Australian Government

Department of Health and Aged Care

Ministerial Submission – Standard
MS22-900246
Version (1)
Date sent to MO: 13 July 2022

NoteTo: Minister Butler

Subject: Briefing on COVID-19 situation – Friday 15 July 2022 11:30am to 12:30pm (ADE)

Recommendations:

1.	**Note** the Department will brief you on the COVID-19 situation on Friday 15 July 2022.	**1. Noted**
2.	s 47C [redacted]	**2. Noted**
3.	s 34(3) [redacted]	**3. Agreed/Not agreed/Please discuss**
4.	s 47C [redacted]	**4. Noted**

Signature ……………………………………………… Date: / /

Comments:

Contact Officer:	Bronwyn Field	First Assistant Secretary, Portfolio Strategies Division	Ph: (02) 6289 3944 Mobile: s 22 [redacted]
Clearance Officer:	Brendan Murphy	Secretary	Ph: (02) 6289 8400 Mobile: s 22 [redacted]

Issues:

1. The Department will brief you on Friday 15 July, 11:30am to 12:30pm (ADE), on the current COVID-19 situation. Under the following agenda items:
   - COVID-19 epidemiology – Professor Paul Kelly
   - National COVID-19 Vaccination Program transition into the Department from 1 August – Trish Garret/s 22 [redacted]

- COVID-19 response measures Transition Strategy – Dr Brendan Murphy.

s 47C

[redacted]

s 34(3)

[redacted]

s 47C

[redacted]

Measure	**Description**	**End date**	**Method for Government consideration**
Measures due to cease on 31 December 2022			
s 22 [redacted]	[redacted]	[redacted]	[redacted]
s 34(3) [redacted]	[redacted]	[redacted]	[redacted]
s 22 [redacted]	[redacted]	[redacted]	[redacted]
s 34(3) [redacted]	[redacted]	[redacted]	[redacted]
s 22 [redacted]	[redacted]	[redacted]	[redacted]

Australian Government
Department of Health

Information Brief
MB22-001605
Version (1)
Date sent to MO: 24/06/2022

To: **Assistant Minister McBride**
cc: **Minister Butler**

Subject: **BETTER ACCESS EVALUATION**

Comments:			
Contact Officer:	Anthea Raven	Assistant Secretary, Mental Health Access Branch, Mental Health Division	Ph: (02) 6289 5609 s22
Clearance Officer:	Tania Rishniw	Deputy Secretary, Primary and Community Care	Ph: (02) 6289 1235 s22

Key Issues:

1. A comprehensive evaluation of the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS)* initiative (Better Access) is currently underway, due be finalised by 31 October 2022.
2. The evaluation will consider the effectiveness of Better Access in improving patient outcomes and increasing access to mental health care, and will recommend potential changes to enhance these. The evaluation Terms of Reference are at **Attachment A**.
3. The evaluation responds to a recommendation from the Productivity Commission Inquiry into Mental Health that the Australian Government commission a rigorous evaluation of Better Access (Recommendation 12, Action 12.3).
4. s 47C

Methodology:

5. The Department of Health and Aged Care (Department) engaged a consortium led by the University of Melbourne (UoM) and including the University of Queensland, Deakin University, Australian National University, LaTrobe University, Monash University and NovoPsych via limited tender, to undertake the evaluation. The cost of the evaluation is approximately $2.11 million (GST exclusive) over two years (2021-22 to 2022-23).

6. The evaluation includes nine studies conducted across two stages. Further information on the studies is provided at **Attachment B**. The results of these studies will be used to answer the evaluation questions at **Attachment C**.

Stakeholder engagement:

7. A Clinical Advisory Group (CAG) comprising clinicians and other experts, and a Stakeholder Engagement Group (SEG) including organisational representatives and people with lived experience of mental illness, have been established to provide feedback and input throughout the evaluation. The membership of both bodies is at **Attachment D**. To date, the CAG has met on four occasions and the SEG has met on three occasions.

Preliminary findings:

8. UoM delivered the first draft interim evaluation report to the Department on 31 May 2022. While the report notes it would be premature to draw definitive conclusions before completion of all studies, it includes early observations – including that the actual role Better Access is playing in the mental health system may differ to the original policy intent.
9. The report suggests Better Access is delivering positive outcomes for many consumers, particularly people with more severe conditions. But it highlights provider wait lists, out-of-pocket costs and referral processes as potential barriers to accessing care. It also suggests the number of sessions used may be associated with improvements in patient outcomes. However, the report notes that further analysis is required.

Limitations:

10. While the evaluation has sought to collect data on the experiences of diverse groups, specific data on the experiences of Aboriginal and Torres Strait Islander, culturally and linguistically diverse and other consumers is limited.
11. Gayaa Dhuwi (Proud Spirit) Australia, the Migration Council of Australia and the Older Person's Advocacy Network (OPAN) are all members of the SEG to help ensure the views of priority populations are considered throughout the evaluation process.
12. UoM in consultation with OPAN has developed additional strategies to engage aged care residents in the evaluation, however the response rate has been low. This may reflect the overall low uptake of Better Access services by aged care residents.
13. The evaluation does not include a detailed cost-effectiveness study, however it will include analysis of expenditure relative to outcomes.

Upcoming critical decisions:

14. Temporary changes to Better Access introduced as part of the COVID-19 response are due to expire on 31 December 2022:
    a. doubling of individual sessions per calendar year from 10 to 20 (August 2020), and
    b. temporary eligibility for residents in aged care facilities (December 2020).
15. The uptake of additional individual sessions has been higher than modelled. Between August 2020 and May 2022 275,570 patients accessed 1,707,540 additional sessions at a cost of $209.4 million.
16. The uptake of services in residential aged care has been significantly lower. Between December 2020 and May 2022, 2,595 patients accessed 4,363 services at a cost of $427,210.
17. s 47C [redacted]

Sensitivities:

18. UoM delivered the first evaluation of Better Access in 2011. It attracted criticism for potential bias by allowing practitioners to select consumers to participate in some studies. As a result, UoM's methodology for the current evaluation involves consumers recruited via Services Australia and random sampling.

19. Some professional groups representing providers ineligible to deliver MBS services, such as counsellors and music and art therapists, have indicated the evaluation will not sufficiently explore opportunities for these professions to contribute to the workforce delivering Better Access services. These professions are represented on the SEG (see **Attachment D**) and stage two of the evaluation will include consultation with a sample of ineligible providers nominated by the CAG and SEG.

Background:

20. Under Better Access, people with a diagnosed mild to moderate mental disorder can receive up to 20 individual sessions (until 31 December 2022) and 10 group sessions per calendar year.

21. Services can be delivered by clinical psychologists, registered psychologists and appropriately trained GPs, social workers and occupational therapists.

22. The majority of MBS-subsidised mental health services are delivered through Better Access, meaning a large portion of Commonwealth mental health expenditure occurs through the initiative.

23. The independent evaluation of Better Access finalised in 2011 showed Better Access improved access to mental health care for people with common mental disorders and that consumers were generally positive about the initiative.

Attachments:

A. Terms of Reference
B. Further detail on evaluation studies
C. Evaluation questions
D. CAG and SEG memberships

Minister	**Assistant Minister McBride**
PDR Number	**MB22-001605**
Subject	**Information brief: Better Access Evaluation**
Contact Officer	Anthea Raven Ph: (02) 6289 5609 Mobile: s22
Clearance Officer	Tania Rishniw Ph: (02) 6289 1235 Mobile: s22
Division/Branch	|Primary and Community Care| Mental Health

Adviser/DLO comments:	Returned to Dept for: REDRAFT ☐ NFA ☐

Terms of Reference - Better Access Evaluation

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

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 patient outcomes. The evaluation will be conducted between August 2021 and October 2022, and will be undertaken in two stages:

1. Stage one of the evaluation (conducted between approximately August 2021 and August 2022) will consider the effectiveness of Better Access in improving patient outcomes and increasing access to mental health care, including:

> **a**. the clinical efficacy of treatment provided including individual patient outcomes and population level outcomes;
>
> **b**. the optimum number of sessions or course of treatment required, on average, to improve patient 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.

2. Stage two (to be conducted between end-August and October 2022) will consider the issues identified under stage one 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, waiting times, out of pocket costs and affordability

Attachment B: Further detail on evaluation studies

- The evaluation includes nine studies being delivered across **two stages**:
    - Stage one (approximately August 2021 to August 2022): is considering the effectiveness of Better Access in achieving its overall aims of improving patient outcomes and increasing access to mental health care.
    - Stage two (approximately February to October 2022): is considering the issues identified in stage one that impact access to services, clinical efficacy and effectiveness of referral pathways, and potential solutions.
        - This stage will also take into account findings and recommendations from the Productivity Commission, MBS Review Taskforce and House of Representatives Select Committee on Mental Health and Suicide Prevention.
        - Findings from processes such as the Royal Commission into Aged Care Quality and Safety (Royal Commission) may also be considered, to the extent relevant.

TABLE 1: Better Access evaluation studies

STAGE ONE	
Study 1	An analysis of MBS data
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 Services Australia
Study 4	Consumer characteristics, treatment patterns and clinical change associated with Better Access treatment services through 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 Longitudinal Study on Women's Health)
Study 6	Qualitative interviews with people with lived experience of mental health conditions
Study 7	Survey of providers and referrers
STAGE TWO	
Study 8	A consultative virtual forum on future reforms to Better Access
Study 9	Piloting a routine outcome measurement and feedback system

Current reporting schedule

UoM will continue to deliver evaluation findings progressively in line with the following schedule:

a. 4 July 2022: Second draft interim report
b. 31 August 2022: Final interim report
c. 10 October 2022: Draft final evaluation report, and
d. 31 October 2022: Final evaluation report.

ATTACHMENT C: EVALUATION QUESTIONS

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?

Attachment D – Better Access evaluation advisory group membership

Better Access Evaluation Stakeholder Engagement Group As at 8 June 2022	
Organisation	**Member**
Department of Health	Mr Mark Roddam (Chair)
Allied Health Professions Australia	Dr Chris Atmore
Australian Association of Psychologists Inc	Ms Amanda Curran
Australian Association of Social Workers	Ms Rachel Reilly
Australian Clinical Psychology Association	Dr David Hallford
Australian College of Mental Health Nurses	Professor Michael Hazelton
Australian College of Rural and Remote Medicine	Ms Jenny Johnson
Australian Counselling Association	Mr Philip Armstrong
Australian Medical Association	Dr Antonio Di Dio
Australian Medical Association	Dr Bill Pring
Australian Music Therapy Association	Ms Bridgit Hogan
Australian, New Zealand and Asian Creative Arts Therapies Association	Dr Kate Dempsey
Australian Psychological Society	Ms Tamara Cavenett
Carer representative	Ms Suzie Adam
Consumer representative	Ms Heather Nowak
Dietitians Australia	Mr Robert Hunt
Exercise & Sports Science Australia	Ms Anita Hobson-Powell
Gayaa Dhuwi (Proud Spirit) Australia	Mr Tom Brideson
Mental Health Australia	Mr Harry Lovelock
Migration Council Australia	Ms Gulnara Abbasova
National Mental Health Commission	Ms Christine Morgan
Occupational Therapy Australia	To be confirmed following departure of ongoing representative
Older Persons Advocacy Network	Ms Samantha Edmonds
PHN Cooperative	Mr Philip Amos
Psychotherapy and Counselling Federation of Australia	Ms Johanna de Wever
Royal Australian and New Zealand College of Psychiatrists	Dr Elizabeth Moore
Royal Australian College of General Practitioners	Dr Caroline Johnson

Better Access Evaluation Clinical Advisory Group As at 8 June 2022	
Member	**Expertise**
Dr Ruth Vine (Chair)	Deputy Chief Medical Officer for Mental Health, Department of Health
Dr Zena Burgess	Psychologist
Dr Joseph Fleming	Mental Health Social Worker
Dr Robert Gordon	Academic in health policy and system reform
Ms Elyse Graham	Occupational Therapist
Dr Steve Hambleton	General Practitioner
Professor Ian Hickie	Academic in clinical psychiatry
Dr Walid Jammal	General Practitioner
Dr David Mitchell	Consultant Psychiatrist
Dr Astha Tomar	Psychiatrist

Australian Government

Department of Health and Aged Care

Ministerial Submission – Standard
MS22-001325
Version (1)
Date sent to MO: 27 September 2022

To: **Minister Butler**
cc: **Assistant Minister McBride**

Subject: **Interim Report for the Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative**

Critical date: N/A

Recommendation/s:

1.	**Note** the interim report and preliminary findings for the evaluation of the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS)* initiative (Better Access).	**1. Noted/Please discuss**
2.	**Note** the final evaluation report will be provided to the Department on 9 December 2022.	**2. Noted/Please discuss**

Signature ……………………………………………… **Date:** / /

Media Release required? **NO**

Comments:

Contact Officer:	s22 [redacted]	*A/g Assistant Secretary, Mental Health Access Branch*	s22 [redacted] s22 [redacted]
Clearance Officer:	*Mark Roddam*	*First Assistant Secretary, Mental Health and Suicide Prevention Division*	Ph: (02) 6289 5323 s22 [redacted]

Issues:

1. The Better Access evaluation interim report (report) was received by the Department on 14 September 2022. The report presents findings from seven studies (see *Background*) and its key findings are summarised below. The Department and/or the University of Melbourne (UoM)-led evaluation team is available to brief you on the report.
2. The findings of the report should be considered with caution, noting the evaluation is still underway and not all evaluation studies have been completed. The final evaluation report is due with the Department on 9 December 2022.

3. The Department does not recommend publishing the interim report until after the final evaluation report has been received and considered. Publication of this report and the final evaluation report simultaneously will ensure any findings and recommendations can be considered holistically, and will help minimise the impact of sensitivities associated with this report (see *Sensitivities*).

Key Preliminary Findings:

4. Findings at this stage of the evaluation provide insights into the uptake of Better Access services, the main access barriers, outcomes for people receiving treatment, and the effectiveness of current treatment planning mechanisms and referral pathways.
5. Rates of uptake and utilisation of Better Access appear to vary across population subgroups. In 2021 these tended to be relatively higher among females, people aged 15-24 and 25-44 years, and people living in major cities (regardless of socio-economic status) and inner regional areas. Better Access utilisation is mainly increasing in areas of medium to high socio-economic status in major cities, indicating it serves some groups better than others and gaps in service delivery are widening.
6. There has been a sustained level of uptake of Better Access treatment. Findings to date indicate the uptake of telehealth and phone services has been substantial, accounting for approximately one third of Better Access treatment services in 2021. The additional 10 sessions, introduced in response to the COVID-19 pandemic, accounted for 14.8% of all individual treatment services in 2021.
7. The main barriers identified to accessing treatment (from the perspective of both consumers and providers) are affordability and wait times. Since 2018, co-payments have increased across most Better Access services. In 2021, 46.4% of all Better Access services (which includes services to prepare and review a mental health treatment plan, mental health consultations, limited psychiatry services, and treatment services), involved a co-payment. This was up by 9.3% from 2018. Further, 64.8% of treatment services involved a co-payment (up by 7.2% from 2018). The median out-of-pocket cost for all Better Access services and treatment services remained the same between 2018 amd 2021 at $74. However, this has since increased to $87 for any Better Access service and $90 for any treatment service in the first half of 2022 (see *Sensitivities*).
8. Findings from a survey of the experiences and outcomes of consumers identified nearly one third of participants (30%) felt they had to wait too long for an appointment. Wait times were also identified as a key access barrier in qualitative interviews with people with lived experience of mental health conditions and a survey of providers and referrers.
9. People who receive Better Access treatment tend to have positive outcomes (for information on how outcomes were analysed see *Background*). This is particularly the case for those who seek care when experiencing relatively severe depression, anxiety and/or psychological distress, with approximately 50-60% experiencing improvements. Findings to date indicate people with higher baseline severity experience greater improvements in symptoms and functioning and there is a greater likelihood of improvement with more sessions. Other characteristics, including age, sex, geographic location and socio-economic circumstances, do not seem to impact outcomes. However, there is some evidence that relatively fewer older consumers experience improvements.
10. Findings related to the effectiveness of treatment planning and referral processes were somewhat mixed. Consumers were generally happy with referral processes, but some

indicated their mental health treatment plan was not accurate or reflective of their circumstances. Allied health professionals considered referral and review processes were not always smooth. However, both allied health professionals and GPs considered good communication between providers was a key success factor.

11. The final evaluation report will include analysis critical to informing the overall findings and recommendations of the evaluation. This includes further analysis on patterns of care within Better Access treatment, using MBS data and data from the Multi-Agency Data Integration Project (MADIP); the relationship between individual-level and area-level of Better Access use, and the uptake by First Nations and children and young people; and, studies being carried out in stage two, namely a consultative virtual forum on future reforms to Better Access and a pilot for a routine outcomes measurement and feedback system.

Limitations:

12. Noting the evaluation is still underway, with further analysis still to occur on a number of studies, inferences cannot be made regarding how co-payments vary across levels of utilisation or the optimum number of sessions. Additional insights on these issues will be included in the final evaluation report.
13. The evaluation does not include a detailed cost-effectiveness study. However, the final evaluation report will include analysis of expenditure, relative to outcomes.
14. While the evaluation has sought to collect data on the experiences of diverse groups, specific data on the experiences of First Nations, culturally and linguistically diverse, residents of aged care facilities, and other consumers is limited.
    - Gayaa Dhuwi (Proud Spirit) Australia, the Migration Council of Australia and the Older Person's Advocacy Network (OPAN) are all members of the evaluation's Stakeholder Engagement Group to help ensure the views of priority populations are considered throughout the evaluation process.
    - Analysis of data from the MADIP currently underway will provide additional information of the uptake of Better Access by First Nations people and children and young people.
    - The findings of augmented studies to give special attention to aged care residents, specifically a survey of the experiences and outcomes of consumers and qualitative interviews, cannot be presented due to the low number of participants. The report acknowledges the difficulties experienced with these studies, and noted this could be due to a number of factors including current stresses in the aged care sector.

Background:

15. The evaluation includes nine studies conducted across two stages (**MB22-001605** refers). This report includes findings from seven studies in stage one, conducted between August 2021 and September 2022, which have considered the effectiveness of Better Access in improving outcomes and increasing access to mental health care. Stage two of the evaluation is underway.
16. Ensuring robust findings on consumer outcomes was a key focus of the evaluation, with a range of studies in stage one examining outcomes. This includes a purpose-designed study analysing routinely-collected clinical data across 11 validated measures of symptoms and functioning. This was complemented by analysis of self-reported

outcomes from consumers from a survey of their experiences and outcomes, data from two randomised control trials, and an analysis of outcomes at a population level using data from Ten to Men and the Australian Longitudinal Study on Women's Health.

Budget/Financial Implications:

The cost of the evaluation is approximately $2.16 million (GST exclusive) over two years (2021-22 to 2022-23).

Sensitivities:

17. Ineligible providers and their professional representative bodies are likely to use information from the report, which indicates workforce capacity and maldistribution issues are contributing to long wait times, to lobby for MBS access. The report noted some providers suggested capacity issues could be overcome by expanding the list of eligible Better Access providers – referencing provisional psychologists, counsellors and mental health nurses. The Department considers changes to address these issues, including expanding the list of eligible providers, must be considered in the context of the final evaluation report, and the current and future role of Better Access in the broader mental health and health system.

18. The mental health sector may raise concerns the median co-payment has increased significantly in the first half of 2022 compared to 2021 (from $74 to $87 for any Better Access service and from $74 to $90 for any treatment service respectively), and use this information to lobby for increases to Medicare rebates or to introduce other financial incentives. Increases to Medicare rebates do not necessarily reduce co-payments because providers are free to determine the fees they charge for the services they provide. Potential solutions should be considered in the context of the final evaluation report.

19 s 47C [redacted]

20. The mental health sector may also raise concerns with findings that Better Access is not necessarily improving outcomes for people with mild mental disorders, and in some cases has led to deterioration. The report acknowledged there could be various explanations for these findings, including differences in treatment effects in the real world compared to controlled trials and because the analysis periods do not align with episodes of care.

Consultations:

The report has been provided to members of the Clinical Advisory Group (CAG) and Stakeholder Engagement Group (SEG) in-confidence (not for further circulation) ahead of their upcoming meetings on 24 October 2022 and 11 November 2022 respectively.

Attachments:

A: Final Interim Report for the Better Access Evaluation.

Minister	**Minister Butler**
PDR Number	**MS22-001225**
Subject	Interim Report for the Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative
Critical Date	**N/A**
Contact Officer	Mark Roddam 02 6289 5323 s22 [redacted]
Clearance Officer	Tania Rishniw 02 6289 1235 s22 [redacted]
Division/Branch	|Primary and Community Care| Mental Health
Has Budget Branch been consulted if there are financial implications?	Not Applicable

Adviser/DLO comments:	Returned to Dept for: REDRAFT ☐ NFA ☐

Quality Assurance Check (completed by line area)	s22 [redacted] s22 [redacted]

THE UNIVERSITY OF
MELBOURNE

Evaluation of the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative*

FINAL INTERIM REPORT

Jane Pirkis, Dianne Currier, Meredith Harris, Cathy Mihalopoulos

Vikas Arya, Michelle Banfield, Bridget Bassilios, Ben Buchanan, Lisa Brophy, Philip Burgess, Julie Byles, Mary Lou Chatterton, Xenia Dolja-Gore, Kathy Eagar, Jan Faller, Ellie Fossey, Maria Ftanou, Jane Gunn, Long Le, Danielle Newton, Leo Roberts, Katrina Scurrah, Matthew Spittal, Roman Scheurer, Caley Tapp, Michelle Williamson

14 September 2022

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Executive summary

Introduction

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (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 have been commissioned to evaluate Better Access and are doing so in two stages via nine inter-related studies. These are:

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

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

- Accessibility
- Responsiveness
- Appropriateness
- Effectiveness
- Sustainability

This Final Interim Report provides findings from Studies 1-7.

Summary and interpretation of findings

Study 1: An analysis of MBS data

Study 1 involves an analysis of the uptake, utilisation and costs of services delivered under Better Access, drawing on MBS data. With the Department of Health's help, we have sourced aggregated, de-identified MBS data from Services Australia, for the period 1 January 2018 to 30 June 2022. From this, we are developing 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., gender, age group, and geographic area group). Analyses for Study 1 are ongoing and will be reported in full in the Final Evaluation Report.

Preliminary results from Study 1 indicate that the reach of Better Access has continued to expand as the program has matured. In 2021, one in every 10.5 Australians received any least one Better Access service and one in 20 received at least one session of psychological treatment through Better Access.

Rates of uptake and utilisation vary 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 socio-economic status) and inner regional areas in 2021. Levels of utilisation have changed over time, with increases particularly apparent for many of these same groups (females, people aged 15-24 and 25-44 years, people in major cities with high or medium socio-economic status).

Changes to the Better Access program rules 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 services has been substantial, accounting for about one-third (32.6%) of Better Access treatment services in 2021. The additional 10 sessions of treatment for people experiencing difficulties due to COVID-19 accounted for 14.8% of individual treatment sessions in 2021. Together these measures contributed to a sustained level of uptake of Better Access treatment sessions (average annual growth of 0.9%) and higher levels of treatment (average annual growth of 7.1% in the rate of services used per 1,000). 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.

Since 2018, rates of co-payment have increased across most types of Better Access services. Overall, in 2021, 46.6% of all Better Access services involved a co-payment by the consumer (up by 9.3% from 35.7% in 2018) and 64.8% of Better Access treatment services involved a co-payment (up by 7.2% 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); 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.

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

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

Irrespective of the measure used, consumers began their episodes of 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,[1] 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 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. This does raise some concerns about how well Better Access may be serving those with mild to moderate conditions, particularly since the program was originally designed for them.

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 fact that new users are being seen suggests that Better Access is providing care to those who may be experiencing a mental health problem for the first time, or at least seeking treatment for the first time. The fact that there are many prior users being seen is likely to reflect the episodic nature of many mental illnesses.

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-D[2] conducted in 2016-2019 and Link-me[3] 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.[1] We also identified consumers who reported use of other mental health professionals/services (including visits to GPs, other mental health specialists, other health professionals, emergency department visits, overnight hospital admissions, and taking mental health-related medications). Across the two trials, 314 consumers were classified as having used Better Access treatment services delivered by allied health professionals (with or without other mental health professionals/services) over a 12-month follow-up period, 420 who used other mental health professionals/services only, and 207 who used none of these mental health professionals/services.

We found evidence that participants classified as users of Better Access had worse mental health symptoms and functioning at baseline than those who used other forms of mental health care only, who in turn had worse mental health than those who did not use mental health care. In contrast, they had similar baseline levels of general health and quality of life, and mental health-related medication use, compared to those who used other forms of mental health care. Our results suggested that those aged 56 years and over may be less likely to use Better Access treatment services than other forms of mental health care. This finding is consistent with other studies, and may reflect attitudes and beliefs of both consumers and practitioners about the benefits of psychological therapy for this group.[4,5] 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 socio-demographic 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

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[1] As an estimated 85% of spending on private psychology services is via Better Access, we are confident that the vast majority of individuals in this group will have used Better Access treatment services (see Study 2 for further detail).

have lower odds of significant improvement in anxiety symptom severity, while females and those with a certificate/diploma qualification had lower odds of significant improvement in functioning, as measured by days out of role. Conversely, significant deterioration was most consistently associated with better baseline levels of mental health, people aged 56 years and over had higher odds of significant deterioration in anxiety symptom severity, while females and those with a certificate/diploma qualification had higher odds of significant deterioration in functioning.

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

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

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

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

Those who did use Better Access treatment services typically accessed a median of 5-6 sessions over the given analysis periods, usually from clinical psychologists and/or psychologists. The results should be considered in the context of the analysis periods in the Study 5 which ranged from 1.87 years to 5.65 years. Half to three quarters of participants paid at least some out-of-pocket costs, with those who did so typically paying between $80 and $100 per session. There was a relationship between prognostic severity and these patterns of service use: those in the "severe" group tended to use more sessions, and those in the "minimal/mild" group were generally more likely to pay out-of-pocket costs. This suggests that those with the greatest levels of need were not only more likely to access Better Access treatment services (as noted above), but also that they were likely to access a greater number of sessions and to pay less for doing so.

Many participants who used Better Access treatment services experienced improvements in their mental health over the given analysis period. Typically, between around 45% and 55% of these participants had better mental health at the end of the analysis period than they did at the beginning. It would be drawing a long bow to attribute this improvement to their use of Better Access treatment services, particularly given the length of the analysis periods and the relatively small "dose" of Better Access treatment that individuals commonly received.

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. 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.

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.

Conclusions

It would be premature to draw definitive conclusions from the evaluation at this point, because we are still to complete the analysis from Study 1 and Studies 8 and 9 are ongoing. However, certain findings are emerging. These findings suggest that 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. Better Access appears to be serving some groups better than others, and these gaps are widening. Of most concern, increases in utilisation over time have been particularly marked for people in areas of relatively high socio-economic status in major cities. Patterns of service use for those who do access Better Access have been influenced by recent changes to the program; telehealth and phone services accounted for about one third of Better Access treatment services in 2021 and the additional 10 sessions accounted for almost 15% of individual treatment sessions in the same year. Those who receive treatment through Better Access tend to have positive outcomes, particularly those who seek care when they are experiencing relatively severe depression, anxiety and/or psychological distress. However, there are also suggestions that Better Access is not always able to provide timely and affordable care, and that the referral processes underpinning the program may not always work optimally.

1. Background

The Better Access initiative

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative was introduced in November 2006 in response to low treatment rates for 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.[1]

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.

Over time, the "rules" around Better Access have changed. 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 are in place until 31 December 2022.

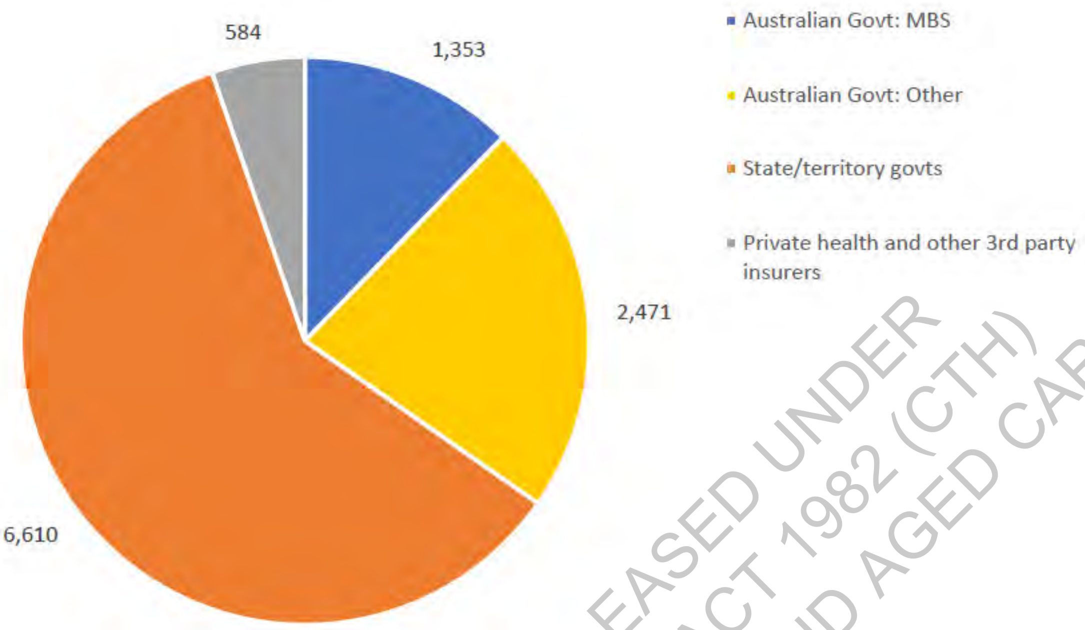
A consolidated list of the Better Access item numbers is provided at Appendix 1.

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. 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,[6] 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 Welfare[6]

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,[7,8] a consumer experiences study,[9,10] and an analysis of MBS and Pharmaceutical Benefits Scheme (PBS) data.[11] 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."*[12]

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.[13]

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, waiting 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.[14]

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.[15]

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."[16] This recommendation led to the creation of the RACF items mentioned above.

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 builds on and will make reference to the findings of the previous evaluation and review activities that have occurred in relation to Better Access. However, it is collecting data from multiple new sources, doing so in a more systematic way than has been possible in the past. It will therefore provide insights that have not been available from the previous evaluations, reviews and inquiries.

The evaluation involves a mixed-methods approach, with quantitative and qualitative data drawn from multiple sources. Some of the studies are purpose-designed and others rely on existing data. We used some of these methods in our previous evaluation, but most are new. The approach is 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 means that the strengths of one study can potentially address the limitations of another and vice versa. It also means that we can triangulate our findings in a way that will allow us to draw conclusions with greater confidence.

We are conducting the evaluation over two stages. Stage 1 considers the effectiveness of Better Access in improving consumer outcomes and increasing access to mental health care. Stage 2 considers the issues identified under Stage 1 that impact access to services, clinical efficacy and effectiveness of referral pathways and will identify potential solutions to address these.

The evaluation involves nine separate studies, seven in Stage 1 and two in Stage 2. The studies are listed in Table 1.1.

Table 1.1: Stages and studies in the evaluation

STAGE	STUDY
Stage 1	Study 1: An analysis of MBS data
	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

The current report

This Final Interim Report presents findings from the seven studies in Stage 1 (Studies 1-7). 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 3-9 describe in detail the methods we have used in each of the seven Stage 1 studies that we are reporting on in this report and present their findings. Section 10 summarises and synthesises the findings from each study, organising them around the evaluation's research questions.

2. Evaluation overview

Governance

Throughout the evaluation, we have been working closely with the Department of Health and the two evaluation advisory groups established by the Department: the Clinical Advisory Group (CAG) and the Stakeholder Engagement Group (SEG).

The CAG comprises 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 are affiliated with a professional body or organisation are participating in their individual capacity only and not as a representative of that professional body or organisation. The role of the CAG is to provide advice and guidance on clinical matters relevant to the evaluation.

The SEG comprises 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., Aboriginal and Torres Strait Islander peoples, older Australians, and people from cultural and linguistically diverse backgrounds). Members who were nominated by an organisation are participating as a representative of that organisation and not in their individual capacity. Consumer and carer representatives are contributing in their individual capacities. The role of the SEG is to provide advice and input on issues related to Better Access from across the full gamut of stakeholders. We have been seeking input and feedback from both groups at key points in the evaluation through formal meetings and out-of-session consultation.

Terms of reference

The evaluation's Terms of Reference are outlined below.

The key objective of the evaluation is to consider the effectiveness of Better Access in achieving its overall aims of improving consumer outcomes and increasing access to mental health care. It will also consider the effectiveness of the current Better Access model and recommend potential changes to enhance its ability to achieve its aims.[17]

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.[17]

The evaluation began in August 2021 and will be completed in December 2022. As noted in Section 1, it is being undertaken in two stages:

- Stage 1 is considering 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;
  b. 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, which has recently begun, is considering 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, waiting times, out-of-pocket costs and affordability.[17]

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.[18] In doing this, we also referred back to our original evaluation of Better Access,[12] 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 seven studies in the evaluation comprise Stage 1. These studies are described briefly below.

Study 1: An analysis of MBS data

Study 1 involves a comprehensive analysis of MBS data, similar to the one we undertook in our previous evaluation of Better Access.[11] More specifically, Study 1 involves an analysis of the uptake, utilisation and costs of services delivered under Better Access. With the Department of Health's help, we have sourced aggregated, de-identified MBS data from Services Australia, for the period 1 January 2018 to 30 June 2022. From this, we are developing 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., gender, age group, and geographic area group).

Analyses for Study 1 are ongoing but we have presented preliminary findings in Section 3. The remaining findings will be reported in the Final Evaluation Report.

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 datasets held by NovoPsych (a subscription-based platform that collects 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 4.

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 5.

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-D[2] and Link-me[3]). 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 6.

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 7.

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 8.

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 9.

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 all 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.

Additional analysis of data from the Multi-Agency Data Integration Project (MADIP)

In addition, to the seven studies in Stage 1, we are working 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 will be able to answer questions that we are unable to answer through the other Stage 1 studies. For example, using linked MBS and Census data from MADIP, we will be able to look at the relationship between individual-level and area-level indicators of Better Access use, and the uptake of Better Access by Indigenous Australians and children and young people. Similarly, using MBS data that has been linked to data from the National Health Survey, we will be 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-10[19]). Using MBS data will allow us to look at the proportion of Better Access users who are "new" users in any given year, and linking this to PBS data will enable us to characterise Better Access users use of other MBS-funded mental health services and PBS-funded mental health medications.

We will report on the MADIP analysis in our Final Evaluation Report.

Stage 2 studies

The last two studies in the evaluation are being conducted in Stage 2 and are still in progress. Each is described below.

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

Study 8 involves a virtual forum with key stakeholders who have been invited to consider the most important features of Better Access, moving forward. Our stakeholders comprise a mix of mental health care provider representatives (who are eligible and not eligible to provide services under Better Access), lived experience and carer representatives, advocates and policy and systems experts.

These stakeholders are taking part in a structured consultation exercise that is being run over three phases. In Phase 1, they will respond to a brief Qualtrics survey that asks them to indicate the three most important features of Better Access, going forward. Our team will then group these features and draft synthesis statements. In Phase 2, the stakeholders will join an online forum on the Loomio platform, discussing and further refining the synthesis statements. They will also consider other relevant issues, including the strategies that might be required to take the particular features of Better Access forward. Stakeholders will be given pseudonyms to minimise the impact of any power relationships. They will also be given certain “rules of engagement” when they join, including instructions to remain respectful at all times.

We will then download the content of the forum, following different threads and organising them into themes. We will redraft the synthesis statements and prepare a second Qualtrics survey. In Phase 3, stakeholders will respond to this second survey, assessing all statements and rating their level of agreement with them. We will then take the ratings an associated content and prepare a “collective view” report that articulates a vision for Better Access, going forward. Dissenting views will also be represented in this report.

Study 8 is currently underway. We have approached 104 stakeholders (doing so predominantly through the organisations represented on the SEG). Ninety have completed onboarding (54 provider representatives [36 from professions eligible to provide Better Access services; 18 from ineligible professions], 16 lived experience representatives, seven carer representatives, four representatives from advocacy organisations, and nine policy and systems experts). The Phase 1 survey is currently in the field, and 74 stakeholders have completed it.

Study 9: Piloting a routine outcome measurement and feedback system

Study 9 is piloting a routine outcome measurement and feedback system, using the NovoPsych platform in a proof-of-concept way. More specifically, Study 9 is exploring the feasibility and acceptability of principles for routinely monitoring outcomes for consumers seen by a psychologists and other providers delivering care through Better Access. We will pilot these principles using the NovoPsych software platform. NovoPsych already does the latter and we have adapted it so that it can be used for the former, trialling the feasibility of establishing a publicly reportable outcomes dataset.

Study 9 is currently underway, with 66 providers recruited.

Relationship between the research questions and the studies

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

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

DOMAIN	RESEARCH QUESTION	STUDY								
		1	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?		✓	✓	✓	✓				
	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?									✓

Study 1: An analysis of MBS data || 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 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	STUDY			
		2	3	4	5
Assessment of Quality of Life instrument (AQoL-8D)[20]	**Consumer-rated measure that assesses quality of life. Comprises 35 items that ask the consumer to rate their quality of life on 8 dimensions (independent living, pain, senses, mental health, happiness, coping, relationships and self-worth). Ratings can be converted to a utility weight with anchors of 1 for 'perfect health' and 0 for 'dead'.**			✓	
Center for Epidemiological Studies – Depression scale (CES-D)[21]	Consumer-rated measure of depressive symptoms in the past week. Comprises 20 items relating to symptoms such as restless sleep, poor appetite and feeling lonely. Each item is scored 0 (Rarely or none of the time, 1 (Some or little of the time), 2 (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 Routine Evaluation (CORE-OM)[22,23]	Consumer-rated measure of psychological distress. Consists of 34 items relating to four domains (subjective wellbeing, problems/symptoms, life functioning, risk/harm). 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 Routine Evaluation (CORE-10)[24]	Abbreviated version of the CORE-OM, also designed to measure psychological distress. Consists of 10 items from the original CORE-OM. Each item is scored the same way as the parent instrument (i.e., on a scale of 0-4). 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 or more indicate severe psychological distress.	✓			
Depression Anxiety and Stress Scale (DASS-21/42)[25,26]	Consumer-rated measure that assesses the negative emotional states of depression, anxiety and stress. The longer form (DASS-42) consists of 42 items, and the shorter form (DASS-21) consists of 21 items. Each item takes the form of a statement relating 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 and Stress Scale (DASS-10)[27]	Abbreviated version of the DASS-42 and DASS-21, also designed to assess depression, anxiety and stress. Consists of 8 items from the original DASS, and 2 additional items relating to substance use and suicidality. As with the original measure, the consumer rates each item on a scale of 0-3 to indicate how much it applied to them in the past week. This yields a total score of 0-30. Severity of depression, anxiety and stress is classified as follows: 0-6 – sub-clinical or mild severity, 7-12 moderate, 13-30 severe.	✓			
EuroQol 5-dimension quality of life questionnaire (EQ-5D-5L)[28]	**Consumer-rated measure that assesses quality of life. Comprises 35 items that ask respondents to rate their quality of life on five domains (mobility, self-care, pain, usual activities, and psychological status). Ratings can be converted to a utility weight with anchors of 1 for "perfect health" and 0 for "dead".**			✓	
Generalised Anxiety Disorder scale (GAD-7)[29]	Consumer-rated measure that assesses anxiety symptoms. Consists of seven questions about how often the consumer been bothered by selected anxiety 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 of Functioning Scale (GAF)[30]	Clinician-rated measure of functioning which seeks a single rating. Ratings range from 1 (Persistent danger of severely hurting self or others OR persistent inability to 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	STUDY			
		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)[19]	Consumer-rated measure developed to assess non-specific psychological distress. 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-10+)[31,32]	Four-item extension to K-10 that asks about total days out of role due to 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 Scale (ORS)[33]	Consumer-rated measure that measures consumers' perceptions of their 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, yielding 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 Questionnaire (PHQ-9)[34]	Consumer-rated measure that assesses depressive symptoms. Consists of nine items relating to how often the consumer has been bothered by depressive symptoms during 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). 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 moderate depression, scores of 15-19 indicate moderately severe depression, and scores of 20-27 indicate severe depression.	✓		✓	✓
Patient Health Questionnaire-2 (PHQ-2)[35]	Consumer-rated measure that assesses the frequency of depressed mood and anhedonia over the past two weeks. It comprises the first two items of the PHQ-9 and can be used to screen for depression as a "first step" approach. Those who screen positive can then be further assessed with the full PHQ-9. The scoring of the individual items is the same as for the PHQ-9, and the total score ranges from 0-6. A score of 3 is regarded as the cut-point for further screening.				✓
Positive and Negative Affect Schedule (PANAS)[36]	Consumer-rated measure of positive and negative affect. Consists of 20 items, 10 relating to positive affect and 10 relating to negative affect. Each item relates to a specific feeling, and the consumer is asked to indicate the extent to which they have felt 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 Life Scale (SWLS)[37]	Consumer-rated measure of global life satisfaction. Consists of 5 items that are 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.	✓			
Self-rated mental health	Purpose-designed consumer-rated measure of mental health before and after receipt 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.[38]			✓	

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's[39] 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[40,41] and other guidance regarding the range of effect sizes likely to be minimally clinically/subjectively important.[42] 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 1: An analysis of Medicare Benefits (MBS) data

Introduction

Study 1 involves an analysis of the uptake, utilisation and costs of services delivered under Better Access, drawing on Medicare Benefits Schedule (MBS) data. With the Department of Health's help, we have sourced aggregated, de-identified MBS data from Services Australia, for the period 1 January 2018 to 30 June 2022. From this, we are developing 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., gender, age group, and geographic area group). This will enable 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 sessions have been taken up), affordability (e.g., the magnitude of benefits paid and the extent to which consumers have paid co-payments), and typical trajectories of care under Better Access (e.g., the proportion of plans that are followed by treatment services, the extent to which episodes of care that involve a review). Study 1 provides context for the evaluation by presenting profiles that are based on all claims for Better Access services nationally.

We have experienced some delays with Study 1. Data from Services Australia have been supplied progressively from 10 August 2022 to 9 September 2022. This has meant that, for the current report, results are limited to preliminary summaries of patterns of uptake, utilisation and costs of the Better Access program. Analyses for Study 1 are ongoing and will be updated in the Final Evaluation Report.

Methods

Preparatory steps

Item groups

An initial step in Study 1 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 according to a set of characteristics including:

- program phase, a classification that indicates if the item was introduced as part of a specific initiative. The categories are: 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 categories are: associated MBS items (including the sub-categories of preparation of mental health treatment plan, review of a mental health treatment plan, mental health consultation, preparation of a psychiatrist assessment and management plan, review of a psychiatrist assessment and management plan, and initial patient consultation), initial 10 individual sessions (including the sub-categories of focussed psychological strategies and psychological therapy services), additional 10 individual sessions (including the sub-categories of focussed psychological strategies and psychological therapy services), group sessions (including the sub-categories of group focussed psychological strategies and group 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 is provided in Appendix 1.

Changes to the Better Access program

Study 1 focuses on patterns of uptake and utilisation of the Better Access MBS items over the past 4.5 years, a period during which significant refinements have been made to the program. To assist our analyses of changes in response to 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. Services Australia extracted MBS data from a national dataset of all services for which Medicare benefits were paid. 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. The extract included all services received from 1 January 2018 to 30 June 2022 and processed up to and including 7 August 2022. We requested data to be organised by calendar year, rather than financial year, because Better Access program rules regarding the permissible number of treatment sessions are based on calendar year. The date of first service included is 1 January 2018 because Services Australia only holds five years of data at the time of extraction.

The data were supplied in de-identified, aggregated form according to a set of specifications developed by our evaluation team. The supplied data included summary statistics (e.g., counts of persons and services, median and interquartile range for out-of-pocket costs) for various combinations of Better Access MBS items (based on the item characteristics described above) in annual, and sometimes quarterly, reference periods. These statistics were stratified by gender (male, female), age group (0-14 years, 15-24 years, 25-44 years, 45-64 years and 65 years and over), and geographic area group. Geographic area group was based on a classification used by the Australian Institute of Health and Welfare (AIHW).[43] Under this classification, geographic areas (statistical area 3 or SA3) were organised into Remoteness Area groups based on the Australian Bureau of Statistics (ABS) Australian Statistical Geography Standard (ASGS)[44] – major cities, inner regional, outer regional and remote (including very remote). Major cities are then split into three socioeconomic groups based on the ABS Index of Relative Socio-economic Disadvantage (IRSD):[45] major cities (higher socioeconomic) - IRSD quintile 5; major cities (medium socioeconomic) - IRSD quintiles 3 and 4; and major cities (lower socioeconomic) - IRSD quintiles 1 and 2. For this report, SA3 was based on the consumer's postal area; where this was not available, it was based on the provider's postal area. Because a consumer's age or address may change during the reference period, their age and SA3 at the last date of service in the reference period were applied to all services for that consumer in the reference period.

Measures

Services Australia supplied summaries of data for Better Access MBS item groups using different types of counting units and summary statistics:

- counts of persons and services;
- sum of provider fees charged and sum of MBS benefits paid; and
- out-of-pocket costs per service (median and interquartile range).

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 1, 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%.

Statistical analyses

We converted counts of persons and services to crude rates per 1,000 population, to enable comparisons 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.[46]

We conducted descriptive analyses, reporting counts, population rates (crude rates per 1,000), percentages and medians (and inter-quartile ranges) as relevant. Services Australia applied cell suppression to any estimate when the number of consumers was between 1 and 5, however total and national level values include all suppressed values. For reporting, where necessary, we applied consequential suppression so that the suppressed cell values could not be calculated.

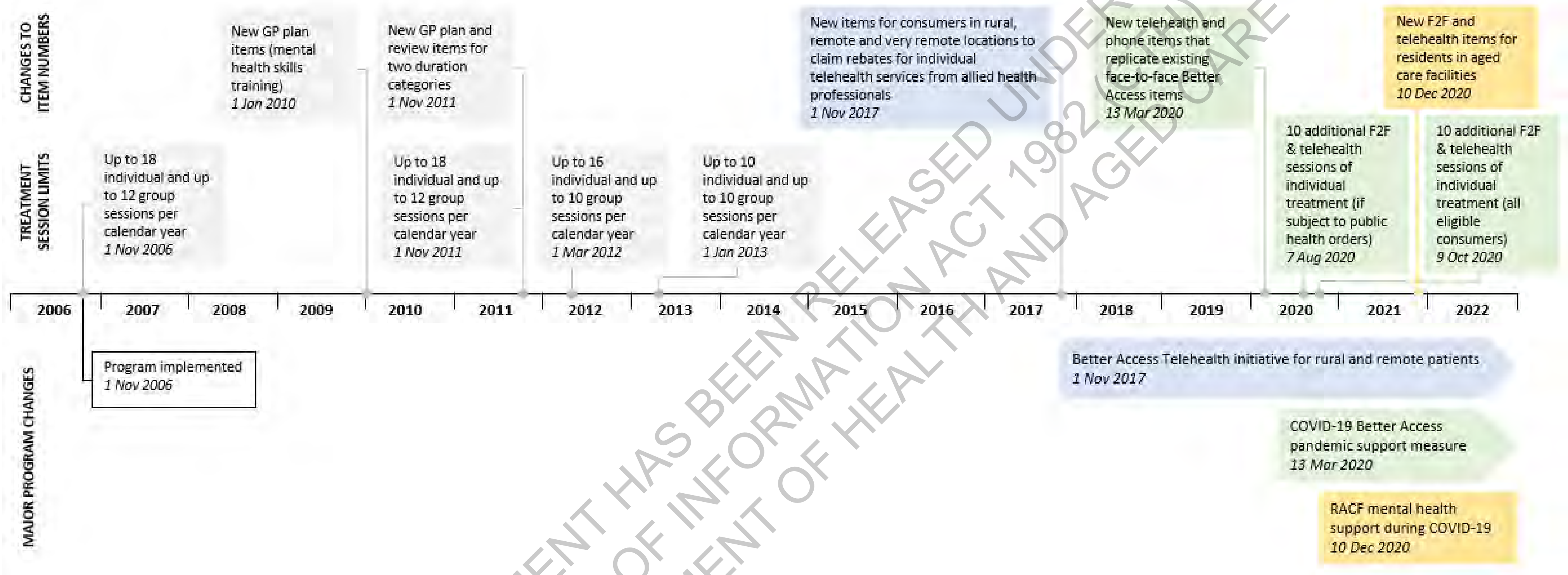
Approvals

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

Acknowledgements

All MBS data reported in Study 1 were supplied by Services Australia. The results reported here are provisional and have not yet been reviewed by Services Australia, as per their conditions of data release prior to publication.

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

To examine the broad question of uptake, simple descriptive statistics were generated from MBS data on the number of people who received Medicare-subsidised Better Access mental health services in each calendar year 2018 through 2021 (the most recent full calendar year of data) and for the first half of 2022, as well as the average annual percentage change between 2018 and 2021.

Tables 3.1 reports uptake of any Better Access service (i.e., any service provided under any of the Better Access MBS items in Appendix 1) and of any Better Access treatment service (i.e., any service provided under 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).

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 10.5 Australians in 2021. When adjusted for population growth, there was a 1.8% average increase per year in the rate of people using Better Access services (from 95.6 per 1,000 population in 2018 to 100.8 per 1,000 in 2021).

In the same year, more than 1.3 million people (one in every 20.2 Australians) received at least one Better Access treatment service. When adjusted for population growth, there was a 0.9% average increase per year (from 49.6 per 1,000 population in 2018 to 50.9 per 1,000 in 2021). People who received treatment services made up approximately half of all Better Access users. This percentage was fairly steady, decreasing slightly from 51.8% in 2018 to 50.5% in 2021.

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

		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 treatment service	Persons	1,260,559	1,321,194	1,342,890	1,338,424	2.0	879,939
	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

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). '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 3.2 through 3.4 report uptake of Better Access services according to key item groups defined by provider type and clinical purpose. In 2021, GPs and other medical practitioners prepared a mental health treatment plan for more than 1.4 million Australians. GPs and other medical practitioners reviewed a mental health treatment plan for more than 500,000 Australian in 2021 (Table 3.2). Growth in the rate of persons receiving a review of a mental health treatment plan was 5.4% per year, on average, compared to 1.1% per year for persons receiving a mental health plan. People who received a mental health treatment plan made up over half (53.7%) of all Better Access users in 2021, while people who received a review of a mental health treatment plan made up approximately one-fifth (20.1%).

GPs and other medical practitioners provided mental health 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 consultation.

Note that 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. The vast majority of people who receive Better Access services from a GP or other medical practitioner receive them from a GP - more than 95% of people who receive a mental health treatment plan, review or consultation and 92% of people who received Focussed psychological strategies (see Appendix 2, Table A2.2).

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

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Preparation of a mental health treatment plan	Persons	1,332,633	1,416,351	1,468,297	1,421,494	2.2	661,998
	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 treatment plan	Persons	441,152	471,323	523,173	533,449	6.5	272,725
	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 consultation	Persons	986,806	989,591	992,758	1,000,284	0.5	510,427
	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 strategies	Persons	10,343	10,161	12,114	12,572	6.7	7,675
	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

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 per 1,000 population) (Table 3.3). Persons using these services made up 27.7% and 20.3%, respectively, of total Better Access users in 2021. Rates of uptake, and share of total Better Access users, was steady between 2018 and 2021.

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, and users of these services made up a smaller share of total Better Access users (3.9% and 0.5%, respectively). 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.

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

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

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 make 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 8.0% 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 consultation has remained fairly steady.

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

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

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 and costs of Better Access services

As with uptake, there have been increases in the utilisation and costs of Better Access services over time. 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).

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 consumer co-payments had increased at a relatively greater rate than benefits paid. Out-of-pocket costs are explored later in this report.

In 2021, approximately 7.3 million Better Access treatment services were delivered, a population-adjusted increase of 7.1% from 225.4 services per 1000 population in 2018 to 276.9 per 1,000 in 2021. 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. 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), again indicating that out-of-pocket costs for consumers have increased relatively more substantially than MBS benefits paid.

Table 3.5: Services, fees charged, and MBS benefits paid, for any Better Access service and any 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	Services	9,567,533	9,873,074	10,647,956	11,295,485	5.7	5,172,960
	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
	Fees charged ($m)	1,333.1	1,372.1	1,478.3	1,612.1	6.5	762.3
	Benefits paid ($m)	1,078.6	1,083.6	1,168.9	1,213.3	4.0	535.0
Any Better Access treatment service	Services	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 services	59.9	60.5	61.7	64.4	2.4	64.8
	Fees charged ($m)	903.3	944.6	1,035.3	1,180.6	9.3	558.8
	Benefits paid ($m)	681.7	691.9	763.2	827.1	6.7	359.6

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, benefits paid, and out-of-pocket costs are expressed in 2021-22 dollars. 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 services, fees charged and benefits paid across key item groups. The largest relative increases in the rate of services used 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%).

