified random sample of consumers aged 18 or over who had received care through the Better Access treatment item numbers during 2021. More specifically, Services Australia classified eligible consumers on the basis of their location of residence and the services they received into 16 mutually exclusive strata (2 x location of residence; 2 x receipt of additional 10 sessions that became available in October 2020; and 4 x provider type from whom they received care) and randomly selected up to 2,500 consumers within each stratum. Where there were fewer than 2,500 consumers in the given stratum, all consumers were included. Table 6.1 shows the relevant item numbers and the 16 strata, as well as the number of consumers approached in each stratum (27,167 in total).

STRATUM	LOCATION OF RESIDENCE	NUMBER OF PROVIDER MBS ITEM NU SESSIONS ^a FROM WHOM CARE WAS RECEIVED		MBS ITEM NUMBERS	NUMBER OF CONSUMERS APPROACHED
1	Major cities and	Received additional	Clinical	93330, 93331, 93332,	2,500
	inner regional areas	sessions	psychologist	93333, 93334, 93335	
2	Major cities and	Received additional	Psychologist	93350, 93351, 93352,	2,500
	inner regional areas	sessions		93353, 93354, 93355	
3	Major cities and	Received additional	Social worker	93362, 93363, 93364,	2,478
_	inner regional areas	sessions		93365, 93366, 93367	
4	Major cities and	Received additional	Occupational	93356, 93357, 93358,	283
	Inner regional areas	sessions	therapist	93359, 93360, 93361	2 5 0 0
5	iviajor cities and	Dian t receive	Clinical	80000, 80005, 80010,	2,500
	inner regional areas	additional sessions	psychologist	80015, 80020, 80001,	
				91181 91167 91182	
6	Maior cities and	Didn't receive	Psychologist	80100, 80105, 80110,	2 500
Ū.	inner regional areas	additional sessions	1 0 / 01 01 0 8 000	80115, 80120, 80101,	2,300
				80111, 80121, 91169,	
				91183, 91170, 91184	
7	Major cities and	Didn't receive	Social worker	80150, 80155, 80160,	2,500
	inner regional areas	additional sessions		80165, 80170, 80151,	,
				80161, 80171, 91175,	
				91187, 91176, 91188	
8	Major cities and	Didn't receive	Occupational	80125, 80130, 80135,	2,500
	inner regional areas	additional sessions	therapist	80140, 80145, 80126,	
				80136, 80146, 91172,	
0	Outen na sia na l	Described additional	Clinian	91185, 91173, 91186	700
9	Outer regional,	Received additional	Clinical	93330, 93331, 93332,	720
	remote areas	Sessions	psychologist	93333, 93334, 93335	
10	Outer regional	Received additional	Psychologist	93350 93351 93352	72/
10	remote and very	sessions	TSYCHOLOGIST	93353 93354 93355	734
	remote areas	000010110			
11	Outer regional,	Received additional	Social worker	93362, 93363, 93364,	82
	remote, and very	sessions		93365, 93366, 93367	
	remote areas				
12	Outer regional,	Received additional	Occupational	93356, 93357, 93358,	6
	remote, and very	sessions	therapist	93359, 93360, 93361	
	remote areas				
13	Outer regional,	Didn't receive	Clinical	80000, 80005, 80010,	2,500
	remote, and very	additional sessions	psychologist	80015, 80020, 80001,	
	remote areas			80011, 80021, 91166,	
14	Outor regional	Didn't racaiva	Devehologist	91181, 91167, 91182	2 500
14	remote and very	additional sessions	PSychologist	80100, 80105, 80110,	2,500
	remote areas			80113, 80120, 80101,	
	Temote areas			91183, 91170, 91184	
15	Outer regional.	Didn't receive	Social worker	80150, 80155, 80160	2.500
	remote, and verv	additional sessions	,	80165, 80170, 80151.	2,000
	remote areas			80161, 80171, 91175,	
				91187, 91176, 91188	
16	Outer regional,	Didn't receive	Occupational	80125, 80130, 80135,	364
	remote, and very	additional sessions	therapist	80140, 80145, 80126,	
	remote areas			80136, 80146, 91172,	
				91185, 91173, 91186	

Table 6.1: Strata used for stratified random sampling approach, with relevant MBS item numbers and number of consumers approached

a. Since October 2020, individuals have been able to access up to 20 individual face-to-face, phone or telehealth sessions per calendar year (i.e., 10 additional sessions over and above the previous cap of 10 sessions)

Services Australia then sent each identified consumer a letter on our behalf, inviting them to complete the online survey. Each letter directed people to the survey via a URL and a QR code. Dedicated URLs/QR codes were allocated to each stratum. Invitation letters were delivered to Australia Post by Services Australia's mail-house on 31 January 2022 and the survey closed on 4 March 2022.

Procedure

Interested consumers used their allocated URL or QR code to access the survey online. They were initially presented with a plain language statement which described what their participation in the survey would involve (see Appendix 5); this was presented on screen but could also be downloaded as a PDF. Once they had read the plain language statement, consumers who chose to participate in the survey clicked on a box indicating that they consented to do so (see Appendix 6). Participants had to check the consent box in order to proceed through to the survey, and doing so took them directly to it.

The survey asked questions about the consumers themselves, their experiences of receiving care through Better Access, and the outcomes of this care (see below for more detail, and see Appendix 7 for the survey instrument itself). The survey was brief and took most participants less than 15 minutes to complete.

Once participants got to the end of the survey, participants were asked if they would like to enter a draw to win a prize (one of 50 gift vouchers valued at \$200 each). If they chose to participate in the prize draw, they were asked to provide relevant details so that they could be contacted if they won.

At this point, they were provided with a second plain language statement which described the MBS data linkage component of the study (see Appendix 8) and were then presented with a second consent form (see Appendix 9). Those who agreed to have their survey and MBS data linked checked a number of boxes indicating that they had been provided with sufficient information to provide consent, and provided relevant details so that Services Australia could locate their information.

Those who did not wish to enter the prize draw and did not consent to data linkage remained anonymous. The identifying details of those who agreed to one or other or both were stored separately from their survey responses.

Survey data were automatically entered into a database held by our independent data services subcontractor, Logicly. Logicly provided us with daily updates on response numbers and ultimately downloaded the final dataset and delivered it to us by secure means.

The survey instrument

The survey went through a number of iterations, with questions being modified on the basis of comments from the Department of Health, the CAG and the SEG. The penultimate version of the survey also underwent cognitive testing. Tight timelines meant that it was not possible for us to engage in a full co-design process when developing the survey, but we had input from consumers at all stages of the design and testing process (e.g., from our lived experience researcher team member and her networks, and the consumer member of the CAG). The final version of the survey is included at Appendix 7.

The final survey contained questions on consumers experiences with and outcomes of Better Access care. More specifically, it asked about the mental health professional the consumer saw in 2021 (or the main professional if they had seen more than one), the circumstances that prompted them to seek care, the process of seeing the mental health professional, the sessions of care, how the care was paid for, their overall satisfaction with care, and the outcomes of care.

The survey also sought some basic demographic details from each participant, including their postcode which was later mapped to the Index of Relative Socioeconomic Disadvantage (IRSD) of the of the Socioeconomic Indexes for Areas (SEIFA).⁵¹

Most of the questions in the survey are self-explanatory. However, further detail may be useful about the specific questions that consumers were asked about the process of seeing the mental health professional, their overall satisfaction with care, and the outcomes of their care:

- The process of seeing the mental health professional: Consumers were asked to rate the extent to which they agreed or disagreed with 11 statements on a scale ranging from 1 (strongly disagree) to 5 (strongly agree). Examples of the statements include "I found the referral process straightforward" and "I was offered sessions at a time that suited me". These statements were based on ones that had been used in the National Audit of Psychological Therapies (NAPT) in the United Kingdom⁷⁸ and were modified for the Better Access context.
- **Overall satisfaction with care:** The single question on consumers' overall satisfaction with their care was "How satisfied were you with your care?" and there were five response options ranging from 1 (very dissatisfied) to 5 (very satisfied). This question is fairly standard and corresponds to those used to assess satisfaction with services in other health care settings in Australia.⁷⁹
- **Outcomes of care:** Three questions were used to assess outcomes of care. Participants were asked to think back to how their mental health was before they received treatment through Better Access, and then to consider how it was after they had done so. More specifically, they were asked "On a scale of 1 to 10, where 1 is the worst possible mental health and 10 is the best possible mental health, how would you rate your mental health before your first session with the mental health professional?" and "On a scale of 1 to 10, where 1 is the worst possible mental health after your last session with the mental health professional?" These questions are based on standard questions about self-rated mental health used in large-scale population surveys like the Australian Health Survey.⁴² In the current context, they were followed by a question about the cause of any change in mental health. It asked, "To what extent would you attribute any change in your mental health to the treatment you received from the mental health professional?" and the response options allowed participants to indicate that Better Access was "entirely responsible", "partially responsible" or "not at all responsible" for any change.

Data analysis

We conducted descriptive analyses, reporting frequencies, percentages and means (and standard deviations) for all variables.

We measured outcomes of care as the difference between participants' self-rated mental health after receipt of care from the mental health professional and their self-rated mental health before this care. This yielded an outcome score that sat between -9 and +9, where positive scores indicated improvement and negative scores indicated deterioration, and a 0 indicated no change. We adopted a standardised difference approach to classifying outcomes on this scale, using an effect size of 0.3 (small-to-medium, as per Cohen's classification⁸⁰) of a standard deviation of the self-rated mental health before receipt of care as the indicator of change (see Section 2 for more detail). This yielded three outcome groups: "Significantly deteriorated"; "No significant change"; and "Significantly improved".

We conducted separate multivariate logistic regression analyses to estimate the strength of association between selected covariates and the outcomes of improvement ("Significantly improved" versus "Significantly deteriorated" and "No significant change" combined) and deterioration ("Significantly deteriorated" versus "Significantly improved" and "No significant change" combined). The covariates of interest were age, sex, sexual identity, country of birth, First Nations status, area of residence, socioeconomic status (as indicated by the SEIFA IRSD), baseline self-rated mental health, provider type (as identified by Services Australia) and self-reported number of sessions. A p<0.05 level was adopted as our criterion for statistical significance. We have reported the results of the regression analyses as adjusted odds ratios.

Approvals

The University of Melbourne Human Research Ethics Committee approved the study (HREC 2022-22999-30805-6). Services Australia External Requests Evaluation Committee approved the mail-out (EREC RMS2089) and the MBS records data linkage (EREC RMS2092).

Acknowledgements

We would like to acknowledge Services Australia for assisting us with recruiting participants for Study 3. We would also like to thank the participants themselves who provided the survey data for Study 3.

All MBS data reported in Study 3 were supplied by Services Australia.

Results

As noted, Services Australia approached 27,167 consumers across the 16 strata. Of these, 2,013 (7.4%) took up the invitation to complete the survey and provided usable data.

Sample description

Table 6.2 profiles the survey sample in terms of their sociodemographic characteristics. It shows that the sample was relatively diverse, with reasonable representation from some smaller groups. The majority of participants were relatively young (with over 50% being aged less than 40), but all age groups were represented. Three quarters were female. Three quarters identified as straight or heterosexual, but a further one fifth identifying as lesbian, gay, homosexual or bisexual. Three quarters were born in Australia, leaving one quarter who were born overseas. All states/territories were represented. There was good representation from people in regional, rural and remote areas as a result of our sampling strategy; one third of the sample resided in these areas. There was also good representation across areas with differing levels of advantage/disadvantage; around one fifth of the sample in most of the five quintiles of the IRSD of the SEIFA.⁵¹ One notable exception to the diversity of the sample was that First Nations people were under-represented, accounting for only 2% of the sample.

		FREQUENCY	%
Age (n=1,980) ^a	18-19	82	4.1
	20-29	454	22.9
	30-39	531	26.8
	40-49	382	19.3
	50-59	256	12.9
	60-69	197	9.9
	70-79	69	3.5
	≥80	9	0.5
Sex (n=1,790) ^a	Female	1,336	74.6
	Male	399	22.3
	Non-binary sex	39	2.2
	Prefer not to say	16	0.9
Sexual identity (n=1,796) ^a	Lesbian, gay or homosexual	125	7.0
	Straight or heterosexual	1,349	75.1
	Bisexual	213	11.9
	Something else	44	2.4
	Don't know	23	1.3
	Prefer not to say	42	2.3
Country of birth (n=1,925) ^a	Australia	1,449	75.3
	Overseas	476	24.7
First Nations status (n=1,780) ^a	Aboriginal	34	1.9
	Torres Strait Islander	1	0.1
	Both Aboriginal and Torres Strait Islander	1	0.1
	Neither Aboriginal nor Torres Strait	1,744	98.0
	Islander		
State of residence (n=1,871) ^a	NSW	390	20.8
	VIC	664	35.5
	QLD	417	22.3
	SA	90	4.8
	WA	164	8.8
	TAS	88	4.7
	ACT	25	1.3
	NT	33	1.8
Area of residence (n=2,013) ^a	Major city	1,399	69.5
	Regional, rural, remote	614	30.5
Area level socioeconomic status	Q1 (Most disadvantaged)	253	13.6
(SEIFA IRSD quintiles; n=1,865) ^{a,b}	Q2	363	19.5
	Q3	391	21.0
	Q4	374	20.1
	Q5 (Least disadvantaged)	484	26.0

Table 6.2: Sociodemographic profile of the survey sample

a. Missing data excluded.

b. Socioeconomic status was ascribed to participants on the basis of their postcode, using quintiles derived from the Index of Relative Socioeconomic Disadvantage (IRSD) of the of the Socioeconomic Indexes for Areas (SEIFA). More specifically, the SEIFA concordance file was used to assign the IRSD. The IRSD file reports deciles which were then converted into quintiles.

Mental health professionals seen by participants via Better Access in 2021

Table 6.3 provides details about the Better Access-funded mental health professionals that survey participants saw in 2021, according to Services Australia (identified by the item numbers against which the services they received were billed, reflected in the strata into which they were classified). Thirty five percent of participants saw a clinical psychologist, 30% saw a psychologist, 25% saw a social worker, and 10% saw an occupational therapist.

Table 6.3: Contact with mental health professional in 2021, according to Services Australia

		FREQUENCY	%
Provider (n=2,013) ^a	Clinical psychologist	695	34.5
	Psychologist	608	30.2
	Social worker	505	25.1
	Occupational therapist	205	10.2

a. As identified by Services Australia.

Table 6.4 shows the degree to which participants correctly identified the type of provider they had seen, comparing their self-report with the determination by Services Australia based on item numbers of the service they had received. Ninety seven percent of those who saw a clinical psychologist correctly indicated that they had seen a psychologist, as did 97% of those who saw a psychologist. Thirty five percent of those who saw a social worker correctly identified that they had done this, but 55% indicated that they had seen a psychologist. Thirty eight percent of those who saw an occupational therapist correctly named this type of provider, but 55% specified a psychologist.

Table 6.4: Correspondence between mental health professional seen according to self-report and Services Australia

			Self-report									
		Psycho	ologist	Social	worker	Occup: ther	ational apist	Uns	ure	Mis	sing	Total
		FREQ	%	FREQ	%	FREQ	%	FREQ	%	FREQ	%	
alia	Clinical psychologist	677	97.4%	7	1.0%	6	0.9%	4	0.6%	1	0.1%	695
stra	Psychologist	591	97.2%	5	0.8%	2	0.3%	10	1.6%	0	0.0%	608
Au	Social worker	280	55.4%	179	35.4%	11	2.2%	35	6.9%	0	0.0%	505
ces	Occupational	112	54.6%	8	4.4%	77	37.6%	6	2.9%	2	1.1%	205
ervi	therapist											
Š	Total	1,660	82.5%	199	9.9%	96	4.8%	55	2.7%	3	0.1%	2,013

The vast majority (91%) of participants were referred to the mental health professional by a GP (see Table 6.5).

Table 6.5: Referral to the mental health professional

		FREQUENCY	%
Referrer (n=1,979) ^a	GP	1,810	91.5
	Psychiatrist	63	3.2
	Other medical practitioner	63	3.2
	Unsure	43	2.2

a. Missing data excluded.

Prior Better Access care

For one third of participants, the episode of care with the mental health professional was their first use of Better Access; two thirds had received care through Better Access prior to this (see Table 6.6).

Table 6.6: Prior use of Better Access

		FREQUENCY	%
Prior use of Better Access	First time using Better Access	615	31.0
(n=1,983)ª	Not first time using Better Access	1,272	64.2
	Unsure	96	4.8

a. Missing data excluded.

The circumstances that prompted participants to seek care

Table 6.7 shows participants' reasons for seeking care from the Better Access-funded mental health professional. Most took this step because they were they were feeling depressed, anxious or highly stressed (77%), recognised that they needed help with their problems (66%), and/or had experience a traumatic event (39%). A number were prompted to see the mental health professional on the basis of a recommendation from others; many were referred by a medical professional (47%) and/or were encouraged to do so by family members or friends (23%).

		FREQUENCY	%
Reasons for seeking care	I was referred by a medical practitioner	954	47.4
(n=2,013)	I was feeling depressed, anxious or highly	1545	76.8
	stressed		
	I had experienced a traumatic event	787	39.1
	I recognised that I needed some help with	1329	66.0
	my problems		
	I was encouraged to do so by family or	461	22.9
	friends		
	Other	94	4.7
	Unsure	94	4.7

Table 6.7: Reasons for seeking care from the mental health professional (multiple responses permitted)

Diagnosis at the time of receiving care

In a further effort to understand what may have been happening for participants at the time they sought care, we asked about the mental health problems they may have been experiencing. More specifically, we asked them whether they were given a diagnosis at the time. Table 6.8 shows that over half of all participants (53%) said they were given a diagnosis, and a further 11% said they were unsure. The remaining 36% said that they weren't given a diagnosis.

Table 6.8: Diagnosis status at time of seeking mental health care

		FREQUENCY	%
Diagnosis status (n=2,013)	Given diagnosis	1,063	52.8
	Not given diagnosis	729	36.2
	Unsure	221	11.0

Table 6.9 shows that those who were given a diagnosis were most commonly told that they had an anxiety disorder (72%) and/or depression (70%). Post-traumatic stress disorder also featured relatively prominently (29%).

Table 6.9: Diagnosis at time of seeking mental health care (multiple responses permitted)

		FREQUENCY	%
Diagnosis (n=1,063)	An anxiety disorder	763	71.8
	Depression	746	70.2
	Bipolar disorder	65	6.1
	An eating disorder	67	6.3
	A personality disorder	73	6.9
	Post-traumatic stress disorder	303	28.5
	A psychotic disorder (e.g., schizophrenia)	0	0.0
	A substance use disorder	48	4.5
	Autism spectrum disorder	43	4.1
	Other	137	12.9
	Unsure	5	0.5

Self-rated mental health at the beginning of the episode

Using the 1-10 scale (with 1 being the worst possible mental health and 10 being the best possible mental health), participants' mean self-rated mental health scores prior to receiving care was 3.48 (SD = 1.73). Figure 6.1 provides a more detailed breakdown and shows that nearly 60% rated their mental health at 3 or below before they received care; the majority of the remainder rated their mental health in the middle of the range, with very few indicating that their mental health was at the upper end of the range.



Figure 6.1: Self-rated mental health before receipt of care^a

Sessions of care

Participants were asked whether they were still receiving sessions of care with the relevant mental health professional. Table 6.10 shows that two thirds (68%) still were.

Table 6.10: Ongoing receipt of sessions of care

		FREQUENCY	%
Still receiving sessions of care	Yes	1,365	68.3
(n=1,999)ª	No	508	25.4
	Unsure	126	6.3

a. Missing data excluded.

They were also asked about the number of sessions they had attended, or would attend (in the case of those who were still receiving care), with the mental health professional. The mean number of sessions was 12.45 (standard deviation 6.64). Table 6.11 provides a breakdown of the session numbers, showing that over half of all survey participants reported receiving (or expecting to receive) 11 or more sessions. It is worth noting here that the number of sessions is likely to be skewed because of the way we sampled participants. One of our sampling criteria in creating the 16 independent strata for the sampling frame was receipt (or non-receipt) of the additional 10 sessions that became available in October 2020. This means that we effectively over-sampled consumers who had already received additional sessions in 2021. Table 6.11 shows that, according to Services Australia, 45% of participants received additional

sessions of care. This is slightly lower than the proportion who reported receiving 11 or more sessions of care.

			FREQUENCY	%
Self-report	Number of sessions of care (n=1,246) ^a	1-2	83	6.7
		3-4	111	8.9
		5-6	144	11.6
		7-10	244	19.6
		11+	664	53.3
Services Australia	Receipt of additional	No additional sessions	1,099	54.6
	sessions of care (n=2,013)	Additional sessions	914	45.4

Table 6.11: Number of sessions of mental health care

a. Missing data excluded.

Figure 6.2 shows that there was no association between self-reported mental health care prior to the episode and receipt of additional sessions of care. The profiles of self-reported mental health care are almost identical for the two groups.



Figure 6.2: Self-rated mental health before receipt of care and receipt of additional sessions^a

a. Missing data excluded.

Participants were asked about the modality and format of the sessions of care that they received. Table 6.12 shows that the majority (79%) received face-to-face sessions but that other formats were also common (51% received sessions via telehealth and 21% via phone). The fact that these percentages well exceed 100% indicates that many participants received sessions in several formats.

Table 6.12 also shows that an overwhelming majority of participants (99%) received individual sessions of care.

			FREQUENCY	%
Session modality (n=2,000) ^a	Face-to-face	Yes	1,583	79.2
		No	417	20.9%
	Via telehealth	Yes	1,020	51.0
		No	980	49.0%
	Via phone	Yes	414	20.7
		No	1,586	79.3%
Session format (n=2,000) ^a	Individual	Yes	1,988	99.4
		No	12	0.6%
	Group	Yes	38	1.9
		No	1,962	98.1%

Table 6.12: Modality and format of sessions

a. Missing data excluded.

Participants were also asked about the adequacy of the number of sessions. Fifty percent of the participants felt that the number of sessions was just right, but a further 38% felt that it was too few (see Table 6.13).

Table 6.13: Adequacy of number of sessions

		FREQUENCY	%
Adequacy of number of sessions	Too many	10	0.5
(n=1,978)ª	Too few	747	37.8
	Just right	989	50.0
	Unsure	232	11.7

a. Missing data excluded.

Additional consideration was given to the 508 participants who indicated that they were no longer seeing the mental health professional (see Table 6.10). Table 6.14 shows that 261 (51%) of these indicated that they had continued seeing the mental health professional for as long as they could have done, but 224 (44%) had stopped seeing the mental health professional before their session limit was up.

Table 6.14: Early cessation of mental health care (those still receiving care only)

		FREQUENCY	%
Continued seeing mental health	Yes	261	51.4
professional for as long as could	No	224	44.1
have done	Unsure	23	4.5

Figure 6.3 focuses on the 224 who ceased their mental health care early, drilling down into their reasons for this. In total, 38% indicated that they did not find the sessions helpful, 32% said that the out-of-pocket costs were too expensive, and 30% said that they did not like the mental health professional's manner or approach. Only 28% indicated that they stopped seeing the mental health professional because they felt better. It should be noted, however, that because participants could provide multiple responses to this question, these responses were not mutually exclusive. For example 24% said that the out-of-pocket costs were too expensive *and* that they felt better. Potentially they may have felt better still if they had been able to afford more sessions.

Figure 6.3: Reasons for early cessation of mental health care (those ceasing care early only; multiple responses permitted)



Table 6.15 shows how the numbers of sessions and early cessation of care are related. Those receiving only 1-2 sessions tended to not still be receiving care, to not have continued seeing the mental health professional for as long as they could have done, and to have ceased care because they did not find the sessions helpful, they did not like the mental health professional's manner or approach, or the out-of-pocket costs were too high. By contrast, those receiving 11+ sessions were more likely to still be receiving care. If they were not still receiving care, they had typically continued seeing the mental health professional for as long as they could have done. Many of those who had ceased care early had done so because the out-of-pocket costs were too high, but a significant proportion had done so because they felt better.

	NUMBER OF SESSIONS ^a													
				1-2		3-4		5-6		7-10		11+		Total
Still	Yes			11	13.3%	26	23.4%	60	41.7%	154	63.1%	557	83.9%	808
receiving	No	No		65	78.3%	67	60.4%	69	47.9%	76	31.1%	81	12.2%	358
sessions of	Unsure			7	8.4%	18	16.2%	15	10.4%	14	5.7%	26	3.9%	80
care	Total		83	100.0%	111	100.0%	144	100.0%	244	100.0%	664	100.0%	1246	
	Continued	Yes		5	11.4%	9	19.6%	11	40.7%	10	40.0%	9	39.1%	44
	seeing	No		39	88.6%	37	80.4%	16	59.3%	15	60.0%	14	60.9%	121
	mental	Total		44	100.0%	46	100.0%	27	100.0%	25	100.0%	23	100.0%	165
	health	Reasons for	I felt better	5	11.4%	9	19.6%	11	40.7%	10	40.0%	9	39.1%	44
	professional	early	The fee I had to pay out of my own	13	29.5%	11	23.9%	6	22.2%	8	32.0%	12	52.2%	50
	for as long as	cessation of	pocket was too expensive											
	dono	care	The other costs associated with seeing	1	2.3%	2	4.3%	0	0.0%	1	4.0%	1	4.3%	5
	uone		the mental health professional were											
			too high (e.g., transport costs,											
			accommodation costs, childcare costs,											
			income lost by attending the sessions)											
			I did not find the sessions helpful	19	43.2%	21	45.7%	9	33.3%	3	12.0%	12	52.2%	64
			I did not like the mental health	17	38.6%	18	39.1%	7	25.9%	4	16.0%	7	30.4%	53
			professional's manner or approach											
			I had difficulty fitting the sessions in	9	20.5%	4	8.7%	2	7.4%	2	8.0%	4	17.4%	21
			around my other commitments											
			The mental health professional moved	0	0.0%	2	4.3%	2	7.4%	3	12.0%	0	0.0%	7
			out of my area											
			I chose to access a different mental	4	9.1%	4	8.7%	1	3.7%	1	4.0%	1	4.3%	11
			health service (i.e., one that wasn't											
			paid for by Medicare)					-		-		-		
			I did not like the session format (e.g.,	6	13.6%	3	6.5%	0	0.0%	2	8.0%	2	8.7%	13
			telehealth, face-to-face)		0.00/		0.00/		0.00/		0.00/		0.00/	
			Language was a barrier for me	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0
			Other	13	29.5%	7	15.2%	7	25.9%	3	12.0%	4	17.4%	34
			Total	44	100.0%	46	100.0%	27	100.0%	25	100.0%	23	100.0%	165

Table 6.15: Number of sessions by early cessation of care and reasons for early cessation

a. Missing data excluded.

Payment for Better Access care

Participants were asked about the payment arrangements for their Better Access care. Table 6.16 shows that, for the majority of participants (70%), Medicare covered some of the costs but they paid residual out-of-pocket costs. For 26% of participants, however, Medicare covered all of the costs. Participants were evenly split between feeling that the fee they paid was affordable (36%) and too expensive (35%).

		FREQUENCY	%
Payment source (n=1,987) ^a	Medicare covered all of the costs	519	26.1
	Medicare covered some of the costs, but I	1,391	70.0
	paid at least some of the costs out of my		
	own pocket		
	Some other payment arrangement	36	1.8
	Unsure	41	2.1
Perceptions of affordability	I didn't pay anything; Medicare covered	510	26.2
(n=1,945) ^a	all of the cost		
	I paid a fee that was affordable	693	35.6
	I paid a fee that was too expensive	670	34.5
	Unsure	72	3.7

Table 6.16: Payment for Better Access care

a. Missing data excluded.

Experiences of seeing the mental health professional

As noted, participants were asked the extent to which they agreed or disagreed with a series of statements about their experiences of seeing the mental health professional. Figure 6.4 shows the results; a positive experience is indicated by agreement with the statement in the blue graphs and disagreement with the statement in the orange graphs.

Overall, the majority of participants indicated that they had positive experiences. Seventy seven percent found the referral process straightforward, 84% were offered sessions at a time that suited them, 92% found the mental health professional empathic, 94% felt that the mental health professional listened to them, 94% indicated that the mental health professional respected their right to make decisions, 87% believed that the mental health professional equipped them with strategies to address the issues they were facing, 82% felt that the support or care provided by the mental health professional met their needs, and 90% had a good relationship with the mental health professional. Only 8% said they had to travel too far to see the mental health professional.

There were two notable exceptions, however. Nearly one third of participants (30%) felt they had to wait too long for an appointment with the mental health professional, and only a little over a third (38%) indicated that they were offered the opportunity for their family and friends to be involved in their support or care if they wanted this. We examined these two variables by provider type, in order to determine whether this had a bearing on participants' experiences (see Table 6.17). In both cases, patterns of responses were similar across provider types.
Figure 6.4: Participants' experiences with seeing the mental health professional^a



I had to travel too far to see the mental health professional



The mental health professional was empathic



I had to wait too long for an appointment with the mental health professional



I was offered sessions at a time that suited me



I was offered the opportunity for my family and friends to be involved in my support or care if I wanted this



Figure 6.4: Participants' experiences with seeing the mental health professional^a (cont.)



The mental health professional equipped me with strategies to address the issues I was facing



The support or care provided by the mental health professional met my needs



a. Missing data excluded.







The mental health professional respected my right to make decisions

I had to wait to long for an appointment with the mental health professional											
	Strongly		Disagree		Neither agree		Agree		Strongly agree		
	disa	gree			nor di	sagree					
	FREQ	%	FREQ	%	FREQ	%	FREQ	%	FREQ	%	
Clinical psychologist	99	14.4	260	37.9	132	19.2	133	19.4	63	9.2	
Psychologist	82	13.8	202	34.0	127	21.4	113	19.0	70	11.8	
Social worker	73	14.9	188	38.5	71	14.5	105	21.5	52	10.6	
Occupational therapist	30	15.1	78	39.2	35	17.6	29	14.6	27	13.6	
Total	284	14.4	728	37.0	365	18.5	380	19.3	212	10.8	
I was offered the opportun	ity for my	r family a	nd friend	s to be in	volved in	my supp	ort or car	e if I wan	ted this		
	Stro	ngly	Disa	Disagree		Neither agree		Agree		Strongly agree	
	disa	gree		-	nor disagree			-			
	FREQ	%	FREQ	%	FREQ	%	FREQ	%	FREQ	%	
Clinical psychologist	59	8.6	116	17.0	255	37.3	173	25.3	80	11.7	
Psychologist	48	8.2	121	20.6	203	34.5	144	24.5	72	12.2	
Social worker	34	7.0	91	18.7	165	33.9	119	24.4	78	16.0	
Occupational therapist	15	7.5	34	17.1	69	34.7	44	22.1	37	18.6	
Total	156	80	362	18 5	602	35 /	180	245	267	126	

Table 6.17: Key experiences by provider type^a

a. Missing data excluded.

Overall satisfaction with care

Figure 6.5 shows that the vast majority of participants were satisfied with their care they received through Better Access (41% satisfied, 45% very satisfied).



Figure 6.5: Overall satisfaction with care^a

a. Missing data excluded.

Outcomes of care

Again using the 1-10 scale (with 1 being the worst possible mental health and 10 being the best possible mental health), participants' mean self-rated mental health scores after receiving care was 7.04 (SD = 1.74). Figure 6.6 shows a reversal of the picture in Figure 6.1; by the end of their episode of care close to 50% of participants rated their mental health at 8 or above after receiving care and diminishingly smaller proportions rated their mental health along the range to the worst possible mental health.



Figure 6.6: Self-rated mental health after receipt of care^a

a. Missing data excluded.

Figure 6.7 shows participants' raw outcome scores, generated by subtracting their self-rated mental health score prior to using Better Access from their self-rated mental health score after their receipt of Better Access care. Possible outcome scores ranged from -9 to +9, with positive scores indicating improvement, negative scores indicating deterioration and 0 indicating no change. The figure is skewed heavily to the right, indicating that the vast majority of participants experienced positive outcomes.



Figure 6.7: Change in self-rated mental health by raw outcome scores^a

a. Missing data excluded.

When the raw outcome scores were translated into outcome groups, 91% of participants fell into the "Improved" group (see Figure 6.8).



Figure 6.8: Change in self-rated mental health by outcome group^a

a. Missing data excluded.

Figure 6.9 shows that seventy eight percent of those whose mental health improved attributed this improvement to the treatment they received from the mental health professional: 2% indicated that the mental health professional was entirely responsible and 76% indicated that they were partially responsible. The remainder indicated that the improvement in their mental health was totally due to other factors.



Figure 6.9: Attribution of reason for improvement for those whose self-rated mental health improved^a

a. Missing data excluded.

Predictors of improvement

Table 6.18 shows the results of the logistic regression analysis that examined predictors of improvement in self-rated mental health. Only three of the covariates in the model had a statistically significant association with improvement (highlighted in grey in the table). The first of these was sex. Being female was associated with higher odds of improvement (OR = 2.69; 95%CI = 1.42-5.08).

The second was self-rated mental health before Better Access care. The better participants' self-rated mental health was when they began their episode of care, the lower their odds of showing improvement (OR = 0.53; 95%Cl = 0.45-0.63).

The final covariate associated with improvement in self-rated mental health was the number of sessions. Compared with those who had 1-2 sessions, those who had more sessions had greater odds of improving. There was some suggestion that there was a dose response effect, with increasingly greater odds associated with increasingly higher numbers of sessions, although the 95%CIs overlapped: 3-4 sessions (OR = 5.18; 95% CI = 1.69-15.87); 5-6 sessions (OR=6.28; 95%CI = 2.18-18.03); 7-10 sessions (OR = 7.45; 95%CI = 2.74-20.25); and 11+ sessions (OR = 8.86; 95%CI = 3.60-21.79).

Age, sexual identity, country of birth, First Nations status, area of residence, socioeconomic status as measured by the SEIFA IRSD, provider type, and whether care was received face-to-face, by telehealth or by phone were not significantly associated with improvement in self-rated mental health.

		ODDS RATIO	95%CI LOW	95%CI HIGH	P VALUE
Age	≤29	1.00			
-	30-39	1.54	0.68	3.48	0.301
	40-49	1.50	0.62	3.60	0.367
	50-59	1.45	0.54	3.92	0.460
	60-69	1.38	0.48	3.97	0.556
	≥70	7.43	0.68	81.25	0.100
Sex	Male	1.00			
	Female	2.69	1.42	5.08	0.002
	Non-binary sex	0.77	0.17	3.48	0.735
	Prefer not to say	1.73	0.14	21.86	0.674
Sexual identity	Straight or heterosexual	1.00			
	Lesbian, gay or homosexual	1.76	0.43	7.25	0.432
	Bisexual	0.47	0.19	1.12	0.088
	Something else	0.47	0.12	1.85	0.278
	Don't know / prefer not to say	0.62	0.12	3.29	0.573
Country of birth	Australia	1.00			
	Overseas	1.23	0.57	2.70	0.597
First Nations status	Not First Nations	1.00			
	First Nations	0.52	0.08	3.29	0.486
Area of residence	Major city	1.00			
	Regional, rural, remote	0.90	0.44	1.85	0.779
SEIFA IRSD quintile ^b	Q1 (Most disadvantaged)	1.00			
	Q2	1.20	0.43	3.34	0.725
	Q3	1.15	0.43	3.07	0.781
	Q4	1.90	0.63	5.75	0.256
	Q5 (Least disadvantaged)	1.48	0.53	4.13	0.459
Self-rated mental health	Before care	0.53	0.45	0.63	0.000
Provider type ^c	Clinical psychologist	1.00			
	Psychologist	0.75	0.36	1.58	0.453
	Social worker	0.64	0.29	1.40	0.260
	Occupational therapist	1.23	0.37	4.10	0.738
No. of sessions	1-2	1.00			
	3-4	5.18	1.69	15.87	0.004
	5-6	6.28	2.18	18.03	0.001
	7-10	7.45	2.74	20.25	0.000
	11+	8.86	3.60	21.79	0.000
Face-to-face sessions	No	1.00			
	Yes	1.00	0.47	2.10	0.995
Telehealth sessions	No	1.00			
	Yes	0.76	0.36	1.57	0.452
Phone sessions	No	1.00			
	Yes	0.95	0.45	2.02	0.902

Table 6.18: Predictors of improvement in self-rated mental health^a

a. Missing data excluded.

b. Socioeconomic status was ascribed to participants on the basis of their postcode, using quintiles derived from the Index of Relative Socioeconomic Disadvantage (IRSD) of the of the Socioeconomic Indexes for Areas (SEIFA). More specifically, the SEIFA concordance file was used to assign the IRSD. The IRSD file reports deciles which were then converted into quintiles.

c. Provider type according to Services Australia.

Predictors of deterioration

Table 6.19 shows the results of the regression analysis that examined predictors of deterioration in selfrated mental health. Again, three covariates were associated with deterioration. Two of these were the same as those in the improvement model, operating in reverse. Self-rated mental health at baseline was significantly associated with deterioration; those with relatively good baseline mental health had greater odds of showing deterioration (OR = 1.92; 95%CI = 1.55-2.38). The number of sessions was also related to deterioration. Using 1-2 sessions as the reference point, there was no difference in the likelihood of deterioration for those who had 3-4 sessions (OR = 0.25; 95%CI=0.06-1.06). Beyond this, however, a greater numbers of session was associated with decreased odds of deterioration: 5-6 sessions (OR=0.06; 95%CI = 0.01-0.38); 7-10 sessions (OR = 0.13; 95%CI = 0.03-0.50); and 11+ sessions (OR = 0.12; 95%CI = 0.04-0.38).

The third covariate related to deterioration was socioeconomic status. The pattern was not straightforward, however. Compared with those living in areas of greatest disadvantage, those living in the next most disadvantaged areas had lower odds of showing deterioration (OR = 0.22; 95%CI = 0.05-0.98). Beyond this, those living in areas of progressively lesser disadvantage were no less likely to show deterioration.

Age, sex, sexual identity, country of birth, First Nations status, area of residence, provider type, and whether care was received face-to-face, by telehealth or by phone were not significantly associated with deterioration in self-rated mental health.

		ODDS RATIO	95%CI LOW	95%CI HIGH	P VALUE
Age	≤29	1.00			
	30-39	0.47	0.15	1.46	0.194
	40-49	0.45	0.13	1.57	0.212
	50-59	0.32	0.07	1.46	0.141
	60-69	0.63	0.15	2.62	0.523
	≥70	0.27	0.02	3.14	0.297
Sex	Male	1.00			
	Female	0.55	0.22	1.38	0.200
	Non-binary sex	6.03	0.81	44.75	0.079
	Prefer not to say	2.31	0.13	42.63	0.574
Sexual identity	Straight or heterosexual	1.00			
	Lesbian, gay or homosexual	0.28	0.03	2.78	0.280
	Bisexual	1.12	0.30	4.21	0.862
	Something else	0.34	0.03	3.63	0.372
	Don't know / prefer not to say	1.51	0.16	14.21	0.718
Country of birth	Australia	1.00			
	Overseas	0.61	0.18	2.01	0.413
First Nations status	Not First Nations	1.00			
	First Nations	1.20	0.09	16.27	0.892
Area of residence	Major city	1.00			
	Regional, rural, remote	0.93	0.34	2.59	0.895
SEIFA IRSD quintile ^b	Q1 (Most disadvantaged)	1.00			
	Q2	0.22	0.05	0.98	0.048
	Q3	0.48	0.14	1.67	0.248
	Q4	0.27	0.07	1.09	0.066
	Q5 (Least disadvantaged)	0.37	0.10	1.35	0.133
Self-rated mental health	Before care	1.92	1.55	2.38	0.000
Provider type ^c	Clinical psychologist	1.00			
	Psychologist	1.47	0.51	4.19	0.476
	Social worker	1.96	0.64	5.95	0.238
	Occupational therapist	1.26	0.26	6.09	0.777
No. of sessions	1-2	1.00			
	3-4	0.25	0.06	1.06	0.061
	5-6	0.06	0.01	0.38	0.003
	7-10	0.13	0.03	0.50	0.003
	11+	0.12	0.04	0.38	0.000
Face-to-face sessions	No	1.00			
	Yes	1.96	0.67	5.76	0.222
Telehealth sessions	No	1.00			
	Yes	2.37	0.86	6.55	0.096
Phone sessions	No	1.00			
	Yes	0.89	0.31	2.61	0.838

Table 6.19: Predictors of deterioration in self-rated mental health^a

a. Missing data excluded.

b. Socioeconomic status was ascribed to participants on the basis of their postcode, using quintiles derived from the Index of Relative Socioeconomic Disadvantage (IRSD) of the of the Socioeconomic Indexes for Areas (SEIFA). More specifically, the SEIFA concordance file was used to assign the IRSD. The IRSD file reports deciles which were then converted into quintiles.

c. Provider type according to Services Australia.

Analysis of data from survey participants with linked MBS data

Linked MBS data were available for 1,317 survey participants (65%). These participants were broadly representative of the total sample of participants, with very similar profiles on the basis of age, sex, sexual identity, country of birth, First Nations status, state of residence, area of residence, and area-level socioeconomic status (see Appendix 10).

According to their MBS claims data:

- 461 of these participants (35%) saw a clinical psychologist, 408 (31%) saw a psychologist, 320 (24%) saw a social worker, and 128 (10%) saw an occupational therapist;
- 217 participants (16%) received 1-2 sessions of care, 195 (15%) received 3-4 sessions, 179 (14%) received 5-6 sessions, 303 (23%) received 7-10 sessions, and 423 (32%) received 11 or more sessions; and
- 1,032 participants (78%) received face-to-face sessions, 573 (44%) received sessions via telehealth, and 200 (15%) received sessions via phone (noting that an individual participant could receive sessions via more than one modality).

Eight hundred and seventy five participants with MBS claims data (66%) paid a co-payment for at least one session of care. Table 6.20 shows that when sessions at which any co-payment was paid was used as the denominator, the median out-of-pocket cost was \$71.60 (inter-quartile range [IQR] = \$37.40-\$91.75). These numbers varied somewhat depending on the type of provider that the participant saw.

	MEDIAN	IQR
Clinical psychologist	\$70.45	\$37.40-\$91.60
Psychologist	\$72.55	\$42.55-\$92.55
Social worker	\$72.20	\$42.20-\$82.90
Occupational therapist	\$72.20	\$22.90-\$102.20
Any provider	\$71.60	\$37.40-\$91.75

Table 6.20: Co-payments paid by participants with linked MBS claims data

Of those who paid a co-payment for at least one session <u>and</u> provided data on the affordability of the fee, 438 (54%) indicated that the co-payment was affordable and 376 (46%) indicated that they thought it was too expensive. Table 6.21 shows the median and IQR for those who indicated via the survey that the fee they paid was affordable and those who thought the fee they paid was too expensive. Not surprisingly, the median was lower for those who felt that the fee was affordable than it was for those who thought it was too expensive (\$61.75 [IQR = \$31.60-\$82.20] versus \$77.55 [IQR = \$51.75-\$100.45]).

Table 6.21: Co-payments by perceived affordability for participants with linked MBS claims data

	MEDIAN	IQR
I paid a fee that was affordable	\$61.75	\$31.60-\$82.20
I paid a fee that was too expensive	\$77.55	\$51.75-\$100.45

Like the overall group of survey participants, the vast majority of this subgroup who provided pre- and post- responses on their self-rated mental health indicated that their mental health got better over the course of their care: 1,066 participants (92%) significantly improved; 63 (5%) experienced no significant change; and 31 (3%) significantly deteriorated.

We repeated the logistic regression analyses for this subgroup, using MBS claims data instead of selfreport data not only for provider type (as we did in the main analyses) but also for all session-related variables. We also included out-of-pocket costs as a covariate. The predictors of improvement are presented in Table 6.22 and the predictors of deterioration are presented in Table 6.23. To a large extent, the results mirrored the findings from the main analyses. Participants' self-rated mental health at the beginning of the episode of care was significantly associated with improvement; the better their initial self-rated mental health, the lower their odds of showing improvement (OR = 0.47; 95%CI = 0.40-0.55) and, conversely, the worse their initial self-rated mental health, the higher their odds of showing deterioration (OR = 2.01; 95%CI = 1.60-2.52). The number of sessions was also related to improvement; compared with those who had 1-2 sessions, those who had more sessions had greater odds of improving: 3-4 sessions (OR = 2.66; 95%CI = 1.03-6.82); 5-6 sessions (OR = 3.18; 95%CI = 1.15-8.78); 11+ sessions (OR = 4.18; 95%CI = 1.67-10.48). Having made a co-payment for at least one session was also associated with greater odds of showing improvement (OR = 4.08; 95%CI = 2.17-7.69).

		ODDS	95%CI	95%CI	P VALUE
		RATIO	LOW	HIGH	
Age	≤29	1.00			
	30-39	1.20	0.53	2.72	0.661
	40-49	1.31	0.54	3.19	0.557
	50-59	0.72	0.28	1.85	0.498
	60-69	1.14	0.41	3.13	0.803
	≥70	4.60	0.77	27.36	0.094
Sex	Male	1.00			
	Female	1.60	0.84	3.06	0.153
	Non-binary sex / prefer not to say	0.66	0.14	3.05	0.594
Sexual identity	Straight or heterosexual	1.00			
	Lesbian, gay or homosexual	0.98	0.30	3.20	0.979
	Bisexual	0.54	0.23	1.30	0.170
	Something else	0.48	0.10	2.39	0.374
	Don't know / prefer not to say	1.05	0.12	8.88	0.966
Country of birth	Australia	1.00			
	Overseas	0.74	0.36	1.55	0.426
First Nations status	Not First Nations	1.00			
	First Nations	0.60	0.08	4.21	0.605
Area of residence	Major city	1.00			
	Regional, rural, remote	1.46	0.73	2.94	0.287
SEIFA IRSD quintile ^b	Q1 (Most disadvantaged)	1.00			
	Q2	1.30	0.50	3.38	0.590
	Q3	1.49	0.59	3.77	0.404
	Q4	1.30	0.47	3.57	0.614
	Q5 (Least disadvantaged)	1.54	0.57	4.17	0.392
Self-rated mental health	Before care	0.47	0.40	0.55	0.000
Provider type ^c	Clinical psychologist	1.00			
	Psychologist	0.87	0.44	1.70	0.676
	Social worker	1.22	0.56	2.63	0.619
	Occupational therapist	3.61	0.87	15.09	0.078
No. of sessions ^d	1-2	1.00			
	3-4	2.66	1.03	6.82	0.042
	5-6	3.18	1.15	8.78	0.026
	7-10	2.19	0.95	5.09	0.067
	11+	4.18	1.67	10.48	0.002
Face-to-face sessions ^d	No	1.00			
	Yes	0.80	0.38	1.68	0.564
Telehealth sessions ^d	No	1.00			
	Yes	0.57	0.27	1.20	0.140
Phone sessions ^d	No	1.00			
	Yes	0.83	0.39	1.81	0.646
Out-of-pocket costs ^d	No	1.00			
	Yes	4.08	2.17	7.69	0.000

Table 6.22: Predictors of improvement in self-rated mental health for participants with linked MBS claims data^a

a. Missing data excluded.

b. Socioeconomic status was ascribed to participants on the basis of their postcode, using quintiles derived from the Index of Relative Socioeconomic Disadvantage (IRSD) of the of the Socioeconomic Indexes for Areas (SEIFA). More specifically, the SEIFA concordance file was used to assign the IRSD. The IRSD file reports deciles which were then converted into quintiles.

- c. Provider type according to Services Australia.d. Session-related information according to MBS claims data from Services Australia.

		ODDS	95%CI	95%CI	P VALUE
		RATIO	LOW	HIGH	
Age	≤29	1.00			
	30-39	0.71	0.19	2.60	0.601
	40-49	0.60	0.14	2.50	0.482
	50-59	1.03	0.20	5.30	0.973
	60-69	0.63	0.11	3.82	0.620
	≥70	0.46	0.04	5.21	0.534
Sex	Male	1.00			
	Female	0.61	0.21	1.73	0.350
	Non-binary sex / prefer not to say	0.90	0.08	9.97	0.933
Sexual identity	Straight or heterosexual	1.00			
	Lesbian, gay or homosexual	0.57	0.06	5.77	0.637
	Bisexual	1.51	0.37	6.19	0.567
	Something else	2.26	0.26	19.81	0.461
	Don't know / prefer not to say	4.12	0.42	40.27	0.223
Country of birth	Australia	1.00			
	Overseas	1.19	0.36	3.89	0.778
First Nations status	Not First Nations	1.00			
	First Nations	2.30	0.17	30.78	0.530
Area of residence	Major city	1.00			
	Regional, rural, remote	0.63	0.19	2.14	0.460
SEIFA IRSD quintile ^b	Q1 (Most disadvantaged)	1.00			
	Q2	0.73	0.13	4.13	0.726
	Q3	0.71	0.12	4.04	0.698
	Q4	0.83	0.14	4.70	0.829
	Q5 (Least disadvantaged)	1.00	0.18	5.47	0.998
Self-rated mental health	Before care	2.01	1.60	2.52	0.000
Provider type ^c	Clinical psychologist	1.00			
	Psychologist	1.18	0.40	3.49	0.759
	Social worker	0.60	0.16	2.31	0.460
	Occupational therapist	0.49	0.05	4.97	0.543
No. of sessions ^d	1-2	1.00			
	3-4	1.14	0.25	5.23	0.867
	5-6	0.38	0.05	2.62	0.324
	7-10	1.17	0.29	4.80	0.824
	11+	0.71	0.16	3.14	0.649
Face-to-face sessions ^d	No	1.00			
	Yes	0.79	0.23	2.68	0.705
Telehealth sessions ^d	No	1.00			
	Yes	1.32	0.37	4.67	0.670
Phone sessions ^d	No	1.00			
	Yes	0.29	0.05	1.61	0.157
Out-of-pocket costs ^d	No	1.00			
	Yes	0.58	0.21	1.61	0.293

Table 6.23: Predictors of deterioration in self-rated mental health for participants with linked MBS claims data^a

a. Missing data excluded.

b. Socioeconomic status was ascribed to participants on the basis of their postcode, using quintiles derived from the Index of Relative Socioeconomic Disadvantage (IRSD) of the of the Socioeconomic Indexes for Areas (SEIFA). More specifically, the SEIFA concordance file was used to assign the IRSD. The IRSD file reports deciles which were then converted into quintiles.

- c. Provider type according to Services Australia.
- d. Session-related information according to MBS claims data from Services Australia.

Discussion

Summary and interpretation of findings

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 smaller but still substantial proportion 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 and deterioration.

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. For the subsample, paying a co-payment was also associated with improvement. These findings relating to out-of-pocket payments, affordability and outcomes speak to questions of access to and the effectiveness of Better Access. On the one hand, out-of-pocket costs may be prohibitive for some, acting as a barrier and limiting access. On the other hand,

those who do pay a co-payment may get greater benefits from their mental health care. The latter finding has been demonstrated elsewhere. Some have suggested that making a contribution to the cost of care can lead to greater commitment to treatment.⁸¹

It is worth commenting on the finding that the majority of participants in the full sample thought they had seen a psychologist, even if they had seen a social worker or an occupational therapist. There is a need to understand the components of care offered by different provider groups, and the education, training and practical experience that might underpin these. Different types of providers are likely to have different approaches and skills, so there might be scope for tailoring the referral process to ensure the best match between consumers' needs and what providers offer. This might involve raising awareness among the general community – and potentially among referrers – about the approaches and skills of different provider groups.

Strengths and limitations

A clear strength of Study 3 is our sampling strategy. With the assistance of Services Australia, we were able to approach a stratified random sample of consumers who were known to have used Better Access in 2021. Our sample was sizeable in absolute terms (n=2,013), which allowed us to present detailed results with a high degree of precision. However, our response rate was 7.4% which may have implications for the generalisability of our findings.

We deliberately over-sampled particular groups (e.g., those in outer regional, remote, and very remote areas). This ensured representation from these groups, but it means that the overall patterns of Better Access use may not mirror those occurring Australia-wide. For example, when we looked at the out-of-pocket costs paid by those who agreed to their survey data and MBS claims data being linked, the median out-of-pocket costs for seeing a psychologist were lower than those identified in Study 1a (\$73 versus \$83), although they were similar for sessions with other allied health professionals. Study 1a showed that the high out-of-pocket costs for psychologists were driven by areas of high and medium socioeconomic status in major cities, which accounted for 56% of all psychologist services in 2021. Our over-sampling of consumers in outer regional, remote, and very remote areas would have skewed out out-of-pocket costs for psychologists.

Our overall sample was diverse and had good representation from a number of priority populations (e.g., people identifying as lesbian, gay, homosexual or bisexual, people born overseas, people living in regional, rural and remote areas, and people living in areas of disadvantage). However, some groups were under-represented, including First Nations people. It is also worth noting that although the sample had good representation across the adult age range, we were unable to include people aged less than 18.

The survey relied on retrospective self-report. This may have introduced recall bias (where participants may not have remembered their experiences accurately) and potentially social desirability bias (where participants may have responded in a manner that they thought would have been viewed favourably). This may have had a particular impact in relation to the questions relating to self-reported mental health. Participants may have had difficulty remembering what their mental health was like before and after their episode of mental health care, and may have been inclined to indicate that it was better after the episode.

We deliberately designed the survey to be relatively short, to maximise the likelihood that participants would complete it. This meant, however, that it was not possible to explore some of the reasons for particular responses. For example, it would have been helpful to understand why only two thirds of participants reported being given a diagnosis, given that this is a requirement of accessing Better Access treatment services. Study 6 provides additional information about some, but not all, of the participants' responses.

Because we recruited participants early in 2022 and our selection criteria relied on people having received relevant Better Access services in 2021, a relatively high proportion of participants (68%) were still receiving care when they completed the survey. This reflects the reality that episodes of care take place over weeks or months, but it does mean that in many cases participants reflecting on their experiences when their care was ongoing.

Conclusions

Study 3 explored the perceptions of more than 2,000 people who saw a mental health professional through Better Access in 2021. These consumers were generally extremely positive about their experience of receiving care, valuing their relationship with the mental health professional and appreciating the strategies they were taught. They did raise some issues, however, notably around the affordability and timeliness of care. In spite of this, they almost universally indicated that the care they received led to improvements in their mental health, indicating that Better Access is effective.

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

Introduction

Study 4 involved new analyses of data from two large-scale randomised controlled trials of tailored approaches to providing primary mental health care, Target-D³ and Link-me.⁴ Some members of the current evaluation team were investigators on these trials, which meant that we had an in-depth understanding of the data collected and how it could be re-analysed in order to address research questions associated with the evaluation. In each trial, general practice attendees predicted to have varying degrees of severity of depression and anxiety over the next three months were randomised into an intervention group (which received the tailored approach) or a control group (which received "usual care"). The original trial analyses were designed to test whether those offered the tailored intervention had better outcomes than those who received usual care.

In the original Target-D and Link-me trials, we collected detailed information about the use of services for mental health delivered by a range of providers in different settings. For the purposes of Study 4, this enabled us to classify a subset of participants in the control groups whose service use characteristics were consistent with use of Better Access treatment services delivered by eligible allied health professionals. In each trial, we also collected information about participants' depression and anxiety symptoms, quality of life and functioning using standardised self-report measures completed on three occasions over the 12 months of follow up. For Study 4, this enabled us to examine factors associated with improvement and deterioration in mental health and quality of life among those we classified as users of Better Access treatment services.

Study 4 complements the picture provided by Studies 2 and 3 by offering additional insights into patterns of mental health care among consumers of Better Access treatment services because of the breadth of mental health service use data collected in each trial. Study 4 further informs the question of whether some consumers improve or deteriorate more than others, because each trial gathered information on a wide range of consumers' sociodemographic and clinical factors. In saying this, however, it is important to note that the standardised measures were collected at set points in time in the original trials, and that these were not designed to correspond with the start and end of an episode of Better Access treatment.

Methods

Study design and data sources

Study 4 was an observational prospective study involving two independent cohorts: the Target-D control group (n=935) and the Link-me control group (n=1264). We focussed on the control group participants because they did not receive any special interventions as part of the original trials, so we assumed that their service use would better reflect 'real-world' patterns among primary care attendees.

Target-D and Link-me shared similar designs and methods, as detailed elsewhere.^{3,4} Briefly, participants were recruited in the waiting rooms of participating general practices. Individuals who screened positive for depressive symptoms (Target-D) or depressive or anxiety symptoms (Link-me) completed a brief clinical prediction tool that drew on information about various psychosocial factors (including gender, mental health history and current symptoms, general health, living situation and financial security) to predict their severity of depression (Target-D) or depression or anxiety (Link-me) in three months' time if

their management plan was unchanged: minimal/mild, moderate, or severe.^{3,4,82} Participants were then randomised into an intervention group (which received treatment recommendations tailored to their predicted level of severity) or a control group (which received usual care) and completed a set of baseline (T0) measures.

Despite the similarities, there were some differences between the trials potentially relevant to our new analyses. As already noted, the clinical prediction tools predicted severity of depression in Target-D, and depression or anxiety in Link-me. In Target-D, participants were followed up 3 months (T1) and 12 months (T2) after baseline; in Link-me, they were followed up 6 months (T1) and 12 months (T2) after baseline. Other differences between the two trials were considered minor (see Table 7.1).

	TARGET-D	LINK-ME
Primary aim	To investigate whether a person-centred e- health platform matching depression care to symptom severity prognosis (Target-D) can improve depressive symptoms relative to usual care	To examine if a patient-completed system Decision Support Tool that stratifies patients into prognostic groups and provides severity- matched treatment recommendations (Link- me) reduces psychological distress among individuals predicted to have minimal/mild or severe symptoms of anxiety or depression
used in Study 4 were collected	2016-2019	2017-2019
Setting	14 general practices in metropolitan Melbourne, Australia	23 general practices in three Australian states (New South Wales, Victoria, Queensland)
Eligibility criteria	18-65 years, English language proficiency, access to internet, screened positive for depressive symptoms, no change to antidepressant medication in past month (if applicable), not currently taking antipsychotic medication, no current psychological treatment (defined as: current use of online programs for mental health, or more than 7 visits to a psychologist or counsellor to talk about emotional wellbeing in the last 12 months and a future appointment the next 3 months)	18-75 years, English language proficiency, telephone and email contact, Medicare card holder, screened positive for depressive symptoms or anxiety symptoms or currently taking medication for mental health
Usual care plus attention control	The control group received a telephone call to reiterate the importance of trial involvement, address questions/concerns as required and administer brief structured interview about research participation. Able to access usual health services and commence additional treatments if needed.	The control group received a prompt on a tablet device to speak with their GP regarding any concerns about their mental health, and an emailed list of contacts for community-based resources and services. Able to access usual health services and commence additional treatments if needed.
Assessment timepoints	Baseline (T0), 3-month follow-up (T1) and 12- month follow-up (T2)	Baseline (T0), 6-month follow-up (T1) and 12- month follow-up (T2)

Table 7.1: Summary of key differences between the Target-D and Link-me trials

For Study 4, we focussed on two follow-up periods as per the original trials: (1) T0-T1: baseline to 3-month (Target-D) or 6-month (Link-me) follow-up; and (2) T0-T2: baseline to 12-month follow-up.

Measures

Classifying participants into treatment groups

In each trial, information about service use was collected using purpose-designed, self-report Resource Use Questionnaires (RUQs) developed by Cathy Mihalopoulos. In Target-D, the RUQ completed at 3 months (T1) asked about services used in the past 3 months (i.e., since baseline or T0) and the RUQ

completed at 12 months (T2) asked about services used in the past 6 months; together they provided a picture of service use for 9 of the 12 months since baseline. In Link-me, the 6-month (T1) and 12-month (T2) RUQs asked about services used in the past 6 months, together providing a picture of service use for the full 12 months since baseline.

The RUQs asked participants about the type, setting, number, and costs of services used for their mental health. The exact list of service types varied somewhat between Target-D and Link-me but included general practitioners, psychologists, psychiatrists, allied health professionals, other health professionals, emergency department visits, and overnight hospital admissions. The settings listed in the RUQs used in Target-D (hospital, GP clinic, community outreach, private practice) and Link-me (doctor's room or other private practice, general community health clinic, specialist community mental health clinic, community-based rehabilitation clinic, hospital outpatient clinic, at a drug or alcohol service, at your home) differed somewhat but allowed us to tag services delivered in private practice-like settings. The RUQs also asked participants to identify medications they were currently taking for mental health from a drop-down list that included antidepressants, anxiolytics, hypnotics and sedatives, antipsychotics, psychostimulants and nootropics, and antiepileptics (the latter were included because they are used as mood stabilisers to treat bipolar disorder).^{83,84}

We used this information to classify participants' service use into three mutually exclusive, hierarchically ordered treatment groups:

- "Better Access treatment services" we classified participants into this group if they reported one or more visits to a psychologist, social worker or occupational therapist in a GP clinic/doctor's room/private practice setting;
- (2) "Other mental health professional/service" we classified participants into this group if they reported one or more visits to another health professional or service for mental health (including: psychologists, social workers and occupation therapists in settings other than private practice; general practitioners; psychiatrists; nurses; other health professionals; emergency department visits; overnight hospital admissions) or reported taking a mental health-related medication; and
- (3) "No mental health professional/service" we classified participants into this group if they did not report using any of the services defined in groups (1) or (2) (see Figure 7.1).

Figure 7.1: Method for classifying participants into one of three hierarchically ordered treatment groups



The treatment group classification was repeated for the T0-T1 and T0-T2 periods because a participant may have used a different mix of services in each period.

The "Better Access treatment services group" included people who received services delivered by eligible allied health providers in private practice-like settings. We did not have information about how those sessions were paid for, so cannot be certain that all of these sessions were funded through Better Access. We were also not able to gauge whether participants may have used Better Access treatment services provided by GPs and other medical practitioners; any such participants would therefore have been classified into group (2). However, focussed psychological strategies delivered by GPs and other medical practitioners make up only 1% of all Better Access treatment services (see Study 1 and elsewhere⁸⁴) so we are confident this would have negligible, if any, impact on the findings

The Link-me RUQ also captured information about use of some other types of programs and strategies (e.g., online therapy, apps, self-help). These were not included in the classification because our focus was on services where we could be confident that contact with a health professional was involved, as this is how Better Access treatment services are delivered.

Describing service utilisation patterns for the "Better Access treatment services" group

For the "Better Access treatment services" group, we used information from the RUQs to derive the following estimates of service use for the T0-T1 and T0-T2 periods:

- number of Better Access treatment services used;
- out-of-pocket costs paid (per session and in total) for Better Access treatment services;
- number of visits with other providers (grouped as primary care providers, mental health specialists/services and other professionals/services) for mental health;
- use of any mental health-related medications; and
- total number of visits combined across Better Access treatment services other mental health services.

In Link-me, the RUQs asked participants to estimate the number of visits with professionals/services and out-of-pocket costs in single units. In Target-D, participants were selected from pre-grouped categories, so we used the category mid-points in our calculations supplemented by published data to estimate upper values for out-of-pocket costs.^{55,56} Out-of-pocket costs were converted to 2021-22 values using the Australian Bureau of Statistics Consumer Price Index for medical and hospital services.⁵⁴

Measures of symptom severity, quality of life and functioning

Participants completed standardised self-report measures of depression and anxiety symptom severity, health-related quality of life, and functioning (Link-me only) at baseline (T0), T1 and T2 (Table 7.2).

DOMAIN	MEASURE	TARGET-D	LINK-ME
Depression symptom severity	Patient Health Questionnaire (PHQ-9) ⁸⁵	✓	<i>√</i>
Anxiety symptom severity	Generalized Anxiety Disorder scale (GAD-7) ⁸⁶	~	~
Health-related quality of life	Assessment of Quality of Life instrument (AQoL- 8D) ²⁶	\checkmark	
	EuroQol 5-dimension quality of life questionnaire (EQ-5D-5L) ³²		~
Functioning ^a	Kessler-10+ (K-10+) ^{35,36}		\checkmark

Table 7.2: Standardised measures used in the Target-D and Link-me trials

a. Days out-of-role due to psychological distress was assessed using the four-item extension of the Kessler Psychological Distress Scale or K10+^{35,36} (Link-me only). Two items ask consumers about the number of days in the past 28 days they were unable to perform, or had to cut down on, their day-to-day activities because of psychological distress. Total days out of role was calculated as the sum of full days out of role plus partial days out of role weighted by 0.5 (range 0-28). The days out of role questions were only asked if the participant reported any psychological distress on the first 10 K10 items, so total days out of role for participants who reported no psychological distress was set to 0 days.

Other measures collected at baseline

Sociodemographic characteristics included age group (18-35, 36-55 and 56+ years) at baseline, gender, First Nations status (Link-me only), main language spoken at home (Link-me only), highest level of education, employment status, whether living alone, manage on available income, health care card holder, and receiving benefit or disability support (Target-D only). *Clinical characteristics* included: selfrated health, history of depressed mood, long-term illness or health problems which limit daily activities or work, and reason for visiting the GP (Link-me only). *Previous treatment* indicators included: saw a doctor or other health professional for mental health in the last month (Target-D) or saw a doctor or other health professional about psychological distress in the last 4 weeks (K10+ item, Link-me), and currently taking an antidepressant (Target-D) or medication (Link-me) for mental health.

Data analyses

We analysed the data for each cohort separately, using a common method. Within each cohort, we conducted analyses for the two time periods of interest, T0-T1 and T0-T2. Analyses were conducted using Stata version 17 (StataCorp, College Station, TX, USA). We used a p<0.05 level to indicate statistical significance.

Participants were included in the analyses if there was sufficient information on the RUQs to classify them into one of the three treatment groups. This meant that for the T0-T1 period, the RUQ must have been completed at T1; for the T0-T2 period, the RUQ must have been completed at both T1 and T2. Participants who could not be classified into a treatment group were compared to those who could, to determine if there were any potential important biases due to loss-to-follow-up. These comparisons were undertaken using t-tests for continuous measures and Pearson's chi-square tests of independence or Fisher's exact test (if a cell size was \leq 5%) for categorical measures.

We compared the characteristics of participants classified as users "Better Access treatment services" with users of "Other mental health professional/services" or "No mental health professional/services" using analysis of variance (ANOVA) for continuous measures and Pearson's chi-squared tests or Fisher's exact test for categorical measures.

As per Studies 2, 3 and 5, we used an effect size methodology to classify change over time on the standardised measures of depression symptoms, anxiety symptoms and quality of life. An effect size of 0.3 of a standard deviation (small-to-medium, as per Cohen's⁴³ classification) of the baseline score of all control group participants was used to calculate an absolute threshold for change score on each measure, and then used to classify change as "significant improvement", "no significant change" or "significant deterioration" (see Section 2 and Appendix 11 for more detail). For total days out of role, we took a different approach because it is a count variable (rather than a score) and we could not find any published precedents for classifying significant change in days out of role.

Australian adults with depression and anxiety disorders have been shown to experience more days out of role than people with no mental disorder (6 days, 4 days and 1.4 days, respectively).⁸⁷ We applied an absolute threshold for change based on the average number of days out of role for Australians without a mental disorder to classify change as "significant improvement", "no significant change" or "significant deterioration" (see Appendix 11 for more detail). For all estimates of change, we present 95% confidence intervals.

Logistic regression analyses were used to explore associations between baseline consumer characteristics and either: (a) significant improvement (versus no significant change or significant deterioration) on each measure or; (b) or significant deterioration (versus no significant change or significant improvement) on each measure. Baseline consumer characteristics were considered one at a time in bivariate models.

Additional regression models considered whether the number of Better Access treatment services used was associated with significant improvement or significant deterioration on each measure. Because the amount of treatment needed to achieve positive change may be different for people with different levels of clinical severity,^{88,89} we controlled for prognostic group and also tested for interaction effects between number of sessions and prognostic group. To maximise the robustness of the models, the minimal/mild and moderate prognostic groups were combined and compared to the severe group; number of Better Access treatment sessions was dichotomised (1-4 vs. 5+ sessions).

Approvals

The University of Melbourne Human Research Ethics Committee approved the original studies (Target-D: 1749832, Link-me: 1543648) and the re-analyses undertaken in the current study (Target-D: 2021-11714-21906-5, Link-me: 2021-11155-21707-4). All participants provided informed consent in the original trials.

Acknowledgements

Target-D and Link-me were funded by the National Health and Medical Research Council and the Department of Health, and were conducted by the University of Melbourne. We would like to acknowledge the participants who took part in these two studies.

Results

Participants included in the analyses

As noted earlier, participants were included in the current analyses if there was sufficient information to classify them into one of the three treatment groups. For Target-D, we included 577 participants in the T0-T1 analyses and 394 in the T0-T2 analyses. For Link-me, we included 718 participants in the T0-T1 analyses and 547 in the T0-T2 analyses (Figure 7.2).

Figure 7.2: Summary of participants included in the re-analysis of control group data from Target-D and Link-me



Participants who were included in the current analyses did not differ significantly from those who were not included on any of the baseline measures of depressive or anxiety symptoms, quality of life or functioning, or their prognostic group. There were modest differences on some baseline sociodemographic characteristics (people aged ≥36 and with a Bachelor's degree or higher [Link-me only] were more likely to be included) and recent treatment indicators (individuals who had recently received treatment for their mental health were more likely to be included) (see Appendix 12 for details).

Characteristics of participants in the "Better Access treatment services" group

As shown in Figure 7.2, approximately one fifth of participants were classified into the "Better Access treatment services" group (Target-D 19.8% and Link-me 22.8%), just under half into the "Other mental health professional/service" group, and approximately one third into the "No mental health professional/service" group. During T0-T2, the proportion classified into the "Better Access treatment" group increased to one third (Target-D 33.5%, Link-me 33.3%).

We examined differences in the baseline characteristics of participants in each of the three treatment groups (see Appendix 13 for details). For ease of comparison, findings discussed are for the T0-T2 period only. Notably, we found a gradient whereby the "Better Access treatment services" group consistently reported the poorest levels of mental health at baseline followed by the "Other mental health professional/service" group, followed by the "No mental health professional/service" group. For example:

Mean baseline scores on mental health measures including depression and anxiety symptoms, total days out of role, and history of depression followed this gradient. For example, mean depression symptom severity scores on the PHQ-9 were higher (indicating worse symptoms) in the "Better Access treatment services" group than the "Other mental health professional/service" group and, in turn, the "No mental health professional/service" group (10.8 vs. 8.7 and 6.7 in Target-D and 12.5 vs. 10.1 and 7.6 in Link-me);

- The "Better Access treatment services" group included relatively *fewer* people with a minimal/mild prognosis (63% vs. 74% and 94% in Target-D; 16% vs. 24% and 60% in Link-me) and, conversely, relatively *more* in the moderate or severe prognostic groups; and
- The "Better Access treatment services" group were the most likely to have consulted a doctor or other health professional for their mental health in the month prior to baseline, followed by the "Other mental health professional/service" group, followed by the "No mental health professional/service" (77% vs. 39% and 24% in Target-D and 66% vs. 40% and 15% in Link-me).

Other baseline measures of general health and functioning (e.g., quality of life, self-rated health, longterm illness/health problems affecting daily work) tended to be more similar between the "Better Access treatment services" and "Other mental health professional/service" groups and poorer than for the "No mental health professional/service" group. For example, the percentages rating their health as fair or poor were 23% and 24% vs. 18% in the Target-D cohort; 38% and 31% vs. 17% in the Link-me cohort). Use of antidepressants or medications for mental health was also more similar among the "Better Access treatment services" and "Other mental health professional/service" groups, and greater than in the "No mental health professional/service" group (e.g., 59% and 70% vs. 11%, respectively, in the Link-me cohort).

Findings on baseline sociodemographic factors varied across the cohorts and this might reflect differences between the studies such as the different locations from which participants were recruited for each trial and the inclusion of people with anxiety symptoms only in Link-me (see Table 7.1). Key findings were:

- In the Link-me cohort, relatively more people in the "Better Access treatment services" group reported difficulty managing on their income than those in the "Other mental health professional/service" or the "No mental health professional/service" group (20% vs. 14% and 9%).
- Some other factors distinguished the "Better Access treatment services" and "Other mental health professional/service" from the "No mental health professional/service" group. For example, in the Link-me cohort, relatively fewer people in the "Better Access treatment services" and "Other mental health professional/service" groups were employed. In the Target-D cohort, relatively more people in these groups were health care card holders. In the Link-me cohort, there were indications that users of Better Access treatment services or other forms of mental health care included relatively fewer people who mainly speak a language other than English at home, compared to those who did not use these services. However, this finding should be interpreted with caution because of small cell sizes and because participants in the trials needed to have sufficient English language proficiency to complete the surveys.
- In the Link-me cohort, the percentage of adults aged 56 years and older in "Better Access treatment services" group was lower than for the "Other mental health professional/service" group, but similar to the "No mental health professional/service" group (24%, 35% and 27% respectively).
- Ad hoc analyses were conducted to examine the types of services used by people who were not classified as "Better access psychological treatment" users (see Appendix 14, Table A14.2a and A11.2b). This showed that the types of services used by those aged 56 years and over in the "Other mental health professional/service" group were: primary care (63-80%, depending on cohort), mental health specialist or service or another professional or service (27-30%), and mental health-related medication (50-90%). In addition, in the Link-me cohort, we found that those aged 56 years and over were less likely than younger adults to see a mental health

specialist or service or another professional or service, and more likely to be taking mental health-related medication.

Service use patterns of participants in the "Better Access treatment services" group

For those in the "Better Access treatment services" group, we examined their patterns of Better Access treatment service utilisation (Tables 7.3a and 7.3b). Again, for ease of comparison, patterns discussed are for the T0-T2 period only. In the Link-me cohort, which had service use information for the entire follow-up period, the mean number of Better Access treatment sessions used was 6.9 during T0-T2. The number of sessions reported by participants in Target-D was lower (median 5.0) than in Link-me, reflecting the shorter period of service use information available. In both cohorts, the number of sessions used tended to increase with prognostic severity, with those in the severe prognostic group using 1.5-2.1 times more sessions on average than those in the minimal/mild prognostic group.

During T0-T2 in the Target-D cohort, nearly two thirds of the "Better Access treatment services" users had paid out-of-pocket costs for their Better Access treatment services, with a median cost per session of \$78. In Link-me, just under half reported that they had paid out-of-pocket costs, with a median cost per session of \$89. The percentage of participants who reported paying out-of-pocket costs was higher in the minimal/mild and moderate prognostic groups in Target-D (68% and 68%, compared to 61% in the severe group), and in the moderate prognostic group in Link-me (60%, compared to 31% in the minimal/mild group and 46% in the severe group). The estimated per session and total out-of-pocket costs for Better Access treatment services were highest for the moderate and severe prognostic groups in Target-D and for the severe prognostic group in Link-me.

As noted earlier, participants classified into the "Better Access treatment services" group might also have used services for mental health from other professionals or services. We found that, in both cohorts, the vast majority (90-92%) of those in the "Better Access treatment services" group had had contact with primary care providers for mental health during the T0-T2 period. This is not surprising given the important role GPs play in delivering mental health care in Australia and is consistent with the operating rules of the Better Access program. Fewer had used other mental health specialists or services or other non-mental health specialists or services; however, this varied considerably by prognostic severity. For example, the probability of using another mental health specialist or service was around 2.0 times higher for the severe prognostic group than the minimal/mild prognostic group, and the median number of other services used for mental health was 1.4-3.6 higher on average. More than half of participants in each cohort reported using medications for mental health (Target-D 55%, Link-me 71%). In both cohorts, the percentage reporting use of medications increased with prognostic severity, from less than half of the minimal/mild prognostic severity.

When we considered all mental health services used (including Better Access treatment services and other professionals/services for mental health) over the T0-T2 period, we found that the median number of services used overall was 10 in the Target D cohort and 12 in the Link-me cohort, increasing with prognostic severity (from 8.5 in the minimal/mild group to 12.0 in the severe group in Target-D and from 7.0 in the minimal/mild group to 16.0 in the severe group in Link-me).

	T0-T1: BASELINE TO 3-MONTH FOLLOW-UP			T0-T2: BASELINE TO 12-MONTH FOLLOW-UP				
	Minimal/ mild	Moderate	Severe	Total	Minimal/ mild	Moderate	Severe	Total
Services used for mental health	n=65	n=25	n=24	n=114	n=83	n=24	n=25	n=132
Better Access treatment services: ^a								
Delivered by a psychologist	65 (100%)	25 (100%)	24 (100%)	114 (100%)	83 (100%)	24 (100%)	25 (100%)	132 (100%)
Number of sessions (grouped):								
1-2	40 (62%)	9 (36%)	12 (50%)	61 (54%)	27 (33%)	6 (25%)	3 (12%)	36 (27%)
3-4	19 (29%)	6 (24%)	6 (25%)	31 (27%)	25 (30%)	5 (21%)	7 (28%)	37 (28%)
5-6	6 (0%)	10 (40%)	6 (25%)	15 (13%)	15 (18%)	7 (29%)	5 (20%)	27 (20%)
7+	0 (970)	10 (40%)	0 (2378)	7 (6%)	16 (19%)	6 (25%)	10 (40%)	32 (24%)
Number of sessions, mean (SD)	2.6 (1.7)	4.0 (2.5)	3.3 (2.3)	3.0 (2.1)	4.4 (3.4)	5.7 (4.3)	6.5 (4.3)	5.0 (3.8)
Any out of pockets costs ^b	48 (74%)	15 (63%)	10 (43%)	73 (65%)	54 (68%)	15 (68%)	14 (61%)	83 (67%)
Out-of-pocket cost per session, median (IQR) ^c	\$73 (56-89)	\$84 (61-166)	\$89 (39-95)	\$84 (61-95)	\$73 (61-95)	\$84 (63-131)	\$84 (56-95)	\$78 (61-95)
Total out-of-pocket costs, median (IQR) $^{\circ}$	\$139 (99-251)	\$292 (142-583)	\$150 (92-250)	\$151 (108-292)	\$326 (183-549)	\$458 (142-917)	\$408 (192-649)	\$331 (183-649)
Other health professionals/services:								
Type (categories not mutually exclusive):								
Primary care ^d	50 (77%)	25 (100%)	21 (88%)	96 (84%)	76 (92%)	23 (96%)	23 (92%)	122 (92%)
Mental health specialist or service ^c	n.a.	n.a.	7 (29%)	16 (14%)	13 (16%)	7 (29%)	9 (36%)	29 (22%)
Other professional or service ^f	n.a.	n.a.	4 (17%)	12 (11%)	22 (27%)	5 (21%)	5 (20%)	32 (24%)
Any visits/contacts	53 (82%)	25 (100%)	23 (96%)	101 (86%)	80 (96%)	24 (100%)	25 (100%)	129 (98%)
Number of visits/contacts, median (IQR) ^g	1.5 (1.5-3.5)	3.0 (1.5-3.5)	3.5 (1.5-5.0)	1.5 (1.5-3.5)	5.0 (3.0-8.5)	5.0 (4.5-8.8)	7.0 (3.0-9.5)	5.0 (3.0-8.5)
Any medication taken for mental health h	23 (35%)	16 (64%)	16 (67%)	55 (48%)	38 (46%)	15 (63%)	19 (76%)	72 (55%)
All mental health care								
Total visits/contacts, median (IQR)	3.5 (3.0-5.0)	7.0 (5.0-7.5)	6.3 (3.0-8.8)	5.0 (3.0-7.0)	8.5 (6.5-13.5)	10.0 (8.5-16.0)	12.0 (8.0-19.0)	10.0 (8.0-14.8)

Table 7.3a: Mental health-related service use among participants in the "Better Access treatment services" group, by follow-up period, for the Target-D cohort

Some categories were merged due to small cell sizes. Data are n (%) unless otherwise stated. Percentages are within prognostic group. IQR, interquartile range. n.a., not available due to small numbers in some cells. SD, standard deviation.

^a Visits to a psychologist or social worker in a GP clinic or private practice setting were assessed in Target-D, however no participants reported seeing a social worker in these settings.

^b In T0-T1, 2 people had missing data for out-of-pocket costs. In T0-T2, 8 people had missing data for out-of-pocket costs.

^c Denominator is people who paid any out-of-pocket costs. Out-of-pockets costs are in 2020/21 dollars.

^d Visits to a GP in a GP clinic or private practice.

^e Visits to a psychiatrist (any location), psychologist (any location other than GP clinic or private practice), alcohol or drug worker (any location); mental health-related overnight stay in hospital.

^f Visits to a GP (any location other than GP clinic or private practice), counsellor (any location), social worker (any location other than GP clinic or private practice), family therapist (any location), mental health-related emergency department visit.

^g Denominator is people who had any visits/contacts with other health professionals/services.

^h Includes the following categories: antidepressants, anxiolytics, hypnotics and sedatives, antipsychotics, psychostimulants and nootropics; and antiepileptics.

	T0-T1: BASELINE TO 6-MONTH FOLLOW-UP			T0-T2: BASELINE TO 12-MONTH FOLLOW-UP				
	Minimal/ mild	Moderate	Severe	Total	Minimal/ mild	Moderate	Severe	Total
Services used for mental health	n=26	n=53	n=85	n=164	n=29	n=60	n=93	n=182
Better Access treatment services: ^a								
Delivered by a psychologist	26 (100%)	53 (100%)	84 (99%)	163 (99%)	29 (100%)	60 (100%)	92 (99%)	181 (99%)
Delivered by a social worker or OT	n.a.	n.a.	n.a.	3 (2%)	n.a.	n.a.	n.a.	6 (3%)
Number of sessions (grouped):								
1-2	14 (54%)	14 (26%)	23 (27%)	51 (31%)	13 (45%)	14 (23%)	25 (27%)	52 (29%)
3-4	3 (12%)	21 (40%)	14 (16%)	38 (23%)	8 (28%)	17 (28%)	11 (12%)	36 (20%)
5-6	Q (25%)	18 (24%)	29 (34%)	51 (31%)	8 (28%)	20 (48%)	15 (16%)	29 (16%)
7+	9 (3370)	10 (2470)	19 (22%)	24 (15%)	8 (2870)	29 (40/0)	42 (45%)	65 (36%)
Number of sessions, mean (SD)	3.4 (2.2)	4.1 (3.0)	5.5 (4.5)	4.7 (3.8)	4.2 (3.6)	5.6 (5.1)	8.7 (14.3)	6.9 (10.8)
Any out of pockets costs	7 (27%)	32 (60%)	36 (42%)	75 (46%)	9 (31%)	36 (60%)	43 (46%)	88 (48%)
Out-of-pocket cost per session, median (IQR) ^b	\$84 (78-179)	\$101 (45-156)	\$105 (70-216)	\$101 (56-179)	\$78 (34-140)	\$84 (45-145)	\$99 (58-190)	\$89 (50-153)
Total out-of-pocket costs, median (IQR) ^b	\$223 (156-1073)	\$335 (168-654)	\$553 (191-1341)	\$436 (168-1073)	\$279 (156-838)	\$335 (179-575)	\$682 (168-2011)	\$419 (173-1067)
Other health professionals/services:								
Type (categories not mutually exclusive):								
Primary care ^c	20 (77%)	41 (77%)	72 (85%)	133 (81%)	26 (90%)	53 (88%)	85 (91%)	164 (90%)
Mental health specialist or service ^d	n.a.	n.a.	43 (51%)	62 (38%)	9 (31%)	28 (48%)	57 (61%)	94 (52%)
Other professional or service ^e	n.a.	n.a.	23 (27%)	40 (24%)	7 (24%)	20 (33%)	44 (47%)	71 (39%)
Any visits/contacts	22 (85%)	46 (88%)	83 (98%)	151 (92%)	28 (97%)	58 (97%)	92 (99%)	178 (98%)
Number of visits/contacts, median (IQR) ^f	2.0 (1.0-5.0)	3.0 (1.0-8.0)	5.0 (2.0-12.0)	4.0 (2.0-9.0)	3.0 (2.0-7.5)	5.0 (2.0-12.0)	11.0 (5.0-21.0)	8.0 (3.0-16.0)
Any medication taken for mental health ^f	11 (42%)	34 (64%)	65 (76%)	110 (67%)	13 (45%)	43 (72%)	73 (78%)	129 (71%)
All mental health care								
Total visits/contacts, median (IQR)	5.0 (3.0-10.0)	7.0 (4.0-12.0)	10.0 (7.0-18.0)	8.0 (5.0-13.0)	7.0 (5.0-12.0)	10.0 (5.0-21.0)	16.0 (11.0-32.0)	12.0 (7.0-23.0)

Table 7.3b: Mental health-related service use among participants in the "Better Access treatment services" group, by follow-up period, for the Link-me cohort

Some categories were merged due to small cell sizes. Data are n (%) unless otherwise stated. Percentages are within prognostic group. IQR, interquartile range. n.a., not available due to small numbers in some cells. OT, occupational therapist. SD, standard deviation.

^a Visits to a psychologist, social worker or occupational therapist in doctor's room or other private practice location were assessed in Link-me.

^b Denominator is people who paid any out-of-pocket costs. Out-of-pockets costs are in 2020/21 dollars.

^c Visits to a GP or nurse/mental health nurse in doctor's room or private practice location.

^d Visits to a psychiatrist (any location), mental health nurse or psychologist (any location other than doctor's room or private practice), other allied health provider or nurse (in a specialist community mental health clinic, community-based rehabilitation clinic, or drug/alcohol service); mental health-related overnight stay in hospital or residential care unit.

^e Visits to a GP or nurse (any location other than doctor's room or private practice), counsellor or other health professional (any location), other allied health provider (any location other than

a specialist community mental health clinic, community-based rehabilitation clinic, or drug/alcohol service), mental health-related emergency department visit.

^f Denominator is people who had any visits/contacts with other health professionals/services.

^g Includes the following categories: antidepressants, anxiolytics, hypnotics and sedatives, antipsychotics, psychostimulants and nootropics; and antiepileptics.

Factors associated with significant improvement or deterioration in depression symptoms, anxiety symptoms, functioning and quality of life

Baseline (T0) scores on the measures of depression and anxiety symptoms, quality of life and functioning for participants in the "Better Access treatment services" group are presented in Appendix 14. These show that, at baseline, people in the "Better Access treatment services" group had a range of levels of problems with their mental health and quality of life, but many had relatively high levels of problems as judged against available reference points (see Table 7.2).

Using the methodologies to classify change, we estimated that over the T0-T2 period, nearly half of participants in the "Better Access treatment services" group experienced "significant improvement" in depression symptom severity (Target-D 46%, Link-me 47%), anxiety symptom severity (Target-D 55%, Link-me 48%), quality of life (Target-D 44%, Link-me 43%) and total days out of role (Link-me 47%). When considered together, more than two thirds experienced "significant improvement" on one or more of the measures of depression symptoms, anxiety symptoms or quality of life (Target-D 68%, Link-me, 70%). In Link-me, when total days out of role was also included, the percentage increased to 80%.

Approximately one quarter experienced "significant deterioration" in depression symptom severity (Target-D 29%, Link-me 27%), anxiety symptom severity (Target-D 22%, Link-me 24%) and total days out of role (Link-me only, 28%) just under one third experienced "significant deterioration" in quality of life (Target-D 32%, Link-me 30%).

When stratified by prognostic group, the percentages classified as "significantly improved" tended to be higher for both the moderate and severe prognostic groups than the overall sample in the Target-D cohort, and higher for the severe prognostic group than the overall sample in the Link-me cohort.

Baseline consumer characteristics associated with significant improvement or deterioration

Tables 7.4a-7.4d show the results of the logistic regression analyses that we conducted to identify baseline consumer characteristics associated with "significant improvement" or "significant deterioration" in depression and anxiety symptoms, quality of life and functioning. Findings varied somewhat across the measures, cohorts and timeframes, but the most consistent findings were that:

- Those with more severe baseline scores on a given measure were more likely to show "significant improvement" on that same measure. Those in the moderate (Target-D) or severe (Link-me) prognostic groups also tended to have higher odds of "significant improvement". In the Link-me cohort, those who had recently consulted for mental health and those with a history of depression had higher odds of "significant improvement" on almost all measures. Those aged 36-55 years (Target-D) or 56 years and over (Link-me) had lower odds of "significant improvement" in anxiety symptom severity, compared to those aged 18-35 years. In the Link-me cohort, female gender and having completed a certificate/diploma qualification (compared to a high school education) were associated with lower odds of "significant improvement" in functioning (i.e., fewer days out of role) (Tables 7.4a-7.4b).
- Overall, fewer factors were identified as predictors of "significant deterioration". Where present, they tended to show opposite effects compared to the analyses of "significant improvement", For example, those with more severe baseline scores on a given measure tended to have *lower* odds of "significant deterioration" on that measure. Being aged 56 years and over was associated with higher odds of "significant deterioration" in anxiety symptom severity. In the Link-me cohort, female gender and having completed a certificate/diploma were associated with higher odds of "significant deterioration" in functioning (i.e., increased number of days out of role) (Tables 7.4c-7.4d).

Table 7.4a: Baseline consumer characteristics associated with significant improvement in depression and anxiety symptoms and quality of life for the Target-D cohort

	Significant improvement in depression symptom severity (PHQ-9)	Significant improvement in anxiety symptom severity (GAD-7)	Significant improvement in quality of life (AQoL-8D)			
	T0-T1: BASELINE TO 6-MONTH FOLLOW-UP					
Baseline score on focal measure ^{1,2}	1.12 (1.04, 1.20)**	1.19 (1.09, 1.29)***	0.09 (0.01, 0.81)*			
Prognostic group: Moderate (ref. Minimal/mild)	2.93 (1.12, 7.69)*	-	3.19 (1.18, 8.61)*			
Age group: 36-55 years (ref. 18-35 years)	-	0.40 (0.16, 0.96)*	-			
Highest level of education: Bachelor's degree or higher (ref. Year 12/equivalent or less)			0.17 (0.06, 0.45)***			
	T0-T2: BASELINE TO 12-MONTH FOLLOW-UP					
Baseline score on focal measure ^{1,2}	-	1.18 (1.08, 1.28)***	-			
Self-rated health: Fair/Poor (ref. Excellent/very good/good)	-	0.35 (0.14, 0.84)*	-			

Data are odds ratios (ORs) and 95% confidence intervals from logistic regression models. *p<0.05; **p<0.01; ***p<0.001. '-', not statistically significant at the p<0.05 level. Only predictors statistically significant at the p<0.05 level are shown.

¹ We examined the baseline score on the focal measure. For example, whether baseline depression symptom severity score was a predictor of significant improvement in depression symptom severity.

² For the PHQ-9 and GAD-7, higher scores indicate poorer mental health so an odds ratio >1 indicates that greater symptom severity at baseline is associated with higher odds of significant improvement. For the AQoL-8D, lower scores indicate poorer quality of life so an odds ratio <1 indicates that poorer quality of life at baseline is associated with higher odds of significant improvement.

Table 7.4b: Baseline consumer characteristics associated with significant improvement in depression and anxiety symptoms, quality of life and functioning for the Link-me cohort

	Significant improvement in depression symptom severity (PHQ-9)	Significant improvement in anxiety symptom severity (GAD-7)	Significant improvement in quality of life (EQ-5D-5L)	Significant improvement in total days out of role (K10+)	
	T0-T1: BASELINE TO 6-MONTH FOLLOW-UP				
Baseline score on focal measure 1,2	1.10 (1.10, 1.16)***	1.24 (1.15, 1.33)***	0.10 (0.03, 0.33)***	1.12 (1.08, 1.17)***	
Prognostic group: Severe (ref. Minimal/mild)	3.88 (1.47, 10.21)**	7.32 (2.51, 21.34)***	3.10 (1.13, 8.50)*	3.91 (1.35, 11.34)*	
Age group: 56 years and over (ref. 18-35 years)	-	0.29 (0.12, 0.68)**	-	-	
Gender: Female (ref. Male)	-	-	-	0.40 (0.20, 0.81)	
History of depression: Yes (ref. No)	-	-	2.97 (1.20, 7.35)*	3.13 (1.27, 7.73)*	
Reason for visit to GP: Mental health (ref. Not mental health)	2.24 (1.17, 4.27)*	2.38 (1.23, 4.57)**	2.16 (1.10, 4.25)*	2.64 (1.32, 5.28)**	
Saw a doctor/health professional for mental health in last month: Yes (ref. No)	1.94 (1.00, 3.75)*	2.99 (1.51 <i>,</i> 5.95)**	2.77 (1.35, 5.67)**	3.81 (1.81, 8.00)***	
	T0-T2: BASELINE TO 12-MONTH FOLLOW-UP				
Baseline score on focal measure 1,2	1.11 (1.05, 1.16)***	1.16 (1.09, 1.24)***	0.07 (0.02, 0.25)***	1.12 (1.08, 1.17)***	
Prognostic group: Severe (ref. Minimal/mild)	3.08 (1.27, 7.48)*	-	2.65 (1.09, 6.42)*	2.70 (1.11, 6.55)*	
Age group: 56 years and over (ref. 18-35 years)	-	0.39 (0.18, 0.85)*	-	-	
Gender: Female (ref. Male)	-	-	-	0.47 (0.23, 0.94)*	
Highest level of education: Certificate/diploma (ref. Year 12/equivalent or less)	-	-	-	0.46 (0.22, 0.98)*	
History of depression: Yes (ref. No)	-	-	-	3.35 (1.47, 7.63)**	
Health care card: Yes (ref. No)		0.51 (0.28, 0.93)*	-	-	
Reason for visit to GP: Mental health (ref. Not mental health)	2.62 (1.42 - 4.81)**	-	-	2.28 (1.25, 4.21)**	
Saw a doctor/health professional for mental health in last month: Yes (ref. No)	1.94 (1.03, 3.65)*	1.88 (1.00, 3.51)*	-	2.08 (1.11, 3.92)*	

Data are odds ratios (ORs) and 95% confidence intervals from logistic regression models. *p<0.05; **p<0.01; ***p<0.001. '-', not statistically significant at the p<0.05 level. 'ref.', Reference category. Only predictors statistically significant at the p<0.05 level are shown. First Nations status and main language spoken at home could not be examined due to small cell sizes. ¹ We examined the baseline score on the focal measure. For example, whether baseline depression symptom severity score was a predictor of significant improvement in depression symptom severity.

² For the PHQ-9, GAD-7 and Total days out of role, higher scores indicate poorer mental health so an odds ratio above 1 indicates that poorer mental health at baseline is associated with higher odds of improvement. For the EQ-5D-5L, lower scores indicate poorer quality of life so an odds ratio below 1 indicates that poorer quality of life at baseline is associated with higher odds of improvement.

Table 7.4c: Baseline consumer characteristics associated with significant deterioration in depression and anxiety symptoms and quality of life for the Target-D cohort

	Significant deterioration in depression symptom severity (PHQ-9)	Significant deterioration in anxiety symptom severity (GAD-7)	Significant deterioration in quality of life (AQoL-8D)	
	T0-T1: BASELINE TO 3-MONTH FOLLOW-UP			
Baseline score on focal measure ^{1,2}	-	0.90 (0.83 - 0.98)*	62.26 (4.33 - 894.69)**	
Gender: Female (ref. Male)	-	0.41 (0.18 - 0.96)*	-	
	T0-T2: BASELINE TO 12-MONTH FOLLOW-UP			
Baseline score on focal measure ^{1,2}	-	0.86 (0.77 - 0.96)**	10.07 (1.18 - 85.91)*	

Data are odds ratios (ORs) and 95% confidence intervals from logistic regression models. *p<0.05; **p<0.01; ***p<0.001. '-', not statistically significant at the p<0.05 level. Only predictors statistically significant at the p<0.05 level are shown.

¹ We examined the baseline score on the focal measure. For example, whether baseline depression symptom severity score was a predictor of significant deterioration in depression symptom severity.

² For the PHQ-9 and GAD-7, higher scores indicate poorer mental health so an odds ratio <1 indicates that greater symptom severity at baseline is associated with lower odds of significant deterioration. For the AQoL-8D, lower scores indicate poorer quality of life so an odds ratio >1 indicates that better quality of life at baseline is associated with higher odds of significant deterioration.

Table 7.4d: Baseline consumer characteristics associated with significant deterioration in depression and anxiety symptoms, quality of life and functioning for the Link-me cohort

	Significant deterioration in depression symptom severity (PHQ-9)	Significant deterioration in anxiety symptom severity (GAD-7)	Significant deterioration in quality of life (EQ-5D-5L)	Significant improvement in total days out of role (K10+)	
	T0-T1: BASELINE TO 6-MONTH FOLLOW-UP				
Baseline score on focal measure 1,2	0.92 (0.87 - 0.97)**	0.83 (0.76 - 0.89)***	20.98 (4.44 - 99.06)***	0.92 (0.87, 0.97)**	
Prognostic group: Severe (ref. Minimal/mild)	0.31 (0.12 - 0.79)*	0.20 (0.08 - 0.51)***	0.32 (0.13 - 0.80)*	0.37 (0.14, 0.93)*	
Age group: 56 years and over (ref. 18-35 years)	-	2.45 (1.03 - 5.86)*	-	-	
History of depression: Yes (ref. No)	-	-	0.25 (0.11 - 0.56)***	-	
Reason for visit to GP: Mental health (ref. Not mental health)	0.49 (0.25 - 0.97)*	-	-	-	
	T0-T2: BASELINE TO 12-MONTH FOLLOW-UP				
Baseline score on focal measure ^{1,2}	0.91 (0.86 - 0.96)***	0.85 (0.79 - 0.92)***	7.32 (1.81 - 29.59)**	0.90 (0.86, 0.95)***	
Highest level of education: Certificate/diploma (ref. Year 12/equivalent or less)	-	-	-	2.63 (1.08, 6.40)*	
Reason for visit to GP: Mental health (ref. Not mental health)	-	0.49 (0.24 - 0.98)*	0.52 (0.28 - 1.00)*	-	
Saw a doctor/health professional for mental health in last month: Yes (ref. No)	-	0.31 (0.15 - 0.63)***	-	-	

Data are odds ratios (ORs) and 95% confidence intervals from logistic regression models. *p<0.05; **p<0.01; ***p<0.001. '-', not statistically significant at the p<0.05 level. Only predictors statistically significant at the p<0.05 level are shown. First Nations status and main language spoken at home could not be examined due to small cell sizes.