Table 3.6: Services, 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 mental health treatment plan	Services	1,334,869	1,418,974	1,473,480	1,425,356	2.2	662,552
	Rate (per 1,000)	52.5	55.1	56.7	54.2	1.1	25.1
	% of BA services	14.0	14.4	13.8	12.6	-3.3	12.8
	Fees charged ($m)	157.6	162.3	166.8	156.4	-0.3	72.1
	Benefits paid ($m)	150.1	153.8	158.7	146.6	-0.8	66.4
Review of a mental health treatment plan	Services	494,123	527,938	618,470	624,547	8.1	288,031
	Rate (per 1,000)	19.4	20.5	23.8	23.8	7.0	10.9
	% of BA services	5.2	5.3	5.8	5.5	2.3	5.6
	Fees charged ($m)	43.1	45.0	52.1	51.8	6.3	23.9
	Benefits paid ($m)	40.5	42.0	49.0	47.7	5.6	21.3
Mental health consultation	Services	1,809,232	1,753,947	1,787,109	1,759,821	-0.9	753,460
	Rate (per 1,000)	71.1	68.1	68.8	67.0	-2.0	28.6
	% of BA services	18.9	17.8	16.8	15.6	-6.3	14.6
	Fees charged ($m)	150.6	141.7	143.2	136.7	-3.2	57.8
	Benefits paid ($m)	147.4	138.2	139.8	132.4	-3.5	55.3
Focussed psychological strategies	Services	32,160	32,325	42,669	44,143	11.1	21,994
	Rate (per 1,000)	1.3	1.3	1.6	1.7	9.9	0.8
	% of BA services	0.3	0.3	0.4	0.4	5.2	0.4
	Fees charged ($m)	5.5	5.3	6.8	7.1	9.0	3.6
	Benefits paid ($m)	4.8	4.5	6.0	6.1	8.5	2.9

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, benefits paid, and out-of-pocket costs are expressed in 2021-22 dollars. Rates are crude rates per 1,000 total population.

Table 3.7: Services, 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 therapy services (clinical psychologists)	Services	2,358,867	2,479,293	2,797,843	3,037,179	8.8	1,409,629
	Rate (per 1,000)	92.7	96.3	107.8	115.6	7.6	53.4
	% of BA services	24.7	25.1	26.3	26.9	2.9	27.2
	Fees charged ($m)	442.7	464.8	517.5	570.5	8.8	269.1
	Benefits paid ($m)	343.6	351.9	396.9	421.8	7.1	185.3
Focussed psychological strategies (psychologists)	Services	2,913,026	3,007,372	3,240,295	3,637,688	7.7	1,664,914
	Rate (per 1,000)	114.5	116.8	124.8	138.4	6.5	63.1
	% of BA services	30.4	30.5	30.4	32.2	1.9	32.2
	Fees charged ($m)	404.8	421.6	455.0	536.3	9.8	254.4
	Benefits paid ($m)	294.1	295.1	317.4	351.5	6.1	150.6
Focussed psychological strategies (social workers)	Services	357,727	386,133	428,297	492,153	11.2	228,301
	Rate (per 1,000)	14.1	15.0	16.5	18.7	10.0	8.7
	% of BA services	3.7	3.9	4.0	4.4	5.2	4.4
	Fees charged ($m)	40.9	43.7	48.4	58.2	12.5	27.9
	Benefits paid ($m)	32.5	34.0	37.4	42.0	8.9	18.5
Focussed psychological strategies (occupational therapists)	Services	71,238	70,266	60,526	63,990	-3.5	27,994
	Rate (per 1,000)	2.8	2.7	2.3	2.4	-4.6	1.1
	% of BA services	0.7	0.7	0.6	0.6	-8.7	0.5
	Fees charged ($m)	9.5	9.1	7.7	8.4	-3.9	3.8
	Benefits paid ($m)	6.8	6.5	5.5	5.7	-5.5	2.3

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, benefits paid, and out-of-pocket costs are expressed in 2021-22 dollars. Rates are crude rates per 1,000 total population.

Table 3.8: Services, 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 psychiatrist assessment and management plan	Services	42,870	41,799	41,515	42,267	-0.5	29,125
	Rate (per 1,000)	1.7	1.6	1.6	1.6	-1.5	1.1
	% of BA services	0.4	0.4	0.4	0.4	-5.8	0.6
	Fees charged ($m)	20.2	19.7	19.5	20.1	-0.3	14.4
	Benefits paid ($m)	19.0	18.2	18.0	17.7	-2.3	11.8
Review of a psychiatrist assessment and management plan	Services	9,033	8,691	8,875	7,681	-5.3	5,541
	Rate (per 1,000)	0.4	0.3	0.3	0.3	-6.3	0.2
	% of BA services	0.1	0.1	0.1	0.1	-10.4	0.1
	Fees charged ($m)	2.6	2.5	2.5	2.1	-6.8	1.6
	Benefits paid ($m)	2.5	2.4	2.4	2.0	-7.3	1.4
Initial patient consultation	Services	144,388	146,336	148,877	160,660	3.6	81,419
	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
	Fees charged ($m)	55.6	56.5	58.9	64.5	5.1	33.7
	Benefits paid ($m)	37.4	37.1	37.8	39.8	2.1	19.1

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, benefits paid, and out-of-pocket costs are expressed in 2021-22 dollars. Rates are crude rates per 1,000 total population.

Uptake and utilisation according to consumer characteristics

Figure 3.2 provides a high-level comparison of the uptake and utilisation of Better Access services according to consumer characteristics, and whether changes over time are comparable across consumers according to their gender, age or where they live. The figure shows that:

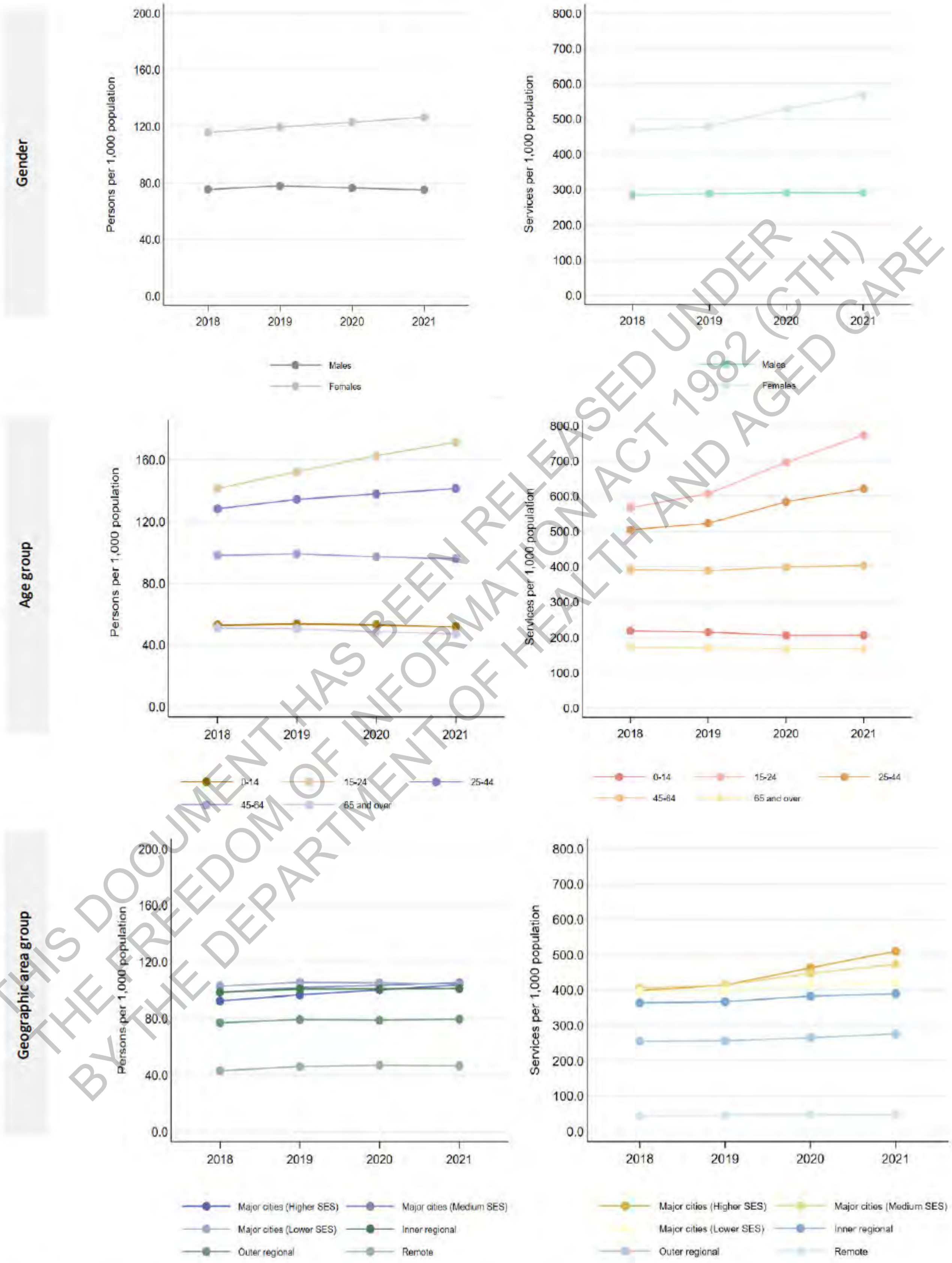
- Uptake of Better Access among females was higher than males (126.4 per 1,000 population vs. 75.0 per 1,000 in 2021, respectively). Since 2018, females have used an increasingly higher number of Better Access services (from 467.2 to 568.1 per 1,000), but utilisation rates among males have stayed about the same (from 284.1 to 290.1 per 1,000).

- In 2021, older people aged 65 and over and young people aged 0-14 had the lowest rates of uptake of Better Access (47.2 and 51.7 per 1,000 population, respectively), compared to people aged 45-64 (95.9 per 1,000) and people aged 25-44 and 15-24 (141.4 and 171.4 per 1,000, respectively). Rates of uptake have increased since 2018 among younger adults 15-24 (from 141.5 to 171.4 per 1,000 population) and 25-44 (from 128.2 to 141.1 per 1,000 population). Rates of utilisation have also increased for these groups (566.8 to 772.4 per 1,000 and 504.1 to 621.0 per 1,000, respectively). Uptake and utilisation rates have stayed about the same for all other age groups.

- Uptake of Better Access is lowest among people in remote and outer regional areas (46.5 and 79.5 per 1,000 in 2021, respectively), compared to people in inner regional areas and major cities (101.2-105.2 per 1,000). Since 2018, utilisation rates have increased for people in major cities (higher socioeconomic status) (from 398.0 to 509.8 per 1,000) and major cities (medium socioeconomic status) (from 405.3 to 472.2 per 1,000), with more modest increases or no change in other geographic area groups.

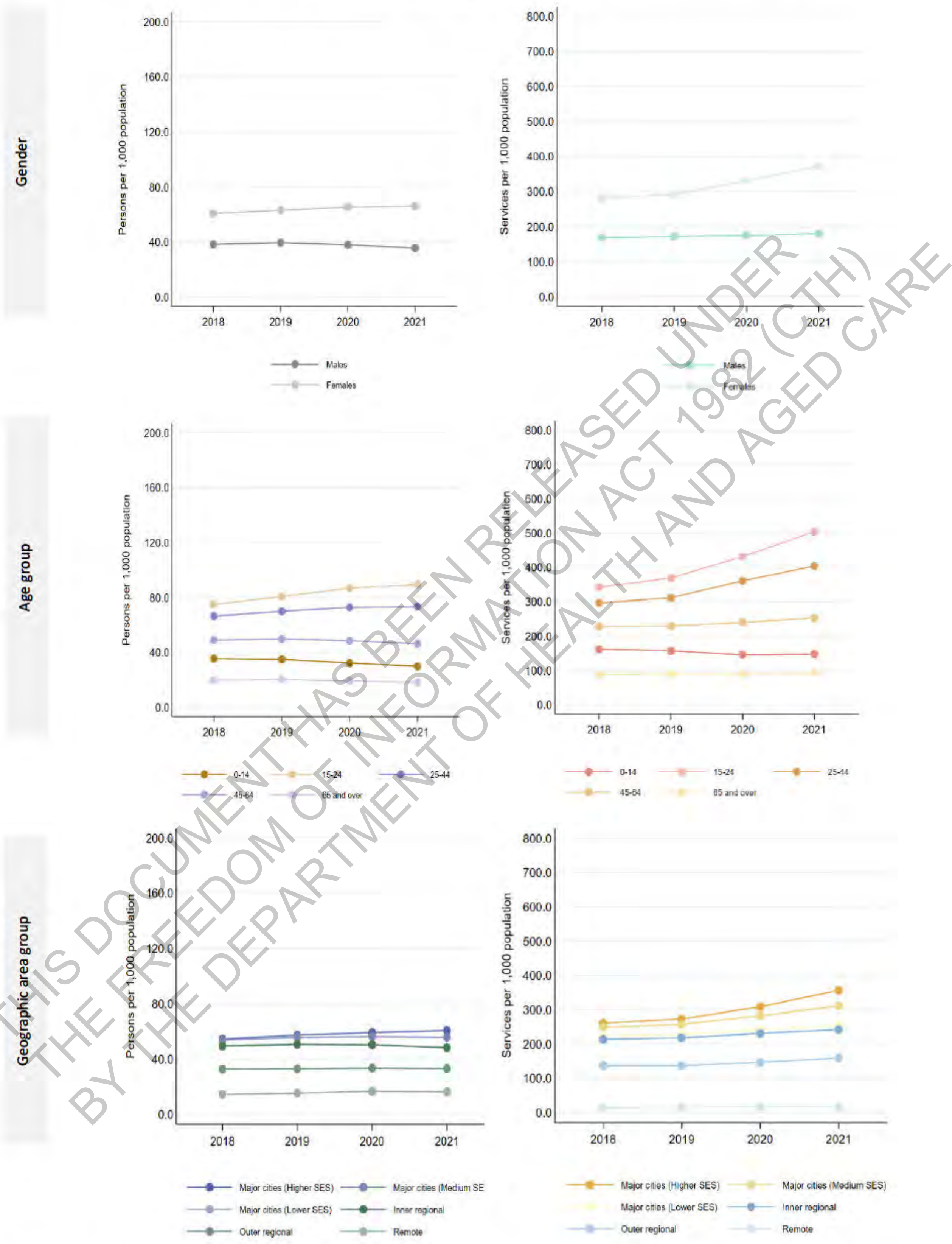
Relative uptake and utilisation patterns were similar when we focused on the Better Access treatment services only (Figure 3.3).

Figure 3.2: Rates of uptake and utilisation of any Better Access service, by consumer characteristics, 2018 to 2021



Note: 'Any Better Access service' refers to a service provided under any of the Better Access MBS items in Appendix 1.

Figure 3.3: Rates of uptake and utilisation of any Better Access treatment service, by consumer characteristics, 2018 to 2021



Note: '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 in uptake and utilisation in response to program refinements

As shown in Figure 3.1 and Appendix 2 Table A2.1, 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 relevant Better Access item groups 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 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 made to allow services to be delivered via telehealth to people in rural, remote and very remote locations. On 1 November 2017, new items were added to Better Access 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 delivered 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.

- On 7 August 2020, an additional 10 Medicare subsidised 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 further sessions in a calendar year 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 treatments sessions to 20 per calendar year across all modes of delivery (face-to-face, telehealth and phone) for all eligible consumers. 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 time trends in the uptake and utilisation of Better Access treatment services, according to mode of delivery (Figure 3.4). Results are also summarised by calendar year to facilitate comparisons (Table 3.9). These show that:

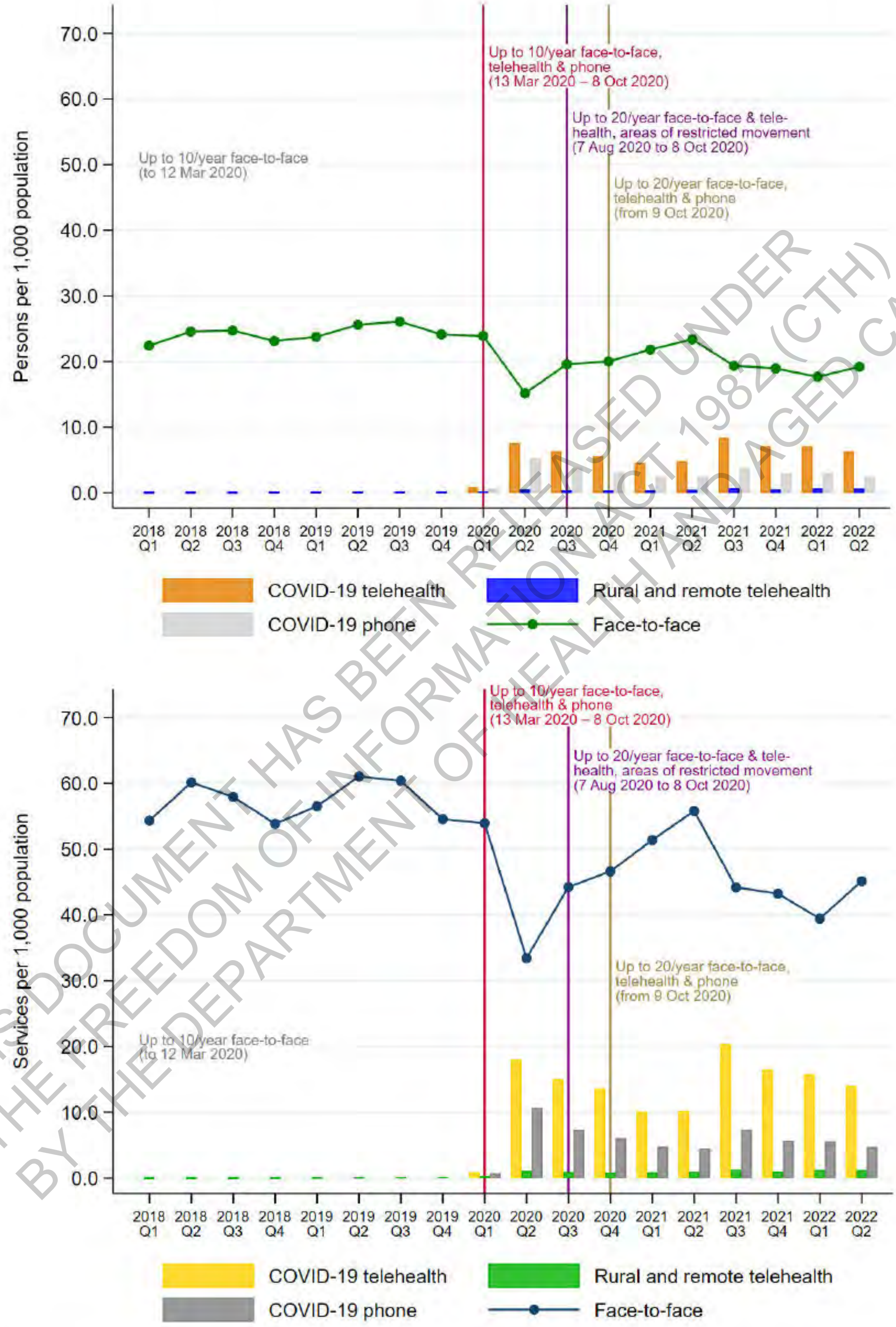
- Following the introduction of the additional 10 sessions without geographical restriction, utilisation of face-to-face services increased in the first half of 2021, but decreased thereafter. This decrease was offset by an increase in utilisation of COVID-19 telehealth services (Figure 3.4).

- Face-to-face remained the most common mode of delivery of Better Access treatment, even after the introduction of equivalent telehealth and phone services. 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).

- In terms of the number of services used, 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 2020 and were similar for the first half of 2022.

- The number of face-to-face services delivered declined between 2018 and 2021 (-4.8% average annual change, adjusted for population growth). However, when utilisation of the telehealth and phone services was added, the total number of treatment services delivered increased by 7.1% annually.

Figure 3.4: 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.

Table 3.9: Uptake and utilisation of sessions of Better Access telehealth services, 2020 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Any Better Access treatment service	Persons (n)	1,260,559	1,321,194	1,342,890	1,338,424	2.0	879,939
	Rate (per 1,000)	49.6	51.3	51.7	50.9	0.9	33.4
	% of BA treatment users	100.0	100.0	100.0	100.0	0	100.0
	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	100.0
Any face-to-face treatment sessions	Persons (n)	1,260,033	1,319,198	1,179,855	1,123,823	-3.7	676,187
	Rate (per 1,000)	49.5	51.2	45.4	42.8	-4.8	25.6
	% of BA treatment users	100.0	99.8	87.9	84.0	-5.6	76.8
	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 telehealth treatment service	Persons (n)	n.a.	n.a.	334,580	365,378	n.a.	252,518
	Rate (per 1,000)	n.a.	n.a.	12.9	13.9	n.a.	9.6
	% of BA treatment users	n.a.	n.a.	24.9	27.3	n.a.	28.7
	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 phone treatment service	Persons (n)	n.a.	n.a.	224,515	191,003	n.a.	108,752
	Rate (per 1,000)	n.a.	n.a.	8.6	7.3	n.a.	4.1
	% of BA treatment users	n.a.	n.a.	16.7	14.3	n.a.	12.4
	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 remote (telehealth)	Persons (n)	2,313	4,752	28,744	36,084	149.9	24,984
	Rate (per 1,000)	0.1	0.2	1.1	1.4	147.2	0.9
	% 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

n.a., not applicable. Data include all claims for services received from 10 December 2020 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:[47,48]

- 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 (as described in (a) above), 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.

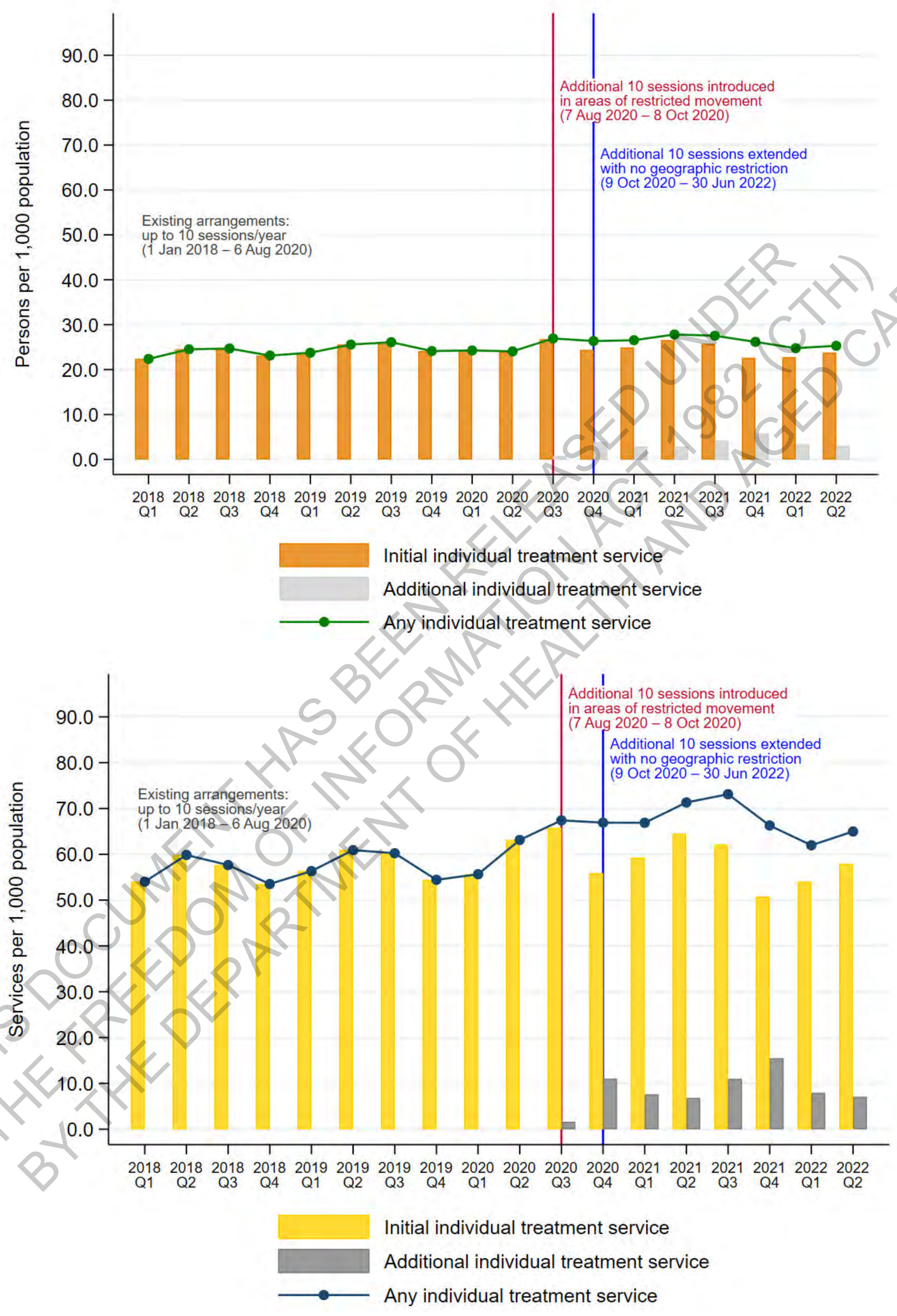
We divided the period between 1 January 2018 and 30 June 2022 into three epochs, capturing the changes to the permissible number of individual Better Access treatment sessions. We described time trends in the uptake and utilisation of individual Better Access treatment services, according to whether they were initial or additional services (Figure 3.5). Results are also summarised by calendar year (Table 3.10). These show that:

- Following the introduction of the additional 10 sessions without geographical restriction, utilisation of Better Access treatment services increased overall.

- 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 3.5: Uptake and utilisation individual Better Access treatment services, by whether the sessions were individual or additional, 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.

Table 3.10: Uptake and utilisation of individual Better Access treatment services, by whether the sessions were individual or additional, 2020 to 2022 year to date

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018-2021	2022 YEAR TO DATE
Any individual treatment service	Persons (n)	1,259,570	1,320,338	1,342,399	1,337,834	2.0	879,595
	Rate (per 1,000)	49.5	51.3	51.7	50.9	0.9	33.4
	% of individual session users	100.0	100.0	100.0	100.0	0	100.0
	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	100.0
Initial individual treatment service	Persons (n)	1,259,570	1,320,338	1,341,526	1,318,705	1.5	839,580
	Rate (per 1,000)	49.5	51.3	51.7	50.2	0.4	31.8
	% of individual session users	100.0	100.0	99.9	98.6	-0.5	95.5
	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 individual treatment service	Persons (n)	. .	. .	100,652	226,845	. .	119,588
	Rate (per 1,000)	. .	. .	3.9	8.6	. .	4.5
	% of individual session users	. .	. .	7.5	17.0	. .	13.6
	Services (n)	. .	. .	328,300	1,071,285	. .	395,852
	Rate (per 1,000)	. .	. .	12.6	40.8	. .	15.0
	% of individual sessions	. .	. .	5.0	14.8	. .	11.8

. ., not applicable. Data include all claims for services received from 10 December 2020 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population.

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.[49,50] 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.[49]

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 consultation services from GPs/other medical practitioners.

Flag fall items were made available as a financial incentive for providers to deliver services in aged care facilities. They are intended to compensate providers for additional expenses, such as travel costs, they might incur in providing these services. A flag fall can be claimed only for the first patient seen on each visit to a residential aged care facility. To avoid over-counting (because some flag fall items can be used in conjunction with services other than Better Access) the flag fall items have not been included in the results presented here.

We described time trends in the uptake and utilisation of the RACF COVID-19 mental health support items (Figure 3.6). Results are also summarised by calendar year (Table 3.11). These show that:

- In 2021, approximately 2,000 persons received at least one service via the dedicated RACF items (Table 3.11). 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 3.6: 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

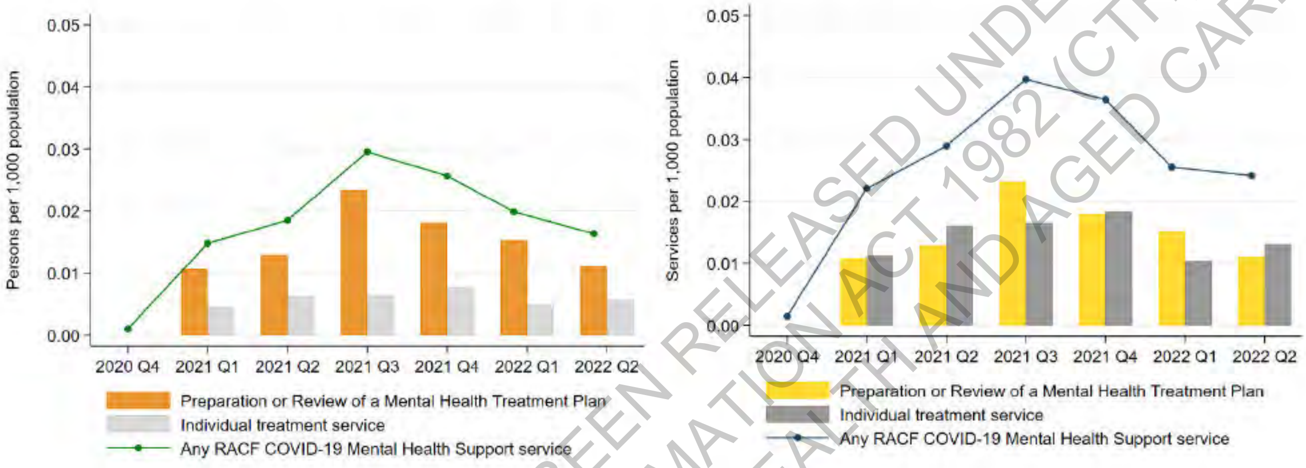


Table 3.11: Uptake and utilisation of the RACF COVID-19 mental health support services available only to residents in aged care facilities, 2020 to 2022 year to date

		2020	2021	2022 YEAR TO DATE
Any RACF COVID-19 mental health support service	Persons (n)	27	2,005	883
	Rate (per 1,000)	0.001	0.076	0.033
	% 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 review of a mental health plan	Persons (n)	n.p.	1,656	690
	Rate (per 1,000)		0.063	0.026
	% of RACF users		82.6	78.1
	Services (n)	n.p.	1,697	692
	Rate (per 1,000)		0.065	0.026
	% RACF services		51.0	52.8
Individual treatment service	Persons (n)	n.p.	402	213
	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. Data include all claims for services received from 10 December 2020 to 30 June 2022 and processed up to 7 August 2022. Rates are crude rates per 1,000 total population.

Affordability to consumers

To examine affordability of Better Access services to consumers, we developed descriptive profiles of the rates of bulk-billing and consumer out-of-pocket costs for Better Access services in key item groups and for consumers in different socio-demographic groups defined by age group, gender, and geographic location/socio-economic disadvantage.

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 3.12). 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. 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 3.12: Bulk-billing and out-of-pocket costs paid by consumers, for any Better Access services and 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 service	Services	9,567,533	9,873,074	10,647,956	11,295,485	5.7	5,172,960
	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 ($)	74	72	77	74	-0.2	87
	OOP 25th percentile ($)	46	48	47	43	-1.8	60
	OOP 75th percentile ($)	97	98	99	99	0.8	109
Any Better Access treatment service	Services	5,733,018	5,975,389	6,569,630	7,275,153	8.3	3,352,832
	Services bulk-billed (%)	46.2	42.7	44.2	34.4	-9.4	30.5
	Services with OOP (%)	52.7	56.3	55.0	64.8	7.2	68.9
	Median OOP ($)	74	75	77	74	0.0	90
	OOP 25th percentile ($)	49	50	50	48	-0.7	65
	OOP 75th percentile ($)	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 3.13-3.15 profile bulk-billing rates and out-of-pocket costs for key Better Access item groups. These show that the percentage of services for which a co-payment was made by the consumer varied depending on the type of provider and service the consumer received. These tables show that:

- 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 consultation (5.4%) (Table 3.13).

- 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 3.14).

- For consultant psychiatrists, the majority of services for initial patient consultation involved a co-payment (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 3.15).

- 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 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 participant saw:

- For services delivered by GPs/other medical practitioners, the median co-payment varied between $41 (interquartile range [IQR] $24-$56) for mental health 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 ($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.

Table 3.13: Bulk-billing and out-of-pocket costs paid by consumers, 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 mental health treatment plan	Services	1,334,869	1,418,974	1,473,480	1,425,356	2.2	662,552
	Services bulk-billed (%)	88.3	87.4	88.6	85.1	-1.2	82.3
	Services with OOP (%)	11.2	12.2	11.1	14.6	9.1	17.4
	Median OOP ($)	46	46	46	46	0.1	45
	OOP 25th percentile ($)	33	32	32	31	-2.5	32
	OOP 75th percentile ($)	66	63	62	60	-3.3	62
Review of a mental health treatment plan	Services	494,123	527,938	618,470	624,547	8.1	288,031
	Services bulk-billed (%)	88.3	87.1	88.7	84.0	-1.6	80.6
	Services with OOP (%)	11.3	12.4	11.0	15.6	11.5	18.9
	Median OOP ($)	44	43	44	42	-1.4	45
	OOP 25th percentile ($)	27	27	27	23	-4.0	30
	OOP 75th percentile ($)	61	58	59	56	-2.4	60
Mental health consultation	Services	1,809,232	1,753,947	1,787,109	1,759,821	-0.9	753,460
	Services bulk-billed (%)	95.9	95.5	95.8	94.4	-0.5	93.2
	Services with OOP (%)	3.9	4.3	4.0	5.4	11.3	6.6
	Median OOP ($)	41	42	43	41	-0.2	45
	OOP 25th percentile ($)	26	26	27	24	-1.7	30
	OOP 75th percentile ($)	57	56	57	56	-0.3	63
Focussed psychological strategies	Services	32,160	32,325	42,669	44,143	11.1	21,994
	Services bulk-billed (%)	66.7	63.9	73.1	67.5	0.4	65.3
	Services with OOP (%)	33.0	35.7	26.5	32.3	-0.7	34.5
	Median OOP ($)	59	61	65	62	1.5	63
	OOP 25th percentile ($)	42	44	42	39	-2.7	45
	OOP 75th percentile ($)	77	88	91	92	6.4	99

OOP, out-of-pocket. Bold type indicates average annual change of 10% or higher. 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 3.14: 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

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

OOP, out-of-pocket. Bold type indicates average annual change of 10% or higher. 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 3.15: Bulk-billing and out-of-pocket costs paid by consumers, 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 psychiatrist assessment and management plan	Services	42,870	41,799	41,515	42,267	-0.5	29,125
	Services bulk-billed (%)	79.0	75.1	74.5	65.6	-6.0	60.4
	Services with OOP (%)	20.6	24.5	25.0	33.8	17.9	38.9
	Median OOP ($)	120	120	118	146	6.9	201
	OOP 25th percentile ($)	68	65	75	81	6.4	142
	OOP 75th percentile ($)	182	175	197	204	3.9	270
Review of a psychiatrist assessment and management plan	Services	9,033	8,691	8,875	7,681	-5.3	5,541
	Services bulk-billed (%)	87.5	87.8	87.0	84.3	-1.3	73.8
	Services with OOP (%)	12.3	12.0	12.9	15.5	8.0	25.6
	Median OOP ($)	90	83	86	100	3.4	144
	OOP 25th percentile ($)	57	44	52	51	-3.7	99
	OOP 75th percentile ($)	136	160	147	149	3.0	149
Initial patient consultation	Services	144,388	146,336	148,877	160,660	3.6	81,419
	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 ($)	158	158	170	171	2.8	204
	OOP 25th percentile ($)	118	118	122	118	0.1	135
	OOP 75th percentile ($)	205	209	213	222	2.7	264

OOP, out-of-pocket. Bold type indicates average annual change of 10% or higher. 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 3.7 to 3.10 profile differences in co-payment rates and median out-of-pockets costs between socio-demographic groups and over time. These show that:

- Overall, there tended to be higher rates of co-payment 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 social workers.

- There was a gradient in co-payment rates and median out-of-pocket costs for people living in major cities, 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 SES 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 SES groups for allied health professional services than for GP/OMP services.

- Overall, the percentage of services with a co-payment was generally similar for people in inner regional, outer regional and remote areas. 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 3.7: Out-of-pocket costs for any Better Access service and any Better Access treatment service, by socio-demographic factors, 2018 to 2022

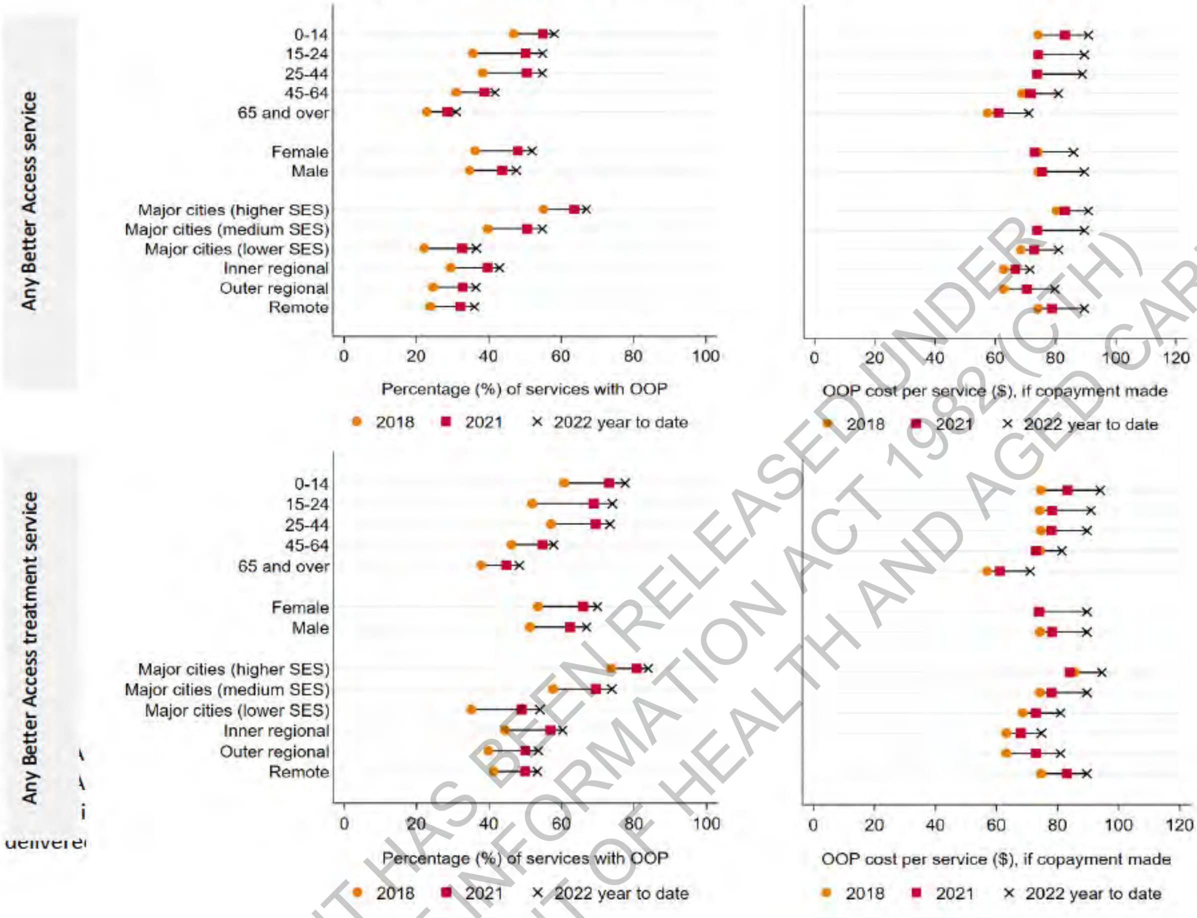


Figure 3.8: Out-of-pocket costs for Better Access services delivered by GPs and other medical practitioners, by socio-demographic factors, 2018 to 2022

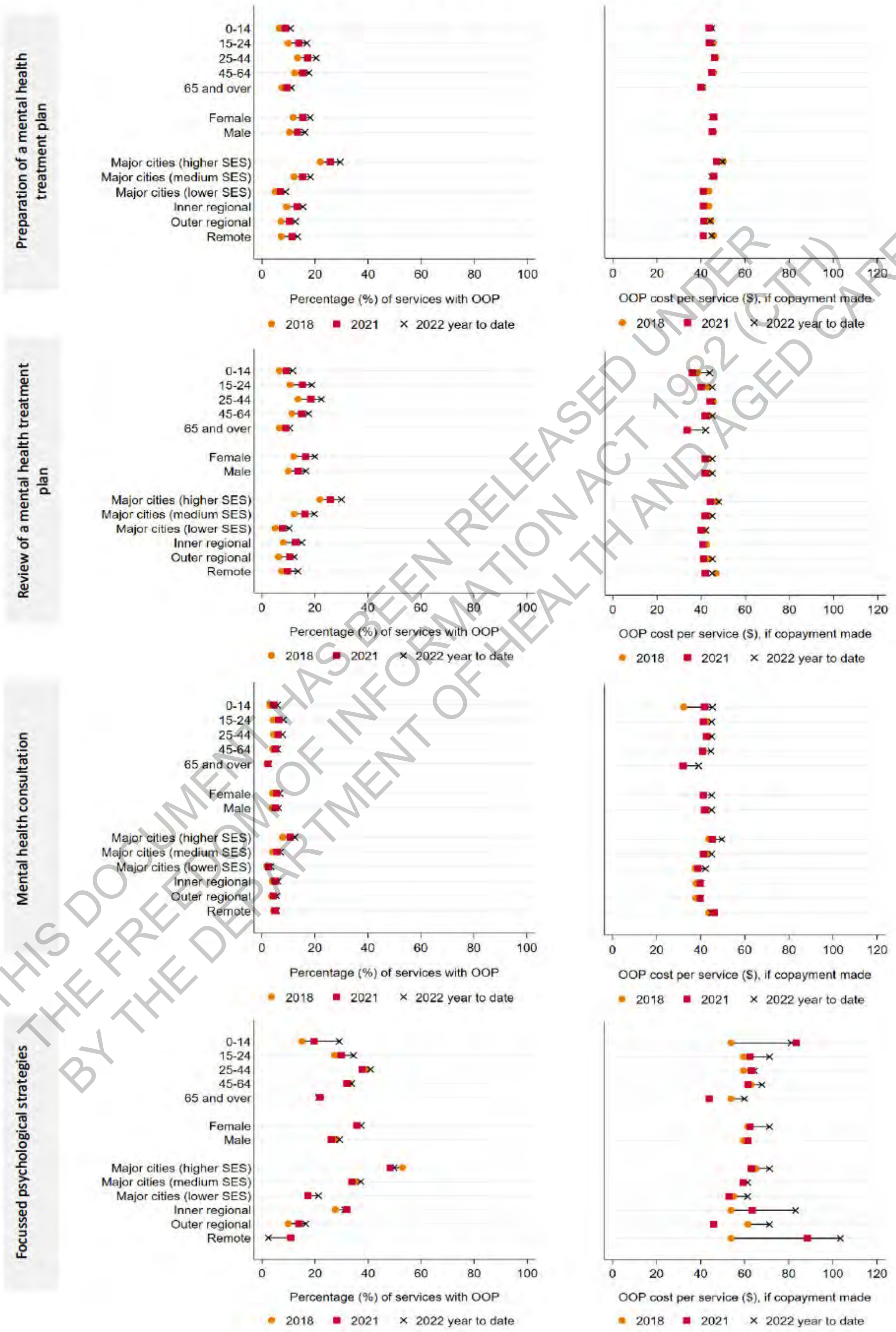


Figure 3.9: Out-of-pocket costs for Better Access services delivered by allied health professionals, by socio-demographic factors, 2018 to 2022

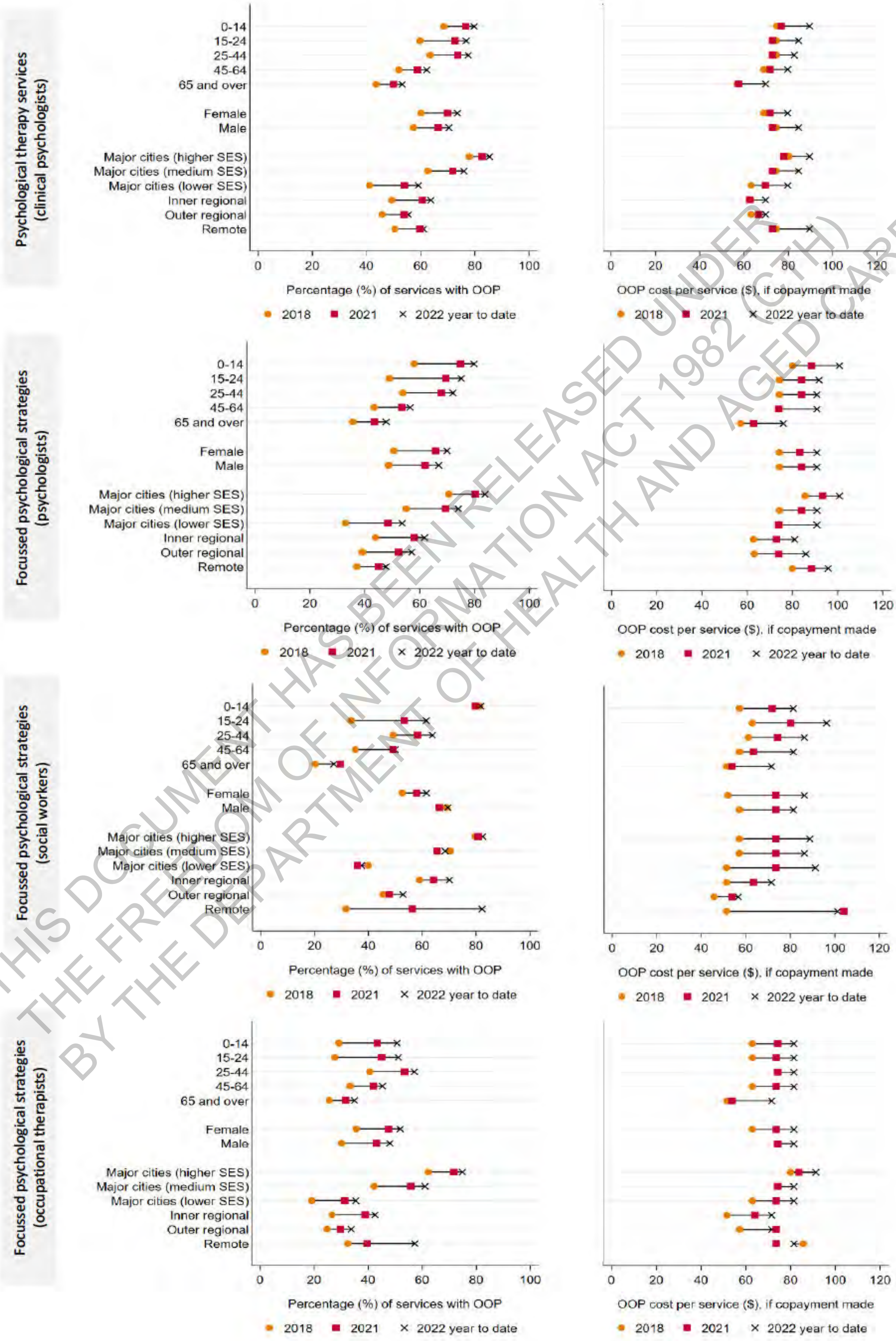
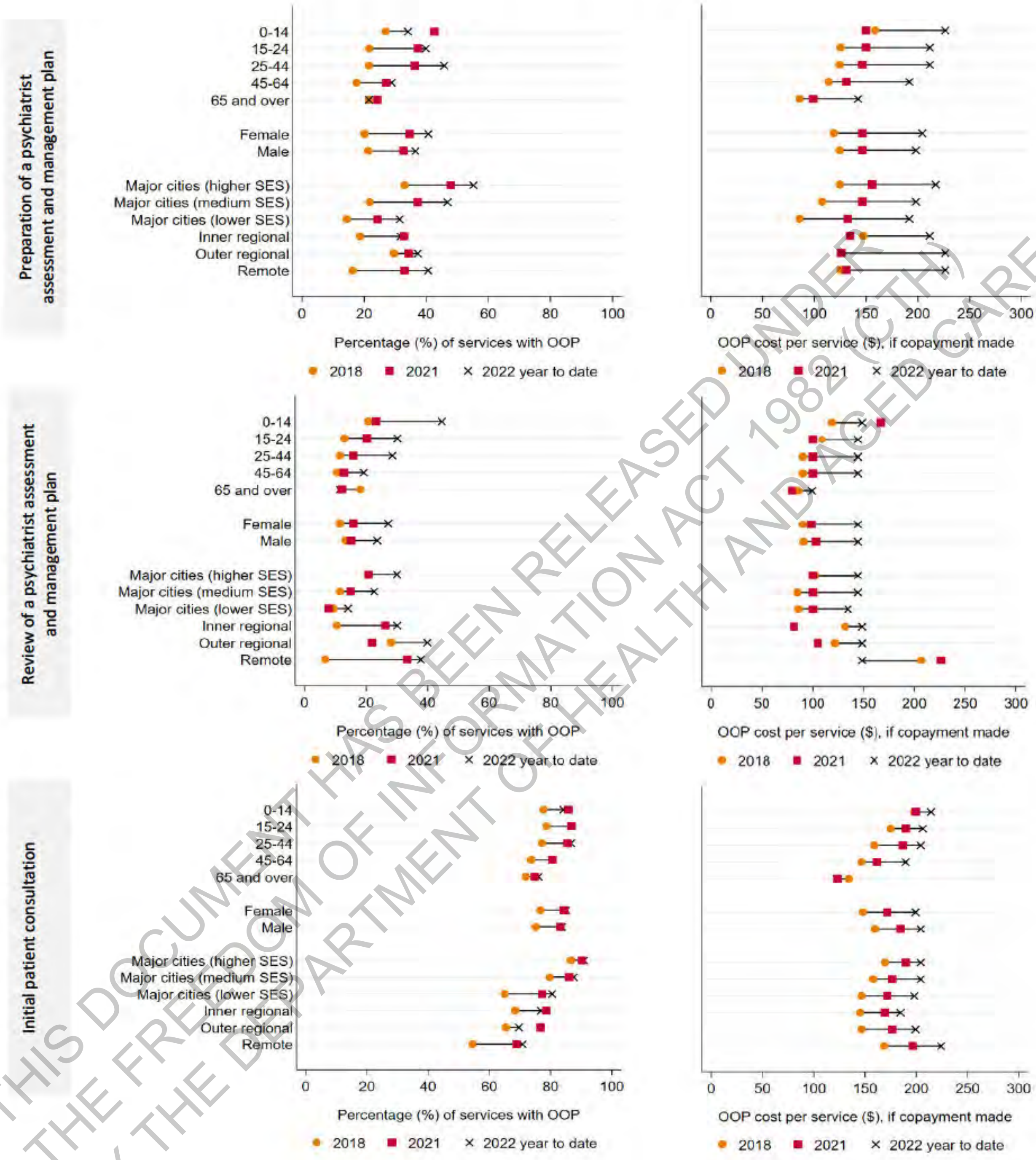


Figure 3.10: Out-of-pocket costs for Better Access services delivered by consultant psychiatrists, by socio-demographic factors, 2018 to 2022



Discussion

Summary and interpretation of findings

The preliminary results for Study 1 show that uptake of Better Access has continued to grow as the program has matured. In 2021, one in every 10.5 Australians received any least one Better Access service and one in 20 received at least one session of psychological treatment through Better Access.

Rates of uptake and utilisation varied across population subgroups, tending to be relatively 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 regardless of socio-economic status and inner regional areas (compared to people living in outer regional and remote areas) in 2021. Levels of utilisation have changed over time, with increases particularly apparent for many of these same groups (females, people aged 15-24 and 25-44 years, people in major cities with high or medium socio-economic status).

Changes to the Better Access program rules 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 services has been substantial, accounting for about one-third (32.6%) of Better Access treatment services in 2021. The additional 10 sessions of treatment for people experiencing difficulties due to COVID-19 accounted for 14.8% of individual treatment sessions in 2021. Together these measures contributed to a sustained level of uptake of Better Access treatment sessions (average annual growth of 0.9%) and higher levels of treatment (average annual growth of 7.1% in the rate of services used per 1,000). 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.

Since 2018, rates of co-payment have increased across most types of Better Access services. Overall, in 2021, 46.6% of all Better Access services involved a co-payment by the consumer (up by 9.3% from 35.7% in 2018) and 64.8% of Better Access treatment services involved a co-payment (up by 7.2% 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); 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.

Strengths and limitations

Study 1 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 will forthcoming analyses of 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 examine changes in mental health using several different types of samples and Study 9 will explore whether routinely collecting outcome data is feasible and acceptable to providers.

Further work on Study 1

This section provides a preliminary overview of the findings from Study 1, focusing on questions relating to the accessibility of the Better Access program. Specifically, it has explored rates of uptake and utilisation of Better Access services, and how these have changed over the last 4.5 years, a period that has seen significant changes to the program. These findings provide important context for the other studies in the evaluation. Analyses for Study 1 are ongoing. Further findings will be presented in the Final Evaluation Report and will also include a focus on describing patterns of care within "episodes" of Better Access treatment.

Conclusions

The preliminary results from Study 1 indicate that the reach of Better Access has continued to expand as the program has matured. The program appears to be serving some groups better than others and these gaps have widened in recent years. Notably, increases in the number of Better Access services used have been greatest among people living in areas of medium or high socio-economic status within major cities. Recent changes to the program, such as the COVID-19 telehealth and phone services and additional 10 sessions of treatment, have been well utilised although uptake of the RACF item numbers has been comparatively modest. The percentage of Better Access services involving a co-payment by the consumer has increased in recent years and median out-of-pocket costs, although fairly steady overall between 2018 and 2021, increased markedly in the first half of 2022. Findings will be updated in the Final Evaluation Report.

4. 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.[14] 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 4.1 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.