¹ We examined the baseline score on the focal measure. For example, whether baseline depression symptom severity score was a predictor of significant deterioration in depression symptom severity.

² For the PHQ-9, GAD-7 and Total days out of role, higher scores indicate poorer mental health so an odds ratio <1 indicates that poorer mental health at baseline is associated with lower odds of significant deterioration. For the EQ-5D-5L, lower scores indicate poorer quality of life so an odds ratio >1 indicates that poorer quality of life at baseline is associated with higher odds of significant deterioration.

Treatment-based factors associated with significant improvement or deterioration

We found some evidence that, after controlling for severity, the number of Better Access treatment sessions used was associated with "significant improvement" on some measures:

- For the T0-T1 period, in the Target-D cohort, we found that people who used 5 or more sessions had nearly three times greater odds of "significant improvement" in depression symptom severity (OR=2.85, 95% CI 1.08, 7.56, p=0.035) and in health-related quality of life (OR=2.88, 95% CI 1.07, 7.70, p=0.036) than those who used 1-4 sessions.
- For the T0-T2 period, we found significant interactions between number of sessions and prognostic group. In the Target-D cohort, those in the severe prognostic group who used five or more sessions had greater odds of "significant improvement" in *depression* symptom severity compared those in the severe group who used 1-4 sessions (OR=10.2, 95% CI 1.28, 81.28, p=0.029). In the Link-me cohort, those in the severe prognostic group who used five or more sessions had greater odds of "significant improvement" in *anxiety* symptom severity compared those in the severe group who used 1-4 sessions (OR=4.79, 95% CI 1.38, 16.57, p=0.013).

There was also evidence of significant interaction effects between number of Better Access treatment sessions used and "significant deterioration" over the T0-T2 period:

Compared to those who in the severe group who used 1-4 sessions, those in the severe group who used 5 or more sessions had lower odds of "significant deterioration" in depression symptoms (Link-me, OR=0.22, 95% CI 0.06, 0.86, p=0.030) and in anxiety symptoms (Target-D, OR=0.07, 95% CI 0.004, 0.97, p=0.048; Link-me, OR=0.24, 95% CI 0.06, 0.97, p=0.045).

Discussion

Summary and interpretation of findings

In Study 4, we found evidence that individuals classified as users of Better Access treatment services delivered by allied health professionals had worse baseline levels of mental health symptoms, quality of life and functioning at baseline than those who used other forms of mental health care, who in turn had worse levels 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 from the Link-me cohort hinted that those aged 56 years and over may be less likely than younger adults to use Better Access treatment services and more likely to use 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 older adults.^{3,4} We also found relatively high percentages of people who reported difficulty managing on their income among the Better Access users (higher than (Link-me) or similar to (Target-D) the percentages among those who used other forms of mental health care, and higher than the percentages who used no services), which may indicate that Better Access treatment is being delivered to those with less resources to pay. 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 consumers classified as users of Better Access treatment services, noting that both trials were completed in 2019 prior to the introduction of an additional 10 treatment sessions in October 2020 in response to the COVID-19 pandemic. We found 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 at least some out-of-pocket payments for these sessions. Those in

the moderate and severe prognostic groups used more Better Access treatment services, and other mental health services, for their mental health.

We were able to explore changes over time in depression and anxiety symptoms, quality of life and functioning among consumers classified as users of Better Access treatment services. We found that approximately half of these individuals reported significant improvements in their mental health and quality of life over 12 months (43-55% on each individual measure and 68-80% on any of the included measures), 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. There was some evidence that some consumers were more likely to improve than others on the basis of sociodemographic factors. One example was that people aged 36-55 years or 56 years and over tended to have lower odds of significant improvement in anxiety symptom severity. Another was that females and those who completed a certificate/diploma qualification (compared to a high school education) had lower odds of significant improvement in functioning as measured by days out of role. Conversely, significant deterioration was most consistently associated with having 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 who had completed a certificate/diploma qualification had higher odds of significant deterioration.

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.

Strengths and limitations

Several strengths of Study 4 should be noted. One is that it involved two cohorts who participated in randomised controlled trials designed for other purposes, and where the selection of participants and collection of data did not involve the Better Access treatment provider. These are important methodological considerations for the current evaluation because, in our previous evaluation of consumer outcomes of Better Access,¹² we relied on Better Access providers to recruit 20 consecutive consumers and to enter the data collected from participants, and both providers and participants knew that data were being collected for the purpose of evaluating Better Access. We could not discount the possibility that these procedures could have introduced biases in favour of Better Access, even though we considered it unlikely. Similarly, in Study 2 of the current evaluation, participants are informed that the survey is being conducted as part of an evaluation of Better Access. In contrast, participants in the original trials that provided data for Study 4 were recruited by trial staff (Target-D and Link-me) or general practice staff (Link-me) in the GP's waiting room and participants entered information about their mental health and wellbeing directly into tablet-devices (at recruitment) or online (at follow-up) themselves. Moreover, the original trials were not conducted for the purposes of evaluating Better Access. Together, these methods reduce the likelihood of biases towards positive outcomes for Better Access.

A second strength is that the Target-D and Link-me trials collected information about a range of types of providers seen for mental health, and the locations of those visits. This meant that, in this evaluation, Study 4 was able to consider whether those we classified as Better Access users had different characteristics from those who used other forms of mental health care, and those who used neither of these forms of mental health care. That said, in Study 4 we could only report on the other forms of mental health care in broad groupings (primary care, other mental health specialist, other professional service) as we did not have a sample size large enough to provide a detailed classification of the professionals and services used. In addition, we did not have information about the nature of these visits (e.g., whether they involved treatment, or assessment or referral). Nonetheless, this is an important

contribution because it provided some indications about factors that may affect access to Better Access treatment specifically (e.g., relatively older age) and those that may affect access to mental health care more generally (e.g., being employed). This improves on previous studies that have also sought to identify factors that differentiate Better Access users from non-Better Access users but were unable to separate the latter into those who did and did not use other forms of mental health care.⁹⁰

A third strength is that the original trials gathered information on a wide range of consumers' sociodemographic and clinical factors. This meant that Study 4 provided additional insights into the question of whether some consumers improved (or deteriorated) more than others, and whether these associations were consistent or varied across several measures of mental health including a measure of functioning (i.e., total days out of role) that was not available in other studies in this evaluation. For example, Study 4 showed that females and consumers with a trade or technical qualification had lower odds of improvement (and higher odds of deterioration) in total days out of role, but not on measures of symptoms and quality of life. This could suggest that these groups experience greater difficulty returning to their usual level of functioning even when other aspects of their mental health improve, which could be an area for clinical focus.

A fourth strength is that we applied a common method to the re-analyses of the Target-D and Link-me data. This allowed us to identify convergent findings, which in turn increased our confidence in those findings. For example, in both trial cohorts, we found that people in the severe prognostic group had higher odds of significant improvements, or lower odds of significant deterioration, in depression and/or anxiety symptoms if they used 5 or more sessions.

There were some potential limitations, however, that should be considered when interpreting the findings. Some of these relate to our measures of service use. Although we were able to identify individuals who used services delivered by eligible allied health providers in private practice settings, we did not have information about how those sessions were paid for, so cannot be certain that all of these sessions were funded through Better Access. However, as noted in Study 2, the vast majority of services delivered by psychologists in Australia are Better Access services, so we are confident that the vast majority of individuals in this group will have used Better Access treatment services. Moreover, we know of no evidence to suggest that the nature of treatment, or the outcomes obtained from treatment, delivered by psychologists under Better Access differs from that delivered in private practice under other funding arrangements. Service use information was gathered in the original trials via self-report. However, previous analyses of the Link-me dataset have shown reasonable concordance between the RUQ responses and administrative data.⁹¹ Some professionals eligible to provide Better Access treatment services were unable to be examined as they were not included in the RUQs (e.g., occupational therapists in Target-D). As noted earlier, we were not able to gauge whether participants may have used Better Access treatment services provided by GPs and other medical practitioners, however these make up only 1% of all Better Access treatment services.⁸⁴ The vast majority of consumers classified in the Better Access group had seen a psychologist. Our study findings are therefore best extrapolated to consumers being treated by psychologists under Better Access.

Other potential limitations relate to the data available in the trial datasets. The original Link-me and Target-D did not gather information on some potentially important factors shown elsewhere to influence outcomes of psychological therapies (such as the content of treatment sessions, therapeutic alliance, and therapist characteristics), so we could not consider these factors in Study 4.⁸⁸ Because the original trials focussed on people with depression and anxiety (and generally did not exclude those with comorbid conditions), the results may not generalise to individuals who *solely* experienced other mental health or substance use problems. However, previous studies have shown that individuals with depression and/or anxiety make up the majority of those who use Better Access treatment services.⁹²⁻⁹⁵

Although not technically limitations of the study, we could not address some topics of interest for the evaluation. The trials were conducted up to 2019, so the data do not capture the impacts of the additional psychological treatment sessions introduced in 2020 in response to COVID-19. Both trials
restricted eligibility to people aged at least 18 years. The Link-me trial collected information about whether participants identified as First Nations people or mainly spoke a language other than English at home but the number of participants in these groups was small (see Appendices 8 and 9). This meant that we were not able to consider whether change in symptoms, quality of life and functioning differed for people in these groups.

Conclusions

Study 4 provides evidence that Better Access treatment services are being used by people with varying levels of severity, and that the volume of these and other mental health services they use varies in line with how unwell they are. Study 4 also provides evidence that many consumers who used Better Access treatment services experienced significant improvement in their mental health over time, particularly those with poorer mental health and quality of life at baseline. For the most part, we did not find evidence that some consumers, defined by their socioeconomic characteristics, were less likely to experience significant improvement following Better Access treatment, although lower rates of improvement in anxiety symptom severity for middle-aged and older adults may warrant attention. There was some suggestion that using five or more sessions may be associated with significant improvements in depression and anxiety symptoms among those with a more severe prognosis.

8. 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)

Introduction

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. Both have collected data on whether participants have been diagnosed with a mental health condition in the past year and both have captured participants' self-rated mental health using standardised measures. Both studies have also linked participants' data to their Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) records.

By using data from Ten to Men and ALSWH, we were able to identify groups of participants with "mental health need" at baseline. Using the linked MBS data we were then able to identify a sub-group who used Better Access treatment services between waves of data collection. We could describe the sociodemographic, clinical and treatment characteristics of these individuals and compare them with others with mental health needs who did not use Better Access services. We were also able to describe their patterns of use of Better Access services. In addition, we were able to determine whether their mental health changed, and whether any improvement or deterioration was associated with their characteristics and patterns of Better Access use.

One of the key ways we described participants' clinical characteristics was in terms of their prognostic severity, assessed at baseline. We did this using adapted versions of the Target-D and Link-me algorithm that we used in Study 4 which classified participants' likely severity of depression (Target-D) or depression or anxiety (Link-me) in three months' time: "minimal/mild", "moderate", or "severe".

Study 5 complements Studies 2, 3 and 4 by providing additional perspectives on who uses Better Access treatment services, how they do so, and what the potential benefits for them may be. It has the advantage of using data from large, relatively representative samples of men and women drawn from the general population, which supports the generalisability of the findings. It does, however, have the same issue as Study 4, which is that the assessments of mental health and wellbeing were done at set points in time (in this case) and not at the beginning and end of Better Access treatment episodes.

Methods

Study design and data sources

Like Study 4, Study 5 is an observational prospective study. It involved independent cohorts drawn from Ten to Men and ALSWH. Ten to Men was initially run by the University of Melbourne and is now run by the Australian Institute of Family Studies. ALSWH is run by the University of Queensland and the University of Newcastle. More detail about Ten to Men and ALSWH can be found on their respective websites – <u>https://tentomen.org.au/</u> and <u>https://alswh.org.au/</u> but each is described briefly below.

Ten to Men and ALSWH have collected longitudinal data from their respective cohorts over multiple waves. Ten to Men used a stratified random household sampling strategy to recruit a single cohort of 16,021 (13,896 aged 18-55, and 2,125 aged 10-17) in 2013/14 and has followed participants over three waves.⁹⁶ ALSWH recruited three cohorts based on year of birth by randomly sampling from the Medicare database in 1996: a 1973-78 cohort (aged 18-23 at recruitment; N=14,247); a 1946-51 cohort (aged 45-50 at recruitment; N=13,714); and a 1921-26 cohort (aged 70-75 at recruitment; N=12,432).⁹⁷ ALSWH recruited a fourth cohort by online and offline methods in 2013, the 1989-95 cohort (aged 18-23 at recruitment; N=17,010).⁹⁸ These cohorts have been followed for a minimum of six and a maximum of nine waves.

Both Ten to Men and ALSWH have collected data on participants' health – including their mental health – via surveys administered at each of the waves. Both studies have also linked participants' survey data to their MBS and PBS claims data.

The longitudinal nature of the data from Ten to Men and ALSWH and the linkage of survey data to MBS data enabled us to identify participants with "mental health need" (see below for operational definition) at a given survey wave, and to determine whether they used Better Access treatment services between that and a subsequent wave. We were then able to compare those who did use these services with those who didn't, to look at specific patterns of Better Access care, and to gauge whether Better Access use was associated with improvements in mental health.

Cohorts and survey waves

We restricted the samples in Study 5 to those aged 18 or over in Ten to Men and those in the 1989-95, 1973-78 and 1946-51 cohorts in ALSWH. We took all three waves of data from Ten to Men, and then selected the three waves for each cohort in ALSWH that were conducted at the closest points in time to these. This option was preferred because we wanted to present results for Ten to Men and ALSWH alongside each other, as we did with Target-D and Link-me in Study 4.

Because of the large gaps in time between included survey waves, we conducted two separate analyses to examine outcomes across pairs of survey waves. The first wave in any pair constituted the baseline wave (T0), and the second pair constituted the follow-up wave (T1). For example, for the ALSWH 1946-51 cohort, the first analysis pair comprised Wave 7 (T0) and Wave 8 (T1), and the second analysis pair comprised Wave 9 (T1).

Figure 8.1 shows the waves that were included for each of the Ten to Men and ALSWH cohorts, and the pairs of waves that made up each of the analyses. It also shows the age of each of the cohorts at the baseline wave in the first analysis.



Figure 8.1: Waves included in each analysis for each cohort

Sampling frame and participant selection for analysis

In order for participants to be included in the Study 5 analysis, they had to satisfy the following four criteria. These criteria were applied in a stepwise fashion:

- 1. Aged ≥18 at the baseline (TO) wave of interest: In the case of Ten to Men participants, this also meant that they had to have completed the correct survey (because a small number of 18 year olds completed a survey designed for younger participants, rather than the adult questionnaire).
- 2. Demonstrated "mental health need" at baseline (TO): For Ten to Men participants, this meant that they had to screen positive for current depressive symptoms as evidenced by a score ≥2 on the first two items of the Patient Health Questionnaire-9 (PHQ-9),³⁸ the PHQ-2.³⁹ For ALSWH participants in the 1973-78 and 1946-51 cohorts, this meant that they had to screen positive for current depressive or anxiety symptoms as evidenced by a score of ≥10 on the Center for Epidemiological Studies Depression scale (CES-D)²⁷ or a score of ≥6 on the Generalised Anxiety Disorder scale (GAD-7).³³ Participants in the ALSWH 1989-95 cohort demonstrated mental health need by a Kessler 10 (K-10) score on ≥16. More detail is provided about each of these measures in Section 2.

- 3. Agreed to Medicare linkage for the period between baseline (T0) and follow-up (T1): For both studies, participants had to have agreed to Medicare linkage so that we could determine whether or not they had used Better Access treatment services in the relevant period.
- 4. *Completed relevant survey waves:* For both studies, participants had to have completed all relevant survey waves so that we could examine change in their mental health between any baseline (T0) and follow-up (T1) survey pair.

Measures

Mental health

Participants in each wave of each study completed standardised self-report measures of mental health relating to domains like depression and anxiety symptom severity, quality of life and functioning. Table 8.1 shows the specific measures that we used to assess mental health in Study 5, and more detail is provided in Section 2. As noted above, the PHQ-2, CES-D, GAD-7 and K-10 were used to determine "mental health need" for particular cohorts; these were taken from the T0 surveys. The latter three measures, and the Patient Health Questionnaire-9 (PHQ-9)³⁸ were used to assess changes in mental health from T0 to T1 in given analyses.

Table 8.1: Standardised mental health measures u	used in Study 5, by study and cohort
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MEASURE	TEN TO MEN	ALSWH 1989-95 COHORT	ALSWH 1973-78 COHORT	ALSWH 1946-51 COHORT
Center for Epidemiological Studies – Depression scale (CES-D) ²⁷			12	12
Generalised Anxiety Disorder scale (GAD-7) ³³			12	12
Kessler-10 (K-10) ²⁵			12	
Patient Health Questionnaire-9 (PHQ- 9) ³⁸	2			
Patient Health Questionnaire-2 (PHQ- 2) ³⁹	1			

10

Used to establish mental health need at T0 Used to assess changes in mental health from T0-T1

Sociodemographic, clinical and treatment variables

Participants also provided a range of other information through the TO surveys. For the purposes of Study 5 we used the following variables:

- Sociodemographic variables: age (in years); First Nations (yes, no); highest level of education received (year 11 or less, year 12 or equivalent, certificate/diploma, bachelor's degree or higher); country of birth (Australia, other); area of residence (metropolitan, regional, rural);
- *Clinical variables:* prognostic severity ("minimal/mild", "moderate", "severe"); lifetime history of depression (yes, no); lifetime history of anxiety (yes, no); and
- *Treatment variables:* currently taking any medication for mental health (yes, no).

Most of these variables are self-explanatory, but the clinical variable of prognostic severity requires additional explanation. We adapted algorithms developed for the Target-D and Link-me trials (and used

in Study 4) to classify participants in terms of their likely severity of depression (Target-D) or depression or anxiety (Link-me) in three months' time: "minimal/mild", "moderate", or "severe".^{3,4,82} These algorithms were based on information collected at baseline about various psychosocial factors (including gender, mental health history and current symptoms, general health, living situation and financial security). Ten to Men and ALSWH captured this sort of information from participants at the various TO points, but because they often did so using different measures we conducted a mapping exercise to ensure that the algorithms were based on information that was as similar as possible across studies. We used the Target-D algorithm for Ten to Men and the Link-me algorithm for ALSWH; this decision was made on the basis of a lack of information about baseline levels of anxiety in Ten to Men.

Use of Better Access treatment services

Information on use (or non-use) of Better Access and other mental health treatment services for any T0-T1 period was based on the linked MBS data. We used participants' Medicare data to classify them into treatment groups, based on their use (or non-use) of Better Access treatment items in any T0-T1 period. For the purposes of Study 5, Better Access treatment items were defined as all items associated with psychological therapy services delivered by clinical psychologists and all items associated with focussed psychological strategies delivered by GPs, psychologists, social workers and occupational therapists.

For those who had used Better Access treatment services, we gathered information on the number of sessions, the type of Better Access provider seen (clinical psychologist, psychologist, social worker, occupational therapist, GP), and the out-of-pocket costs paid. All costs were converted to June 2022 dollars using the Consumer Price Index (CPI) figures for Medical and Hospital Services provided by the Australian Bureau of Statistics.⁵⁴

Data analyses

All analyses were conducted using Stata version 17 (StataCorp, College Station, TX, USA). The ALSWH analyses were conducted within the Secured Unified Research Environment (SURE), held by the Sax Institute. As per SURE requirements, we suppressed numbers ≤10 in ALSWH outputs. For consistency, we did the same for Ten to Men outputs.

Data were analysed separately for each study cohort and T0-T1 time period of interest.

We identified participants who had and hadn't used Better Access treatment services and described them in terms of key sociodemographic, clinical and treatment characteristics using summary statistics (means, percentages). We conducted a multivariable logistic regression to examine whether any of these characteristics were associated with use of Better Access treatment services.

For those who had used Better Access treatment services, we examined their patterns of use. We calculated summary statistics (medians, percentages) to describe these patterns.

We used the same effect size methodology that we used in Studies 2, 3 and 4 to classify change in measures of mental health (e.g., depression and anxiety symptom severity, quality of life and functioning) for Better Access users. As in those studies, we used an effect size of 0.3 (small-to-medium, as per Cohen's⁴³ classification) of a standard deviation of the baseline score of all participants who had used Better Access treatment services to calculate an absolute threshold for change score on each measure, and then used this to classify change as "significant improvement", "no significant change" or "significant deterioration".

We then conducted further multivariable logistic regression analyses to explore associations between individuals' baseline characteristics and their treatment patterns and either: (a) significant improvement (vs. no significant change or significant deterioration) on each measure or; (b) or significant deterioration (vs. no significant change or significant improvement) on each measure.

We conducted sensitivity analyses alongside each of the multivariable logistic regression analyses, exploring coefficient correlation matrices and goodness of fit scores after fitting different models. We ultimately chose models that appeared stable and not impacted by multicollinearity.

Approvals

Both Ten to Men and ALSWH received initial ethics approvals from the ethics committees of the responsible organisations. All participants provided informed consent. For both Ten to Men and ALSWH it is not necessary to obtain separate ethical approval for use of the data as the existing Australian Institute of Family Studies and ALSWH Data Access Committee approvals provide this coverage. The analyses of Ten to Men and ALSWH data for Study 5 were granted an exemption from Human Research Ethics Review under the National Statement on Ethical Conduct in Human Research and relevant University of Queensland policy (PPL 4.20.07).

Acknowledgements

The research on which Study 5 is based was conducted as part of Ten to Men by the University of Melbourne and the Australian Institute of Family Studies and as part of the ALSWH by the University of Queensland and the University of Newcastle. We are grateful to the Department of Health for funding these longitudinal studies. We also acknowledge the boys and men who provided the survey data for Ten to Men and the women who provided the survey data for ALSWH. We also acknowledge the Department of Health for providing MBS and PBS data, and, for the ALSWH, the Australian Institute of Health and Welfare as the Integrating Authority.

Results

Participants included in the analyses

Table 8.2 shows the participants who satisfied the four relevant criteria to be included in each analysis. The highest number of participants in any single analysis was 6,979 (ALSWH, 1989-95 cohort, Analysis 1) and the lowest number was 1,550 (Ten to Men, Analysis 2).

	TEN T	O MEN	ALS 1989-95	WH COHORT	ALS 1973-78	WH COHORT	ALS 1946-51	WH COHORT
	ANALYSIS 1: T0 (WAVE 1, 2013/14) - T1 (WAVE 2, 2015/16)	ANALYSIS 2: T0 (WAVE 2, 2015/16) - T1 (WAVE 2, 2020/21)	ANALYSIS 1: T0 (WAVE 1, 2013) – T1 (WAVE 3, 2015)	ANALYSIS 2: T0 (WAVE 3, 2015) – T1 (WAVE 6, 2019)	ANALYSIS 1: T0 (WAVE 6, 2012) – T1 (WAVE 7, 2015)	ANALYSIS 2: T0 (WAVE 7, 2015) – T1 (WAVE 8, 2018)	ANALYSIS 1: T0 (WAVE 7, 2013) – T1 (WAVE 8, 2015)	ANALYSIS 2: T0 (WAVE 8, 2015) – T1 (WAVE 9, 2019)
Cohort at baseline wave	13,896	10,729	17,010	8,961	8,009	7,186	9,151	8,622
1. Aged ≥18 at baseline	13,891 (5 removed ^a)	10,729 (0 removed ^a)	16,997 (13 removed ^a)	8,961 (0 removed ^a)	8,009 (0 removed ^a)	7,186 (0 removed ^a)	9,151 (0 removed ^a)	8,622 (0 removed ^a)
2. Demonstrated "mental health need" at baseline	4,608 (9,283 removed ^b)	3,430 (7,299 removed ^b)	13,459 (3,538 removed ^b)	6,630 (2,331 removed ^b)	2,895 (5,114 removed ^b)	3,040 (4,146 removed ^b)	2,730 (6,421 removed ^b)	2,632 (5,990 removed ^b)
3. Agreed to Medicare linkage for the period between baseline and follow-up	2,942 (1,666 removed ^c)	2,398 (1,032 removed ^c)	13,444 (15 removed ^c)	6,630 (0 removed ^c)	2,706 (189 removed ^c)	2,875 (165 removed ^c)	2,585 (145 removed ^c)	2,512 (120 removed ^c)
4. Completed relevant survey waves	2,293 (649 removed ^d)	1,550 (848 removed ^d)	6,979 (6,465 removed ^d)	4,743 (1,887 removed ^d)	2,146 (560 removed ^d)	2,404 (471 removed ^d)	2,185 (400 removed ^d)	2,056 (456 removed ^d)

Table 8.2: Participant selection by study, cohort and analysis

a. Removed because they were aged <18 at baseline

b. Removed because they did not demonstrate "mental health need" at baseline

c. Removed because they did not agree to Medicare linkage for the period between baseline and follow-up

d. Removed because they did not complete relevant survey waves

Use of Better Access treatment services between T0 and T1

Table 8.3 splits the participants in each analysis into those who used and did not use Better Access treatment services between the relevant survey waves. The proportions of Better Access users vary across study cohorts and analyses, with the lowest proportion being 10.6% in Analysis 1 for Ten to Men, and the highest proportion being 44.7% in Analysis 2 for the ALSWH 1989-95 cohort. For these two cohorts, the proportions of participants using Better Access increased over time, doubling from Analysis 1 to Analysis 2. For the other two cohorts, the proportions remained the same at around one quarter (ALSWH 1973-78 cohort) and a little over one tenth (ALSWH 1946-51 cohort).

	TEN TO	O MEN	ALS 1989-95	WH COHORT	ALS 1973-78	WH COHORT	ALSWH 1946-51 COHORT		
	ANALYSIS 1: T0 (WAVE 1, 2013/14) - T1 (WAVE 2, 2015/16)	ANALYSIS 2: T0 (WAVE 2, 2015/16) - T1 (WAVE 2, 2020/21)	ANALYSIS 1: T0 (WAVE 1, 2013) – T1 (WAVE 3, 2015)	ANALYSIS 2: T0 (WAVE 3, 2015) – T1 (WAVE 6, 2019)	ANALYSIS 1: T0 (WAVE 6, 2012) – T1 (WAVE 7, 2015)	ANALYSIS 2: T0 (WAVE 7, 2015) – T1 (WAVE 8, 2018)	ANALYSIS 1: T0 (WAVE 7, 2013) – T1 (WAVE 8, 2015)	ANALYSIS 2: T0 (WAVE 8, 2015) – T1 (WAVE 9, 2019)	
Used Better Access treatment services	243 (10.6%)	358 (23.1%)	1,562 (22.4%)	2,121 (44.7%)	540 (25.2%)	646 (26.9%)	278 (12.7%)	254 (12.4%)	
Did not use Better Access treatment services	2,050 (89.4%)	1,192 (76.9%)	5,417 (77.6%)	2,622 (55.3%)	1,606 (74.8%)	1,758 (73.1%)	1,907 (87.3%)	1,802 (87.6%)	
Total	2,293	1,550	6,979	4,743	2,146	2,404	2,185	2,056	

Table 8.3: Use of Better Access treatment services by study, cohort and analysis

Prognostic severity at TO

As noted, all participants who were ultimately included in the analysis demonstrated "mental health need" at T0 in any given analysis. The prognostic severity algorithms enabled us to categorise participants further into "minimal/mild", "moderate" and "severe" groups. Table 8.4 shows that prognostic severity differed between cohorts. Most notably, only around one fifth of participants in the Ten to Men cohort were classified as "severe" compared with half to two thirds of those in the various ALSWH cohorts. By contrast two thirds of Ten to Men participants were classified as "minimal/mild" compared with around one fifth of participants in most of the other cohorts.

Table 9.4. Drognostic coverity	a by ctudy	cohort	and analy	veie
Table 0.4. Prognostic seventy	΄ μγ διάμγ,	CONDIC	anu anal	1212

	TEN TO	D MEN	ALS 1989-95	WH COHORT	ALS 1973-78	WH COHORT	ALSWH 1946-51 COHORT		
	ANALYSIS	ANALYSIS	ANALYSIS	ANALYSIS	ANALYSIS	ANALYSIS	ANALYSIS	ANALYSIS	
	1: T0	2: T0	1: T0	2: T0	1: T0	2: T0	1: T0	2: T0	
	(WAVE 1,	(WAVE 2,	(WAVE 1,	(WAVE 3,	(WAVE 6,	(WAVE 7,	(WAVE 7,	(WAVE 8,	
	2013/14)	2015/16)	2013) –	2015) –	2012) –	2015) –	2013) –	2015) –	
	- T1	- T1	T1	T1	T1	T1	T1	T1	
	(WAVE 2,	(WAVE 2,	(WAVE 3,	(WAVE 6,	(WAVE 7,	(WAVE 8,	(WAVE 8,	(WAVE 9,	
	2015/16)	2020/21)	2015)	2019)	2015)	2018)	2015)	2019)	
Minimal/mild	1,335	982	322	606	104	110	44	37	
	(64.6%)	(67.1%)	(20.8%)	(30.1%)	(19.7%)	(18.6%)	(16.3%)	(15.7%)	
Moderate	291	197	263	356	115	135	60	41	
	(14.1%)	(13.4%)	17%)	(17.7%)	(21.8%)	(22.8%)	(22.2%)	(17.4%)	
Severe	439	285	966	1,051	308	347	166	158	
	(21.3%)	(19.5%)	(62.2%)	(52.2%)	(58.5%)	(58.6%)	(61.5%)	(66.9%)	

a. Prognostic severity was determined using algorithms adapted from those used in Target-D and Link-me, reported in Study 4. In Target-D, 72.5% of participants were classified as "minimal/mild", 15.5% as "moderate", and 12.0% as "severe". In Link-me, 32.9% were classified as "minimal/mild", 33.8% as "moderate", and 33.3% as "severe". The most appropriate comparisons here are between Target-D and Ten to Men (which use the depression algorithm); and between Link-me and ALSWH (which use both the depression and anxiety algorithms).

Characteristics of participants who used Better Access treatment services

Table 8.5 provides an overview of the characteristics of participants who used Better Access treatment services. Although there were some differences across studies and cohorts, Better Access users tended to be relatively well educated, born in Australia, and living in metropolitan areas. Their levels of prognostic severity varied, but often relatively high proportions could be classified as "severe". High proportions had

a lifetime history of depression. Smaller, but often still substantial, proportions had a lifetime history of anxiety. A minority (usually well under half) were taking medication for their mental health.

The multivariable logistic regression allows comparisons to be made between the users of Better Access treatment services and their counterparts who did not use these services. The results are summarised in Table 8.6 and reported in full in Appendix 15). Several key sociodemographic, clinical and treatment characteristics stood out as being associated with use of Better Access treatment services across most cohorts and analyses.

The factors that were most consistently associated with higher odds of using Better Access (statistically significant in most analyses with most cohorts) were clinical ones: worse levels of prognostic severity, a lifetime history of depression or anxiety, and current use of medication for mental health. Rurality was consistently associated with lower odds of using Better Access treatment services.

Some other factors – notably age and education level – were associated with differential odds of using Better Access (statistically significant in some analyses with some cohorts, but not others). Older age was associated with lower odds of using Better Access in one analysis for Ten to Men, the ALSWH 1973-78 cohort, and the ALSWH 1946-51 cohort, but not in either analysis for the ALSWH 1989-95 cohort. Higher levels of education were consistently associated with greater odds of using Better Access for most analyses with the three ALSWH cohorts, but there was no significant effect of education for the Ten to Men cohort.

		TEN TO MEN			ALSWH 1989-95 COHORT				ALSWH 1973-78 COHORT				ALSWH 1946-51 COHORT				
Analysis		ANALYS (WA 2013/1 (WA 2015	51S 1: T0 VE 1, L4) – T1 VE 2, 5/16)	ANALYSIS 2: T0 (WAVE 2, 2015/16) – T1 (WAVE 3, 2020/21)		ANALYSIS 1: T0 (WAVE 1, 2013) – T1 (WAVE 3, 2015)		ANALYSIS 2: T0 (WAVE 3, 2015) – T1 (WAVE 6, 2019)		ANALYSIS 1: T0 (WAVE 6, 2012) – T1 (WAVE 7, 2015)		ANALYSIS 2: T0 (WAVE 7, 2015) – T1 (WAVE 8, 2018)		ANALYSIS 1: T0 (WAVE 7, 2013) – T1 (WAVE 8, 2015)		ANALYSIS 2: T0 (WAVE 8, 2015) – T1 (WAVE 9, 2019)	
Bette	er Access treatment services	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Ν	1	243	2,050	358	1,192	1,562	5,417	2,121	2,622	540	1,606	646	1,758	278	1,907	254	1,802
	Mean age, years	37.6	38.8	38.3	41.0	20.6	20.6	22.4	22.4	36.3	36.3	39.0	39.3	64.2	64.3	67.0	67.1
	First Nations																
	Yes	-	2%	-	2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	No	97%	98%	97%	98%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Highest level of education received																
hic	Year 11 or less	13%	14%	9%	11%	7%	6%	3%	3%	5%	7%	4%	7%	32%	43%	33%	42%
grap	Year 12 or equivalent	16%	15%	17%	13%	46%	44%	29%	27%	9%	13%	11%	10%	20%	20%	17%	21%
Bom	Certificate/diploma	45%	43%	45%	45%	27%	26%	27%	29%	31%	28%	31%	29%	24%	21%	28%	20%
ode	Bachelor's degree or higher	26%	28%	29%	32%	20%	24%	41%	41%	55%	52%	54%	54%	24%	16%	22%	17%
Soci	Country of birth																
•.	Australia	88%	80%	87%	80%	92%	92%	93%	92%	93%	94%	93%	93%	82%	79%	84%	78%
	Other	12%	20%	13%	20%	8%	8%	7%	8%	7%	6%	7%	7%	18%	21%	16%	22%
	Area of residence																
	Metropolitan	57%	59%	65%	60%	79%	75%	79%	74%	67%	57%	62%	56%	45%	37%	43%	37%
	Regional	15%	12%	11%	13%	16%	17%	15%	17%	23%	27%	27%	27%	42%	40%	41%	42%
	Rural	30%	29%	24%	27%	5%	8%	6%	9%	10%	16%	11%	17%	13%	23%	16%	21%
	Prognostic severity																
	Minimal/mild	36%	68%	55%	71%	21%	43%	30%	47%	20%	34%	18%	36%	16%	28%	16%	29%
_	Moderate	21%	13%	15%	13%	17%	19%)	18%	20%	22%	27%	23%	25%	22%	23%	17%	22%
nica	Severe	42%	19%	30%	16%	62%	38%	52%	33%	58%	39%	59%	39%	61%	49%	67%	49%
CI	History of depression (lifetime)																

Table 8.5: Characteristics of participants who did and did not use Better Access treatment services, by study, cohort and analysis

			TEN TO MEN			ALS	ALSWH 1989-95 COHORT			ALSWH 1973-78 COHORT				ALSWH 1946-51 COHORT			
Analysis		ANALYS (WA 2013/1 (WA 2015	SIS 1: TO VE 1, I4) – T1 VE 2, 5/16)	ANALYSIS 2: T0 (WAVE 2, (WAVE 1, 2013) 2015/16) – T1 (WAVE 3, 2015) 2020/21)		ANALYSIS 2: T0 (WAVE 3, 2015) – T1 (WAVE 6, 2019)		ANALYSIS 1: T0 (WAVE 6, 2012) – T1 (WAVE 7, 2015)		ANALYSIS 2: T0 (WAVE 7, 2015) – T1 (WAVE 8, 2018)		ANALYSIS 1: T0 (WAVE 7, 2013) - T1 (WAVE 8, 2015)		ANALYSIS 2: TO (WAVE 8, 2015) – T1 (WAVE 9, 2019)			
Bett	er Access treatment services	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Ν		243	2,050	358	1,192	1,562	5,417	2,121	2,622	540	1,606	646	1,758	278	1,907	254	1,802
	Yes	71%	36%	57%	35%	94%	75%	90%	77%	94%	84%	92%	77%	-	92%	-	92%
	No	29%	64%	43%	65%	6%	25%	10%	23%	6%	16%	8%	23%	-	8%	-	8%
	History of anxiety (lifetime)																
	Yes	56%	22%	42%	21%	90%	68%	88%	72%	52%	26%	53%	28%	67%	41%	70%	60%
	No	44%	78%	58%	79%	10%	32%	12%	28%	48%	74%	47%	72%	33%	59%	30%	40%
nent	Currently taking any medication for mental health																
eatn	Yes	37%	13%	28%	14%	34%	11%	29%	11%	31%	15%	40%	17%	46%	30%	46%	30%
Ľ	No	63%	87%	72%	86%	66%	89%	71%	89%	69%	85%	60%	83%	54%	70%	54%	70%

- Suppressed

	TEN T	O MEN	ALSWH	1989-95	ALSWH	1973-78	ALSWH 1946-51	
		1	COH	IORT	COH	IORT	COH	IORT
Analysis	1	2	1	2	1	2	1	2
Sociodemographic			_					
Mean age, years		\downarrow				\checkmark	\checkmark	
Highest level of education received ^d								
Year 12 or equivalent						1		1
Certificate/diploma			1	1		1		
Bachelor's degree or higher			1	1	1	1		1
Country of birth ^e								
Other		\downarrow		\checkmark				
Area of residence ^f								
Regional					\checkmark			\checkmark
Rural			\downarrow	\checkmark	\checkmark	\checkmark	\checkmark	\checkmark
Clinical								
Prognostic severity ^g								
Moderate	1						1	
Severe	1		1	1	1	1	1	1
History of depression (lifetime) ^h								
Yes	1	1			1	1	1	1
History of anxiety (lifetime) ^h								
Yes	1	1	1		1	1	1	1
Treatment								
Currently taking any medication for mental health ^h								
Yes	1	1		1	1	1	1	1

Table 8.6: Sociodemographic, clinical and treatment variables associated with use of Better Access treatment services^{a,b,c}

a. Results from multivariable logistic regression

 Shaded cells indicate statistically significant results (white cells indicate that the results were not statistically significant); up arrows and down arrows indicate increased and decreased likelihood of Better Access treatment use, respectively

c. Model also controlled for First Nations status (Ten to Men only) and elapsed days between survey waves

d. Reference category: Year 11 or less

e. Reference category: Australia

f. Reference category: Metropolitan

g. Reference category: Minimal/mild

h. Reference category: No

Patterns of use of Better Access treatment services

We explored in more detail the patterns of use of Better Access treatment services for those who used them. These findings should be considered in the context of the "window of opportunity" that participants had to do this, due to the schedule of survey waves. Figure 8.2 summarises the time that elapsed between T0 and T1 for each cohort and analysis. The shortest period was 1.87 years (Ten to Men, Analysis 1) and the longest period was 4.65 years (Ten to Men, Analysis 2).



Figure 8.2: Elapsed time (in years) between T0 and T1 for users of Better Access treatment services, by study, cohort and analysis

Number of sessions of Better Access treatment

Table 8.7 provides a summary of the number of sessions that those who used Better Access treatment services received in each T0 to T1 period. Across cohorts and analyses, participants typically accessed a median of 5-6 sessions.

There was evidence of a dose-response effect, whereby the median number of sessions increased as a function of severity. This was also apparent when the number of sessions was categorised; relatively higher proportions of those in the "minimal/mild" group tended to have 1-2 sessions, and, conversely, relatively higher proportions of those in the "severe" group were more likely to have 7-10 sessions or more.

Type of Better Access provider seen

Table 8.8 shows the types of Better Access providers who provided participants with treatment services. Participants may have seen more than one type of provider. As a general rule, around 40% of participants received treatment services from a clinical psychologist and around 50% did so from a psychologist. Smaller proportions (typically less than 10%) received treatment services from a social worker. Smaller proportions still received treatment services from occupational therapists and GPs or other medical practitioners, as evidenced by the number of cells in which data were suppressed.

In the main, the provider-based patterns of service use did not differ by participants' levels of prognostic severity. The exception to this was for women in the ALSWH 1946-51 cohort. Higher proportions of those who were classified as "minimal/mild" at T0 received treatment from a psychologist than did so from a clinical psychologist. Conversely, those who were classified as "severe" at T1 were more likely to receive treatment from a clinical psychologist.

TEN TO MEN											
	ANALYSIS 1: T	0 (WAVE 1, 201	3/14) – T1 (WA\	/E 2, 2015/16)	ANALYSIS 2: 1	0 (WAVE 2, 201	.5/16) – T1 (WA\	/E 2, 2020/21)			
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total			
	n=80	n=47	n=93	n=243	n=190	n=53	n=103	n=358			
1-2	30 (37.5%)	7 (15%)	19 (20.4%)	63 (25.9%)	36 (18.9%)	9 (17%)	19 (18.4%)	70 (19.5%)			
3-4	12 (15%)	14 (29.8%)	12 (12.9%)	41 (16.9%)	30 (15.8%)	10 (18.9%)	13 (12.6%)	53 (14.8%)			
5-6	-	-	21 (22.6%)	48 (19.8%)	45 (23.7%)	-	14 (13.6%)	69 (19.3%)			
7-10	18 (22.5%)	12 (25.5%)	19 (20.4%)	53 (21.8%)	33 (17.4%)	11 (20.7%)	12 (11.7%)	57 (15.9%)			
11-20	-	-	21 (22.6%)	37 (15.2%)	34 (17.9%)	10 (18.9%)	25 (24.3%)	72 (20.2%)			
21-50	-	-	-	-	12 (6.3%)	4 (7.5%)	20 (19.4%)	37 (10.3%)			
Median (IQR)	4 (2-7)	5 (3-8)	6 (4-10)	5 (2-9)	6 (3-10)	6 (4-11)	9 (4-18)	6 (3-12)			
			ALSW	H 1989-95 COH	ORT						
	ANALYSIS 1: T0 (WAVE 1, 2013) – T1 (WAVE 3, 2015) ANALYSIS 2: T0 (WAVE 3, 2015) – T1 (WAVE 6										
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total			
	n=322	n=263	n=966	n=1562	n=606	n=356	n=1051	n=2121			
1-2	75 (23.3%)	70 (26.6%)	195 (20.2%)	344 (22%)	119 (19.6%)	59 (16.6%)	127 (12.1%)	327 (15.4%)			
3-4	77 (23.9%)	52 (19.8%)	179 (18.5%)	310 (19.8%)	97 (16%)	48 (13.5%)	129 (12.3%)	293 (13.8%)			
5-6	67 (20.8%)	46 (17.5%)	153 (15.8%)	268 (17.2%)	106 (17.5%)	51 (14.3%)	132 (12.6%)	308 (14.5%)			
7-10	70 (21.8%)	-	223 (23.1%)	337 (21.6%)	117 (19.3%)	63 (17.7%)	202 (19.2%)	400 (18.9%)			
11-20	-	47 (17.9%)	192 (19.9%)	272 (17.4%)	113 (18.7%)	95 (26.7%)	262 (24.9%)	487 (23%)			
21-50	-	-	24 (2.5%)	31 (2%)	54 (8.9%)	40 (11.2%)	199 (18.9%)	306 (14.4%)			
Median (IQR)	5 (3-8)	5 (2-10)	6 (3-10)	5 (3-10)	6 (3-12)	8 (4-14)	10 (5-18)	8 (4-15)			
ALSWH 1973-78 COHORT											
			ALSW	H 1973-78 COH	ORT	_					
	ANALYSIS	1: T0 (WAVE 6, 2	ALSW 2012) – T1 (WAV	H 1973-78 COH /E 7, 2015)	ORT ANALYSIS	2: T0 (WAVE 7,	2015) – T1 (WA\	/E 8, 2018)			
	ANALYSIS Min/mild	1: T0 (WAVE 6, 2 Moderate	ALSW 2012) – T1 (WA\ Severe	H 1973-78 COH /E 7, 2015) Total	ORT ANALYSIS Min/mild	2: T0 (WAVE 7, Moderate	2015) – T1 (WA\ Severe	/E 8, 2018) Total			
	ANALYSIS Min/mild n=104	1: T0 (WAVE 6, 2 Moderate n=115	ALSW 2012) – T1 (WAN Severe n=308	H 1973-78 COH /E 7, 2015) Total n=540	ANALYSIS Min/mild n=110	2: T0 (WAVE 7, Moderate n=135	2015) – T1 (WAN Severe n=347	/E 8, 2018) Total n=646			
1-2	ANALYSIS Min/mild n=104 21 (20.2%)	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%)	ALSW 2012) – T1 (WAN Severe n=308 49 (15.9%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%)	ORT ANALYSIS Min/mild n=110 28 (25.5%)	2: T0 (WAVE 7, Moderate n=135 23 (17%)	2015) – T1 (WA\ Severe n=347 58 (16.7%)	/E 8, 2018) Total n=646 120 (18.6%)			
1-2 3-4	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%)	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%)	ALSW 2012) – T1 (WAN Severe n=308 49 (15.9%) 52 (16.9%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%)	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%)	2015) – T1 (WAN Severe n=347 58 (16.7%) 61 (17.6%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%)			
1-2 3-4 5-6	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%)	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) -	ALSW 2012) – T1 (WAX Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%)	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%)	2015) – T1 (WAN Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%)			
1-2 3-4 5-6 7-10	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) -	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%)	ALSW 2012) – T1 (WAX Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) -	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%)	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%)			
1-2 3-4 5-6 7-10 11-20	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%)	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%)	ALSW 2012) – T1 (WAX Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 57 (18.5%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%)	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%)	2015) – T1 (WAN Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%)			
1-2 3-4 5-6 7-10 11-20 21-50	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) -	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) -	ALSW 2012) – T1 (WAX Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 57 (18.5%) 38 (12.3%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) -	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%)	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR)	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11)	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10)	ALSW 2012) – T1 (WAV Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11)	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12)	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14)	Ke 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 6 (3-12)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR)	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11)	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10)	ALSW 2012) – T1 (WAN Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW	H 1973-78 COH F 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12)	2015) – T1 (WA\ Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14)	Ke 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 6 (3-12)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR)	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11) ANALYSIS Min (mild	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10) 1: T0 (WAVE 7, 2 Moderate	ALSW 2012) – T1 (WAX Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW 2013) – T1 (WAX	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH /E 8, 2015)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS Min/mild	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12) 2: T0 (WAVE 8, Moderate	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14) 2015) – T1 (WAV	KE 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 6 (3-12)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR)	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11) ANALYSIS Min/mild	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10) 1: T0 (WAVE 7, 2 Moderate n=60	ALSW 2012) – T1 (WAV Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW 2013) – T1 (WAV Severe	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH /E 8, 2015) Total n=278	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS Min/mild n=27	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12) 2: T0 (WAVE 8, Moderate	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14) 2015) – T1 (WAV Severe	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 61 (9.4%) 6 (3-12) /E 9, 2019) Total			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR)	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11) ANALYSIS Min/mild n=44 14 (21.8%)	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10) 1: T0 (WAVE 7, 2 Moderate n=60 22 (28.2%)	ALSW 2012) – T1 (WAX Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW 2013) – T1 (WAX Severe n=166 27 (22.2%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH /E 8, 2015) Total n=278 75 (27%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS Min/mild n=37 12 (25.2%)	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12) 2: T0 (WAVE 8, Moderate n=41 11 (26.8%)	2015) – T1 (WA Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14) 2015) – T1 (WA Severe n=158 41 (26%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 6 (3-12) /E 9, 2019) Total n=254 67 (26.4%)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR) 1-2 2-4	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11) - 5 (3-11) ANALYSIS Min/mild n=44 14 (31.8%)	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10) 1: T0 (WAVE 7, 2 Moderate n=60 23 (38.3%) 11 (18.2%)	ALSW 2012) – T1 (WAV Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW 2013) – T1 (WAV Severe n=166 37 (22.3%) 26 (15.6%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH /E 8, 2015) Total n=278 75 (27%) 48 (17.2%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS Min/mild n=37 13 (35.2%)	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12) 2: T0 (WAVE 8, Moderate n=41 11 (26.8%)	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14) 2015) – T1 (WAV Severe n=158 41 (26%) 32 (20.2%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 6 (3-12) /E 9, 2019) Total n=254 67 (26.4%) 50 (19.7%)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR) 1-2 3-4 5-6	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11) ANALYSIS Min/mild n=44 14 (31.8%) -	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10) 1: T0 (WAVE 7, 2 Moderate n=60 23 (38.3%) 11 (18.3%)	ALSW 2012) – T1 (WAX Severe n=308 49 (15.9%) 52 (16.9%) 52 (16.9%) 62 (20.1%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW 2013) – T1 (WAX Severe n=166 37 (22.3%) 26 (15.6%) 30 (12.1%)	H 1973-78 COH F 1973-78 COH 7 Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH 75 (27%) 48 (17.3%) 51 (18.2%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS Min/mild n=37 13 (35.2%) - 12 (32.4%)	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12) 2: T0 (WAVE 8, Moderate n=41 11 (26.8%) -	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14) 2015) – T1 (WAV Severe n=158 41 (26%) 32 (20.3%) 22 (12.9%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 6 (3-12) Total n=254 67 (26.4%) 50 (19.7%)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR) 1-2 3-4 5-6	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11) ANALYSIS Min/mild n=44 14 (31.8%) - -	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10) 1: T0 (WAVE 7, 2 Moderate n=60 23 (38.3%) 11 (18.3%) - 10 (16.7%)	ALSW 2012) – T1 (WAX Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW 2013) – T1 (WAX Severe n=166 37 (22.3%) 26 (15.6%) 30 (18.1%) 20 (17.5%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH /E 8, 2015) Total n=278 75 (27%) 48 (17.3%) 51 (18.3%) 47 (16.0%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS Min/mild n=37 13 (35.2%) - 12 (32.4%)	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12) 2: T0 (WAVE 8, Moderate n=41 11 (26.8%) - -	2015) – T1 (WAX Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14) 2015) – T1 (WAX Severe n=158 41 (26%) 32 (20.3%) 22 (13.9%) 28 (17.7%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 6 (3-12) /E 9, 2019) Total n=254 67 (26.4%) 50 (19.7%) 44 (17.3%)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR) 1-2 3-4 5-6 7-10	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11) ANALYSIS Min/mild n=44 14 (31.8%) - - - - - - -	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10) 1: T0 (WAVE 7, 2 Moderate n=60 23 (38.3%) 11 (18.3%) - 10 (16.7%)	ALSW 2012) – T1 (WAV Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW 2013) – T1 (WAV Severe n=166 37 (22.3%) 26 (15.6%) 30 (18.1%) 29 (17.5%) 20 (48.4%)	H 1973-78 COH /E 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH /E 8, 2015) Total n=278 75 (27%) 48 (17.3%) 51 (18.3%) 47 (16.9%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS Min/mild n=37 13 (35.2%) - 12 (32.4%) -	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12) 2: T0 (WAVE 8, Moderate n=41 11 (26.8%) - - -	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14) 2015) – T1 (WAV Severe n=158 41 (26%) 32 (20.3%) 22 (13.9%) 28 (17.7%) 25 (45.0%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 63 (3-12) Total n=254 67 (26.4%) 50 (19.7%) 44 (17.3%) 43 (16.9%)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR) 1-2 3-4 5-6 7-10 11-20 21 50	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11) ANALYSIS Min/mild n=44 14 (31.8%) - - - - - - - - - - - - -	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) - 26 (22.6%) 20 (17.4%) - 6 (3-10) 1: T0 (WAVE 7, 2 Moderate n=60 23 (38.3%) 11 (18.3%) - 10 (16.7%) -	ALSW 2012) – T1 (WAX Severe n=308 49 (15.9%) 52 (16.9%) 52 (16.9%) 62 (20.1%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW 2013) – T1 (WAX Severe n=166 37 (22.3%) 26 (15.6%) 30 (18.1%) 29 (17.5%) 30 (18.1%)	H 1973-78 COH F 1973-78 COH 7 7, 2015) Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH /F 8, 2015) Total n=278 75 (27%) 48 (17.3%) 51 (18.3%) 47 (16.9%) 40 (14.4%) 47 (6.1%)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS Min/mild n=37 13 (35.2%) - 12 (32.4%) - -	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12) 2: T0 (WAVE 8, Moderate n=41 11 (26.8%) - - - - - -	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14) 2015) – T1 (WAV Severe n=158 41 (26%) 32 (20.3%) 22 (13.9%) 28 (17.7%) 25 (15.8%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 6 (3-12) Total n=254 67 (26.4%) 50 (19.7%) 44 (17.3%) 43 (16.9%) 34 (13.4%)			
1-2 3-4 5-6 7-10 11-20 21-50 Median (IQR) 1-2 3-4 5-6 7-10 11-20 21-50 Madian (IQC)	ANALYSIS Min/mild n=104 21 (20.2%) 23 (22.1%) 21 (20.2%) - 21 (20.2%) - 5 (3-11) ANALYSIS Min/mild n=44 14 (31.8%) - - - - - - - - - - - - -	1: T0 (WAVE 6, 2 Moderate n=115 21 (18.3%) 26 (22.6%) 20 (22.6%) 20 (17.4%) - 6 (3-10) 1: T0 (WAVE 7, 2 Moderate n=60 23 (38.3%) 11 (18.3%) - 10 (16.7%) - - 2 (2.7)	ALSW 2012) – T1 (WAV Severe n=308 49 (15.9%) 52 (16.9%) 50 (16.2%) 62 (20.1%) 57 (18.5%) 38 (12.3%) 7 (3-13) ALSW 2013) – T1 (WAV Severe n=166 37 (22.3%) 26 (15.6%) 30 (18.1%) 29 (17.5%) 30 (18.1%) 14 (8.4%) 6 (2.11)	H 1973-78 COH F 1973-78 COH 7 Total n=540 93 (17.2%) 106 (19.6%) 91 (16.9%) 101 (18.7%) 99 (18.3%) 50 (9.3%) 6 (3-11.5) H 1946-51 COH 7 (3-11.5) H 1946-51 COH 7 (16.9%) 48 (17.3%) 51 (18.3%) 47 (16.9%) 40 (14.4%) 17 (6.1%) 5 (2.40)	ORT ANALYSIS Min/mild n=110 28 (25.5%) 21 (19.1%) 18 (16.4%) - 26 (23.6%) - 5 (2-11) ORT ANALYSIS Min/mild n=37 13 (35.2%) - 12 (32.4%) - - - 2 (2.6)	2: T0 (WAVE 7, Moderate n=135 23 (17%) 25 (18.5%) 21 (15.6%) 26 (19.3%) 30 (22.2%) 10 (7.4%) 6 (3-12) 2: T0 (WAVE 8, Moderate n=41 11 (26.8%) - - - - - - - - - - - - -	2015) – T1 (WAV Severe n=347 58 (16.7%) 61 (17.6%) 43 (12.4%) 68 (19.6%) 72 (29.7%) 45 (13%) 7 (3-14) 2015) – T1 (WAV Severe n=158 41 (26%) 32 (20.3%) 22 (13.9%) 28 (17.7%) 25 (15.8%) 10 (6.3%)	/E 8, 2018) Total n=646 120 (18.6%) 122 (18.9%) 92 (14.2%) 116 (18%) 135 (20.9%) 61 (9.4%) 63 (3-12) /E 9, 2019) Total n=254 67 (26.4%) 50 (19.7%) 44 (17.3%) 43 (16.9%) 34 (13.4%) 16 (6.3%)			

Table 8.7: Number of Better Access treatment sessions by study, cohort and analysis

Suppressed

Table 8.8: Type of Better Access provider seen by study, cohort and analysis^a

				TEN TO MEN				
	ANALYSIS	5 1: TO (WAVE 1 2015	, 2013/14) – T1 5/16)	(WAVE 2,	ANALYSIS 2: 1	FO (WAVE 2, 20	15/16) – T1 (WA	VE 2, 2020/21)
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total
	n=80	n=47	n=93	n=243	n=190	n=53	n=103	n=358
Clinical psychologists	31 (37.4%)	18 (36%)	37 (36.3%)	97 (39.9%)	88 (41.1%)	25 (43.1%)	53 (40.8%)	171 (47.8%)
Psychologists	42 (50.6%)	26 (52%)	55 (53.9%)	138 (56.8%)	112 (52.3%)	30 (51.7%)	66 (50.8%)	214 (59.8%)
Social workers	-	-	-	18 (7.4%)	11 (5.1%)	-	-	23 (6.4%)
Occupational therapists	-	-	-	-	-	-	-	-
GPs/OMPs ^{b,c}	-	-	-	-	-	-	-	-
	1		ALSW	Н 1989-95 СОН	ORT			
	ANALYSIS	1: T0 (WAVE 1, 2	2013) – T1 (WA	VE 3, 2015)	ANALYSIS	2: T0 (WAVE 3,	2015) – T1 (WA	VE 6, 2019)
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total
	n=322	n=263	n=966	n=1562	n=606	n=356	n=1051	n=2121
Clinical psychologists	162 (45.4%)	129 (44%)	479 (44.4%)	775 (44.5%)	323 (44.3%)	190 (44.4%)	601 (43.4%)	1176 (43.9%)
Psychologists	173 (48.4%)	139 (47.4%)	530 (49.2%)	849 (48.7%)	365 (50%)	214 (50%)	677 (48.9%)	1318 (49.1%)
Social workers	12 (3.4%)	19 (6.5%)	51 (4.7%)	83 (4.8%)	31 (4.2%)	20 (4.6%)	84 (6.1%)	148 (5.5%)
Occupational therapists	-	-	-	15 (0.9%)	-	-	-	21 (0.8%)
GPs/OMPs ^{b,c}	-	-	-	19 (1.1%)	-	-	-	20 (0.7%)
			ALSW	Н 1973-78 СОН	ORT			
	ANALYSIS	1: T0 (WAVE 6, 1	2012) – T1 (WA	VE 7, 2015)	ANALYSIS	2: T0 (WAVE 7,	2015) – T1 (WA	VE 8, 2018)
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total
	n=104	n=115	n=308	n=540	n=110	n=135	n=347	n=646
Clinical psychologists	49 (41.2%)	53 (43.1%)	155 (43.4%)	263 (42.9%)	55 (45.9%)	61 (41.2%)	171 (43.9%)	311 (43.4%)
Psychologists	56 (47.1%)	59 (48%)	175 (49.1%)	297 (48.5%)	54 (45%)	70 (47.3%)	189 (48.5%)	341 (47.7%)
Social workers	12 (10.1%)	-	20 (5.6%)	42 (6.9%)	-	13 (8.8%)	20 (5.1%)	46 (6.4%)
Occupational therapists	-	-	-	-	-	-	-	-
GPs/OMPs ^{b,c}	-	-	-	-	-	-	-	-
			ALSW	Н 1946-51 СОН	ORT			
	ANALYSIS	1: T0 (WAVE 7, 1	2013) – T1 (WA	VE 8, 2015)	ANALYSIS	2: T0 (WAVE 8,	2015) – T1 (WA	VE 9, 2019)
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total
	n=44	n=60	n=166	n=278	n=37	n=41	n=158	n=254
Clinical psychologists	12 (27.3%)	27 (40.9%)	67 (37.7%)	108 (36.5%)	12 (30.8%)	15 (31.3%)	56 (32.7%)	91 (33%)
Psychologists	28 (63.6%)	34 (51.5%)	92 (51.6%)	160 (54.1%)	24 (61.5%)	28 (58.3%)	100 (58.5%)	160 (58%)
Social workers	-	-	15 (8.4%)	22 (7.4%)	-	-	11 (6.4%)	19 (6.9%)
Occupational therapists	-	-	-	-	-	-	-	-
GPs/OMPs ^{b,c}	-	-	-	-	-	-	-	-

- Suppressed

a. Participants may have seen more than one type of provider

b. Other medical practitioners

c. Better Access MBS items for Other medical practitioners were introduced progressively after 1 July 2018

Out-of-pocket costs

Table 8.9 profiles the out-of-pocket costs paid by participants who received Better Access treatment services. Across the board, somewhere between half and three quarters of these participants paid at least some out-of-pocket costs, usually paying somewhere between \$80 and \$100 per session. For the Ten to Men cohort and the ALSWH 1989-95 cohort, the proportion increased as a function of time, with more paying out-of-pocket costs in Analysis 2 than did so in Analysis 1. This pattern did not hold for the ALSWH 1973-78 and 1946-51 cohorts, however; their proportions remained more consistent across analyses.

There was some evidence of a relationship between out-of-pocket costs and level of severity. In general, participants in the "minimal/mild" group were more likely to pay out-of-pocket costs than those in the "severe" group.

	ANALYSIS	1: T0 (WAVE 1) 2015	, 2013/14) – T1 5/16)	(WAVE 2,	ANALYSIS 2:	TO (WAVE 2, 20	15/16) – T1 (WA	VE 2, 2020/21)
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total
	n=80	n=47	n=93	n=243	n=190	n=53	n=103	n=358
% incurring any out-of-pocket costs	52 (65.0%)	29 (61.7%)	28 (30.1%)	117 (48.1%)	129 (67.9%)	38 (71.6%)	53 (51.4%)	226 (63.1%)
Median out-of- pocket cost per	\$71.4 (\$50.2- \$86.7)	\$63.9 (\$21.2- \$82.7)	\$61.9 (\$35.4- \$85.6)	\$63.9 (\$36.1- \$82.7)	\$74.9 (\$53.3- \$95.6)	\$69.0 (\$45.7- \$81.5)	\$63.4 (\$40.6- \$78.1)	\$69.7 (\$48.3- \$89.7)
30331011 (1011)	Ş80.77	902.77	AI SW/	902.77	999.07 ORT	Ş61.57	<i>Ş</i> 70.1)	
		1 · TO (WAVE 1	2013) – T1 (WA	VF 3 2015)		2. TO (WAVE 3	2015) – T1 (WA	VE 6 2019)
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total
	n=322	n=263	n=966	n=1562	n=606	n=356	n=1051	n=2121
% incurring any out-of-pocket costs	210 (65.2%)	161 (61.2%)	511 (53%)	889 (56.9%)	467 (77.1%)	262 (73.4%)	743 (70.7%)	1555 (73.3%)
Median out-of- pocket cost per session (IQR) ^a	\$66.9 (\$42.7- \$91.8)	\$61.1 (\$45.9- \$86.7)	\$64.4 (\$46.0- \$88.5)	\$65.4 (\$45.3- \$88.5)	\$81.9 (\$62.9- \$101.6)	\$77.7 (\$59.6- \$97.8)	\$71.6 (\$50.2- \$88.5)	\$75.4 (\$55.4- \$95.3)
			ALSW	Н 1973-78 СОН	ORT			
	ANALYSIS :	1: T0 (WAVE 6, 2	2012) – T1 (WA	VE 7, 2015)	ANALYSIS	2: TO (WAVE 7,	, 2015) – T1 (WA	VE 8, 2018)
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total
	n=104	n=115	n=308	n=540	n=110	n=135	n=347	n=646
% incurring any out-of-pocket costs	85 (81.7%)	88 (76.5%)	214 (69.5%)	396 (73.3%)	87 (79.1%)	102 (75.5%)	232 (66.8%)	460 (71.2%)
Median out-of- pocket cost per session (IQR) ^a	\$63.3 (\$42.4- \$86.7)	\$60.1 (\$44.6- \$81.9)	\$63.0 (\$44.6- \$83.7)	\$62.5 (\$43.2- \$83.7)	\$69.7 (\$51.7- \$85.8)	\$69.9 (\$56.6- \$94.4)	\$69.3 (\$49.3- \$90.0)	\$69.7 (\$51.7- \$90.0)
	1		ALSW	Н 1946-51 СОН	ORT			
	ANALYSIS	1: TO (WAVE 7, 2	2013) – T1 (WA	VE 8, 2015)	ANALYSIS	2: T0 (WAVE 8,	, 2015) – T1 (WA	VE 9, 2019)
	Min/mild	Moderate	Severe	Total	Min/mild	Moderate	Severe	Total
	n=44	n=60	n=166	n=278	n=37	n=41	n=158	n=254
% incurring any out-of-pocket costs	26 (59.1%)	37 (61.7%)	78 (47.0%)	143 (51.4%)	22 (59.4%)	20 (48.8%)	72 (45.6%)	125 (49.2%)
Median out-of- pocket cost per session (IQR) ^a	\$65.0 (\$45.2- \$86.7)	\$60.1 (\$34.7- \$92.2)	\$51.9 (\$33.8- \$69.7)	\$55.9 (\$35.6- \$78.1)	\$64.8 (\$50.2- \$86.0)	\$48.7 (\$29.5- \$79.7)	\$51.7 (\$31.9- \$71.9)	\$51.9 (\$33.0- \$75.3)

Table 8.9: Out-of-pocket costs by study, cohort and analysis

a. Denominator = sessions at which an out-of-pocket cost was paid

Changes in mental health for users of Better Access treatment services

Figure 8.3 shows the change in mental health from T0 to T1 for participants who use Better Access treatment services in the intervening period. Typically, between around 45% and 55% of these participants had better mental health at T1 than they did at T0.



Figure 8.3: Changes in mental health over time, by study, cohort, analysis and measure





Significant deterioration No significant change Significant improvement



Significant deterioration No significant change Significant improvement ALSWH 1989-95 cohort, Analysis 2: K-10



Significant deterioration No significant change Significant improvement

ALSWH 1973-78 cohort, Analysis 2: CES-D



Significant deterioration No significant change Significant improvement



Figure 8.3: Changes in mental health over time, by study, cohort, analysis and measure (cont.)

60

50

40

30

20

10

0

70

Percentage

Significant deterioration No significant change Significant improvement



Significant deterioration No significant change Significant improvement



53

Significant deterioration No significant change Significant improvement

ALSWH 1946-51 cohort, Analysis 2: CES-D

ALSWH 1973-78 cohort, Analysis 2: GAD-7

30

50



Significant deterioration No significant change Significant improvement



Significant deterioration No significant change Significant improvement

The multivariable logistic regression analyses highlight key predictors of improvement and deterioration. Tables 8.10 and 8.11 summarise the findings from these and the results are reported in full in Appendix 16.

The most consistent predictor was prognostic severity at T0; across most cohorts and analyses, and irrespective of the measure chosen to assess change in mental health, those who were in the "severe" group at baseline were the most likely to demonstrate significant improvement and the least likely to demonstrate significant deterioration.

Of note, the number of sessions was also related to improvement and deterioration in some analyses for some cohorts, but not in the direction that might have been expected based on Studies 2, 3 and 4. In Study 5, compared with participants who had 1-2 sessions, those who had more sessions had lower odds of showing improvement and greater odds of showing deterioration.

Other variables were either not associated with improvement or deterioration in any analyses, or were inconsistently associated with improvement or deterioration in a small number of analyses only.

Table 8.10: Sociodemographic, clinical and treatment variables associated with improvement in mental health between T0 and T1^{a,b,c}

	TEN TO MEN ALSWH 1989-95 COHORT		SWH 9-95 IORT	ALSWH 1973-78 COHORT			ALSWH 1946-51 COHORT					
Measure	PH	PHQ-9 K-10		CES-D GA		GA	D-7 CES		S-D G		D-7	
Analysis	1	2	1	2	1	2	1	2	1	2	1	2
Mean age, years									\downarrow			
Highest level of education received ^d												
Year 12 or equivalent				1					1			
Bachelor's degree or higher				1								
Country of birth ^e												
Other			\checkmark	\checkmark	\downarrow			1				
Prognostic severity ^f												
Moderate				1	1	1			1			
Severe	1	1	1	1	1	1			1	1		
History of depression (lifetime) ^g												
Yes						\checkmark						
History of anxiety (lifetime) ^g												
Yes			1									
Number of treatment sessions ^h												
5-6							\checkmark					
7-10			\checkmark				\checkmark		\downarrow			
11-20		\downarrow	\checkmark			\checkmark	\checkmark					
21-100											\downarrow	
Received treatment from clinical psychologist ^g												
Yes										\checkmark		
Received treatment from psychologist ^g												
Yes				\rightarrow								
Paid any out of pocket cost ^g												
Yes				\uparrow	1				\uparrow			
Currently taking any medication for mental health ^g												
Yes			T									

a. Results from multivariable logistic regression

 Shaded cells indicate statistically significant results (white cells indicate that the results were not statistically significant); up arrows and down arrows indicate increased and decreased likelihood of Better Access treatment use, respectively

c. Model also controlled for First Nations status (Ten to Men only), area of residence, receipt of treatment from a social worker, receipt of treatment from an occupational therapist, receipt of treatment from a GP, and elapsed days between survey waves

d. Reference category: Year 11 or less

e. Reference category: Australia

f. Reference category: Minimal/mild

g. Reference category: No

h. Reference category: 1-2

Table 8.11: Sociodemographic, clinical and treatment variables associated with deterioration in mental health between T0 and T1^{a,b,c}

	TEN T	N TO MEN ALSWH ALSV 1989-95 COHORT		WH 1973-78 COHORT		ALSWH 1946		-51 COHORT				
Measure	PHQ-9		K-10		CES-D		GAD-7		CES-D		GAD-7	
Analysis	1	2	1	2	1	2	1	2	1	2	1	2
Mean age, years								1	1			
Highest level of education received ^d												
Year 12 or equivalent				\downarrow								
Certificate/diploma												
Bachelor's degree or higher				\downarrow								
Area of residence ^e												
Rural										1		
Prognostic severity ^f												
Moderate				\downarrow	\downarrow		\downarrow		\downarrow			
Severe	→		\checkmark	\downarrow	\downarrow	\rightarrow	\rightarrow		\rightarrow	\downarrow		
History of depression (lifetime) ^g												
Yes				\uparrow								
History of anxiety (lifetime)												
Yes	1											
Number of treatment sessions ^h												
3-4												1
5-6							1					
7-10							1		1		1	
11-20		1					1		1		1	
Received treatment from social worker ^g												
Yes		\uparrow										
Currently taking any medication for mental health ^g												
Yes			\downarrow									

a. Results from multivariable logistic regression

b. Shaded cells indicate statistically significant results; up arrows and down arrows indicate increased and decreased likelihood of improvement in mental health, respectively

c. Model also controlled for First Nations status (Ten to Men only), country of birth, receipt of treatment from a clinical psychologist, receipt of treatment from a psychologist, receipt of treatment from an occupational therapist, receipt of treatment from a GP, and elapsed days between survey waves

d. Reference category: Year 11 or less

e. Reference category: Metropolitan

f. Reference category: Minimal/mild

g. Reference category: No

h. Reference category: 1-2

Discussion

Summary and interpretation of findings

Study 5 followed Ten to Men and ALSWH participants identified as having mental health need over time and examined their use of Better Access treatment services. There was considerable variability in use across cohorts and over time, with the men in Ten to Men and the women in the ALSWH 1946-51 cohort making the lowest use of Better Access treatment services initially, with only a little over 10% using these services in Analysis 1. For the men in Ten to Men, this figure doubled by Analysis 2, but for the ALSWH 1946-51 cohort women it remained relatively stable. Around 25% of the women in the ALSWH 1989-95 and 1973-78 cohorts used Better Access treatment services in Analysis 1. This figure rose to 45% for the former group by Analysis 2 but remained the same for the latter group. The findings with respect to the ALSWH cohorts can be contrasted with those from an earlier study that considered Better Access uptake by the 1973-78 and 1946-51 cohorts early in the life of the program.⁹⁹ At that point, the uptake by women in both of these cohorts who reported mental health problems was around 10%, suggesting that those in the 1973-78 cohort may have become more inclined to seek mental health care as the program has continued.

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. Better Access users were more likely to fall into the "severe" prognostic severity group, 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. This issue has been identified in previous studies of Better Access use that have used ALSWH data,¹⁰⁰ and is likely to relate to the availability of the providers who offer Better Access treatment services in rural areas.

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. This finding is consistent with a previous analysis of data from women in the ALSWH 1973-78 cohort.⁶⁵ 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. Considering the duration of these periods, it might have been anticipated that median numbers of sessions would have been higher. For most of the time covered by Study 5, participants would have been eligible for 10 sessions of Better Access treatment per calendar year.¹ 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. Again, this would seem to be appropriate.

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.

The key predictor of improvement was prognostic severity; those in the "severe" group at baseline were the most likely to show improvement. Again, this is consistent with Studies 2, 3 and 4.

ⁱ Initially, consumers were eligible for up to 18 individual sessions of Better Access treatment in a calendar year (six, plus a further six following a GP review, and then a further six in exceptional circumstances, following a further GP review). The number of individual sessions was reduced from 18 to 10 from November 2011. However, there were community concerns regarding the impact of these changes on people with more complex needs, so a transitional arrangement was established for the period March to December 2012. This allowed for an additional six sessions of individual therapy to be provided in exceptional circumstances, for the 2012 calendar year only, giving a total maximum allowable number of 16 sessions in 2012. From January 2013, the maximum total was 10 individual sessions for all, until the additional 10 sessions were introduced in 2020.

Perhaps more surprising however, is that in some analyses greater numbers of sessions were associated with lesser likelihood of improvement and greater likelihood of deterioration. This may relate to the far longer time periods between waves of data collection, and the fact that participants' levels of symptoms and functioning and consequent needs for care may have varied considerably over time. Some people may have had a single episode of care whereas others may have had multiple episodes. In this context, number of sessions may have acted more like a proxy for greater fluctuations in mental health than as an indicator of treatment "dose".

Strengths and limitations

Strengths

Study 5 had many strengths. It drew on data from Ten to Men and ALSWH, two large longitudinal studies that provide representative samples of men and women in the general Australian population. These samples included men and women from across the adult age spectrum, enabling us to build on a previous longitudinal study that examined Better Access use for those aged 45 and over.¹⁰¹ We applied the same methods to the analysis of data from Ten to Men and ALSWH, which allowed us to identify convergent findings. This in turn increased our confidence in these findings.

Ten to Men and ALSWH were designed for purposes other than evaluating Better Access, so the likelihood of recruitment bias was reduced. Recruiting participants from the general population for a longitudinal study that was more specifically about mental health – or even more specifically about Better Access – might have introduced biases. Recruiting participants through mental health providers might also have had this effect.

Study 5 involved linkage between survey data and MBS records, which allowed us to determine with certainty whether participants had used Better Access treatment services and, if so, in what volumes and at what financial cost to them.

Limitations

Study 5 also had some limitations. There may have been some biases introduced due to loss-to-follow-up in Ten to Men and ALSWH. In both of these studies, there was attrition over successive waves. Those who dropped out may have differed from those who continued to contribute data, including on key variables relating to their mental health. Evidence for this sort of bias comes from a study on retention of women in the ALSWH 1989-95 cohort which showed that patterns of response to the various surveys were associated with a range of factors, including self-rated mental health.¹⁰²

Although we could identify participants' Better Access use, we could not gauge what other mental health services they might have accessed. We could have identified a certain amount of mental health care that was delivered through non-Better Access MBS items (e.g., psychiatrist items), but we could not identify mental health care delivered by GPs and billed against standard consultation items. We also could not identify mental health care delivered in other settings (e.g., through Primary Health Networks, via community health centres, in private hospital settings, or through public sector inpatient and community services). Our users of Better Access treatment services may have also been using many of these services, as may our non-users. Indeed, our non-users may potentially have been heavy users of some of these other services.

A consequence of this is that our comparison group of non-users of Better Access services may have been quite heterogeneous. We were unable to split this group into those who used other mental health services and those who used no mental health services. Study 4 did do this, however.

Most of the study periods did not extend beyond 2019, which limited our ability to consider the changes to Better Access that were made in the context of the COVID-19 pandemic (e.g., the additional 10 sessions).

We classified participants into different prognostic severity groups using algorithms that were used in the Target-D and Link-me randomised controlled trials. We did the same in Study 4, but because that study used data from these trials, the classification was straightforward. In Study 5 we did not always have the same variables available to us as were used in the original algorithms, which meant that we had to use proxy variables. These generally had good face validity and the resultant allocation to prognostic severity groupings corresponded reasonably well to Target-D and Link-me. However, the algorithms were imperfect.

The mental health measures were completed at set points in time (i.e., at survey waves), rather than at the beginning and the end of Better Access episodes. The time between waves was lengthy, and participants' mental health may have been influenced by many other factors, over and above their experience with Better Access. This may have explained the finding regarding the direction of the relationship between session numbers and improvement or deterioration, which stood in contrast to that from the other studies. We could potentially have looked at the time between the T0 assessment of mental health and the first instance of Better Access use, and the time between the last instance of Better Access use and the T1 assessment of mental health. However, this would have required us to structure the datasets in a different way, and group Better Access services into episodes. Time constraints meant that this was beyond the scope of the current study.

We used various criteria to select the covariates in our logistic regression analyses, including making sure that the same (or very similar) variables were captured across all four cohorts. We also opted for simple models, and tried to maximise stability and minimise multicollinearity. It is possible, however, that we could have chosen other covariates that might have been more strongly associated with Better Access use or outcomes. For example, we chose level of education as our key indicator of socioeconomic status, partly because employment status might have been less relevant to the ALSWH 1946-51 cohort (many of whom would have been retired by the survey waves we considered). Alternative indicators, such as concession card status were not available across all cohorts.

Conclusions

The above limitations aside, Study 5 provides additional insights into who uses Better Access and how they use it. It suggests that increasingly higher proportions of those with mental health needs are accessing Better Access treatment services, although perhaps not in equivalent numbers across all segments of the population. In general, access seems to be related to clinical need; relatively high numbers of users of these services can be classified as having severe current mental health problems, and many have a previous history of depression and/or anxiety. However, there is evidence that in rural areas with equivalent levels of need to their metropolitan counterparts are missing out. Over time and on average, those who do use Better Access treatment services have a fairly modest number of sessions, most commonly seeing clinical psychologists and psychologists. Most pay a co-payment, and this is usually somewhere between \$80 and \$100 per session. Significant proportions of those who receive Better Access treatment services in their mental health over time, particularly those who have severe mental health problems prior to treatment.

9. Study 6: Qualitative interviews with people with lived experience of mental illness

Introduction

Study 6 took the form of individual qualitative interviews with people with lived experience of mental illness. We sought to interview consumers who had received focussed psychological strategies or psychological therapy services from psychologists, social workers and occupational therapists via Better Access during 2021, and individuals with mental illness who had not utilised Better Access services throughout 2021. Study 6 was designed to complement the Study 3 survey of consumers. It set out to offer an in-depth exploration of the consumer experience and include the voices of people with lived experience of mental illness who had not used Better Access.

Methods

Study design

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.

Sampling, recruitment and interview procedure

A call for expressions of interest (EOI) to participate in the study was circulated by Beyond Blue to Blue Voices (their lived experience network) and Lived Experience Australia to their membership (see Appendix 17). Our original proposal only involved recruiting through Beyond Blue but we expanded our approach to include Lived Experience Australia on advice from the SEG.

To be eligible, people had to have a lived experience of mental health conditions. Interested individuals were asked to complete an online EOI form (see Appendix 18). The EOI form made it clear that we were interested in talking to people who had and hadn't received treatment services through Better Access, and explicitly asked whether "In the past year, did you receive treatment services from a psychologist, social worker or occupational therapist that were paid for, at least in part, by Medicare?"

Potential participants were asked to provide some basic sociodemographic information on the EOI form, as well as information on their mental health diagnosis mental health and wellbeing over the previous year. The EOI form remained live for a period of three weeks. Once the EOI period had closed, we contacted participants via email or telephone to answer any questions they had and to arrange a mutually agreeable time for an interview. We initially created a preferred list of potential participants that ensured that our sample would be as varied as possible in terms of sociodemographic and clinical characteristics. We contacted the individuals on this list first. However, many of them did not respond to this contact, so we ultimately contacted all eligible individuals who had submitted an EOI. All individuals who indicated they would like to proceed to an interview at that initial contact were emailed a copy of the plain language statement (see Appendix 19).

Interviews took place between January and March 2022. Interviews were conducted via Zoom or telephone due to the desire to recruit participants Australia-wide and the uncertainties around travel and face-to-face meeting in general due to COVID-19. Interviews were conducted by two experienced qualitative researchers on our team (DN and MW). At the time of the interview, the interviewers confirmed that the participant had received the plain language statement, summarised the key points of this document, and answered any questions the participant may have had. Participants were asked to

provide their verbal consent to being interviewed and to the interview being recorded (see Appendix 20). All participants consented to the interview being recorded.

The interview schedule

Separate interview schedules were created for users of Better Access and non-users of Better Access. Each interview schedule was semi-structured and went through a number of iterations, with questions being modified on the basis of comments from the Department of Health, the CAG and the SEG. The final versions of the two interview schedules are included as Appendix 21 and Appendix 22.

Participants who had used Better Access were asked about the accessibility of the program, the appropriateness of the services received under the program, the outcomes of their participation, and their views on potential improvements for the program. Participants who had not used Better Access were asked about the accessibility of the program and its appropriateness, the outcomes of alternative treatment pathways they used, and their views on potential improvements to the Better Access program. Because Study 6 expressly aimed to capture the input of those living with mental illness and their experience of engaging with treatment services, both groups were asked about their personal experience of mental illness.

Data analysis

Individual interviews were transcribed by a professional transcription company and uploaded to NVivo 12 for analysis. Thematic analysis of the interviews was undertaken by the two researchers who conducted the interviews (DN and MW). They initially used the interview schedule to deductively identify key themes and develop a coding framework that captured the full range of responses. The preliminary coding framework was shared with the evaluation coordinator (DC) in order to ensure that the framework adequately addressed key research questions. The two researchers then independently coded two of the interviews and determined their level of agreement. The framework was further refined and finalised addressing any areas of disagreement.

Approvals

The University of Melbourne Human Research Ethics Committee approved the study (HREC 2022-22921-26065-4).

Acknowledgements

We would like to acknowledge Beyond Blue and Lived Experience Australia for assisting us with recruiting participants for Study 6. We would also like to thank the participants themselves for willingly sharing their experiences.

Results

Sample description

In total, 56 individuals submitted an EOI to participate in Study 6. Two of these individuals did not meet the eligibility criteria. All individuals who submitted an EOI were contacted. Seventeen people were unresponsive to initial contact and/or arranging a mutually agreeable time for an interview. Interviews were conducted with 37 participants. Twenty of these initially identified as Better Access users and 17 as non-users, but once we began the interviews it became apparent that three of the non-users had actually made use of Better Access services. This meant that our final sample included 23 Better Access users and 14 non-users.

Data from participant EOI forms provides an overview of sample sociodemographic and clinical characteristics (see Table 9.1). Most participants in the user and non-user groups were female (83% and 86%, respectively). Better Access users were mostly in the 18-29 age group (30%) whereas non-users were mostly in the 50-59 age group (36%). Most Better Access users were from South Australia (22%) and Victoria (22%). The majority of non-users were from Victoria (43%). Only one participant within the Better Access user group identified as First Nations. None of the participants in the non-user group identified as First Nations. None of their cultural background in their own words. The majority of participants in both the user and non-user groups described their cultural background as Australian (48% and 36%, respectively). Most participants in both user and non-user groups spoke English at home (91% and 93%, respectively).

		USERS OF BE	TTER ACCESS	NON-USERS OF		
				BETTER	ACCESS	
		FREQUENCY	%	FREQUENCY	%	
Sex	Female	19	82.6	12	85.7	
	Male	4	17.4	1	7.1	
	Non-binary	-	-	1	7.1	
Age	18-29	7	30.4	2	14.3	
	30-39	5	21.7	3	21.4	
	40-49	2	8.7	3	21.4	
	50-59	3	13	5	35.7	
	60-69	5	21.7	1	7.1	
	70+	1	4.3	-	-	
State of	New South Wales	4	17.4	2	14.3	
residence	Queensland	4	17.4	1	7.1	
	South Australia	5	21.7	2	14.3	
	Victoria	5	21.7	6	42.9	
	Western Australia	4	17.4	3	21.4	
	Tasmania	1	4.3	-	-	
First Nations	First Nations	1	4.3	-	-	
status	Not First Nations	20	87	14	100	
	Prefer not to say	2	8.7	-	-	
Cultural	Australian	11	47.8	5	35.7	
background ^a	Australian/American/Chilean	1	4.3	-	-	
	Caucasian	1	4.3	-	-	
	English/Irish	1	4.3	-	-	
	German	1	4.3	-	-	
	Greek	1	4.3	-	-	
	African	-	-	1	7.1	
	Italian Australian	1	4.3	-	-	
	Jewish Australian	1	4.3	-	-	
	American/Australian	-	-	1	7.1	
	Australian/German/Scottish/	-	-	1	7.1	
	Welsh					
	Canadian First Nations	-	-	1	7.1	
	Egyptian	-		1	7.1	
	Estonian/Australian	1	4.3	_	_	
	European	-		1	7.1	
	Sri Lankan	-	-	1	7.1	
	Missing	4	17.3	2	14.2	
English spoken	Yes	22	95.7	13	92,9	
at home	No	1	4.3	1	7.1	
Ever been given	Yes	23	100	13	92.9	
a mental health	No					
diagnosis	Unsure	-	_	1	7 1	
Mental health	Anxiety	17	72 0		42 9	
diagnosis	Depression	19	82.6	8	57.1	

Table 9.1: Sociodemographic and clinical profile of participants

		USERS OF BE	TTER ACCESS	NON-US BETTER	NON-USERS OF BETTER ACCESS		
В	ipolar	4	17.4	3	21.4		
E	ating disorder	2	8.7	1	7.1		
Р	ersonality disorder	2	8.7	5	35.7		
P (F	ost-traumatic stress disorder PTSD)	10	43.5	9	64.3		
P	sychotic disorder	-	-	1	7.1		
S	ubstance use	-	-	2	14.3		
0	other	3	13	3	21.4		

a. Free text response

Participants were asked the following question: "On average, how would you rate your mental health over the last year?" Participants were asked to rate their mental health on the same scale that we used in Study 3. This scale runs from 1-10, with 1 representing the worst possible mental health and 10 representing the best possible mental health. Users of Better Access rated their mental health on average over the last year between 2 and 8 (M=4.61, SD=1.97). Non-users of Better Access rated their mental health health on average over the past year between 3 to 7 (M=5.38, SD=1.45).

Participants were also asked whether they had ever been given a mental health diagnosis. All participants in the Better Access user group said they had been given a mental health diagnosis and all except one participant in the non-user group said they had been given a diagnosis at some point. Among Better Access users, diagnoses of depression (82.6%), anxiety (73.9%), and post-traumatic stress disorder (PTSD; 43.5%) were most common. Among non-users, the same diagnoses topped the response list, although they were listed in a different order: PTSD (64.3%); depression (57.1%); and anxiety (42.9%).

Users of Better Access

Participants who had used Better Access discussed their experiences with doing so. They noted the type of provider they had seen, discussed various elements of the referral process, talked about the format and number of sessions, and highlighted barriers and enablers to use. They also discussed the mental health conditions and other reasons that led to their seeking mental health care, and the outcomes of their care. In addition, they reflected on future reforms that might be made to Better Access. More detail is provided below.

Type of provider

All participants said they had seen a psychologist through Better Access in the past year. No participants reported seeing an occupational therapist or a social worker.

Reasons for seeking care

Participants were asked what prompted them to seek care from a mental health professional in the last year. Many participants sought mental health care for a long-standing mental health issue. Some were prompted to seek help through an experience of grief, chronic pain or a traumatic event. Some made the decision by themselves, whereas others were prompted by their family members or friends, or were referred by their acute mental health care team or psychiatrist.

Referral process: Accuracy of mental health treatment plan

The majority of participants were given a copy of their mental health treatment plan. Among those who read their plan, most reported that they felt that it was an accurate representation of the way they were feeling.

"Yeah I did read it and it was pretty accurate." (DN13)

"So I don't remember the exact detail but I know relative to the state I was in at the time I think it matched up..." (MW15)

However, several participants felt that their plan was "vague" or haphazardly put together due to the GP's time constraints.

"... some of them have felt just rushed and thrown together ... I try to remember they are a GP and this isn't their field they're just trying to help put it together and give you the right access to what you need ..." (DN19)

"I feel like GPs don't have the time to put a lot of effort into actually creating a really, really detailed comprehensive treatment plan or care plan or whatever you want to call it ... I think the more detail that that professional can have about me prior to my first appointment is important ..." (MW10)

"Yeah I did read the plan, I think I guess the nature of GP appointments is they are quite quick so they probably don't capture the extent of the concern or how you're feeling, but I guess at a surface level they capture I guess the bare minimum details." (DN12)

One participant expressed concern that their mental health treatment plan did not include an up-to-date list of their medications.

"I find it frustrating sometimes because as someone who is a chronic user of the – when I'm really unwell I need to use the healthcare system, a combination of public and private quite regularly and also GPs and primary healthcare as well and so there's a lot of information that these various organisations or health entities have about me and it frustrates me because when I receive my mental health care plan and I can actually look at it and review it my medication never seems to be accurate or up to date and tends to have old medication listed on there because along with my treatment I get put on different medications and get taken off medications and the context of me having the Better Access scheme for many, many years is really relevant because I think that's a really important part of my overall experience of the scheme." (MW10)

Another participant described how the GP's recommendations in their plan had been misleading and had led to some confusion with their treating psychologist.

"... so for example with my last mental health plan I know that my GP in relation to work, because I did, I am unhappy in my work and it's not a healthy work environment particularly for someone with anxiety, she kind of said in my mental health plan that she'd like my psychologist to explore some kind of career coaching with me, to look at alternative options for employment. And so that went back to my psychologist and she was quite perplexed and said you know I'm a psychologist I'm not a career coach. You know so I'm not sure what your GP is intending or what you want to get out of our sessions, but you know I can certainly give you tools to deal with the current environment that you're in, and of course I understand that it's a stressful environment and I would encourage you to think yourself about alternatives, but I'm not a career coach. So I guess there can sometimes, because back and forth is very surface level between them ... the reality is my psychologist has spent you know hundreds more hours with me than my GP ever will, she's aware of the very complex nature of my condition and I guess you know GPs aren't specialists, so they don't necessarily specialise in something like OCD, and it can maybe feel difficult to write a mental health plan around a complex condition like that, in you know a 15 minute consult. So they're obviously looking for a quick recommendation that they can make." (DN12)

Referral process: Context of receiving mental health treatment plan

Most participants reported that they had made an appointment with their GP specifically to request a mental health treatment plan. For some, this was an extension of a pre-existing plan.

"... essentially I just said to him I need to have new mental health care plan and he gave me the K10 and gave me the paperwork." (MW10)

"Yeah I was fully aware of the procedure so I was going through depression and anxiety at the time and so I booked an appointment with my GP and told him that I wanted to see a psychologist and get the mental health care plan for the purpose of rebates and he was fine with that." (MW05)

"The more recent ones I've gone specifically for it, that's the only reason I'm seeing a GP just to get the mental health care plan." (MW18)

Several participants indicated that they were prompted by another person (e.g., family member, friend) to seek a mental health treatment plan from their GP.

"It was my parents; it was my mum who took me to see the GP ..." (MW18)

"Yeah so I was, I guess I was referred into the process. I didn't know necessarily about Better Access at the time that I went to the GP, I was in the midst of a severe period of anxiety, but I didn't know that that's what it was at the time. A friend booked an appointment for me with my GP because I guess she could see what I couldn't see. I went to the GP and I didn't really know what the options were for me or what was going to happen really, so I was kind of just referred into the process and told that mental health plan would be written up for me and I was referred to a particular preferred psychologist ..." (DN12)

Referral process: Prior relationship with GP

Although most participants had an existing relationship with the GP who wrote their mental health treatment plan, some saw a new GP for their plan.

Referral process: Choice of mental health professional

Most participants did not have a specific mental health professional in mind when they received a mental health treatment plan from their GP. Most were referred to a psychologist selected by the GP.

"I just went with the recommended psychologist. I mean thankfully for me that psychologist was a great fit for me and it's still the psychologist that I see to this day, so I think I was very lucky." (DN12)

"...the practice I go to is like, I don't know what you'd call them in the medical world, but they've got like an in-house psychologist's room, and then they've got a pathology and then they've got, I don't know what the other three rooms are, but they're like specialist people. So no, my GP had someone on site already. But I don't know if I had a choice, I wasn't sure if I had a choice ... So yeah, so I went to the one that the GP suggested ..." (MW12)

"... [the GP] referred me to someone in particular that he thought I would work well with." (MW15).

One participant reported that their GP provided them with a list of recommended psychologists and encouraged them do their own research to determine which one would be the best fit for them.

"So when I went to see my GP I said I didn't really know who I wanted to see and he gave me a list of all the popular local psychologists and said these are the people you can look through that I can recommend and you decide who you want and so yes I decided and I knew who I wanted but I did get a bit of guidance from the GP, not a direct referral but just a recommendation." (MW05)

Several participants requested to see a psychologist they had seen previously. Others took the initiative of choosing their own psychologist. Among those participants who found their own psychologist, driving factors were the psychologist's location, their availability, their willingness to bulk-bill, and the relevance of their skill set to the participant's specific issues.

"... I honestly based it on sort of geographic things – but it turned out to be a really good match." (MW15)

"...I was just looking and wanting to find one that was available – so yeah I booked in for yeah just based on the fact that there was like an appointment available." (DN18)

"But finding her, oh I did ring a lot of psychologists, mainly in my local area, but they all charged that gap thing, and I thought no, I've never had to pay this gap thing before, so it took me a while to find one without that gap thing." (MW06)

"Well I guess when I searched for them online I made a little short list and then I called maybe, I don't know, three to five people. It was a bit of sort of list of questions that I had specific to my issues. [I] had a conversation with some of them, and then basically picked the one where I felt most comfortable based on that one little conversation over the phone, and I'm very, very lucky that it actually worked out really well ... I have social anxiety and things and I absolutely hate phone calls, so it was very challenging for me to do that. But having said that, I wouldn't, I don't think I would've been comfortable just going with somebody my GP or anybody else recommended." (DN20)

Several participants were referred to their current psychologist by their psychiatrist or their previous psychologist.

"... the psychiatrist recommended somebody to me and so I went to see her." (MW09)

"...his [psychiatrist] recommendation was this particular counsellor to work on an element of what I was trying to move through if you like." (DN04)

"I couldn't see her [previous psychologist] anymore so I was quite fortunate in that she had a colleague who she put me on to so that's how I got onto the current psychologist I am working with ..." (DN14)

Several participants reported that they had seen a number of psychologists before finding one who was the right fit.

"I found one [psychologist] and then I had to go through a couple to find who I was happy with." (DN05)

Referral process: Smoothness of referral process

Most participants reported that the referral process had been smooth.

"... I'm quite fortunate that I have a very empathetic, thorough GP, so the process has always been quite good for me." (DN12)

"... from the start it was fairly easy. I went to him, I asked ... it was just a very quick – give minute maybe – conversation ... and I searched for my own psychologist and just told him I want a referral for this person, and that was it. So very easy and stress free." (DN20)

The referral process was particularly smooth for those participants who had obtained previous mental health treatment plans. These individuals were already familiar with the process and GPs were seen as having the benefit of having prior information to hand.

"I have done it a few times before so a lot of the information was kind of already there, but it was just like quick questions like K10 and you know how has my sleep been, memory that kind of thing." (MW08)

However, several participants experienced difficulties with the process. Some experienced administrative- issues.

"Yeah I found – I had trouble at times with like them giving referrals to the wrong places and stuff and having to chase that up but then I found out later that you don't even need a referral you just need like the mental health care plan for I guess most places – yeah so at times it wasn't easy..." (DN18)

"... just trying to get the right information to the psychologist can be a bit of a hassle sometimes and what they need for Medicare and what numbers or whatever, I mean it goes above my head so to speak but sometimes there seems to be a bit of a hassle." (DN14)

"... I wasn't happy with that GP surgery I was seeing as well, the receptionists there were terrible, you know you'd ring up and say oh can you see if my GP has sent my new mental health plan to my psychologist, and they'd never ring back and confirm or deny, yeah." (MW06)

One participant was frustrated by the wait time to see their GP.

"...it was a pain in the arse, yeah trying to get a hold of the doctor was a pain ..." (DN05).

Another participant felt that their GP seemed inexperienced in completing a mental health treatment plan.

"...it was almost like she'd never done one before you know. Yeah, she was a little bit aaah, who's your psychologist and she kept re-asking me the questions all the time and I think she was confused how to fill out the mental health plan, and then where to send the information to, and it, yeah." (MW06)

One participant found it emotionally distressing having to 'open up' to their GP at the risk of feeling overwhelmed.

"Oh yeah quite upsetting yeah just upsetting in my own ways like about how I feel – about having to open up again that's basically it ... once it starts it sort of I go deeper yeah." (DN09).

Another participant spoke about a prior traumatic experience with approaching a GP for a mental health treatment plan. The practice receptionist had recommended this GP as someone particularly skilled in mental health. The GP provided the plan, but the participant was left feeling vulnerable, ashamed, and in doubt as to whether they were sufficiently in need of a plan.

"Yeah so they kind of told me that I needed to be happier and let all my trauma go, that I don't really need to be, like you shouldn't focus on being sad, just kind of a lot of comments like that around psychology being a waste of time and me choosing to feel this way ... Yeah, and it's really

unfortunate because it feels very vulnerable for me to be talking about my mental health and they had a good understanding of my other experiences, so yeah. And then she wanted to ask more questions about, what was it, because I'd mentioned that I have a difficult relationship with my parents, and then they'd ask for more information, examples, and I'm kind of like I kind of don't want to talk more about that. Because I knew it wasn't relevant to the care plan, but yeah just with all the kind of comments, it was a really awful experience ... I kind of went home and I was like 'I don't want to feel this way' ..." (DN11)

Communication between mental health professional and GP

Around half of the participants felt that their GP and their psychologist communicated appropriately with each other.