Table 4.1: Scope of the four datasets

DATASET	PROVIDERS	PERIOD OVER WHICH DATA WERE AVAILABLE
NovoPsych	≈3,000 (mostly psychologists but also other providers)	January 2013 to February 2022
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

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)[22,23]
- Clinical Outcomes in Routine Evaluation (CORE-10)[24]
- Depression Anxiety and Stress Scale (DASS-21/42)[25,26]
- Depression Anxiety and Stress Scale (DASS-10)[27]
- Generalised Anxiety Disorder scale (GAD-7)[29]
- Global Assessment of Functioning Scale (GAF)[30]
- Kessler-10 (K-10)[19]
- Outcome Rating Scale (ORS)[33]
- Patient Health Questionnaire (PHQ-9)[34]
- Positive and Negative Affect Schedule (PANAS)[36]
- Satisfaction With Life Scale (SWLS)[37]

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.[33] 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,[51] private health insurance companies,[52] the Department of Veterans Affairs[6] and the Department of Defence.[6] 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.[53]

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 4.2) or quartiles. Scores were rounded down for the purposes of categorisation.

Table 4.2: Baseline severity cut-offs used for measures in purpose-designed analyses

MEASURE	CUT-OFFS USED TO INDICATE BASELINE SEVERITY
Clinical Outcomes in Routine Evaluation (CORE-OM)[22,23]	Non-clinical: 0 Clinical: ≥1
Clinical Outcomes in Routine Evaluation (CORE-10)[24]	Non-clinical range: ≤10 Mild: 11-14 Moderate: 15-19 Moderate to severe: 20-24 Severe: ≥25
Depression Anxiety and Stress Scale (DASS-21/42) – Depression[25,26]	Normal: ≤9 Mild: 10-13 Moderate: 14-20 Severe: 21-27 Extremely severe: ≥28
Depression Anxiety and Stress Scale (DASS-21/42) - Anxiety[25,26]	Normal: ≤7 Mild: 8-9 Moderate: 10-14 Severe: 15-19 Extremely severe: ≥20
Depression Anxiety and Stress Scale (DASS-21/42) - Stress[25,26]	Normal: ≤14 Mild: 15-18 Moderate: 19-25 Severe: 26-33 Extremely severe: ≥34
Depression Anxiety and Stress Scale (DASS-10)[27]	Sub-clinical or mild: ≤6 Moderate: 7-12 Severe: ≥13
Generalised Anxiety Disorder scale (GAD-7)[29]	No GAD: ≤9 GAD: ≥10
Global Assessment of Functioning Scale (GAF)[30]	Quartile 1 Quartile 2 Quartile 3 Quartile 4
Kessler-10 (K-10)[19]	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)[34]	No depression: ≤4 Mild depression: 5-9 Moderate depression: 10-14 Moderately severe depression: 15-19 Severe depression: ≥20
Positive and Negative Affect Schedule (PANAS)[36] – Negative	Quartile 1 Quartile 2 Quartile 3 Quartile 4
Positive and Negative Affect Schedule (PANAS)[36] – Negative	Quartile 1 Quartile 2 Quartile 3 Quartile 4
Satisfaction With Life Scale (SWLS)[37]	Quartile 1 Quartile 2 Quartile 3 Quartile 4

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.[33]

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.

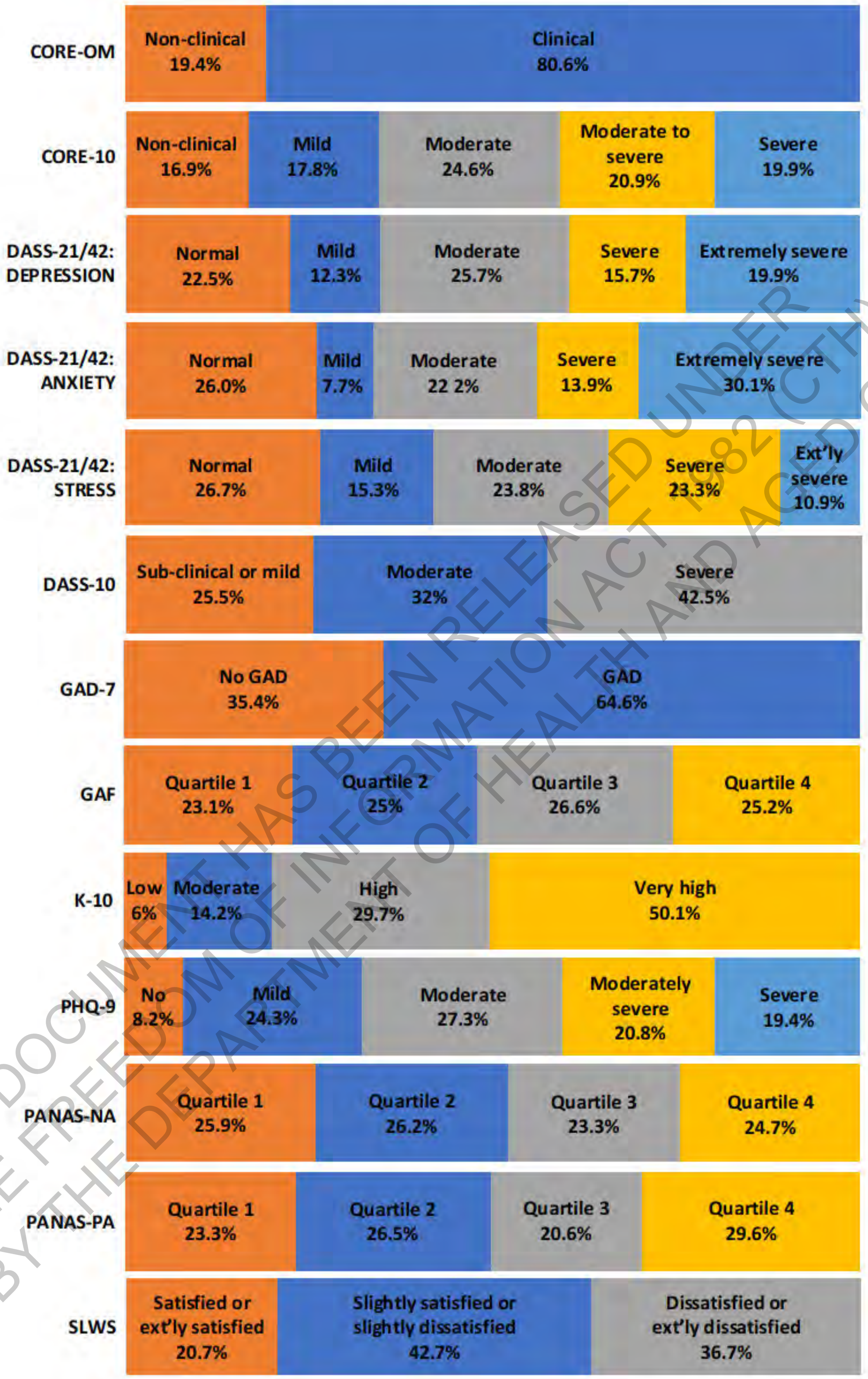
Table 4.3 profiles the episodes included in the analysis for each measure. Across all measures, around two thirds of episodes were delivered to females. Between 40% and 65% of episodes were provided to people under the age of 40. The number of outcome assessments that were administered in a given episode 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.

Table 4.3: Breakdown of episodes included in analyses, by measure

		CORE-OM	CORE-10	DASS-21/42	DASS-10	GAD-7	GAF	K-10	PHQ-9	PANAS	SWLS
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 outcome assessments in episode	**2**	62%	46%	59%	15%	64%	8%	67%	60%	6%	6%
	3	20%	21%	21%	14%	20%	4%	21%	22%	4%	4%
	4	7%	10%	8%	14%	7%	6%	7%	7%	7%	7%
	5+	11%	23%	13%	57%	9%	82%	6%	11%	83%	83%

Figure 4.1 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 4.1: Baseline severity, by measure



Figures 4.2-4.14 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 4.2: Outcomes on the CORE-OM

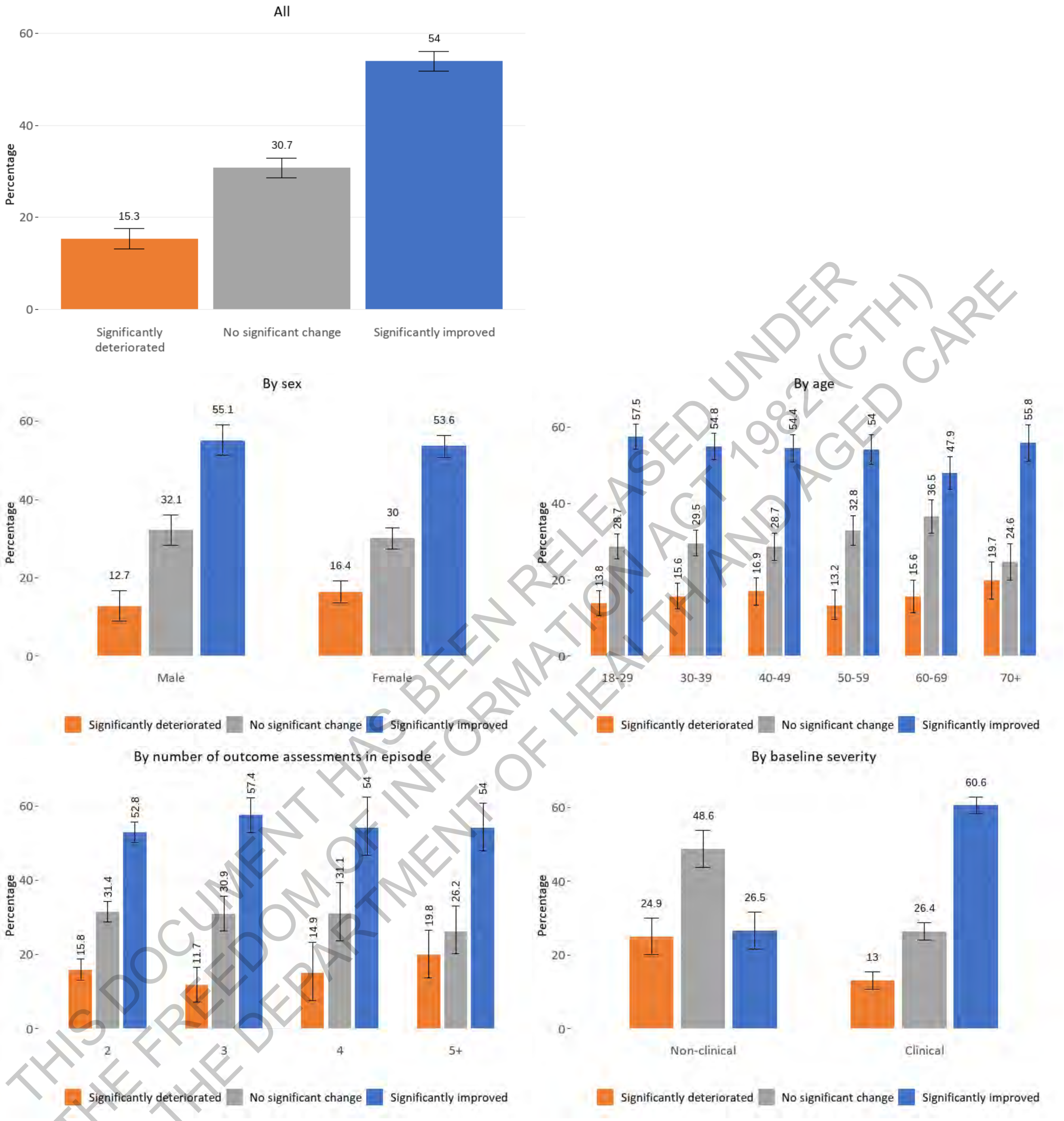


Figure 4.3: Outcomes on the CORE-10

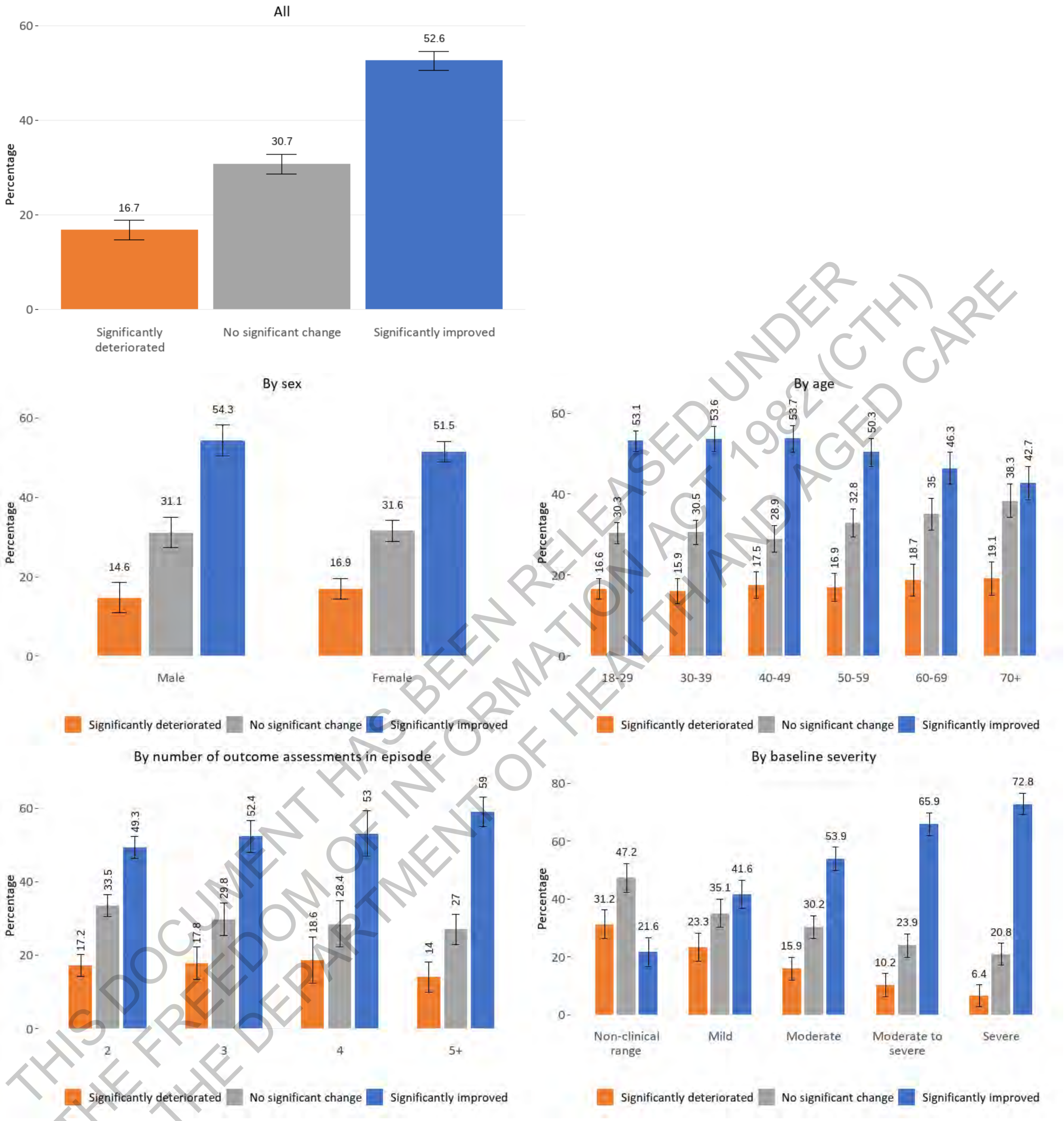


Figure 4.4: Outcomes on the DASS-21/42 – Depression

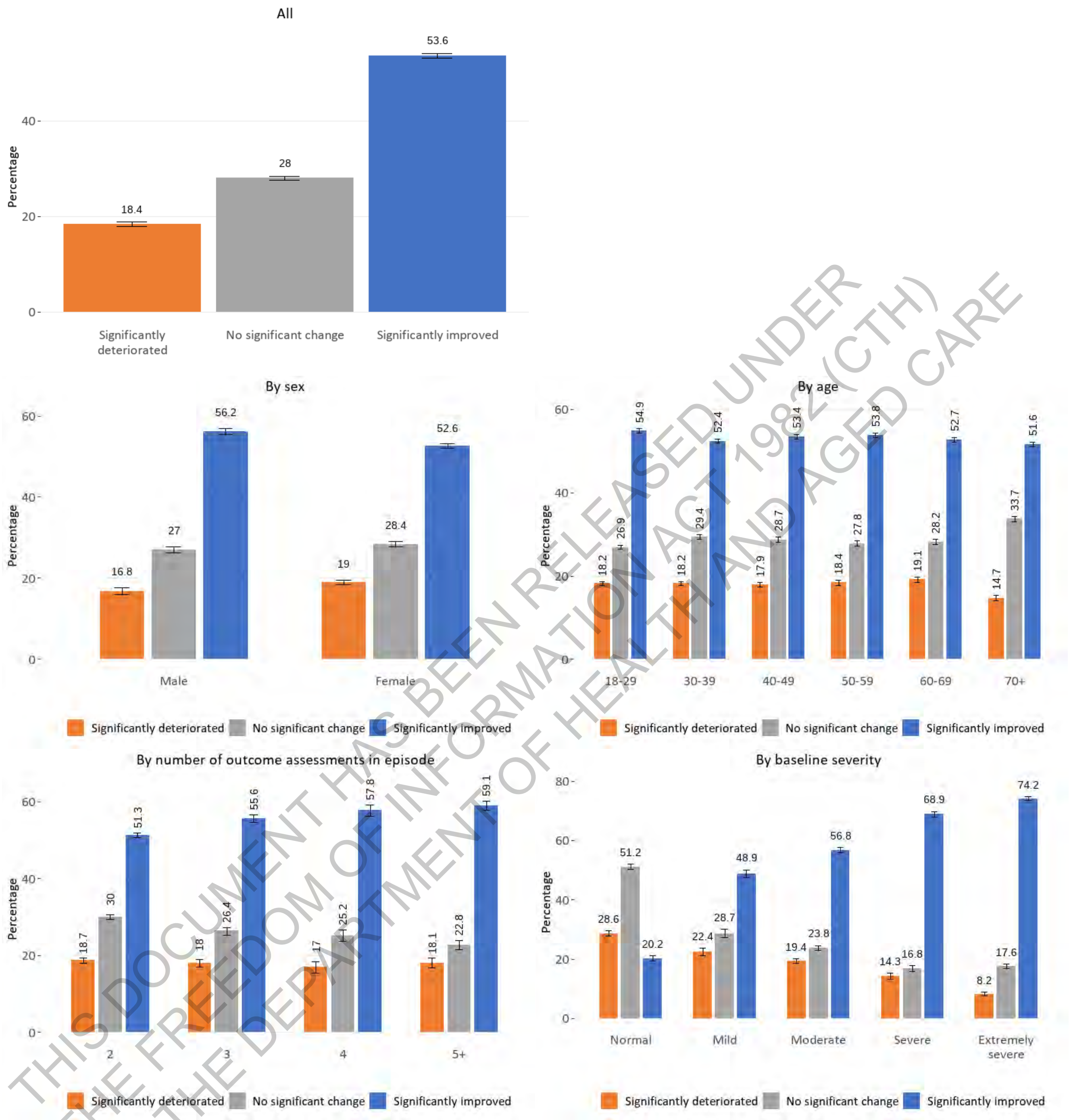


Figure 4.5: Outcomes on the DASS-21/42 – Anxiety

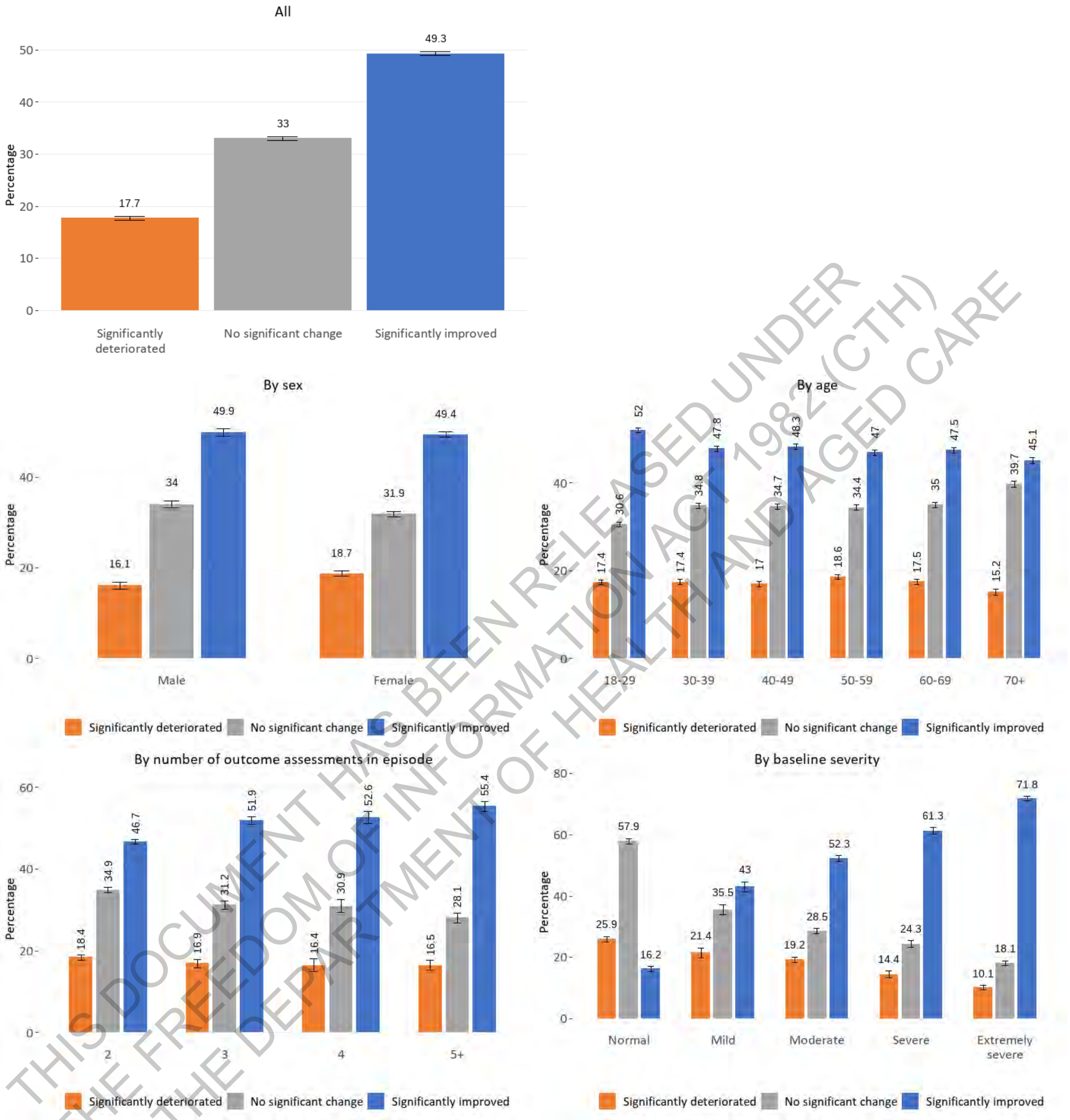


Figure 4.6: Outcomes on the DASS-21/42 – Stress

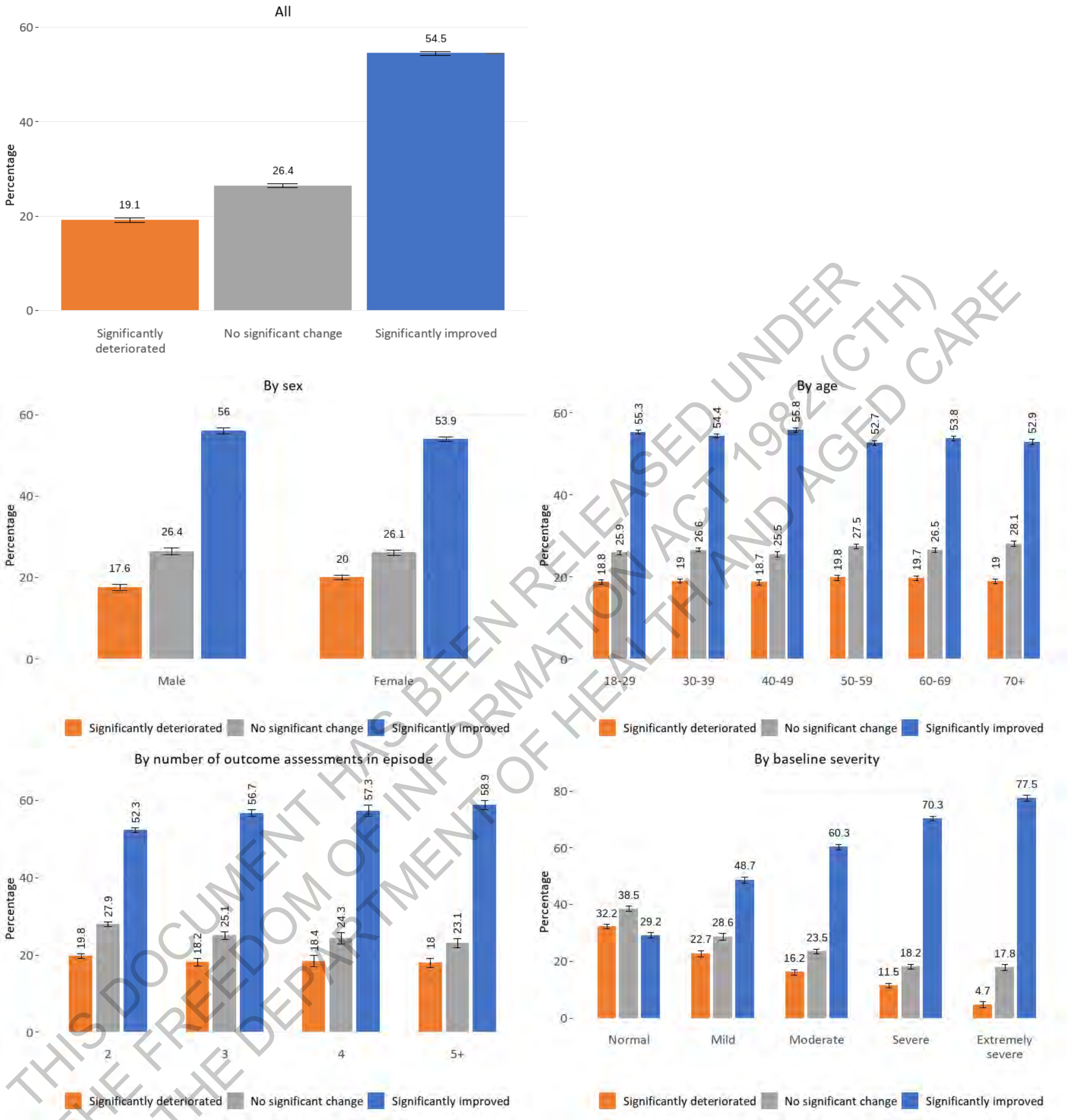


Figure 4.7: Outcomes on the DASS-10

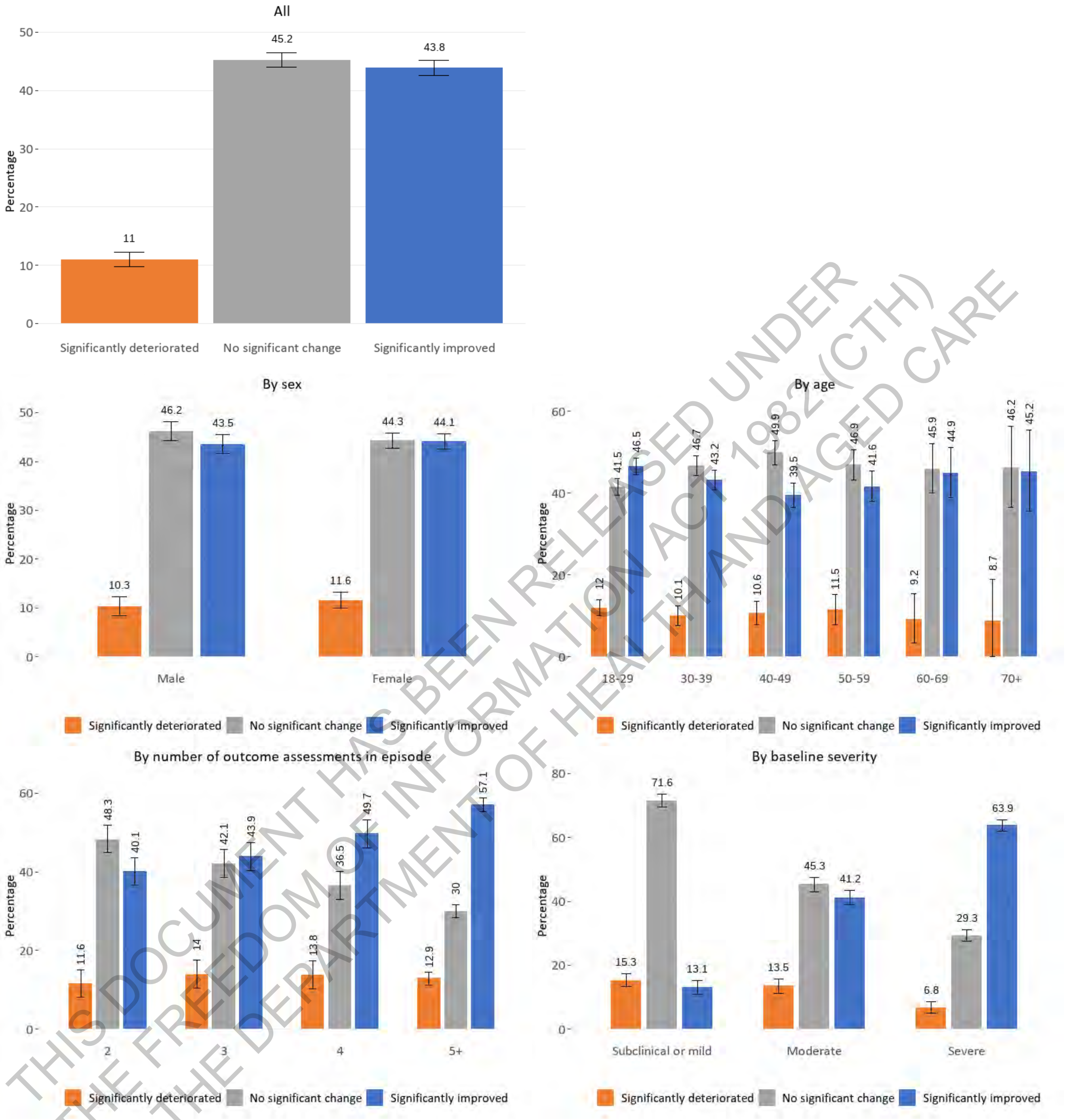


Figure 4.8: Outcomes on the GAD-7

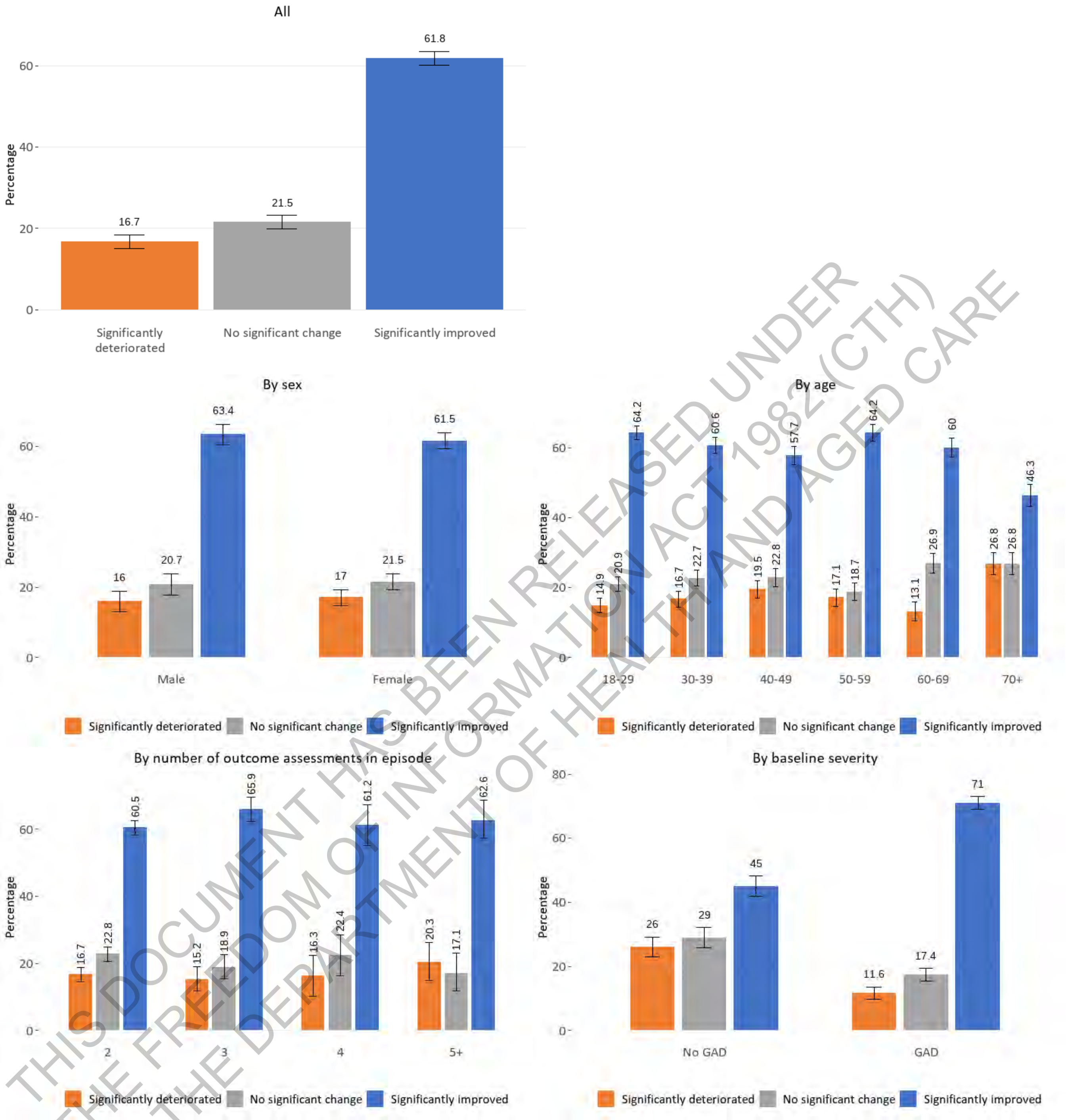
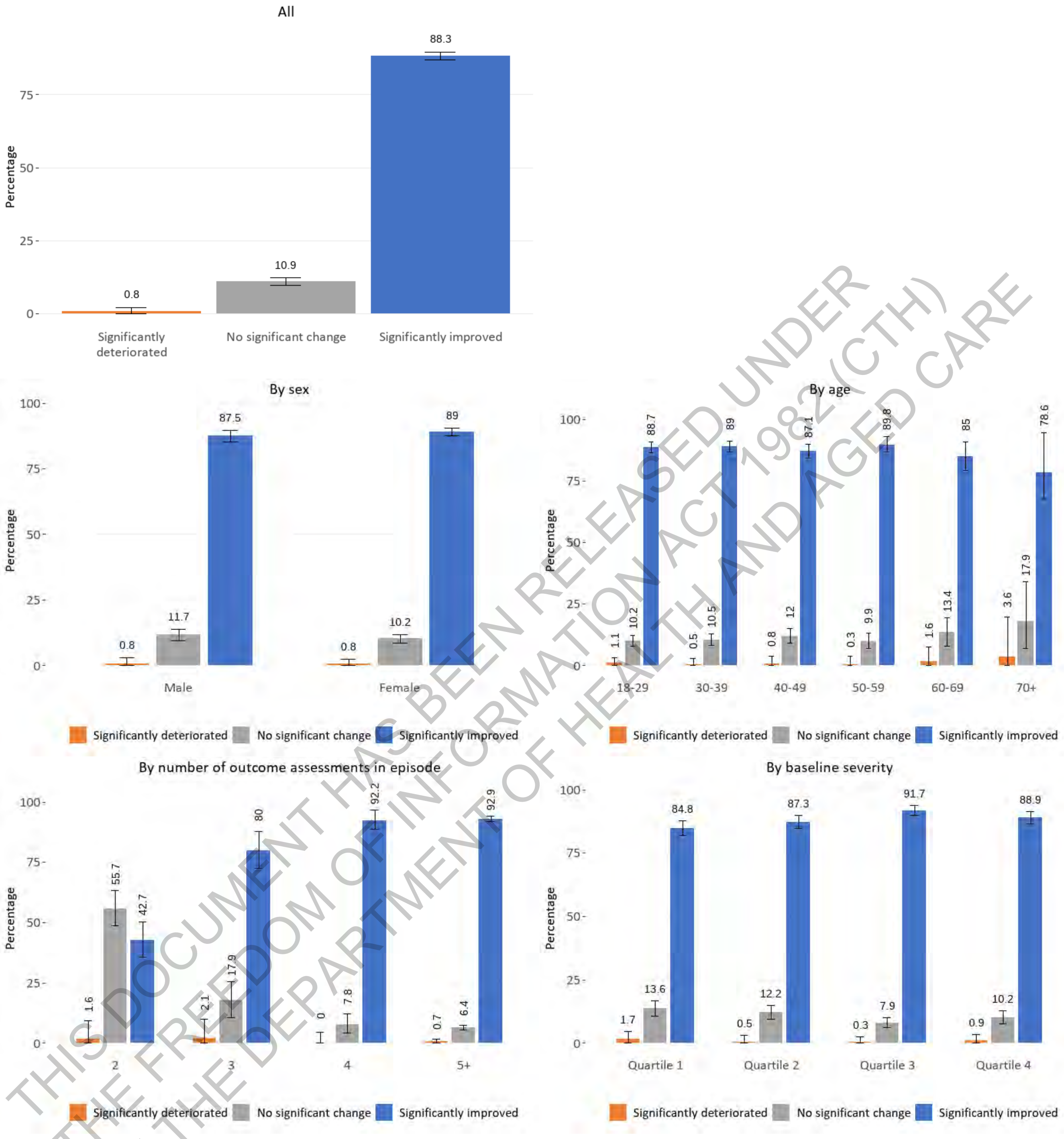


Figure 4.9: Outcomes on the GAF



All

By sex

By age

By number of outcome assessments in episode

By baseline severity

Figure 4.10: Outcomes on the K-10

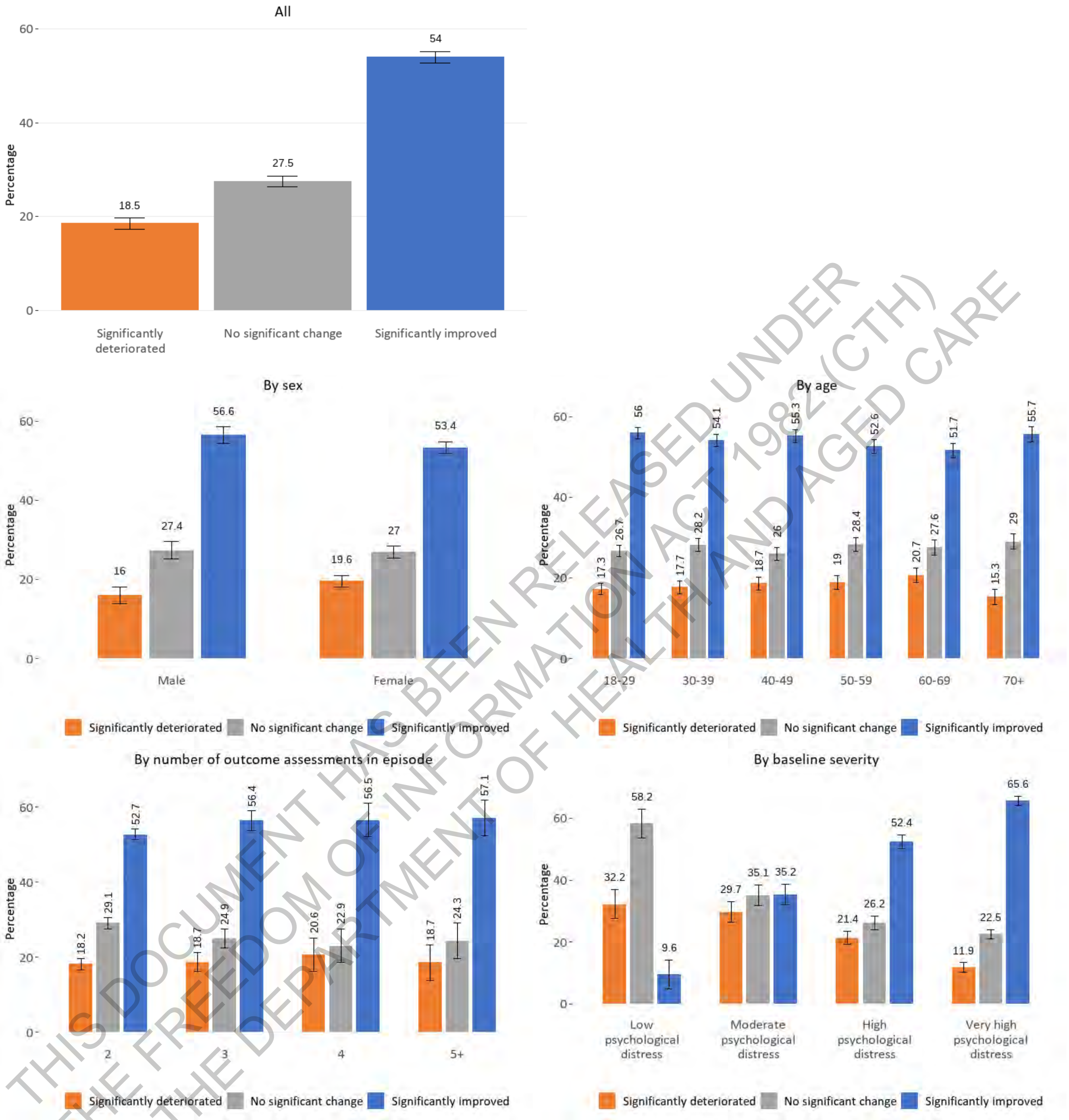


Figure 4.11: Outcomes on the PHQ-9

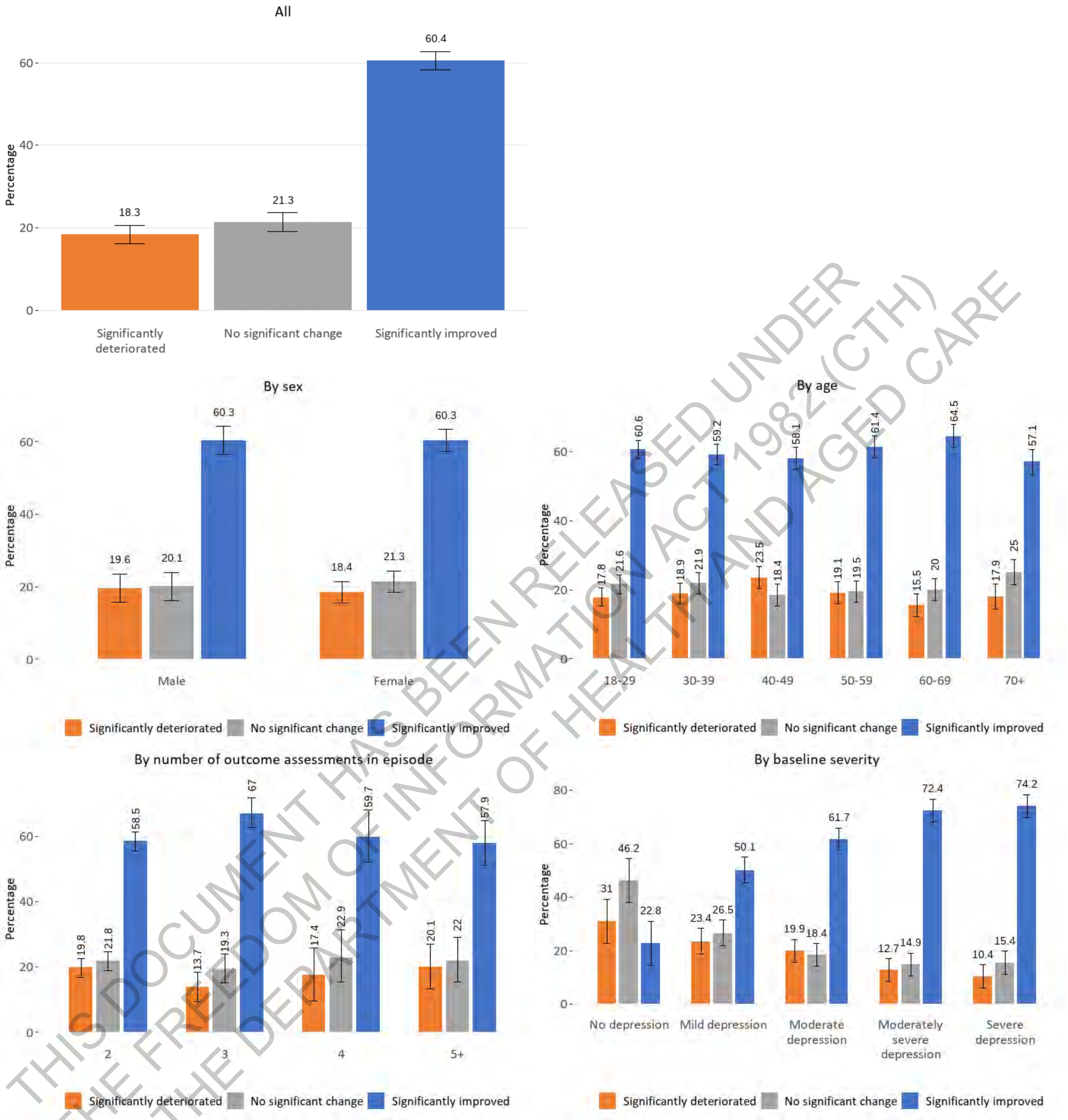


Figure 4.12: Outcomes on the PANAS-NA

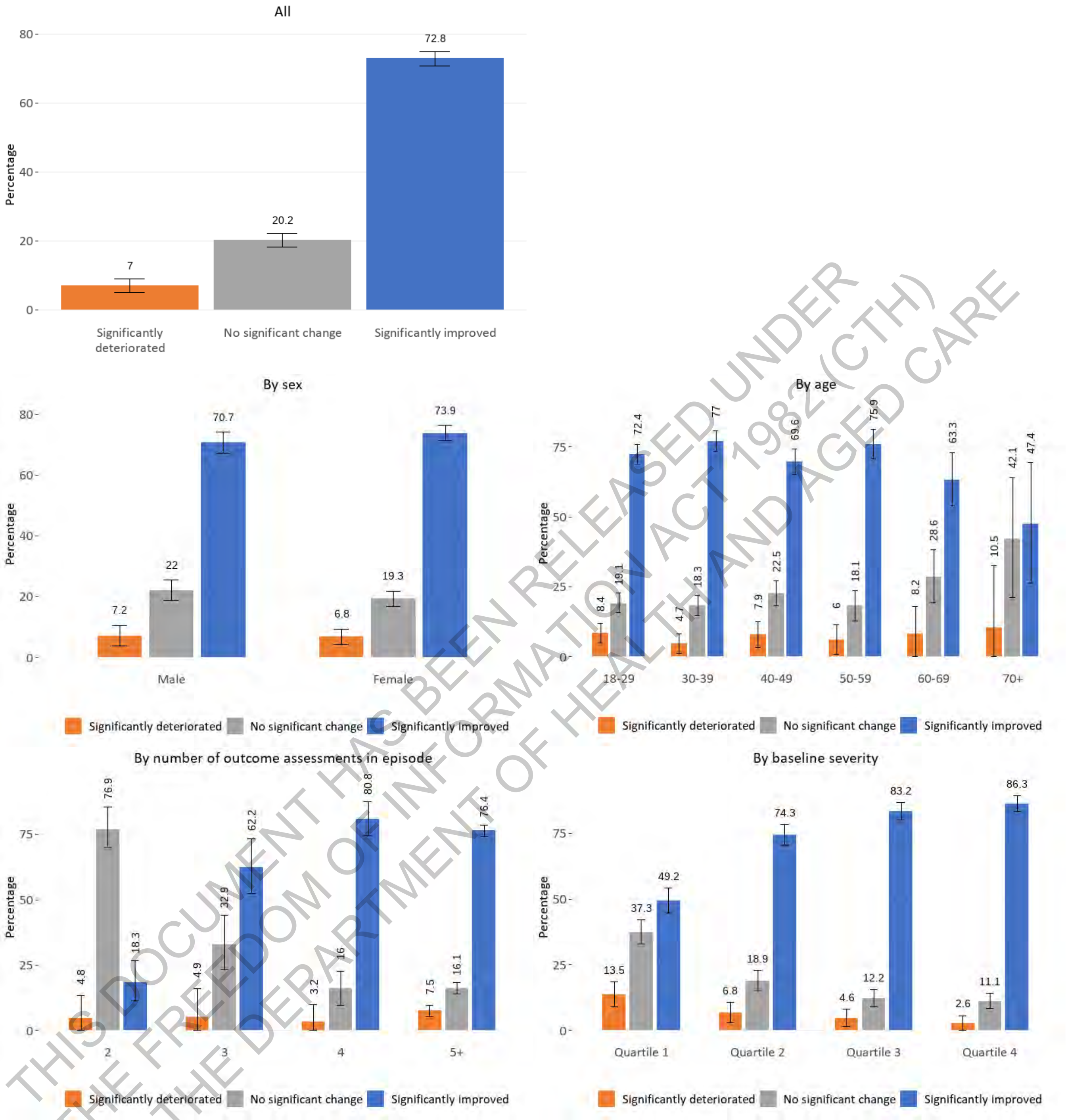


Figure 4.13: Outcomes on the PANAS-PA

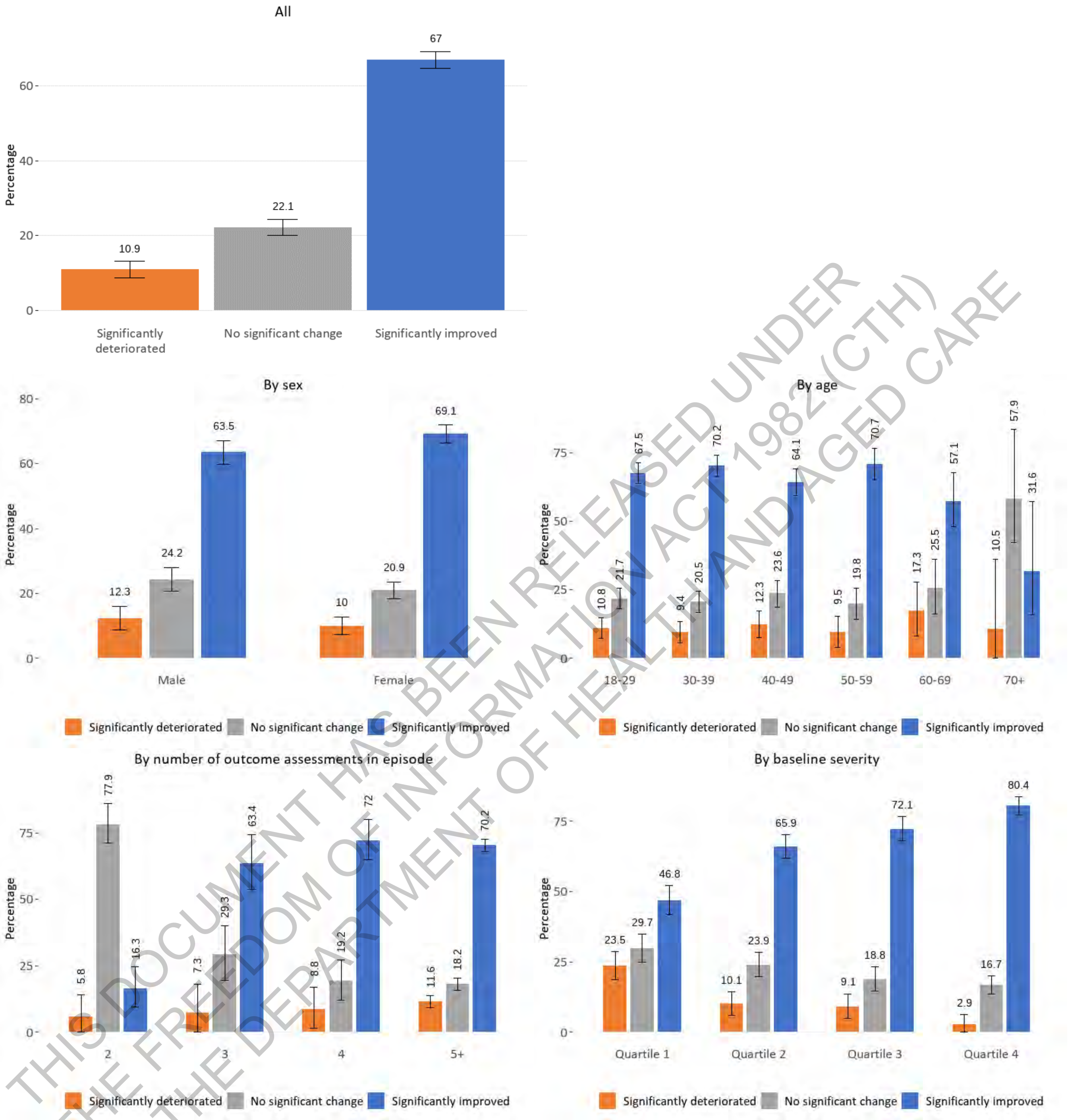
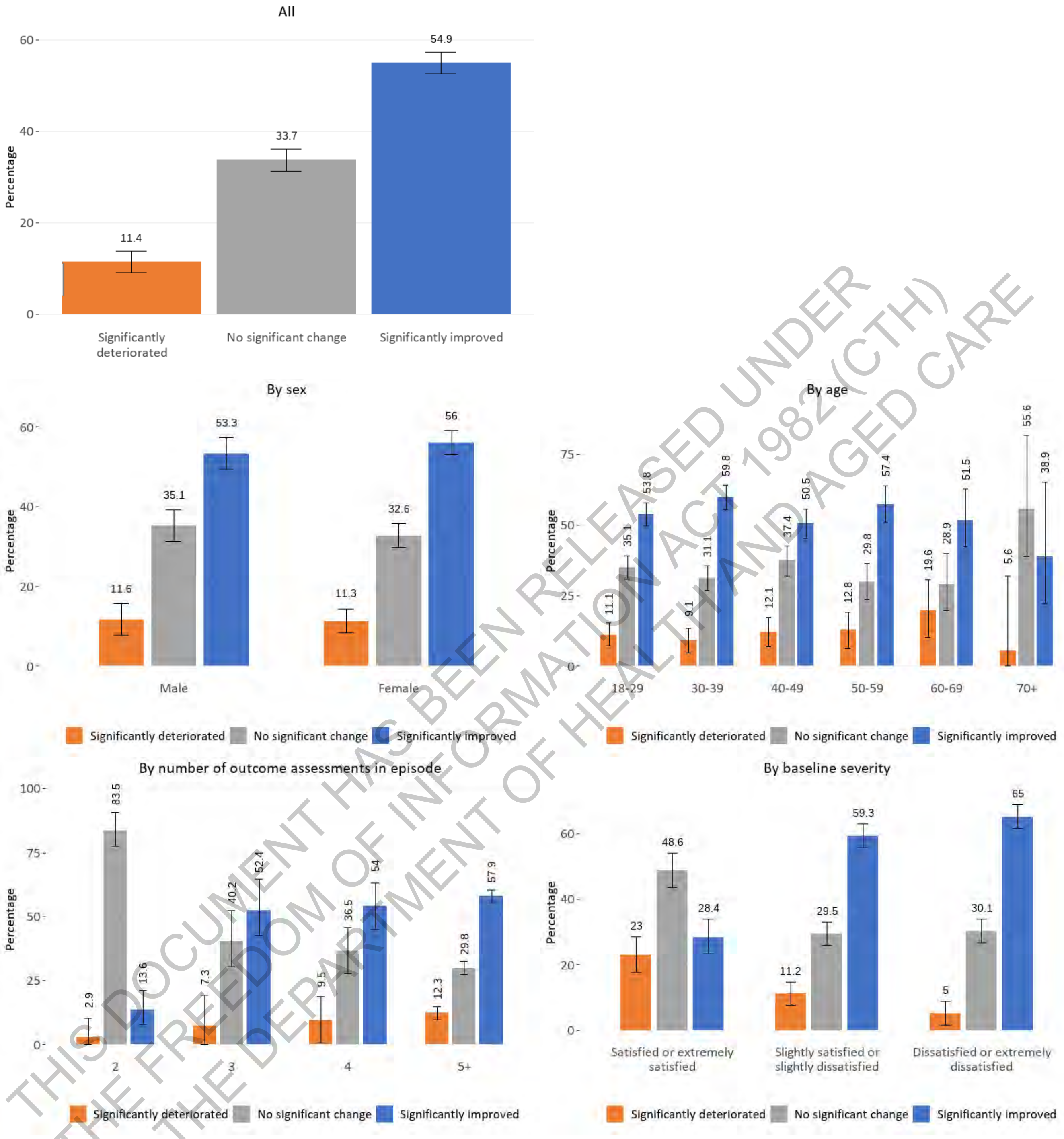


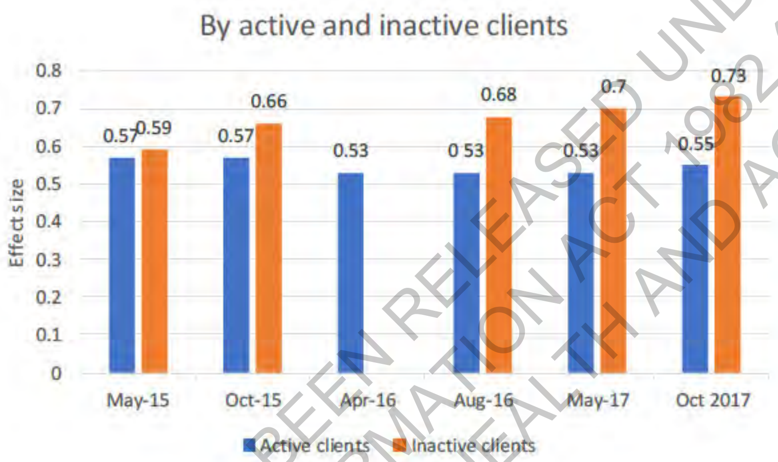
Figure 4.14: Outcomes on the SWLS



Pre-existing outputs

The pre-existing outputs represented 2,775 episodes of care. Figure 4.15 presents the key results, describing outcomes at six cross-sectional time points as measured by the ORS.[33] 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 4.15: Outcomes on the ORS



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 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,[1] 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. This does raise some concerns about how well Better Access may be serving those with mild to moderate conditions, particularly since the program was originally designed for them.[1]

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 ≤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, Aboriginal and Torres Strait Islander 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.