"... so they wrote to each other, that sort of thing ... there was discussion there, there was nothing that suggested that things were falling through the cracks or yeah they weren't aware of what was going on in terms of the whole situation – psychologist based treatment or medication – like no one was in the dark. (MW15)

"And there has been a time when I was going through a particularly difficult period, and I wasn't on antidepressants at the time, and my psychologist, I said something about at some point I think I might have to look at it, and my psychologist offered to ring the doctor for me, and I trust him enough to do that. So I'm quite happy with the communication." (MW17)

However, a similar number of participants were not aware of any communication between their GP and psychologist.

"I don't think they communicated. He filled out the form, sent the form to her and she just told me that she'd received the form. That's basically it ..." (DN13)

"No I don't think, it doesn't like stand out to me as there being a heap of communication. I guess more of just the like follow the steps and the process ..." (DN18)

Format of sessions: Face-to-face

Face-to-face sessions were strongly preferred by most participants. Being face-to-face meant that the consumer and the psychologists could pick up on each other's body language and non-verbal cues. Participants also felt that being face-to-face made it easier to develop rapport and establish trust with their psychologist.

"... with a counsellor it's just a better experience if it's actually with that person and then you have the benefit of all of their body language and they have the benefit of all of my body language instead of just someone's face you know it's just not the same especially if you're particularly upset." (DN04)

because my sessions have been quite emotional, it felt in person has felt better and I feel that my psychologist has been able to probably pick up on things that might not translate through telehealth. You know body language and things like that. Yeah I think that's definitely my preference." (DN12)

Participants also felt that face-to-face sessions gave them the opportunity to engage with their psychologist in a separate space where their confidentiality was protected and there were no interruptions.

"Yeah I definitely prefer face-to-face. I think, I don't know, it feels safer somehow, I know that's probably an odd word to use, but it feels yeah I find often with telehealth you know because I live with other people it can be difficult to find, to carve out time that's private and that won't be overheard, and when it's in person I know that there's like this little cocoon that we're in for that time, and you know I won't be interrupted and I won't be overheard, and I know that whatever we discuss is just between us ..." (DN12)

"... if I go face-to-face I'm in her office at the clinic and it feels like it's a protected safe space ..." (MW10)

Format of sessions: Telehealth

Although face-to-face sessions were generally preferred, telehealth sessions were generally seen as an acceptable second-best option when face-to-face sessions were not possible. Telehealth sessions were seen as particularly acceptable under certain circumstances (e.g., when distance was an issue).

"... [it] means that you actually can have a consultation ... it's better to have a consultation than no consultation." (DN13)

"It's been great, it turned out really good actually – we do it by video link yeah so that took a bit of getting used to to start with ... it's not as good as seeing somebody face-to-face for my particular problems but we've managed to cope with it..." (DN14)

"I think I'd always prefer face-to-face but it is very convenient to be able to see her via Zoom because it saves travel time, because when I saw her in Sydney it was 1½ hours door to door with public transport ..." (MW18)

Some found telehealth sessions to be preferable when they were experiencing high levels of anxiety and were struggling to leave the house.

"...I get anxious and that's the other reason why sometimes it's better to do it online because if I'm having an anxiety attack about leaving the house you know so there's some really good things ..." (DN13)

"...twice was because I could have gone in person and just couldn't like for personal you know my anxiety was through the roof and I just didn't feel like I could leave the house and it's just nice to have that option." (DN04)

On the flip-side, several participants commented that telehealth sessions could be "impersonal."

"The video session feels weird ... you're in your own home and you're talking about really personal like sometimes distressing shit and you're talking to a computer like it just feels a bit depersonalising in a way." (MW10)

"Oh I didn't like it. It just seems very impersonal to me." (DN15)

Several participants found telehealth sessions to be unsatisfactory due to technological issues.

"... I think telehealth has its challenges. I mean if I was doing it today if I was having a session with her today my internet would not ... I don't think it would cope like it's barely coping with this and so imagine if you're in the middle of talking about something really like traumatic and it's just like your internet connection's unstable and the Zoom just kicks you out like it did to me before." (MW10) "... I think I worry about being dysregulated and having...a Zoom issue and then all of a sudden like she's cut out..." (DN11)

"Internet issues obviously make it difficult ... the reception itself is bad, Zoom or Skype constantly freeze or people can't hear me or it lags by up to a minute ..." (DN20)

One participant noted that the technology associated with telehealth exacerbated their anxiety.

"Having PTSD anxiety is my constant companion, so I always worry am I clicking in at the right time, am I you know what I mean? So don't want to do the wrong thing. So that would be the main thing." (MW17)

Format of sessions: Phone

Several participants spoke positively about phone sessions.

"No problems at all, it means I can smoke or have a coffee or something like that – but I tell them that's what I am doing ... It didn't worry me whether it was via video or a phone and phone just seemed to work so yeah." (DN05)

"It didn't worry me one way or the other, I mean it's always pleasant to see somebody's face when you're talking to them, but we've had no trouble on the phone, because we sort of know each other through all the sessions, so I'm not worried about doing telephone sessions." (MW09)

Several participants appreciated having the option of phone sessions when anxiety made it difficult for them to leave the house.

"... sometimes I do struggle to get out of the house, so it's really convenient that I don't have to necessarily." (DN20)

"...sometimes if I'm just having a really chronic anxiety moment and I don't want to go anywhere I still feel like it's great that you can access that support without you know having to get in a car and drive and make lots of decisions ... so it's like, 'Well do I have the energy to get in the car and drive for an hour?' Sometimes I don't have that emotional energy but I do have the emotional energy to take a phone call ..." (DN04)

However, one participant indicated that telephone sessions increased their anxiety.

"... I feel that yeah telehealth and stuff like that is a bit awkward – for me especially I get a bit anxious with phone calls and things – so it takes me a bit to work up to doing that ..." (DN19)

Another participant person found phone sessions to be problematic due to concerns about privacy and technological issues.

"... when I was on the telephone I found it a lot more tricky because I had to be a lot more aware of my surroundings, whether I would be overheard by my housemates, whether the call would drop out, etc. So even though the service and the delivery of the therapy was probably still the same because of the different environment I felt that I didn't get the full benefit." (MW05)
Group sessions

None of the participants had group-based psychological support under Better Access. When asked if this was something that would interest them, the majority stated that it would not. The primary reason for this was a stronger preference for individual sessions.

"... I wouldn't want to use group therapy rather than my individual therapy." (DN11)

"... I know it sounds funny but my mental health is all about me not about someone else's mental health." (DN13)

"... look for me it's too personal, and I suppose I'm being selfish, I want their undivided attention on me ..." (DN15)

Several participants had negative prior experiences with group therapy.

"... when I first started therapy I was in a group for two years. I have complex PTSD and back when I was 29 years of age they didn't connect PTSD to the sorts of traumas that I've experienced, so consequently there was a lot of damage done for me in those two years ... so I'll never do it again, ever. There are some people that it's not suitable for." (MW17)

Others did not feel that they would derive any comfort or benefit from shared experiences with others.

"No, I've only ever done group when I was in hospital and I hated it ... I've just never sought comfort from knowing that other people are experiencing what I'm experiencing and I just think that's really shit that other people have to experience what I'm experiencing so it doesn't make me feel better that there's more than one. I don't find that sort of solidarity in understanding that it's common. I understand why it has merit but it's just not something I've ever been interested in." (DN04)

Number of sessions

Most participants felt that the number of Better Access sessions they had with their psychologist were too few, particularly for those with more complex or "serious" mental health issues.

"So yeah I guess like with me I feel complex with my mental health history, but I feel like it's too few even if you don't have a complex mental health issues." (DN11)

"I felt it was too few but like I also read up on like the Better Access and how it's recommended for people with like mild to moderate mental illness and so I am kind of like it could be debated that the problems I came in were potentially like too serious or something for it to be appropriate for it to be resolved in six sessions." (DN18)

"So 10 [is] not enough. If it was like, I think for some people it's like yeah a great intervention, but when it's something that's a bit more chronic or longstanding then it is you know a lot less efficient ... There's been times where my life has been more in danger due to for example depression and I've been functioning a lot less due to that, but still only have 10 sessions kind of thing." (MW18)

Several participants noted that even if they had accessed the additional 10 sessions the total number of sessions was insufficient for them.

"It's a great thing that it exists, because without it I wouldn't have been able to access the amount of care that I have been. And even then I have to say though it's not enough, even with the 20 sessions it's not enough." (DN20)

"Umm – I think that like with the 20 because of COVID I think that's a decent number – I would personally still like more but I know that the extra sessions are ending soon and I think they were necessary before the pandemic and they'll still be necessary afterwards you know like depends on the person's level of illness but unless you've got NDIS or are somehow severely ill but also working a well-paying job you are not going to be able to afford the support you need." (MW08)

Several participants reported that they used up all their Better Access sessions during the year and continued to see their psychologist through other means.

"It was too few, I'm continuing now, even though I've gone past the limit because it's still helping me, and while it's still helping me I will go on with it." (MW09)

Although a number of participants would have liked more sessions, several felt that the number of sessions they had received had been enough for them.

"I didn't really keep too much track. I believe that with the mental health care plan, you're allowed two of them now because of COVID, and you would get a referral for 10 and then if you needed another 10 you just had to go back to your GP. So I think I would have used about 15 to 20 of those sessions. It was enough." (MW05)

"10 forty minute sessions is, it works for me yeah." (MW06)

Barriers to Better Access use

Participants were asked whether they had encountered any barriers to engaging with a mental health professional through Better Access. Most participants cited barriers of a financial nature. These included: needing to have enough money to make the initial full payment to the psychologist before receiving the rebate; feeling that the gap payment was too high; having to take time off work to see the psychologist and losing income as a result; and travel and parking costs.

"... with my current clinical psychologist I have to pay out-of-pocket something like \$101 or something because a full fee I think is something like \$220 or \$230. I get the Medicare subsidy for clinical psychologist and then I have to pay out-of-pocket so I'm always like I've got to factor in 'Crap, do I have enough money in my account to pay?' because you have to pay straight after your session." (MW10)

"And the subsidy isn't enough like the fact that people have to pay \$100 out-of-pocket is just it's not viable because if you look at people with mental health conditions they're most likely unemployed or have problems with their housing so then how are people supposed to pay \$100 for a session." (MW10)

"... it's really just the financial side that's difficult yeah also I guess having to take like time off work and things to go to appointments that's also yeah – that also has a financial impact but there's not really anyway around that and I'm casual at the moment so it's unstable to begin with." (MW08)

"... the hospital parking is really expensive anyway so sometimes that's a barrier." (MW08)

Several participants spoke about having to find alternative means of paying when their Better Access sessions ran out.

"... I ran out of my 20 sessions ... and then I was paying for it out of my own pocket. My psychologist, God bless him, gave me a massive discount. But then he's not responsible for the trauma I've experienced ..." (MW17)

"I think in the first year I may have ticked over the 10 I think, I think I did a session or two [on] private health insurance after I sort of went through the 10 but for me it was absolutely necessary and yeah at the time my folks anything that wasn't covered by Medicare or private health insurance they sort of supplemented so I was yeah very lucky on that front." (MW15)

For some, the location of their psychologist was a barrier. Although this did not stop them from continuing to see their psychologist, it made receiving mental health support more difficult.

"The location wasn't great for me but because they were specialised in suicide prevention and because I was referred by the public mental health care system and I was told it's a really good clinic to go to and that you could also see registrars there as well for medication basically people were telling me just do it so okay I trusted people telling me it was good so I went ... [The location] definitely made it more challenging especially on those days where you just can't be bothered leaving the house or you just don't have energy and you have to trek like 25-30 minutes to get there ..." (MW10)

"I think sometimes just getting there was difficult yeah like it's not that far away but it's still like 40 minutes or so from here with public transport." (MW08)

Less common barriers included: poor compatibility with mental health professionals; lack of awareness about the Better Access program; wait times; confusion about the expiration date of Better Access sessions; having to return to the GP if they felt that they were not well matched to the mental health professional; lack of follow-up from the GP; and a fear of being judged by GPs and mental health professionals.

Factors enabling Better Access use

Participants were asked about the factors that helped or enabled them to engage with their mental health professional through Better Access. Financial aspects of the Better Access scheme were by far the most important enabler, with the fact that sessions were available at a reduced cost – or at no cost – being particularly prominent in participants' responses.

"Definitely the subsidised sessions like the fact that I save \$130 or something ... and get a rebate ... So that's like I'm grateful to even have that so that's probably one of the main things." (MW10)

"It's made it so much easier for me. I have complex PTSD and so my psychology bills from when I started to get help at 29 years of age, and I'm 66 now, I dread to think how much it's cost me, financially, and the Better Access program while it doesn't cover the full cost of the fee, because I have other health issues, I reach the safety net ... in January every year, so which reduces the cost of my psychology fee to \$27 or something like that, 20 something dollars, which makes it possible for me. And for the last 3 years I've needed psychology sessions pretty much weekly. So yeah. I'm very grateful for the Better Access program ..." (MW17)

"... I'd be lost without the Better Access program to be honest, like it's just, I can't afford to be paying the sessions out-of-pocket because I'm on Centrelink ..." (DN11)

"I mean I think without that rebate I probably wouldn't be able to afford to have had regular sessions over the last five years. And I certainly do empathise with people who need more than a session a month, because it can get quite costly. So yeah that's, you know being able to access that rebate has been really, really important in terms of me accessing a service full stop." (DN12) "... I don't pay a gap. You know that nasty little gap and that is a real deterrent for people. If I had to pay a gap I don't know if I could go. I couldn't maybe afford it so that makes a big difference too especially for people with mental health issues, with health issues and things like that a lot of us are on a very low income and if we have to pay that gap." (DN13)

"... I mean if I go to anyone else they're not going to give me a huge discount straight away are they. It's only because we've got this kind of longstanding relationship now I think that she's [psychologist] doing it. And so when that day comes, and I have no income still, because I'm too unhealthy to work, then I'm going to be in trouble." (DN20)

Several participants also commented that rapid processing of the rebate acted as an enabler.

"So overall it's pretty easy. I mean the Medicare rebate gets processed immediately when I finish my session. I pay and it gets processed immediately and the receptionist will actually keep me standing at the desk until she says I've received the confirmation from Medicare." (MW10)

The additional ten sessions were also mentioned as enablers.

"So the COVID sessions have probably been a bit life changing in the sense of being able to see my psychologist more, and I'm not sure if you're familiar with EMDR ... so I've been doing that and it's a very intense trauma therapy and trying to have intense trauma therapy spaced out over 10 sessions it's hard, so we've been doing like incredible intense amount of work which I only got to do because of the COVID sessions. So yeah, super lucky." (DN11)

"... he [GP] told me about the whole 20 instead of 10 sessions that the government was now doing. I otherwise would not know that so that was very helpful to know I had that backup and I didn't have to wait a full year for another one." (MW05)

The manner and approach of the psychologist was also frequently mentioned as an enabler. Experiencing good rapport and feeling safe, comfortable, and accepted were important factors that encouraged participants to continue with the process of receiving mental health care.

"Sure my experience has been really good. It's been a really positive experience. Like I said, I was very lucky to be paired up with someone that I just naturally clicked with and it has really helped me and she is someone that is you know thinks a bit like – she's a bit quirky and fun and you know not so by the books and that actually really helps when you, you know, with personality wise. So no, she's great. I've had a really positive experience with her." (DN19)

"Yeah, so she has a fantastic sense of humour and humour is something that I use a lot and she's also very fluent in sarcasm so I like have met my match in terms of using sarcasm she'll just give it back to me. She doesn't take any bullshit like she's really empathetic and compassionate and validating but she also like when push comes to shove she'll be like '[___] you're not doing this and I know you can do it.' Like she'll push me if she has to and she needs to and sometimes that's exactly what I need but she's got a good balance." (MW10)

"... yeah just feeling like relaxed and comfortable and feeling like I could open up and feeling like I wasn't going to be judged or anything like that." (MW12)

The specific skill set, and high standards of the psychologist were also seen as important.

"I found their approach was really useful. I found it made more sense to me than CBT, so yeah like I kind of could see that she was empathetic and understanding and also very trained at helping young people who are dealing with BPD or BPD symptoms." (MW08) "I've always felt that she was using best practice as well like she knows her stuff. The assessments she gives me are reputable – what's the word? – like standardised assessments I guess. Reputable standardised assessments." (MW10)

Another strong enabler was the flexibility of the sessions. This included such things as being able to book several appointments in advance, flexibility with appointments times (including the option of after-hours and weekend appointments), the ability to get an urgent appointment if required, and willingness of the psychologist to allow rescheduling of appointments with minimal fuss.

"... there's been a couple of times over the years when I've been in a bad way, and he's actually come in on a Saturday and seen me." (MW17)

"The flexibility to make it sort of as acute as I needed to, so I could go you know a number of weeks in a row just first off to get going and then drop back or manage as I need to sort of ongoing after that – so I think that approach was really good, I think being able to sort of dial up or down really beneficial." (MW15)

"And just her ease of being able to schedule things about what's going on in our lives, or reschedule if I have to, if I have to do something for work that day, you know she's just very easy to work with, very understanding and her staff, like her receptionist and the lady that does all her appointments, is fantastic to deal with as well." (MW06)

Less commonly mentioned enablers included: having the option to see the psychologist via telehealth; clear communication about number of sessions and their expiry date; and having a direct referral from the GP to a specific psychologist.

Changes to health and wellbeing since seeing the mental health professional

All participants reported positive changes to their health and wellbeing since seeing their psychologist. Several participants reported feeling more hopeful and empowered.

"I do have a feeling when I finish each time I finish a session with her I walk out feeling more hopeful and I walk out feeling more empowered and more like I've got someone who can help me fight this or I'll manage this and like I do walk out of the sessions feeling a little bit more motivated ..." (MW10)

Many also reported that they had a better understanding and acceptance of themselves and a greater willingness to share their story with others.

"... it's also made me feel a lot more secure in everything I've gone through so I can speak about it mostly openly with most people. Still not my parents sadly, but to other people, which is great." (MW16)

"... she explained to me what was going on in a way that made sense to me, and really helped improve I guess my mental health, like resilience and understanding of things, and it became very helpful to be able to I guess yeah just like go through things and process things and stuff like that." (MW18)

Others reported that seeing their psychologist had helped them to get back into the workforce, improved their social skills and confidence, improved their sleep, or reduced their experience of chronic pain. Some felt that their psychologist had equipped them with useful tools to self-manage their mental wellbeing which had resulted in a reduction in the symptoms associated with their mental health condition.

Influences on changes to health and wellbeing

According to participants, the manner and approach of their psychologist had the biggest influence on positive changes in their mental wellbeing. Good rapport, the ability of the psychologist to make participants feel safe and listened to, and the psychologist's capacity to provide objectivity on their situation was seen as especially helpful.

"... her being supportive and listening to what I had to say and understanding it and not telling me what to do just basically opening up and listening and rephrasing obviously in a different way so you can see it in a different way – so you know doing your steps of 'Okay I'm thinking of this now but what's been good about it? Anything good come out of it?' sort of thing." (DN09)

"... his empathy, his care, I know that he respects me as a person, that he's very affirming of me in terms of my intelligence." (MW17)

Several participants particularly appreciated the techniques, strategies, and exercises that their psychologist gave them.

"I think exercises. Whenever I would have something that I was really stressing about just a simple exercise to say 'Okay, well when you feel this way, fill out this form.' It would sort of say like 'What's the situation? What are your emotions? What are you doing? Are you mindreading? Are you saying should a lot? And how can you better approach this?', you know. Like how can you look outside the box? I found that to be really helpful. I feel if professionals utilise those a lot more and maybe even go a bit more creative with other activities, that would really help because it kind of empowers the person in sort of taking control of their emotions." (MW05)

Other services and supports used during the last year

Participants reported using other professional services during the last year, visiting GPs, psychiatrists and counsellors. Some indicated that they saw these professionals in addition to their Better Access providers because what they offered was complementary. For example, one participant with a debilitating chronic condition saw a counsellor from an organisation specialising in that condition. This participant indicated that their Better Access psychologist and the counsellor "brought different things to the table". They felt that the counsellor was particularly knowledgeable about their physical health condition and how this impacted their mental health.

Some participants indicated that they had seen a psychologist or a social worker who was providing services through schemes other than Better Access; none indicated that they had seen an occupational therapist in this context. For example, one participant said that they had seen a social worker funded through the NDIS:

"I saw them maybe once a fortnight or so for a couple of hours, and for the most part we just kind of sat around and chatted about stuff, not as deeply I guess as I would with the psychologist, kind of more just talking about everyday things, and that was good because again don't really have other people to do that with. So that social connection was good. And having some company". (DN20)

Participants also used telephone helplines. Many also accessed websites (e.g., Beyond Blue, SANE Australia, headspace) or used apps (e.g., meditation apps) and self-help books.

Potential improvements to Better Access: Increasing the available number of sessions

Participants were asked to reflect on the Better Access program and to consider whether they felt it could be improved in any way. Most commonly, they suggested that the number of sessions should be increased. They often coupled this with the suggestion that the rebate should be higher.

"... more sessions like definitely at least 20 maybe 30 sessions a year with a rebate and hopefully a higher amount back as well." (MW08)

"Definitely, definitely increasing the number of sessions..." (MW17)

This was seen as especially important for those with high levels of need.

"So I feel like at the moment it caters for people with mild illness, like 10 sessions a year that might be good if you've just been diagnosed with something and you just need a bit of help, but I think for people with severe or ongoing illness they really need more than that ... I think they could assess it based on severity of illness but there are some people who really need to be going every week and for me I need to be going about every fortnight and in the past when I've struggled financially that's been pushed to once a month, once every two months and that was terrible. My health just spirals even more yeah and just gets more and more suicidal." (MW08)

Participants felt that GPs and mental health professionals should be enabled to decide whether a person should have access to more subsidised sessions. They also felt that certain diagnoses should warrant access to a greater number of subsidised sessions.

"...there needs to be the ability for the GP and the psychologist to make a call on how many sessions a patient requires. If somebody's going through a messy divorce they might only need 10 or 20 sessions. Mind you if you've got complex trauma 10 sessions you are not even going to scrape the surface, you know. Let alone 20. But if it's just your normal stress at work or whatever, that 10 or 20 sessions fine. But if you've had complex trauma ... 10 sessions, 20 sessions, I mean that's ridiculous." (MW17)

"... I understand increasing the number of sessions would be a huge, huge cost to the government, but maybe it can only be for certain conditions, where it's you know evidence based that they do need a higher level of support ... but if they were to make such a change, they definitely need to consult with actual consumers ... to make sure they don't just pick random things." (DN20)

Many participants expressed a desire for the additional 10 sessions to remain in place permanently.

"I mean I think it's been great that the sessions have been extended to you know up to 20 a year with COVID. It would be great to see that happen on an ongoing basis ..." (DN12)

Potential improvements to Better Access: Modifying the referral and review process

Many participants commented on changes that they felt might improve the referral and review process required improvements. In fact, some of these improvements had already been made through the introduction of new item numbers under the COVID-19 arrangements. For example, some wanted to be able to have a telehealth or phone consultation with the GP to get a mental health treatment plan or have a review and extension of an existing plan, presumably not realising that these modifications had already been put in place.

"And that, you know, I understand mental health care plans yeah it's probably harder to do over the phone, but at the same time like through my work the clinicians can do intake assessment over the phone. So I think at the very least telehealth should be an option ..." (MW18) "I find it really annoying that I have to go back to my GP after six sessions and then after another four to have the thing renewed every time. It's a bit of a nuisance for me and for my GP just to fill out that paperwork. I did ask him when I saw him last week if it was possible to do that over the phone, and he said no, that would save both of us a bit of time and hassle, if that was kind of changed." (DN20)

Many felt that there should be less frequent reviews with GPs. They particularly questioned the requirement to see the GP after six sessions in order to access the additional four sessions.

"Yeah, and I don't fully understand the reasoning between having six, getting a new care plan, getting an extra four, I'm not sure I fully get that one." (DN11)

"... less running back and forth to your doctor to have it renewed ..." (DN20)

Some participants expressed frustration at the fact that they had been told that to see a different psychologist they had to return to their GP to have their mental health treatment plan updated. They felt that it was important that people could change their psychologist with ease if necessary.

"... it's a pain in the neck if you see a psychologist and you don't relate to them and then you have to go back to the GP...." (DN01)

"... I think it's tricky with the GP because if I want to find a psychologist I have to go to the GP, rewrite the referral, and then try them, and then if they don't work go to the GP, rewrite the referral, try them. And that's a tricky process ... it makes for a lot more steps just to find someone that you're going to make a fit with." (DN11)

Potential improvements to Better Access: Increasing community promotion

Many participants felt that Better Access program needed greater promotion within the community. They were concerned that many people could be struggling and in need of support but not know that Better Access is available to them.

"Yes I think it needs a lot more promotion especially in just I feel like you know if the government did one of those public service announcements or those campaigns or whatever just letting people know that would be really good because fortunately studying psychology and having used services myself I've been able to talk to my friends when they're having it rough and I'd say 'Have you thought about a mental health care plan?' and they've never heard of it before and the relief that comes over when they realise 'Oh my gosh, there's a way and just by being an Australian I have access to that.' It's a game changer for them." (MW05)

"Well I don't think most people know about it. I mean it was news to me, and I've been around the mental health traps for years. But a lot of people don't realise that it's available and, because of financial considerations they decide not to see a psychologist. So I would put money into advertising ... saying you do not have to suffer."

Non-users of Better Access

Participants who had not used Better Access were asked about their prior knowledge of the Better Access program, their reasons for not using the program, and the barriers and enablers to its use. They also provided insights into other supports they had used, sometimes as an alternative to Better Access. In addition, they talked about ways in which Better Access might be improved. More detail is provided below.

Knowledge of Better Access

The majority of participants knew about Better Access, but many did not know the name of the program or specific details about it. Only two participants did not know about Better Access at all.

"So I didn't really know the name of the scheme that it was called Better Access until I looked it up because I did know that I had accessed free Medicare sessions under a mental health treatment plan in the past, I just didn't know that it was called Better Access." (MW04)

"Nobody calls it that nobody never heard of that ... it's just the mental health plan ... but nobody calls it that – not even the GP – even the doctor you get it from ..." (MW11)

A number of participants were unclear about the scope of Better Access, with some indicating that they did not know that it was possible to see a social worker or occupational therapist through the program.

"I had no idea that it was more than just the psychologist." (DN10)

Participants were asked who they thought the Better Access program was intended for. Some indicated that they thought it was for everyone, solely for adults, or for those who could not afford a private psychologist. One participant thought it was for people requiring long term support who were not able to afford ongoing psychological care.

"My honest answer is everyone. There are so many people who don't seem to know about it though." (DN03)

"... the funding to actually access a psychologist ... it can be very costly, and a lot of people who've got mental health challenges are unable to work ... it's also for people who need ... more long-term support ..." (MW07)

However, more participants felt it was for wealthy people who could afford the gap fee.

"... mostly people in wealthier parts of Australia are ... more able to do Better Access because they are able to cover the cost ... It is hard if someone has ... a mental health impairment that affects their ability to work ...because they would not be able to afford ... the gap in the fees" (MW04)

Many participants thought that Better Access was best suited to people who have relatively mild mental health issues. One participant felt the process of Better Access was too difficult to navigate for anyone other than those with mild symptoms.

"I honestly think that Better Access is intended for ... people who have a ... short term mental health issue that's not complex that a mental health professional would know how to diagnose straight away and treat straight away ... I personally don't think that the amount of sessions ... are enough to target mental health issues that are complex or where there's some kind of overlap of issues or where there was a bit of doubt over the diagnosis or where people just needed like ongoing types of therapies or ongoing long-term management. I don't think that Better Access is intended for them." (MW04)

Reasons for not using Better Access

Participants were asked why they had not used Better Access in the past 12 months and they gave various reasons. Most commonly, they said they were seeking support through other means. These included other services and providers (e.g., GPs, mental health nurses, hospital based psychiatric services, headspace) and other funding schemes (e.g., the NDIS, workers' compensation, the redress scheme for childhood sexual abuse, and employment-sponsored arrangements).

"... mainly because I am actually with the NDIS now and they've been looking after the psychologist fees." (MW02)

"I don't feel I got left by the wayside though, you know like my GP I mean she was one of my support systems, and when I was really struggling she said I want to see you every week." (DN03)

Some participants felt that others were more "deserving" of Better Access than they were.

"... other people need the help more than I do." (DN03)

A few participants did not like the types of therapy offered by eligible Better Access providers.

"I guess on the whole part of the reason I don't do it is because I haven't found psychologists useful ... I've never found them helpful ...they always seem very focussed on like a script that doesn't necessarily fit me, like CBT is like the golden thing and CBT is just not for me ... I find psychologists generally sort of follow a slightly more formulaic approach and it doesn't often fit with me." (DN16)

Other participants explained their reasons for not using Better Access in terms of specific barriers. These are described below.

Barriers to Better Access use

All participants cited financial barriers. More specifically, they commented on being unable to afford the co-payments charged by most providers.

"... a lot of practitioners charge above and beyond what the amounts are so you're probably still going to be out-of-pocket." (DN02)

Another frequently mentioned barrier related to finding the right providers. Participants were concerned about finding a suitable provider to match needs in the first instance, and, relatedly, wasting a session on seeing a provider who is not the right "fit". Participants also described a lack of provider availability, and issues with changing providers.

"... I don't know who the hell to ring. I've got all this list, but which one covers what I'm after sort of thing." (DN17)

"... I kind of wasted two of my 10 sessions with someone that I just didn't gel with and wasn't getting forward movement ... and I felt like I'd wasted two of my precious 10 sessions." (DN03)

"You've got to see a few before you work out which one's the best one for you ... you kind of get sick of telling the same over and over and over and over again ..." (DN07)

"... every time I felt it was time to see a psychologist it would have to be a new one, and that is, oh my God, because you get to the point in your life ... where you think 'Are you worth it?' And I remember the last psych I ever saw I was fed up to the eyeballs with the whole system, the psych system, and I sat in there and I interviewed him. I wanted to know whether he was worth it, my time and my having to regurgitate so much again, you know." (MW01)

Other themes included barriers such as wait times, that the number of sessions was not sufficient to have a positive and lasting impact on the mental health issue, and stigma around mental illness and help-seeking.

"... I've definitely found some places that the wait times were kind of hard ... especially with mental health ... sometimes it's something that you need right now ..." (DN10)

"I just don't think there was enough sessions. After six it was like just barely getting to know them ... and then it was over (laughter) so I had to either find another way of paying for it or just wait till the next year." (MW02)

"... people ...seem to think anything to do with mental health is either not real ... or ... this too shall pass you know if I just let it go, and just bide my time I'm sure I'll feel better. So I think there's that aspect that people don't ... want the shame and stigma of potentially being diagnosed with mental health conditions." (DN03)

Some mentioned the inconvenience of the referral processes as a barrier, particularly where the onus was on them to find a mental health professional and/or they had complex needs.

"... I didn't feel like the hassle ... was worth it. ... it's the whole process, like if I just had to go to the GP and get a plan it would be okay, but it's the then finding somebody, the GP can never suggest anybody particularly, ... the process of searching through ... psychologists to see which one I think might be helpful or might work well with me" (DN16)

"... my GP she said that we needed to have a name ... to fill out the form... I had no idea how to do that ... there's no names of any social workers on the internet, it just tells you information about how ... to become a social worker and what a social worker does..." (DN06)

"... when ... I would have to ... call places myself it – it's a lot more difficult ... I get a lot of anxiety about making phone calls and actually like initiating these things myself..." (DN10)

"... my slightly complex needs, like I can't just first name off the list ... so I guess that adds a complexity as well ..." (DN02)

Factors enabling Better Access use

Participants were asked what would help someone in accessing Better Access. They frequently mentioned the GP in this process. In particular, they noted the likely benefits of consumers having a good relationship with their GP, and the GP knowing about Better Access and being aware of potential providers to refer to.

"... we have a good relationship now so I would feel confident telling her that I would like to be back on the Better Access and be more open with her about my mental health issues." (MW04)

"I would think that mental health is pretty huge now with the amount of people you know needing support at some point in their life that they're [the GP] just going to have to get a bit more clued in ..." (DN02)

"If you've got a doctor that understands you, that even helps you even more. So I guess you've just got to find the right doctor that understands what's going on, and then get you to see the right professional." (DN07)

"... GPs to have access to lists of ... social workers ... in the areas around them ... have access to names and telephone numbers that are up to date ..." (DN06)

All participants raised the theme of financial affordability to enable access Better Access. For some, this related to being able to afford the co-payment, needing more transparency around the fee structure, or providers allowing for bulk-billing if needed.

"... if the system allowed a GP to state that in their belief that patient could not afford the out-ofpocket expenses, that that might be helpful to many people." (DN03)

"I guess knowing their fee structure ..." (MW02)

"I was lucky enough that I was able to see a student psychologist because that wait list was shorter and the fee was more affordable." (MW13)

Another frequently cited theme related to finding the right provider with the right specialty area or therapeutic approach to suit individual needs. Cultural awareness of providers was also raised. Participants suggested several potential enablers, including trialling providers without using up the limited number of sessions, pre-meetings with providers, a provider catalogue or database, and a support person role.

"I would see anybody if there was a social worker here offering sessions that were rebated but a mental health occupational therapist I would definitely be interested in accessing an appointment with those kind of people." (DN02)

"... they could do like a meet and greet ... sometimes you just know that you're going to click ... after ... the first session ... On the NDIS you can ask for a free meet and greet ... so you can get a bit of a feel for each other ... I just found that really helpful" (MW02)

"...not all psychologists are the same, not all social workers are the same, not all occupational therapists – they're specialists, have special interests or special areas, having that is great so that you can be matched well ... if they have a specialty ... whether it's cultural – Aboriginal, culturally and linguistically diverse, disability focussed – that will be useful as well ...because compatibility matters so those details I think will help ... accessibility ..." (MW11)

"... being able to get a better sense of how psychologists work just from their website, like they often don't have very much information on their website about you know what therapies they use and things like that, or – so having a better sense of them before I went would be helpful." (DN16)

"Probably if you had a support person to go with you, or a support worker ... some people need support workers and they haven't got the NDIS." (DN07)

Other themes raised around enablers to Better Access use included greater opportunities for different session modalities and formats. In particular, participants commented on being telehealth and group sessions.

"I am really happy that I don't have to trudge along because I've just been to so many appointments over the last 17 years ... so I am happy just to do it by telehealth." (DNO2)

"Because I'm a social person if there can be more groups, so it's less formal, it would definitely be a big help." (MW13)

A final key theme centred around raising awareness of Better Access through positive portrayals of helpseeking success stories.

"...when I go to my GP's office I can see signs for 'If you're male ... and you're over this age, have you had these check-ups?' ... There's all sorts of information there about physical preventative medicine. I don't see anything about mental health." (DN03)

"...hearing testimonials from real human beings ... 'Because of Better Access ... I've been able to stay on track' and 'What the program says it was going to do it's done for me' ..." (MW01)

Likelihood of future Better Access use

When asked whether or not they would use Better Access at some point in the future, most participants said they would. Some said that they would use Better Access for early intervention or maintenance of chronic or complex conditions, with the caveat that this depended on no gap fee and ability to find a provider. Two participants said they were unlikely to as their current support was stable.

"... it's actually a way of preventing escalation of mental health issues ... so there's going to be less admissions into hospital." (MW07)

"...if there was no out-of-pocket expense then I probably would" (MW02)

Other services and supports used during the last year

Participants indicated that they had used a range of services and supports other than Better Access. These typically included hospital psychiatric services or emergency departments, crisis lines, and online resources and apps.

"... [I] was hospitalised for three months, and as a result of the hospitalisation once I was discharged I continued to see that psychiatrist via Zoom ... I'll go to the Beyond Blue website now and again just to kind of, what am I trying to say? – normalise my feelings. You know I'll read or listen to some case studies and go yeah okay, it's all right [____] yeah this is okay you know." (DN03)

"I just use the helplines in between when things build up ... to take the edge off." (MW11)

Less frequently, participants mentioned having relied on friends and family or whatever supports were available. Other services mentioned included peer support, and mental health nurses. Some also mentioned self-managing with meditation, diet and exercise. Some participants mentioned having accessed services through other schemes, such as the NDIS or employment-funded services. Others mentioned services like Partners in Wellbeing, headspace and Beyond Blue's NewAccess.

"So I have a lot of safety nets in place. I have people ... when I start to slide downhill. These are friends or family members ... [to whom] ... I say 'Look, I am struggling' ... in my willingness to be proactive and vulnerable in helping ... I don't think that's the norm ..." (DN03)

"Going to the same coffee shop every day, seeing the same people, there's an expectation, they expect to see you, there's like, 'Oh I didn't see you last week, where were you?' So, they're not called mental health services but they are critically important for my mental health. I have a list of people on my wall here in front of me, my beautiful wall, which reminds me to check in with these people on a regular basis. That's not a mental health service, but if I don't check in with these people, there's something that's lacking in my life. So, I now don't call anything a mental health service or activity, but by gee it makes every difference to my mental wellbeing." (MW01)

"Because I'm a peer ambassador ... I often rely on their support systems ... Sometimes I go on the forums ... with people with lived experience. I find that quite helpful." (MW07)

"... NDIS is where I get my payment for my psychologist ..." (DN06)

"I don't find them helpful [the GP and psychiatrist] but I think I use them as a security type thing knowing that I can't access other health support." (DN02)

"... sometimes, [if] I want support I'll take the support that I can get ... because I can't afford to go into private I just take what I can get." (DN10)

Influences on changes to health and wellbeing

Participants were asked to talk about the most and least helpful influences on any observed changes to their mental wellbeing.

Those who had seen providers through avenues other than Better Access discussed the fact that their relationship with the provider and the techniques the provider offered were helpful. Other helpful influences were also mentioned, including peer support and not feeling alone. For one person, coming off medication had the biggest impact.

"So, this is someone's job and someone who's been trained in how to empathetically listen without judgement. And I find that a huge, huge help." (DN03)

"...their attitude, you know the ability to listen, and ... to offer strategies or to help you in the right direction, has been the biggest help." (DN17)

"... I had good experiences with them generally. I felt that they were validating ... it was really good to chat to people who were understanding and who were going through similar kinds of issues. I found that really beneficial ... we could come to an understanding and share some resources and things like that." (MW04)

"... it's not so much about the program, but it's about the approach the psychologist took, she did psycho-dynamic therapy ... where there is a focus ... on an individual treatment program for the individual, rather than your sort of like, there's a focus on your diagnosis and your symptoms ..." (MW07)

"... with peer support I could just kind of just go into the service when I felt like using the service and if I didn't feel like using the service for a while then that was ... it was more flexible to me and ... I could also access it at other times where I wouldn't be able to access a psychologist or a GP." (MW04)

"Coming off the medication and feeling my feelings or the feelings and feeling the emotions and realising that they don't kill you, it's just the response to those feelings and emotions. It's like behaviour stuff, so that's – it's like 'Whoa, I don't have to scream and run around if this happens', I just 'Oh yeah, there's sadness in me, okay.' Definitely coming off medications." (SW01)

Participants were also asked about the least helpful influence on any change in their health and wellbeing. Participants talked about service delivery issues (e.g., treatment modality), provider issues, issues relating to diagnoses, and eligibility for services being tied to certain conditions.

"... using telehealth is negligible benefit I think ... I would put the phone down thinking oh I didn't get much from that ... And then the time came where she said well you know I can see you in our office now, and I remember sitting in the waiting room thinking I'm going to tell her this can be my last appointment ... and honestly within 20 minutes of being in person with her I was sobbing." (DN03)

"I think the online stuff, it's just too much effort – just too busy – the website, your chatting to somebody – I don't have enough time to get the words out who wants to be typing them yeah I don't find them as useful at all" (MW11)

"... when you feel that you're not listened to ... I was trying to explain what I needed, but ... they wanted, what they thought would be good for me ..." (MW07)

"Psychs telling me that I'm not depressed and I'm wasting their time. That's not very helpful ..." (MW01)

"So, if you don't accept treatment then you don't get paid so if you don't accept medication for your mental health, you don't get paid so I've kind of been in the psychiatric system but this is since about 2004." (DN02)

Potential improvements to Better Access: Increasing the available number of sessions

When participants were asked how Better Access might be improved, the most commonly mentioned recommendation was that more sessions should be offered.

"... you could have more sessions in a year...because 10 sessions is really very few unless ... you have some sort of mild anxiety disorder ... but for anybody with serious mental health concerns, big mental health concerns, it's probably not helpful." (DN16)

Potential improvements to Better Access: More flexible service delivery

Some participants suggested that there should be more flexibility around the delivery of Better Access services. They commented on the frequency, timing, duration and modality of sessions, offering some novel suggestions as to how services might be improved.

"I think that frequency, length of session and then time of session as well – so having something that is suited to you like as often as you might need it ... that could be after hours if you need it ... something that we can fit into our lives opposed to having like move everything else around if we've got other stuff on, that ... you can ... tailor it to your own needs a little bit more." (DN10)

"... I think there should be more telehealth because sometimes going to an office ... and if they use swipe cards ... that's not a very nice experience but if you're at home you might feel more comfortable and if you have a bad session you know you have to travel home and then you're sad the whole time so if you're at home you're already at home." (MW03)

"... they come to you in your home to see you – imagine your social worker comes to you ... I could see people who would benefit from that ... everyone is not technologically savvy – not everyone has a Wi-Fi or a laptop so I think that option ... of mobile social workers, psychologists, occupational therapists that would be great." (MW11)

Potential improvements to Better Access: Reducing the cost of care

Participants also frequently commented on the benefits of reducing the cost to the consumer of Better Access.

"I'd love it to be free ... I'm thinking even if the first five sessions were totally subsidised, and then the next 10 was co-payment, the next five were co-payment, something like that, remove the barrier at the start." (DN03)

Potential improvements to Better Access: Tailoring care to consumers' needs

A number of participants suggested that Better Access could be improved if care was more closely tailored to consumers' needs.

"... might be able to work on something like vocational supports or you know finding things in the community, doing things that aren't that specific like brain mental health stuff but more of the social mental health stuff...a trusting relationship and then yeah that holistic stuff as well is very, very big for me" (DN10)

"I don't know if we can have services for people who have just given birth for example, because you know having a child is a huge life transformation, are there services that can focus on someone has just lost a partner, someone's partner has just died, I haven't been through that but I imagine that grief is also life transforming. So perhaps can we focus on where someone's at in their life, rather than just wait for them to have the pain, by pain I mean mental anguish and you know suicide thoughts perhaps. Can we be a bit more prescriptive?" (MW01)

Potential improvements to Better Access: Improving the referral process

Participants reflected on issues with Better Access referrals, returning to the point above about difficulties with finding the right mental health professional. They suggested that GPs should be better equipped to make direct referrals, and that there should be better resources for consumers to find their own mental health professionals.

"The GP needs better resources to refer ... to assist him for referrals." (DN02)

"... if there could be a way where the GPs could look up like almost like bulk-billing kind of professionals." (MW02)

"I don't know whether it's database work ... it feels like it needs to be consolidated and then the GP could potentially access something like that and in the session in the appointment ..." (DN02)

"... I think in an ideal world you'll be able to go online and then find a GP you can see and have this conversation – and also maybe go online and be able to match yourself ... to a particular kind of psychologist or social worker or an occupational therapist – or find out where you can see bulk-billing people" (MW03)

"... have a website where you can then search for provider – social worker, occupational therapist ... and you get a choice ... and then be able to have ... information about what specialties they may have ... they do telehealth, they don't ... are they culturally competent? ... what are their niches? ... using that then you're able to fill in the form and it gets sent to them directly and you are contacted to book an appointment – very empowering." (MW11)

Potential improvements to Better Access: Increasing community promotion

Participants frequently mentioned the need to raise awareness about the availability of Better Access, with many mentioning the benefits of reducing stigma and promoting help-seeking.

"Oh I would love it to be normalised, like we were talking about the posters in GPs' offices and stuff. I'd love it to be normalised. It'd be great if she could hand me some written information about it, and in that written information are testimonials from people with or without a photo, with or without a name, but preferably at least with a first name, that could say you know I'm so glad I started this Better Access program because ... Because that would help normalise it a little bit for someone who's just like new to this whole world of mental illness and mental unwellness." (DN03)

Discussion

Summary and interpretation of findings

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 be improved by increasing the number of available sessions, modifying the referral process, and 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.

Strengths and limitations

Study 6 had a number of strengths, notably that it provided more in-depth information on Better Access than any of the other studies, and that it included the perspectives of those who had not used Better Access services.

It also had certain limitations, however. Like any qualitative study, the number of participants was relatively small and, by design, not representative of the general population of users and non-users of

Better Access. Both groups were recruited through large non-government mental health organisations, so even the non-users were likely to be relatively familiar with the mental health system. Ultimately only 14 participants had not used Better Access and although the total sample was relatively diverse, there were certain groups that were clearly under-represented (e.g., we only had one First Nations participant in the user group and none in the non-user group).

Importantly, none of the users of Better Access had seen a social worker or an occupational therapist; all had seen psychologists. This reflects the fact relatively smaller number of people who have seen the former providers. In 2021, 1,333,160 people were provided with care by allied health professionals through the Better Access treatment item numbers. Of these, only 102,851 (7.7%) were seen by a social worker and only 12,097 (0.9%) were seen by an occupational therapist.^j In Study 3 we were able to oversample these people to ensure that they were well represented, but in Study 6 we had no way of preferentially inviting them to participate. We considered recruiting them through providers themselves, but we decided against this partly because of the complexity of having a two-step recruitment process (recruiting providers and then asking them to recruit consumers) and partly because we were criticised for doing this in our previous evaluation of Better Access on the grounds that providers might be more inclined to recruit consumers who had had positive experiences.¹⁰³⁻¹⁰⁵

Our eligibility criteria meant that only adults took part in the interviews. We had no participants aged 18 or under, and the age patterns differed for users and non-users (with proportionally more younger people in the user group and proportionally more older people in the non-user group).

Conclusions

Study 6 provides evidence that Better Access is achieving positive health and wellbeing outcomes for many consumers, not just in terms of reductions in symptoms but also in terms of outcomes that consumers see as making a real difference to the way they lead their lives. The users of Better Access interviewed in Study 6 were generally positive about the way the program operates; most found the referral process relatively straightforward, appreciated the flexibility of session delivery, and valued the approach and skills of providers. The interview participants who had not used Better Access had generally not done so because they were receiving care through other sources, rather than because of a lack of awareness of the program. Both users and non-users highlighted financial barriers to uptake of Better Access.

^j Data provided by Services Australia in the context of Study 1a.

10. Study 7: A survey of providers and referrers

Introduction

Study 7 involved a survey of providers and referrers from the main professional groups whose services are eligible for rebates under Better Access. More specifically, clinical psychologists, psychologists, social workers, occupational therapists, general practitioners (GPs) and psychiatrists were invited to complete the survey. Survey participants were asked their views on how well the program works, what the barriers and facilitators are to its use, and what modifications might be desirable.

Methods

Study design

Study 7 involved a cross-sectional survey of providers and referrers who worked in private practice in 2021 and who were eligible to deliver services under Better Access (but may or may not have done so). The survey explored these providers' and referrers' views about how Better Access currently operates and how it might operate in the future.

Sampling and recruitment

We recruited providers and referrers through relevant provider group organisations via an invitation. The Department of Health initially liaised with SEG representatives from the relevant organisations regarding how they might support recruitment for the study. We then engaged directly with these organisations. Eight organisations agreed to distribute a notice about the survey to their membership. In addition, we were approached by a ninth organisation which also assisted with recruitment. The final list of recruiting organisations is provided in Table 10.1.

Table 10.1: Organisations that assisted with Study 7 recruitment

RECRUITING ORGANISATION
Australian Association of Psychologists Inc.
Australian Association of Social Workers
Australian Clinical Psychology Association
Australian College of Rural and Remote Medicine
Australian Psychological Society
Institute of Clinical Psychologists
Occupational Therapy Australia
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners

These organisations sent the invitation notice to their membership via a range of channels (see Appendix 23). These included direct emails to membership lists, notices in member newsletters, and social media. This strategy maximised the reach of the invitation but meant that we were unable to determine how many people saw it. This in turn meant that we were unable to calculate a response rate.

Procedure

Each invitation notice included a URL and a QR code that was unique to the organisation that distributed it. Because most organisations represented a single provider group, this allowed us to keep track of the provider group that individual participants came from.

Interested providers and referrers used the URL or QR code to access the survey online. They were initially presented with a plain language statement which described what their participation in the survey would involve (see Appendix 24); this was presented on screen and could also be downloaded as a PDF. Once they had read the plain language statement, providers and referrers who chose to participate in the survey clicked on a box indicating that they consented to do so (see Appendix 25). Participants had to check the box in order to proceed through to the survey, and doing so took them directly to it.