5. 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.[7,8,10,12,54] 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 that are presented in the Interim Report. 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 5.1 shows the relevant item numbers and the 16 strata, as well as the number of consumers approached in each stratum (27,167 in total).

Table 5.1: Strata used for stratified random sampling approach, with relevant MBS item numbers and number of consumers approached

STRATUM	LOCATION OF RESIDENCE	NUMBER OF SESSIONS[a]	PROVIDER FROM WHOM CARE WAS RECEIVED	MBS ITEM NUMBERS	NUMBER OF CONSUMERS APPROACHED
1	Major cities and inner regional areas	Received additional sessions	Clinical psychologist	93330, 93331, 93332, 93333, 93334, 93335	2,500
2	Major cities and inner regional areas	Received additional sessions	Psychologist	93350, 93351, 93352, 93353, 93354, 93355	2,500
3	Major cities and inner regional areas	Received additional sessions	Social worker	93362, 93363, 93364, 93365, 93366, 93367	2,478
4	Major cities and inner regional areas	Received additional sessions	Occupational therapist	93356, 93357, 93358, 93359, 93360, 93361	283
5	Major cities and inner regional areas	Didn't receive additional sessions	Clinical psychologist	80000, 80005, 80010, 80015, 80020, 80001, 80011, 80021, 91166, 91181, 91167, 91182	2,500
6	Major cities and inner regional areas	Didn't receive additional sessions	Psychologist	80100, 80105, 80110, 80115, 80120, 80101, 80111, 80121, 91169, 91183, 91170, 91184	2,500
7	Major cities and inner regional areas	Didn't receive additional sessions	Social worker	80150, 80155, 80160, 80165, 80170, 80151, 80161, 80171, 91175, 91187, 91176, 91188	2,500
8	Major cities and inner regional areas	Didn't receive additional sessions	Occupational therapist	80125, 80130, 80135, 80140, 80145, 80126, 80136, 80146, 91172, 91185, 91173, 91186	2,500
9	Outer regional, remote, and very remote areas	Received additional sessions	Clinical psychologist	93330, 93331, 93332, 93333, 93334, 93335	720
10	Outer regional, remote, and very remote areas	Received additional sessions	Psychologist	93350, 93351, 93352, 93353, 93354, 93355	734
11	Outer regional, remote, and very remote areas	Received additional sessions	Social worker	93362, 93363, 93364, 93365, 93366, 93367	82
12	Outer regional, remote, and very remote areas	Received additional sessions	Occupational therapist	93356, 93357, 93358, 93359, 93360, 93361	6
13	Outer regional, remote, and very remote areas	Didn't receive additional sessions	Clinical psychologist	80000, 80005, 80010, 80015, 80020, 80001, 80011, 80021, 91166, 91181, 91167, 91182	2,500
14	Outer regional, remote, and very remote areas	Didn't receive additional sessions	Psychologist	80100, 80105, 80110, 80115, 80120, 80101, 80111, 80121, 91169, 91183, 91170, 91184	2,500
15	Outer regional, remote, and very remote areas	Didn't receive additional sessions	Social worker	80150, 80155, 80160, 80165, 80170, 80151, 80161, 80171, 91175, 91187, 91176, 91188	2,500
16	Outer regional, remote, and very remote areas	Didn't receive additional sessions	Occupational therapist	80125, 80130, 80135, 80140, 80145, 80126, 80136, 80146, 91172, 91185, 91173, 91186	364

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 3); 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 4). 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 5 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 6) and were then presented with a second consent form (see Appendix 7). 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 5.

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 Socio-economic Indexes for Areas (SEIFA).[55]

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 Kingdom[56] 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.[57]

- **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 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.[38] 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 classification[58]) 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, Aboriginal or Torres Strait Islander status, area of residence, socio-economic 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. The results reported here are provisional and have not yet been reviewed by Services Australia, as per their conditions of data release prior to publication.

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 5.2 profiles the survey sample in terms of their socio-demographic 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.[55] One notable exception to the diversity of the sample was that Aboriginal and Torres Strait Islander people were under-represented, accounting for only 2% of the sample.

Table 5.2: Socio-demographic profile of the survey 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
Aboriginal or Torres Strait Islander (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 Islander	1,744	98.0
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 socio-economic status (SEIFA IRSD quintiles; n=1,865)[a,b]	Q1 (Most disadvantaged)	253	13.6
	Q2	363	19.5
	Q3	391	21.0
	Q4	374	20.1
	Q5 (Least disadvantaged)	484	26.0

a. Missing data excluded.

b. Socio-economic 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 Socio-economic 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 5.3 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 5.3: 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 5.4 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 5.4: Correspondence between mental health professional seen according to self-report and Services Australia

		Self-report										
		Psychologist		Social worker		Occupational therapist		Unsure		Missing		Total
		FREQ	%	FREQ	%	FREQ	%	FREQ	%	FREQ	%	
Services Australia	Clinical psychologist	677	97.4%	7	1.0%	6	0.9%	4	0.6%	1	0.1%	695
	Psychologist	591	97.2%	5	0.8%	2	0.3%	10	1.6%	0	0.0%	608
	Social worker	280	55.4%	179	35.4%	11	2.2%	35	6.9%	0	0.0%	505
	Occupational therapist	112	54.6%	8	4.4%	77	37.6%	6	2.9%	2	1.1%	205
	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 5.5).

Table 5.5: 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 5.6).

Table 5.6: Prior use of Better Access

		FREQUENCY	%
Prior use of Better Access (n=1,983)[a]	First time using Better Access	615	31.0
	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 5.7 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%).

Table 5.7: Reasons for seeking care from the mental health professional (multiple responses permitted)

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

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 5.8 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 5.8: 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 5.9 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 5.9: 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

Sessions of care

Participants were asked whether they were still receiving sessions of care with the relevant mental health professional. Table 5.10 shows that two thirds (68%) still were.

Table 5.10: Ongoing receipt of sessions of care

		FREQUENCY	%
Still receiving sessions of care (n=1,999)[a]	Yes	1,365	68.3
	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 5.11 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 5.11 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.

Table 5.11: Number of sessions of mental health 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 sessions of care (n=2,013)	No additional sessions	1,099	54.6
		Additional sessions	914	45.4

a. Missing data excluded.

Participants were asked about the modality and format of the sessions of care that they received. Table 5.12 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 5.12 also shows that an overwhelming majority of participants (99%) received individual sessions of care.

Table 5.12: Modality and format of sessions

			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%

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 5.13).

Table 5.13: Adequacy of number of sessions

		FREQUENCY	%
Adequacy of number of sessions (n=1,978)[a]	Too many	10	0.5
	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 5.10). Table 5.14 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 5.14: Early cessation of mental health care (those still receiving care only)

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

Figure 5.1 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 5.1: Reasons for early cessation of mental health care (those ceasing care early only; multiple responses permitted)

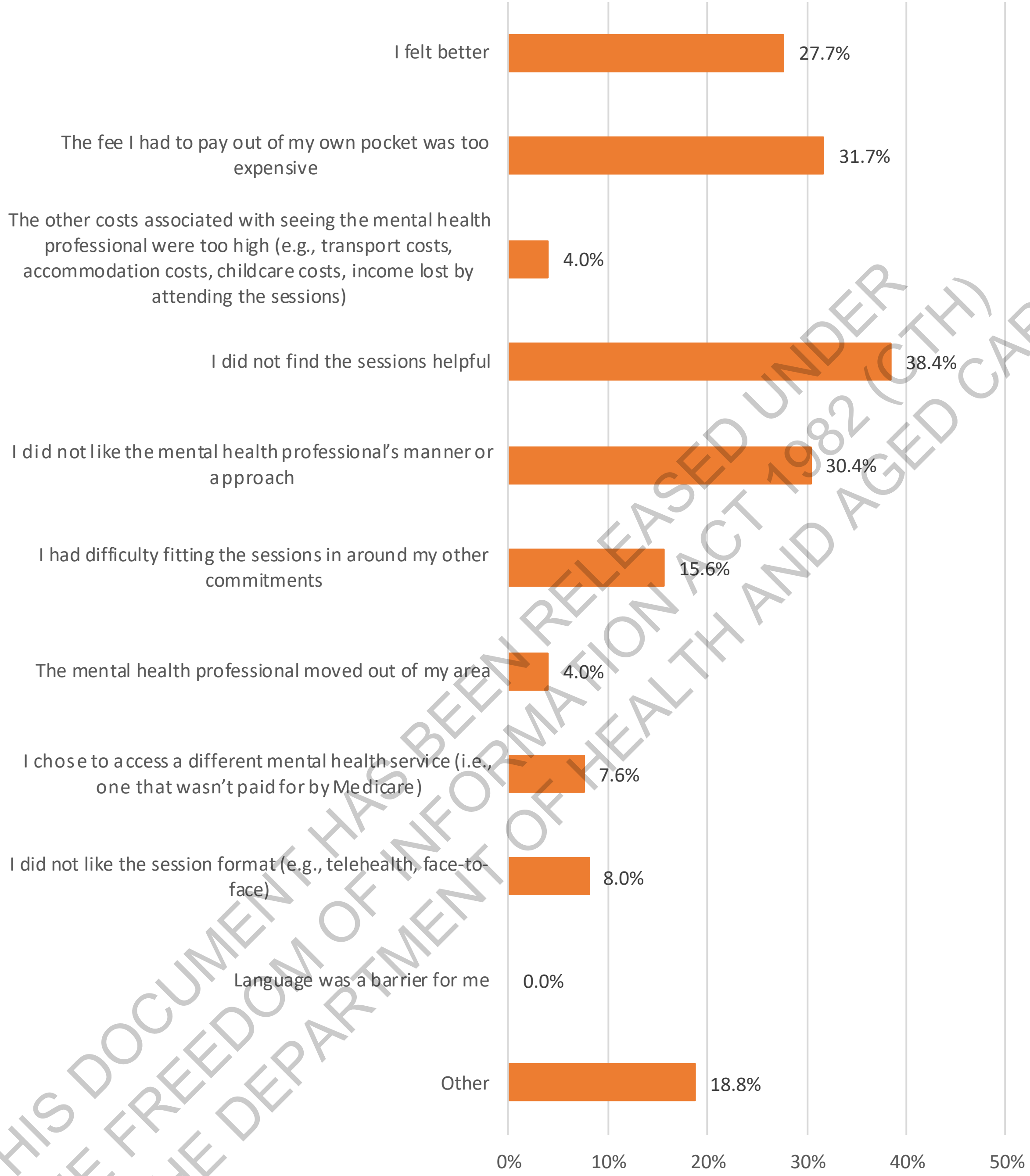


Table 5.15 shows how the numbers of sessions and early cessation of care are related. Those receiving only 1-2 sessions tended to not still be receiving care, to not have continued seeing the mental health professional for as long as they could have done, and to have ceased care because they did not 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.

Table 5.15: Number of sessions by early cessation of care and reasons for early cessation

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

a. Missing data excluded.

Payment for Better Access care

Participants were asked about the payment arrangements for their Better Access care. Table 5.16 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%).

Table 5.16: Payment for Better Access care

		FREQUENCY	%
Payment source (n=1,987)[a]	Medicare covered all of the costs	519	26.1
	Medicare covered some of the costs, but I paid at least some of the costs out of my own pocket	1,391	70.0
	Some other payment arrangement	36	1.8
	Unsure	41	2.1
Perceptions of affordability (n=1,945)[a]	I didn't pay anything; Medicare covered all of the cost	510	26.2
	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

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 5.2 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.

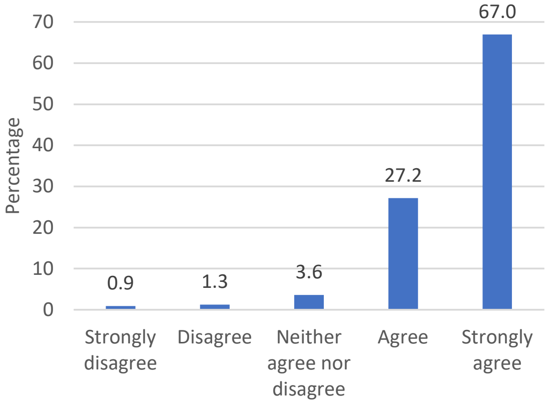
Overall, the majority of participants indicated that they had positive experiences. Seventy seven percent found the referral process straightforward, 84% were offered sessions at a time that suited them, 92% found the mental health professional empathic, 94% felt that the mental health professional listened 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 5.17). In both cases, patterns of responses were similar across provider types.

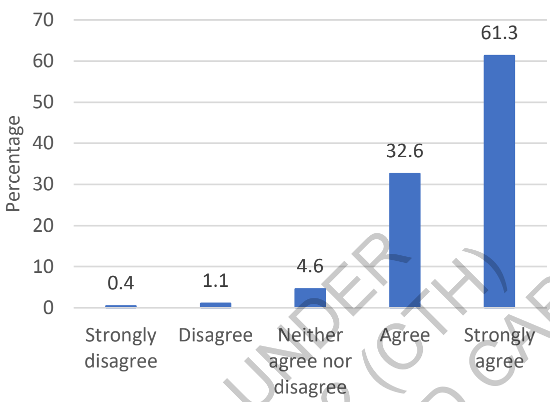
Figure 5.2: Participants' experiences with seeing the mental health professional[a]

Figure 5.2: Participants' experiences with seeing the mental health professional[a] (cont.)

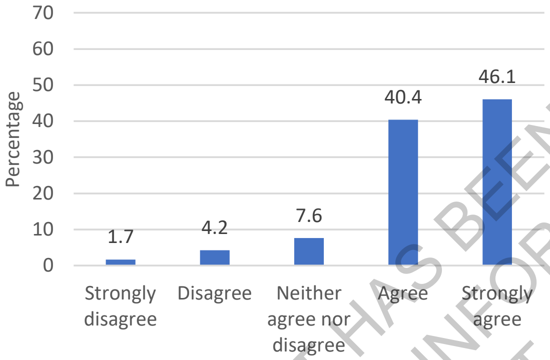
The mental health professional listened to me



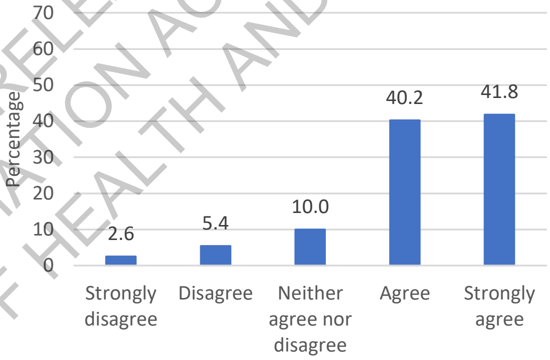
The mental health professional respected my right to make decisions



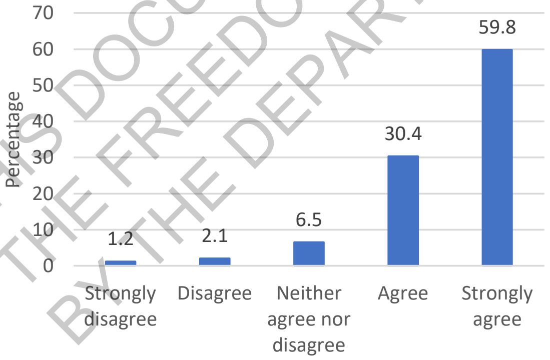
The mental health professional equipped me with strategies to address the issues I was facing



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



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



a. Missing data excluded.

Table 5.17: Key experiences by provider type[a]

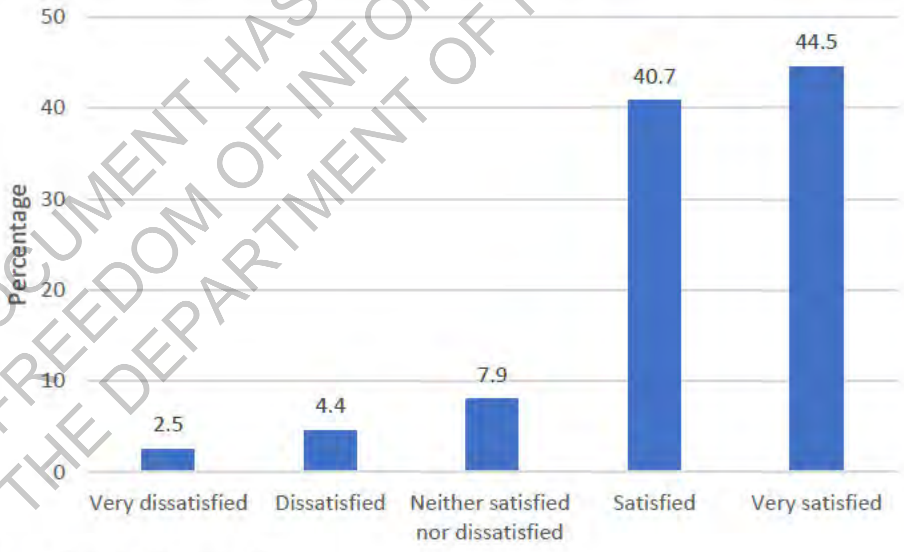
I had to wait to long for an appointment with the mental health professional	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	FREQ	%	FREQ	%	FREQ	%	FREQ	%	FREQ	%
Clinical psychologist	99	14.4	260	37.9	132	19.2	133	19.4	63	9.2
Psychologist	82	13.8	202	34.0	127	21.4	113	19.0	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 opportunity for my family and friends to be involved in my support or care if I wanted this										
	Strongly disagree		Disagree		Neither agree nor disagree		Agree		Strongly agree	
	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	8.0	362	18.5	692	35.4	480	24.5	267	13.6

a. Missing data excluded.

Overall satisfaction with care

Figure 5.3 shows that the vast majority of participants were satisfied with their care they received through Better Access (41% satisfied, 45% very satisfied).

Figure 5.3: Overall satisfaction with care[a]

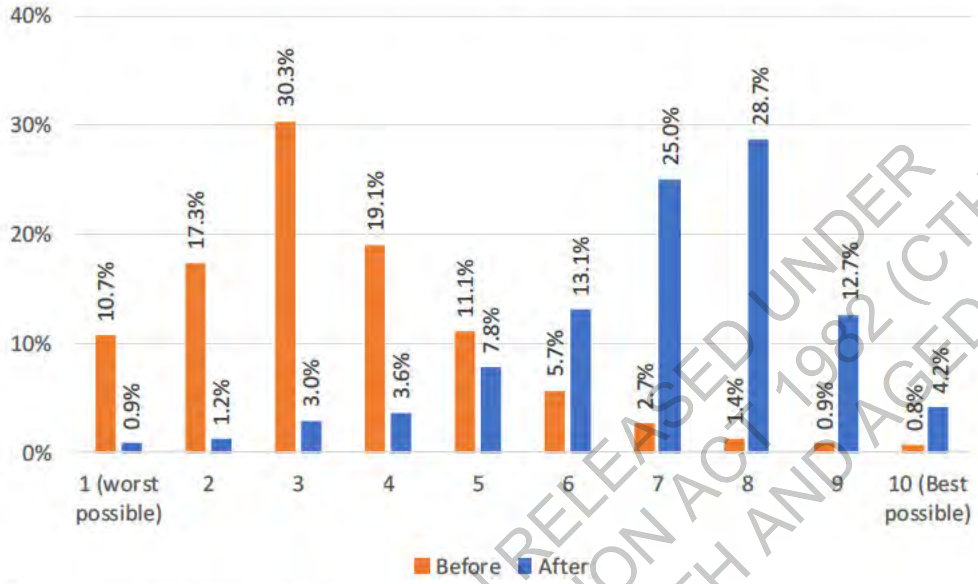


a. Missing data excluded.

Outcomes of care

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 and after receiving care were 3.48 (SD = 1.73) and 7.04 (SD = 1.74), respectively. Figure 5.4 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. This picture was reversed when participants were asked to think about their mental health at the end of the episode; close to 50% 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.

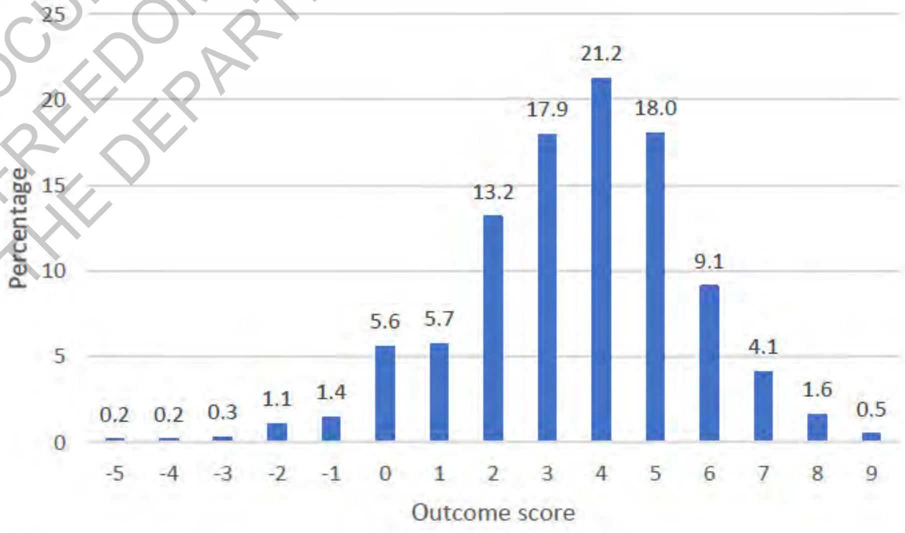
Figure 5.4: Self-rated mental health before and after receipt of care[a]



a. Missing data excluded.

Figure 5.5 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.

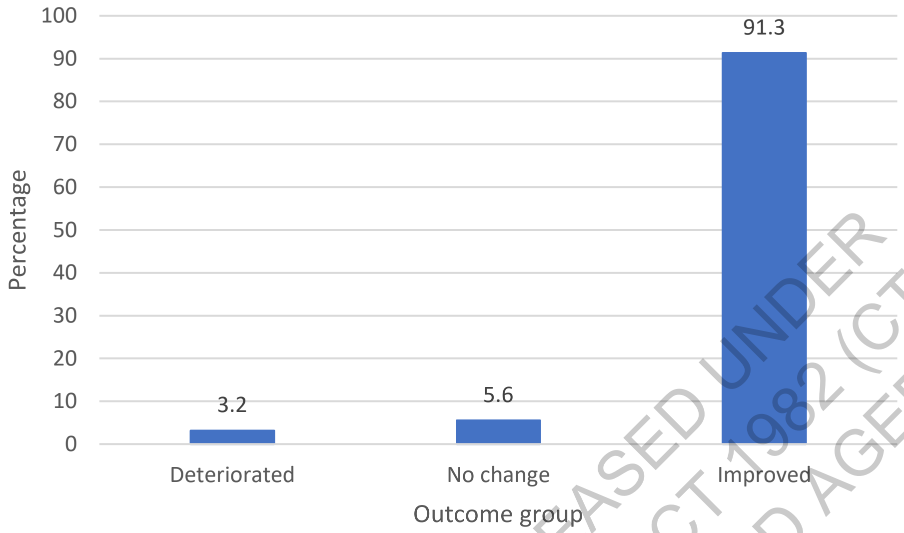
Figure 5.5: Change in self-rated mental health by raw outcome scores[a]



a. Missing data excluded.

When the raw outcome scores were translated into outcome groups, 91% of participants fell into the "Improved" group (see Figure 5.6).

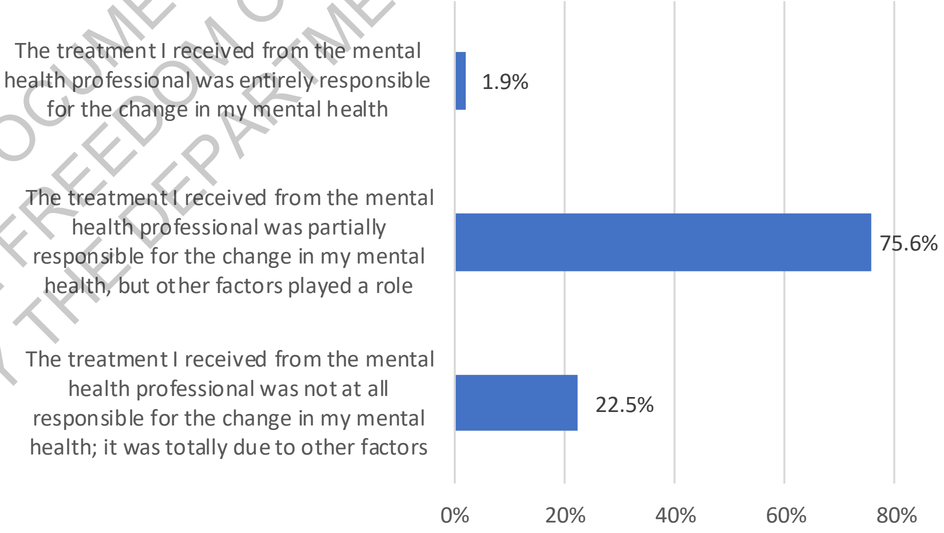
Figure 5.6: Change in self-rated mental health by outcome group[a]



a. Missing data excluded.

Figure 5.7 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 5.7: Attribution of reason for improvement for those whose self-rated mental health improved[a]



a. Missing data excluded.

Predictors of improvement

Table 5.18 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%CI = 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, Aboriginal or Torres Strait Islander status, area of residence, socio-economic 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.

Table 5.18: Predictors of improvement in self-rated mental health[a]

		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
Aboriginal or Torres Strait Islander status	Neither Aboriginal nor Torres Strait Islander	1.00			
	Aboriginal and/or Torres Strait Islander	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

a. Missing data excluded.

b. Socio-economic 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 Socio-economic 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 5.19 shows the results of the regression analysis that examined predictors of deterioration in self-rated 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 socio-economic 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, Aboriginal or Torres Strait Islander 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.

Table 5.19: Predictors of deterioration in self-rated mental health[a]

		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
Aboriginal or Torres Strait Islander status	Neither Aboriginal nor Torres Strait Islander	1.00			
	Aboriginal and/or Torres Strait Islander	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

a. Missing data excluded.

b. Socio-economic 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 Socio-economic 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, Aboriginal and Torres Strait Islander identity, state of residence, area of residence, and area-level socio-economic status (see Appendix 8).

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 5.20 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.

Table 5.20: Co-payments paid by participants with linked MBS claims data

	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

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 5.21 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 5.21: 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 self-report 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 5.22 and the predictors of deterioration are presented in Table 5.23.

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).

Table 5.22: Predictors of improvement in self-rated mental health for participants with linked MBS claims data[a]

		ODDS RATIO	95%CI LOW	95%CI HIGH	*P* VALUE
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
Aboriginal or Torres Strait Islander status	Neither Aboriginal nor Torres Strait Islander	1.00			
	Aboriginal and/or Torres Strait Islander	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

a. Missing data excluded.

b. Socio-economic 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 Socio-economic 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.

Table 5.23: Predictors of deterioration in self-rated mental health for participants with linked MBS claims data[a]

		ODDS RATIO	95%CI LOW	95%CI HIGH	*P* VALUE
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
Aboriginal or Torres Strait Islander status	Neither Aboriginal nor Torres Strait Islander	1.00			
	Aboriginal and/or Torres Strait Islander	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

a. Missing data excluded.

b. Socio-economic 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 Socio-economic 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 fact that new users are being seen suggests that Better Access is providing care to those who may be experiencing a mental health problem for the first time, or at least seeking treatment for the first time. The fact that there are many prior users being seen is likely to reflect the episodic nature of many mental illnesses.

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.[59]

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 1 ($73 versus $83), although they were similar for sessions with other allied health professionals. Study 1 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 downwards.

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 Aboriginal and Torres Strait Islander 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.

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

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-D[2] and Link-me.[3] 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' socio-demographic 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.[2,3] 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.[2,3,60] 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 6.1).

Table 6.1: Summary of key differences between the Target-D and Link-me trials

	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
Year(s) in which data 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)

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).[61,62]

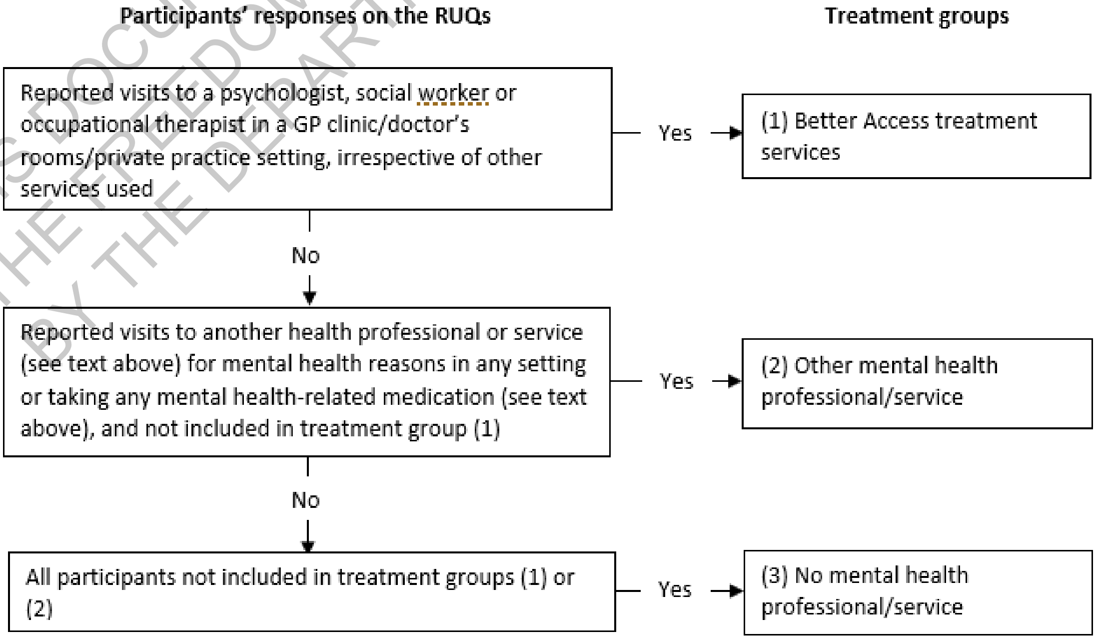
We used this information to classify participants' service use into three mutually exclusive, hierarchically ordered treatment groups:

(1) "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 6.1).

Figure 6.1: 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. However, as noted in Study 2, the vast majority of private psychology services delivered in Australia are Better Access services. 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 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[62] 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.[63,64] Out-of-pocket costs were converted to 2021-22 values using the Australian Bureau of Statistics Consumer Price Index for medical and hospital services.[65]

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 6.2).

Table 6.2: Standardised measures used in the Target-D and Link-me trials

DOMAIN	MEASURE	TARGET-D	LINK-ME
Depression symptom severity	Patient Health Questionnaire (PHQ-9)[66]	✓	✓
Anxiety symptom severity	Generalized Anxiety Disorder scale (GAD-7)[67]	✓	✓
Health-related quality of life	Assessment of Quality of Life instrument (AQoL-8D)[20]	✓	
	EuroQol 5-dimension quality of life questionnaire (EQ-5D-5L)[28]		✓
Functioning[a]	Kessler-10+ (K-10+)[31,32]		✓

a. Days out-of-role due to psychological distress was assessed using the four-item extension of the Kessler Psychological Distress Scale or K10+[31,32] (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

Socio-demographic characteristics included age group (18-35, 36-55 and 56+ years) at baseline, gender, Indigenous 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: self-rated 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 ≤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's[39] 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 9 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).[68] 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 9 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,[69,70] 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.

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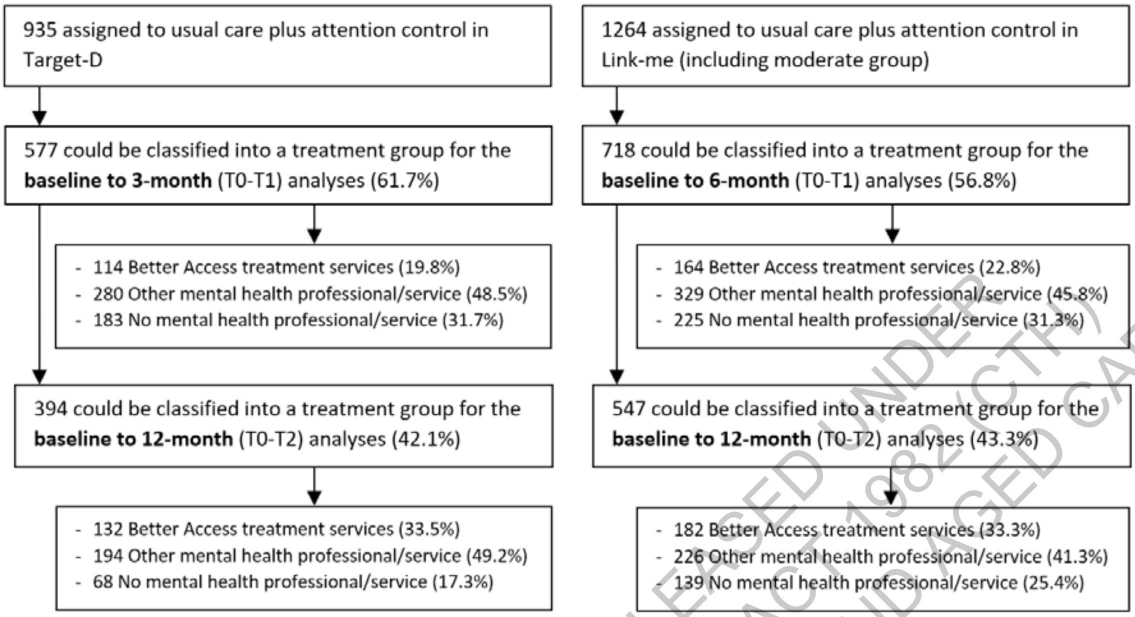
Results

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 6.2).

Figure 6.2: 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 socio-demographic 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 10 for details).

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

As shown in Figure 6.2, 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 11 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, long-term 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 socio-demographic 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 6.1). 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 11, Table A11.2a 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 6.3a and 6.3b). 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 group to three-quarters among the severe prognostic group.

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).

Table 6.3a: Mental health-related service use among participants in the "Better Access treatment services" group, by follow-up period, for the Target-D cohort

	T0-T1: BASELINE TO 3-MONTH FOLLOW-UP				T0-T2: BASELINE TO 12-MONTH FOLLOW-UP			
Services used for mental health	**Minimal/ mild n=65**	**Moderate n=25**	**Severe n=24**	**Total n=114**	**Minimal/ mild n=83**	**Moderate n=24**	**Severe n=25**	**Total 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 (9%)	10 (40%)	6 (25%)	15 (13%)	15 (18%)	7 (29%)	5 (20%)	27 (20%)
7+				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) [c]	$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)

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.

Table 6.3b: Mental health-related service use among participants in the "Better Access treatment services" group, by follow-up period, for the Link-me cohort

	T0-T1: BASELINE TO 6-MONTH FOLLOW-UP				T0-T2: BASELINE TO 12-MONTH FOLLOW-UP			
Services used for mental health	**Minimal/ mild n=26**	**Moderate n=53**	**Severe n=85**	**Total n=164**	**Minimal/ mild n=29**	**Moderate n=60**	**Severe n=93**	**Total 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	9 (35%)	18 (24%)	29 (34%)	51 (31%)	8 (28%)	29 (48%)	15 (16%)	29 (16%)
7+			19 (22%)	24 (15%)			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)

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 12. 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 6.2).

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 6.4a-6.4d 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 6.4a-6.4b).

- 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 6.4c-6.4d).

Table 6.4a: 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 6.4b: 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, 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. Indigenous 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 6.4c: 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 6.4d: 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. Indigenous 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 socio-demographic 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 socio-demographic 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,[7] 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.[71]

A third strength is that the original trials gathered information on a wide range of consumers' socio-demographic 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.[72] 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.[62] 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.[69] 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.[73-76]

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 Aboriginal and Torres Strait Islander 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 socio-economic 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.

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)

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 – https://tentomen.org.au/ and https://alswh.org.au/ 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.[77] 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).[78] ALSWH recruited a fourth cohort by online and offline methods in 2013, the 1989-95 cohort (aged 18-23 at recruitment; N=17,010).[79] 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.

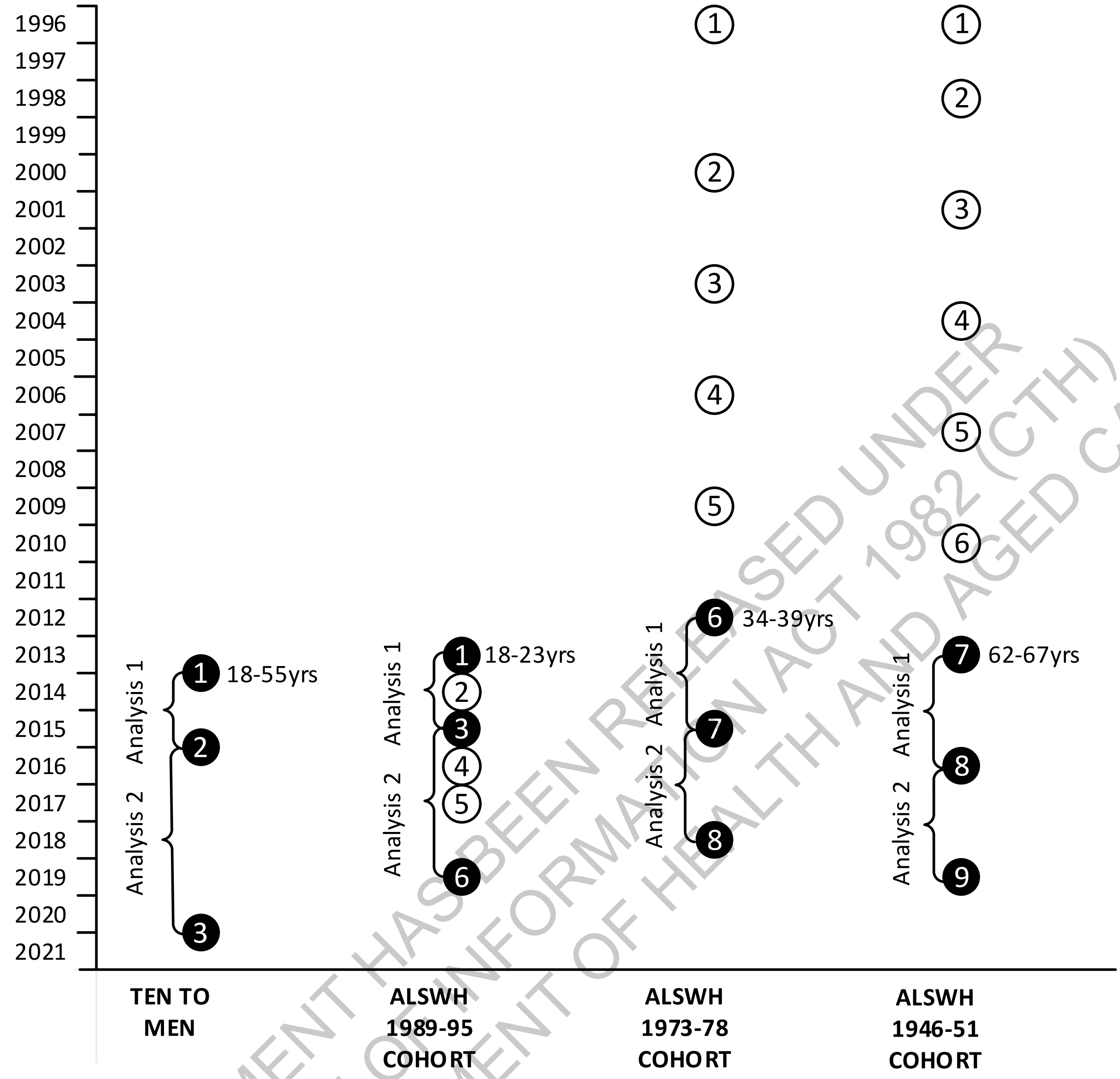
Cohorts and survey waves

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 8 (T0) and Wave 9 (T1).

Figure 7.1 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 7.1: 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 (T0) 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 (T0):* 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),[34] the PHQ-2.[35] 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)[21] or a score of ≥6 on the Generalised Anxiety Disorder scale (GAD-7).[29] 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 7.1 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)[34] were used to assess changes in mental health from T0 to T1 in given analyses.

Table 7.1: Standardised mental health measures used in Study 5, by study and cohort

MEASURE	TEN TO MEN	ALSWH 1989-95 COHORT	ALSWH 1973-78 COHORT	ALSWH 1946-51 COHORT
Center for Epidemiological Studies – Depression scale (CES-D)[21]			❶❷	❶❷
Generalised Anxiety Disorder scale (GAD-7)[29]			❶❷	❶❷
Kessler-10 (K-10)[19]			❶❷	
Patient Health Questionnaire-9 (PHQ-9)[34]	❷			
Patient Health Questionnaire-2 (PHQ-2)[35]	❶			

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

Socio-demographic, clinical and treatment variables

Participants also provided a range of other information through the T0 surveys. For the purposes of Study 5 we used the following variables:

- *Sociodemographic variables:* age (in years); Aboriginal or Torres Strait Islander (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".[2,3,60] 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 T0 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.[65]

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's[39] 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 7.2 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).

Table 7.2: Participant selection by study, cohort and analysis

	TEN TO MEN		ALSWH 1989-95 COHORT		ALSWH 1973-78 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)
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])

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 7.3 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).

Table 7.3: Use of Better Access treatment services by study, cohort and analysis

	TEN TO MEN		ALSWH 1989-95 COHORT		ALSWH 1973-78 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**

Prognostic severity at T0

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 7.4 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 7.4: Prognostic severity[a] by study, cohort and analysis

	TEN TO MEN		ALSWH 1989-95 COHORT		ALSWH 1973-78 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)
Minimal/mild	1,335 (64.6%)	982 (67.1%)	322 (20.8%)	606 (30.1%)	104 (19.7%)	110 (18.6%)	44 (16.3%)	37 (15.7%)
Moderate	291 (14.1%)	197 (13.4%)	263 17%)	356 (17.7%)	115 (21.8%)	135 (22.8%)	60 (22.2%)	41 (17.4%)
Severe	439 (21.3%)	285 (19.5%)	966 (62.2%)	1,051 (52.2%)	308 (58.5%)	347 (58.6%)	166 (61.5%)	158 (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 7.5 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 7.6 and reported in full in Appendix 13). 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.

Table 7.5: Characteristics of participants who did and did not use Better Access treatment services, by study, cohort and analysis

		TEN TO MEN				ALSWH 1989-95 COHORT				ALSWH 1973-78 COHORT				ALSWH 1946-51 COHORT			
Analysis		**ANALYSIS 1: T0 (WAVE 1, 2013/14) – T1 (WAVE 2, 2015/16)**		**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)**	
Better Access treatment services		**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
N		**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**
Sociodemographic	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
	Aboriginal or Torres Strait Islander																
	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																
	Year 11 or less	13%	14%	9%	11%	7%	6%	3%	3%	5%	7%	4%	7%	32%	43%	33%	42%
	Year 12 or equivalent	16%	15%	17%	13%	46%	44%	29%	27%	9%	13%	11%	10%	20%	20%	17%	21%
	Certificate/diploma	45%	43%	45%	45%	27%	26%	27%	29%	31%	28%	31%	29%	24%	21%	28%	20%
	Bachelor's degree or higher	26%	28%	29%	32%	20%	24%	41%	41%	55%	52%	54%	54%	24%	16%	22%	17%
	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%
Clinical	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%
	Severe	42%	19%	30%	16%	62%	38%	52%	33%	58%	39%	59%	39%	61%	49%	67%	49%
	History of depression (lifetime)																

		TEN TO MEN				ALSWH 1989-95 COHORT				ALSWH 1973-78 COHORT				ALSWH 1946-51 COHORT			
Analysis		**ANALYSIS 1: T0 (WAVE 1, 2013/14) – T1 (WAVE 2, 2015/16)**		**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)**	
Better Access treatment services		**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
N		**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%
Treatment	Currently taking any medication for mental health																
	Yes	37%	13%	28%	14%	34%	11%	29%	11%	31%	15%	40%	17%	46%	30%	46%	30%
	No	63%	87%	72%	86%	66%	89%	71%	89%	69%	85%	60%	83%	54%	70%	54%	70%

- Suppressed

Table 7.6: Sociodemographic, clinical and treatment variables associated with use of Better Access treatment services[a,b,c]

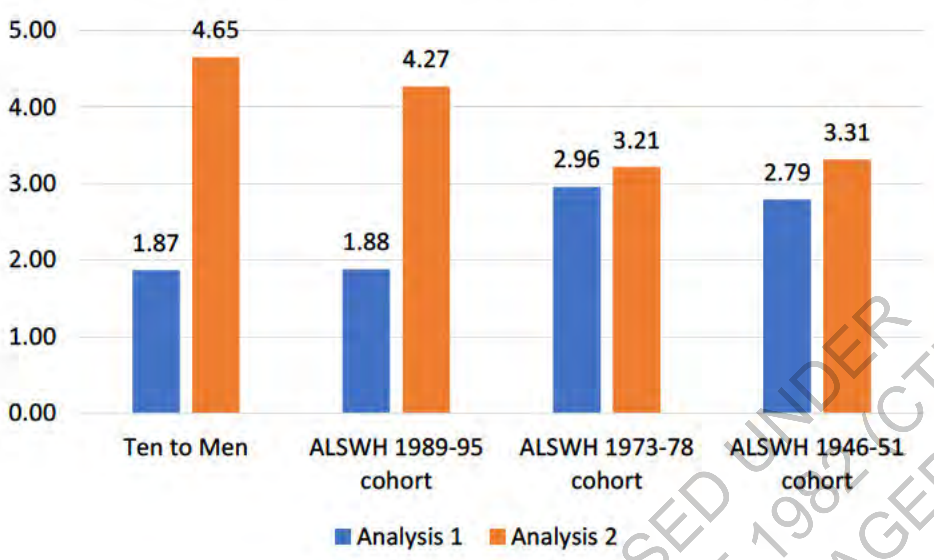
	TEN TO MEN		ALSWH 1989-95 COHORT		ALSWH 1973-78 COHORT		ALSWH 1946-51 COHORT	
Analysis	**1**	**2**	**1**	**2**	**1**	**2**	**1**	**2**
Sociodemographic								
Mean age, years		↓				↓	↓	
Highest level of education received[d]								
Year 12 or equivalent						↑		↑
Certificate/diploma			↑	↑		↑		
Bachelor's degree or higher			↑	↑	↑	↑		↑
Country of birth[e]								
Other		↓		↓				
Area of residence[f]								
Regional					↓			↓
Rural			↓	↓	↓	↓	↓	↓
Clinical								
Prognostic severity[g]								
Moderate	↑						↑	
Severe	↑		↑	↑	↑	↑	↑	↑
History of depression (lifetime)[h]								
Yes	↑	↑			↑	↑	↑	↑
History of anxiety (lifetime)[h]								
Yes	↑	↑	↑		↑	↑	↑	↑
Treatment								
Currently taking any medication for mental health[h]								
Yes	↑	↑		↑	↑	↑	↑	↑

a. Results from multivariable logistic regression
b. 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 Aboriginal or Torres Strait Islander 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 7.2 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 7.2: 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 7.7 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 7.8 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.

Table 7.7: Number of Better Access treatment sessions by study, cohort and analysis

TEN TO MEN								
	ANALYSIS 1: T0 (WAVE 1, 2013/14) – T1 (WAVE 2, 2015/16)				**ANALYSIS 2: T0 (WAVE 2, 2015/16) – T1 (WAVE 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)
ALSWH 1989-95 COHORT								
	ANALYSIS 1: T0 (WAVE 1, 2013) – T1 (WAVE 3, 2015)				**ANALYSIS 2: T0 (WAVE 3, 2015) – T1 (WAVE 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**
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								
	ANALYSIS 1: T0 (WAVE 6, 2012) – T1 (WAVE 7, 2015)				**ANALYSIS 2: T0 (WAVE 7, 2015) – T1 (WAVE 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**
1-2	21 (20.2%)	21 (18.3%)	49 (15.9%)	93 (17.2%)	28 (25.5%)	23 (17%)	58 (16.7%)	120 (18.6%)
3-4	23 (22.1%)	26 (22.6%)	52 (16.9%)	106 (19.6%)	21 (19.1%)	25 (18.5%)	61 (17.6%)	122 (18.9%)
5-6	21 (20.2%)	-	50 (16.2%)	91 (16.9%)	18 (16.4%)	21 (15.6%)	43 (12.4%)	92 (14.2%)
7-10	-	26 (22.6%)	62 (20.1%)	101 (18.7%)	-	26 (19.3%)	68 (19.6%)	116 (18%)
11-20	21 (20.2%)	20 (17.4%)	57 (18.5%)	99 (18.3%)	26 (23.6%)	30 (22.2%)	72 (29.7%)	135 (20.9%)
21-50	-	-	38 (12.3%)	50 (9.3%)	-	10 (7.4%)	45 (13%)	61 (9.4%)
Median (IQR)	5 (3-11)	6 (3-10)	7 (3-13)	6 (3-11.5)	5 (2-11)	6 (3-12)	7 (3-14)	6 (3-12)
ALSWH 1946-51 COHORT								
	ANALYSIS 1: T0 (WAVE 7, 2013) – T1 (WAVE 8, 2015)				**ANALYSIS 2: T0 (WAVE 8, 2015) – T1 (WAVE 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**
1-2	14 (31.8%)	23 (38.3%)	37 (22.3%)	75 (27%)	13 (35.2%)	11 (26.8%)	41 (26%)	67 (26.4%)
3-4	-	11 (18.3%)	26 (15.6%)	48 (17.3%)	-	-	32 (20.3%)	50 (19.7%)
5-6	-	-	30 (18.1%)	51 (18.3%)	12 (32.4%)	-	22 (13.9%)	44 (17.3%)
7-10	-	10 (16.7%)	29 (17.5%)	47 (16.9%)	-	-	28 (17.7%)	43 (16.9%)
11-20	-	-	30 (18.1%)	40 (14.4%)	-	-	25 (15.8%)	34 (13.4%)
21-50	-	-	14 (8.4%)	17 (6.1%)	-	-	10 (6.3%)	16 (6.3%)
Median (IQR)	4 (2-7.5)	3 (2-7)	6 (3-11)	5 (2-10)	3 (2-6)	6 (2-10)	5 (2-10)	5 (2-9)

- Suppressed

Table 7.8: Type of Better Access provider seen by study, cohort and analysis[a]

TEN TO MEN								
	ANALYSIS 1: T0 (WAVE 1, 2013/14) – T1 (WAVE 2, 2015/16)				**ANALYSIS 2: T0 (WAVE 2, 2015/16) – T1 (WAVE 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]	-	-	-	-	-	-	-	-
ALSWH 1989-95 COHORT								
	ANALYSIS 1: T0 (WAVE 1, 2013) – T1 (WAVE 3, 2015)				**ANALYSIS 2: T0 (WAVE 3, 2015) – T1 (WAVE 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%)
ALSWH 1973-78 COHORT								
	ANALYSIS 1: T0 (WAVE 6, 2012) – T1 (WAVE 7, 2015)				**ANALYSIS 2: T0 (WAVE 7, 2015) – T1 (WAVE 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]	-	-	-	-	-	-	-	-
ALSWH 1946-51 COHORT								
	ANALYSIS 1: T0 (WAVE 7, 2013) – T1 (WAVE 8, 2015)				**ANALYSIS 2: T0 (WAVE 8, 2015) – T1 (WAVE 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 7.9 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.

Table 7.9: Out-of-pocket costs by study, cohort and analysis

	TEN TO MEN							
	ANALYSIS 1: T0 (WAVE 1, 2013/14) – T1 (WAVE 2, 2015/16)				**ANALYSIS 2: T0 (WAVE 2, 2015/16) – T1 (WAVE 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 session (IQR)[a]	$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)
	ALSWH 1989-95 COHORT							
	ANALYSIS 1: T0 (WAVE 1, 2013) – T1 (WAVE 3, 2015)				**ANALYSIS 2: T0 (WAVE 3, 2015) – T1 (WAVE 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)
	ALSWH 1973-78 COHORT							
	ANALYSIS 1: T0 (WAVE 6, 2012) – T1 (WAVE 7, 2015)				**ANALYSIS 2: T0 (WAVE 7, 2015) – T1 (WAVE 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)
	ALSWH 1946-51 COHORT							
	ANALYSIS 1: T0 (WAVE 7, 2013) – T1 (WAVE 8, 2015)				**ANALYSIS 2: T0 (WAVE 8, 2015) – T1 (WAVE 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)

a. Denominator = sessions at which an out-of-pocket cost was paid

Changes in mental health for users of Better Access treatment services

Figure 7.3 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 7.3: Changes in mental health over time, by study, cohort, analysis and measure

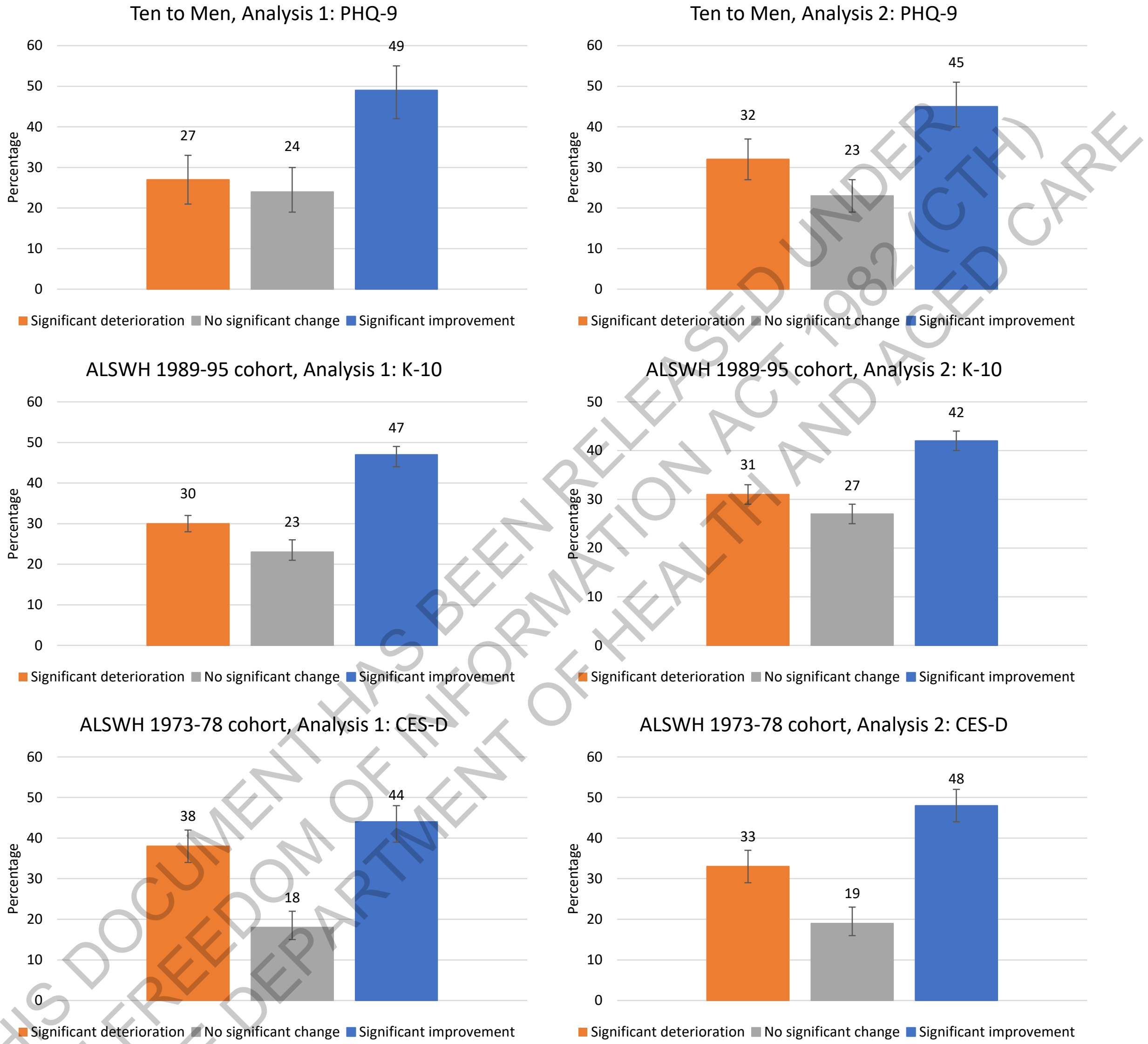
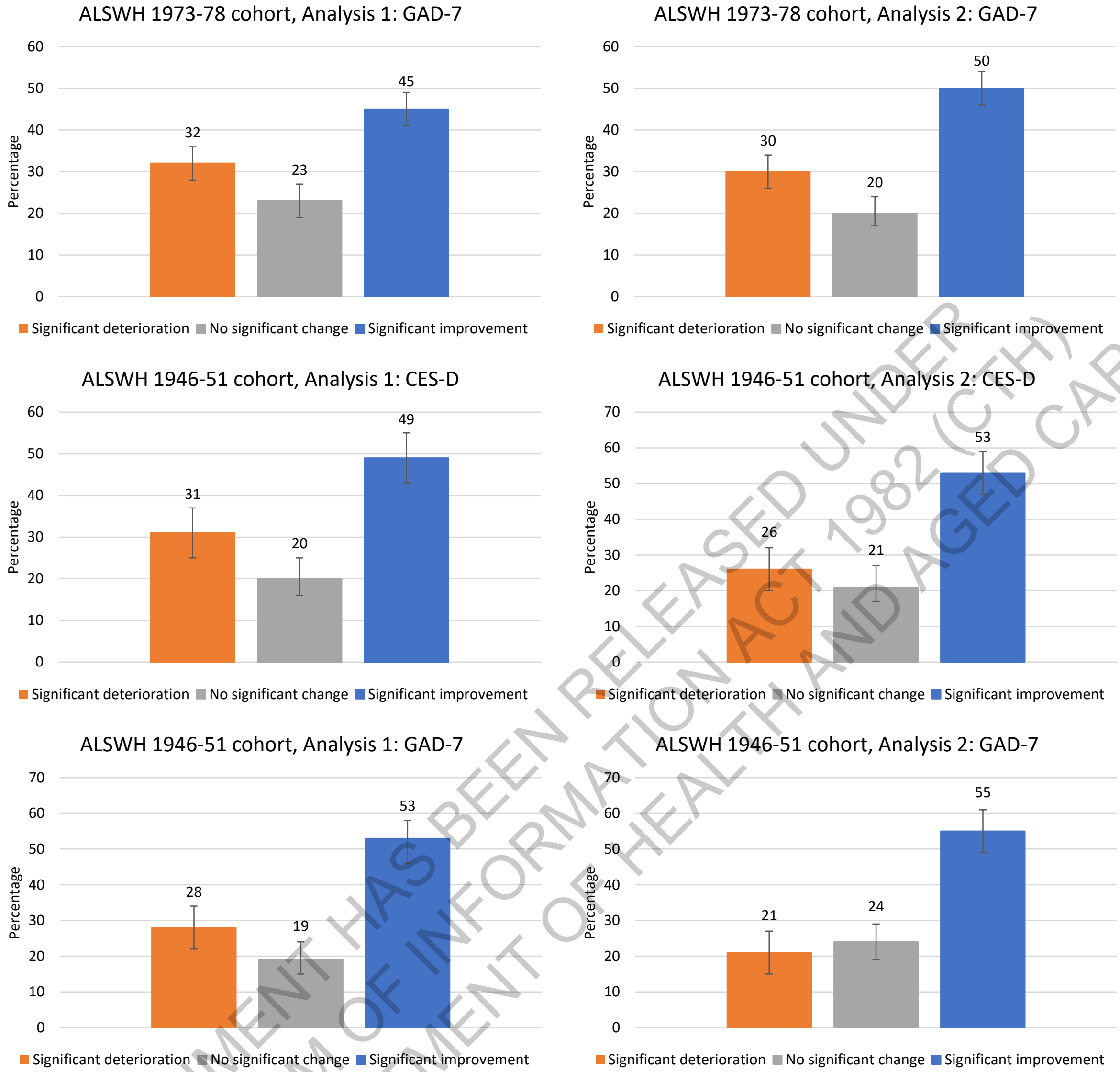


Figure 7.3: Changes in mental health over time, by study, cohort, analysis and measure (cont.)



The multivariable logistic regression analyses highlight key predictors of improvement and deterioration. Tables 7.10 and 7.11 summarise the findings from these and the results are reported in full in Appendix 14.

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 7.10: 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		ALSWH 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									↓			
Highest level of education received[d]												
Year 12 or equivalent				↑					↑			
Bachelor's degree or higher				↑								
Country of birth[e]												
Other			↓	↓	↓			↑				
Prognostic severity[f]												
Moderate				↑	↑	↑			↑			
Severe	↑	↑	↑	↑	↑	↑			↑	↑		
History of depression (lifetime)[g]												
Yes						↓						
History of anxiety (lifetime)[g]												
Yes			↑									
Number of treatment sessions[h]												
5-6							↓					
7-10			↓				↓		↓			
11-20		↓	↓			↓	↓					
21-100											↓	
Received treatment from clinical psychologist[g]												
Yes										↓		
Received treatment from psychologist[g]												
Yes				↓								
Paid any out of pocket cost[g]												
Yes				↑	↑				↑			
Currently taking any medication for mental health[g]												
Yes			↑									

a. Results from multivariable logistic regression
b. 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 Aboriginal or Torres Strait Islander 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 7.11: Sociodemographic, clinical and treatment variables associated with deterioration in mental health between T0 and T1[a,b,c]

	TEN TO MEN		ALSWH 1989-95 COHORT		ALSWH 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								↑	↑			
Highest level of education received[d]												
Year 12 or equivalent				↓								
Certificate/diploma												
Bachelor's degree or higher				↓								
Area of residence[e]												
Rural										↑		
Prognostic severity[f]												
Moderate				↓	↓		↓		↓			
Severe	↓		↓	↓	↓	↓	↓		↓	↓		
History of depression (lifetime)[g]												
Yes				↑								
History of anxiety (lifetime)												
Yes	↑											
Number of treatment sessions[h]												
3-4												↑
5-6							↑					
7-10							↑		↑		↑	
11-20		↑					↑		↑		↑	
Received treatment from social worker[g]												
Yes		↑										
Currently taking any medication for mental health[g]												
Yes			↓									

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 Aboriginal or Torres Strait Islander 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.[80] 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,[81] 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 cohorts at least – is consistent with that reported in a previous analysis.[82] 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.[b] 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 and the relatively small "dose" of Better Access treatment that individuals commonly received. 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.

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[b] 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.[83] 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.[84]

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 socio-economic 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 experience improvements in their mental health over time, particularly those who have severe mental health problems prior to treatment.

8. 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 15). 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 16). 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 socio-demographic 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 socio-demographic 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 17).

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 18). 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 19 and Appendix 20.

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 socio-demographic and clinical characteristics (see Table 8.1). 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 Aboriginal. None of the participants in the non-user group identified as either Aboriginal or Torres Strait Islander. Participants were asked to describe 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).

Table 8.1: Socio-demographic and clinical profile of participants

		USERS OF BETTER 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 residence	New South Wales	4	17.4	2	14.3
	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	-	-
Aboriginal or Torres Strait Islander	Aboriginal or Torres Strait Islander	1	4.3	-	-
	Neither Aboriginal nor Torres Strait Islander	20	87	14	100
	Prefer not to say	2	8.7	-	-
Cultural background[a]	Australian	11	47.8	5	35.7
	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/ Welsh	-	-	1	7.1
	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 at home	Yes	22	95.7	13	92.9
	No	1	4.3	1	7.1
Ever been given a mental health diagnosis	Yes	23	100	13	92.9
	No	-	-	-	-
	Unsure	-	-	1	7.1

		USERS OF BETTER ACCESS		NON-USERS OF BETTER ACCESS	
Mental health diagnosis	Anxiety	17	73.9	6	42.9
	Depression	19	82.6	8	57.1
	Bipolar	4	17.4	3	21.4
	Eating disorder	2	8.7	1	7.1
	Personality disorder	2	8.7	5	35.7
	Post-traumatic stress disorder (PTSD)	10	43.5	9	64.3
	Psychotic disorder	-	-	1	7.1
	Substance use	-	-	2	14.3
	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 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-of-pocket 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." (DN02)*

> *"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 help-seeking 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. 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 Aboriginal or Torres Strait Islander 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.[c] 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.[85-87]

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.

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[c] Data provided by Services Australia in the context of Study 1.

9. 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 9.1.

Table 9.1: 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 21). 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 22); 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 23). 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 24 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 24.

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 9.2 details these.

Table 9.2: Items in pop-up boxes in the survey

PROVIDER OR REFERRER GROUP	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, 93313
Psychologists	Focussed psychological strategies	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).

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Results

In total, 2,386 providers and referrers responded to the survey. Table 9.3 describes participants in terms of their professional and socio-demographic 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.

Table 9.3: Professional and socio-demographic characteristics of participants

		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 (n=2,377)[a]	<1 year	21	0.9%
	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%

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 9.4 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.

Table 9.4: Common presenting conditions (multiple responses permitted)

		FREQUENCY	%
Conditions consumers commonly present with in professional's private practice (n=2,386)	Anxiety disorders	2,314	97.0%
	Depression	2,256	94.6%
	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%

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 9.5 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.

Table 9.5: Provision of psychological therapy services (PTS) or focussed psychological strategies (FPS) by allied health professionals under Better Access in 2021

	CLINICAL PSYCHOLOGISTS (n=569)[a]		PSYCHOLOGISTS (n=1,133)[a]		SOCIAL WORKERS (n=395)[a]		OCCUPATIONAL THERAPISTS (n=104)[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%

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 9.6 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.

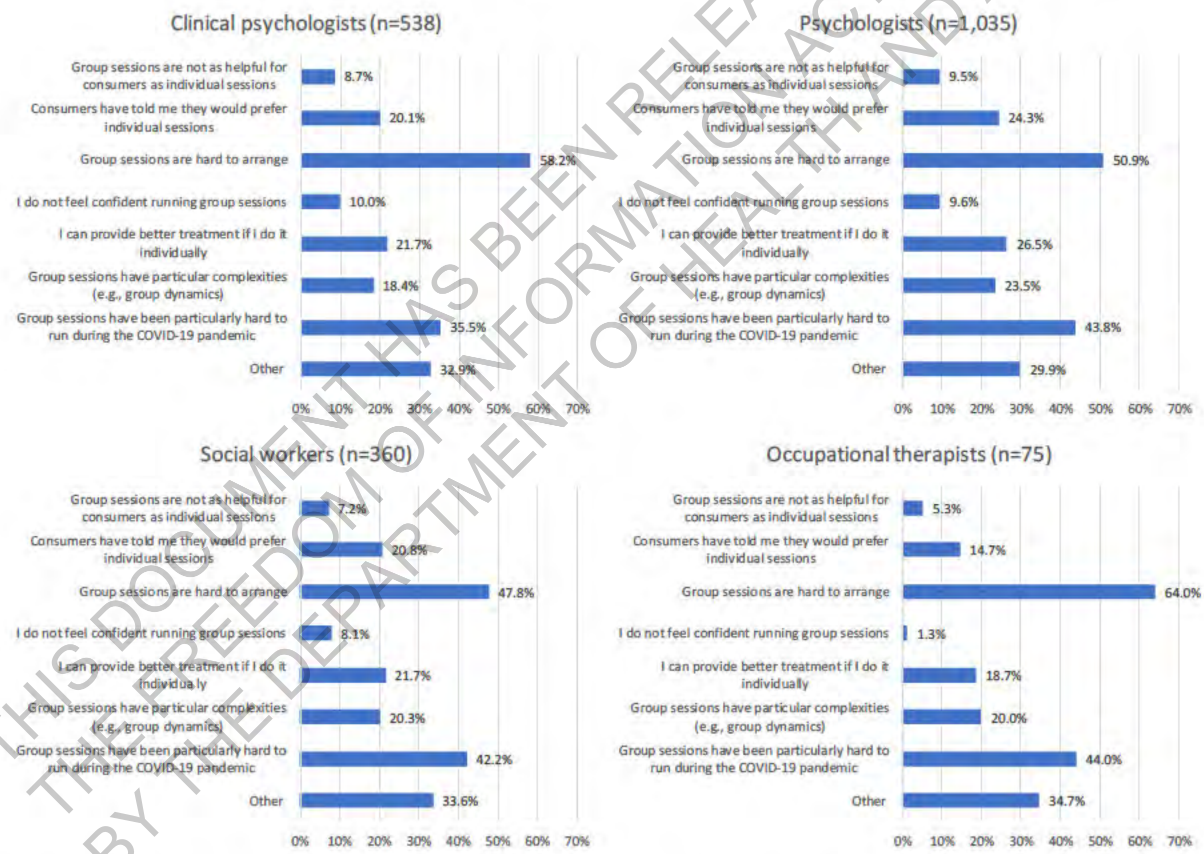
Table 9.6: Allied health professionals' provision of group-based Better Access services in 2021

	CLINICAL PSYCHOLOGISTS (n=563)[a]		PSYCHOLOGISTS (n=1,099)[a]		SOCIAL WORKERS (n=385)[a]		OCCUPATIONAL THERAPISTS (n=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%

a. Missing data excluded.

The allied health professionals who had not provided any group-based services were asked about their reasons for this. Figure 9.1 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 9.1: 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 9.7 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).

Table 9.7: Allied heath professionals' provision of Better Access services to consumers in residential aged care facilities in 2021

	CLINICAL PSYCHOLOGISTS (n=564)[a]		PSYCHOLOGISTS (n=1,094)[a]		SOCIAL WORKERS (n=384)[a]		OCCUPATIONAL THERAPISTS (n=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%

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 9.2 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 9.3 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 waiting 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 waiting 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 9.4 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.

Figure 9.2: Allied health professionals' views on the processes and outcomes of providing Better Access care[a]


Better Access enables me to offer consumers appropriate mental health care

Better Access enables consumers to access my services through a smooth referral process

Better Access enables me to provide consumers with mental health care that is accessible

Better Access enables me to provide consumers with mental health care that is timely

Better Access enables me to provide consumers with mental health care that is affordable

Better Access enables me to provide consumers with mental health care that they can benefit from

Better Access enables me to provide consumers with mental health care that reduces their symptoms

Better Access enables me to provide consumers with mental health care that improves their levels of functioning

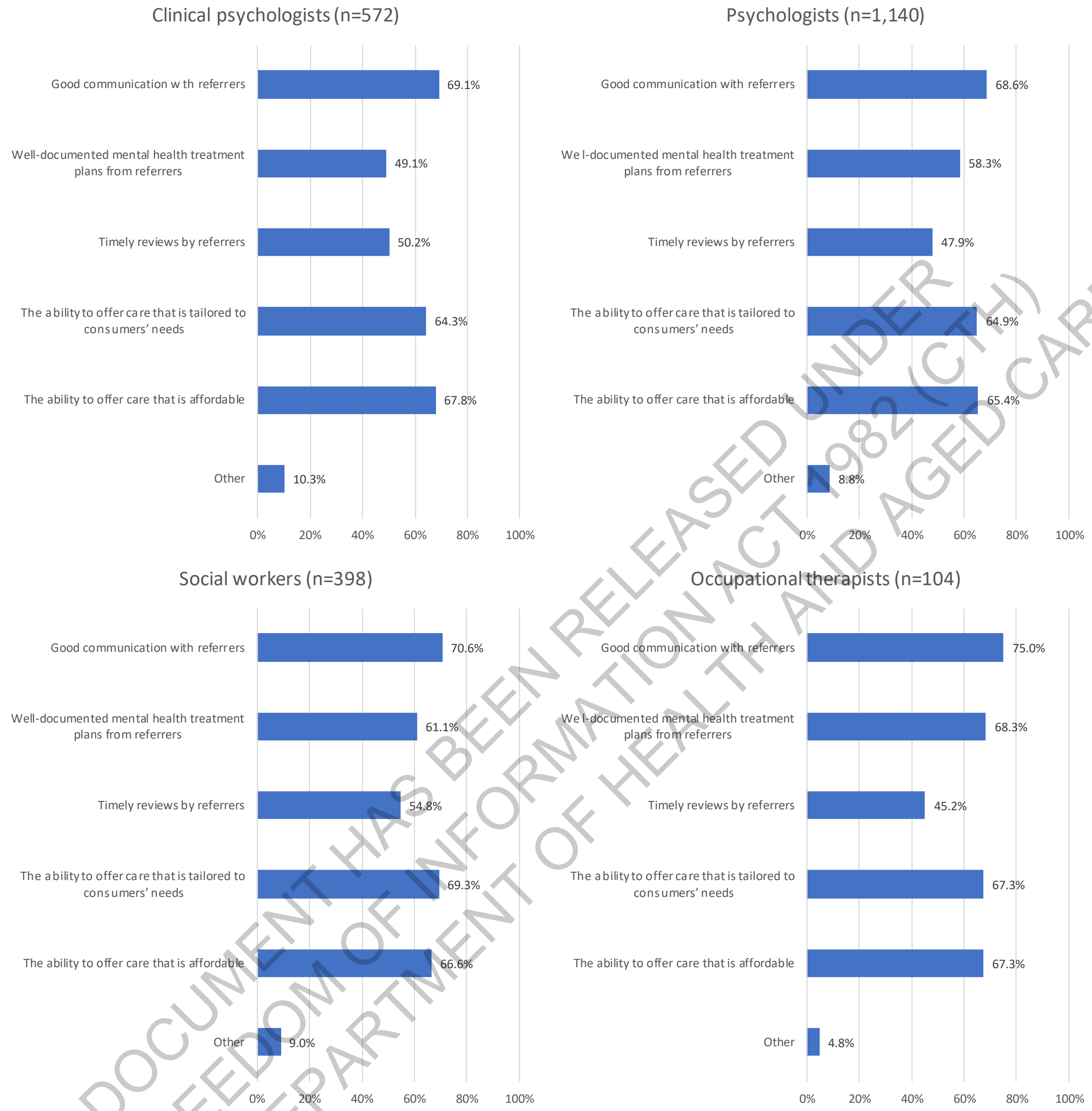
Better Access enables me to provide consumers with mental health care that addresses their presenting issues

Better Access enables me to provide consumers with mental health care that improves their overall mental health and wellbeing

a. Missing data excluded.

Figure 9.3: Allied health professionals' perceived barriers to the provision of Better Access care (multiple responses permitted)

Figure 9.4: 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.[88] The vast majority (96%) had done so (see Table 9.8).

Table 9.8: GPs' completion of mental health skills training

		FREQUENCY	%
Completion of mental health skills training recognised through the General Practice Mental Health Standards Collaboration (n=45)	Yes	43	95.6%
	No	1	2.2%
	Unsure	1	2.2%

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 9.9). 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.[88]

Table 9.9: 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 (n=43)	Level 1: Mental Health Skills Training	26	60.5%
	Level 1 extended: Mental Health Continuing Professional Development	16	37.2%
	Level 2: Focussed Psychological Strategies Skills Training	11	25.6%
	Level 2 extended: Focussed Psychological Strategies Continuing Professional Development	13	30.2%

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 9.10). 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 9.10: GPs' preparation or review of mental health treatment plans under Better Access in 2021

		FREQUENCY	%
Preparation or review of mental health treatment plans under Better Access in 2021 (n=45)	Yes	43	95.6%
	No	2	4.4%
	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 9.5).

These GPs were also asked about the provider group to which they had made referrals. Figure 9.6 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 9.7 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 9.5: Percentage of consumers referred to a clinical psychologist, psychologist, social worker or occupational therapist by GPs following preparation of a mental health treatment plan

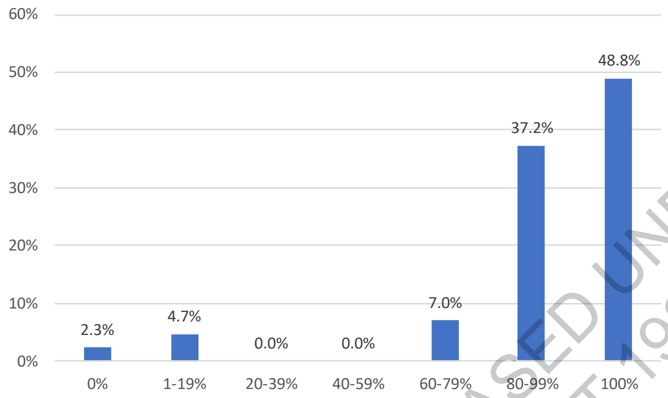


Figure 9.6: Provider group to whom GPs referred (GPs who referred only)

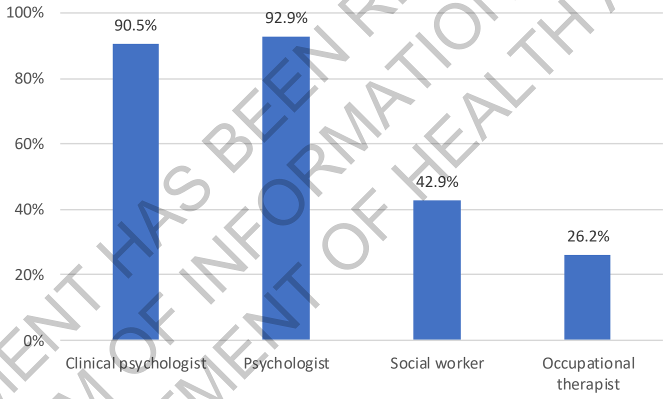
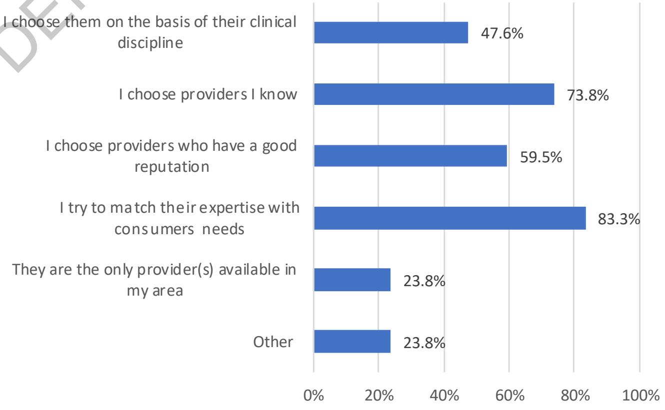


Figure 9.7: GPs' basis for selecting provider for referral (GPs who referred only)



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 9.8). These statements were similar to those presented to allied health professionals (see Figure 9.2).

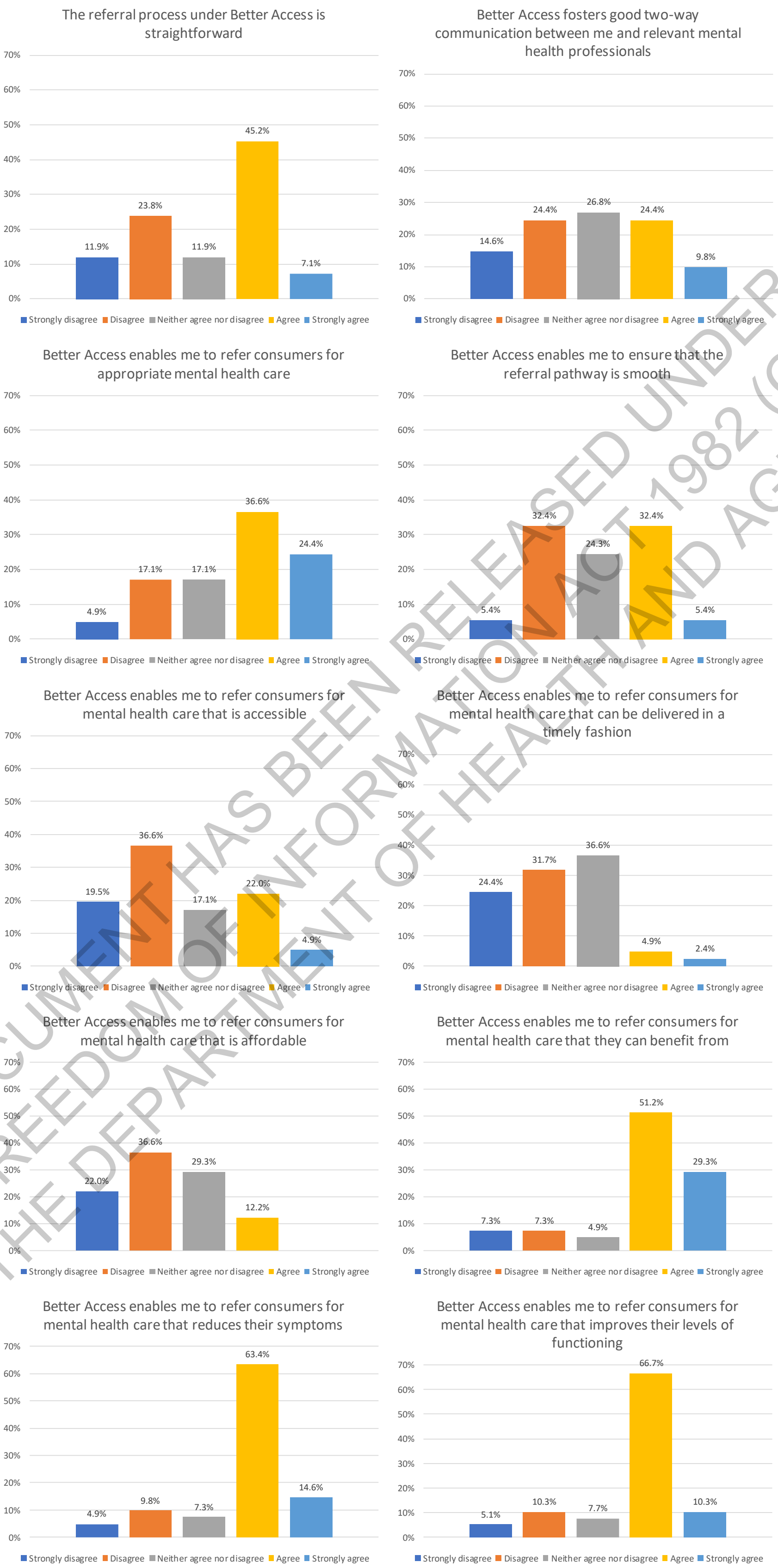
As a group, the GPs were generally positive about the outcomes of referring consumers to allied health professionals under Better Access. Around 70% agreed or strongly agreed that Better Access enables them to refer consumers for mental health care they can benefit from, that reduces their symptoms, 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 9.8: GPs' views on processes and outcomes of referring to clinical psychologists, psychologists, social workers and occupational therapists for Better Access care[a]



a. Missing data excluded.

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 9.11 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 were 50 (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 9.11: GPs' use of mental health treatment consultation items and focussed psychological strategies items under Better Access in 2021

		FREQUENCY	%
Use of mental health treatment consultation items under Better Access in 2021 (n=43)[a]	Yes	32	74.4%
	No	9	20.9%
	Unsure	2	4.7%
Use of focussed psychological strategies items under Better Access in 2021 (n=43)[a]	Yes	10	23.3%
	No	33	76.7%
	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 9.12. 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 9.12: 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)

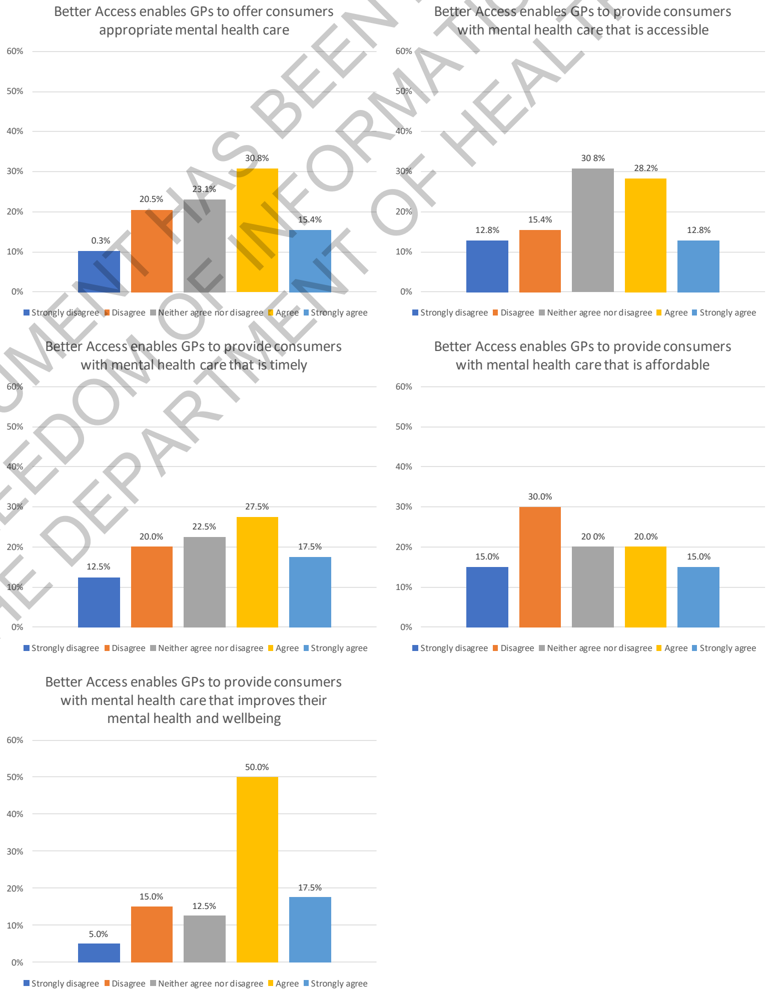
GPs WHO DID NOT USE MENTAL HEALTH TREATMENT CONSULTATION ITEMS (N=9)			GPs WHO DID NOT USE FOCUSSED PSYCHOLOGICAL STRATEGIES ITEMS (N=33)		
	FREQUENCY	%		FREQUENCY	%
I didn't see any consumers who required mental health care	0	0.0%	I didn't see any consumers who required mental health care	0	0.0%
I referred all consumers who required mental health care on to other providers	3	33.3%	I referred all consumers who required mental health care on to other providers	9	27.3%
I provided mental health care consultations, but I did so using the Focussed Psychological Strategies items under Better Access	3	33.3%	I provided mental health care consultations, but I did so using the GP Mental Health Treatment items under Better Access	15	45.5%
I provided mental health care consultations, but I did so using other Medicare item numbers, not the Better Access ones	6	66.7%	I provided mental health care consultations, but I did so using other Medicare item numbers, not the Better Access ones	14	42.4%
Other	0	0.0%	I did not want my services to be contributing to the Better Access session cap for consumers	4	12.1%
			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 outcome-related statements. Their views were mixed, with at least 10% endorsing each of the responses to most statements (see Figure 9.9). 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 9.9: GPs' views on the processes and outcomes of providing Better Access care[a]

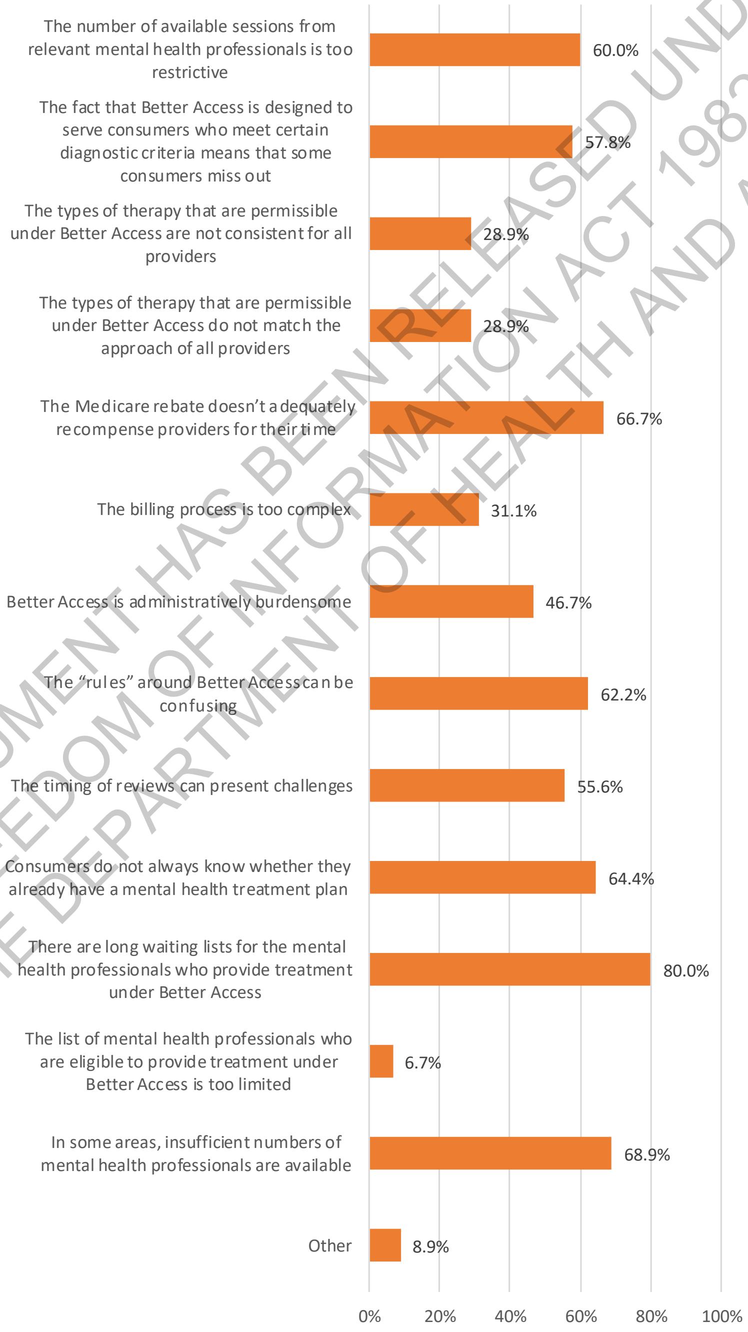


a. Missing data excluded.

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 9.10 shows that 80% identified long waiting 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 9.10: 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.

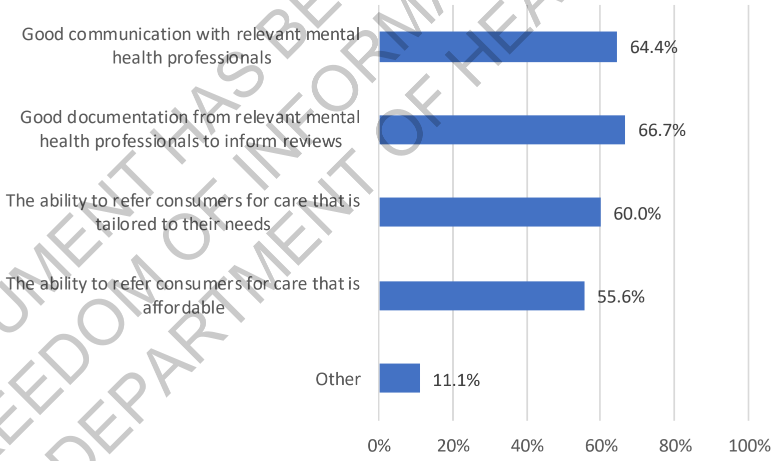
GPs also expanded on the issue of waiting lists. They commented that long wait times were a consequence of providers being at capacity or unavailable, and that they resulted in some consumers dropping out of the process of seeking care.

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 9.11). Sixty percent or more of all participating GPs endorsed these factors as facilitators.

Figure 9.11: 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 9.13 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 9.13: 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 psychiatrist assessment and management plan or conduct of initial consultation with a new consumer under Better Access in 2021 (n=126)	Yes	68	54.0%
	No	47	37.3%
	Unsure	11	8.7%

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 9.14).

Table 9.14: 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 necessary	6	12.8%
I provided the equivalent of these services, but I did so using other Medicare item numbers, not the Better Access ones	34	72.3%
Other	9	19.1%

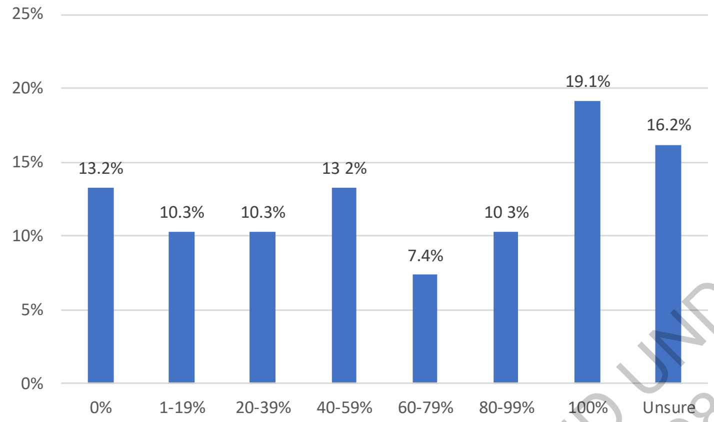
A number of these psychiatrists provided additional reasons in the free text responses as to why they had not used the relevant Better Access items. Some were unaware of the program or how to use it, but most had other reasons. These included the compliance burden associated with Better Access, it not 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 9.12 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.

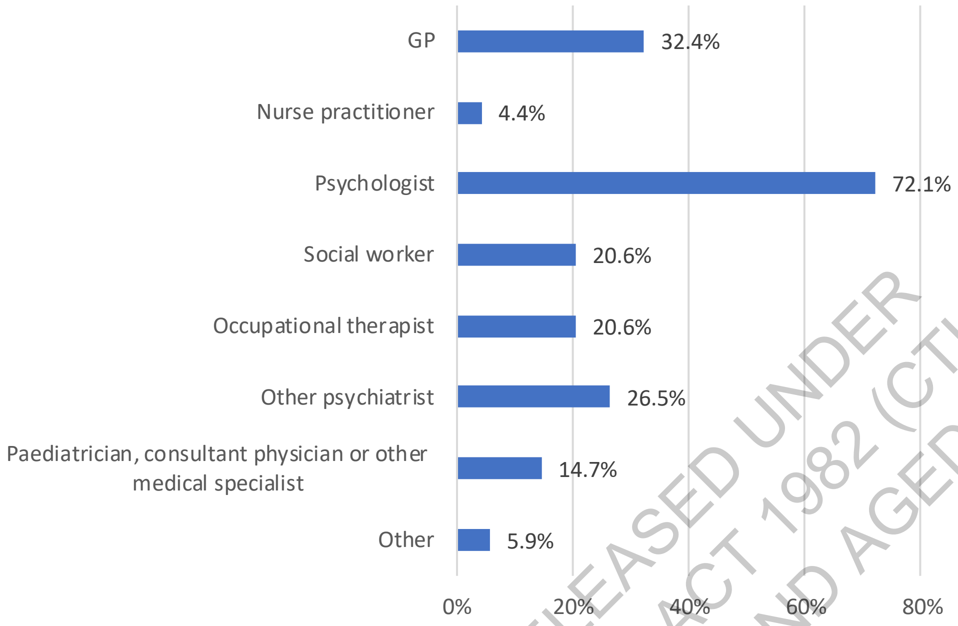
Figure 9.12: Percentage of consumers referred to a clinical psychologist, psychologist, social worker or occupational therapist by psychiatrists following preparation of a psychiatrist assessment and management plan or conduct of an initial consultation with a new consumer (psychiatrists who prepared a plan or conducted an initial consultation only)



These psychiatrists were also asked about the providers to whom they made referrals. Figure 9.13 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 9.13: 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

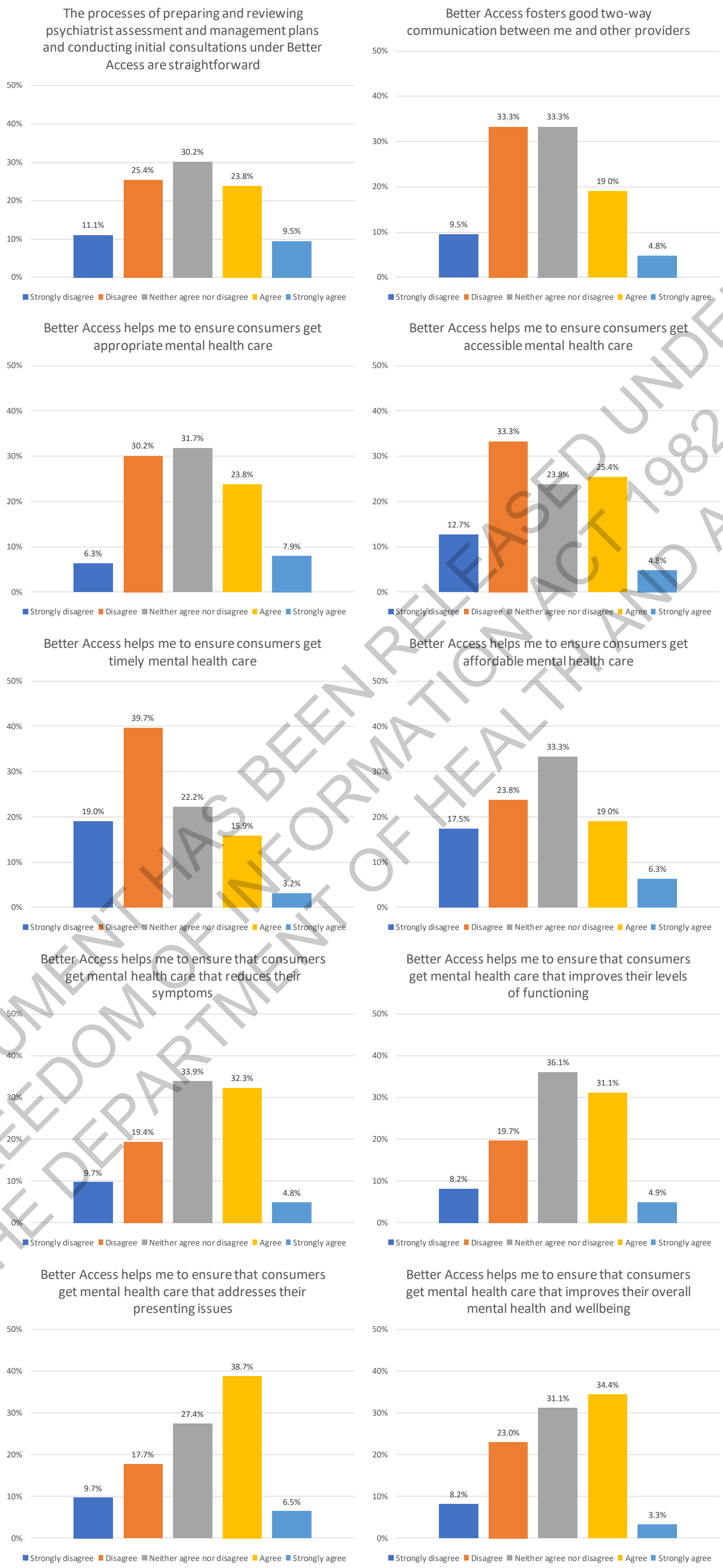
Psychiatrists who had used the relevant Better Access items were asked their views on the processes and outcomes of providing mental health care through the program. More specifically, they were asked to think about the different ways that they might see consumers under Better Access and indicate their level of agreement with a series of statements related to the processes and outcomes of doing so. Figure 9.14 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 9.14 Psychiatrists’ views on the processes and outcomes of seeing consumers under Better Access[a]



a. Missing data excluded.

All providers and referrers

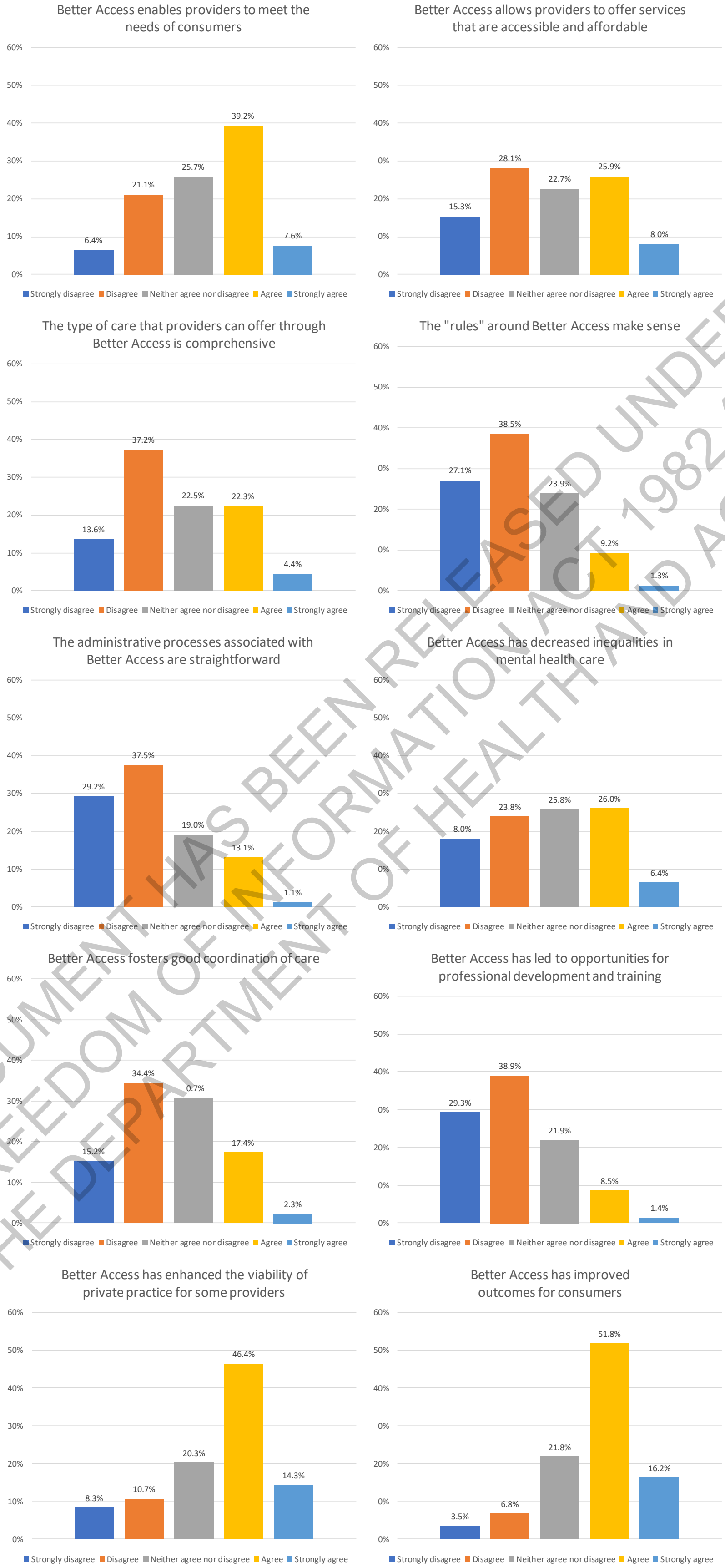
Participants’ views on Better Access more broadly

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 9.15 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.