The survey was anonymous and asked questions about participants' use of Better Access and their views about how it operates (see below for more detail, and see Appendix 26 for the survey instrument itself). The survey was brief and took most participants less than 15 minutes to complete.

Survey data were automatically entered into a database held by our independent data services subcontractor, Logicly. Logicly provided us with regular updates on response numbers and ultimately downloaded the final dataset and delivered it to us by secure means.

Provider organisations circulated the notice advertising the survey to their respective members from the week beginning 21 February 2022. The survey was open until 25 March 2022.

The survey instrument

The survey went through a number of iterations, with questions being modified on the basis of comments from the Department of Health, the CAG and the SEG. The final version of the survey is included at Appendix 26.

The final survey contained questions on the participants and their experiences with using Better Access care. More specifically, it asked about their use of Better Access in 2021. Participants were asked about the extent to which they agreed or disagreed with various process- and outcome-related statements to do with Better Access, as well as about the barriers and facilitators to its use. The survey also sought some basic demographic details from each participant, as well as some information on their professional history and the profile of their practice. There were some common core questions but the different provider and referrer groups were asked different sets of questions based on the different ways in which they use Better Access. The vast majority of the questions were closed-ended, but there was a single question at the end of the survey for all participants which asked: "Is there anything else you would like to tell us about Better Access?" Additionally, a number of questions had "Other (please describe)" options which allowed for free text responses.

The survey contained pop-up boxes to orient respondents to the particular Better Access items that were being referred to when particular services were mentioned. Table 10.2 details these.

Table 10.2: Items in pop-up boxes in the su	irvey
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	SERVICE	ITEMS
Clinical psychologists	Psychological therapy services	80000, 80005, 80010, 80015, 80020, 80001, 80011, 80021, 91166, 91181, 91167, 91182, 93330, 93331, 93332, 93333, 93334, 93335, 93375, 93376, 93312,
Psychologists	Focussed psychological strategies	93313 80100, 80105, 80110, 80115, 80120, 80101, 80111, 80121, 91169, 91183, 91170, 91184, 93350, 93351, 93352, 93353, 93354, 93355, 93381, 93382, 93316, 93319
Social workers	Focussed psychological strategies	80150, 80155, 80160, 80165, 80170, 80151, 80161, 80171, 91175, 91187, 91176, 91188, 93362, 93363, 93364, 93365, 93366, 93367, 93385, 93386, 93326, 93327
Occupational therapists	Focussed psychological strategies	80125, 80130, 80135, 80140, 80145, 80126, 80136, 80146, 91172, 91185, 91173, 91186, 93356, 93357, 93358, 93359, 93360, 93361, 93383, 93384, 93322, 93323
General practitioners	Preparation of mental health treatment plan	2700, 2701, 2702, 2715, 2717, 2710, 92124, 92125, 92128, 92129, 92112, 92113, 92116, 92117, 93400, 93401, 93402, 93403, 93404, 93405, 93406, 93407, 93408, 93409, 93410, 93411
	Review of mental health treatment plan	2712, 2719, 92114, 92126, 93421, 93422, 93423
	GP mental health treatment consultation	2713, 92115, 92127
	Focussed psychological strategies	2721, 2723, 2725, 2727, 2729, 2731, 2733, 2735, 91818, 91819, 91842, 91843, 93300, 93301, 93302, 93303, 93304, 93305, 93287, 93288
Psychiatrists	Initial consultation with a new consumer	296, 297, 299, 92437, 92477
	Preparation of psychiatrist assessment and management plan	291, 92435, 92475
	Review of psychiatrist assessment and management plan	293, 92436, 92476

Data analysis

We conducted descriptive analyses of the responses to the closed-ended questions, reporting frequencies and percentages (or medians and inter-quartile ranges) for all variables as appropriate using Stata version 17. All free text responses were combined for each provider group and the main themes were identified deductively using NVivo version 12.

Approvals

The University of Melbourne Human Research Ethics Committee approved the study (HREC 2021-22854-23484-3).

Acknowledgements

We would like to acknowledge the Australian Association of Psychologists Inc., the Australian Association of Social Workers, the Australian Clinical Psychology Association, the Australian College of Rural and Remote Medicine, the Australian Psychological Society, the Institute of Clinical Psychologists, Occupational Therapy Australia, the Royal Australian and New Zealand College of Psychiatrists, and the Royal Australian College of General Practitioners for assisting us with recruiting participants for Study 7. We would also like to thank all of the providers and referrers who completed the survey.

Results

In total, 2,386 providers and referrers responded to the survey. Table 10.3 describes participants in terms of their professional and sociodemographic details. Although around half were psychologists and a further quarter were clinical psychologists, there were still relatively high absolute numbers of social workers, occupational therapists, GPs and psychiatrists. Almost four fifths were female, and the majority were from the most populous states. There was good variability in terms of how long they had worked in their respective professions.

		FREQUENCY	%
Professional group (n=2,385) ^a	Clinical psychologist	572	24.0%
	Psychologist	1,140	47.8%
	Social Worker	398	16.7%
	Occupational therapist	104	4.4%
	GP	45	1.9%
	Psychiatrist	126	5.3%
Gender (n=2,367) ^a	Female	1,891	79.9%
	Male	443	18.7%
	Non-binary	13	0.5%
	Prefer not to say	20	0.8%
State/territory (n=2,338) ^a	NSW	625	26.7%
	VIC	768	32.8%
	QLD	435	18.6%
	SA	118	5.0%
	WA	294	12.6%
	TAS	42	1.8%
	ACT	41	1.8%
	NT	15	0.6%
Years working in profession	<1 year	21	0.9%
(n=2,377)ª	1-5 years	284	11.9%
	6-10 years	382	16.1%
	11-15 years	454	19.1%
	16-20 years	360	15.1%
	>20 years	876	36.9%

Table 10.3: Professional and sociodemographic characteristics of participants

a. Missing data excluded.

Participants were asked to think about the consumers in their private practice and to indicate the conditions that they commonly present with. They could offer multiple responses, and many did. Table 10.4 shows that very high proportions of participants indicated that they saw consumers with anxiety disorders and depression (97% and 95%, respectively). Almost all other conditions were frequently endorsed as well, suggesting that overall we recruited a group of participants who provide services to a broad range of consumers.

		FREQUENCY	%
Conditions consumers commonly	Anxiety disorders	2,314	97.0%
present with in professional's	Depression	2,256	94.6%
private practice (n=2,386)	Bipolar disorder	966	40.5%
	Eating disorders	871	36.5%
	Personality disorders	1,347	56.5%
	Post-traumatic stress disorder	1,988	83.3%
	Psychotic disorders (e.g., schizophrenia)	451	18.9%
	Substance use disorders	1,101	46.1%
	Childhood behavioural/emotional disorders (e.g., ADHD, conduct disorders)	1,156	48.5%
	Other	763	31.6%

Table 10.4: Common presenting conditions (multiple responses permitted)

With one exception, remainder of the survey results are split by professional group, reflecting the fact that the clinical psychologists, psychologists, social workers and occupational therapists were asked one set of questions, GPs were asked a second set, and psychiatrists were asked a third set. This in turn reflects the fact that these three groups offer different services under Better Access. The exception was the penultimate question, which asked about their views on Better Access overall; responses to this question are reported for all provider groups together.

Clinical psychologists, psychologists, social workers and occupational therapists

Allied health professionals' provision of services under Better Access

Participants from each of the four groups of allied health professionals were asked whether they had provided psychological therapy services or focussed psychological strategies under Better Access in 2021. Table 10.5 shows that the vast majority (97% or more of clinical psychologists, psychologists and social workers and nearly 80% of occupational therapists) had done so. For the small number who had not done so, the reason was usually that they had provided psychological therapy services or focussed psychological strategies, but delivered them through other programs or funding mechanisms.

	CLIN PSYCHO (n=5	ICAL LOGISTS 69)ª	PSYCHO (n=1,	LOGISTS 133)ª	SOCIAL V (n=3	VORKERS 95)ª	OCCUPA THERA (n=1	ATIONAL APISTS 04)ª
Yes	564	98.6%	1,103	96.9%	385	97.0%	82	78.8%
No	5	0.9%	30	2.6%	10	2.5%	22	21.2%
Unsure	3	0.5%	5	0.4%	2	0.5%	0	0.0%

Table 10.5: Provision of psychological therapy services (PTS) or focussed psychological strategies (FPS) by allied health professionals under Better Access in 2021

a. Missing data excluded.

The median number of consumers for whom the clinical psychologists provided these psychological therapy services or focussed psychological strategies in 2021 was 60 (IQR 40-100). The equivalent figures for psychologists, social workers and occupational therapists were 60 (IQR 30-100), 50 (IQR 20-100) and 20 (IQR 8-35), respectively.

Allied health professionals' provision of group versus individual sessions

Participating allied health professionals provided the vast majority of these services as individual sessions. Table 10.6 shows that group sessions accounted for only 4% of Better Access services provided

by clinical psychologists, 6% of those provided by psychologists, 7% of those provided by social workers, and 7% of those provided by occupational therapists.

	CLIN PSYCHO (n=5	ICAL LOGISTS 63)ª	PSYCHO (n=1,	LOGISTS 099)ª	SOCIAL V (n=3	VORKERS 185) ^a	OCCUPA THERA (n=	ATIONAL APISTS 81)ª
Yes	25	4.4%	64	5.8%	25	6.5%	6	7.4%
No	538	95.6%	1035	94.2%	360	93.5%	75	92.6%
Unsure	0	0.0%	0	0.0%	0	0.0%	0	0.0%

Table 10.6: Allied health professionals' provision of group-based Better Access services in 2021

a. Missing data excluded.

The allied health professionals who had not provided any group-based services were asked about their reasons for this. Figure 10.1 shows the results. Across all allied health professional groups, the most common reason was that groups were hard to arrange. This was consistently followed by the observation that group sessions have been particularly hard to run during the COVID-19 pandemic.

Figure 10.1: Reasons why allied health professional who did not provide group-based Better Access services in 2021 elected not to do so (multiple responses permitted)



Further information on reasons for not providing group sessions came from free text responses. Some reflected the closed-ended responses regarding provider and consumer treatment preferences, provider training, experience with and confidence in running groups, and the impact of COVID-19.

Other free text responses suggested that allied health professionals had additional issues with providing group sessions, the most common of which was the minimum participant number mandated for groups (i.e., six). Participants pointed out that smaller practices do not have enough consumers with similar

presenting problems to constitute a group. They also noted that the rules around non-attendance mean that even if a group with the required numbers has been booked, if there are no-shows (as is often the case), then consumers are not eligible for the rebate which makes it costly for them, and not viable for providers.

Other reasons for not delivering group sessions included privacy concerns on the part of consumers in rural and remote areas, the complexity of the rules, and the lack of a suitable space to run face-to-face groups. Participants also commented on the time and organisational burden required to set up and run groups, that two providers were ideally required to run a group session effectively, and that the rebates were too low to cover the cost to the practice.

Allied health professionals delivery of sessions for consumers in residential aged care facilities

The majority of the psychological therapy services and focussed psychological strategies delivered by participating allied health professionals were provided to community-dwelling consumers. Table 10.7 shows that only a small minority of participating allied health professionals indicated that they had provided these services in residential aged care facilities (4% of clinical psychologists, 5% of psychologists, 8% social workers, and no occupational therapists).

	CLIN PSYCHO (n=5	ICAL LOGISTS 64)ª	PSYCHO (n=1,	LOGISTS 094)ª	SOCIAL V (n=3	VORKERS 884) ^a	OCCUPA THERA (n=1	ATIONAL APISTS 81)ª
Yes	21	3.7%	55	5.0%	29	7.6%	0	0.0%
No	540	95.7%	1029	94.1%	351	91.4%	81	100.0%
Unsure	3	0.5%	10	0.9%	4	1.0%	0	0.0%

Table 10.7: Allied heath professionals' provision of Better Access services to consumers in residential aged care facilities in 2021

a. Missing data excluded.

Allied health professionals' views on the processes and outcomes of providing Better Access care

Allied health professionals who had delivered psychological therapy services and focussed psychological strategies were asked to rate their level of agreement with 10 statements on the processes and outcomes associated with the provision of Better Access care. Figure 10.2 shows the results. There were very high levels of agreement with the statements that related to outcomes, with over 80% of all provider groups agreeing or strongly agreeing 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.

There was more variability in terms of the level of agreement with the process-related statements, however. Although relatively high proportions of each provider group agreed that Better Access enables them to offer consumers mental health care that is appropriate, available via a smooth referral process, accessible, timely and affordable, lower proportions were in strong agreement with these statements, and substantial proportions were in active disagreement. The most extreme example of this related to the perceived affordability of Better Access. 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.

Allied health professionals who contributed free text responses elaborated on some of these process issues. In particular, they commented on the affordability and timeliness of Better Access care. With respect to affordability, some noted that they were forced to charge significant co-payments because the rebates were too low, which meant that the cost of care could be prohibitive for some consumers. On

timeliness, some indicated that they and their colleagues had "full books" which meant that consumers had to wait for considerable periods for an appointment. They discussed this from a range of angles. For example, some suggested that expanding eligibility requirements to additional providers (e.g., provisional psychologists, accredited counsellors) might be helpful. Others noted the importance of credentialing and support for an expanded workforce, noting that current demand issues are leading inexperienced graduates to go straight into private practice, without sufficient supervision and guidance to develop their skills.

Barriers experienced by allied health professionals in relation to Better Access

All allied health providers who participated in the survey were asked to reflect on barriers to the delivery of Better Access. Participants were presented with a list of potential barriers and could endorse as many as they chose to. Figure 10.3 shows that a significant majority of participants from each provider group endorsed many of the barriers, although patterns differed somewhat across groups. For clinical psychologists, the most commonly cited barrier was "The process of referral and review by a GP or other medical practitioner is not always smooth" (endorsed by 81% of this group). This was recognised as an important barrier by the other provider groups too, but the most frequently noted barrier for these groups was "The Medicare rebate doesn't adequately recompense providers for their time" (endorsed by 90% of psychologists, 83% of social workers, and 80% of occupational therapists). Other barriers that featured prominently across groups were "The fee-for-service model does not reward mental health professionals for essential elements of good practice (e.g., case conferences between providers)" and "The process of referral and review by a GP or other medical practitioner is not always smooth".

The free text comments shed additional light on some of these barriers, particularly those relating to the referral and review process. Criticisms of the referral process included that GPs acted as "gatekeepers" and that consumers should be able to self-refer, that the mental health treatment plan was often incomplete or of poor quality, and that reporting back to the GP was not adequately compensated. Some participants also noted that wait times for GPs could be lengthy, particularly in regional areas. They also commented that GPs are not always optimally equipped to diagnose and make treatment recommendations for people with mental health problems, which can lead to medication being prescribed as the first-line treatment when psychological therapy might be more appropriate. Some social workers and occupational therapists felt that GPs were often not aware that they provided mental health treatment services, and were therefore unlikely to refer consumers to them under Better Access.

The review process was criticised even more soundly than the referral process. A number of allied health professionals commented that the process should operate the same way it does with other specialists whose services are listed on the MBS, with an initial referral but then no requirement for a review. Others felt that the review process was administratively burdensome, generated little useful feedback, interrupted, delayed or even curtailed consumers' treatment, and created an additional cost barrier for consumers.

Some felt that the referral and review process equated to a mistrust of their professionalism, indicating that they should be accorded due professional respect by being permitted to determine the need for, type and duration of treatment for consumers.

The free text responses also further elucidated the view that the Medicare rebate does not adequately recompense providers for their time. Providers from all allied health professional groups – but particularly psychologists, social workers and occupational therapists – felt that the rebate was too low to sustain a viable private practice, particularly given the administrative load. Some mentioned that in order to sustain their private practice they had to reduce the number of Better Access consumers they saw and/or charge significant co-payments, because bulk-billing was not sustainable. This impacted on affordability for consumers. Others noted that this had led providers to opt out of Better Access provision, further reducing the available pool of providers.

As noted, psychologists, social workers and occupational therapists who provided free text comments were particularly concerned about the level of compensation for their services. They indicated that the differential rebate levels meant that they had to charge comparatively higher co-payments. They felt that this had an impact on the relative demand for their services, and that it influenced GPs' referral decisions. More explicitly, they perceived that demand for clinical psychologists outstripped supply, and that this had flow-on effects for consumers in terms of wait lists.

Beyond this, some allied health professionals commented more generally about the administrative burden associated with delivering Better Access services. They also discussed the complexity of the "rules" around Better Access, noting, for example, that it is not always easy to find information when new items are introduced. Some mentioned that it is difficult to contact and obtain definitive information from Medicare officials.

In the context of the "rules" some commented on the nature and format of the care they could provide under Better Access. Some felt that the permissible types or modes of therapy were too restrictive, suggesting that the evidence base for effective treatments was now broader than what was reflected in the Better Access "rules" (e.g., family and relationship/couples therapy were noted as a particular gap). Others felt that the number of sessions was too restrictive, seeing this as an impediment to offering the most appropriate care, particularly for consumers with certain diagnoses (e.g., personality disorders). Although the additional 10 sessions introduced during the COVID-19 pandemic were universally welcomed, a number of allied health professionals still felt that the number of sessions should be determined by the provider on a case-by-case basis, rather than mandated. As a final comment on this topic, some noted that issues associated with the "rules" around permissible therapies and number of sessions had come into stark relief in the context of Better Access now being increasingly used by consumers with complex needs and severe mental health problems.

More generally, some allied health professionals commented on the activities that were not covered by the "rules" of Better Access. Some of these related to activities that did not involve direct contact with consumers (e.g., administrative tasks like preparing reports and writing support letters, professional development, and dealing with cancellations). Others related to expanding the eligibility criteria for consumers (e.g., enabling services to be delivered to children with no diagnosis but in need of early intervention due to trauma) or increasing the range of permissible services that might be provided to consumers (e.g., educational and developmental assessments). Still others placed emphasis on improving the quality of care by facilitating case conferencing and collaborative arrangements.

Facilitators experienced by allied health professionals in relation to Better Access

The survey also sought allied health professionals' opinions on factors that facilitated the delivery of Better Access care. Again, all participating allied health professionals were asked to indicate whether particular factors resonated with them as facilitators. Figure 10.4 shows that "Good communication with referrers" was the most commonly endorsed facilitator across all four professional groups (endorsed by 70% of clinical psychologists, 69% of psychologists, 71% of social workers and 75% of occupational therapists. "The ability to provide care that is affordable" and "The ability to provide care that is tailored to consumers' needs" were also consistently commonly endorsed.

Some of the free text responses related directly to facilitators. In particular, a number of allied health professionals commented on the fact that the very existence of Better Access improved access to psychological services for many. Telehealth was identified as an important addition to the program, particularly for those in rural and regional areas. The provision for the additional sessions was also seen by many to be a facilitator because it enabled them to provide treatment that was more appropriate for particular individuals' circumstances.





Strongly disagree Disagree Neither agree nor disagree Agree Strongly Agree

60%





Strongly disagree Disagree Neither agree nor disagree Agree Strongly Agree











Strongly disagree 📕 Disagree 🗏 Neither agree nor disagree 📕 Agree 📕 Strongly Agree







a. Missing data excluded.





Strongly disagree Disagree Neither agree nor disagree Agree Strongly Agree

Better Access enables me to provide consumers with mental health care that is timely



Strongly disagree Disagree Neither agree nor disagree Agree Strongly Agree

Better Access enables me to provide consumers with mental health care that they can benefit from



Strongly disagree Disagree Neither agree nor disagree Agree Strongly Agree

Better Access enables me to provide consumers with mental health care that improves their levels of functioning



Strongly disagree Disagree Neither agree nor disagree Agree Strongly Agree

Better Access enables me to provide consumers with mental health care that improves their overall mental health and wellbeing



Strongly disagree Disagree Neither agree nor disagree Agree Strongly Agree

Figure 10.3: Allied health professionals' perceived barriers to the provision of Better Access care (multiple responses permitted)



Occupational therapists (n=104)





Clinical psychologists (n=572)





Social workers (n=398)

restrictive The fact that Better Access is designed to serve consumers who meet certair diagnostic criteria means that some ... The types of therapy that are permissible under Better Access are not consistent for all providers The types of therapy that are permissible under Better Access do not match the approach of all providers The Medicare rebate doesn't a dequately recompense providers for their time

The billing process is too complex

Better Access is administratively burdensome

The "rules" around Better Access can be confusing

The process of referral and review by a GP or other medical practitioner is not always smooth

The referral and review process can create a hurdle for consumers getting into care and continuing to receive care

The information available in mental health treatment plans sometimes lacks sufficient detail

The fee-for-service model does not reward mental health professionals for essential elements of good practice

Figure 10.4: Allied health professionals' perceived facilitators to the provision of Better Access care (multiple responses permitted)



General practitioners

Mental health skills training completed by GPs

Participating GPs were asked whether they had completed the mental health skills training that is recognised by the General Practice Mental Health Standards Collaboration.¹⁰⁶ The vast majority (96%) had done so (see Table 10.8).

Table 10.8: GPs' completion of mental health skills training

		FREQUENCY	%
Completion of mental health skills	Yes	43	95.6%
training recognised through the	No	1	2.2%
General Practice Mental Health	Unsure	1	2.2%
Standards Collaboration (n=45)			

Of these, 61% had completed Level 1 training and 37% had completed Level 1 continuing professional development. Twenty six percent had completed Level 2 training and 30% had completed Level 2 continuing professional development (see Table 10.9). Level 1 training makes GPs eligible for a higher Medicare rebate when they prepare mental health treatment plans, and Level 2 training enables them to use selected item numbers if they deliver focussed psychological strategies.¹⁰⁶

Table 10.9: GPs' levels of mental health skills training (GPs who had completed mental health skills training only; multiple responses permitted)

		FREQUENCY	%
Level of mental health skills	Level 1: Mental Health Skills	26	60.5%
(n=43)	Training		
	Level 1 extended: Mental Health	16	37.2%
	Continuing Professional		
	Development		
	Level 2: Focussed Psychological	11	25.6%
	Strategies Skills Training		
	Level 2 extended: Focussed	13	30.2%
	Psychological Strategies		
	Continuing Professional		
	Development		

Preparation and review of mental health treatment plans by GPs under Better Access

Almost all of the participating GPs (96%) indicated that they had prepared or reviewed mental health treatment plans under Better Access in 2021 (see Table 10.10). The median number of consumers that they estimated they had prepared mental health treatment plans for was 50 (IQR 20-100). Only two indicated that they had prepared or reviewed mental health treatment plans for consumers in residential aged care facilities.

Table 10.10: GPs' preparation or review of mental health treatment plans under Better Access in 2021

		FREQUENCY	%
Preparation or review of mental	Yes	43	95.6%
health treatment plans under	No	2	4.4%
Better Access in 2021 (n=45)	Unsure	0	0.0%

Referral to clinical psychologists, psychologists, social workers and occupational therapists by GPs

The GPs who had prepared mental health treatment plans were asked about the proportion of consumers whom they then referred to clinical psychologists, psychologists, social workers or occupational therapists. Almost half of these GPs (49%) indicated that they had referred 100% of these consumers, and a further 37% indicated that they had referred 80-99% of them (see Figure 10.5).

These GPs were also asked about the provider group to which they had made referrals. Figure 10.6 shows that the largest proportions had made referrals to clinical psychologists (91%%) and psychologists (93%), but that 43% had referred to social workers and 26% had referred to occupational therapists.

The GPs were also asked about how they made decisions when selecting individual providers. Figure 10.7 shows that they most commonly responded by indicating that they tried to match the consumer's needs to the provider's skills (83%). Many also indicated that they chose providers they knew (74%) and/or selected them on the basis of their reputation (60%).



Figure 10.5: Percentage of consumers referred to a clinical psychologist, psychologist, social worker or occupational therapist by GPs following preparation of a mental health treatment plan









GP's views on the processes and outcomes of referring consumers to clinical psychologists, psychologists, social workers and occupational therapists for Better Access care

Referring GPs were asked about the processes and outcomes of referring consumers to clinical psychologists, psychologists, social workers and occupational therapists. More specifically, they were asked to indicate the extent to which they agreed with a series of statements about these processes and outcomes (see Figure 10.8). These statements were similar to those presented to allied health professionals (see Figure 10.2).

As a group, the GPs were generally positive about the outcomes of referring consumers to allied health professionals under Better Access. Around 70% agreed or strongly agreed that Better Access enables them to refer consumers for mental health care they can benefit from, that reduces their symptoms, and that improves their levels of functioning.

Their views about the processes of referring consumers for Better Access care were more mixed. A majority agreed or strongly agreed that the referral process under Better Access is straightforward and that the program enables them to refer consumers for appropriate mental health care, although significant minorities disagreed or strongly disagreed in both cases. Only one third agreed or strongly agreed that Better Access fosters good two-way communication between GPs and relevant mental health professionals, and only a quarter agreed or strongly agreed that enables them to ensure that the referral pathway is smooth and that the resultant care is accessible and delivered in a timely fashion.

A number of GPs had more to say about the referral process in their free text responses. Many said that the process was cumbersome, different from any other specialist referral they made, and placed additional time and cost burdens on consumers. Some also questioned whether it was appropriate for GPs to act as "gatekeepers", given the maturity of the Better Access program and the professionalism of treating providers. Independently of this, some also noted that finding an appropriate and available provider to refer to was becoming increasingly difficult.

Several GPs also commented on the review process. Some felt that reviews were not always necessary, that they occurred too soon in the course of a consumer's care, or that the reports from treating providers were sub-optimal (e.g., late, poor quality or non-existent). Some also commented on difficulties in ascertaining how many sessions a consumer had used. By contrast, other GPs felt that reviews supported high quality consumer care by, for example, fostering good communication between providers.

Figure 10.8: GPs' views on processes and outcomes of referring to clinical psychologists, psychologists, social workers and occupational therapists for Better Access care^a



Better Access enables me to refer consumers for appropriate mental health care



Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

Better Access enables me to refer consumers for mental health care that is accessible



Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

Better Access enables me to refer consumers for mental health care that is affordable



Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree





a. Missing data excluded.



Better Access enables me to ensure that the

referral pathway is smooth



Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree

Better Access enables me to refer consumers for mental health care that can be delivered in a timely fashion



Strongly disagree Disagree II Neither agree nor disagree Agree Strongly agree

Better Access enables me to refer consumers for mental health care that they can benefit from



Strongly disagree 📕 Disagree 📓 Neither agree nor disagree 📕 Agree 📕 Strongly agr

Better Access enables me to refer consumers for mental health care that improves their levels of functioning



Strongly disagree 📕 Disagree 🗏 Neither agree nor disagree 📕 Agree 📕 Strongly agree

Provision of mental health care by GPs using the mental health treatment consultation items and focussed psychological strategies items under Better Access

Participating GPs were asked whether they had provided mental health care using the GP mental health treatment consultation items and focussed psychological strategies items under Better Access in 2021. Table 10.11 shows that three quarters had used the mental health treatment consultation items but only one quarter had used the focussed psychological strategies items. The median numbers of consumers for whom GPs provided mental health care under the mental health treatment consultations items and the focussed psychological strategies items of (IQR 20-100) and 35 (IQR 3-70), respectively. Only one GP had provided mental health treatment consultations in residential aged care facilities, and only one had provided focussed psychological strategies in this setting.

Table 10.11: GPs' use of mental health treatment consultation items and focussed psychological strategies items under Better Access in 2021

		FREQUENCY	%
Use of mental health treatment	Yes	32	74.4%
consultation items under Better	No	9	20.9%
Access in 2021 (n=43)ª	Unsure	2	4.7%
Use of focussed psychological	Yes	10	23.3%
strategies items under Better	No	33	76.7%
Access in 2021 (n=43) ^a	Unsure	0	0.0%

a. Missing data excluded.

GPs who had not used the given sets of items were asked about their reasons and offered a similar but not identical set of response options in relation to the two sets of items. The results are shown in Table 10.12. Most commonly, those who had not used one set of items had not done so because they had used the other or because they had provided mental health care under non-Better Access items.

Table 10.12: Reasons why GPs who did not use mental health treatment consultation items or focussed psychological strategies items in 2021 elected not to do so (multiple responses permitted)

GPs WHO DID NOT USE MENTAL HEALTH TREATMENT			GPs WHO DID NOT USE FOCUSSED PSYCHOLOGICAL		
CONSULTATION ITEMS (N=9)			STRATEGIES ITEMS (N=33)		
	FREQUENCY	%		FREQUENCY	%
I didn't see any consumers	0	0.0%	I didn't see any consumers	0	0.0%
who required mental			who required mental		
health care			health care		
I referred all consumers	3	33.3%	I referred all consumers	9	27.3%
who required mental			who required mental		
health care on to other			health care on to other		
providers			providers		
I provided mental health	3	33.3%	I provided mental health	15	45.5%
care consultations, but I did			care consultations, but I did		
so using the Focussed			so using the GP Mental		
Psychological Strategies			Health Treatment items		
items under Better Access			under Better Access		
I provided mental health	6	66.7%	I provided mental health	14	42.4%
care consultations, but I did			care consultations, but I did		
so using other Medicare			so using other Medicare		
item numbers, not the			item numbers, not the		
Better Access ones			Better Access ones		
Other	0	0.0%	I did not want my services	4	12.1%
			to be contributing to the		
			Better Access session cap		
			for consumers		
			Other	6	18.2%

GPs' views on the processes and outcomes of providing mental health care under Better Access care

Participating GPs were asked to think about situations where they or other GPs had provided mental health care using the mental health treatment consultation items or the focussed psychological strategies items and rate the extent to which they agreed or disagreed with five process-related and outcomerelated statements. Their views were mixed, with at least 10% endorsing each of the responses to most statements (see Figure 10.9). Overall, slightly higher proportions agreed or strongly agreed with most of the process-related statements relating to the fact that Better Access enables GPs to offer consumers mental health care that is appropriate, accessible and timely. However, responses were weighted towards disagreement or strong disagreement in the case of the statement about Better Access enabling GPs to provide mental health care that is affordable. A significant majority (68%) agreed or strongly agreed that their being able to provide care through Better Access yielded positive outcomes for consumers as evidenced by improvements in their mental health and wellbeing.

The free text comments provide further insights about participating GPs' views on the processes and outcomes associated with their provision of Better Access care. Some remarked that they deliver a substantial amount of informal mental health care, including offering support to consumers while they are waiting to see an allied health professional, and providing services in areas where there are relatively few allied health professionals. Others commented specifically on the rule that if they deliver focussed psychological strategies, this counts towards the consumer's session cap; they noted that this introduces a "competition" model, rather than fostering holistic and comprehensive care.



Figure 10.9: GPs' views on the processes and outcomes of providing Better Access care^a

a. Missing data excluded.
Barriers experienced by GPs in relation to Better Access

Participating GPs were asked to consider the barriers they experienced in relation to Better Access. Figure 10.10 shows that 80% identified long wait lists for clinical psychologists, psychologists, social workers and occupational therapists as a barrier. Sixty percent or more also noted that that the number of sessions these allied health professionals can provide is too restrictive, the Medicare rebate doesn't adequately recompense providers for their time, the "rules" around Better Access can be confusing, consumers do not always know whether they already have a mental health treatment plan, and, in some areas, insufficient numbers of allied health professionals are available.



Figure 10.10: GPs' perceived barriers to the provision of Better Access care (multiple responses permitted)

Some participating GPs elaborated on several of these barriers in free text responses. In particular, they expanded on the issue of affordability, noting that allied health professionals seldom bulk-billed. They indicated that the allied health professionals' rebates were too low to make private practice viable, resulting in significant co-payments for consumers that made services unaffordable.

GPs also expanded on the issue of wait lists. They commented that long wait times were a consequence of providers being at capacity or unavailable, and that they resulted in some consumers dropping out of the process of seeking care.

The free text comments from some participating GPs offered further insights into their frustration with the "rules" around Better Access. They noted that there was a lot of confusion around the eligibility of consumers, billing, and session numbers and caps. They also noted that information around rule changes was not always easy to come by, and could be confusing. One GP noted that the confusion around the rules can damage relationships between GPs and allied health professionals.

Facilitators experienced by GPs in relation to Better Access

Participating GPs were also asked to indicate which factors they believed acted as facilitators to the provision of Better Access care. There was strong agreement that good communication with relevant allied health professionals, good documentation from these professionals to inform reviews, and the ability to refer consumers for tailored care acted as facilitators (see Figure 10.11). Sixty percent or more of all participating GPs endorsed these factors as facilitators.



Figure 10.11: GPs' perceived facilitators to the provision of Better Access care (multiple responses permitted)

Psychiatrists

Preparation and review of psychiatrist assessment and management plans and conduct of initial consultations with new consumers under Better Access

Participating psychiatrists were asked whether they had prepared or reviewed a psychiatrist assessment and management plan (items 291, 92435 and 92475, and items 293, 92436 and 92476, respectively) or conducted an initial consultation with a new consumer (items 296, 297, 299, 92437 and 92477) under Better Access in 2021. Table 10.13 shows that 54% had done this. The mean number of consumers for whom the psychiatrists provided these services in 2021 was 25 (IQR 5-50). Only 6% had provided these services to consumers in residential aged care facilities.

 Table 10.13: Psychiatrists' preparation or review of psychiatrist assessment and management plan or conduct of initial consultation with a new consumer under Better Access in 2021

		FREQUENCY	%
Preparation or review of	Yes	68	54.0%
psychiatrist assessment and	No	47	37.3%
management plan or conduct of	Unsure	11	8.7%
initial consultation with a new			
consumer under Better Access in			
2021 (n=126)			

Those who had not done so were asked about their reasons. Most commonly, they indicated that they had provided the equivalent of these services but done so using other Medicare item numbers, not the Better Access ones. Seventy two percent endorsed this response (see Table 10.14).

Table 10.14: Reasons why psychiatrists who did not prepare or review psychiatrist assessment and management plans or conduct initial consultations with new consumers in 2021 elected not to do so (multiple responses permitted)

	FREQUENCY	%
I didn't see any consumers for whom this was appropriate or	6	12.8%
necessary		
I provided the equivalent of these services, but I did so using other	34	72.3%
Medicare item numbers, not the Better Access ones		
Other	9	19.1%

A number of these psychiatrists provided additional reasons in the free text responses as to why they had not used the relevant Better Access items. Some were unaware of the program or how to use it, but most had other reasons. These included the compliance burden associated with Better Access, it not being relevant to their practice focus, or their not taking on new consumers in 2021.

Some made specific comments about why they had not prepared a psychiatrist assessment and management plan (item 291). They identified various issues, the most significant of which was that the item can be only used once per year per consumer. There were concerns that if a consumer had been seen under this item in the previous 12 months (which was sometimes difficult to ascertain) a claim might be rejected. Some also expressed concerns that item 291 did not allow for any follow-up with the psychiatrist, with one mentioning that this might have medico-legal ramifications if the consumer subsequently ended up at a point of crisis.

Referral to other mental health professionals by psychiatrists

Psychiatrists who indicated that they prepared or reviewed a psychiatrist assessment and management plan or conducted an initial consultation with a new consumer under Better Access in 2021 were then asked what proportion of these consumers they referred for treatment. Figure 10.12 shows that 13% did not refer any of these consumers for treatment, but most of the remainder did, with 19% referring all of them on. Figure 10.12: Percentage of consumers referred to a clinical psychologist, psychologist, social worker or occupational therapist by psychiatrists following preparation of a psychiatrist assessment and management plan or conduct of an initial consultation with a new consumer (psychiatrists who prepared a plan or conducted an initial consultation only)



These psychiatrists were also asked about the providers to whom they made referrals. Figure 10.13 shows that they most commonly referred to psychologists, with 72% indicating that they did this. This was followed by GPs (32%), other psychiatrists (27%), social workers (21%) and occupational therapists (21%).

Several free text responses made by psychiatrists related to referrals to other providers. Some psychiatrists commented on the lack of available psychologists to whom referrals could be made. One also noted that allied health professionals do not always know that they can accept referrals from psychiatrists. Some also had questions around the consumers that Better Access is targeting for referral. For example, some noted that the consumers they see typically have severe and complex mental health problems, and referring some of these to allied health professionals might mean that they would not receive the appropriate type or intensity of care. Others were more positive, noting that Better Access helps to provide a more holistic approach by making the approaches of psychiatrists and allied health professionals available in tandem.



Figure 10.13: Provider group to whom psychiatrists referred (psychiatrists who made referrals only; multiple responses permitted)

Psychiatrists' views on the processes and outcomes of providing mental health care under Better Access care

Psychiatrists who had used the relevant Better Access items were asked their views on the processes and outcomes of providing mental health care through the program. More specifically, they were asked to think about the different ways that they might see consumers under Better Access and indicate their level of agreement with a series of statements related to the processes and outcomes of doing so. Figure 10.14 shows that their views were mixed. With the process-related statements, there were often greater levels of disagreement than agreement. For example, 59% disagreed or strongly disagreed that Better Access helps them to ensure that consumers get timely mental health care, compared with only 19% who agreed or strongly agreed with the statement. The reverse was true for the outcome-related statements, however. Again, taking one example, 44% agreed or strongly agreed that Better Access helps them ensure that consumers get mental health care that addresses their presenting issues, compared with 27% who disagreed or strongly disagreed.

Some psychiatrists also made some additional comments in the form of free text responses, particularly in relation to certain processes. For example, some commented on receiving referrals from GPs, noting that mental health treatment plans can be poor and are an unnecessary expense for Better Access when standard referral processes would be adequate. Others felt that the reporting requirements associated with the program were excessive.

Psychiatrists also commented on the affordability issue, noting that rebates are too low to enable providers to offer bulk-billed or reduced-fee services in a sustainable way. This means that the co-payments borne by consumers can act as a disincentive to their engaging in care.

Some psychiatrists went on to consider changes to the "rules" around Better Access that they considered might be helpful, moving forward. These included coverage of parent-only sessions for children, increased session availability for certain presenting problems or conditions (e.g., trauma, personality disorders), and case conferences. Some also mentioned broadening the range of eligible providers to include, for example, mental health nurses.

Figure 10.14 Psychiatrists' views on the processes and outcomes of seeing consumers under Better Access^a





Better Access helps me to ensure that consumers get mental health care that reduces their symptoms



Better Access helps me to ensure that consumers get mental health care that addresses their presenting issues







Better Access helps me to ensure consumers get accessible mental health care



Strongry usagree Disagree Mineriner agree nor usagree Agree Strongry at

Better Access helps me to ensure consumers get affordable mental health care



Better Access helps me to ensure that consumers get mental health care that improves their levels

of functioning



Better Access helps me to ensure that consumers

get mental health care that improves their overall mental health and wellbeing



All providers and referrers

Participants' views on Better Access more broadly

All participating providers and referrers were asked to think about Better Access more broadly. More specifically, they were asked to think about the overall Better Access program and rate the extent to which they agreed or disagreed with a series of statements about the program. Figure 10.15 shows the results.

Once again, participants' views were mixed. As a general rule, comparatively higher proportions disagreed or strongly disagreed with statements relating to the processes underpinning Better Access. Most notably, 66% disagreed or strongly disagreed that the "rules" around Better Access make sense and 67% disagreed or strongly disagreed with that the administrative processes associated with Better Access are straightforward; the equivalent figures for agreement and strong agreement with these statements were 11% and 14%, respectively.

The reverse was true for the outcome-related statements, however. For example, 68% of participants agreed or strongly agreed that Better Access has improved outcomes for consumers, compared with only 10% who disagreed or strongly disagreed with this statement.



















ngly agree

Better Access has decreased inequalities in mental health care



Better Access has led to opportunities for professional development and training



Better Access has improved outcomes for consumers



259

Figure 10.16: All participants' views on the overall Better Access program^a

Discussion

Summary and interpretation of findings

The Study 7 survey offered detailed insights into what 2,386 providers and referrers think about Better Access. These providers and referrers represented the major professional groups that are eligible to deliver services under Better Access: 572 clinical psychologists; 1,140 psychologists; 398 social workers; 104 occupational therapists; 45 GPs; and 126 psychiatrists.

The majority 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. 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.

Strengths and limitations

Study 7 presented the views of 2,386 providers and referrers from the key provider groups that are eligible to provide care through Better Access. This sizeable sample was recruited in a systematic way, via invitations distributed by the organisations that represent them. However, it was not possible for us to determine response rates for the different provider groups because we could not establish the relevant denominators (i.e., the numbers who would potentially have seen the invitations). However, some groups – notably GPs – had lower uptake of the survey than the other groups. On a related point, it was not possible for us to determine how representative our samples of different providers were of all providers in a given group, so some caution should be exercised in generalising the findings.

We tried to keep the survey as brief as possible in order to encourage participation, but this meant that we were unable to drill down further into some of the nuances of providers' and referrers' practices. For example, it might have been desirable to ask more about the type of therapy offered by participants, but this would have required a considerable number of additional questions. Similarly, it might have been useful to consider whether participants viewed the advantages and disadvantages of Better Access differently for different consumer groups (e.g., children and adolescents), but this would have required substantial "branching" of questions.

Conclusions

Study 7 elicited the views of 2,386 providers and referrers about the responsiveness and appropriateness of Better Access. All of these providers were eligible to deliver services through Better Access and most of them had done so in 2021. The vast majority were extremely positive about the outcomes that Better Access achieves for consumers. Significant numbers expressed concerns about some of the processes related to the program, however. Most notably, they questioned whether Better Access is always able to provide timely and affordable care. Good communication between referrers and providers was seen to be critical to the program's success.

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

Introduction

Study 8 involved consultations with a broad range of key stakeholders about future reforms to Better Access. It was done in the context of the engagement with stakeholders that has already occurred as part of relevant recent inquiries and reviews by the Productivity Commission Inquiry into Mental Health,¹⁹ the MBS Review Taskforce¹⁸ and the House of Representatives Select Committee Inquiry into Mental Health and Suicide Prevention.²⁰ The consultations with stakeholders in these previous reviews was extensive. For example, the Productivity Commission received 1,244 written submissions and 488 comments and heard from around 400 participants in public forums and roundtables. We did not wish to replicate these consultations in Study 8, but instead sought to engage with a broad and diverse range of stakeholders around a very specific topic – future directions for Better Access.

We used a novel online approach to seeking stakeholders' views and our aim was to identify a collective view of the most salient issues and priorities for future reform. We acknowledged that universal consensus could not be expected across the diversity of standpoints and interests stakeholders represented, but our goal was to identify those areas where consensus was strongest, as well as to capture the range of differences.

The consultation process involved stakeholders nominating their priorities, taking part in a wide-ranging and inclusive discussion about the nominated priorities, and then participating in a rating and ranking exercise to assess levels of agreement and dissent.

Methods

Study design

Study 8 was based on a modified Delphi method developed by the Hunt Laboratory for Intelligence Research at the University of Melbourne to address different questions (see Barnett et al for more detail).¹⁰⁷ Study 8 had a three phase design. Phase 1 involved an online survey designed to identify the most salient issues for Better Access going forward from the perspectives of participating stakeholders. We then identified the main topics raised in the survey and developed 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 we then revised the statements based on the content of the discussion. In Phase 3, stakeholders were asked to rate their level of agreement with the revised synthesis statements and rank priorities for reform in a second online survey.

Sampling and recruitment

The sampling frame was designed to include as diverse a range of stakeholders as possible. We sought advice about the composition of the sample from the CAG, SEG and the Department of Health. The final sampling frame comprised 104 individuals: 55 service provider representatives (35 eligible Better Access providers; 18 ineligible providers; two First Nations providers; 20 consumers and people with lived experience; 10 carers; eight representatives from advocacy organisations; six health systems experts; and five policy makers.

The majority of individuals were approached via professional associations or non-government organisations. The exception was the health systems experts and policy makers who were identified by

our evaluation team in consultation with the Department of Health. More detail about the organisations approached to nominate representatives and quotas for stakeholder groups is available in Appendix 27.

We provided information about Study 8 to the recruiting organisations, and these organisations then identified individuals to nominate in the way that suited them best. Some nominated representatives directly and others called on their membership for expressions of interest. Nominations were forwarded to our team and we then followed up nominees for an onboarding process. This included providing them with the plain language statement and obtaining their consent to participate (see Appendices 28-30).

Data collection and analysis

Phase 1: Survey 1

Participants were invited to complete an initial online survey (Survey 1) which had a single question: "What do you regard as the three most important features of Better Access, going forward? They might be features that exist that should be retained or they might be new features that should be added" Participants could enter responses of up to 350 characters. The survey was open from 5 September to 11 September 2022.

We derived 31 synthesis statements covering 21 topic areas from the responses to Survey 1. Synthesis statements were derived by initially grouping together survey responses on similar topics using the Trello platform, and then synthesising the key elements mentioned into a single statement. Synthesis statements were phrased as propositions, designed to facilitate discussion.

Phase 2: Online discussion forum

Participants were invited to comment on the synthesis statements derived from the Survey 1 responses, propose alternative formulations, and discuss their views on the statements with each other in an online discussion forum. The forum was run on Loomio which is an online asynchronous text-based discussion platform. Participants were instructed to contribute to the forum using pseudonyms in order to mitigate any perceived or actual power imbalances. The forum was open from 19 September to 4 October 2022.

The discussion content was downloaded, and each topic thread was read by two members of the evaluation team. The first "reader" identified the key themes and subthemes in the discussion and reformulated the synthesis statements for the topic. The second "reader" reviewed the discussion, themes and the reformulated synthesis statements, and then discussed refinements with the initial reviewer. The evaluation lead then undertook a final review and revision of the entire set of synthesis statements. This process resulted in 56 revised synthesis statements.

Phase 3: Survey 2

Participants were then invited to complete a second online survey (Survey 2) in which rated their level of agreement or disagreement with each of the 56 revised synthesis statements. In addition, participants were asked to rank a list of 18 overarching topic areas in order of priority for reform^k. The survey was open from 11 October to 21 October 2022.

We calculated frequencies and percentages for the agreement ratings for each of the 56 synthesis statements. We calculated mean rankings and 95% CIs for each of the 18 topic areas, based on which the overall ranking was determined.

^k From the original 21 topics the two 'Number of sessions" topics were combined, and the "Eligible providers" and "Early career practitioners" topics were combined as they addressed the same underlying issues. The "Achieving its aims" topic was omitted as it was not reform-related.

Approvals

The University of Melbourne Human Research Ethics Committee approved the study (HREC 2022-24221-32180-5).

Acknowledgements

We would like to acknowledge the stakeholder organisations for assisting with recruitment for the study and all participants for their time and contribution to the three phases of the consultative forum.

Results

Sample description

Table 11.1 details the response per participant group. Ninety of the 104 nominated representatives (87%) consented to participate. Of the 14 non-participants, nine (64%) resulted from the organisation declining to take up the invitation due to lack of capacity, five (36%) were nominees who did not complete the onboarding, and one (0%) did not respond to the invitation.

Table 11.1: Stakeholder groups, quotas, and participation numbers

STAKEHOLDER GROUP	QUOTA	PARTICIPATED (%)
Current eligible service providers	35	35 (100%)
Current ineligible service providers	18	18 (100%)
First Nations service providers	2	1 (50%)
Consumers, people with lived experience, and carers	30	23 (77%)
Representatives from advocacy organisations	8	4 (50%)
Health system experts	6	4 (75%)
Policy makers	5	5 (100%)
Total	104	90 (87%)

Seventy-seven participants (86%) completed Survey 1. Sixty-eight (76%) participated in the Loomio discussion forum, 57 of whom (84%) made at least once comment. Seventy-seven participants (86%) responded to Survey 2. Appendix 27 provides additional details of responses by participant group and study phase.

Below we describe the results of each phase by topic (in alphabetical order). We present the original synthesis statement derived from Survey 1, a brief description of the scope of the discussion in Phase 2, and finally levels of agreement with the revised synthesis statements from Phase 3 including noting any prominent dissenting views expressed in Phase 2.

Topic discussion

Topic: Achievement of policy aims

For this topic, the synthesis statement generated from the Phase 1 survey was: "Better Access is an efficient program that is currently meeting the needs of the Australian population."

In the Phase 2 discussion there was little outright agreement with this statement. Although participants felt that the program had been successful in a number of ways, there was a strong feeling that improvements were required. In particular, participants noted that although Better Access effectively supports those with mild to moderate levels of distress and people who are relatively well-off and living in cities, it is less effective in supporting people with more severe, complex, or chronic levels of need and people with minimal financial resources in more geographically isolated areas.

From this discussion, two revised synthesis statements were generated: "Better Access currently only meets the needs of people with mild to moderate mental health problems" and "Better Access currently only meets the needs of relatively well-off urban Australians." Sixty five percent of participants who took part in the Phase 3 survey agreed or strongly agreed with the former statement and 68% agreed or strongly agreed with the latter (see Figure 11.1).

Figure 11.1: Levels of agreement/disagreement with synthesis statements on achievement of policy aims









Topic: Additional item numbers for non-billable activity

The synthesis statement generated from the Phase 1 survey in relation to this topic was: "New item numbers should be created that provide a rebate for currently non-billable support activities (e.g., case-conferencing, liaising with support agencies and families, administration). This would strengthen continuity of care and make care more holistic."