Figure 9.16: All participants' views on the overall Better Access program[a]



a. Missing data excluded.

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.

10. Discussion

Addressing the research questions

The findings from the evaluation to date address a number of the research questions across the various domains articulated in the Evaluation Plan. We have summarised those we can currently address below, noting that we will expand on these in our Final Evaluation Report when we have completed the remaining analysis of data from Study 1, undertaken the analysis of MADIP data, and completed Studies 8 and 9. We will also provide an overarching discussion of the extent to which Better Access is achieving its policy aims, and make recommendations for the program, going forward. In doing so, we will draw on the previous reviews and inquiries that have examined Better Access.[13-16]

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 1 found that, in 2021, more than 2.6 million Australians (one in every 10.5 Australians) received at least one Better Access service and more than 1.3 million people (one in every 20.2 Australians) received at least one session of psychological treatment through Better Access. When adjusted for population growth, this amounted to a 1.8% average increase per year since 2018 in the rate of people using any Better Access services, and a 0.9% average increase per year in the rate of people using any Better Access treatment service.

Study 1 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 remains dominant mode of delivery, uptake of telehealth and phone services has been substantial, accounting for about one-third (32.6%) of Better Access treatment services in 2021. The additional 10 sessions of treatment for people experiencing difficulties due to COVID-19 accounted for 14.8% of all individual treatment sessions in 2021. Together these measures contributed to the sustained level of uptake of Better Access treatment and growth in levels of treatment service utilisation (a population-adjusted, average annual increase of 7.1% in the number of treatment services used). 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.

Do patterns of uptake vary by different groups of item numbers (e.g., plans, treatment services, treatment services by provider type)?

Preliminary findings from Study 1 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 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?

The preliminary findings reported from Study 1 show that around half (46.6%) of all Better Access services delivered in 2021 involved a co-payment by the consumer (up by 9.3% per year from 35.7% in 2018). Nearly two-thirds (64.8%) of Better Access treatment services used in 2021 involved a co-payment (up by 7.2% from 52.7% in 2018). Co-payment rates varied considerably across providers and service types, varying from 5.4% of mental health 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 32.3% for Focussed Psychological Strategies delivered by GPs/other medical practitioners to 68.8% for Psychological Therapy Services delivered by clinical psychologists. Co-payment rates increased across most types of Better Access services.

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.

Findings relating to how co-payments vary across levels of utilisation will be included in the Final Evaluation Report.

What is the relationship between use of Better Access treatment services and use of other mental health services?

Study 4 provided some insights into the relationship between use of Better Access and other mental health services. 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.[74-76] 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.

Who are the main users of Better Access?

Study 1 showed that uptake of Better Access is higher among females than males (126.4 per 1,000 population vs. 75.0 per 1,000 in 2021, respectively). Since 2018, females have used an increasingly higher number of Better Access services (from 467.2 to 568.1 per 1,000), but utilisation rates among males have stayed about the same (from 284.1 to 290.1 per 1,000). Older people aged 65 and over and young people aged 0-14 had the lowest rates of uptake of Better Access (47.2 and 51.7 per 1,000 population, respectively), compared to people aged 45-64 (95.9 per 1,000) and people aged 25-44 and 15-24 (141.4 and 171.4 per 1,000, respectively). Rates of uptake have increased since 2018 among people aged 15-24 (from 141.5 to 171.4 per 1,000 population) and 25-44 (from 128.2 to 141.1 per 1,000 population). Rates of utilisation have also increased for these groups (566.8 to 772.4 per 1,000 and 504.1 to 621.0 per 1,000, respectively). Uptake and utilisation rates have stayed about the same for all other age groups. Similar patterns were seen for Better Access treatment services.

Has Better Access reached groups in the population who are traditionally disadvantaged in terms of access to access to mental health care?

Study 1 showed that uptake of Better Access was lowest among people in remote and outer regional areas (46.5 and 79.5 per 1,000 in 2021, respectively), compared to people in inner regional areas and major cities (101.2-105.2 per 1,000). Since 2018, utilisation rates have increased for people in major cities (higher socioeconomic status) (from 398.0 to 509.8 per 1,000) and major cities (medium socioeconomic status) (from 405.3 to 472.2 per 1,000), with more modest increases or no change in other geographic area groups. Again, similar patterns were seen for Better Access treatment services.

Responsiveness

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

Studies 3, 6 and 7 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.

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 is designed to encourage more people to seek support for their mental ill-health, particularly those with mild to moderate mental health conditions who may respond well to short-term evidence-based interventions.[1] Studies 2, 3, 4 and 5 suggest that Better Access is reaching this target group, although 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.[89] In Studies 4 and 5, for example, we used a particular definition of severity that related to prognosis.

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 self-rated 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.[74,76]

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.[73] This group also had similar levels of *general* health and functioning to those who used other mental health services.

Do the treatment planning and referral pathways in Better Access work optimally?

Studies 3, 6 and 7 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.

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.

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.[90] 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.[91] 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.

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 and 7 that mental health workforce issues may be influencing provision of services through Better Access. In particular, the barriers identified in relation to waiting 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.

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.[92] 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.[92] 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 socio-economic 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 years 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.[74]

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 improvements.

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.[69]

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. We cannot determine the optimal number of sessions, and nor can we answer questions about cost-effectiveness. However, we may be able to look at costs and outcomes together in our Final Evaluation Report where we could potentially consider the findings from Study 1 (costs) in the light of Studies 2, 3, 4 and 5 (outcomes).

Conclusions

It would be premature to draw definitive conclusions from the evaluation at this point, because we are still to complete the analysis from Study 1 and Studies 8 and 9 are ongoing. However, certain findings are emerging. These findings suggest that 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. Better Access appears to be serving some groups better than others, and these gaps are widening. Of most concern, increases in utilisation over time have been particularly marked for people in areas of relatively high socio-economic status in major cities. Patterns of service use for those who do access Better Access have been influenced by recent changes to the program; telehealth and phone services accounted for about one third of Better Access treatment services in 2021 and the additional 10 sessions accounted for almost 15% of individual treatment sessions in the same year. Those who receive treatment through Better Access tend to have positive outcomes, particularly those who seek care when they are experiencing relatively severe depression, anxiety and/or psychological distress. However, there are also suggestions that Better Access is not always able to provide timely and affordable care, and that the referral processes underpinning the program may not always work optimally.

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Appendix 1: List of Better Access item numbers

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee[8]	Benefit paid[8]	Last date of operation
Original	Associated MBS items	Mental health consultation	General Practitioners	2713	Face to face	NA	20+	$73.95	$73.95	
Original	Associated MBS items	Mental health consultation	Other Medical Practitioners (OMPs)	279	Face to face	NA	20+	$59.15	$59.15	
Original	Associated MBS items	Initial patient consultation	Psychiatrists	296	Face to face	Consulting room	45+	$272.50	$231.65	
Original	Associated MBS items	Initial patient consultation	Psychiatrists	297	Face to face	In hospital	45+	$272.50	$231.65	
Original	Associated MBS items	Initial patient consultation	Psychiatrists	299	Face to face	Call out	45+	$325.80	$276.95	
Original	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	2700	Face to face	NA	20-40	$73.95	$73.95	
Original	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	2701	Face to face	NA	40+	$108.85	$108.85	
Original	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	2702	Face to face	NA	Not timed			31/10/2011
Original	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	2715	Face to face	NA	20-40	$93.90	$93.90	
Original	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	2717	Face to face	NA	40+	$138.30	$138.30	
Original	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	2710	Face to face	NA	Not timed			31/10/2011
Original	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	272	Face to face	NA	20-40	$59.15	$59.15	
Original	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	276	Face to face	NA	40+	$87.10	$87.10	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
Original	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	281	Face to face	NA	20-40	$75.10	$75.10	
Original	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	282	Face to face	NA	40+	$110.65	$110.65	
Original	Associated MBS items	Preparation of a psychiatrist assessment and management plan	Psychiatrists	291(4,5)	Face to face	NA	45+	$473.80	$402.75	
Original	Associated MBS items	Review of a mental health treatment plan	General Practitioners	2712	Face to face	NA	Not timed	$73.95	$73.95	
Original	Associated MBS items	Review of a mental health treatment plan	General Practitioners	2719	Face to face	NA	Not timed			29/02/2012
Original	Associated MBS items	Review of a mental health treatment plan	Other Medical Practitioners (OMPs)	277	Face to face	NA	Not timed	$59.15	$59.15	
Original	Associated MBS items	Review of a psychiatrist assessment and management plan	Psychiatrists	293(5)	Face to face	NA	30-45	$296.20	$251.80	
Original	Associated MBS items	3 Step Mental Health Process	General Practitioners	2574(1)	Face to face	NA	20-40			30/04/2007
Original	Associated MBS items	3 Step Mental Health Process	General Practitioners	2575(1)	Face to face	NA	20-40			30/04/2007
Original	Associated MBS items	3 Step Mental Health Process	General Practitioners	2577(1)	Face to face	NA	40+			30/04/2007
Original	Associated MBS items	3 Step Mental Health Process	General Practitioners	2578(1)	Face to face	NA	40+			30/04/2007
Original	Associated MBS items	3 Step Mental Health Process	Other Medical Practitioners (OMPs)	2704(1)	Face to face	NA	25-45			30/04/2007
Original	Associated MBS items	3 Step Mental Health Process	Other Medical Practitioners (OMPs)	2705(1)	Face to face	NA	45+			30/04/2007
Original	Associated MBS items	3 Step Mental Health Process	Other Medical Practitioners (OMPs)	2707(1)	Face to face	NA	25-45			30/04/2007
Original	Associated MBS items	3 Step Mental Health Process	Other Medical Practitioners (OMPs)	2708(1)	Face to face	NA	45+			30/04/2007
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	2721	Face to face	Consulting room	30-40	$95.65	$95.65	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	2723(2)	Face to face	Call out	30-40	$95.65	$95.65	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	2725	Face to face	Consulting room	40+	$136.85	$136.85	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	2727(2)	Face to face	Call out	40+	$136.85	$136.85	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	283	Face to face	Consulting room	30-40	$76.50	$76.50	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	285(3)	Face to face	Call out	30-40	$76.50	$76.50	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	286	Face to face	Consulting room	40+	$109.50	$109.50	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	287(3)	Face to face	Call out	40+	$109.50	$109.50	
Original	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	80000	Face to face	In clinic	30-50	$102.85	$87.45	
Original	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	80005	Face to face	Call out	30-50	$128.55	$109.30	
Original	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	80010	Face to face	In clinic	50+	$151.05	$128.40	
Original	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	80015	Face to face	Call out	50+	$176.70	$150.20	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	80100	Face to face	In clinic	20-50	$72.90	$62.00	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	80105	Face to face	Call out	20-50	$99.15	$84.30	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	80110	Face to face	In clinic	50+	$102.85	$87.45	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	80115	Face to face	Call out	50+	$129.20	$109.85	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	80125	Face to face	In clinic	20-50	$64.20	$54.60	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	80130	Face to face	Call out	20-50	$90.45	$76.90	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	80135	Face to face	In clinic	50+	$90.70	$77.10	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	80140	Face to face	Call out	50+	$116.90	$99.40	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	80150	Face to face	In clinic	20-50	$64.20	$54.60	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	80155	Face to face	Call out	20-50	$90.45	$76.90	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	80160	Face to face	In clinic	50+	$90.70	$77.10	
Original	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	80165	Face to face	Call out	50+	$116.90	$99.40	
Original	Group sessions	Group psychological therapy health services	Clinical Psychologists	80020	Face to face	NA	60+	$38.35 per patient (6-10 patients)	$32.60 per patient (6-10 patients)	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
Original	Group sessions	Group focussed psychological strategies services	Psychologists	80120	Face to face	NA	60+	$26.25 per patient (6-10 patients)	$22.35 per patient (6-10 patients)	
Original	Group sessions	Group focussed psychological strategies services	Occupational Therapists	80145	Face to face	NA	60+	$23.05 per patient (6-10 patients)	$19.60 per patient (6-10 patients)	
Original	Group sessions	Group focussed psychological strategies services	Social Workers	80170	Face to face	NA	60+	$23.05 per patient (6-10 patients)	$19.60 per patient (6-10 patients)	
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	2729	Telehealth	NA	30-40	$95.65	$95.65	31/12/2021
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	2731	Telehealth	NA	40+	$136.85	$136.85	31/12/2021
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	371	Telehealth	NA	30-40	$76.50	$76.50	31/12/2021
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	372	Telehealth	NA	40+	$109.50	$109.50	31/12/2021
Rural and remote	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	80001	Telehealth	NA	30-50	$102.85	$87.45	
Rural and remote	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	80011	Telehealth	NA	50+	$151.05	$128.40	
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	80101	Telehealth	NA	20-50	$72.90	$62.00	
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	80111	Telehealth	NA	50+	$102.85	$87.45	
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	80126	Telehealth	NA	20-50	$64.20	$54.60	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	80136	Telehealth	NA	50+	$90.70	$77.10	
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	80151	Telehealth	NA	20-50	$64.20	$54.60	
Rural and remote	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	80161	Telehealth	NA	50+	$90.70	$77.10	
Rural and remote	Group sessions	Group psychological therapy health services	Clinical Psychologists	80021	Telehealth	NA	60+	$38.35 per patient (6-10 patients)	$32.60 per patient (6-10 patients)	
Rural and remote	Group sessions	Group focussed psychological strategies services	Psychologists	80121	Telehealth	NA	60+	$26.25 per patient (6-10 patients)	$22.35 per patient (6-10 patients)	
Rural and remote	Group sessions	Group focussed psychological strategies services	Occupational Therapists	80146	Telehealth	NA	60+	$23.05 per patient (6-10 patients)	$19.60 per patient (6-10 patients)	
Rural and remote	Group sessions	Group focussed psychological strategies services	Social Workers	80171	Telehealth	NA	60+	$23.05 per patient (6-10 patients)	$19.60 per patient (6-10 patients)	
COVID-19	Associated MBS items	Mental health consultation	General Practitioners	92115	Telehealth	NA	20+	$87.00	$73.95	
COVID-19	Associated MBS items	Mental health consultation	General Practitioners	92127	Phone	NA	20+	$87.00	$73.95	
COVID-19	Associated MBS items	Mental health consultation	Other Medical Practitioners (OMPs)	92121	Telehealth	NA	20+	$69.55	$59.15	
COVID-19	Associated MBS items	Mental health consultation	Other Medical Practitioners (OMPs)	92133	Phone	NA	20+	$69.55	$59.15	
COVID-19	Associated MBS items	Initial patient consultation	Psychiatrists	92437	Telehealth	NA	45+	$272.50	$231.65	
COVID-19	Associated MBS items	Initial patient consultation	Psychiatrists	92477	Phone	NA	45+	$272.50	$231.65	
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	92124	Phone	NA	20-40	$87.00	$73.95	30/06/2021

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	92125	Phone	NA	40+	$128.05	$108.85	30/06/2021
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	92128	Phone	NA	20-40	$110.45	$93.90	30/06/2021
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	92129	Phone	NA	40+	$162.70	$138.30	30/06/2021
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	92130	Phone	NA	20-40	$69.55	$59.15	30/06/2021
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	92131	Phone	NA	40+	$102.45	$87.10	30/06/2021
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	92134	Phone	NA	20-40	$88.35	$75.10	30/06/2021
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	92135	Phone	NA	40+	$130.15	$110.65	30/06/2021
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	92112	Telehealth	NA	20-40	$87.00	$73.95	
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	92113	Telehealth	NA	40+	$128.05	$108.85	
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	92116	Telehealth	NA	20-40	$110.45	$93.90	
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	92117	Telehealth	NA	40+	$162.70	$138.30	
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	92118	Telehealth	NA	20-40	$69.55	$59.15	
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs)	92119	Telehealth	NA	40+	$102.45	$87.10	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
			(w/o MH skills training)							
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	92122	Telehealth	NA	20-40	$88.35	$75.10	
COVID-19	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	92123	Telehealth	NA	40+	$130.15	$110.65	
COVID-19	Associated MBS items	Preparation of a psychiatrist assessment and management plan	Psychiatrists	92435(4)	Telehealth	NA	45+	$473.80	$402.75	
COVID-19	Associated MBS items	Preparation of a psychiatrist assessment and management plan	Psychiatrists	92475(4)	Phone	NA	45+	$473.80	$402.75	
COVID-19	Associated MBS items	Review of a mental health treatment plan	General Practitioners	92114	Telehealth	NA	Not timed	$87.00	$73.95	
COVID-19	Associated MBS items	Review of a mental health treatment plan	General Practitioners	92126	Phone	NA	Not timed	$87.00	$73.95	
COVID-19	Associated MBS items	Review of a mental health treatment plan	Other Medical Practitioners (OMPs)	92120	Telehealth	NA	Not timed	$69.55	$59.15	
COVID-19	Associated MBS items	Review of a mental health treatment plan	Other Medical Practitioners (OMPs)	92132	Phone	NA	Not timed	$69.55	$59.15	
COVID-19	Associated MBS items	Review of a psychiatrist assessment and management plan	Psychiatrists	92436	Telehealth	NA	30-45	$296.20	$251.80	
COVID-19	Associated MBS items	Review of a psychiatrist assessment and management plan	Psychiatrists	92476	Phone	NA	30-45	$296.20	$251.80	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	91818	Telehealth	NA	30-40	$112.50	$95.65	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	91842	Phone	NA	30-40	$112.50	$95.65	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	91819	Telehealth	NA	40+	$161.00	$136.85	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	91843	Phone	NA	40+	$161.00	$136.85	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	91820	Telehealth	NA	30-40	$90.00	$76.50	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	91844	Phone	NA	30-40	$90.00	$76.50	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	91821	Telehealth	NA	40+	$128.80	$109.50	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	91845	Phone	NA	40+	$128.80	$109.50	
COVID-19	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	91166	Telehealth	NA	30-50	$102.85	$87.45	
COVID-19	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	91181	Phone	NA	30-50	$102.85	$87.45	
COVID-19	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	91167	Telehealth	NA	50+	$151.05	$128.40	
COVID-19	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	91182	Phone	NA	50+	$151.05	$128.40	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	91169	Telehealth	NA	20-50	$72.90	$62.00	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	91183	Phone	NA	20-50	$72.90	$62.00	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	91170	Telehealth	NA	50+	$102.85	$87.45	

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COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	91184	Phone	NA	50+	$102.85	$87.45	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	91172	Telehealth	NA	20-50	$64.20	$54.60	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	91185	Phone	NA	20-50	$64.20	$54.60	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	91173	Telehealth	NA	50+	$90.70	$77.10	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	91186	Phone	NA	50+	$90.70	$77.10	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	91175	Telehealth	NA	20-50	$64.20	$54.60	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	91187	Phone	NA	20-50	$64.20	$54.60	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	91176	Telehealth	NA	50+	$90.70	$77.10	
COVID-19	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	91188	Phone	NA	50+	$90.70	$77.10	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	93300(6)	Face to face	NA	30-40	$112.50	$95.65	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	93301(6)	Telehealth	NA	30-40	$112.50	$95.65	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	93302(6)	Phone	NA	30-40	$112.50	$95.65	

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COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	93303(6)	Face to face	NA	40+	$161.00	$136.85	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	93304(6)	Telehealth	NA	40+	$161.00	$136.85	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	93305(6)	Phone	NA	40+	$161.00	$136.85	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	93306(6)	Face to face	NA	30-40	$90.00	$76.50	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	93307(6)	Telehealth	NA	30-40	$90.00	$76.50	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	93308(6)	Phone	NA	30-40	$90.00	$76.50	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	93309(6)	Face to face	NA	40+	$128.80	$128.80	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	93310(6)	Telehealth	NA	40+	$128.80	$109.50	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	93311(6)	Phone	NA	40+	$128.80	$109.50	
COVID-19	Additional 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93330(6)	Face to face	NA	30-50	$102.85	$87.45	
COVID-19	Additional 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93331(6)	Telehealth	NA	30-50	$102.85	$87.45	
COVID-19	Additional 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93332(6)	Phone	NA	30-50	$102.85	$87.45	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
COVID-19	Additional 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93333(6)	Face to face	NA	50+	$151.05	$128.40	
COVID-19	Additional 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93334(6)	Telehealth	NA	50+	$151.05	$128.40	
COVID-19	Additional 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93335(6)	Phone	NA	50+	$151.05	$128.40	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93350(6)	Face to face	NA	20-50	$72.90	$62.00	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93351(6)	Telehealth	NA	20-50	$72.90	$62.00	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93352(6)	Phone	NA	20-50	$72.90	$62.00	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93353(6)	Face to face	NA	50+	$102.85	$87.45	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93354(6)	Telehealth	NA	50+	$102.85	$87.45	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93355(6)	Phone	NA	50+	$102.85	$87.45	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93356(6)	Face to face	NA	20-50	$64.20	$54.60	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93357(6)	Telehealth	NA	20-50	$64.20	$54.60	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93358(6)	Phone	NA	20-50	$64.20	$54.60	

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COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93359(6)	Face to face	NA	50+	$90.70	$77.10	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93360(6)	Telehealth	NA	50+	$90.70	$77.10	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93361(6)	Phone	NA	50+	$90.70	$77.10	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93362(6)	Face to face	NA	20-50	$64.20	$54.60	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93363(6)	Telehealth	NA	20-50	$64.20	$54.60	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93364(6)	Phone	NA	20-50	$64.20	$54.60	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93365(6)	Face to face	NA	50+	$90.70	$77.10	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93366(6)	Telehealth	NA	50+	$90.70	$77.10	
COVID-19	Additional 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93367(6)	Phone	NA	50+	$90.70	$77.10	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	93400	Face to face	NA	20-40 mins	$87.00	$73.95	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	93401	Face to face	NA	40+ mins	$128.05	$108.85	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	93402	Face to face	NA	20-40 mins	$110.45	$93.90	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	93403	Face to face	NA	40+ mins	$162.70	$138.30	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	93404	Telehealth	NA	20-40 mins	$87.00	$73.95	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	93405	Telehealth	NA	40+ mins	$128.05	$108.85	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	93406	Telehealth	NA	20-40 mins	$110.45	$93.90	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	93407	Telehealth	NA	40+ mins	$162.70	$138.30	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	93408	Phone	NA	20-40 mins	$87.00	$73.95	6/08/2021
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/o MH skills training)	93409	Phone	NA	40+ mins	$128.05	$108.85	6/08/2021
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	93410	Phone	NA	20-40 mins	$110.45	$93.90	6/08/2021
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	General Practitioners (w/ MH skills training)	93411	Phone	NA	40+ mins	$162.70	$138.30	6/08/2021
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	93431	Face to face	NA	20-40 mins	$69.55	$59.15	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	93432	Face to face	NA	40+ mins	$102.45	$87.10	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	93433	Face to face	NA	20-40 mins	$88.35	$75.10	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	93434	Face to face	NA	40+ mins	$130.15	$110.65	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	93435	Telehealth	NA	20-40 mins	$69.55	$59.15	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	93436	Telehealth	NA	40+ mins	$102.45	$87.10	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	93437	Telehealth	NA	20-40 mins	$88.35	$75.10	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	93438	Telehealth	NA	40+ mins	$130.15	$110.65	
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	93439	Phone	NA	20-40 mins	$69.55	$59.15	6/08/2021
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/o MH skills training)	93440	Phone	NA	40+ mins	$102.45	$87.10	6/08/2021
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	93441	Phone	NA	20-40 mins	$88.35	$75.10	6/08/2021
RACF COVID-19 Mental Health Support items	Associated MBS items	Preparation of a mental health treatment plan	Other Medical Practitioners (OMPs) (w/ MH skills training)	93442	Phone	NA	40+ mins	$130.15	$110.65	6/08/2021
RACF COVID-19 Mental Health Support items	Associated MBS items	Review of a mental health treatment plan	General Practitioners	93421	Face to face	NA	Not timed	$87.00	$73.95	
RACF COVID-19 Mental Health Support items	Associated MBS items	Review of a mental health treatment plan	General Practitioners	93422	Telehealth	NA	Not timed	$87.00	$73.95	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
RACF COVID-19 Mental Health Support items	Associated MBS items	Review of a mental health treatment plan	General Practitioners	93423	Phone	NA	Not timed	$87.00	$73.95	
RACF COVID-19 Mental Health Support items	Associated MBS items	Review of a mental health treatment plan	Other Medical Practitioners (OMPs)	93451	Face to face	NA	Not timed	$69.55	$59.15	
RACF COVID-19 Mental Health Support items	Associated MBS items	Review of a mental health treatment plan	Other Medical Practitioners (OMPs)	93452	Telehealth	NA	Not timed	$69.55	$59.15	
RACF COVID-19 Mental Health Support items	Associated MBS items	Review of a mental health treatment plan	Other Medical Practitioners (OMPs)	93453	Phone	NA	Not timed	$69.55	$59.15	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	2733	Face to face	NA	30-40	$112.50	$95.65	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	2735	Face to face	NA	40+	$161.00	$136.85	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	941	Face to face	NA	30-40	$90.00	$76.50	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	942	Face to face	NA	40+	$128.80	$109.50	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93375	Face to face	NA	30-50	$102.85	$87.45	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93376	Face to face	NA	50+	$151.05	$128.40	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93381	Face to face	NA	20-50	$72.90	$62.00	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93382	Face to face	NA	50+	$102.85	$87.45	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93385	Face to face	NA	20-50	$64.20	$54.60	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93386	Face to face	NA	50+	$90.70	$77.10	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93383	Face to face	NA	20-50	$64.20	$54.60	
RACF COVID-19 Mental Health Support items	Initial 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93384	Face to face	NA	50+	$90.70	$77.10	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	93287(6)	Face to face	NA	30-40	$112.50	$95.65	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	General Practitioners	93288(6)	Face to face	NA	40+	$161.00	$136.85	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	93291(6)	Face to face	NA	30-40	$90.00	$76.50	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	Other Medical Practitioners (OMPs)	93292(6)	Face to face	NA	40+	$128.80	$109.50	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93312(6)	Face to face	NA	30-50	$102.85	$87.45	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Psychological therapy health services	Clinical Psychologists	93313(6)	Face to face	NA	50+	$151.05	$128.40	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93316(6)	Face to face	NA	20-50	$72.90	$62.00	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	Psychologists	93319(6)	Face to face	NA	50+	$102.85	$87.45	

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee(8)	Benefit paid(8)	Last date of operation
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93326(6)	Face to face	NA	20-50	$64.20	$54.60	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	Social Workers	93327(6)	Face to face	NA	50+	$90.70	$77.10	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93322(6)	Face to face	NA	20-50	$64.20	$54.60	
RACF COVID-19 Mental Health Support items	Additional 10 individual sessions	Focussed psychological strategies treatment services	Occupational Therapists	93323(6)	Face to face	NA	50+	$90.70	$77.10	
RACF COVID-19 Mental Health Support items	Flag Fall Incentive Items(7)		General Practitioners	90001				$56.75	$56.75	
RACF COVID-19 Mental Health Support items	Flag Fall Incentive Items(7)		Other Medical Practitioners (OMPs)	90002				$41.25	$41.25	
RACF COVID-19 Mental Health Support items	Flag Fall Incentive Items(7)		Clinical Psychologists, Psychologists, Occupational Therapists or Social Workers	90003				$47.05	$40.00	

Notes to table:

Current as at 30 June 2022. This list was developed from material supplied by the Department of Health: a list of the Better Access items (current at 24 March 2021) on 22 August 2021, a further list of inactive items on 23 August 2021, and a further list of obsolete items on 14 December 2021 (current as at 26 October 2021). Further updates have been added.

This list does not include Home Care Shared Care Plans, which can also be used to refer patients to Better Access services. MBS items for specialists, including psychiatrists and paediatricians (104, 105, 107, 108), consultant psychiatrist services (293-370) and consultant paediatricians (110-133) are gateway items through which these medical practitioners can refer clients into Better Access services. They are not recognised as Better Access services.

Yellow shading indicates items that have been discontinued. Grey shading indicates Flag Fall Incentive Items – see footnote (7).

(1) Introduced in 2002 as part of the Better Outcomes in Mental Health Care initiative, the 3 Step Mental Health Process items 2574, 2575, 2577, 2578, 2704, 2705, 2707 and 2708 were discontinued after 30 April 2007, following the introduction of the new mental health care items for GPs on 1 November 2006 (items 2710 and 2712) as part of the Better Access initiative. These items were used by GPs/Other medical practitioners to complete the original three step mental health process, Prepare a mental health treatment plan and Review a mental health treatment plan.

(2) For less than six patients being attended in a call-out, the fee is the base item fee + $26.75 (to be divided by the number of patients). For seven or more patients the fee is the base item fee + $2.10 per patient.

(3) For less than six patients being attended in a call-out, the fee is the base item fee + $21.40 (to be divided by the number of patients). For seven or more patients the fee is the base item fee + $1.70 per patient.

(4) This session includes conduct of a mental health assessment, diagnosis, treatment plan development and referral (as necessary).

(5) These items existed prior to 1 November 2006, but the fees and rebates attached to them were increased as part of the Better Access initiative.

(6) In response to the COVID-19 pandemic an additional 10 individual psychological therapy sessions were made available under Better Access. The footnoted items count towards sessions 11-20.

Program phase	Category	Sub-category	Provider	Item No.	Mode of Delivery	Location	Service length (mins)	Schedule Fee[8]	Benefit paid[8]	Last date of operation

(7) **Not to be included in total number of Better Access services.** These items provide a financial incentive for providers to deliver services in aged care facilities, and compensate providers for any additional expenses they might incur e.g. travel costs, flag fall items have been created. A flag fall can only be claimed for the initial attendance at one residential aged care facility on one occasion. These items *should not* be included when counting the total number of Better Access services. They have been included in this master list in case specific data is needed on their usage.

(8) As at 24 March 2021.

Appendix 2. Supplementary data (Study 1)

Table A2.1: Summary of changes to Better Access[a]

Initiative	#	Start date (if after 01 Nov 2006)	End date (if before 30 Jun 2022)	Type of change		Description
				Item numbers	Treatment session limit	
Original	1	-	30 Apr 2007	•		3 Step Mental Health Process items retired.
	2	01 Jan 2010	31 Oct 2011	•		New item 2702 (MHTP) for GPs who had not completed mental health skills training.
	3	01 Nov 2011	*Until #6*		•	Limit reduced. Up to 10 individual and up to 10 group allied health sessions/year.
	4	01 Nov 2011	-	•		GP MHTP item 2702 replaced by 2700 (20-40 mins) and 2701 (>40 mins). GP review item 2710 replaced by 2715 (20-40 mins) and 2717 (>40 mins).
	5	01 Nov 2011	01 Mar 2012	•		Temporary new item 2719 for review of MHTP under 2702/2710.
	6	01 Mar 2012	31 Dec 2012		•	Transitional arrangement following session 2011 reduction (see #3). Up to 16 individual and up to 10 group PTS/FPS sessions allowed to address concerns that session limit reduction would disadvantage people with complex problems.
	7	01 Jan 2013	*Until #13/14*		•	Limit reduced (resumes #3). Up to 10 individual and up to 10 group PTS/FPS sessions/year.
	8	01 Jul 2018	-	•		10 new items for OMPs to deliver MHTPs, reviews, consultations and FPS.
Rural and remote (teleheath)	9	01 Nov 2017	*Until #10*	•		8 new items for individual telehealth consultations from allied health professionals for consumers in rural/remote/very remote locations. Up to 7 of the 10 sessions/year can be videoconference. 4 new items for group videoconferencing.
	10	01 Sep 2018	-	•		All 10 individual telehealth consultations from allied health consultations for consumers in rural/remote/very remote locations can be delivered via videoconference without the requirement for a face-to-face consultation.
	11	01 Nov 2018	31 Dec 2021	•		4 new videoconference items for individual FPS services delivered by GPs and OMPs for consumers in rural/remote/very remote locations.
COVID-19	12	13 Mar 2020 - 06 Apr 2020	GP/OMP MHTP phone items only - 30 Jun 2021	•		New telehealth and phone items introduced that replicate existing face-to-face treatment, consultation, plan and review item services.
	13	07 Aug 2020	*Until #14*		•	Existing face-to-face, phone and telehealth individual session limit increased to 20 individual sessions/year for people in areas where public health orders restricted movement.
	14	09 Oct 2020	-		•	Existing face-to-face, phone and telehealth individual session limit increased to 20 individual sessions/year, not geographically restricted.
RACF	15	10 Dec 2020	-		•	RACF residents whose mental health is impacted by the COVID-19 pandemic can access up to 20 individual sessions/year.
	16	10 Dec 2020	GP/OMP MHTP phone items only – 06 Aug 2021	•		30 new face-to-face, telehealth and phone items for GPs and OMPs to prepare a MHTP or review for RACF residents.

-, indicates items are current as of 30 Jun 2022. GP, general practitioner. FPS, Focussed Psychological Strategies. MHTP, Mental Health Treatment Plan. OMP, other medical practitioner. PTS, Psychological Therapy Services. RACF, residential aged care facility.

[a] Changes in this table describe the addition or retirement of MBS item numbers or changes to treatment session limits.

Table A2.2: Persons receiving Better Access services delivered by GPs and other medical practitioners, by provider type, 2018 to 2022

		2018	2019	2020	2021	AVERAGE ANNUAL CHANGE (%) 2018 TO 2021	2022 YEAR TO DATE
Preparation of a mental health treatment plan	Persons	1,332,633	1,416,351	1,468,297	1,421,494	2.2	661,998
	% GP	99.1	97.9	97.4	97.7	-0.5	98.2
	% OMP	0.9	2.1	2.6	2.3	36.6	1.8
Review of a mental health treatment plan	Persons	441,152	471,323	523,173	533,449	6.5	272,725
	% GP	99.3	98.4	98.2	98.5	-0.3	98.8
	% OMP	0.9	1.7	1.9	1.7	22.7	1.2
Mental health consultation	Persons	986,806	989,591	992,758	1,000,284	0.5	510,427
	% GP	98.6	96.4	95.7	96.2	-0.8	96.6
	% OMP	2.4	4.7	5.4	4.8	25.2	3.9
Focussed Psychological Strategies	Persons	10,343	10,161	12,114	12,572	6.7	7,675
	% GP	95.4	89.8	90.6	91.9	-1.2	91.6
	% OMP	8.1	10.9	10.8	9.3	4.7	8.4

GP, general practitioner. OMP, other medical practitioner. Data include all claims for services received from 1 January 2018 to 30 June 2022 and processed up to and including 7 August 2022. For '% GP' and '% OMP', the denominator is the number of people who received each type of service from a GP or other medical practitioner. The percentage may sum to more than 100% because some people may have received services from a GP or other medical practitioner.

Appendix 3: Survey plain language statement (Study 3)

The Better Access Survey – People's use, experience and outcomes

Responsible Researcher: Professor Jane Pirkis; j.pirkis@unimelb.edu.au; Tel: +61 3 3844 0647
Research Team: Meredith Harris, Cathy Mihalopoulos, Dianne Currier, Mary-Lou Chatterton, Matthew Spittal, Katrina Scurrah, Leo Roberts, Long Le

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About this project

Our team has been commissioned by the Department of Health to conduct an evaluation of what is known as the "Better Access program" or just "Better Access". Under Better Access, people can see a psychologist, social worker or occupational therapist for sessions of mental health care, and those sessions are funded – wholly or partially – by Medicare. In order for this to happen, their GP provides them with a mental health treatment plan and refers them on to one of these mental health professionals.

This project is one component of the evaluation and has two parts. Firstly (Part A), we are conducting a **survey** with people who have used Better Access in 2021. The survey will ask those who have used Better Access services why they have, about what services they used, and what their experiences were.

In the second part (Part B), we are asking people if they will agree to us linking their Medicare claims information for Better Access services to their survey answers to get a fuller picture of how Better Access services were used. More information about Part B of the project and how to opt in is provided at the end of the survey.

The following provides you with further information about the **survey** part of this project, so that you can decide if you would like to take part.

<u>You can complete the survey without agreeing to linking your Medicare claims information.</u>

Please take the time to read this information carefully and contact the evaluation team if you would like to ask any other questions about the project.

What will I be asked to do?

If you agree to participate in the **survey** part of the project you will be asked to complete an online survey which will take 15 to 20 minutes. Logicly are managing the survey.

What are the possible benefits?

Participating in the survey will give you the opportunity to provide your perspective on the Better Access services you received. You will also be able to enter a draw to win one of 50 gift vouchers valued at $200 each. There will also be broader benefits, because the information you and other participants provide will help to shape the way in which Better Access is delivered in the future.

What are the possible risks?

The risks of participating are small. However, because we will be asking you to think about mental health care you may have received in the past year, there is a possibility that you might feel uncomfortable or distressed. If this happens, you can stop the survey at any time. If you are feeling upset, you might want to talk to your family or friends or contact your service provider or GP. You can also call one of the services listed on the useful support services sheet. The project team is also available to help you obtain support. Please contact us on (03) 8344 0457 if you would like someone to follow-up with you.

Do I have to take part?

No. Participation is completely voluntary. You don't have to answer any question you don't want to and can stop the survey at any time and withdraw from providing any further information. We will not know which survey responses belong to you so will not be able to withdraw any survey information you have already entered. Your participation or withdrawal will have no bearing on any future care you may receive through Better Access or any other program.

Will I hear about the results of this project?

We will provide written reports on the findings of the overall evaluation to the Department of Health, and these reports will include information about what survey participants have told us. Some or all of those reports will be made publicly available. We will also prepare an academic journal article on this project.

What will happen to information about me?

We will protect the confidentiality of your data, subject to any legal requirements. Any personal information that you provide us, such as your name and email address, will be stored separately from your survey responses. All information we collect from you will be held under password protection and not shared with anyone outside the project team. Information presented in reports or journal articles will be grouped together so no individual participant can be identified.

Who is funding this project?

This project has been funded by the Australian Department of Health.

Where can I get further information?

If you would like more information about the project, please contact Dr Dianne Currier betteraccesseval-3@unimelb.edu.au

Who can I contact if I have any concerns about the project?

This project has human research ethics approval from The University of Melbourne (Project ID 22999). If you have any concerns or complaints about the conduct of this project, which you do not wish to discuss with the research team, you should contact the Research Integrity Administrator, Office of Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 3 8344 1376 or Email: research-integrity@unimelb.edu.au. All complaints will be treated confidentially. In any correspondence please provide the name of the research team and/or the name or ethics ID number of the research project.

Appendix 4: Survey consent (Study 3)

[The statement below followed the plain language statement. Participants had to check the "Yes" box in order to proceed through to the survey]

Having read the above information, do you agree to participate in this project?

Survey Consent Declaration:

○ Yes, I have read and understood the information provided to me and would like to proceed in taking part in the online survey.

○ No, I do not consent to take part

Date: ___/___/_____

Appendix 5: Survey (Study 3)

The Better Access Survey - People's use, experience and outcomes

You have been invited to complete this survey because you are one of the many people in Australia who received treatment services from a mental health professional **in 2021** that were paid for, at least in part, by Medicare. These Medicare-funded services are delivered under what is known as the Better Access program.

We are interested in the Better Access services that you received from **a psychologist**, **a social worker** or **an occupational therapist**. There are some other professionals who can deliver services under Better Access, but we are not asking you about these professionals. It is also possible that you have seen a psychologist, a social worker or an occupational therapist through some other program that is not funded through Medicare (e.g., through a community mental health service). These mental health professionals are also outside the scope of the survey. The survey about the services you received from **a psychologist, a social worker or an occupational therapist under the Better Access program**.

We'd like you to think back to the mental health professional you saw and answer a few questions about your experiences with seeing them. If you saw more than one mental health professional whose services were at least partially funded by Medicare, think about **the main one** you saw.

The mental health professional you saw in 2021

1. Was the mental health professional from whom you received Better Access services (i.e., Medicare-funded treatment services) **a psychologist**, **a social worker** or **an occupational therapist**? (If you saw more than one of these mental health professionals through Better Access, please tick the one you would describe as **the main one**)	☐ A psychologist ☐ A social worker ☐ An occupational therapist ☐ Unsure
2. Who referred you to the mental health professional?	☐ A general practitioner ☐ A psychiatrist ☐ Another type of medical practitioner ☐ Unsure
3. Was this the first time you had received Medicare-funded treatment services from a mental health professional?	☐ Yes ☐ No ☐ Unsure

The circumstances that prompted you to seek care

4. People seek care from mental health professionals for a variety of reasons. What prompted you to seek care on this occasion? **(Tick all that apply)**	☐ I was referred by a medical practitioner ☐ I was feeling depressed, anxious or highly stressed ☐ I had experienced a traumatic event ☐ I recognised that I needed some help with my problems ☐ I was encouraged to do so by family or friends ☐ Other (Please describe) ______________________________________ ☐ Unsure

5. At the time you sought care from the mental health professional, were you given a mental health diagnosis?	☐ Yes ☐ No → Go to question 7 ☐ Unsure → Go to question 7
6. What was the diagnosis? **(Tick all that apply)**	☐ An anxiety disorder ☐ Depression ☐ Bipolar disorder ☐ An eating disorder ☐ A personality disorder ☐ Post-traumatic stress disorder ☐ A psychotic disorder (e.g., schizophrenia) ☐ A substance use disorder ☐ Autism spectrum disorder ☐ Other (Please describe) ____________________________________ ☐ Unsure

The outcomes of the care

	1 **Worst possible mental health**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** **Best possible mental health**	**Unsure**
7. 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 **<u>before your first session</u>** with the mental health professional?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. 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 **<u>after your most recent session</u>** with the mental health professional?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

9. To what extent do you think that the treatment you received from the mental health professional was responsible for any change in your mental health?	☐ The treatment I received from the mental health professional was entirely responsible for the change in my mental health ☐ The treatment I received from the mental health professional was partially responsible for the change in my mental health, but other factors played a role ☐ The treatment I received from the mental health professional was not at all responsible for the change in my mental health; it was totally due to other factors ☐ Not applicable; my mental health didn't change ☐ Unsure

The experience of seeing the mental health professional

Please rate the extent to which you agree or disagree with the following statements.	1 Strongly disagree	2 Disagree	3 Neither disagree nor agree	4 Agree	5 Strongly agree
10. I found the referral process straightforward	☐	☐	☐	☐	☐
11. I had to wait too long for an appointment with the mental health professional	☐	☐	☐	☐	☐
12. I had to travel too far to see the mental health professional	☐	☐	☐	☐	☐
13. I was offered sessions at a time that suited me	☐	☐	☐	☐	☐
14. The mental health professional was empathic	☐	☐	☐	☐	☐
15. I was offered the opportunity for my family and friends to be involved in my support or care if I wanted this	☐	☐	☐	☐	☐
16. The mental health professional listened to me	☐	☐	☐	☐	☐
17. The mental health professional respected my right to make decisions	☐	☐	☐	☐	☐
18. The mental health professional equipped me with strategies to address the issues I was facing	☐	☐	☐	☐	☐
19. The support or care provided by the mental health professional met my needs	☐	☐	☐	☐	☐
20. I had a good relationship with the mental health professional	☐	☐	☐	☐	☐

The sessions of care

21. Were your sessions with the mental health professional face-to-face (e.g., in their rooms) or via telehealth (e.g., over Zoom or some other video conferencing platform) or phone? **(Tick all that apply)**	☐	Face-to-face
	☐	Via telehealth
	☐	Via phone
	☐	Unsure
22. Were your sessions with the mental health professional delivered to you individually or did you attend them as part of a group? **(Tick all that apply)**	☐	Individually
	☐	In a group
	☐	Unsure
23. Are you still seeing the mental health professional (or planning to continue seeing them)?	☐	Yes → Go to question 26
	☐	No
	☐	Unsure → Go to question 26
24. Did you continue seeing the mental health professional for as long as you could have done?	☐	Yes → Go to question 26
	☐	No
	☐	Unsure → Go to question 26
25. Why did you stop seeing the mental health professional? **(Tick all that apply)**	☐	I felt better
	☐	The fee I had to pay out of my own pocket was too expensive
	☐	The other costs associated with seeing 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 ☐ I did not like the mental health professional's manner or approach ☐ I had difficulty fitting the sessions in around my other commitments ☐ The mental health professional moved out of my area ☐ I chose to access a different mental health service (i.e., one that wasn't paid for by Medicare) ☐ I did not like the session format (e.g., telehealth, face-to-face) ☐ Language was a barrier for me ☐ Other (Please describe) ______________________________ ☐ Unsure
26. In total, how many sessions did you attend (or will you attend) with the mental health professional?	_____ ☐ Unsure
27. How would you describe the number of sessions?	☐ Too many ☐ Too few ☐ Just right ☐ Unsure

Overall satisfaction with care

	1 Very dissatisfied	2 Dissatisfied	3 Neither dissatisfied nor satisfied	4 Satisfied	5 Very satisfied
28. How satisfied were you with your care?	☐	☐	☐	☐	☐

Payment

29. Which of the following most accurately describes the way in which your sessions with the mental health professional were paid for?	☐ Medicare covered all of the costs ☐ Medicare covered some of the costs, but I paid at least some of the costs out of my own pocket ☐ Some other payment arrangement (Please describe) ______________________________ ☐ Unsure
30. Which of the following best describes what you paid for your sessions with the mental health professional?	☐ I didn't pay anything; Medicare covered all of the cost ☐ I paid a fee that was affordable ☐ I paid a fee that was too expensive ☐ Unsure

Finally, a few questions about you

31. What is your postcode?	______________________________________
32. What is your age?	☐ ≤19
	☐ 20-24
	☐ 25-29
	☐ 30-34
	☐ 35-39
	☐ 40-44
	☐ 45-49
	☐ 50-54
	☐ 55-59
	☐ 60-64
	☐ 65-69
	☐ 70-74
	☐ 75-79
	☐ ≥80
33. Are you:	☐ Female
	☐ Male
	☐ Non-binary sex
	☐ Prefer not to say
34. How would you describe your sexual identity	☐ Lesbian, gay or homosexual
	☐ Straight or heterosexual
	☐ Bisexual
	☐ Something else
	☐ Don't know
	☐ Prefer not to say
35. Which country were you born in?	☐ Australia
	☐ England
	☐ New Zealand
	☐ India
	☐ Philippines
	☐ Vietnam
	☐ Italy
	☐ Other (Please specify) ______________________________________
36. Do you identify as Aboriginal or Torres Strait Islander?	☐ Aboriginal
	☐ Torres Strait Islander
	☐ Both Aboriginal and Torres Strait Islander
	☐ Neither Aboriginal nor Torres Strait Islander

END SCREENS

SCREEN 1

Enter your details below if you would like to go into the prize draw

Name

Phone………………… Email……………………….

NEXT

SCREEN 2

SURVEY COMPLETE NEXT

Thank you very much for completing this survey. We really appreciate the fact that you were prepared to share your views and experiences.

Remember that if anything about the survey has left you feeling upset, you might want to talk to your family or friends or contact your service provider or GP. You can also call on of the services listed on the useful support services sheet [hyperlink to downloadable support services sheet]. The project team is also available to help you obtain support.

☐ Check this box if you would like the evaluation psychologist to check in with you.

START NEXT

SCREEN 3

Part 2: Linking your Medicare Records to your Survey Responses

Click **NEXT** for more information on what's involved in linking your Medicare records to your survey responses including how to participate.

EXIT NEXT

Thank you very much for completing this survey. We really appreciate the fact that you were prepared to share your views and experiences.

Remember that if anything about the survey has left you feeling upset, you might want to talk to your family or friends or contact your service provider or GP. You can also call on of the services listed on the useful support services sheet [hyperlink to downloadable support services sheet]. The project team is also available to help you obtain support.

Appendix 6: Data linkage plain language statement (Study 3)

THE BETTER ACCESS SURVEY – PEOPLE'S USE, EXPERIENCE AND OUTCOMES

Responsible Researcher: Professor Jane Pirkis; j.pirkis@unimelb.edu.au; Tel: +61 3 3844 0647
Research Team: Meredith Harris, Cathy Mihalopoulos, Dianne Currier, Mary-Lou Chatterton, Matthew Spittal, Katrina Scurrah, Leo Roberts, Long Le

About this project

As we described earlier, our team has been commissioned by the Department of Health to conduct an evaluation of "Better Access". Understanding how people use the services offered through Better Access and their experiences of them is one component of the evaluation.

In this second part of the Better Access Survey project, we are asking people who completed the Survey if they would agree to us linking their Medicare Benefits Schedule claims information (MBS records) to their survey answers to get a fuller picture of how services are used. We are only interested in claims information for Better Access services, not any other Medicare claims.

This page provides you with further information about the second part of this project - **MBS records data linkage** - so that you can decide if you would like to take part.

Please take the time to read this information carefully and contact the evaluation team if you have any other questions about the MBS records data linkage.

What will I be asked to do?

You will be asked to sign the consent form authorising the study to access your complete MBS information as outlined in the consent form. Medicare collects information on your doctor and other medical service provider visits and the associated costs. If you agree we will ask Services Australia (the organisation that administers Medicare records) to provide us your MBS claims information related to your Better Access service use for the past two years (2020 and 2021).

Services Australia is not involved in the conduct of this study other than to release your MBS records. They will not provide your MBS records to the study without your consent. To participate in this part of the study, you must complete the 'Services Australia Participant Consent Form' that follows this information.

Services Australia collect your Medicare claims information so they can process and manage your applications and payments and provide services to you. Your MBS records that Services Australia hold are protected by the Privacy Act 1988 and cannot be given to a third party without your consent. Services Australia only share your information with other parties where you have agreed, or where the law allows or requires it. For more information about privacy, go to **servicesaustralia.gov.au/privacy.**

The following table gives an example of the type of information that may be included in the MBS records

Date of service	Item number	Item description	Provider charge	Schedule Fee	Benefit paid	Patient out-of-pocket	Item category
20/04/09	00023	Level B consultation	$38.30	$34.30	$34.30	$4.00	1
22/06/09	11700	ECG	$29.50	$29.50	$29.50		2

What are the possible benefits?

There is no direct benefit to you if you agree to linking your MBS records, however it will give our evaluation team additional information that will allow us to get a more in-depth picture of how services are used and if the current program is meeting people's needs. This will support broader benefits, because the information you and other survey participants provide will help to shape the way in which Better Access is delivered in the future. You don't have to agree to your MBS records data linkage to go into the gift voucher draw.

What are the possible risks?

The risks of agreeing to linkage are very small. An unauthorised person may access your data or your privacy may be breached. However, this is extremely unlikely as the evaluation team and Services Australia both have very strict rules about storing and accessing MBS records, and any information that can identify you will be removed and stored separately from your MBS records and linked survey information.

Do I have to agree?

No. The consent to release your MBS records by Services Australia is completely voluntary and there will be no cost to you. If you do not want to consent to the release of your MBS records by Services Australia you do not have to. Choosing not to participate in the MBS records data linkage will not affect your current or future medical care in any way.

You may change your mind at any time about releasing your information to the Study. People withdraw from studies for various reasons and you do not need to provide a reason.

You can withdraw your consent to release your MBS records by completing the 'Services Australia Participant Withdrawal of Consent Form'. You can also use that form to choose if the study should destroy or keep your MBS records. You can download the form here or contact the study coordinator on (03) 8344 0457 and she will send it to you.

If you do withdraw your consent from the study and your information has already been analysed and/or included in a publication, your MBS records may not be able to be withdrawn or destroyed. In such circumstances, your MBS records will continue to form part of the project study records and results. Your privacy will continue to be protected at all times.

Will I hear about the results of this project?

We will provide written reports on the findings of the overall evaluation to the Department of Health, and these reports will include information about what survey participants have told us. Some or all of those reports will be made publicly available. We will also prepare an academic journal article on this component of the Better Access evaluation.

What will happen to information about me?

We will protect your confidentiality, subject to any legal requirements. We will not share your information with anyone outside the evaluation team and the small number of staff involved in the linkage at Services Australia. Only authorised members of the evaluation team, the Services Australia data team, and Logicly, who are managing the survey, will have access to your personal details.

Your consent form containing your personal details will be sent securely to Services Australia to authorise the release of your MBS records. Services Australia and the University of Melbourne will both retain a copy of your consent form for the life of the study as a record of your consent. Your personal details will be removed from your MBS records and survey responses and stored separately on password protected secure University servers, or hosted through cloud computing providers, physically located within Australian borders. Your MBS records will not be sent outside of Australian.

Your MBS records will be securely destroyed after the final publication of the study. However, if you withdraw from the Study you can request the destruction of your MBS records as described above. All information will be securely destroyed at the completion of the study in a manner appropriate to the security classification of the record content.

Who is funding this project?

This project has been funded by the Australian Department of Health.

Where can I get further information?

If you would like more information about the project, please contact the Project Coordinator Dr Dianne Currier betteraccesseval-3@unimelb.edu.au

Who can I contact if I have any concerns about the project?

This project has human research ethics approval from The University of Melbourne (Project ID 22999). If you have any concerns or complaints about the conduct of this project, which you do not wish to discuss with the research team, you should contact the Research Integrity Administrator, Office of Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 3 8344 1376 or Email: research-integrity@unimelb.edu.au.

All complaints will be treated confidentially. In any correspondence please provide the name of the research team and/or the name or ethics ID number of the research project.

Services Australia has confirmed that a Human Research Ethics Committee (HREC) that is registered with the National Health and Medical Research Council (NHMRC) and operates within guidelines set out by the NHMRC has approved this research and any associated documents. If you have a privacy complaint in relation to the use of your Services Australia information, you should contact the Office of the Australian Information Commissioner. You will be able to lodge a complaint with them.

Website:	www.oaic.gov.au
Telephone:	1300 363 992
Email:	enquiries@oaic.gov.au
Mail:	GPO Box 5218, Sydney NSW 2001

Your personal information Services Australia hold is protected by the Privacy Act 1988 and cannot be given to a third party without your consent or where otherwise permitted by law. For more information about privacy, go to **servicesaustralia.gov.au/privacy**

Appendix 7: Data linkage consent (Study 3)

THE BETTER ACCESS SURVEY – PEOPLE'S USE, EXPERIENCE AND OUTCOMES

Medicare Claims Data Linkage Consent Form

Responsible Researcher: Professor Jane Pirkis Tel: +61 3 3844 0647 Email: j.pirkis@unimelb.edu.au
Additional Researchers: Meredith Harris, Cathy Mihalopoulos, Dianne Currier, Mary-Lou Chatterton, Matthew Spittal, Katrina Scurrah, Leo Roberts, Long Le

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Participant ID: [Autogenerated by Logicly]

This form is for you to complete to Consent to release of Medicare Benefits Schedule (MBS) information by Services Australia to the University of Melbourne for the purposes of the "Better Access Survey – People's use, experience and outcomes" project.

Rights and Privacy

I understand that:
☐ my MBS information will be disclosed by Services Australia for the purposes of the study.
☐ the results of this research may be published in articles or journals.
☐ I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements; my data will be password protected and accessible only by the named researchers; and my name will never be disclosed by Services Australia, used in the study or published.
☐ my participation in the study is completely voluntary.
☐ I can withdraw my participation in the study at any time (refer to participant information sheet and withdrawal of consent form) and I do not have to provide a reason for my withdrawal.

Consent

☐ I understand the information provided to me about the study I am participating in.
☐ I have been given the opportunity to ask questions, and any questions I have asked have been answered to my satisfaction.
☐ I acknowledge that the possible effects of participating in this research project have been explained to my satisfaction.
☐ I consent to the disclosure by Services Australia of my MBS information to researchers for the purposes of the study.

Participant Details

Please complete the following section so Services Australia can locate your information and provide it to the University of Melbourne.

1. Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name: ________________________________ First given name: _________________________

Other given name (s): __________________________

Date of birth: ___ /____/_____
DD / MM / YYYY

2. Medicare card number: ______________________

3. Permanent address: ____

Postal address (if different to above): ____

AUTHORISATION

4. I authorise Services Australia to provide my:

☐ Medicare claims history

For the period of **01/01/2020** to: **31/12/2021** to the *"Better Access Survey – People's use, experience and outcomes"* project.

DECLARATION

☐ I declare that the information on this form is true and correct.

Dated: [DD/MM/YY Autogenerated]

Appendix 8: Comparison between all participants and participants with linked MBS claims data (Study 3)

Table A8.1: Socio-demographic profile of all participants and participants with linked MBS claims data

		ALL PARTICIPANTS (N=2,013)		PARTICIPANTS WITH LINKED MBS CLAIMS DATA (N=1,317)	
		FREQUENCY	%	FREQUENCY	%
Age[a]	18-19	82	4.1	56	4.3
	20-29	454	22.9	302	23
	30-39	531	26.8	344	26.2
	40-49	382	19.3	252	19.2
	50-59	256	12.9	170	12.9
	60-69	197	9.9	138	10.5
	70-79	78	4	53	4.1
Sex[a]	Female	1,336	74.6	888	73.9
	Male	399	22.3	282	23.5
	Non-binary sex	39	2.2	25	2.1
	Prefer not to say	16	0.9	7	0.6
Sexual identity[a]	Lesbian, gay or homosexual	125	7.0	90	7.5
	Straight or heterosexual	1,349	75.1	904	75.0
	Bisexual	213	11.9	146	12.1
	Something else	44	2.4	28	2.3
	Don't know/prefer not to say	65	3.6	37	3.1
Country of birth[a]	Australia	1,449	75.3	981	78.0
	Overseas	476	24.7	276	22.0
Aboriginal or Torres Strait Islander[a]	Aboriginal and/or Torres Strait Islander	36	2.1	25	2.1
	Neither Aboriginal nor Torres Strait Islander	1,744	98	1	97.9
State of residence[a]	NSW	390	20.8	254	20.2
	VIC	664	35.5	444	35.3
	QLD	417	22.3	285	22.7
	SA	90	4.8	59	4.7
	WA	164	8.8	111	8.8
	TAS	88	4.7	67	5.3
	ACT	25	1.3	17	1.4
	NT	33	1.8	20	1.6
Area of residence[a]	Major city	1,399	69.5	889	67.5
	Regional, rural, remote	614	30.5	428	32.5
Area level socio-economic status (SEIFA IRSD quintiles[a,b]	Q1 (Most disadvantaged)	253	13.6	180	14.4
	Q2	363	19.5	243	19.4
	Q3	391	21.0	267	21.3
	Q4	374	20.1	254	20.3
	Q5 (Least disadvantaged)	484	26.0	308	24.6

a. Missing data excluded.

b. Socio-economic 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 Socio-economic 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.

Appendix 9: Methodology for classifying change (Study 4)

The difference or ‘change’ between baseline and follow-up scores on measures of depressive and anxiety symptoms and quality of life was classified using an effect size methodology. For each measure, a “small-to-medium” effect size threshold was set at 0.3 of a standard deviation of the baseline total score (using baseline data from all individuals in the Target-D and Link-me control groups who completed the measure). This yielded an absolute threshold of change score for each measure. For example, for the PHQ-9 (range of scores 0-27) the change threshold was 1, therefore change was classified as “significant improvement” if the change score was 2 or more, “significant deterioration” if the change score was -2 or less, and “no significant change” if the change score was between -1 and 1.

For total days out of role (range of values 0-28 in increments of 0.5), an absolute threshold for change equivalent was set as the average number of days out of role for Australians without a mental disorder (1.4 days), therefore change was classified as “significant improvement” if the change in total days out of role was 2 or more, “significant deterioration” if the change was -2 or less, and “no significant change” if the change score was between -1.5 and 1.5.

Table A9.1. Change thresholds by measure

Measure	SD	N	Absolute threshold of change score	Interval of change scores for ‘significant improvement’ [a,b]		Interval of change scores for ‘no significant change’ [a,b]		Interval of change scores for ‘significant deterioration’ [a,b]	
				Max.	Min.	Max.	Min.	Min.	Max.
Target-D									
PHQ-9 total	5.7	935	1	27	2	1	-1	-2	-27
GAD-7 total	5.1	935	1	21	2	1	-1	-2	-21
AQoL-8D utility weights	0.20	843	0.05	-1.04	>-0.05	-0.05	0.05	<0.05	1.04
Link-me									
PHQ-9 total	6.2	1,264	1	27	2	1	-1	-2	-27
GAD-7 total	5.4	1,264	1	21	2	1	-1	-2	-21
EQ-5D-5L utility weights	0.27	1,252	0.07	-1.281	>-0.07	-0.07	0.07	<0.07	1.281
Total days out of role	n/a	n/a	1.4	28	2	1.5	-1.5	-2	-28

SD = standard deviation; Max.=maximum; Min.=minimum.

[a] The interval is the range of possible change values on each measure.

[b] For measures where higher scores indicate poorer mental health (PHQ-9 and GAD-7), a positive change score indicates improvement and a negative change score indicates deterioration. For measures where higher scores indicate better health (AQoL-8D and EQ-5D-5L), a negative change score indicates improvement and a positive change score indicates deterioration.

Appendix 10: Comparison of included and not included participants (Study 4)

Table A10.1a: Comparison of participants who were included in the current analyses with those who were not included, for the Target-D cohort (N=935)

	Baseline to 3-month follow-up			Baseline to 12-month follow-up		
	Included (n=577)	Not included (n=358)	p-value	Included (n=394)	Not included (n=541)	p-value
Depressive symptom severity (PHQ-9 total), mean (SD) [1]	9.2 (5.4)	9.3 (6.1)	0.775	9.1 (5.3)	9.4 (5.9)	0.454
Anxiety symptom severity (GAD-7 total), mean (SD) [1]	8.6 (5.0)	8.8 (5.4)	0.573	8.4 (4.8)	8.9 (5.4)	0.142
Quality of life (AQoL-8D), mean (SD) [1]	0.56 (0.19)	0.57 (0.21)	0.667	0.57 (0.19)	0.57 (0.21)	0.744
Prognostic group						
Minimal/mild	417 (72%)	261 (73%)		290 (74%)	388 (72%)	
Moderate	96 (17%)	49 (14%)		62 (16%)	83 (15%)	
Severe	64 (11%)	48 (13%)	0.326	42 (11%)	70 (13%)	0.570
Age group						
18-35 years	297 (51%)	249 (70%)		194 (49%)	352 (65%)	
36-55 years	211 (37%)	89 (25%)		143 (36%)	157 (29%)	
56 years and over	69 (12%)	20 (6%)	<0.001	57 (14%)	32 (6%)	<0.001
Gender						
Male	160 (28%)	117 (33%)		101 (26%)	176 (33%)	
Female	413 (72%)	240 (67%)	0.116	289 (73%)	364 (67%)	0.028
Highest level of education						
Year 12 or equivalent or less	159 (28%)	99 (28%)		105 (27%)	153 (28%)	
Certificate/diploma	137 (24%)	93 (26%)		103 (26%)	127 (23%)	
Bachelor's degree or higher	281 (49%)	166 (46%)	0.705	186 (47%)	261 (48%)	0.628
Employment						
Employed	391 (71%)	219 (70%)		276 (73%)	334 (68%)	
Unemployed	161 (29%)	94 (30%)	0.789	101 (27%)	154 (32%)	0.127
Manage on available income						
Easily/not too bad/difficult some of the time	504 (87%)	313 (87%)		346 (88%)	471 (87%)	

	Baseline to 3-month follow-up			Baseline to 12-month follow-up		
	Included (n=577)	Not included (n=358)	p-value	Included (n=394)	Not included (n=541)	p-value
Difficult all the time/impossible	73 (13%)	45 (13%)	0.971	48 (12%)	70 (13%)	0.731
Receiving benefit or disability support						
Yes	88 (16%)	45 (14%)		54 (14%)	79 (16%)	
No	462 (84%)	270 (86%)	0.501	321 (86%)	411 (84%)	0.486
Health care card holder						
Yes	140 (26%)	88 (28%)		96 (26%)	132 (27%)	
No	406 (74%)	222 (72%)	0.382	278 (74%)	350 (73%)	0.573
Live alone						
Yes	69 (12%)	40 (11%)		49 (12%)	60 (11%)	
No	508 (88%)	318 (89%)	0.716	345 (88%)	481 (89%)	0.527
Self-rated health						
Excellent/very good/good	446 (77%)	283 (79%)		304 (77%)	425 (79%)	
Fair/poor	131 (23%)	75 (21%)	0.529	90 (23%)	116 (21%)	0.610
History of depression						
Yes	375 (65%)	218 (61%)		258 (65%)	335 (62%)	
No	202 (35%)	140 (39%)	0.206	136 (35%)	206 (38%)	0.264
Long-term illness or health problems which limit daily activities/work						
Yes	174 (30%)	96 (27%)		120 (30%)	150 (28%)	
No	403 (70%)	262 (73%)	0.273	274 (70%)	391 (72%)	0.363
Saw doctor/other health professional for mental health in last month						
Yes	267 (46%)	139 (39%)		193 (49%)	213 (39%)	
No	310 (54%)	219 (61%)	0.026	201 (51%)	328 (61%)	0.003
Currently taking an antidepressant						
Yes	152 (26%)	74 (21%)		106 (27%)	120 (22%)	
No	425 (74%)	284 (79%)	0.049	288 (73%)	421 (78%)	0.096

SD, standard deviation. Data are n (%) unless otherwise stated. PHQ-9=Patient Health Questionnaire, 9-item version. GAD-7=Generalized Anxiety Disorder scale, 7-item version. AQoL-8D=Assessment of Quality of Life-8 Dimensions.

[1] Denominators may vary due to missing data or the omission of categories due to small cell sizes.

Table A10.1b: Comparison of participants who were included in the current analyses with those who were not included, for the Link-me cohort (N=1264)

	Baseline to 6-month follow-up			Baseline to 12-month follow-up		
	Included (n=745)	**Not included (n=519)**	**p-value**	**Included (n=553)**	**Not included (n=711)**	**p-value**
Depressive symptom severity (PHQ-9 total), mean (SD) [1]	10.3 (6.2)	10.7 (6.3)	0.307	10.3 (6.3)	10.7 (6.2)	0.276
Anxiety symptom severity (GAD-7 total), mean (SD) [1]	8.3 (5.4)	8.7 (5.5)	0.292	8.1 (5.4)	8.7 (5.4)	0.059
Quality of life (EQ-5D-5L utility weights), mean (SD) [1]	0.62 (0.27)	0.63 (0.27)	0.426	0.62 (0.26)	0.62 (0.27)	0.697
Total days out of role (K10+), median (IQR) [1,2]	3.5 (0.0-12.5)	3.5 (0.0-11.3)	0.563	3.0 (0.0-12.0)	3.5 (0.0-12.0)	0.683
Prognostic group						
Minimal/mild	234 (31%)	182 (35%)		172 (31%)	244 (34%)	
Moderate	266 (36%)	161 (31%)		192 (35%)	235 (33%)	
Severe	245 (33%)	176 (34%)	0.190	189 (34%)	232 (33%)	0.483
Age group						
18-35 years	282 (38%)	275 (53%)		190 (34%)	367 (52%)	
36-55 years	263 (35%)	165 (32%)		201 (36%)	227 (32%)	
56 years and over	200 (27%)	79 (15%)	<0.001	162 (29%)	117 (16%)	<0.001
Gender						
Male	213 (29%)	140 (27%)		159 (29%)	194 (27%)	
Female	530 (71%)	379 (73%)	0.510	392 (71%)	517 (73%)	0.537
Indigenous status						
Aboriginal/Torres Strait Islander/Aboriginal and Torres Strait Islander	17 (2%)	24 (5%)		8 (1%)	33 (5%)	
None of the above	728 (98%)	495 (95%)	0.024	545 (99%)	678 (95%)	0.001
Main language spoken at home						
English	732 (98%)	497 (96%)		548 (99%)	681 (96%)	
Other	13 (2%)	22 (4%)	0.009	5 (1%)	30 (4%)	<0.001
Highest level of education						
Year 12 or equivalent or less	234 (31%)	217 (42%)		161 (29%)	290 (41%)	
Certificate/diploma	253 (34%)	171 (33%)		188 (34%)	236 (33%)	
Bachelor's degree or higher	258 (35%)	131 (25%)	<0.001	204 (37%)	185 (26%)	<0.001
Employment status						

	Baseline to 6-month follow-up			Baseline to 12-month follow-up		
	Included (n=745)	**Not included (n=519)**	**p-value**	**Included (n=553)**	**Not included (n=711)**	**p-value**
Employed	489 (66%)	366 (71%)		370 (67%)	485 (68%)	
Unemployed	256 (34%)	153 (29%)	0.068	183 (33%)	226 (32%)	0.622
Manage on available income						
Easily/not too bad/difficult some of the time	640 (86%)	451 (87%)		472 (85%)	619 (87%)	
Difficult all the time/impossible	105 (14%)	68 (13%)	0.614	81 (15%)	92 (13%)	0.381
Health care card holder						
Yes	282 (38%)	214 (41%)		206 (37%)	290 (41%)	
No	463 (62%)	305 (59%)	0.226	347 (63%)	421 (59%)	0.201
Live alone						
Yes	136 (18%)	76 (15%)		106 (19%)	106 (15%)	
No	609 (82%)	443 (85%)	0.091	447 (81%)	605 (85%)	0.044
Self-rated health						
Excellent/very good/good	532 (71%)	337 (65%)		391 (71%)	478 (67%)	
Fair/poor	213 (29%)	182 (35%)	0.015	162 (29%)	233 (33%)	0.186
History of depression						
Yes	491 (66%)	323 (62%)		373 (67%)	441 (62%)	
No	254 (34%)	196 (38%)	0.180	180 (33%)	270 (38%)	0.046
Long-term illness or health problems which limit daily activities/work						
Yes	304 (41%)	177 (34%)		240 (43%)	241 (34%)	
No	441 (59%)	342 (66%)	0.016	313 (57%)	470 (66%)	0.001
Reason for visiting GP						
Physical health	298 (40%)	180 (35%)		230 (42%)	248 (35%)	
Mental health and wellbeing	447 (60%)	339 (65%)	0.055	323 (58%)	463 (65%)	0.015
Saw doctor/other health professional for psychological distress in last 4 weeks (K10+)						
Yes	311 (43%)	190 (38%)		227 (42%)	274 (40%)	
No	417 (57%)	314 (62%)	0.078	314 (58%)	417 (60%)	0.413
Currently taking medication for mental health						
Yes	369 (50%)	229 (44%)		281 (51%)	317 (45%)	

	Baseline to 6-month follow-up			Baseline to 12-month follow-up		
	Included (n=745)	**Not included (n=519)**	**p-value**	**Included (n=553)**	**Not included (n=711)**	**p-value**
No	376 (50%)	290 (56%)	0.058	272 (49%)	394 (55%)	0.028

SD, standard deviation. IQR, interquartile range. Data are mean (SD) or n (%). PHQ-9=Patient Health Questionnaire, 9-item version. EQ-5D-5L=EuroQol 5-dimensions. GAD-7=Generalized Anxiety Disorder scale, 7-item version. K10+=Four-item extension of the standard 10-item K10. n.a., not available due to small numbers in some cells.

[1] Denominators may vary due to missing data or the omission of categories due to small cell sizes.

[2] Among the subset of participants who reported any psychological distress at T0.

Appendix 11: Baseline characteristics of the three treatment groups (Study 4)

Table A11.1a: Baseline characteristics of participants across the 3 treatment groups for the Target-D cohort

	Baseline to 3-month follow-up (T0-T1) (n=577)				**Baseline to 12-month follow-up (T0-T2) (n=394)**			
	Better Access treatment (n=114)	**Other mental health care (n=280)**	**No mental health care (n=183)**	***p*-value**	**Better Access treatment (n=132)**	**Other mental health care (n=194)**	**No mental health care (n=68)**	***p*-value**
Depressive symptom severity (PHQ-9 total), mean (SD) [1]	11.2 (5.8)	9.8 (5.1)	7.1 (5.0)	<0.001	10.8 (5.7)	8.7 (4.9)	6.7 (4.1)	<0.001
Anxiety symptom severity (GAD-7 total), mean (SD) [1]	10.1 (5.3)	8.9 (4.7)	7.2 (4.8)	<0.001	9.8 (5.2)	8.0 (4.4)	6.9 (4.5)	<0.001
Quality of life (AQoL-8D utility weights), mean (SD) [1]	0.51 (0.19)	0.55 (0.18)	0.63 (0.19)	<0.001	0.53 (0.18)	0.58 (0.18)	0.64 (0.20)	<0.001
Prognostic group								
Minimal/mild	65 (57%)	191 (68%)	161 (88%)		83 (63%)	143 (74%)	64 (94%)	
Moderate	25 (22%)	61 (22%)	10 (5%)		24 (18%)	n.a.	n.a.	
Severe	24 (21%)	28 (10%)	12 (7%)	<0.001	25 (19%)	n.a.	n.a.	<0.001
Age group								
18-35 years	62 (54%)	144 (51%)	91 (50%)		76 (58%)	89 (46%)	29 (43%)	
36-55 years	40 (35%)	103 (37%)	68 (37%)		41 (31%)	75 (39%)	27 (40%)	
56 years and over	12 (11%)	33 (12%)	24 (13%)	0.939	15 (11%)	30 (15%)	12 (18%)	0.206
Gender								
Male	38 (33%)	77 (28%)	45(25%)		39 (30%)	45 (23%)	17 (25%)	
Female	74 (65%)	202 (72%)	137 (75%)	0.299	90 (68%)	148 (76%)	51 (75%)	0.375
Highest level of education								
Year 12 or equivalent or less	31 (27%)	86 (31%)	42 (23%)		32 (24%)	56 (29%)	17 (25%)	
Certificate/diploma	27 (24%)	65 (23%)	45 (25%)		35 (27%)	52 (27%)	16 (24%)	
Bachelor’s degree or higher	56 (49%)	129 (46%)	96 (52%)	0.486	65 (49%)	86 (44%)	35 (51%)	0.800
Employment status								
Employed	83 (75%)	183 (68%)	125 (73%)		95 (75%)	134 (72%)	47 (73%)	
Unemployed	27 (25%)	88 (32%)	46 (27%)	0.224	31 (25%)	53 (28%)	17 (27%)	0.764
Manage on available income								

	Baseline to 3-month follow-up (T0-T1) (n=577)				Baseline to 12-month follow-up (T0-T2) (n=394)			
	Better Access treatment (n=114)	**Other mental health care (n=280)**	**No mental health care (n=183)**	***p*-value**	**Better Access treatment (n=132)**	**Other mental health care (n=194)**	**No mental health care (n=68)**	***p*-value**
Easily/not too bad/difficult some of the time	99 (87%)	235 (84%)	170 (93%)		115 (87%)	170 (88%)	61 (90%)	
Difficult all the time/impossible	15 (13%)	45 (16%)	13 (7%)	0.018	17 (13%)	24 (12%)	7 (10%)	0.864
Receiving benefit or disability support								
Yes	19 (17%)	49 (18%)	20 (12%)		16 (13%)	30 (16%)	8 (13%)	
No	90 (83%)	222 (82%)	150 (88%)	0.191	109 (87%)	157 (84%)	55 (87%)	0.665
Health care card holder								
Yes	27 (25%)	81 (30%)	32 (19%)		32 (26%)	56 (30%)	8 (13%)	
No	81 (75%)	188 (70%)	137 (81%)	0.033	92 (74%)	130 (70%)	56 (88%)	0.021
Live alone								
Yes	12 (11%)	37 (13%)	20 (11%)		14 (11%)	31 (16%)	4 (6%)	
No	102 (89%)	243 (87%)	163 (89%)	0.662	118 (89%)	163 (84%)	64 (94%)	0.070
Self-rated health								
Excellent/very good/good	84 (74%)	209 (75%)	153 (84%)		101 (77%)	147 (76%)	56 (82%)	
Fair/poor	30 (26%)	71 (25%)	30 (16%)	0.047	31 (23%)	47 (24%)	12 (18%)	0.526
History of depression								
Yes	94 (82%)	188 (67%)	93 (51%)		107 (81%)	121 (62%)	30 (44%)	
No	20 (18%)	92 (33%)	90 (49%)	<0.001	25 (19%)	73 (38%)	38 (56%)	<0.001
Long-term illness or health problems which limit daily activities/work								
Yes	44 (39%)	92 (33%)	38 (21%)		45 (34%)	64 (33%)	11 (16%)	
No	70 (61%)	188 (67%)	145 (79%)	0.002	87 (66%)	130 (67%)	57 (84%)	0.019
Saw doctor/other health professional for mental health in last month								
Yes	89 (78%)	136 (49%)	42 (23%)		101 (77%)	76 (39%)	16 (24%)	
No	25 (22%)	144 (51%)	141 (77%)	0.000	31 (23%)	118 (61%)	52 (76%)	0.000
Currently taking an antidepressant								
Yes	43 (38%)	104 (37%)	5 (3%)		45 (34%)	n.a.	n.a.	
No	71 (62%)	176 (63%)	178 (97%)	<0.001	87 (66%)	n.a.	n.a.	<0.001

	Baseline to 3-month follow-up (T0-T1) (n=577)				**Baseline to 12-month follow-up (T0-T2) (n=394)**			
	Better Access treatment (n=114)	**Other mental health care (n=280)**	**No mental health care (n=183)**	***p*-value**	**Better Access treatment (n=132)**	**Other mental health care (n=194)**	**No mental health care (n=68)**	***p*-value**

SD, standard deviation. Data are n (%) unless otherwise stated. PHQ-9=Patient Health Questionnaire, 9-item version. AQoL-8D=Assessment of Quality of Life-8 Dimensions. GAD-7=Generalized Anxiety Disorder scale, 7-item version. K10+=Four-item extension of the standard 10-item K10. n.a., not available due to small numbers in some cells.

[1] Denominators may vary due to missing data or the omission of categories due to small cell sizes.

Table A11.1b: Baseline characteristics of participants across the 3 treatment groups for the Link-me cohort

	Baseline to 6-month follow-up (T0-T1) (n=718)				Baseline to 12-month follow-up (T0-T2) (n=547)			
	Better Access treatment (n=164)	**Other mental health care (n=329)**	**No mental health care (n=225)**	***p*-value**	**Better Access treatment (n=182)**	**Other mental health care (n=226)**	**No mental health care (n=139)**	***p*-value**
Depressive symptom severity (PHQ-9 total), mean (SD) [1]	12.9 (6.8)	10.7 (6.2)	8.1 (4.9)	<0.001	12.5 (6.6)	10.1 (6.1)	7.6 (4.6)	<0.001
Anxiety symptom severity (GAD-7 total), mean (SD) [1]	10.1 (5.7)	8.4 (5.5)	7.0 (4.7)	<0.001	9.9 (5.3)	7.8 (5.5)	6.5 (4.7)	<0.001
Quality of life (EQ-5D-5L utility weights), mean (SD) [1]	0.54 (0.30)	0.58 (0.26)	0.73 (0.20)	<0.001	0.56 (0.28)	0.59 (0.26)	0.75 (0.18)	<0.001
Total days out of role (K10+), median (IQR) [1,2]	7.3 (2.0-16.0)	4.0 (0.0-14.0)	1.0 (0.0-5.0)	<0.001	7.5 (2.0-16.0)	3.0 (0.0-13.0)	0.0 (0.0-3.5)	<0.001
Prognostic group								
Minimal/mild	26 (16%)	68 (21%)	128 (57%)		29 (16%)	55 (24%)	84 (60%)	
Moderate	53 (32%)	138 (42%)	64 (28%)		60 (33%)	95 (42%)	36 (26%)	
Severe	85 (52%)	123 (37%)	33 (15%)	<0.001	93 (51%)	76 (34%)	19 (14%)	<0.001
Age group								
18-35 years	69 (42%)	109 (33%)	98 (44%)		77 (42%)	58 (26%)	53 (38%)	
36-55 years	58 (35%)	122 (37%)	73 (32%)		61 (44%)	88 (39%)	49 (35%)	
56 years and over	37 (23%)	98 (30%)	54 (24%)	0.086	44 (24%)	80 (35%)	37 (27%)	0.006
Gender								
Male	46 (28%)	84 (26%)	73 (32%)		44 (24%)	61 (27%)	49 (35%)	
Female	117 (71%)	244 (74%)	152 (68%)	0.215	137 (75%)	164 (73%)	90 (65%)	0.087
Indigenous status								
Aboriginal or Torres Strait Islander or Aboriginal and Torres Strait Islander	4 (2%)	8 (2%)	5 (2%)		4 (2%)	n.a.	n.a.	
None of the above	160 (98%)	321 (98%)	220 (98%)	1.000	178 (98%)	n.a.	n.a.	0.667
Main language spoken at home								
English	n.a.	n.a.	n.a.		n.a.	n.a.	n.a.	
Other	n.a.	n.a.	n.a.	0.005	n.a.	n.a.	n.a.	0.020
Highest level of education								
Year 12 or equivalent or less	51 (31%)	97 (29%)	77 (34%)		52 (29%)	62 (27%)	44 (32%)	
Certificate/diploma	50 (30%)	128 (39%)	66 (29%)		63 (35%)	83 (37%)	42 (30%)	

	Baseline to 6-month follow-up (T0-T1) (n=718)				Baseline to 12-month follow-up (T0-T2) (n=547)			
	Better Access treatment (n=164)	**Other mental health care (n=329)**	**No mental health care (n=225)**	***p*-value**	**Better Access treatment (n=182)**	**Other mental health care (n=226)**	**No mental health care (n=139)**	***p*-value**
Bachelor's degree or higher	63 (38%)	104 (32%)	82 (36%)	0.132	67 (37%)	81 (36%)	53 (38%)	0.785
Employment status								
Employed	99 (60%)	205 (62%)	170 (76%)		111 (61%)	146 (65%)	107 (77%)	
Unemployed	65 (40%)	124 (38%)	55 (24%)	0.001	71 (39%)	80 (35%)	32 (23%)	0.008
Manage on available income								
Easily/not too bad/difficult some of the time	130 (79%)	282 (86%)	205 (91%)		145 (80%)	194 (86%)	127 (91%)	
Difficult all the time/impossible	34 (21%)	47 (14%)	20 (9%)	0.004	37 (20%)	32 (14%)	12 (9%)	0.013
Health care card holder								
Yes	68 (41%)	130 (40%)	73 (32%)		73 (40%)	86 (38%)	46 (33%)	
No	96 (59%)	199 (60%)	152 (68%)	0.129	109 (60%)	140 (62%)	93 (67%)	0.425
Live alone								
Yes	33 (20%)	62 (19%)	34 (15%)		37 (20%)	44 (19%)	24 (17%)	
No	131 (80%)	267 (81%)	191 (85%)	0.380	145 (80%)	182 (81%)	115 (83%)	0.781
Self-rated health								
Excellent/very good/good	101 (62%)	225 (68%)	185 (82%)		113 (62%)	157 (69%)	116 (83%)	
Fair/poor	63 (38%)	104 (32%)	40 (18%)	<0.001	69 (38%)	69 (31%)	23 (17%)	<0.001
History of depression								
Yes	131 (80%)	249 (76%)	95 (42%)		146 (80%)	170 (75%)	54 (39%)	
No	33 (20%)	80 (24%)	130 (58%)	<0.001	36 (20%)	56 (25%)	85 (61%)	<0.001
Long-term illness or health problems which limit daily activities/work								
Yes	83 (51%)	152 (46%)	59 (26%)		92 (51%)	107 (47%)	40 (29%)	
No	81 (49%)	177 (54%)	166 (74%)	<0.001	90 (49%)	119 (53%)	99 (71%)	<0.001
Reason for visiting GP								
Mental health and wellbeing (+/- physical health)	102 (62%)	161 (49%)	26 (12%)		105 (58%)	109 (48%)	15 (11%)	
Not mental health (physical health only or neither)	62 (38%)	168 (51%)	199 (88%)	<0.001	77 (42%)	117 (52%)	124 (89%)	<0.001
Saw doctor/other health professional for psychological distress in last 4 weeks (K10+)								
Yes	106 (65%)	156 (49%)	38 (17%)		118 (66%)	88 (40%)	20 (15%)	

	Baseline to 6-month follow-up (T0-T1) (n=718)				Baseline to 12-month follow-up (T0-T2) (n=547)			
	Better Access treatment (n=164)	**Other mental health care (n=329)**	**No mental health care (n=225)**	***p*-value**	**Better Access treatment (n=182)**	**Other mental health care (n=226)**	**No mental health care (n=139)**	***p*-value**
No	56 (35%)	165 (51%)	181 (83%)	<0.001	62 (34%)	133 (60%)	115 (85%)	<0.001
Currently taking medication for mental health								
Yes	101 (62%)	234 (71%)	24 (11%)		108 (59%)	158 (70%)	15 (11%)	
No	63 (38%)	95 (29%)	201 (89%)	<0.001	74 (41%)	68 (30%)	124 (89%)	<0.001

SD, standard deviation. IQR, interquartile range. Data are n (%) unless otherwise stated. PHQ-9=Patient Health Questionnaire, 9-item version. GAD-7=Generalized Anxiety Disorder scale, 7-item version. EQ-5D-5L=EuroQol 5-dimensions. K10+=Four-item extension of the standard 10-item K10.

[1] Denominators may vary due to missing data.

[2] Among the subset of participants who reported any psychological distress at T0.

Table A11.2a: Type of services used for mental health among participants who used Other mental health care but did not use Better Access treatment services, by age group, for the Target-D cohort

	BASELINE TO 3-MONTH FOLLOW-UP (N=280)				BASELINE TO 12-MONTH FOLLOW-UP (N=194)			
	18-35 years (n=144)	**36-55 years (n=103)**	**56 years and over (n=33)**	***p*-value**	**18-35 years (n=114)**	**36-55 years (n=280)**	**56 years and over (n=183)**	***p*-value**
Primary care [a]								
Yes	113 (78%)	83 (81%)	21 (64%)		81 (91%)	64 (85%)	24 (80%)	
No	31 (22%)	20 (19%)	12 (36%)	0.118	8 (9%)	11 (15%)	6 (20%)	0.251
Mental health specialist or service [b] or Other professional or service [c]								
Yes	54 (38%)	34 (33%)	12 (36%)		36 (40%)	35 (47%)	8 (27%)	
No	90 (63%)	69 (67%)	21 (64%)	0.766	53 (60%)	40 (53%)	22 (73%)	0.169
Any medication taken for mental health [d]								
Yes	55 (38%)	45 (44%)	19 (58%)		31 (35%)	33 (44%)	15 (50%)	
No	89 (62%)	58 (56%)	14 (42%)	0.121	58 (65%)	42 (56%)	15 (50%)	0.261

Data are n (%). Percentages are within age group.

[a] Visits to a GP in a GP clinic or private practice.

[b] Visits to a psychiatrist, psychologist or alcohol or drug worker in any location; mental health-related overnight stay in hospital. Does not include Better Access treatment services.

[c] Visits to a counsellor, social worker, family therapist in any location; GP in any location other than GP clinic or private practice; mental health-related emergency department visit.

[d] Includes the following categories: antidepressants, anxiolytics, hypnotics and sedatives, antipsychotics, psychostimulants and nootropics; and antiepileptics.

Table A11.2b: Results of ad hoc analyses of the types of services used for mental health among the Other mental health care group, by age group, for the Link-me cohort

	BASELINE TO 3-MONTH FOLLOW-UP (N=329)				BASELINE TO 12-MONTH FOLLOW-UP (N=226)			
	18-35 years (n=109)	**36-55 years (n=122)**	**56 years and over (n=98)**	***p*-value**	**18-35 years (n=58)**	**36-55 years (n=88)**	**56 years and over (n=80)**	***p*-value**
Primary care [a]								
Yes	64 (59%)	75 (61%)	49 (50%)		42 (72%)	66 (75%)	50 (63%)	
No	45 (41%)	47 (39%)	49 (50%)	0.214	16 (28%)	22 (25%)	30 (38%)	0.188
Mental health specialist or service [b] or Other professional or service [c]								
Yes	55 (51%)	55 (46%)	27 (28%)		31 (54%)	49 (56%)	24 (30%)	
No	53 (49%)	65 (54%)	69 (72%)	0.003	26 (46%)	39 (44%)	55 (70%)	0.002
Any medication taken for mental health [d]								
Yes	60 (55%)	90 (74%)	82 (84%)		33 (57%)	64 (73%)	72 (90%)	
No	49 (45%)	32 (26%)	16 (16%)	<0.001	25 (43%)	24 (27%)	8 (10%)	<0.001

Data are n (%). Percentages are within age group.

[a] Visits to a GP or nurse/mental health nurse in GP clinic or private practice location.

[b] 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.

[c] 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.

[d] Includes the following categories: antidepressants, anxiolytics, hypnotics and sedatives, antipsychotics, psychostimulants and nootropics; and antiepileptics.

Appendix 12: Changes in symptoms, quality of life and functioning (Study 4)

Table A12.1. Change scores and classification of change for the Target-D and Link-me cohorts, total and stratified by prognostic group

	Target-D				Link-me			
	Minimal/ mild	Moderate	Severe	Total	Minimal/ mild	Moderate	Severe	Total
Depression symptom severity (PHQ-9)								
Baseline to 3-months/6-months (T0-T1)	n=65	n=24	n=24	n=113	n=26	n=53	n=85	n=164
T0 score, mean (SD)	7.2 (3.2)	14.3 (2.7)	18.6 (3.5)	11.1 (5.8)	5.9 (2.3)	8.3 (4.0)	17.9 (5.0)	12.9 (6.8)
Significant improvement, % (95%CI)	32% (22, 44)	58% (39, 76)	54% (35, 72)	42% (34, 52)	27% (14, 46)	45% (33, 59)	59% (48, 69)	49% (42, 57)
No significant change, % (95%CI)	25% (16, 36)	4% (1, 20)	17% (7, 36)	19% (12, 27)	27% (14, 46)	21% (12, 33)	20% (13, 30)	21% (16, 28)
Significant deterioration, % (95%CI)	43% (32, 55)	38% (21, 57)	29% (15, 49)	39% (30, 48)	46% (29, 65)	34% (23, 47)	21% (14, 31)	29% (23, 37)
Baseline to 12-months (T0-T2)	n=82	n=24	n=25	n=131	n=29	n=60	n=93	n=182
T0 score, mean (SD)	7.3 (3.2)	14.2 (2.7)	19.2 (3.4)	10.9 (5.8)	5.7 (2.4)	8.2 (4.0)	17.5 (4.7)	12.6 (6.6)
Significant improvement, % (95%CI)	43% (33, 53)	50% (31, 69)	52% (34, 70)	46% (38, 54)	31% (17, 49)	38% (27, 51)	58% (48, 68)	47% (40, 54)
No significant change, % (95%CI)	27% (18, 37)	21% (9, 40)	24% (12, 43)	25% (19, 33)	31% (17, 49)	30% (20, 43)	22% (14, 31)	26% (20,33)
Significant deterioration, % (95%CI)	30% (22, 41)	29% (15, 49)	24% (12, 43)	29% (22, 37)	38% (22, 56)	32% (21, 44)	20% (13, 30)	27% (21, 34)
Anxiety symptom severity (GAD-7)								
Baseline to 3-months/6-months (T0-T1)	n=62	n=24	n=23	n=109	n=26	n=53	n=85	n=164
T0 score, mean (SD)	8.0 (4.6)	11.2 (4.5)	14.2 (4.9)	10.0 (5.2)	5.8 (2.0)	6.5 (4.7)	13.7 (4.5)	10.1 (5.7)
Significant improvement, % (95%CI)	34% (23, 46)	46% (28, 65)	57% (37, 74)	41% (32, 51)	19% (9, 38)	34% (23, 47)	64% (53, 73)	47% (39, 55)
No significant change, % (95%CI)	34% (23, 46)	8% (2, 26)	26% (13, 46)	27% (19, 36)	31% (17, 50)	32% (21, 45)	20% (13, 30)	26% (20, 33)
Significant deterioration, % (95%CI)	32% (22, 45)	46% (28, 65)	17% (7, 39)	32% (24, 41)	50% (32, 68)	34% (23, 47)	16% (10, 26)	27% (21, 35)
Baseline to 12-months (T0-T2)	n=76	n=22	n=21	n=119	n=29	n=60	n=93	n=182
T0 score, mean (SD)	7.8 (4.1)	12.5 (4.7)	14.0 (4.9)	9.7 (5.1)	6.3 (2.7)	6.5 (4.4)	13.1 (4.3)	9.9 (5.3)
Significant improvement, % (95%CI)	55% (44, 66)	55% (35, 73)	57% (37, 76)	55% (46, 64)	38% (23, 56)	40% (29, 53)	57% (47, 67)	48% (41, 56)
No significant change, % (95%CI)	25% (17, 36)	18% (7, 39)	19% (8, 40)	23% (16, 31)	45% (28, 62)	28% (19, 41)	23% (15, 32)	28% (22, 35)
Significant deterioration, % (95%CI)	20% (12, 30)	27% (13, 48)	24% (11, 45)	22% (15, 30)	17% (8, 35)	32% (21, 44)	20% (13, 30)	24% (18, 30)
Quality of life (AQoL-8D in Target-D, EQ-5D-5L in Link-me)								

	Target-D				Link-me			
	Minimal/ mild	**Moderate**	**Severe**	**Total**	**Minimal/ mild**	**Moderate**	**Severe**	**Total**
Baseline to 3-months/6-months (T0-T1)	n=61	n=23	n=23	n=107	n=26	n=53	n=83	n=162
T0 score, mean (SD)	0.63 (0.15)	0.39 (0.09)	0.31 (0.09)	0.51 (0.19)	0.76 (0.13)	0.69 (0.21)	0.37 (0.30)	0.54 (0.30)
Significant improvement, % (95%CI)	33% (22, 45)	61% (41, 78)	43% (26, 63)	41% (32, 51)	23% (11, 42)	38% (26, 51)	48% (38, 59)	41% (33, 48)
No significant change, % (95%CI)	41% (30, 54)	26% (13, 46)	39% (22, 59)	37% (29, 47)	27% (14, 46)	23% (13, 36)	28% (19, 38)	26% (20, 33)
Significant deterioration, % (95%CI)	26% (17, 38)	13% (5, 32)	17% (7, 37)	22% (15, 30)	50% (32, 68)	40% (28, 53)	24% (16, 34)	33% (27, 41)
Baseline to 12-months (T0-T2)	n=75	n=22	n=21	n=118	n=29	n=60	n=92	n=181
T0 score, mean (SD)	0.62 (0.16)	0.41 (0.09)	0.32 (0.09)	0.53 (0.19)	0.73 (0.16)	0.70 (0.20)	0.41 (0.28)	0.56 (0.28)
Significant improvement, % (95%CI)	40% (30, 51)	55% (35, 73)	48% (28, 68)	44% (35 ,53)	31% (17, 49)	30% (20, 43)	54% (44, 64)	43% (36, 50)
No significant change, % (95%CI)	25% (17, 36)	14% (5, 33)	29% (14, 50)	24% (17, 32)	34% (20, 53)	43% (32, 56)	15% (9, 24)	28% (22, 35)
Significant deterioration, % (95%CI)	35% (25, 46)	32% (16, 53)	24% (11, 45)	32% (24, 41)	34% (20, 53)	27% (17, 39)	30% (22, 40)	30% (24, 37)
Days out of role due to psychological distress (K10+) [1]								
Baseline to 6-months (T0-T1)	n.a.	n.a.	n.a.	n.a.	n=26	n=51	n=85	n=162
T0 (days), mean (SD)					4.3 (5.7)	6.2 (6.1)	13.8 (9.2)	9.9 (8.9)
Significant improvement, % (95%CI)					19% (8, 37)	40% (28, 53)	49% (39, 59)	41% (34, 49)
No significant change, % (95%CI)					41% (25, 51)	38% (26, 51)	30% (22, 41)	23% (28, 42)
Significant deterioration, % (95%CI)					41% (25, 59)	23% (13, 36)	21% (14, 31)	25% (19, 32)
Baseline to 12-months (T0-T2)	n.a.	n.a.	n.a.	n.a.	n=29	n=58	n=93	n=180
T0 (days), mean (SD)					4.7 (5.7)	5.6 (6.1)	14.0 (8.7)	9.8 (8.7)
Significant improvement, % (95%CI)					30% (17, 48)	43% (31, 56)	55% (45, 65)	47% (40, 54)
No significant change, % (95%CI)					40% (25, 58)	28% (18, 40)	18% (13, 29)	25% (20, 32)
Significant deterioration, % (95%CI)					30% (17, 48)	29% (18, 36)	26% (18, 36)	28% (22, 35)
Any of: depression symptom severity (PHQ-9), anxiety symptom severity (GAD-7), or quality of life (AQoL/EQ-5D-5L)								
Baseline to 6-months (T0-T1)	n=61	n=23	n=23	n=107	n=26	n=53	n=83	n=162
Significant improvement, % (95%CI)	54% (42, 66)	74% (53, 87)	70% (49, 84)	62% (52, 70)	38% (22, 57)	66% (53, 77)	80% (70, 87)	69% (61, 75)
Baseline to 12-months (T0-T2)	n=75	n=22	n=21	n=118	n=29	n=60	n=92	n=181
Significant improvement, % (95%CI)	68% (57, 77)	68% (47, 84)	67% (45, 83)	68% (59, 76)	52% (34, 69)	63% (51, 74)	80% (71, 87)	70% (63, 76)

	Target-D				Link-me			
	Minimal/ mild	Moderate	Severe	Total	Minimal/ mild	Moderate	Severe	Total
Any of: depression symptom severity (PHQ-9), anxiety symptom severity (GAD-7), or quality of life (EQ-5D-5L) or Days out of role due to psychological distress (K10+) [1]								
Baseline to 6-months (T0-T1)	n.a.	n.a.	n.a.	n.a.	n=26	n=51	n=83	n=160
Significant improvement, % (95%CI)					46% (29, 65)	80% (68, 89)	87% (78, 92)	78% (71, 84)
Baseline to 12-months (T0-T2)	n.a.	n.a.	n.a.	n.a.	n=29	n=58	n=92	n=179
Significant improvement, % (95%CI)					66% (47, 80)	78% (65, 86)	86% (77, 92)	80% (73, 85)

SD, standard deviation. 95%CI, 95% confidence interval. IQR, interquartile range. n.a., not available because the measure was not collected in the cohort. PHQ-9=Patient Health Questionnaire, 9-item version. GAD-7=Generalized Anxiety Disorder scale, 7-item version. AQoL-8D=Assessment of Quality of Life-8 Dimensions. EQ-5D-5L=EuroQol 5-dimensions, K10+=extended version of the Kessler Psychological Distress scale. Percentages may not sum to 100 due to rounding.

[1] Among the subset of participants who reported any psychological distress at T0.