In Phase 2, there was general agreement that the amount of non-billable work was a considerable burden on providers, particularly for complex cases. Participants felt that where additional work was required, it should be recompensed. However, some participants some expressed concern that the introduction of new item numbers might be open to rorting and that some form of compliance checking or auditing would be required.

The revised synthesis statement presented in the Phase 3 survey read: "New item numbers should be created that provide a rebate for currently non-billable support activities (e.g., case-conferencing, liaising with support agencies and families, administration), and the appropriate use of these item numbers should be monitored." There was very strong agreement with the synthesis statement, with 85% of participants supporting it (see Figure 11.2).

Figure 11.2: Levels of agreement/disagreement with synthesis statement on additional item numbers for non-billable activities

New item numbers should be created that provide a rebate for currently non-billable support activities (e.g., case-conferencing, liaising with support agencies and families, administration), and the appropriate use of these item numbers should be monitored.



Topic: Affordability

In the Phase 1 survey, considerable emphasis was given to issues of affordability. Participants' views were synthesised into the following statement: "The affordability of Better Access services should be improved. There may be different ways of doing this, including increasing the number of bulk-billing providers, increasing the Medicare rebate to bring down the out-of-pocket payment for consumers, or capping what can be charged above the rebate."

This statement generated considerable discussion in Phase 2. There appeared to be consensus that the affordability of Better Access should be improved, but there were disparate views on how this could best be achieved. This resulted in a new, more specific, set of synthesis statements for Phase 3. Levels of agreement/disagreement with these revised synthesis statements are shown in Figure 11.3.

In Phase 3, there was almost universal agreement that *"The affordability of Better Access should be improved"*, with 97% agreeing or strongly agreeing with this proposition. In terms of solutions, suggestions that would increase affordability for consumers without impinging on the financial viability of individual providers' practices were particularly well endorsed. Eighty six percent of participants agreed or strongly agreed that *"The affordability of Better Access services should be improved by increasing the Medicare rebate to bring down the out-of-pocket payment for consumers, including a compliance mechanism to ensure cost reduction is passed onto consumers."* Similarly, 81% agreed or strongly agreed that *"The affordability of Better Access services should be improved by lowering the safety net threshold for high-risk and/or high-need members of the community"*.

There was strong recognition that increasing bulk-billing rates or reducing the permissible co-payment amount would improve affordability, but some felt that these measures might have detrimental effects for providers. Ninety percent of participants agreed or strongly agreed that *"The affordability of Better Access services should be improved by increasing the financial viability of bulk-billing for providers."* A considerably lower proportion (61%) agreed or strongly agreed that *"The affordability of Better Access services should be improved by mandating providers to bulk-bill a proportion of Better Access consumers, but only if schedule fees are appropriately set and regularly reviewed."* In the Phase 2 discussion, there were concerns about how this sort of mandate might be regulated. A similar proportion (60%) endorsed the proposition that *"The affordability of Better Access services should be improved by capping what can be charged above the rebate."* In Phase 2, some participants cautioned that imposing caps may be anticompetitive, contravene consumer law, and would likely result in caps that would not keep pace with inflation or the cost of providing services. The proposition that *"The affordability of Better Access services should be improved by offering services via telehealth at lower cost than face-to-face sessions"* was comparatively less well accepted than other suggestions. Only 36% of participants agreed or strongly agreed with this. In the discussion it was noted that this would position telehealth as a lower quality offering and reduce choice for consumers.



The affordability of Better Access services should be improved by mandating providers to bulk-bill a proportion of Better Access consumers, but only if schedule fees are appropriately set and regularly reviewed.







Figure 11.3: Levels of agreement/disagreement with synthesis statements on affordability

The affordability of Better Access services should be improved by increasing the financial viability of bulk-billing for providers.



The affordability of Better Access services should be improved by increasing the Medicare rebate to bring down the out-of-pocket payment for consumers, including a compliance mechanism to ensure cost reduction is passed onto consumers.



The affordability of Better Access services should be improved by lowering the safety net threshold for high-risk and/or high-need members of the community.



Figure 11.3: Levels of agreement/disagreement with synthesis statements on affordability (cont.)



The affordability of Better Access services should be improved by offering services via telehealth at lower cost than face-to-face sessions.

Topic: Cultural appropriateness

The Phase 1 survey resulted in the following two synthesis statements in relation to cultural appropriateness: "It is critical to ensure that Better Access providers are adequately trained in areas such as cultural competence, working with older adults in aged care facilities, and trauma-informed practice" and "Increasing diversity among providers is critical to make culturally appropriate/relevant treatment available."

The Phase 2 discussion led to the first of these statements being expanded because participants felt that the required range of cultural competencies was not adequately reflected in the original statement. The revised statement read: *"It is critical to ensure that Better Access providers are adequately trained in areas such as cultural competence, gender and sexual orientation safety, domestic and family violence, working with older adults in aged care facilities, and trauma-informed practice."* In Phase 2 participants expressed concern that it may not be possible for all providers to attain such competencies, and that ensuring providers are culturally competent is outside the remit of Better Access and is the responsibility of universities and other training providers. Despite this, in Phase 3 there was strong support for the revised synthesis statement, with 94% of participants agreeing or strongly agreeing with it (see Figure 11.4)

The second synthesis statement did not alter from the original, and in Phase 3 82% agreed or strongly agreed that *"Increasing diversity among providers is critical to make culturally appropriate/relevant treatment available."* During the discussion in Phase 2, however, some participants warned that this might be difficult to achieve, particularly in rural and regional areas.

Figure 11.4: Levels of agreement/disagreement with synthesis statements on cultural appropriateness

It is critical to ensure that Better Access providers are adequately trained in areas such as cultural competence, gender and sexual orientation safety, domestic and family violence, working with older adults in aged care facilities, and trauma-informed practice.



Increasing diversity among providers is critical to make culturally appropriate/relevant treatment available.



Topic: Diagnosis eligibility requirements

In the Phase 1 survey there were various comments about the requirement that consumers be given a diagnosis to access Better Access. These comments were synthesised into the following statement: *"Consideration should be given to the requirement that a person be given a diagnosis to use Better Access. This requirement may be a barrier to help-seeking and may limit the overall reach of the program. Another approach, such as evaluating the person's degree of functional impairment in relation to their mental health, may be more inclusive."*

Following the discussion in Phase 2, this statement was split into four revised synthesis statements. The Phase 3 responses to these are shown in Figure 11.5. There was strong agreement with the first of these, with 86% of participants agreeing or strongly agreeing that *"The requirement that a person be given a diagnosis to use Better Access is inappropriate, particularly for some groups of consumers (e.g., children), and may be a barrier to help-seeking and limit the overall reach of the program."* It is worth noting that, despite this, in the Phase 2 discussion some participants were wary about the removal the diagnosis requirement and felt that some criteria should remain in place to ensure that Better Access program did not become a panacea for all things related to mental health when there were various other services and supports available that may be more appropriate.

The Phase 3 responses to the other three revised synthesis statements give insights into participants' reasons for rejecting the diagnosis requirement. Many (85%) felt that *"Diagnoses may not be culturally appropriate and may feel stigmatising"*; in the Phase 2 discussion, some felt that diagnoses may be overly pathologizing. Many Phase 3 participants thought that a focus on emotional or psychological distress or functional impairment might be preferable. Eighty one percent agreed or strongly agreed that *"Identifying the person's level of emotional or psychological distress (mild, moderate, or severe) may be more appropriate and inclusive than requiring that they be given a diagnosis to use Better Access"* and 74% agreed or strongly agreed that *"Evaluating the person's degree of functional impairment in relation to their mental health treatment needs may be more appropriate and inclusive than requiring that they be given a diagnosis to use Better Access."* More generally, participants in the Phase 2 discussion felt that treating providers should be able make their own assessment of consumers.

Figure 11.5: Levels of agreement/disagreement with synthesis statements on diagnosis eligibility requirements

The requirement that a person be given a diagnosis to use Better Access is inappropriate, particularly for some groups of consumers (e.g., children), and may be a barrier to help-seeking and limit the overall reach of the program.



Identifying the person's level of emotional or psychological distress (mild, moderate, or severe) may be more appropriate and inclusive than requiring that they be given a diagnosis to use Better Access.



90 80 70 52.0 60 50 Percentage 33.8 40 30 20 5.2 5.2 3.9 10 0 Strongly Disagree Neither Agree Strongly

disagree

Evaluating the person's degree of functional impairment in relation to their mental health treatment needs may be more appropriate and inclusive than requiring that they be given a diagnosis to use Better Access.

agree nor

disagree

agree



Topic: Differential provider rebates

The Phase 1 survey resulted in the following synthesis statement in relation to differential provider rebates: "All providers should receive the same rebates. The differential rebates are outdated, divisive, unjust, not based on evidence of differences in the effectiveness of different providers, based on a false distinction between focussed psychological strategies and psychological therapy services, and choke the workforce. The lower rebates for certain providers also make the gap payment unaffordable for consumers and make private practice unsustainable."

There was considerable discussion around this proposition in Phase 2, and views were divided. As a result, we split the proposition in two for Phase 3, with one statement proposing that the rebate should be the same for all providers and the other proposing that it should differ based on training levels. The responses to each were more evenly distributed than those for many other topics (see Figure 11.6). Forty four percent agreed or strongly agreed with the statement that *"All allied health providers should attract the same rebate for reasons of equity and because their approaches are equally effective"*, but 36% disagreed or strongly disagreed. Similarly, 55% agreed or strongly agreed that *"Rebate levels should reflect differences in provider training levels"* but 22% disagreed or strongly disagreed.

The Phase 2 discussion sheds further light on this. Those who favoured the same rebate for all tended to think that the differential rebates were outdated, divisive, unjust, not based on evidence of differences in the effectiveness of different providers and were based on a false distinction between focussed psychological strategies and psychological therapy services. These participants felt that the rebate should be based on the service provided not the provider providing the service, suggesting that this would result in decreased administration costs and increased accessibility and choice for consumers, particularly those on low incomes. They also commented that there was no evidence to suggest that those with higher qualifications achieve better outcomes for consumers. By contrast, those who favoured a differential rebate based on levels of training felt that there should be a financial acknowledgement of advanced training and competencies. They were concerned that without this there would be a lack of incentive for new practitioners to complete higher level training.



Figure 11.6: Levels of agreement/disagreement with synthesis statements on differential provider rebates

Topic: Early career practitioners

All allied health providers should attract the same rebate for

reasons of equity and because their approaches are equally

Phase 1 participants suggested that early career practitioners could make a useful contribution to the Better Access workforce. From this, the following synthesis statement was generated: *"To build the workforce, especially in underserved areas (e.g., rural and remote areas, areas of low socioeconomic status), early career, pre-endorsed practitioners should be permitted to deliver Better Access services with suitable supervision. The requirement to have a set period of clinical practice experience should be removed but appropriate credentialing should be retained (e.g., conditions around registration and qualifications)."*

The discussion that ensued in Phase 2 and the rating exercise in Phase 3 suggested that a majority of participants were in favour of expanding the workforce via early career practitioners but that they thought that this should be done carefully and cautiously, and that there were significant risks (see Figure 11.7). Two thirds of participants (65%) agreed or strongly agreed that *"To build the workforce, especially in underserved areas (e.g., rural and remote areas, areas of low socioeconomic status), early career, pre-endorsed practitioners should be permitted to deliver Better Access services provided suitable supervision is available."* Less than half (46%) agreed or strongly agreed, however, that *"The requirement to have a set period of clinical practice experience before being eligible to provide Better Access services should be removed but appropriate credentialing should be retained (e.g., conditions around registration and qualifications)."* In the Phase 2 discussion, concerns were expressed that permitting early career practitioners to deliver Better Access as a solution to workforce issues in regional and underserved communities was not acceptable. It was felt that would result in those communities being staffed by underqualified practitioners, exacerbating the current perception that regions receive poorer quality and more transient care than metropolitan areas. There were also concerns that such an approach to

Rebate levels should reflect differences in provider training levels.

addressing workforce issues would only increase the risk of harm to the consumer. It was felt that continuity of care would be compromised, particularly in regional areas, with early career practitioners requiring incentivization to remain in regional areas post-placement. Ensuring adequate supervision was also seen to be problematic and burdensome with many participants voicing concerns about attracting and retaining supervisors, particularly in regional areas. Telehealth supervision was raised as a potential option particularly for early career practitioners in regional areas.

Figure 11.7: Levels of agreement/disagreement with synthesis statements on early career practitioners

To build the workforce, especially in underserved areas (e.g., rural and remote areas, areas of low socioeconomic status), early career, pre-endorsed practitioners should be permitted to deliver Better Access services provided suitable supervision is available.



The requirement to have a set period of clinical practice experience before being eligible to provide Better Access services should be removed but appropriate credentialing should be retained (e.g., conditions around registration and qualifications).



Topic: Eligible providers

Responses to the Phase 1 survey identified the topic of eligible providers as an important for consideration for the future of Better Access. Comments were synthesised into two statements: *"Expanding the range of eligible providers will address provider shortages in underserved areas (e.g., rural and remote areas, areas of low socioeconomic status), increase the availability of bulk-billing, reduce waiting times, empower patients to select the care they want, and address upstream factors including the social determinants of mental health" and "Any type of health or allied health professional should be eligible to deliver services under Better Access, as long as they are credentialed and/or registered and/or have Masters level qualifications, and deliver therapies for which there is robust evidence of effectiveness."*

These statements were fleshed out in the discussion in Phase 2, and the second statement was split in two for the rating exercise in Phase 3. The level of agreement/disagreement with these statements is shown in Figure 11.8.

In Phase 3, two thirds of participants (65%) agreed or strongly agreed that "Expanding the range of eligible providers will address provider shortages in underserved areas (e.g., rural and remote areas, areas of low socioeconomic status), increase the availability of bulk-billing, reduce waiting times, empower consumers to select the care they want, and address upstream factors including the social determinants of mental health." The same proportion of participants (65%) agreed or strongly agreed that "Any health or allied health professional who delivers evidence-based mental health therapies should be eligible to provide services under Better Access."

The Phase 2 discussion shed further light on this. Some participants felt that expanding Better Access to include providers without foundational mental health training would be inappropriate. Credentialing was seen as an important mechanism for ensuring that practitioners meet minimum standards for quality practice and that appropriate oversight from registering bodies is in place. In Phase 3, 70% of participants

agreed or strongly agreed that "Any health or allied health professional who meets minimum standards of qualification and competency and is registered by an accredited body (e.g., AHPRA) should be eligible to provide services under Better Access."

Figure 11.8: Levels of agreement/disagreement with synthesis statements on eligible providers

Expanding the range of eligible providers will address provider shortages in underserved areas (e.g., rural and remote areas, areas of low socioeconomic status), increase the availability of bulkbilling, reduce waiting times, empower consumers to select the care they want, and address upstream factors including the social determinants of mental health.



Any health or allied health professional who delivers evidencebased mental health therapies should be eligible to provide services under Better Access.



Any health or allied health professional who meets minimum standards of qualification and competency and is registered by an accredited body (e.g., AHPRA) should be eligible to provide services under Better Access.



Topic: Geographic access

Addressing workforce shortages in rural and remote areas was raised as a priority area for reforms to Better Access in the Phase 1 survey. The comments were synthesised into the following statement: *"The scarcity of providers in rural and remote areas must be addressed. This might involve incentivising providers to practice in these areas, providing outreach, or offering telehealth and phone services."*

In the discussion that ensued in Phase 2 participants shared insights about how this might be done and in Phase 3 there was universal or near-universal agreement with each of three revised statements (see Figure 11.9). All participants (100%) agreed or strongly agreed that *"The relative scarcity of providers in rural and remote areas must be addressed"* and 97% agreed or strongly agreed that *"Incentives to attract new providers and reward existing providers should be implemented to address workforce shortages in rural and remote areas (e.g., increased training and supervision opportunities, financial incentives)."* However, in Phase 2, participants noted that it was important that initiatives to address scarcity of

services in rural and remote areas should not result in reduced quality of offerings and that the permanent workforce be grown rather than encouraging short-term transient providers. Some had additional ideas about incentives, mentioning scholarships for local regional residents and improved training and supervision opportunities for the existing workforce in regional areas.

Almost all participants (99%) felt that *"Funding for telehealth and phone services for rural and remote areas should be continued"*, noting that it should not be assumed that telehealth is accessible to all.

Figure 11.9: Levels of agreement/disagreement with synthesis statements on geographic access

The relative scarcity of providers in rural and remote areas must be addressed

0

Disagree

0

Neither

agree nor

disagree

79.2

Agree

20.8

Strongly

agree

90

80

70

60

50

40

30

20

10

0

Strongly

disagree

Percentage





Incentives to attract new providers and reward existing providers should be implemented to address workforce shortages in rural and remote areas (e.g., increased training and supervision opportunities, financial incentives).



Topic: GP mental health treatment plan and review

A number of participants listed changes to the mental health treatment plan and review process as key in the Phase 1 survey. This resulted in two initial synthesis statements. The first was about removal of the plan and its associated processes: *"The administrative burden of referral, review, and reporting should be removed. This could be done by removing the requirement for a GP mental health treatment plan and allowing consumers to self-refer, removing or reducing the frequency of GP reviews over the life of a plan, and/or reducing the frequency of allied health professional reports back to the GP." The second synthesis statement proposed an alternative in the form of an online referral and communication platform: <i>"The referral process could be streamlined by establishing an online platform where GPs can complete the*"

referral and send this electronically to allied health professionals. Allied health professionals and GPs could then communicate via this online platform for seamless and collaborative care."

The Phase 2 discussion was wide-ranging on this issue. Many participants recognised communication and collaboration between GPs and allied health professionals as important, and the mental health treatment plan was seen as one means of facilitating communication between GPs and other providers. However, there was little support for the current mental health treatment plan preparation and review arrangements as a means for achieving this. There was some scepticism about GPs' ability to accurately diagnose mental health problems. Comments were also made about the variable quality of plans, and how plans work for consumers who do not have a regular GP. Many felt that a simple GP referral would be sufficient, potentially via an online platform that could be used for subsequent communication between the GP and the allied health professional. Some felt that consumers should have the option of self-referral but others thought this was a risky approach, raising concerns about potential conflicts of interest and risk management. Although there were mixed views on the value of the mental health treatment plan, the review process had very little support in the discussion where it was described as overly burdensome for consumers and providers, an administrative hurdle with little clinical value, and doing little to facilitate collaborative care between GPs and providers.

In Phase 3, the original synthesis statement was split into four revised statements, and Figure 11.10 shows the responses to these. Over half of the participants (55%) agreed or strongly agreed that *"The administrative burden of referral, review and reporting should be reduced by removing the requirement for a GP mental health treatment plan and allowing consumers to self-refer directly to the mental health professional."*

There were also strong levels of agreement regarding the frequency of GP reviews and allied health professional reports back to GPs. Seventy four percent agreed or strongly agreed that *"The administrative burden of referral, review and reporting should be reduced by removing or lessening the frequency of GP reviews over the life of a mental health treatment plan"* and 65% agreed or strongly agreed that *"The administrative burden of referral, review and reporting should be reduced by lessening the frequency of allied health professional reports back to the GP."*

The greatest endorsement was for a statement about streamlining the process via an online platform. Almost all participants (92%) agreed or strongly agreed that *"The referral and reporting process could be streamlined by establishing a secure, low-cost online platform where the GP could complete the referral and send it electronically to the allied health professional, and both providers could communicate."*

Figure 11.10: Levels of agreement/disagreement with synthesis statements on GP mental health treatment plan and review

The administrative burden of referral, review and reporting should be reduced by removing the requirement for a GP mental health treatment plan and allowing consumers to self-refer directly to the mental health professional.



The administrative burden of referral, review and reporting should be reduced by lessening the frequency of allied health professional reports back to the GP.





The referral and reporting process could be streamlined by establishing a secure, low-cost online platform where the GP could complete the referral and send it electronically to the allied health professional, and both providers could communicate.



Topic: Integration with other parts of the health system

In the Phase 1 survey, participants raised the integration of Better Access with other parts of the health system as a priority. These comments were synthesised into the following statement: "Better Access providers should be integrated with other parts of the health system (e.g., with GPs, community mental health services, emergency departments, and inpatient mental health services). Integration would involve collaboration and coordination with other services that the consumer may or may not already be accessing. It would include referral to and from various services and providers - e.g., physical health or psychosocial support services, counsellors (for consumers with milder conditions). Integration would be facilitated by electronic data linkage. This would enhance care and result in better outcomes for the consumer."

In the Phase 2 discussion, it was generally accepted that greater integration was required, with comments made about better integration of both allied health professionals and GPs. There was recognition that there might be barriers to establishing new systems and processes of integration, including issues of privacy and informed consent. There were also suggestions that better integration would require financial investment and the development of overarching, cross-service platforms.

The administrative burden of referral, review and reporting should be reduced by removing or lessening the frequency of GP reviews over the life of a mental health treatment plan. In Phase 3, the original synthesis statement was split to reflect some of the Phase 2 discussion (see Figure 11.11). Ninety four percent of participants in the Phase 3 survey agreed or strongly agreed that *"Allied health professionals who provide services through Better Access should be better integrated with other parts of the health system, as appropriate (e.g., through collaboration and coordination with GPs, emergency departments, community and inpatient mental health services, and physical health and psychosocial support services)."* Seventy four percent agreed or strongly agreed that *"A key role of the GP is to facilitate integration on behalf of the consumer by facilitating referring to and from various services and providers."*

Figure 11.11: Levels of agreement/disagreement with synthesis statements on integration with other parts of the health system

Allied health professionals who provide services through Better Access should be better integrated with other parts of the health system, as appropriate (e.g., through collaboration and coordination with GPs, emergency departments, community and inpatient mental health services, and physical health and psychosocial support services).



A key role of the GP is to facilitate integration on behalf of the consumer by facilitating referring to and from various services and providers.



Topic: Involvement of consumers and carers in care

In Phase 1, the involvement of consumers in care was seen as a critical feature of Better Access going forward, as was the involvement of family members and carers. The various comments in relation to this were synthesised into the following two statements to prompt discussion in Phase 2: *"Consumers should be more involved in the development of their own mental health treatment plans"* and *"Means of encouraging more family and carer support for consumers and better sharing of information should be investigated."*

In Phase 2 there was some discussion about how these goals might be operationalised, with suggestions that increasing consumers' mental health knowledge would aid them in making decisions about their care, and that introducing a Medicare item number for GPs to consult with families and carers could be beneficial. There was also discussion about the need to assess family and carer involvement in light of the needs and wishes of consumers.

In Phase 3 the original statements were modified slightly. The level of agreement/disagreement with them is shown in Figure 11.12. There was widespread support for both statements, with 94% of participants agreeing or strongly agreeing that *"Consumers should be empowered to be more involved in the development of their own mental health treatment plans"* and 95% agreeing or strongly agreeing 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."*

Figure 11.12: Levels of agreement/disagreement with synthesis statements on involvement of consumers and carers in care

Consumers should be empowered to be more involved in the development of their own mental health treatment plans.



Processes that encourage family and carer support for consumers and better sharing of information should be established where appropriate and safe for the consumer.



Topic: Monitoring and outcomes

In Phase 1 there were a number of suggestions about quality and safety monitoring and routine outcome measurement. These were synthesised into the following two statements: *"Systems should be implemented for monitoring safety and quality, technology security, market demand, reporting of adverse events (e.g., suicide), and identification of provider training needs. These systems should be developed and implemented with input from people with lived experience of mental illness"* and *"Routine outcome measurement should be implemented to ensure quality and safety, regulated practice, population level outcomes and overall economic value of the Better Access program. People with lived experience should have key input into the design of routine outcome measurement. Such measurement might potentially be implemented at a local level, at least in the first instance."*

The discussion that ensued in Phase 2 suggested that participants valued monitoring and outcome measurement but that they felt that the purpose of each needs to be clearly articulated. They commented on goals related to service improvement, accountability in terms of government spending, and providing feedback to providers on how consumers were progressing. They noted concerns about the feasibility of introducing routine outcome measurement, commenting on the additional burden for providers and technical issues. They also suggested that measures of symptom severity and levels of functioning potentially used for outcome monitoring might not be able to capture the varying needs of Better Access consumers or the subjective experience of mental illness. They also noted that if such a routine outcome measurement system was to be developed, it should be informed by people with lived experience of mental illness.

The statements were modified accordingly for the Phase 3 survey, and the responses reflect the discussion (see Figure 11.13). Seventy three percent of participants agreed or strongly agreed that "Routine outcome measurement should be implemented for service improvement and to ensure quality and safety, regulated practice, population level outcomes and the overall economic value of the Better Access program." A smaller though still significant proportion (56%) agreed or strongly agreed that "Establishing a system of routine outcome measurement ensures that the consumer is at the centre of treatment."

Seventy eight percent agreed or strongly agreed that *"Generic, standardised measures of outcome will not be able to capture the complexity of presentations to Better Access providers."* Ninety two percent agreed or strongly agreed that *"Any system of routine outcome measurement should be developed and implemented with input from people with lived experience of mental illness."*

Figure 11.13: Levels of agreement/disagreement with synthesis statements on monitoring and outcomes

Routine outcome measurement should be implemented for service improvement and to ensure quality and safety, regulated practice, population level outcomes and the overall economic value of the Better Access program.



Generic, standardised measures of outcome will not be able to capture the complexity of presentations to Better Access providers.



that the consumer is at the centre of treatment.

Establishing a system of routine outcome measurement ensures



Any system of routine outcome measurement should be developed and implemented with input from people with lived experience of mental illness.



Topic: Multidisciplinary teams and holistic treatment

In the Phase 1 survey there were comments on multidisciplinary teams and holistic treatment that were synthesised into the following statement: "There is a need for a broader workforce than mental health professionals delivering therapy in isolation. Multidisciplinary teams made up of peer workers, physical and psychosocial support services, housing services etc. would allow for a much more holistic approach. All of these providers/services should be remunerated for working collaboratively."

This statement prompted considerable discussion in Phase 2. Much of this discussion centred around the contention that Better Access is serving people with increasingly complex needs, partly because of shortfalls in the public sector mental health system, and that their needs are only likely to be met by multidisciplinary teams. The statement prompted participants to think about the kinds of providers who might make up multidisciplinary teams, as well as how these teams might operate and be recompensed. Peer workers were promoted, as were additional item numbers that would allow for case conferencing and care coordination, additional training for providers, and shared care between Better Access providers and the public sector system. There were suggestions that much of this would not be possible within the existing Better Access system, and that alternative models of care would be required.

The statement was revised and split into two for the Phase 3 survey and the responses are shown in Figure 11.14. The majority of participants (92%) agreed or strongly agreed with the first revised statement, which was *"People with complex and chronic mental health problems require a multidisciplinary approach for effective treatment, and consideration should be given to how Better Access can provide such an approach to meet the needs of this group."* Concerns about how a multidisciplinary approach could be incorporated into the current Better Access model were reflected in the fact that 75% of participants agreed or strongly agreed that *"Better Access Medicare-funded service model cannot accommodate a holistic multidisciplinary approach (which would include integrated private and public health, mental health, and social support services) without a fundamental restructure."*

Figure 11.14: Levels of agreement/disagreement with synthesis statements on multidisciplinary teams and holistic treatment

People with complex and chronic mental health problems require a multidisciplinary approach for effective treatment, and consideration should be given to how Better Access can provide such an approach to meet the needs of this group.



Better Access Medicare-funded service model cannot accommodate a holistic multidisciplinary approach (which would include integrated private and public health, mental health, and social support services) without a fundamental restructure.



Topic: Number of sessions in relation to need

Many Phase 1 participants commented on aligning session numbers to consumer need as a key area for reform to Better Access. Some felt the number of sessions should reflect need, while others considered that all individuals should have the same number of sessions available to them. Their comments were synthesised into two statements. The first of these was: *"The number of sessions should match clinical need. The current number of sessions is only adequate for simple mental health issues. People with moderate to severe or chronic mental illness should be entitled to more sessions, as should people in crisis, people with complex issues, people who have experienced trauma, and people who require more extensive treatment for recovery. This will ensure continuity of care and reduce demand on hospital and other mental health services. It will assist people to work towards recovery rather than management of their diagnosis." The second synthesis statement was: <i>"No one mental illness should be prioritised over another and all people should be entitled to the same number of sessions in a year, regardless of their diagnosis."*

These statements generated a considerable amount of discussion in Phase 2, much of which focused on the idea that the session numbers mean that Better Access is not ideal for people with complex needs. There was an acknowledgement, however, that Better Access was not designed to provide long-term psychosocial support for those who may require more extensive treatment for recovery.

The Phase 2 discussion yielded a revised set of four statements for Phase 3 and the levels of agreement/disagreement with these are shown in Figure 11.15. Eighty-seven percent of Phase 3 participants agreed or strongly agreed that *"The current number of Better Access sessions is only adequate for people with simple mental health issues, and a greater number of sessions should be*

available for people with more complex needs who require more extensive treatment for recovery (e.g., people with moderate-to-severe or chronic mental illness, people who have experienced trauma)."

There was much less agreement (34%) with the statement that "No one mental illness should be prioritised over another, and all people should be entitled to the same number of sessions in a year regardless of their diagnosis." However, this appeared to be driven, at least in part, by the fact that many participants did not think that diagnosis was the appropriate way to assess need and that levels of functioning and distress should be considered, and that decisions about session numbers should be based on clinical judgement and discussions with the consumer. Ninety percent of participants agreed or strongly agreed that "Diagnosis is not the optimal way of determining how many sessions a person needs, and functionality and distress should be considered as well as or instead of diagnosis." Ninety- five percent agreed or strongly agreed that "Clinical judgement and consumer input should play a role in determining the number of sessions required."

Figure 11.15: Levels of agreement/disagreement with synthesis statements on number of sessions in relation to need

The current number of Better Access sessions is only adequate for people with simple mental health issues, and a greater number of sessions should be available for people with more complex needs who require more extensive treatment for recovery (e.g., people with moderate-to-severe or chronic mental illness, people who have experienced trauma).



Diagnosis is not the optimal way of determining how many sessions a person needs, and functionality and distress should be considered as well as or instead of diagnosis.



No one mental illness should be prioritised over another, and all people should be entitled to the same number of sessions in a year regardless of their diagnosis.



Clinical judgement and consumer input should play a role in determining the number of sessions required.



Topic: Number of sessions – general

In Phase 1 there were also more general comments about the session numbers available through Better Access. These did not relate to levels of need, but rather to the additional 10 sessions and whether these

should be made available in an ongoing way, as part of standard practice. Some felt that they should; others felt that offering 20 sessions to all would benefit existing consumers but create greater access problems for new consumers. These comments were synthesised into two statements: *"Better Access is not a short term intervention so the number of available sessions should be expanded to a standard 20 per year, with the option of carrying sessions over into the next year"* and *"Access to sessions for new consumers should be prioritised over extending the number of sessions for existing consumers."*

Phase 2 participants discussed these alternative propositions at length, with the discussion favouring the former. Some felt that the proposition to prioritise new consumers was unethical. The synthesis statements were not changed for the Phase 3 survey (see Figure 11.16). Seventy five percent of Phase 3 participants agreed or strongly agreed with the first statement, supporting the expansion of the number of sessions to a standard 20 per year. There was much more limited support for the second statement, with only 27% agreeing or strongly agreeing that new consumers should be prioritised.

Figure 11.15: Levels of agreement/disagreement with synthesis statements on number of sessions – general

Better Access is not a short-term intervention so the number of available sessions should be expanded to a standard 20 per year, with the option of carrying sessions over into the next year.



Access to sessions for new consumers should be prioritised over extending the number of sessions for existing consumers.



Topic: Raising awareness of Better Access

Some participants in Phase 1 made recommendations about raising awareness of Better Access among the general community and among referring GPs. In both cases, this awareness raising encompassed increasing understanding about what different providers have to offer. These recommendations were synthesised into the following two statements: *"There is a need to improve community awareness of the Better Access program, including understanding of the skills and approaches of different providers"* and *"There is a need to equip GPs with knowledge about what different allied health professionals have to offer through Better Access."*

These recommendations resonated with participants in Phase 2. There was discussion about why awareness raising was important, with participants suggesting that it would lead to consumers being better matched to providers. There were also comments about allied health professionals taking the lead in educating GPs about their skills and approaches.

The synthesis statements remained unchanged for Phase 3. In Phase 3, 86% of participants agreed or strongly agreed with the former statement and 84% agreed or strongly agreed with the latter (see Figure 11.16).

Figure 11.16: Levels of agreement/disagreement with synthesis statements on raising awareness of Better Access

There is a need to improve community awareness of the Better Access program, including understanding of the skills and approaches of different providers.



There is a need to equip GPs with knowledge about what different allied health professionals have to offer through Better Access.



Topic: Telehealth

Telehealth was also raised by participants in Phase 1 and their comments were synthesised into the following statement: "Telehealth options should continue to be offered and strengthened. Telehealth has many benefits, providing access for those living in rural and remote areas, residents of aged care facilities, and people who may be unable to travel. It also provides treatment options for those who do not wish to physically attend services for privacy or other reasons."

The statement generated rich discussion in Phase 2, with many participants commenting on the benefits of telehealth. These included improving access for those living areas with relatively few providers and/or in residential aged care facilities, offering privacy for those in small communities in regional, rural, and remote areas, and providing an alternative option for people who were unable to travel or did not wish to attend face-to-face sessions for personal reasons. Some participants cautioned, however, that telehealth should be seen as an adjunct to face-to-face care rather than a replacement. Some also commented on the need for phone sessions in areas where technological issues made the internet unreliable.

In Phase 3, the original statement was synthesised into a much briefer statement which read: *"Telehealth options that allow for online sessions (e.g., via Zoom) should continue to be offered."* There was almost universal support for this statement, with 99% of participants agreeing or strongly agreeing with it (see Figure 11.17).

Figure 11.17: Levels of agreement/disagreement with synthesis statement on telehealth

Telehealth options that allow for online sessions (e.g., via Zoom) should continue to be offered.



Topic: Types of therapy

The Phase 1 survey yielded a number of responses related to the types of therapy available under Better Access. These responses were synthesised into two statements. The first of these was: *"The current list of therapies is outdated, and whole-of-person care should be offered that goes beyond individual therapy and is aligned with a biopsychosocial approach. This care might include early intervention and preventive approaches, resilience building, low-intensity supports, online post-treatment support, and social prescribing. Offering a broader range of services would reduce waitlists, improve consumer outcomes, reduce consumer costs, give consumers choice and empower them, make access more equitable, and better respond to diverse needs. Practitioners should decide what is appropriate for individual consumers." The second statement was: <i>"Any additional therapies that are made eligible must be evidence-based."*

In Phase 2 much of the discussion of these two statements centred around the idea that mental health and physical health are two sides of the same coin, and that both are influenced by social determinants. For participants, the corollary of this was that in order for Better Access to provide whole-of-person care, a wider range of therapies and supports is required than is currently available. Many saw the list of currently approved therapies as outdated and limited. There was an acknowledgement that if new therapies were to be added that they must be evidence-based but participants had different views about what constituted evidence. Some emphasised evidence from scientific studies, albeit with disagreement over the level of evidence that is acceptable with some arguing for randomised controlled trials in samples of people with mental illness and others arguing for observational studies in more diverse samples. Other participants gave preference to the views of people with lived experience about what works.

The Phase 2 discussion resulted in the original synthesis statements being modified for the rating exercise in Phase 3. There were three synthesis statements rated in Phase 3 and the ratings are shown in Figure 11.18. Ninety two percent of participants agreed or strongly agreed with the first of these: *"In order to provide whole-of-person care, a wider range of therapies and supports is required than is currently available through Better Access (e.g., therapies that address social determinants and physical health problems, and a broader range of mental health focussed therapies)."* High proportions also agreed with the other two statements: *"If additional therapies are to be added to the list of those offered through Better Access, they must have evidence of effectiveness from scientific studies"* (87%) and *"If additional therapies are to be added to the ymust have support from people with lived experience of mental health problems"* (78%).

Figure 11.18: Levels of agreement/disagreement with synthesis statements on types of therapy

In order to provide whole-of-person care, a wider range of therapies and supports is required than is currently available through Better Access (e.g., therapies that address social determinants and physical health problems, and a broader range of mental health focussed therapies). If additional therapies are to be added to the list of those offered through Better Access, they must have evidence of effectiveness from scientific studies.



If additional therapies are to be added to the list of those offered through Better Access, they must have support from people with lived experience of mental health problems.



Topic: Training for allied health professionals

Some Phase 1 participants recommended that undergraduate training and continuing professional education for allied health professionals should be key features of Better Access, moving forward. The various recommendations were synthesised into the following statement: *"To strengthen workforce capability there is a need for additional mental health training at undergraduate level for all allied health courses. There is also a need for continuing professional development that promotes understanding of Better Access and engagement with people with lived experience."*

This statement generated a range of responses in Phase 2. Some participants felt that mental health training should be included in all allied health professional undergraduate courses. Others felt that integrating generic mental health training into undergraduate degrees might be less beneficial than investing in postgraduate mental health training for those who had chosen to pursue clinical careers. Some felt that continuing professional development around Better Access would be helpful, whereas others thought this was unnecessary as allied health professionals are already required to undertake ongoing professional development to maintain their registration. A number of participants commented on the need to incorporate the perspectives of people with lived experience into allied health professionals' training at all levels.

The discussion in Phase 2 led to the original statement being split into three. The level of agreement/disagreement with these revised statements is shown in Figure 11.19. Eighty two percent agreed or strongly agreed that *"Mental health training should be core to all allied health professional graduate and undergraduate courses."* Eighty seven percent agreed or strongly agreed that *"There is a need for continuing professional development for Better Access providers to promote understanding of the program and its associated administrative requirements."* Ninety one percent agreed or strongly agreed that *"The quality of care provided through Better Access would be improved by incorporating the perspectives of people with lived experience into allied health professionals' undergraduate and postgraduate training and continuing professional development."*

Figure 11.19: Levels of agreement/disagreement with synthesis statements on training for allied health professionals





There is a need for continuing professional development for Better Access providers to promote understanding of the program and its associated administrative requirements.



The quality of care provided through Better Access would be improved by incorporating the perspectives of people with lived experience into allied health professionals' undergraduate and postgraduate training and continuing professional development.



Topic: Training for GPs

Some Phase 1 participants cited training for GPs as a key feature of Better Access in the future. Their comments were synthesised into the following two statements: "GPs need more basic and ongoing training in providing mental health treatment and in what allied health professionals can offer. They also need regular feedback/support from allied health professionals to increase their competence and confidence, and this should be remunerated" and "The current training for GPs to access higher mental health treatment plan rebates is useful upskilling."

In Phase 2 discussions, participants noted that the current training in mental health assessment and treatment that GPs undertake to access the higher rebates for preparing mental health treatment plans was useful. They discussed expansions to training, noting that information about what specific allied health professionals can offer would be valuable. Some participants felt that regular professional development in the area of mental health should be mandatory, while others indicated that this would not be feasible given the range of presenting issues that GPs manage.

The original statements were simplified and reduced to a single statement for Phase 3. As Figure 11.20 shows, 84% of participants agreed or strongly agreed that *"GPs need more basic and ongoing training in conducting mental health assessments and providing mental health treatment."*



Figure 11.20: Levels of agreement/disagreement with synthesis statement on training for GPs

GPs need more basic and ongoing training in conducting mental health assessments and providing mental health treatment.

Ranking of priorities for reform

The final exercise in the Phase 3 survey involved participants ranking the broad topic areas in terms of priorities for reform. Figure 11.21 shows the overall ranking, based on mean rank.

In general terms, rankings fell into four broad groups. The top-ranked group (ranked 1-3) were focussed on improving Better Access for consumers: improved affordability, increased involvement of consumers and carers in care, and more equitable geographic access. Affordability was ranked particularly highly. The next group of priorities (ranked 4-10) largely concerned the scope of the Better Access: the amount and type of care, and who should provide that care. The third group of priorities (ranked 12-15) related to reforms to the current structures and requirements associated with Better Access, such as rebate levels, diagnostic eligibility and the referral and review processes. The final and lowest rank group of priorities (ranked 16-18) concerned quality improvement initiatives, training of relevant providers and routine outcome monitoring.


Figure 11.21: Priorities for reform by mean ranking

Discussion

Summary and interpretation of findings

The aim of the process was to identify a collective view of reform priorities for Better Access. As would be expected, given the diversity of stakeholders and the varying nature and degree of their involvement with Better Access, there was diversity in the views expressed. However, there was broad agreement on a number of priorities for reform. The divergence of views tended to relate to the specific mechanisms through which these priorities might be achieved.

Collective views on areas for reform

There was a collective view 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 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 increasing making Better Access care more integrated and multidisciplinary. Some 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 does not add 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.

Strengths and limitations

Study 8 had a number of strengths. It involved a large number of stakeholders with different relationships to the Better Access program. It included significant representation from people with lived experience of mental illness and family members/carers. The majority of these stakeholders were nominated by professional organisations and peak bodies, and most had an in-depth understanding of Better Access.

The three-phase process allowed participants to generate a list of priorities for reform, to discuss these at length in a safe environment, and to rate and rank them. The overall response rate and the response rate for each of the phases was high, and participants were very engaged in the process. Ultimately, the Study 8 design allowed us to identify a collective view of potential reforms, but also to take account of dissenting views.

Study 8 also had several limitations, however. The sample included more service providers than representatives from other groups. This may have meant that some of the discussion of the technical and administrative aspects of Better Access may have been less relevant to people with lived experience of mental illness, carers, and representatives from advocacy organisations. However, discussion of those topics invariably intersected with broader questions around affordability and access which were relevant to all participants. There was also the potential for the most engaged participants to dominate the discussion and therefore have a disproportionate influence over the extent and tone of the discussion. However, the three-phase process mitigated this; the Phase 1 survey allowed all participants to contribute topics to the list to be discussed, the analysis of the discussion forum in Phase 2 was inclusive of the full range of views across the topics and not just those which attracted the most discussion, and the Phase 3 survey gave all participants equal standing in assessing the relative importance of topics and priorities for reform.

Conclusions

Study 8 explored the views of 90 stakeholders with involvement in, or knowledge of, Better Access or the public mental health treatment system. Collective views emerged on several areas for future reform. These included addressing current issues with affordability and access, expanding the scope of the program to accommodate consumers with a broader range of needs, streamlining program processes and requirements, and including the input of people with lived experience of mental illness. There was less agreement on the mechanisms for achieving such changes.

Many of the issues discussed by participants related to the fact that the scope of Better Access has changed; whereas it was originally designed to provide short-term interventions for people with mild to moderate mental illness, it is now also serving people with more complex needs who may require longer-term care. Any reforms to Better Access must take place in the context of the role of Better Access in the broader mental health system. Decisions about the position and role of Better Access will determine the target consumer cohort for the program, which will in turn define the types of providers and therapies required.

12. Study 9: Piloting a routine outcome measurement and feedback system

Introduction

Both the MBS Review Taskforce¹⁸ and Productivity Commission¹⁹ identified a need for routine consumer outcome data to support continuous quality improvement at the program level and at the clinical practice level. At a program level, aggregated outcome data can be used to assess whether Better Access is achieving its goals, and to identify areas for improvement. At the clinical practice level, providers can use consumer outcome data to track individual consumers' progress over time and to guide feedback-informed therapy, and many providers already use outcome measurement tools for this purpose.

There are precedents for systematic collection of consumer outcome data to inform program quality improvement elsewhere in the Australian mental health system. Outcome data from public sector inpatient and community services are collated and reported on by the Australian Mental Health Outcomes and Classification Network (AMHOCN) via the Mental Health National Outcomes and Casemix Collection (MH-NOCC).¹⁰⁸ In primary mental health care, outcome data are collated by Primary Health Networks via the Primary Mental Health Care Minimum Data Set (PMHC MDS).¹⁰⁹ There are also examples from overseas, including data collected through *iaptus*,¹¹⁰ the clinical software that supports routine outcome measurement for the Improving Access to Psychological Therapies (IAPT) program in the United Kingdom.¹¹¹

Study 9 examined the potential feasibility, acceptability and utility of routine collection of outcome data in the context of Better Access. It also considered whether routine outcome measurement could yield data of sufficient quality for program-level monitoring and quality improvement purposes. Importantly, Study 9 focussed on potential targets for program-level reform and not on assessing the effectiveness of treatment for individual consumers, the psychometric properties of any specific outcome measure, or the performance of individual providers or provider types.

Methods

Study design

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, aged 18 years and older, 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 (<u>https://novopsych.com.au/</u>) was used to manage the data. The NovoPsych platform is used by psychological service providers to collect and analyse consumer outcome data to support and improve their clinical practice. Study 9 did not evaluate the NovoPsych platform but used it as an already-established outcome data collection platform to host the study.

Sampling and recruitment

We used a multi-pronged recruitment strategy. Professional organisations circulated a notice about the study to their membership via direct email, newsletters, and/or social media channels. Organisations included the Australian Association of Psychologists Inc, Australian Association of Social Workers, Australian Clinical Psychology Association, Australian Psychological Society, Institute of Clinical Psychologists, and Occupational Therapy Australia. In addition, NovoPsych circulated the notice to all current users. In both cases, the notice directed providers to the study registration page where they were

provided with more information and asked to register their interest and answer some eligibility questions.

Providers were eligible to participate in Study 9 if they: (a) were a clinical psychologist, psychologist, social worker or occupational therapist who provided Better Access services; (b) were currently accepting new consumers; and (c) anticipated providing Better Access services to at least one new consumer aged 18 or over in the six-week period following the commencement of the study. New and existing NovoPsych users were eligible to participate.

Eligible providers were then contacted and directed to an onboarding page where they reviewed the study's plain language statement (see Appendix 31), provided their consent to participate if they decided they wished to take part (see Appendix 32), and provided additional information about their practice.

Data collection and analysis

Routine outcome measurement

Participating providers were given NovoPsych accounts or accessed the study interface via their existing accounts if they were a current NovoPsych user. They invited eligible new consumers to participate in the study, providing them with a plain language statement (see Appendix 33) and seeking informed consent (see Appendix 34) from those who agreed to take part. At each treatment session for these consumers the providers entered a session number and the relevant MBS item number, and consumers completed the DASS-21 by entering responses directly into the NovoPsych database via tablet, smartphone, or computer. In order to capture the entire episode of care, participating providers were asked to enrol the new consumer, collect their consent, and administer the DASS-21 at the first session. The DASS-21 was selected as the outcome measure as it is brief, widely used, and has sound psychometric properties.^{3, 4} An introductory webinar was held on 12 September 2022 to introduce the study, provide information on undertaking routine outcome measurement as part of clinical practice, and offer instructions on using the NovoPsych platform. The consumer enrolment period was six weeks (12 September to 23 October 2022), and the total data collection period was 10 weeks (12 September to 20 November 2022).

Data quality review

De-identified session-based data were extracted from the NovoPsych system and provided to the evaluation team. Data were examined for completeness, uniqueness, validity (implausible values) and timeliness of data capture using Excel and STATA SE16. Results are reported as frequencies and percentages.

The magnitude of improvement or deterioration in DASS-21 scores was not analysed because Study 9 was not designed to quantify consumer outcomes. Studies 2, 3, 4 and 5 did this.

Provider survey

In Week 8 of the data collection period all 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 (see Appendix 35). The survey included a mix of closed and open-ended questions on using routine outcome measures for the purposes of quality improvement and supporting clinical practice. All providers who had agreed to take part in the study were eligible to participate in the survey even if they had not enrolled any consumers or conducted any outcome measurement. The survey was open from 31 October to 7 November 2022.

Frequencies and percentages were computed for responses to closed questions using STATA SE16 and responses to open-ended questions were summarised, and common themes were identified as relevant.

Approvals

The University of Melbourne Human Research Ethics Committee approved the study (HREC 2022-24222-31752-5).

Acknowledgements

We would like to acknowledge the professional organisations that assisted us with recruitment for the study. We would also like to thank the providers and consumers who contributed to the study.

Results

Sample description

Figure 12.1 shows the provider and consumer recruitment and data collection flow. In total, 156 Better Access providers registered their interest in participating, 58% of whom were current NovoPsych users. Six of those registering interest were ineligible and 73 (48.7%) of the remaining 150 progressed to the onboarding stage where they provided their consent to participate.

Figure 12.1: Provider and consumer samples



Providers who completed onboarding

The majority of the 73 providers who completed onboarding were clinical psychologists (n=31, 43%) or psychologists (n=28, 38%), with fewer social workers (n=12, 16%) and only two occupational therapists (3%). Similar proportions of participating providers were based in New South Wales (22%), Victoria (26%) Queensland (21%) and Western Australia (22%). Fewer came from South Australia (7%) and Tasmania (3%), and none came from the Northern Territory or the Australian Capital Territory.

Over half (57%) of the 73 onboarded providers were solo practitioners (see Figure 12.2). Better Access consumers comprised over 50% of all consumers for 80% of participating providers (see Figure 12.3). Only 3% of these providers' practices were "bulk-billing only" practices; 54% exclusively charged a co-payment and 42% sometimes bulk-billed and sometimes charged a co-payment.

The main types of therapy practiced by the 73 onboarded providers were cognitive behavioural therapy (CBT) and acceptance and commitment therapy (ACT), with other therapies mentioned including eye movement desensitisation and reprocessing therapy (EMDR), relationship, family and couples therapy, counselling, dialectical behaviour therapy (DBT), schema therapy, interpersonal therapy (IPT) and psychodynamic and trauma-informed therapy approaches.





Figure 12.3: Percentage of onboarded providers' consumers accounted for by Better Access consumers (n=73)





Over the course of the 10-week data collection period, 17 providers withdrew from the study without recruiting any consumers. Reasons provided for withdrawal included not having enough time to

participate, not taking new consumers, health reasons, being uncomfortable with the technology, feeling that participation would take time out of sessions with consumers, the brevity of the consumer recruitment period, feeling that routine outcome measurement was not appropriate for consumer who had complex needs or required particular types of therapy, privacy concerns, and personal reasons. In total, 56 providers remained in the study.

Providers who obtained consent from at least one consumer

Twelve (21%) of the 56 providers who remained in the study obtained consent from at least one consumer and collected at least one DASS-21 measurement.

Consenting consumers

Forty five consumers consented to participate, but for 10 (27%) of these no further data were captured.

Consumers for whom at least one DASS-21 was collected

Outcome measurement data were available for 35 consumers. Between them, these consumers had data recorded for a total of 88 sessions. Table 12.1 shows the number of sessions record per participating consumer. The maximum number of session records for a single consumer was six.

# OF SESSIONS RECORDED ^a	# OF CONSUMERS	%
1	10	29
2	9	26
3	9	26
4	4	11
5	2	6
6	1	3
Total	35	100%

Table 12.1: Number of session records per consumer

^a This table indicates the number of session records not the session number. For example, a consumer may have three session records in the dataset, but these may be for data collected at session 2, 3 and 4 of their course of treatment.

Providers who completed the provider survey

Twenty five (45%) provider participants completed the service provider survey, the majority (64%) of whom were existing NovoPsych users at the commencement of the study. The mix of survey participant professions reflected the overall provider sample in the study (52% were clinical psychologists, 32% were psychologists, 12% were social workers, and 4% were occupational therapists). All survey participants had previously used outcome measurement as part of their clinical practice, with 76% indicated they did so frequently, 16% occasionally and 8% infrequently.

Data quality review

Completeness

As noted, outcome data were collected for 88 sessions for 35 consumers. There were 10 additional consumers who were enrolled and consented but for whom no further data were collected.

There were nine consumers for whom session data were recorded but for whom one or more session record was missing from their sequence of sessions. Five consumers had no Session 1 record, one consumers had no Session 2 record, two consumers had no Session 1 and 2 record, and one consumer was missing records for Sessions 1-3.

The NovoPsych platform was programmed in a forced-response manner, which meant that the session number and MBS item number were recorded first, and then the DASS-21 scores. This meant that where DASS-21 data were recorded for a session, there was no missing data in the session number and MBS item number fields. However, nine (10.2%) of the 88 sessions had session and MBS item numbers recorded but no DASS-21 scores.

The NovoPsych database does not retain incomplete DASS-21 records so for the nine instances where DASS-21 data were missing, there was no information available at all (e.g., whether entry of the DASS-21 scores was begun but halted, and if so at what point). There are several potential reasons for missing DASS-21 data, including that the provider forgot or chose not to ask the consumer to complete the DASS-21, or that the consumer declined to complete the measure or began but did not finish doing so.

There is some indication that the proportion of sessions with missing DASS-21 data increased progressively with the number of the session, albeit with an exception for Session 3 (see Figure 12.4). However, it is difficult to draw firm conclusions about this because of the small number of consumers for whom five or six sessions were recorded.



Figure 12.4: Percentage of sessions missing DASS-21 data, by session number

Participating providers were contacted in the final week of data collection and asked to review their session data and enter missing session numbers and dates in the consumer's record. As noted, the data entry logic of the NovoPsych platform meant that these were sessions at which the DASS-21 would not have been entered. Seven providers added data for a total of 10 sessions. Three of those providers ceased collecting outcome data after the first session, and the other four collected data in at least the first three sessions before ceasing.

Uniqueness

There was one duplicate record identified for one consumer. This was entered at both Session 2 and Session 3, but all other values, including the date of DASS-21 completion, were the same.

Validity

The structure of the NovoPsych platform minimised the likelihood of implausible values. There were no implausible MBS item numbers as a closed set of MBS item numbers was provided in a drop-down format with no mechanism for entering alternative item numbers.

Session number was programmed to be pre-fill based on the previous session entered, however providers could also manually enter numbers. It was evident that they did this in order to account for missing session records (see above). Although there were some missing session records and there were

potential inaccuracies in the session numbers entered (see below), there were no implausible values *per se*.

The closed-response structure of the DASS-21 measure ruled out the possibility for out-of-range values in scores.

Timeliness of data capture

The study protocol required participating providers enrol and consent consumers and commence collecting routine outcome data from the first session of a new episode of care. The provider survey (see below) indicated that a number of providers prefer to have the DASS-21 completed prior to the session. They achieved this either by emailing the participant a link to self-complete the DASS-21 online or allowing them to complete it in the practice waiting room.

Irrespective of whether the first outcome measurement was administered prior to or during the first session, a comparison of the date the consumer provided consent with the date of Session 1 DASS-21 administration provides a proxy indicator of whether this occurred. For 13 (37%) of the 35 consumers, consent and Session 1 DASS-21 completion occurred on the same day, and for a further five (14%) the DASS-21 was completed the day following consent.

Data for the remaining 22 (63%) consumers directly suggests that outcome measurement did not commence in the first session. For two consumers consent and first DASS-21 were recorded as being completed on the same date but at Session 2. For five consumers (14%) there was a gap of two to seven days between consent and DASS-21 completion and the session was recorded as Session 2 with no Session 1 recorded. For seven consumers (20%) the session was marked as Session 1 but there was a gap of between four and 16 days between the consent date and the DASS-21 completion date, making it likely that there was a prior unrecorded session at which consent was collected. In the remaining instances, the first DASS-21 completion was recorded as occurring at Session 3 (two consumers) or Session 4 (one consumer) with the consumer consent dates between seven and 35 days prior to session dates.

The data do not provide any further explanation of the putative delays in commencing outcome data collection, but there are several plausible explanations. These include the provider being unwilling or judging it inappropriate to administer the DASS-21 in the first session with a new consumer, that they forgot to do so, that they made an error entering the session number, or that the consumer was unwilling, or only partially completed the DASS-21 at the initial session so no record was retained.

Provider survey

Feasibility of routine outcome measurement

We used the ability of providers to enroll consumers as a proxy indicator of feasibility of routine outcome measurement, although we note that if routine outcome measurement were to be implemented at scale the processes for collecting outcome data would need to be simpler. Figures 12.5 and 12.6 show the number of consumers approached and recruited by providers who responded to the survey. Nine (36%) survey participants did not approach any consumers to participate in the study. Among the remaining 16, seven (28%) had no consumer agree, and nine (36%) enrolled consumers and collected outcome data.



Figure 12.5: Number of consumers approached by providers who participated in the survey

Figure 12.6: Number of consumers enrolled by providers who participated in the survey



Survey participants provided a range of reasons for not approaching consumers including that they had not seen any new Better Access consumers, all their consumers were aged under 18, they did not feel being approached to participate in a study was appropriate for their consumers, the DASS-21 was not suitable for their consumers, they did not have time, or they forgot.

We also considered the ease of administering outcome measurement as an indicator of feasibility. All survey participants were asked about this, irrespective of whether they had enrolled consumers in Study 9. Figures 12.7 and 12.8 show the results. In total, 84% of survey participants agreed or strongly agreed that it was easy to explain outcome measurement to consumers, with only 12% disagreeing. There were mixed responses on frequency of measurement, with over 50% of survey participants indicating that administering outcome assessments at every session is overly burdensome but 28% not finding this to be the case.



Figure 12.7: Agreement/disagreement that the process of explaining outcome measurement to consumers is easy

Figure 12.8. Agreement/disagreement that it is overly burdensome to administer outcome assessments at every session



Usefulness of routine outcome measurement

The survey asked providers about the usefulness of routine outcome measurement in the context of clinical practice. Eighty percent of survey participants agreed or strongly agreed that incorporating routine outcome measurement was beneficial to their interaction with consumers (see Figure 12.9).

Figure 12.9: Agreement/disagreement that routine outcome measurement is beneficial to their interaction with consumers



Survey participants indicated a range of ways in which conducting routine outcome measurement was useful to their clinical practice, as well as potential barriers (Figure 12.10). In terms of benefits, aiding in adjusting treatment was most commonly endorsed (76%). Smaller, but still sizeable proportions of survey participants found it provided another avenue for consumers to raise issues (28%) and allowed consumers' progress to be tracked (19%). The most frequently noted barriers to routine outcome measurement were that the assessment scales were not appropriate for the complexity of some consumers' issues (40%) and some consumers were uncomfortable with it (36%). When describing other issues, the length of the outcome measure and challenges faced by providers who preferred consumers to complete the measure prior to the session (e.g., via an email link) were noted.



Figure 12.10: Benefits of and potential barriers to routine outcome measurement^a

^a Multiple responses permitted

Acceptability of routine outcome measurement: Acceptability to consumers

Survey participants were asked whether their consumers had expressed concerns about outcome measurement. Figure 12.11 shows that almost one quarter (24%) indicated that none of their consumers had expressed concerns about outcome measurement. The most commonly endorsed concerns related to consumers having difficulty understanding the benefit of outcome measurement (36%), feeling that it wasted time during the session (32%), worrying about how their data would be used (28%), and data security and privacy concerns (24%).



Figure 12.11: Consumer concerns regarding outcome measurement^a

^a Multiple responses permitted

Survey participants were invited to respond to open-ended questions about barriers to and enablers for achieving consumer engagement with routine outcome measurement. Some of the barriers related to the concerns noted above, including time taken from the session, data security and privacy concerns, and consumers not seeing the value of outcome measurement. Other barriers related to the literacy level of consumers, technical or compliance issues (e.g., consumers not completing measures prior to the session), and providers not understanding the benefits sufficiently or feeling comfortable enough to get consumers on board. Several survey participants commented on the difference between outcome measurements being conducted as part of a research study and outcome measurement being done more routinely, noting that the complexity of the consent process for the former acted as a barrier for some consumers.

Key enablers centred around the attitudes and abilities of providers, including their level of motivation and engagement, their ability to seamlessly integrate outcome measurement into the session, and their capacity to demonstrate the benefits to the consumer by providing meaningful feedback. The use of appropriate measures and making measurement voluntary were also considered enablers.

Acceptability of routine outcome measurement: Acceptability for clinical practice (self)

Eighty percent of survey participants agreed or strongly agreed that they found conducting routine outcome measurement to support their own clinical practice acceptable, with only 12% disagreeing or strongly disagreeing (see Figure 12.12).



Figure 12.12: Agreement/disagreement that routine outcome measurement to support clinical practice is acceptable (self)

Only three survey participants indicated that they did not find routine outcome measurement acceptable for their own clinical practice. Their reasons were that it did not deal with the complexity of their consumers' issues, or that was incompatible with their therapeutic approach or their interpersonal consumer-therapist style.

Survey participants were asked to provide comments on their main considerations around conducting routine outcome measurement to support their own clinical practice. The two main themes that emerged related to technology and implementation considerations. Technology considerations included the platform needing to be of "high integrity", to be secure and easy to use during and prior to sessions, and to ideally have automated administration and scoring features. Implementation considerations related to the need for upskilling practice administration staff to support outcome measurement, the time required to set up the system and procedures, and the need for additional support and skill development for providers. Beyond these two main themes, other factors that were noted included the need for a range of valid and appropriate measures to be available, and an acknowledgement that that outcome measurement would not be suited to all consumer situations and/or presenting conditions.

Acceptability of routine outcome measurement: Acceptability for clinical practice (peers and profession as a whole)

Around half (48%) of the survey participants agreed or strongly agreed their peers and profession as a whole would consider using routine outcome measurement to support clinical practice acceptable (see Figure 12.13). Only 8% thought it would not be acceptable, with a substantial proportion (44%) of survey participants neither agreeing nor disagreeing.





Those who felt that their peers and the profession as a whole would not consider routine outcome measurement acceptable for supporting their clinical practice gave the same reasons as above (i.e., that it did not deal with the complexity of their consumers' issues, or that was incompatible with their therapeutic approach or their interpersonal consumer-therapist style).

Similarly, when they were asked to comment on the main considerations they thought would be relevant to their peers and profession in implementing outcome measurement, survey participants tended to reiterate the comments they had made regarding their own clinical practice (i.e., perceived benefits for consumers, time considerations for providers, and the appropriateness for consumers with complex needs). The most commonly raised new considerations were that routine outcome measurement needed to be able to be seamlessly integrated into regular practice and its purpose understood. Other comments included that many clinicians probably already do conduct outcome measurement in some form, but probably not in an optimal manner. Finally, several survey participants noted that they did not feel that they could speak on behalf of their peers.

Acceptability of routine outcome measurement: Acceptability for program-level quality improvement (self)

Levels of acceptability of routine outcome measurement as a quality improvement mechanism for Better Access tended to be lower than levels of acceptability of routine outcome measurement for supporting clinical practice (see Figure 12.14). Around half (48%) of the participants agreed or strongly agreed that they would find it acceptable to provide deidentified data collected from routine outcome measurement to policy makers for the purpose of understanding if the Better Access program is achieving its goals and for identifying areas for improvement. Twenty four percent disagreed or strongly disagreed, and 28% neither agreed nor disagreed.





When asked to indicate the factors that impacted on their own acceptability rating, a majority of survey participants highlighted the importance of routine outcome measurement for monitoring the extent to which Better Access is achieving its goals (52%) and for informing improvements to the program (64%; Figure 12.15). However, there were also high levels of endorsement of factors that negatively impacted on participants' perceptions of the acceptability of routine outcome measurement for quality assurance purposes, particularly concerns about how the data would be used (72%).





^a Multiple responses permitted

It is worth highlighting some of the "other" concerns that survey participants noted. These included concerns that outcome measurement would be taken as the sole indicator of effectiveness of treatment or of individual providers' performance. In this context, participants mentioned that outcome measurement tools can only capture change against specific constructs and cannot account for the complexity of conditions or change in other areas of a consumer's situation. There were also concerns about the frequency of assessment being a burden to the provider and the consumer.

Acceptability of routine outcome measurement: Acceptability for program-level quality improvement (peers and profession as a whole)

The majority of survey participants (60%) did not have a view on acceptability to their peers and profession of providing deidentified data from routine outcome measurement for monitoring and quality improvement purposes (see Figure 12.16). Of those who did express a view, more agreed it would be acceptable (24%) than disagreed or strongly disagreed (16%).

Figure 12.16: Agreement/disagreement that it would be acceptable to provide deidentified outcome measurement data for program-level monitoring and quality improvement (peers and profession as a whole)



Figure 12.17 shows that when survey participants were asked about the factors that might have an impact on acceptability for their peers and profession, there was much lower endorsement of the importance for program-level outcome monitoring (32%) and somewhat lower endorsement of the importance of quality improvement (52%) than when survey participants reported their own views. There were generally also higher levels of endorsement of the factors that would negatively impact acceptability, with the exception of concerns about how the data would be used. Where "other" factors were described, these were similar to those that survey participants indicated for themselves, although one participant made the additional comment that a lack of remuneration for involvement in routine outcome measurement would impact on its acceptability.

Figure 12.17: Factors impacting on acceptability to self of routine outcome measurement being used as a mechanism of quality improvement (peers and profession as a whole)^a



^a Multiple responses permitted

Facilitators of routine outcome measurement for program-level quality improvement

At the end of the survey, participants were asked an open-ended question about the factors that would facilitate the acceptance and implementation of routine outcome measurement for the purpose of program-level quality improvement. Participants identified a range of facilitators. Some of these related to implementation and included the need for prior consultation with providers (e.g., on the scope of routine outcome measurement, the specific measures, the frequency of data collection, and the use to which data would be put), and consideration of costs and funding models required to support routine outcome measurement. Other facilitators were related to the logistics of routinely collecting outcomes and included suggestions about automating the collection process, providing free access to relevant software, and not requiring lengthy consumer consent processes. Still other facilitators were about communication and education; participants underscored the need for the rationale, purpose and use of data to be clearly explained to providers, and highlighted the importance of transparency around the implications of poor outcomes being identified at a program level. Integration into clinical training and alignment with best practice were noted as a potential approaches to increasing acceptability and uptake. The fact that outcome measurement cannot capture all of the relevant changes that may be occurring for a given consumer was again mentioned. The need for strong assurances around anonymity and data privacy and security were also prominent in the responses. Finally, there was some resistance to the prospect of mandating outcome data collection and the suggestion that if it were optional it might be more readily accepted.

Discussion

Summary and interpretation of findings

In Study 9, 12 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 later 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 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.

Undertaking outcome measurement is clearly feasible at an individual practice level. Indeed, it is widely done already (e.g., in Study 2, we had data on over 86,000 episodes of care from four platforms, including NovoPsych). 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.

Strengths and limitations

Study 9 used an established and easy-to-use platform to host the outcome data collection and the sample included a mix of providers who had and had not previously used outcome measurement as part of their clinical practice. There were, however, limitations that should be considered when interpreting the results.

The limited provider sample size and the truncated data collection period significantly impacted on the amount of data collected. With only a six-week recruitment window, many providers had few, if any, new

Better Access consumers commencing treatment. Those who did enrol consumers had a maximum of 10 opportunities to collect outcome data if they saw consumers weekly, but as recruitment often took place later in the six-week window and consumers had less frequent sessions the maximum number of session recorded for any consumer was six.

Another limitation is the composition of the provider sample, with a lack of representation of social workers and occupational therapists. While the aim of the study was not to compare outcomes by provider type, important information on the feasibility and acceptability of outcome measurement among those two professions is missing. Nonetheless, many of the issue impacting on acceptability identified by clinical psychologist and psychologist participants will also be relevant to social workers and occupational therapists. Another sample issue is the bias in the provider survey participant sample toward those who have prior experience of and thus are more amenable to using routine outcome measurement in their clinical practice. The reluctance to survey participants to speak on behalf of their peers and profession signals that the study findings should be interpreted with caution and that further consultation and pilot programs are required.

The fact that providers were trialing routine outcome data collection in the context of a research study proved a barrier to enrolling some consumers. Some barriers (e.g., formal consent process, concerns about use of the data, lack of clarity around the purpose) may not reflect those that would exist if routine outcome collection was rolled out more broadly.

Conclusions

The benefits of routine outcome measurement to support clinical practice are well known and were reinforced by the, admittedly small, sample of Better Access providers who participated in Study 9. However, participating providers expressed considerable reservations about the level of acceptability of collecting outcome data for program monitoring and quality improvement purposes. Those reservation were amplified when participants reflected on their peers and professions possible attitudes to acceptability.

To maximise acceptability, any system contemplated must be efficient, flexible and easy-to-use, and have robust data governance and transparency around data use. Financial incentives are also likely to be required to guarantee provider buy-in. Beyond system characteristics, achieving a high level of engagement from providers is critical. As Study 9 demonstrated, even service providers who are amenable to collecting outcome measures may encounter difficulties in motivating consumers and not necessarily collect data in a protocol-compliant way.

Although limited in scale, Study 9 indicates that introducing routine outcome measurement to Better Access for the purposes of monitoring and quality improvement is a major undertaking that will require significant effort and investment in consultation and communication, system design, technology, and ongoing administrative and financial support.

13. Addressing the research questions

The findings from the evaluation address the research questions across the various domains articulated in the Evaluation Plan. We have summarised these below.

Accessibility

What is the overall level of uptake of Better Access services, and how has this changed over time (and in response to program refinements)?

Study 1a showed that, in 2021, more than 2.6 million Australians (one in every 10 Australians) received at least one Better Access service and more than 1.3 million people (one in every 20 Australians) received at least one session of psychological treatment through Better Access. In recent years, the number of treatment services delivered has increased more than the number of people treated. When adjusted for population growth, the number of treatment services delivered increased by an average of 7% per year while the number of persons treated increased by 1% per year. For every person treated through Better Access in 2021, 5.4 sessions were used (up from 4.5 in 2018).

Study 1a also showed that changes to the program rules around Better Access have influenced the ways people receive psychological treatment through the program. Although face-to-face service provision remained dominant mode of delivery, uptake of telehealth and phone services has been substantial, accounting for one third (33%) of Better Access treatment services in 2021. The additional 10 sessions of treatment for people experiencing difficulties due to COVID-19 accounted for 15% of all individual treatment sessions in 2021. Through the expansion of Better Access services to residents in aged care facilities in late 2020, approximately 400 RACF residents received 1,600 Better Access treatment sessions. Together these program changes contributed to the sustained level of uptake of Better Access treatment and growth in levels of treatment service utilisation.

Study 1b suggested that these program refinements may have differentially favoured existing Better Access users. In recent times, an overall reduction in the percentage of new users (a decline from 56% in 2018 to 50% in 2021) has occurred in parallel with an increase in the median number of services provided to all users. In 2021, new users were more likely to only receive their treatment services face-to-face compared to continuing users (65% versus 52%) and were less likely to use additional sessions (8% versus 27%).

The overall 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 increase of 4.0% 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 6.7% since 2018). This equates to \$618 per person treated and \$31 per capita in 2021.

Do patterns of uptake vary by different groups of item numbers (e.g., plans, treatment services, treatment services by provider type)?

Findings from Study 1a showed that, in 2021, GPs and other medical practitioners prepared a mental health treatment plan for more than 1.4 million Australians (54.1 per 1,000 population), reviewed a mental health treatment plan for more than 500,000 (20.3 per 1,000), and provided mental health treatment consultations to approximately 1 million people (38.1 per 1,000).

People who received Better Access treatment services made up approximately half of all Better Access users in 2021. People who received focussed psychological strategies delivered by psychologists accounted for the greatest proportion of this group (approximately 730,000 people or 28.0 per 1,000),

followed by those who received psychological therapy services from a clinical psychologist (approximately 540,000 or 20.5 per 1,000), followed by those who received focussed psychological strategies delivered by social workers (approximately 100,000 people or 3.9 per 1,000), GPs/other medical practitioners (approximately 12,500 people or 0.5 per 1,000) and occupational therapists (approximately 12,000 people or 0.5 per 1,000).

In 2021, consultant psychiatrists conducted an initial patient consultation for approximately 150,000 Australians (5.7 per 1,000), prepared a psychiatrist assessment and management plan for 42,000 (1.6 per 1,000), and a review of a psychiatrist assessment and management plan for 7,500 (0.3 per 1,000).

Do patterns of utilisation vary by levels of co-payment?

Findings from Study 1a showed that the costs of Better Access services to consumers have increased. Copayment rates increased across most types of Better Access services with the biggest jump occurring in 2021 and continuing into 2022. In 2021, around half (47%) of all Better Access services involved a copayment by the consumer (up by 9% per year from 36% in 2018). Nearly two thirds (65%) of Better Access treatment services used in 2021 involved a co-payment (up by 7% from 53% in 2018). Co-payment rates varied considerably across providers and service types, varying from 5.4% of mental health treatment consultations delivered by GPs/other medical practitioners to 83.8% of initial patient consultations delivered by consultant psychiatrists. For treatment services, co-payment rates ranged from 32% for focussed psychological strategies delivered by GPs/other medical practitioners to 69% for psychological therapy services delivered by clinical psychologists.

For services where the consumer paid a co-payment, the median out-of-pocket cost per service in 2021 was \$74 for all Better Access services and \$74 for Better Access treatment services. Between 2018 and 2021, the average annual change in median out-of-pocket costs was modest across most item groups (change of no more than +/- 5%). In the first half of 2022, however, median co-payments showed strong increases compared to 2021 (\$87 for all Better Access services and \$90 for treatment services). The largest increases were for treatment services delivered by allied health professionals and initial patient consultations delivered by psychiatrists.

For people living in major cities, there was a gradient in co-payment rates and median out-of-pocket costs, whereby those residing in areas of greatest disadvantage were the least likely to make a co-payment and, if a co-payment was made, to pay lower out-of-pocket costs while people in higher socioeconomic status areas were the most likely to make a co-payment and to pay a higher amount. This was generally true across all provider and item groups, although there tended to be more variation by socioeconomic areas for allied health professional services than for GP/other medical practitioner services. For people in inner regional, outer regional and remote areas, the percentage of services with a co-payment was generally similar. Median co-payments overall were higher for people in remote compared to inner regional and outer regional areas, although this varied across providers and item groups.

Study 1a also found that, as the number of sessions a consumer received increased, so too did the likelihood that they made a co-payment at a given session or at any previous session. For example, for consumers who had a mental health treatment plan prepared in 2018, just over half made a co-payment at their first session (55%); this proportion was higher in later years (68% in 2021 and 72% in 2022). The proportion of consumers who had made a co-payment at any previous session increased with each additional session received. The increases were greater for plans prepared in 2018-2020 (up by 21%-23% by the 20th session) than for plans prepared in 2021 (up by 13% by the 20th session). These findings may indicate that people who are able to afford co-payments are more likely to go on to receive more treatment. The attenuated increase in 2021 could be because co-payment rates were higher to start with and thus there was less scope for them to increase.

What is the relationship between use of Better Access treatment services and use of other mental health services?

Study 1a the relationships between the uptake of Better Access treatment services and other Commonwealth-funded mental health services, using data collated at an area level. It found a positive relationship of uptake of Better Access treatment 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 provided more detail on the relationship between Better Access use and use of antidepressants/anxiolytics, overlaying the data with an individual-level measure of socioeconomic status (equivalised household income) and considering levels of need (as assessed by the K-10). It suggested that those on the lowest incomes may be preferentially offered pharmacological treatment instead of psychological therapies; their use of Better Access treatment services was the lowest of all income groups and they were most likely to be dispensed antidepressants/anxiolytics.

Study 4 provided further insights into the relationship between use of Better Access and other mental health services at an individual level. Broadly speaking, our Study 4 estimates of Better Access treatment service utilisation and the percentages who made out-of-pocket payments for these services correspond to previous studies of Better Access treatment users.⁹³⁻⁹⁵ Study 4 contributed new information about the use of other mental health care among Better Access treatment users, and showed that this varied in line with their levels of mental health need. Specifically, we found that individuals with greater prognostic severity used more Better Access treatment services and were also more likely to use services delivered by other mental health specialists and services or other professionals. Overall, half to three quarters of Better Access treatment users also used medications for mental health at some point during follow-up; again, those with greater levels of prognostic severity were the most likely to do so. These findings reflect that people with more severe problems are more likely to require more intensive levels of care or care that addresses multiple needs; however we did not have information in Study 4 about the temporal relationships between the different types of services used or the reasons for their use.

Stakeholders in Study 8 also commented on the relationship between Better Access and other mental health services, in the context of considering multidisciplinary holistic treatment. They were very much in favour of whole-of-person care and acknowledged that the current parameters of Better Access make it difficult for the program to deliver this in isolation.

Who are the main users of Better Access?

Study 1a showed that, in all years from 2018 to 2021, rates of uptake and utilisation of any Better Access service, and of any Better Access treatment service, were highest among females (compared to males), people aged 15-24 and 25-44 years (compared to those aged 0-14, 45-64 or 65 and over), and people living in major cities and inner regional areas (compared to people living in outer regional and remote areas). Levels of uptake and utilisation changed over time, with increases particularly apparent for some of these same groups (females, people aged 15-24 and 25-44 years, people in major cities in high socioeconomic status areas).

Study 1a also showed that the uptake of new services introduced in Better Access in response to the COVID-19 epidemic, namely the COVID-19 telehealth and phone treatment services and the additional 10

individual treatment sessions, tended to be higher among people aged 15-24 and 25-44, females, and people in higher socioeconomic status areas in major cities. An exception was for rates of uptake of COVID-19 phone treatment services which were highest among people in lower socioeconomic status areas in major cities.

Has Better Access reached groups in the population who are traditionally disadvantaged in terms of access to access to mental health care?

Study 1a showed that rates of uptake and utilisation of Better Access treatment services increased for people in remote areas (by 4.1% and 10.2% on average per year, respectively, between 2018 to 2021) – on par with increases for people in higher socioeconomic areas in major cities – although the rates themselves remained lower than for people living in all other areas. This increase in remote areas was due to a relatively smaller drop-off in the use of face-to-face treatment services coupled with relatively higher uptake of only the telehealth and/or phone treatment options.

In contrast, people aged 65 and over and males, and people living in major cities in lower socioeconomic status areas and in regional areas, who traditionally have lower rates of access to mental health care, experienced relatively lower (or negative) rates of growth in uptake and utilisation than their counterparts. As noted above, an exception was that rates of uptake of COVID-19 phone treatment services were higher among people in lower socioeconomic status areas within major cities (10.0 per 1,000 persons) compared to other geographic area groups (1.8 to 7.5 per 1,000).

Study 1a also showed that males (compared to females) and people in outer regional and remote areas (compared to those in major cities and inner regional areas) were somewhat less likely to receive Better Access treatment following a mental health treatment plan and, when they did, were less likely to receive a review, and used fewer treatment sessions.

Study 1b also shed light on the question of whether Better Access is reaching people who are traditionally disadvantaged in terms of access to mental health care. It confirmed the finding from Study 1a that people on low incomes are significantly less likely to use any Better Access service and any Better Access treatment service than those on higher incomes, despite the fact that their levels of need are greater. Study 1b also highlighted that this disparity has increased over time.

In addition, Study 1b showed that First Nations people use Better Access services at higher rates than non-First Nations people, but that this higher level of use is not commensurate with their greater levels of need.

Responsiveness

What are the barriers and facilitators to consumers accessing Better Access?

Studies 3, 6, 7 and 8 shed light on the barriers consumers face in accessing Better Access. Study 3 suggested that, for some consumers at least, out-of-pocket costs for appointments may be prohibitive. The findings from Study 6 and Study 7 were consistent with this. Study 6 interview participants who had and hadn't used Better Access highlighted financial barriers to using the program. The providers and referrers who took part in Study 7 consistently noted that the affordability and timeliness of care provided through Better Access act as barriers, as did the participants from across stakeholder groups in Study 8. Living in a regional, rural, or remote area was also identified by Study 8 stakeholders as a barrier for consumer access due to the limited provider workforce.

Studies 3 and 6 also highlight some consistent facilitators to consumers using Better Access. Sometimes these were the converse of the barriers; the fact that Medicare made services free or affordable for many was seen as particularly important. Many of the consumers who participated in Study 3 found the referral process straightforward, and most were positive about the mental health professional they saw. For

Study 6 participants, the strongest enablers mostly related to mental health professionals themselves and their manner, approach, and flexibility. GPs were seen to play an important role in enabling access in a number of different ways.

Appropriateness

Is Better Access reaching consumers with mild to moderate mental health conditions?

Better Access was originally designed to encourage more people to seek support for their mental illhealth, particularly those with mild to moderate mental health conditions who may respond well to short-term evidence-based interventions.² Studies 1b, 2, 3, 4, 5 and 8 suggest that Better Access is reaching this target group, but also that it is reaching people with potentially lesser and greater levels of need. It is important to acknowledge that the definitions of minimal/mild, moderate and severe that we used in these studies may not correspond exactly to the definitions of severity of mental health conditions applied in the Better Access program guidelines.¹¹² In Studies 4 and 5, for example, we used a particular definition of severity that related to prognosis.

Study 1b showed that use of Better Access varied as a function of psychological distress, with 6% of those with low levels of psychological distress using treatment services in 2017-18 compared with 25% of those with very high levels of psychological distress.

In all of our purpose-designed analyses in Study 2, there was considerable variability in terms of baseline scores on the given measure. This suggests that Better Access services are being made available to those with mild to moderate mental health conditions, as well as to those with more severe conditions.

In Study 3, survey participants entered their episodes of Better Access care with varying levels of selfrated mental health. Many (nearly 60%) rated their mental health at 3 or below on our 10-point scale before they received care, but most of the remainder gave their mental health a mid-range score. This suggests that although a majority may have come into Better Access care with severe mental health conditions, a substantial proportion are likely to have done so with mild to moderate conditions.

Our Study 4 analyses also showed that, over a 12-month period, Better Access treatment services were used by people with varying levels of prognostic severity and symptoms, quality of life and functioning. Our Study 5 findings were consistent with this, showing that over longer periods (between 1.87 and 4.65 years) Better Access services were accessed by people with differing levels of prognostic severity. Collectively, these findings are broadly consistent with those from previous studies.^{93,95} Stakeholders in Study 8 repeatedly emphasised that in their experience people with more complex and chronic conditions were increasingly using Better Access.

Study 4 extended the information in Studies 2, 3 and 5 by enabling us to make comparisons between those who used Better Access (with or without other mental health services), and those who used other mental health services alone. The former had poorer *mental health* at baseline than those who used other mental health services only (noting that this category included a range of different professionals and service types) or no mental health services, which is consistent with findings reported from the 45 and Up study.⁹² This group also had similar levels of *general* health and functioning to those who used other mental health services.

What are the typical trajectories of care under Better Access (e.g., what proportion of plans are followed by treatment services, how many episodes of care involve a review)?

Study 1a showed that approximately two thirds of mental health treatment plans were followed by one or more treatment sessions, although the data suggested a decline in this proportion in 2021. Study 1b confirmed this. Study 1a showed that 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 more than 21 or more sessions and <1% received 31 or more. An uptick in the percentage of episodes with 11-20 and 21-30 sessions in 2020 corresponds to the introduction of the additional 10 sessions in response to COVID-19.

Study 1a showed that more than one third of mental health treatment plans that were followed by treatment sessions involved a formal review through the dedicated MBS items, although again the data suggested that this proportion had decreased over time. 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.

Study 1a also estimated that the median wait time between a mental health treatment plan and the first treatment session increased from 18 days in 2018 to 22 days in 2021 (an average change of 6.9% each year). Study 1b produced similar findings for adults only over slightly different time periods, showing median wait times of 14 days in 2017-2018 and 19 days in 2020-21.

In Study 1a, median wait times were longer for those aged 0-14 and 15-24, compared to older age groups and were shorter for people in major cities (higher and medium socioeconomic status areas) than for people in other geographic areas. Similarly, Study 1b found that an inverse relationship between wait times and income levels, with wait times being longest for those on low incomes. This socioeconomic gradient became more pronounced over time.

Do the treatment planning and referral pathways in Better Access work optimally?

Studies 3, 6, 7, and 8 provide insights into the way in which the treatment planning and referral pathways in Better Access are operating. The most positive findings came from Study 3. In this study, over 90% of the survey participants indicated that they were referred to their Better Access mental health professional via a GP. The majority indicated that they found the referral process straightforward.

In Study 6, however, the views of interview participants were not quite so consistent. Although the majority of those who had used Better Access found the referral process smooth, some experienced difficulties with it. Most felt that their mental health treatment plan reflected their current situation, but a few reported that the plan was not accurate.

Study 7 added the perspective of providers and referrers on these processes. Their views suggest that the treatment planning and referral pathways in Better Access may not always work optimally, but when they do they are one of the keys to the success of the program in achieving positive outcomes for consumers. The various provider and referrer groups we surveyed highlighted the importance of the treatment planning and referral pathways from their different viewpoints. For example, the importance of seamless referral channels was highlighted by allied health professionals, many of whom felt that the process of referral and review by a GP or other medical practitioner is not always smooth. Allied health professionals also noted that good communication with referrers acted as a facilitator. GPs supported this, indicating that good communication with and documentation from relevant allied health professionals were key facilitators.

Stakeholder participants in Study 8 likewise noted the value of the mental health treatment plan as a mechanism for coordinating care but pointed to shortcomings with the referral process related to variable quality of mental health treatment plans, diagnosis requirements, and awareness of the services offered by different allied health providers. The review requirements were generally considered by Study 8 participants as overly burdensome for both providers and consumers and more efficient mechanisms for coordinating care should be investigated.

Is the care provided through Better Access consistent with best practice?

Studies 3 and 6 did not ask consumers about to detail the care they received through Better Access, and Study 7 did not ask providers about the specific care they offer through the program. Nonetheless, all three studies provide indications about whether Better Access care is consistent with best practice. Study 8 provided a more general consideration of what constitutes best practice.

A relevant concept here is minimally adequate treatment, which has been defined elsewhere on the basis of findings from psychotherapy trials and clinical practice guidelines as receipt of cognitive behavioural therapy or psychotherapy via six or more consultations of 30 minutes or longer average.¹¹³ However, the precise number of recommended sessions varies by diagnosis, and will be influenced by a range of factors, including whether the consumer presents with comorbidities.¹¹⁴ The majority of Study 3 survey participants appreciated the strategies that their mental health professional taught them, and it might be reasonable to assume that these strategies would have been delivered in the context of cognitive behavioural therapy or some other evidence-based approach mandated by Better Access. The average number of sessions that participants received (or expected to receive) was 12.45, although again we note that this reflects our sampling strategy which involved deliberately over-sampling people who had received additional sessions over and above the standard 10.

One of the consistent findings from Study 7 was that many providers felt that Better Access enabled them to deliver care that is "appropriate" and "tailored to consumers' needs". These sorts of features are key to "best practice" care. In Study 8 stakeholder elaborated further on this arguing that providers, in partnership with consumers, are best placed to determine what is the most appropriate care and treatment options should not be restricted to the current set of therapies approved by Better Access. However, there was no agreement on the threshold of evidence required before a treatment approach be considered best practice and included as part of Better Access.

The majority of Study 3 participants, and all of the Study 6 participants reported positive outcomes from the care they received through Better Access. The majority of providers and referrers who took part in the Study 7 survey were confident that Better Access is achieving positive outcomes for consumers in terms of reducing their symptoms, increasing their levels of functioning, and improving their overall mental health and wellbeing. The fact that Better Access seems to lead to positive outcomes for consumers suggests that providers are offering them high quality care.

Are mental health workforce issues impacting upon provision of Better Access?

There were some indications from Studies 3, 6, 7, and 8 that mental health workforce issues may be influencing provision of services through Better Access. In particular, the barriers identified in relation to wait lists and delays in receipt of care suggest that there may be capacity issues, particularly for allied health professionals. Some providers in Study 7 suggested that these capacity issues might be overcome by expanding the list of eligible providers to include, for example, provisional psychologists, accredited counsellors, and mental health nurses. Stakeholders participating in Study 8 concurred that for regional, rural, and remote consumers workforce was a significant and urgent issue impacting on the availability and quality of care. They were also in agreement that across Better Access as a whole there is a capacity issue with respect to workforce. Although various solutions were suggested by stakeholder participants, there was no clear agreement on which approach to take with arguments made for and against

expanding the eligible provider types, introducing new therapy types, restricting or expanding session numbers and so on.

Effectiveness

Does the mental health of consumers who receive care under Better Access improve?

Studies 2, 3, 4 and 5 provide strong evidence that the mental health of significant proportions of consumers who receive care under Better Access improves. Study 6 provides further support for this, bringing in the perspectives of a selected group of Better Access consumers.

It is worth noting here that these studies deliberately assessed outcomes in different ways. Studies 2, 4 and 5 largely used standardised measures of symptom severity (e.g., CES-D, CORE-OM, CORE-10, DASS-21/42, DASS-10, GAD-7, K-10, ORS, PHQ-9, PHQ-2, PANAS), level of functioning (e.g., GAF, K-10+), and quality of or satisfaction with life (SLWS, AQoL8D, EQ-5D-5L). Study 3 used a purpose-designed, self-rated measure of mental health. Study 6 sought more qualitative information, allowing participants to describe outcomes in their own words.

In all of the purpose-designed and pre-existing analyses in Study 2, significant improvement was evident in a majority of episodes (most commonly, improvement occurred in 50-60% of episodes). Significant deterioration occurred in far fewer episodes (usually around 10-15%).

The mental health of participants in Study 3 unequivocally improved, according to their own self-report. Over 90% of participants reported improvement in their self-rated mental health; less than 4% reported deterioration. The majority attributed this improvement, at least in part, to the treatment they received from the mental health professional.

Data from Study 4 also add weight to the argument that the mental health of Better Access users improves. Study 4 showed that between two given points in time, 43%-55% of people that we classified as users of Better Access treatment services experienced significant improvement on measures of depression symptoms, anxiety symptoms, quality of life and functioning over a 12-month period. Conversely, 22%-32% experienced significant deterioration over the same period. The fact that these differ somewhat (smaller proportions improved and larger proportions deteriorated) from what was typically observed in Studies 2 and 3 makes sense because the baseline and follow-up assessment points were not designed to correspond to the beginning and end of an episode of Better Access care. Thus, the Target-D and Link-me cohorts will have included a mix of people who had already commenced an episode of Better Access treatment, people who completed an episode within the follow-up period, and people who were still in care at the end of follow-up. Study 4 further showed that 68-80% of participants improved on *any* of the included measures. This is an important finding given that people seek help for different types of problems and might experience improvements in one but not another domain.

Study 5 also supports the conclusion that the mental health of consumers who receive care under Better Access improves. Participants in Ten to Men and the ALSWH who used Better Access treatment services between any two waves of data collection (T0 and T1) tended to have better mental health at T1 than T0. Typically, between around 45% and 55% of these participants had better mental health at T1 and 25-35% had worse mental health. The same observations made in relation to Study 4 apply here; the data collection waves were not designed to correspond to the beginning and end of Better Access episodes.

It is worth commenting here on the fact that not everyone experienced improvement. In each of the above studies, a proportion of participants remained the same or deteriorated. There may be a number of reasons for this. In Studies 2 and 3, where pre- and post- measures of outcome were closely tied to episodes of care, the reasons may include treatment effects (e.g., of evidence-based forms of care like CBT) may not be as positive in the real world as they were in controlled trials due to factors related to the original trials. These might include journals being more likely to publish studies with positive results, and

researchers "cherry-picking" findings that tell a positive story (or one that aligns with their own views with respect to their treatment approach) or using inappropriate control groups.¹¹⁵ In addition, treatments may not have the same benefits for heterogeneous groups of consumers as they do for more tightly defined groups who typically take part in trials.¹¹⁵ In Studies 4 and 5, some of these reasons may also have applied. In addition, the fact that the study periods did not align to episodes of care may have meant that other factors in people's lives over and above their Better Access use had a significant bearing on changes in their mental health.

Are outcomes better for some consumers than others?

Studies 2, 3, 4 and 5 drilled down into whether outcomes are better for some consumers than others. In Study 2, outcomes were generally similar for both males and females. In Study 3, survey participants in major cities were no more likely to show improvement than their counterparts in regional, rural and remote areas. The average socioeconomic status of participants' area of residence also had no bearing on outcomes. In Studies 2 and 4 there were some indications that age might make a difference; in Study 2 there were suggestions that relatively lower proportions of older consumers might show improvement on various outcomes, and in Study 4 middle-aged and older adults were also somewhat less likely younger adults to show improvement on anxiety symptom severity. In Study 4, females and those with a certificate/diploma qualification were somewhat less likely to show improvement in functioning, as measured by days out of role. In Study 5, some sociodemographic variables were associated with improvement, but these were not consistent across measures, cohorts or analyses (e.g., younger age was associated with improvement on the CES-D for the ALSWH 1946-51 cohort, but this pattern did not hold elsewhere).

The key variable that was consistently associated with outcomes in Studies 2, 3, 4 and 5, however, was level of baseline severity. In Study 2, consumers who presented for care with the greatest baseline severity were most likely to experience improvement in their symptoms or level of functioning. In Study 3, there was a strong relationship with baseline self-rated mental health and outcomes, with those who entered their Better Access episode of care with worse self-rated mental health more likely to show improvement. This makes sense; those who begin treatment with severe mental health symptoms have had a greater window of opportunity for improvement. In Study 4, the key variables associated with improvement in symptoms, quality of life and functioning were indicators of mental health at baseline. In Study 5, the pattern was the same; the strongest, most consistent predictor of outcomes was baseline severity. This across-the-board finding is as expected, because individuals with higher scores on given measures have a greater window of opportunity for improvement and are less likely to demonstrate floor effects. This finding is largely consistent with our previous evaluation of Better Access.⁹³

We also examined whether outcomes were worse for some consumers than others. Generally speaking, we found patterns relating to deterioration to be the reverse of those for improvement. For example, in Study 4 we found that 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, as measured by days out of role.

Do certain treatment-based factors influence outcomes (e.g., the total number of sessions, the mode of service delivery)?

In Studies 2, 3, 4 and 5 we also considered whether various treatment-based factors were associated with outcomes.

In Study 2 we did this in a limited way, using the number of outcome assessments in the episode as a proxy for the number of sessions, recognising that this is an imperfect indicator. The number of outcome assessments in the given episode was not usually associated with differential outcomes, but where it was improvement was greater in episodes with more outcome assessments. There may be a typical optimal

number of sessions, but we were unable to assess that in Study 2. We would note, however, that consumers who had completed treatment showed greater levels of improvement than those who were still receiving treatment.

In Study 3, we were able to look at a greater range of treatment-based factors. These included the number of sessions, as well as the type of provider seen and the modality through which sessions were delivered. The provider and session modality were not associated with differential outcomes, but the number of sessions received was. Those who received more than 1-2 sessions had greater odds of improvement than those who received only 1-2 sessions. Those who received only 1-2 sessions tended to have ceased care early, and to have done so because they did not find the sessions helpful, they did not like the mental health professional's manner or approach, or the out-of-pocket costs were too high. They did not generally cease care because they felt better. Modality of session delivery (face-to-face, or telehealth phone) was not associated with improvement.

In Study 4, we found some evidence that using five or more sessions of Better Access treatment might increase the odds of significant improvement, or reduce the odds of significant deterioration, in anxiety and depression symptoms among those with a more severe prognosis. These findings are consistent with the idea that more severely unwell people may require a greater amount of psychological treatment to achieve similar outcomes to less severely unwell people.⁸⁸

In Study 5, we also found evidence that the number of sessions was associated with improvement and deterioration, but the results went in the opposite direction. This may have been a function of the amount of time that elapsed between waves of data collection, and the fact that participants' mental health may have varied considerably over time, as may their need for and receipt of care. In this context, the number of sessions may have been a marker for fluctuations in mental health, rather than an indicator of treatment "dose".

Taken together, these findings suggest that greater numbers of sessions equate to greater levels of improvement, particularly for people with high levels of baseline severity, although the picture is not clear-cut. We cannot determine the optimal number of sessions, and nor can we answer questions about cost-effectiveness.

Sustainability

What might future reforms to Better Access look like?

Study 8 captured views on areas for future reform to Better Access from a sizeable and diverse group of stakeholders. Collectively, the group placed considerable emphasis on equity, noting that there is a need to address the affordability of the program and to address issues of geographic access. They also discussed the importance of accommodating consumers with a broad range of needs, involving consumers and carers in care, and streamlining program processes and requirements.

What is the feasibility and acceptability of principles for routinely monitoring outcomes for consumers seen by psychologists and other allied health professionals delivering care through Better Access, and providing feedback to those providers?

Study 9 showed that assessing outcomes in a routine way is feasible, particularly for the purpose of supporting clinical practice by providing feedback to providers. However, acceptability would be likely to be an issue if routine outcome measurement were to be implemented for program monitoring and quality improvement purposes. Addressing this would require consideration of administrative and system issues, data governance and transparency, and financial incentives.

14. Conclusions and recommendations

This final chapter provides a summary of the key findings from the evaluation 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.¹

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 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.

¹ 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.¹⁹ 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."*¹¹⁶ 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.¹¹⁶ 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.¹¹⁶

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.⁶⁶ 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.¹¹⁶ 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.¹¹⁷

Workforce distribution issues were raised by the MBS Review Taskforce, particularly in relation to the lack of providers in rural and remote areas,¹⁸ and are also being picked up by the National Mental Health Workforce Strategy.¹¹⁷ 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.¹⁹ 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.¹⁹ 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)¹¹⁸ 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 Standards¹¹⁹ 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 copayment 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.¹⁸

The MBS Review Taskforce also recommended a range of actions to address rising out-of-pocket costs,¹⁸ many of which are now being considered by the Strengthening Medicare Taskforce.²² These included, but were not limited to, further investigation of the Extended Medicare Safety Net (EMSN).¹⁸ 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.^{18,22} 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.^{18,22,56}

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.^{19,20} 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.^{19,20} 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.^{19,20} 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^{61,120} 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.¹⁹ 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 Commission¹⁹ and the MBS Review Taskforce.¹⁸ 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 <u>done</u> <u>at scale</u> 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*,¹¹⁰ the clinical software that supports routine outcome measurement for the Improving Access to Psychological Therapies (IAPT) program in the United Kingdom.¹¹¹ 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.¹¹⁰

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,¹¹⁰ 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]).^{108,109} 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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