Appendix 13: Predictors of use of Better Access treatment services between T0 and T1 (Study 5)

Table A13.1: Multivariable regression investigating the association between sociodemographic, clinical and treatment variables and use of Better Access treatment services^{a,b}

		TEN TO MEN		**ALSWH 1989-95 COHORT**		**ALSWH 1973-78 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)**
N		**Better Access users = 243; Better Access non-users = 2050**	**Better Access users = 358; Better Access non-users = 1192**	**Better Access users = 278; Better Access non-users = 1907**	**Better Access users = 254; Better Access non-users = 1802**	**Better Access users = 540; Better Access non-users = 1606**	**Better Access users = 646; Better Access non-users = 1758**	**Better Access users = 1562; Better Access non-users = 5417**	**Better Access users = 2121; Better Access non-users = 2622**
Sociodemographic	Mean age, years	0.98 (0.97-1.00)	**0.97 (0.96-0.98)**	0.97 (0.88-1.06)	0.95 (0.86-1.05)	0.98 (0.92-1.06)	**0.89 (0.83-0.96)**	**1.05 (1.00-1.09)**	0.99 (0.95-1.03)
	Aboriginal or Torres Strait Islander								
	Yes	1.00	1.00	N/A	N/A	N/A	N/A	N/A	N/A
	No	1.33 (0.56-3.16)	1.13 (0.46-2.76)	N/A	N/A	N/A	N/A	N/A	N/A
	Highest level of education received								
	Year 11 or less	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Year 12 or equivalent	1.33 (0.76-2.36)	1.35 (0.78-2.32)	1.40 (0.94-2.07)	1.01 (0.65-1.58)	0.91 (0.52-1.59)	**2.22 (1.26-3.91)**	0.98 (0.75-1.29)	**1.61 (1.08-2.37)**
	Certificate/diploma	1.15 (0.72-1.83)	1.24 (0.78-1.96)	**1.49 (1.02-2.17)**	**1.92 (1.32-2.80)**	1.57 (0.96-2.56)	**2.00 (1.20-3.32)**	0.88 (0.66-1.17)	1.27 (0.86-1.88)
	Bachelor's degree or higher	1.35 (0.81-2.24)	1.16 (0.71-1.88)	**1.99 (1.34-2.94)**	**1.90 (1.27-2.83)**	**1.64 (1.01-2.65)**	**2.25 (1.36-3.70)**	0.79 (0.59-1.08)	**1.63 (1.11-2.41)**
	Country of birth								
	Australia	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Other	0.71 (0.45-1.11)	**0.60 (0.41-0.88)**	0.74 (0.51-1.07)	**0.64 (0.43-0.95)**	1.13 (0.73-1.75)	1.05 (0.70-1.56)	0.94 (0.74-1.20)	0.87 (0.68-1.11)
	Area of residence								

		TEN TO MEN		ALSWH 1989-95 COHORT		ALSWH 1973-78 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)**
N		**Better Access users = 243; Better Access non-users = 2050**	**Better Access users = 358; Better Access non-users = 1192**	**Better Access users = 278; Better Access non-users = 1907**	**Better Access users = 254; Better Access non-users = 1802**	**Better Access users = 540; Better Access non-users = 1606**	**Better Access users = 646; Better Access non-users = 1758**	**Better Access users = 1562; Better Access non-users = 5417**	**Better Access users = 2121; Better Access non-users = 2622**
	Metropolitan	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Regional	1.16 (0.75-1.81)	0.77 (0.51-1.16)	0.82 (0.60-1.12)	0.73 (0.53-1.01)	**0.73 (0.57-0.94)**	0.88 (0.69-1.12)	0.90 (0.76-1.08)	**0.83 (0.69-0.99)**
	Rural	1.03 (0.72-1.46)	0.81 (0.59-1.10)	**0.50 (0.33-0.77)**	**0.63 (0.41-0.97)**	**0.52 (0.36-0.73)**	**0.58 (0.42-0.80)**	**0.54 (0.40-0.73)**	**0.57 (0.44-0.74)**
Clinical	Prognostic severity								
	Minimal/mild	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Moderate	**1.67 (1.07-2.62)**	0.93 (0.62-1.38)	1.46 (0.93-2.29)	1.45 (0.89-2.36)	1.27 (0.92-1.73)	1.27 (0.94-1.72)	**1.27 (1.03-1.57)**	1.07 (0.88-1.30)
	Severe	**1.66 (1.07-2.57)**	1.09 (0.75-1.57)	**1.63 (1.10-2.43)**	**2.11 (1.40-3.16)**	**1.87 (1.41-2.48)**	**1.95 (1.49-2.56)**	**1.69 (1.42-2.01)**	**1.51 (1.27-1.78)**
	History of depression (lifetime)								
	Yes	**1.77 (1.16-2.69)**	**1.78 (1.28-2.46)**	1.51 (0.67-3.41)	1.88 (0.66-5.37)	**1.63 (1.07-2.49)**	**2.18 (1.31-3.63)**	**2.03 (1.57-2.63)**	**1.60 (1.29-1.97)**
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	History of anxiety (lifetime)								
	Yes	**2.14 (1.49-3.09)**	**1.85 (1.35-2.53)**	**2.38 (1.74-3.24)**	1.11 (0.80-1.54)	**2.29 (1.82-2.88)**	**2.05 (1.65-2.55)**	**2.44 (1.99-2.98)**	**2.01 (1.68-2.41)**
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Treatment	Currently taking any medication for mental health								
	Yes	**1.74 (1.21-2.51)**	**1.47 (1.03-2.09)**	1.31 (0.96-1.76)	**1.70 (1.25-2.30)**	**1.63 (1.25-2.11)**	**2.02 (1.59-2.55)**	**2.87 (2.46-3.34)**	**2.47 (2.02-2.95)**
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Elapsed days between survey waves		0.99 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)	0.99 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (1.00-1.00)	1.00 (1.00-1.00)

a. Results reported as odds ratios and 95% confidence intervals
b. Shaded cells indicate statistically significant results

Appendix 14: Predictors of improvement and deterioration in mental health between T0 and T1 (Study 5)

Table A14.1: Multivariable regression investigating the association between sociodemographic, clinical and treatment variables and improvement in mental health between T0 and T1[a,b]

		TEN TO MEN		ALSWH 1989-95 COHORT		ALSWH 1973-78 COHORT				ALSWH 1946-51 COHORT			
		PHQ-9		K-10		CES-D		GAD-7		CES-D		GAD-7	
		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)	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)
Sociodemographic	Mean age, years	0.99 (0.96-1.03)	1.02 (0.99-1.04)	0.98 (0.91-1.06)	1.00 (0.94-1.06)	0.91 (0.80-1.05)	0.97 (0.85-1.10)	1.07 (0.94-1.23)	0.91 (0.80-1.02)	**0.78 (0.62-0.97)**	1.04 (0.85-1.28)	0.96 (0.79-1.17)	0.82 (0.67-1.01)
	Aboriginal or Torres Strait Islander												
	Yes	3.37 (0.42-26.53)	0.74 (0.14-3.83)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	No	1.00	1.00	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												
	Year 11 or less	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Year 12 or equivalent	1.85 (0.53-6.37)	0.86 (0.31-2.34)	1.08 (0.67-1.73)	**2.41 (1.25-4.65)**	0.99 (0.34-2.90)	2.06 (0.71-5.93)	0.86 (0.30-2.48)	2.16 (0.78-5.91)	**2.83 (1.14-7.01)**	0.49 (0.18-1.28)	1.42 (0.63-3.18)	0.59 (0.23-1.49)
	Certificate/diploma	2.20 (0.79-6.07)	0.64 (0.27-1.48)	1.31 (0.79-2.16)	1.85 (0.96-3.56)	0.82 (0.33-2.06)	1.42 (0.55-3.65)	0.76 (0.31-1.86)	1.01 (0.41-2.45)	2.43 (0.99-5.95)	2.09 (0.95-4.61)	1.85 (0.83-4.13)	1.24 (0.57-2.69)
	Bachelor's degree or higher	1.72 (0.56-5.25)	1.10 (0.44-2.72)	1.13 (0.66-1.95)	**2.48 (1.29-4.79)**	0.87 (0.35-2.16)	1.34 (0.52-3.43)	1.10 (0.45-2.67)	0.79 (0.32-1.92)	2.24 (0.88-5.66)	1.36 (0.56-3.27)	2.23 (0.95-5.20)	1.60 (0.68-3.75)
	Country of birth												
	Australia	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00

	Other	0.95 (0.34-2.66)	1.30 (0.63-2.68)	**0.59 (0.37-0.94)**	**0.60 (0.40-0.89)**	**0.41 (0.17-0.98)**	1.91 (0.94-3.90)	0.98 (0.47-2.06)	**2.01 (1.02-3.96)**	0.50 (0.23-1.10)	0.83 (0.35-1.93)	0.50 (0.24-1.07)	0.92 (0.41-2.09)
	Area of residence												
	Metropolitan	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Regional	0.68 (0.25-1.83)	0.68 (0.25-1.83)	0.95 (0.69-1.30)	1.01 (0.77-1.33)	1.17 (0.71-1.92)	0.76 (0.49-1.17)	0.84 (0.52-1.35)	0.99 (0.66-1.49)	0.77 (0.38-1.54)	1.07 (0.53-2.15)	1.20 (0.63-2.27)	0.70 (0.35-1.40)
	Rural	1.23 (0.56-2.66)	1.23 (0.56-2.66)	1.62 (0.91-2.89)	1.01 (0.65-1.55)	1.51 (0.76-2.97)	1.38 (0.75-2.56)	1.55 (0.81-2.97)	1.27 (0.71-2.28)	1.10 (0.41-2.99)	0.46 (0.17-1.22)	0.78 (0.32-1.94)	1.00 (0.39-2.53)
Clinical	Prognostic severity												
	Minimal/mild	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Moderate	1.04 (0.40-2.73)	1.34 (0.66-2.74)	1.39 (0.91-2.11)	**2.05 (1.49-2.83)**	**5.24 (2.55-10.75)**	**3.07 (1.62-5.80)**	1.60 (0.89-2.88)	1.40 (0.81-2.42)	**15.14 (4.08-56.26)**	2.01 (0.63-6.32)	1.62 (0.62-4.25)	0.78 (0.25-2.41)
	Severe	**8.86 (3.34-23.47)**	**2.32 (1.17-4.59)**	**4.44 (3.13-6.27)**	**3.96 (3.01-5.22)**	**8.61 (4.38-16.91)**	**7.76 (4.33-13.90)**	1.15 (0.68-1.94)	1.13 (0.70-1.83)	**23.16 (6.69-80.11)**	**2.96 (1.13-7.78)**	0.98 (0.42-2.26)	0.65 (0.25-1.64)
	History of depression (lifetime)												
	Yes	1.09 (0.43-2.73)	1.45 (0.80-2.64)	0.82 (0.46-1.45)	0.79 (0.53-1.18)	0.42 (0.17-1.07)	**0.42 (0.20-0.90)**	0.74 (0.31-1.71)	0.97 (0.49-1.91)	0.08 (0.01-1.24)	0.09 (0.01-1.21)	0.20 (0.01-2.61)	-
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	History of anxiety (lifetime)												
	Yes	0.53 (0.23-1.21)	0.72 (0.40-1.29)	**1.57 (1.02-2.42)**	1.32 (0.95-1.85)	0.95 (0.61-1.47)	1.46 (0.98-2.18)	1.16 (0.76-1.76)	1.19 (0.81-1.74)	1.29 (0.64-2.61)	0.67 (0.33-1.36)	0.84 (0.44-1.59)	0.53 (0.26-1.06)
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Better Access treatment	Number of treatment sessions												
	1-2	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	3-4	1.14 (0.38-3.34)	0.50 (0.22-1.14)	0.89 (0.62-1.29)	1.10 (0.76-1.59)	1.17 (0.61-2.26)	0.77 (0.41-1.41)	0.58 (0.31-1.08)	0.73 (0.41-1.29)	0.80 (0.31-2.02)	0.82 (0.35-1.92)	0.85 (0.36-1.99)	0.44 (0.18-1.03)
	5-6	0.68 (0.24-1.87)	0.60 (0.28-1.28)	0.91 (0.62-1.33)	0.83 (0.57-1.20)	1.00 (0.50-1.98)	0.91 (0.46-1.77)	**0.50 (0.26-0.95)**	0.71 (0.38-1.33)	1.01 (0.36-2.78)	1.18 (0.47-2.98)	0.61 (0.25-1.50)	1.04 (0.40-2.64)
	7-10	1.17 (0.43-3.17)	0.46 (0.20-1.04)	**0.67 (0.46-0.96)**	0.93 (0.66-1.32)	0.73 (0.36-1.44)	0.68 (0.36-1.25)	**0.50 (0.26-0.96)**	0.61 (0.34-1.09)	**0.32 (0.11-0.87)**	1.44 (0.52-3.93)	0.43 (0.17-1.06)	0.57 (0.22-1.51)
	11-20	1.85 (0.62-5.52)	**0.30 (0.13-0.69)**	**0.61 (0.42-0.90)**	0.78 (0.55-1.10)	1.30 (0.65-2.59)	**0.45 (0.24-0.84)**	**0.43 (0.22-0.83)**	0.59 (0.33-1.05)	0.38 (0.12-1.13)	2.37 (0.78-7.16)	0.45 (0.16-1.20)	0.62 (0.22-1.76)

	21-100	-	0.57 (0.21-1.53)	0.70 (0.30-1.63)	0.90 (0.61-1.32)	1.01 (0.44-2.29)	0.51 (0.24-1.07)	0.47 (0.21-1.06)	0.55 (0.27-1.12)	1.74 (0.41-7.26)	1.72 (0.41-7.19)	**0.13 (0.03-0.60)**	0.54 (0.13-2.11)
	Received treatment from clinical psychologist												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	0.77 (0.16-3.72)	0.86 (0.40-1.87)	0.94 (0.63-1.42)	0.99 (0.76-1.29)	1.18 (0.63-2.21)	1.20 (0.63-2.28)	1.01 (0.54-1.87)	1.28 (0.69-2.36)	0.98 (0.27-3.52)	**0.21 (0.05-0.79)**	0.87 (0.27-2.78)	1.81 (0.54-6.07)
	Received treatment from psychologist												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	0.76 (0.15-3.70)	0.79 (0.36-1.72)	0.88 (0.58-1.32)	**0.74 (0.56-0.96)***	1.48 (0.79-2.78)	1.13 (0.59-2.18)	0.94 (0.50-1.75)	1.14 (0.60-2.13)	0.82 (0.23-2.90)	0.34 (0.09-1.29)	0.78 (0.25-2.45)	1.40 (0.41-4.80)
	Received treatment from social worker												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	1.96 (0.30-12.78)	0.45 (0.14-1.45)	0.76 (0.39-1.45)	1.09 (0.72-1.66)	1.28 (0.53-3.03)	1.42 (0.58-3.44)	0.78 (0.33-1.79)	0.83 (0.35-1.97)	0.60 (0.12-2.99)	1.91 (0.38-9.52)	1.38 (0.30-6.29)	1.91 (0.41-4.80)
	Received treatment from occupational therapist												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	-	-	0.34 (0.08-1.44)	0.77 (0.29-1.99)	0.63 (0.05-7.86)	1.70 (0.38-7.50)	-	1.81 (0.44-7.39)	-	-	0.20 (0.01-7.27)	0.80 (0.03-16.74)
	Received treatment from general practitioner												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	-	2.10 (0.12-35.10)	1.28 (0.43-3.82)	1.48 (0.51-4.25)	0.41 (0.04-4.26)	2.65 (0.33-21.21)	2.21 (0.31-15.51)	6.30 (0.63-62.53)	1.52 (0.13-17.07)	0.22 (0.01-2.91)	0.67 (0.07-6.33)	2.19 (0.14-33.83)
	Paid any out of pocket cost												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	1.56 (0.73-3.35)	0.81 (0.48-1.36)	1.11 (0.87-1.41)	**1.33 (1.06-1.68)**	**1.61 (1.01-2.57)**	1.01 (0.66-1.54)	0.86 (0.55-1.34)	1.26 (0.84-1.88)	**2.08 (1.05-4.10)**	0.78 (0.41-1.49)	0.98 (0.54-1.79)	1.14 (0.60-2.18)

Other treatment	Currently taking any medication for mental health												
	Yes	0.87 (0.39-1.93)	0.91 (0.48-1.73)	**1.33 (1.03-1.71)**	0.93 (0.74-1.16)	0.76 (0.48-1.21)	0.86 (0.57-1.27)	0.67 (0.43-1.05)	0.98 (0.67-1.44)	0.80 (0.41-1.56)	0.91 (0.46-1.78)	0.85 (0.46-1.58)	1.10 (0.57-2.10)
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Elapsed days between survey waves		0.99 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)	0.99 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)	0.99 (0.99-1.00)	1.00 (0.99-1.00)	0.99 (0.99-1.00)	0.99 (0.99-1.00)	0.99 (0.99-1.00)	0.99 (0.99-1.00)

a. Results reported as odds ratios and 95% confidence intervals
b. Shaded cells indicate statistically significant results

Table A14.2: Multivariable regression investigating the association between sociodemographic, clinical and treatment variables and deterioration in mental health between T0 and T1^{a,b}

		TEN TO MEN		ALSWH 1989-95 COHORT		ALSWH 1973-78 COHORT				ALSWH 1946-51 COHORT			
		PHQ-9		K-10		CES-D		GAD-7		CES-D		GAD-7	
		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)	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)
Sociodemographic	Mean age, years	1.00 (0.97-1.04)	0.97 (0.95-1.00)	0.96 (0.88-1.04)	0.96 (0.89-1.02)	1.03 (0.90-1.18)	1.02 (0.90-1.16)	1.01 (0.88-1.16)	**1.15 (1.01-1.31)**	**1.32 (1.03-1.69)**	0.87 (0.68-1.11)	1.12 (0.90-1.39)	1.08 (0.84-1.38)
	Aboriginal or Torres Strait Islander												
	Yes	1.29 (0.15-11.11)	1.04 (0.21-5.15)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	No	1.00	1.00	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												
	Year 11 or less	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Year 12 or equivalent	0.26 (0.06-1.02)	1.75 (0.54-5.63)	1.14 (0.66-1.95)	**0.49 (0.26-0.92)**	1.43 (0.43-4.67)	0.43 (0.15-1.25)	2.32 (0.62-8.57)	0.86 (0.27-2.75)	0.75 (0.29-1.89)	2.11 (0.76-5.82)	0.89 (0.37-2.15)	1.91 (0.67-5.46)
	Certificate/diploma	0.43 (0.15-1.26)	2.30 (0.83-6.40)	0.77 (0.43-1.38)	0.53 (0.28-1.01)	2.28 (0.82-6.33)	0.57 (0.22-1.44)	2.62 (0.82-8.37)	1.10 (0.39-3.06)	0.45 (0.16-1.25)	0.53 (0.21-1.36)	0.69 (0.28-1.70)	1.13 (0.44-2.91)
	Bachelor's degree or higher	0.33 (0.10-1.07)	1.60 (0.54-4.75)	1.12 (0.61-2.07)	**0.41 (0.21-0.76)**	1.96 (0.71-5.40)	0.68 (0.27-1.71)	2.42 (0.76-7.62)	1.91 (0.69-5.24)	0.49 (0.18-1.35)	0.89 (0.32-2.47)	0.82 (0.32-2.08)	0.76 (0.25-2.35)
	Country of birth												
	Australia	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Other	1.45 (0.50-4.21)	0.84 (0.38-1.84)	0.98 (0.61-1.58)	1.20 (0.81-1.79)	1.76 (0.83-3.71)	0.58 (0.26-1.27)	1.24 (0.57-2.67)	0.64 (0.30-1.36)	1.65 (0.70-3.91)	1.73 (0.67-4.47)	1.24 (0.55-2.79)	0.80 (0.28-2.29)
	Area of residence												
	Metropolitan	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Regional	1.68 (0.59-4.77)	0.98 (0.43-2.24)	0.96 (0.68-1.36)	1.07 (0.80-1.43)	0.97 (0.59-1.59)	1.09 (0.71-1.68)	0.99 (0.60-1.64)	0.77 (0.50-1.21)	0.66 (0.30-1.43)	1.13 (0.50-2.55)	1.12 (0.56-2.27)	0.64 (0.27-1.48)

	Rural	0.88 (0.36-2.12)	1.27 (0.69-2.33)	1.16 (0.63-2.13)	1.25 (0.80-1.97)	0.75 (0.38-1.50)	0.66 (0.34-1.29)	0.81 (0.40-1.65)	0.52 (0.26-1.04)	1.78 (0.65-4.90)	**3.30 (1.11-9.82)**	1.78 (0.66-4.73)	0.52 (0.16-1.70)
Clinical	Prognostic severity												
	Minimal/mild	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Moderate	1.46 (0.58-3.68)	1.09 (0.52-2.25)	0.75 (0.51-1.08)	**0.69 (0.51-0.93)**	**0.29 (0.16-0.53)**	0.69 (0.40-1.19)	**0.49 (0.26-0.91)**	0.84 (0.47-1.50)	**0.14 (0.04-0.44)**	0.57 (0.17-1.84)	0.70 (0.23-2.17)	2.43 (0.62-9.47)
	Severe	**0.17 (0.05-0.50)**	0.67 (0.32-1.39)	**0.23 (0.16-0.32)**	**0.25 (0.19-0.33)**	**0.23 (0.13-0.40)**	**0.32 (0.19-0.53)**	**0.56 (0.32-0.95)**	0.66 (0.40-1.11)	**0.07 (0.02-0.21)**	**0.35 (0.13-0.94)**	1.36 (0.52-3.58)	1.26 (0.38-4.10)
	History of depression (lifetime)												
	Yes	1.01 (0.39-2.58)	0.96 (0.51-1.82)	1.27 (0.77-2.11)	**1.96 (1.34-2.86)**	1.09 (0.71-1.69)	0.89 (0.59-1.34)	0.83 (0.53-1.28)	0.77 (0.51-1.16)	7.66 (0.76-77.30)	2.25 (0.18-27.34)	1.91 (0.13-27.20)	-
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	History of anxiety (lifetime)												
	Yes	**2.50 (1.03-6.07)**	1.14 (0.62-2.09)	0.83 (0.55-1.26)	1.05 (0.76-1.46)	1.09 (0.71-1.69)	0.89 (0.59-1.34)	0.83 (0.53-1.28)	0.77 (0.51-1.16)	0.97 (0.45-2.05)	1.64 (0.71-3.80)	0.73 (0.35-1.48)	1.73 (0.73-4.08)
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Better Access treatment	Number of treatment sessions												
	1-2	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	3-4	0.61 (0.19-1.90)	2.19 (0.90-5.30)	0.84 (0.57-1.25)	1.01 (0.68-1.49)	1.12 (0.59-2.12)	1.25 (0.67-2.33)	1.65 (0.80-3.42)	1.66 (0.87-3.16)	0.65 (0.23-1.85)	1.07 (0.40-2.85)	1.90 (0.70-5.14)	**2.83 (1.06-7.56)**
	5-6	1.12 (0.39-3.22)	1.89 (0.81-4.38)	0.94 (0.63-1.41)	1.10 (0.75-1.62)	0.98 (0.50-1.93)	1.39 (0.71-2.73)	**2.75 (1.33-5.67)**	1.57 (0.77-3.17)	0.98 (0.32-3.00)	1.20 (0.44-3.30)	2.64 (0.95-7.37)	1.08 (0.33-3.46)
	7-10	0.68 (0.23-1.99)	2.00 (0.81-4.92)	0.97 (0.65-1.43)	1.05 (0.72-1.52)	1.36 (0.70-2.64)	0.98 (0.51-1.87)	**2.45 (1.17-5.09)**	1.63 (0.84-3.13)	**5.35 (1.85-15.47)**	0.64 (0.18-2.27)	**2.85 (1.01-8.03)**	1.55 (0.47-5.10)
	11-20	0.39 (0.10-1.45)	**3.38 (1.42-8.04)**	1.02 (0.67-1.55)	1.20 (0.84-1.72)	0.82 (0.41-1.63)	1.52 (0.82-2.81)	**2.52 (1.21-5.26)**	1.68 (0.87-3.21)	**3.65 (1.10-12.10)**	0.97 (0.28-3.32)	**3.22 (1.05-9.85)**	1.06 (0.26-4.22)
	21-100	-	1.12 (0.35-3.56)	0.98 (0.37-2.57)	1.37 (0.91-2.07)	0.94 (0.40-2.16)	1.33 (0.62-2.86)	1.52 (0.61-3.77)	1.55 (0.71-3.41)	0.71 (0.10-4.68)	1.89 (0.42-8.44)	3.04 (0.76-12.10)	0.86 (0.13-5.34)
	Received treatment from clinical psychologist												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	0.42 (0.04-4.21)	1.50 (0.69-3.28)	1.06 (0.68-1.65)	1.03 (0.78-1.36)	0.71 (0.37-1.3)	0.75 (0.38-1.47)	1.10 (0.59-2.05)	0.80 (0.41-1.58)	0.34 (0.06-1.78)	1.47 (0.40-5.34)	1.17 (0.34-3.93)	0.22 (0.02-2.00)

	Received treatment from psychologist												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	0.32 (0.03-3.27)	1.62 (0.73-3.60)	1.10 (0.71-1.70)	1.24 (0.93-1.64)	0.73 (0.38-1.41)	1.00 (0.50-1.98)	1.11 (0.59-2.08)	0.94 (0.47-1.89)	0.50 (0.10-2.56)	1.42 (0.38-5.31)	1.87 (0.55-6.32)	0.25 (0.02-2.33)
	Received treatment from social worker												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	0.15 (0.11-2.25)	**3.56 (1.17-10.74)**	1.55 (0.79-3.02)	1.10 (0.71-1.71)	0.75 (0.31-1.80)	0.90 (0.36-2.22)	1.22 (0.53-2.81)	0.67 (0.26-1.71)	0.29 (0.04-2.06)	0.94 (0.17-4.91)	1.39 (0.28-6.70)	0.06 (0.03-1.07)
	Received treatment from occupational therapist												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	-	7.04 (0.50-98.36)	1.99 (0.58-6.83)	1.31 (0.49-3.50)	3.46 (0.28-42.49)	0.80 (0.17-3.74)	7.33 (0.57-93.93)	0.79 (0.16-3.75)	-	-	8.56 (0.24-302.92)	-
	Received treatment from general practitioner												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	-	1.24 (0.08-19.03)	0.92 (0.28-2.99)	0.28 (0.06-1.31)	0.74 (0.10-5.42)	1.00 (0.14-6.94)	0.72 (0.06-7.53)	0.34 (0.03-3.41)	0.47 (0.03-7.19)	1.15 (0.67-2.98)	*2.86 (0.28-28.90)*	1.58 (0.05-47.94)
	Paid any out of pocket cost												
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
	Yes	0.74 (0.32-1.68)	0.99 (0.57-1.70)	0.89 (0.68-1.15)	0.82 (0.64-1.04)	0.65 (0.41-1.04)	1.05 (0.67-1.63)	0.92 (0.57-1.48)	0.71 (0.46-1.12)	0.52 (0.25-1.08)	1.41 (0.67-2.98)	0.76 (0.39-1.48)	0.84 (0.38-1.83)
Other treatment	Currently taking any medication for mental health												
	Yes	0.62 (0.25-1.50)	0.77 (0.39-1.54)	**0.69 (0.51-0.92)**	0.93 (0.72-1.19)	1.20 (0.76-1.89)	1.05 (0.69-1.58)	0.90 (0.56-1.45)	1.19 (0.78-1.80)	0.82 (0.39-1.71)	1.14 (0.53-2.46)	1.01 (0.50-2.00)	0.94 (0.42-2.10)
	No	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Elapsed days between survey waves		1.00 (0.99-1.00)	0.99 (0.99-1.00)	1.00 (0.99-1.00)	0.99 (0.99-1.00)	0.99 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)	1.00 (0.99-1.00)

a. Results reported as odds ratios and 95% confidence intervals
b. Shaded cells indicate statistically significant results

Appendix 15: Recruitment notice (Study 6)

HAVE YOUR SAY ON BETTER ACCESS, AN INITIATIVE THAT GIVES PEOPLE MEDICARE REBATES FOR MENTAL HEALTH SERVICES

Type: Research study (interviews)

Who can take part? People with a lived experience of mental health conditions, who have and have not used Better Access in the past year.

Our team has been commissioned by the Department of Health to conduct an evaluation of what is known as "Better Access". Under Better Access, people can see a psychologist, social worker or occupational therapist for sessions of mental health care, and those sessions are funded – wholly or partially – by Medicare. The evaluation will help the Department improve the way people access mental health care.

We are seeking **expressions of interest** from people who would like to take part in an interview about Better Access. We want to hear from people who **have** and **haven't** used Better Access **in the past year**.

We will ask those who have used Better Access services why they have, what their experiences were, and whether they would change anything. We will also ask those who haven't used Better Access services why they haven't, what the barriers were, and what might make them likely to use them in the future. The interviews will take about an hour. All participants will receive a $50 gift voucher as a thank you for giving up their time.

If you think you might like to take part in an interview, please click [hyperlink to EOI form] and complete the **expression of interest** form.

Appendix 16: Expression of interest form (Study 6)

EXPRESSION OF INTEREST

INTERVIEWS WITH PEOPLE WHO HAVE AND HAVEN'T USED BETTER ACCESS

Our team has been commissioned by the Department of Health to conduct an evaluation of what is known as "Better Access". Under Better Access, people can see a psychologist, social worker or occupational therapist for sessions of mental health care, and those sessions are funded – wholly or partially – by Medicare. In order for this to happen, their GP provides them with a mental health treatment plan and refers them on to one of these mental health professionals.

This project is one component of the evaluation. We are conducting interviews with people with lived experience of mental health conditions who **have** and **haven't** used Better Access **in the past year**.

We will ask those who have used Better Access services why they have, what their experiences were, and whether they would change anything. We will ask those who haven't used Better Access services why they haven't, what the barriers were, and what might make them likely to use them in the future. The interviews will take about an hour.

The interview has some questions about your mental health experiences. It's possible that reflecting on our experiences can bring about strong feelings and emotions, so we encourage you to consider whether now is the right time for you to participate. If you participate we have support processes in place if you need them.

Participants must be aged 18 years or over. Participation in the interviews is completely voluntary. All of the information from the interviews will be treated confidentially, and no participant will be identified when the findings from the interviews are reported.

If you are interested in participating in an interview, please complete this **expression of interest form**. We will select 20 people who have used Better Access and 20 people who haven't, making sure that we get a mix of people from different locations and groups. We may not be able to include everyone who expresses interest. Unfortunately, we can't include carers in the project at this time.

Expressions of interest close on [DATE]. We will be in touch as soon as possible after that to let you know whether we will be asking you to take part in an interview or not.

Professor Jane Pirkis and Dr Dianne Currier (University of Melbourne), A/Professor Michelle Banfield (Australian National University), Professor Lisa Brophy (LaTrobe University)

Name: ___________________________________

Address: ____
State: ________________
Postcode: _____________

Phone: ___________________
Email address: _____________

1. Age group (tick one response only)

[ ] 18-29
[ ] 30-39
[ ] 40-49
[ ] 50-59
[ ] 60-69
[ ] ≥70

2. Sex (tick one response only)

[ ] Female
[ ] Male
[ ] Non-binary sex
[ ] Prefer not to say

3. Do you identify as Aboriginal or Torres Strait Islander? (tick one response only)

[ ] Aboriginal
[ ] Torres Strait Islander
[ ] Both Aboriginal and Torres Strait Islander
[ ] Neither Aboriginal nor Torres Strait Islander

4. How would you describe your cultural background? (dropdown list check box)

____

5. Do you speak English at home? (tick one response only)

[ ] Yes
[ ] No
If no what language do you speak at home ____

6. Your Better Access use in the past year

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? (tick one response only)

[ ] Yes
[ ] No
[ ] Unsure

7. Your mental health in the past year

On average, how would you rate your mental health over the past year? (tick one response only)

[ ] 1 (Worst possible mental health)
[ ] 2
[ ] 3
[ ] 4
[ ] 5
[ ] 6
[ ] 7
[ ] 8

[ ] 9
[ ] 10 (Best possible mental health)

8. Have you ever been given a mental health diagnosis? (tick one response only)

[ ] Yes
[ ] No
[ ] Unsure

9. If you answered "yes" to Question 8, what was that diagnosis? (tick as many responses as apply)

[ ] An anxiety disorder(s)
[ ] Depression
[ ] Bipolar disorder
[ ] An eating disorder
[ ] A personality disorder
[ ] Post-traumatic stress disorder
[ ] A psychotic disorder (e.g., schizophrenia)
[ ] A substance use disorder
[ ] Other (Please describe) ____________________________________
[ ] Unsure

10. Please tell us why you would like to take part in an interview about Better Access (free text, 1000-character limit)

____
____
____
____
____

THANK YOU FOR COMPLETING THIS EXPRESSION OF INTEREST. WE WILL BE IN TOUCH AS SOON AS POSSIBLE.

Appendix 17: Plain language statement (Study 6)

INTERVIEWS WITH PEOPLE WHO HAVE AND HAVEN'T USED BETTER ACCESS

Professor Jane Pirkis (Responsible Researcher)
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About this project

Our team has been commissioned by the Department of Health to conduct an evaluation of what is known as the "Better Access program" or just "Better Access". Under Better Access, people can see a psychologist, social worker or occupational therapist for sessions of mental health care, and those sessions are funded – wholly or partially – by Medicare. In order for this to happen, their GP provides them with a mental health treatment plan and refers them on to one of these mental health professionals.

This project is one component of the evaluation. We are conducting in-depth qualitative interviews with people with lived experience of mental health conditions who **HAVE** and **HAVEN'T** used Better Access **in the past year**. We will ask those who have used Better Access services why they have, what their experiences were, and whether they would change anything. We will ask those who haven't used them why they haven't, what the barriers were, and what might make them likely to use them in the future.

Thank you for your interest in participating in this project. The following few pages will provide you with further information about this project, so that you can decide if you would like to take part.

Please take the time to read this information carefully. You may ask questions about anything you don't understand or want to know more about.

Your participation is voluntary. If you don't wish to take part, you don't have to. If you begin participating, you can also stop at any time.

What will I be asked to do?

Should you agree to participate you will be asked to take part in an interview via Zoom or on the telephone. We anticipate that the interview will take about an hour.

What are the possible benefits?

Participating in the interview will give you the opportunity to provide your perspective on Better Access. You will also receive a gift voucher valued at $50 for your time. There will also be broader benefits, because the information you and other participants provide will help to shape the way in which Better Access is delivered in the future.

What are the possible risks?

The risks of participating are small. However, because we will be asking you to think about mental health care you may have received in the past year, there is a possibility that you might feel uncomfortable or distressed. If this happens, we can stop the interview. We have processes in place to offer support if you do experience distress, including a list of services and help to connect you with the appropriate ones. We have also included some information on support services at the end of this document.

Do I have to take part?

No. Participation is completely voluntary. You are able to withdraw at any time up until the analysis is finalised. Your participation or withdrawal will have no bearing on any future care you may receive through Better Access or any other program. If you withdraw part way through the interview, you will be able to choose whether to allow us to use any information that you have already provided.

Will I hear about the results of this project?

We will provide written reports on the findings of the overall evaluation to the Department of Health, and these reports will include information about what participants in the interviews have told us. We will also prepare an academic journal article on this project. In addition, we will provide brief summary to interested participants.

What will happen to information about me?

All of the information that you provide during the interview will be treated confidentially. The interviews will be recorded and transcribed, and each participant will be allocated a number so that their name will not be attached to the recording or the transcription. When we analyse the transcripts and write up the findings, we will report on broad themes to ensure that no participant can be identified. We may use direct quotations to illustrate the themes, but again we will present these in a way that guarantees that no participant can be identified. The recordings and transcripts will be stored on password-protected computers that will only be accessible to members of the research team. All recordings and transcripts will be retained for a period of at least years and then destroyed.

Who is funding this project?

This project has been funded by the Department of Health.

Where can I get further information?

If you would like more information about the project, please contact Dr Dianne Currier dianne.currier@unimelb.edu.au or Dr Maria Ftanou mftanou@unimelb.edu.

Who can I contact if I have any concerns about the project?

This project has human research ethics approval from The University of Melbourne (Project ID 22921) . If you have any concerns or complaints about the conduct of this research project, which you do not wish to discuss with the research team, you should contact the Research Integrity Administrator, Office of Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 83441814 or Email: research-integrity@unimelb.edu.au. All complaints will be treated confidentially. In any correspondence please provide the name of the research team and/or the name or ethics ID number of the research project.

USEFUL SUPPORT SERVICES

If you are feeling distressed or would like some additional support, please contact your GP or usual mental health clinician and let them know how you are feeling.

If you need urgent medical help, please call an ambulance on **000** (or if you are on a mobile and that doesn't work you can call **112**).

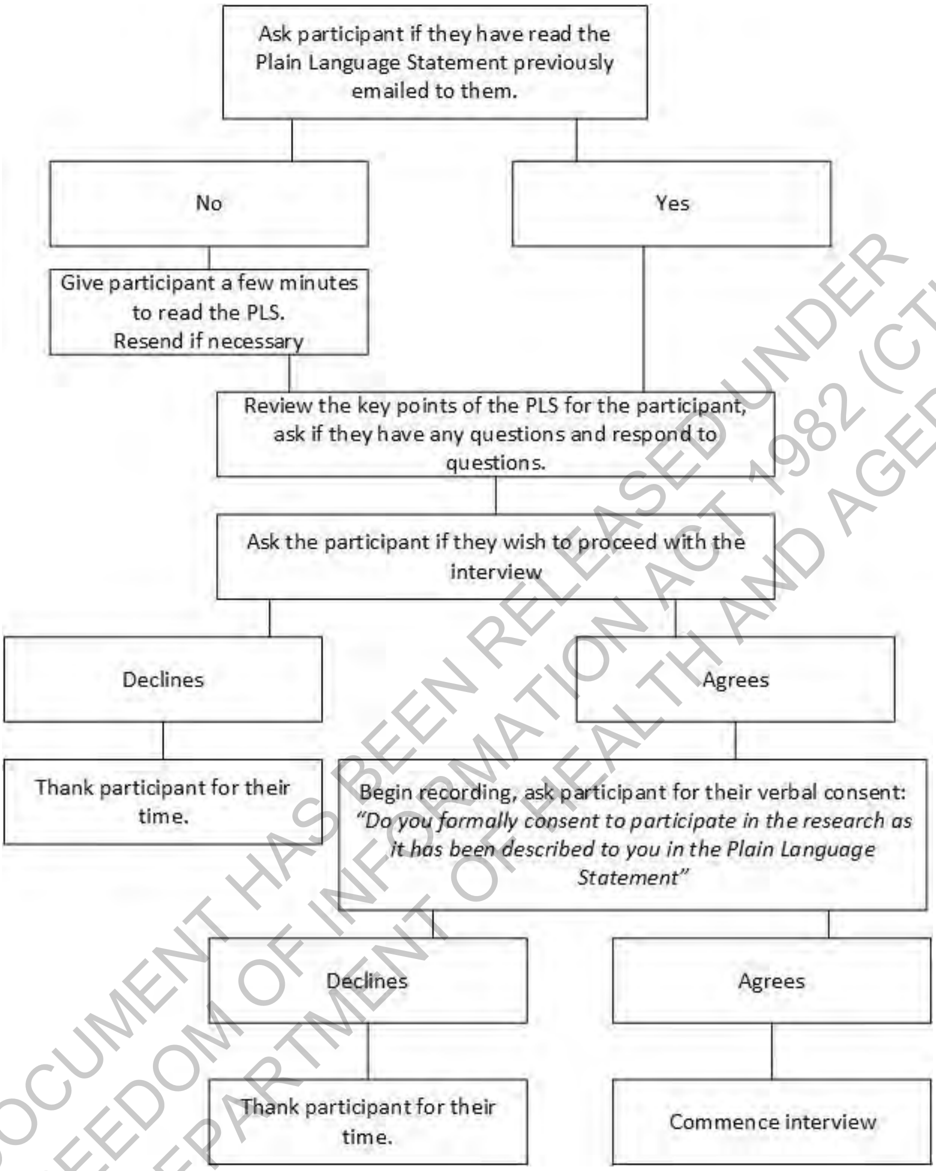
There are also some other numbers that you can call at any time, night or day if you want help and support:

24/7 Crisis Support Services

LIFELINE **24 hours a day, 7 days a week** **Crisis support over the phone, for all ages** Lifeline also has an online crisis support chat from 7pm to 4am, 7 days a week. To find out more, you can do an internet search for "Lifeline" or go to www.lifeline.org.au and click on the "online services" tab.	13 11 14 (free call from mobiles)
Kids Helpline – Teens and Young Adults **24 hours a day, 7 days a week** **Phone support and counselling, for ages 13-25** Kids Helpline also have WebChat Counselling available between 8am and midnight, 7 days a week and Email Counseling. For more information, search for "Kids Helpline" or go to www.kidshelp.com.au/teens	1800 55 1800 (free to call)
Suicide Call Back Service **24 hours a day, 7 days a week** **Phone crisis counselling and support, ages 15 plus** Crisis support for people who are suicidal, carers of someone who is suicidal and people bereaved by suicide. The Suicide Call Back Service provides immediate telephone support in a crisis and can provide up to 6 further telephone counselling sessions with the same counsellor. For more information go to https://www.suicidecallbackservice.org.au	1300 659 467

Appendix 18: Consent protocol and script (Study 6)

Consent protocol



Consent script

Interviewer: Thank you once again for agreeing to participate in this interview. You should have received a copy of the Plain Language Statement by email describing all the details of this study.

Interviewer: Have you had a chance to read that document?

Participant responds yes → *continue to summary and consent*
Participant responds 'no, did not read' → Interviewer: You can take a few minutes now to read through it.

Participant responds 'did not receive' → Interviewer: I can send it through to you again now and give you a few minutes to read through it.

Participant has had the opportunity to read the PLS

Interviewer: I'll just summarise the key points for you [summary of key points]

Interviewer: Do you have any questions? [Answer questions]

Interviewer: Are you happy to go ahead with the interview?

Participant responds 'yes'

Interviewer: I would like to start recording now and ask you for your formal consent to participate:

[commence recording]

> Do you formally consent to participate in the research as it has been described to you in the Plain Language Statement?

Participant responds 'yes'

Interviewer: While you are used to speaking about your experiences with mental health, in case you do get upset today we would like you to nominate a support person who you can contact if you feel distressed during the interview.

[Record name of support person]

Appendix 19: Interview schedule for users of Better Access (Study 6)

PEOPLE WHO HAVE USED BETTER ACCESS IN THE PAST YEAR

Thank you once again for agreeing to participate in this interview.

While you are used to speaking about your experiences with mental health, in case you do feel distressed today we would like you to nominate a support person who you can contact if you feel distressed during the interview.

[Record name of support person]

As you know, we are doing these interviews as part of our evaluation of what is known as “Better Access”. Under Better Access, people can see a psychologist, social worker or occupational therapist for sessions of mental health care, and those sessions are funded – wholly or partially – by Medicare. In order for this to happen, their GP provides them with a mental health treatment plan and refers them on to one of these mental health professionals.

You have indicated that you are one of the many people in Australia who saw a psychologist, social worker or occupational therapist through Better Access **during the past year.** As I said, this means that the services you received were paid for, at least in part, by Medicare. You may have paid for some of the cost out of your own pocket though. Can I just check that is correct – you saw a psychologist, social worker or occupational therapist through the Better Access program during the past year?

Note for interviewer: If the participant indicates that they actually did not receive Better Access services in the past year, they should be asked the questions for those who HAVE NOT USED Better Access in the past year.

I’ll be asking you some questions about your experiences with accessing and receiving care via Better Access services, and about whether things changed for you as a result. Just as a reminder, if you are feeling stressed or uncomfortable at any point, we can stop the interview.

If you’re ready, we’ll start the interview now.

Overarching theme 1: Accessibility

1. Can I start by asking you what professional qualification the mental health professional you saw through the Better Access program had? Was it a psychologist, a social worker or an occupational therapist you saw in the past year?

    - *Note for interviewer: It is possible that some people may have seen more than one type of professional. If this is the case, explore their experiences with each one.*

Psychologist	[ ] Yes [ ] No [ ] Not sure
Social worker	[ ] Yes [ ] No [ ] Not sure
Occupational therapist	[ ] Yes [ ] No [ ] Not sure

2. In order to see the mental health professional through Better Access, your GP – or possibly some other medical practitioner – would have written a mental health treatment plan and referred you. What do you remember about this process?

- *Prompts:*
    - *Did you know that the GP wrote the plan?*
    - *Did your GP give you a copy of the plan?*
    - *Did you think the plan accurately described how you were feeling at the time?*
    - *Was the referral process smooth?*
    - *Did you feel that the GP and the mental health professional communicated appropriately with each other, and with you?*

3. Apart from the referral, what else can you tell me about how you went about accessing care from the mental health professional under the Better Access program?

    - *Prompts:*
        - *Had you made the decision to see a mental health professional before the GP suggested it?*
        - *Did you have a particular mental health professional in mind?*

4. Can you comment on your experience with seeing the mental health professional via Better Access?

5. What did you think about the number of sessions you had with the mental health professional? Was it too few, too many, or just the right number?

6. Were the sessions face-to-face or by telehealth (e.g., by telephone or Zoom), or a mix?

    6a. **If face-to-face**: How did you find this?

    6b. **If telehealth**: Did you have phone or zoom services?
    [for each mode mentioned]
    1. How did you find the **phone** sessions?
    2. How did you find the **zoom** sessions?

    6c: If a mix – ask about each mode separately
    1. How did you find the **face-to-face** sessions?
    2. How did you find the **phone** sessions?
    3. How did you find the **zoom** sessions?

7. Did you have any group sessions? How did you find those?

8. Would you be interested in group therapy in the future? If Yes – why? If No – why not?

9. What are the things that helped or enabled you to engage with the mental health professional through Better Access?

    - *Prompts:*
        - *Referral by the GP*
        - *The fact that the mental health professional's services were at least partly paid for by Medicare*
        - *Location of the mental health professional*
        - *Mental health professional's manner and approach*
        - *Flexibility of the sessions*

10. Were there things that made it hard for you to engage with the mental health professional through Better Access? How did they impact on you?

    - *Prompts:*
        - *Finances/cost – Was this because the out-of-pocket payment was too high, or something else (e.g., other costs associated with attending the sessions, like transport costs, accommodation costs, childcare costs, income lost by attending the sessions)?*
        - *Location – Was this because the mental health professional was some distance away from where you live? How much travel was involved? Did this limit your access to the mental health professional?*
        - *Choice of mental health professional – Was this because the choice of mental health professional was limited?*
        - *Wait times – Were there long wait times to get in to see the mental health professional?*
        - *Mental health professional's manner and approach*

Overarching theme 2: Appropriateness

11. Can you tell me what prompted you to seek care from the mental health professional when you did?

12. Was there a particular mental health issue or condition that led you to seek care from the mental health professional? If so, how would you describe this?

    - *Note for interviewer: If the participant indicates a particular mental health issue or condition, continue with Questions 11-14. If they don't, then skip to the next section.*

13. How does/did that mental health issue/condition impact on your day-to-day life?

14. Does it fluctuate? If so, how much?

15. Do you think being able to access a mental health professional via Better Access is an appropriate way to help you with this mental health issue/condition? Why? Why not?

Overarching theme 3: Effectiveness

16. Have you noticed any change in your health and wellbeing since seeing the mental health professional through Better Access? If so, was that change for the better or for the worse? To what extent would you attribute any change to the care provided by this mental health professional? Have there been any other benefits (or disadvantages) of receiving care from this mental health professional?

17. From your experience with seeing the mental health professional, what would you say had the biggest influence on any change in your health and wellbeing. What helped the most? What was the least helpful?

    - *Prompts:*
        - *The total number of sessions?*
        - *The format of the sessions (face-to-face, telehealth)?*
        - *The manner and approach of the mental health professional?*

18. Did you continue seeing the mental health professional for all of the sessions of care you were offered? If not, can you please tell me a little about why you discontinued?

19. Do you see any other mental health professionals or use any other services for your mental health apart from the one you saw through Better Access? Or any other supports or resources? If so, what impact do they have?

Overarching theme 4: Sustainability

20. Reflecting on the Better Access program, and in particular the way it enables people to access mental health professionals by wholly or partially funding sessions through Medicare, is there anything you would change about it?

21. In an ideal world what would the Better Access program look like? Or, based on your experience, how could it be improved?

Thank you for participating in this interview.

If the distress protocol has been enacted during the interview follow the Stage 2 Steps.

If the distress protocol has not been required, remind participants that if they do feel distressed in the coming days as a result of their participation to contact their nominated support person, their service provider if they are in services, use the resources provided or contact the research team.

Appendix 20: Interview schedule for non-users of Better Access (Study 6)

PEOPLE WHO HAVE NOT USED BETTER ACCESS IN THE PAST YEAR

Thank you once again for agreeing to participate in this interview.

While you are used to speaking about your experiences with mental health, in case you do get upset today we would like you to nominate a support person who you can contact if you feel distressed during the interview.

[Record name of support person]

As you know, we are doing these interviews as part of our evaluation of what is known as "Better Access". Under Better Access, people can see a psychologist, social worker or occupational therapist for sessions of mental health care, and those sessions are funded – wholly or partially – by Medicare. In order for this to happen, their GP provides them with a mental health treatment plan and refers them on to one of these mental health professionals.

You have indicated that you did not see a psychologist, social worker or occupational therapist through Better Access **during the past year.** You may have done this more than a year ago, but not in the past year. Or, during the past year, you may have received mental health services from these sorts of mental health professionals but done so through some other program that was not funded by Medicare. But, just to confirm, during the past year you did not receive services from a psychologist, social worker or occupational therapist that were paid for, at least in part, by Medicare. Can I just check that is correct?

Note for interviewer: If the participant indicates that they actually did receive Better Access services in the past year, they should be asked the questions for those who HAVE USED Better Access in the past year.

I'll be asking you some questions about why you haven't used Better Access, and whether you think you might do so in the future. Just as a reminder, if you are feeling stressed or uncomfortable at any point, we can stop the interview.

If you're ready, we'll start the interview now.

Overarching theme 1: Accessibility

1. Can I start by asking you about what you know about Better Access? Had you heard of the program before you expressed your interest in taking part in an interview with us?
   - *Prompts:*
     - *You may have known that it was possible to see a psychologist, social worker or occupational therapist through Medicare, but not known that the program was called Better Access*
     - *Or you may have not known that it was possible to see a psychologist, social worker or occupational therapist through Medicare at all*

2. Who do you think Better Access is intended for?

3. I understand that you didn't see a mental health professional through Better Access in the past year, but did you do so before that? To put the question another way, before last year, had you ever seen

a psychologist, social worker or occupational therapist whose services were paid for – at least in part – by Medicare? If so, can you elaborate on that previous contact?

4. In the past year, did your GP write a mental health treatment plan for you? If not, do you think this might have been helpful? If so, can you tell me a little bit more about what it involved?

   - *Prompts:*
     - *If your GP did not write a mental health treatment plan for you, why do you think this was?*
     - *If your GP did write a mental health treatment plan for you, did it involve a referral to a psychologist, social worker or occupational therapist? And if so, can you tell me why you chose not to follow through with the referral? Perhaps you couldn't find someone who you felt was skilled in helping with the issue or condition you were experiencing, for example.*
     - *If it didn't involve a referral to one of these mental health professionals, did the GP themselves provide you with sessions of mental health care? Or did they refer you to some other kind of mental health professional, like a psychiatrist?*

5. There may be many reasons why you didn't see a psychologist, social worker or occupational therapist through Better Access in the past year. I'd like to explore some possibilities with you if that's okay. One reason might be that you felt you didn't have a need to see a professional of this kind, perhaps because you were feeling pretty good. Or maybe it seemed too difficult. Or perhaps there was another reason.

6. Were there other things that made it hard for you to engage with a psychologists, social worker or occupational therapist through Better Access? How did they impact on you?

   - *Prompts:*
     - *Finances/cost – Was this because the out-of-pocket payment was too high, or something else (e.g., other costs associated with attending the sessions, like transport costs, accommodation costs, childcare costs, income lost by attending the sessions)?*
     - *Location – Was this because the mental health professional was some distance away from where you live? How much travel was involved? Did this limit your access to the mental health professional?*
     - *Choice of mental health professional – Was this because the choice of mental health professional was limited? Or you couldn't find one who you thought could meet your needs?*
     - *Wait times – Were there long wait times to get in to see the mental health professional?*
     - *Other issues – e.g., mobility issues.*

7. Do you think you are likely to see a psychologists, social worker or occupational therapist through Better Access in the future? Why? Why not?

8. What are the things that you think might help or enable people like yourself to see a psychologists, social worker or occupational therapist through Better Access?

   - *Prompts:*
     - *Referral by the GP*
     - *The fact that the mental health professional's services were at least partly paid for by Medicare*
     - *Location of the mental health professional*
     - *Mental health professional's manner and approach*
     - *Flexibility of the sessions*
     - *Support for people with mobility issues, i.e. home visits*

Overarching theme 3: Effectiveness

9. Do you see any mental health professionals or use any services for your mental health outside those who might be available through Better Access? Or any other supports or resources? Can you tell me what services or supports or mental health professionals you used:

   Prompts:
   - *Community mental health services*
   - *Emergency room/hospital*
   - *Private psychologists*
   - *PHN funded mental health professionals*
   - *Online services or apps*
   - *Others?*

10. Thinking about the services you described just now, what impact do they have? [Ask the participant to reflect separately on each of the services, mental health professionals or resources they mention in question 9]

11. From your experience with seeing other mental health professionals or using other services, what would you say has the biggest influence on any change in your health and wellbeing. What helps the most? What is the least helpful?

   - *Prompts:*
     - *The total number of sessions?*
     - *The format of the sessions (face-to-face, telehealth)?*
     - *The manner and approach of the mental health professional?*

Overarching theme 4: Sustainability

12. Reflecting on the Better Access program, and in particular the way it enables people to access mental health professionals by wholly or partially funding sessions through Medicare, is there anything you would change about it?

13. In an ideal world what would the Better Access program look like? How could it be improved?

Thank you for participating in this interview

If the distress protocol <u>has</u> been enacted during the interview follow the Stage 2 Steps.

If the distress protocol <u>has not</u> been required, remind participants that if they do feel distressed in the coming days as a result of their participation to contact their nominated support person, their service provider if they are in services, use the resources provided or contact the research team.

Appendix 21: Sample invitation notice (Study 7)

A team led by Professor Jane Pirkis (Melbourne School of Population and Global Health, University of Melbourne) is conducting an evaluation of Better Access, the Medicare-funded program that reimburses psychologists and other selected providers for referring and/or delivering mental health care.

The evaluation team is asking GPs, psychiatrists, psychologists, social workers and occupational therapists to complete a survey about Better Access. The only requirement is that they have worked as a clinician in private practice in 2021.

If this describes you, the team would be interested in your views about how Better Access works and whether it promotes access to treatment for people with mild to moderate mental health conditions. You may be someone who regularly makes referrals or provides care under Better Access, or you may be someone who rarely or never does so. The team is interested in your views either way.

Participation in the survey should take no longer than 15 minutes total.

If you would like to know more or to complete the survey, please click on this link http://begin.ws/AAPI .

The survey will be open until 5.00pm Friday 25th March.

Appendix 22: Plain language statement (Study 7)

Plain Language Statement

MELBOURNE SCHOOL OF POPULATION AND GLOBAL HEALTH

Better Access Evaluation: Referrers and Providers Survey

Associate Professor Dianne Currier (Responsible Researcher)
Tel: +61 3 9035 7557
Email: dianne.currier@unimelb.edu.au

Dr Maria Ftanou, Justine Fletcher, Dr Bridget Bassilios, Professor Jane Pirkis, Professor Cathy Mihalopoulos, Associate Professor Meredith Harris, Professor Matthew Spittal, Ms Michelle Williamson, Dr Katrina Scurrah

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Introduction

Thank you for your interest in participating in this research project. The following few pages will provide you with further information about the project, so that you can decide if you would like to take part in this research.

Please take the time to read this information carefully.

Your participation is voluntary. If you don't wish to take part, you don't have to. If you begin participating, you can also stop at any time.

What is this research about?

The Better Access initiative 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 helpful.

The Department of Health has commissioned the University of Melbourne to evaluate the Better Access scheme. As part of the evaluation this project aims to understand the perspective of service providers on how well the scheme works, the barriers and facilitators to its use, and what modifications might be desirable.

We are asking GPs, psychiatrists, psychologists, social workers and occupational therapists to complete the survey if they have worked as a clinician in private practice in the last year. You may be someone who regularly makes referrals or provides care under Better Access, or you may be someone who rarely or never does so. We're interested in your views either way.

What will I be asked to do?

If you decide to participate, you will be asked to complete an online survey. You will be asked some questions about yourself and your clinical practice. You will be asked about your reasons for choosing to, or choosing not to, refer people for care or provide care yourself through Better Access. You will also be asked some more general questions about the things that act as barriers and facilitators for clinicians' use of Better Access.

All participants will be asked for recommendations they may have on improving Better Access.

What are the possible benefits?

The project will not provide any direct benefits to you as a participant. However, the information obtained from this project will be used in deliberations about how Better Access might be modified in the future.

What are the possible risks?

The survey questions are about the delivery of mental health services, and there is a small risk that this might upset you. If you are experiencing distress as a result of participating in the survey, you may want to seek the support of friends, family or a trusted colleague. Alternatively, general support is available by calling Lifeline on 13 11 14.

Do I have to take part?

No. Participation is completely voluntary. You can withdraw at any time. You will not be able to withdraw any data you provide because it is an anonymous survey and not linked to any of your personal details.

Will I hear about the results of this project?

The findings of the overall evaluation of the Better Access scheme will be shared with representatives from your professional organisation and they will be able to circulate that information to their membership.

We will also publish the study findings in academic journals and present them at conferences and other presentations.

What will happen to information about me?

Your participation in the study will be entirely confidential as the survey is anonymous. We will use a company called Strategic Data to develop the survey and to collect the survey data. They will have access to all the data you provide during the study, but this information will only be seen by those working directly on this project.

At the end of the study, Strategic Data will provide us with the survey response data. All data will be held securely in the Centre for Mental Health at the University of Melbourne for five years after we publish the final article about this study. We will also be producing research reports and journal articles as a result of this project.

As the data provided in your survey is anonymous so you are not able to withdraw the data once you have submitted the online survey.

Who is funding this project?

We have been funded by the Australian Government Department of Health to evaluate the role and effectiveness of Better Access.

Where can I get further information?

If you would like more information about the project, please contact the researchers at betteraccesseval-7@unimelb.edu.au or (03) 8344 0457.

Who can I contact if I have any concerns about the project?

This project has human research ethics approval from The University of Melbourne [22854]. If you have any concerns or complaints about the conduct of this research project, which you do not wish to discuss with the research team, you should contact the Research Integrity Administrator, Office of Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 8344 1814 or Email: research-integrity@unimelb.edu.au. All complaints will be treated confidentially. In any correspondence please provide the name of the research team and/or the name or ethics ID number of the research project.

Appendix 23: Survey consent (Study 7)

[The statement below followed the plain language statements. Participants had to check the “Yes” box in order to proceed through to the survey]

Having read the above information, do you agree to participate in this research?

○ Yes, I have read and understood the information provided to me and would like to proceed in taking part in the online survey.

○ No, I do not consent to take part

Date: ___/___/_____

Appendix 24: Survey (Study 7)

Survey for referrers and providers[d]

Thank you once again for agreeing to complete this survey. As you know, we are conducting this survey as part of our evaluation of Better Access. Better Access takes the form of a series of item numbers on the Medicare Benefits Schedule (MBS) that reimburse selected: (1) general practitioners (GPs) for preparing and reviewing Mental Health Treatment Plans and providing Focussed Psychological Strategies and other mental health care services (2) clinical psychologists for delivering Psychological Therapy Services; (3) psychologists, GPs and other medical practitioners, and social workers and occupational therapists for delivering Focussed Psychological Strategies; and (4) psychiatrists for preparing and reviewing Psychiatrist Assessment and Management Plans and conducting initial consultations with new consumers.

We are seeking the views of GPs, psychiatrists, clinical psychologists, psychologists, social workers and occupational therapists who worked in private practice in 2021. These professionals can make referrals or provide mental health care under Better Access. Other medical professionals and paediatricians may also deliver Better Access funded services but we are not asking them to complete the survey.

If you are a GP, psychiatrist, psychologist, social worker or occupational therapist and you worked in private practice **in 2021**, we are interested in your views about how Better Access works and whether it promotes access to treatment for people with mild to moderate mental health conditions. You may be someone who regularly makes referrals or provides care under Better Access, or you may be someone who rarely or never does so. We are interested in your views either way. If you have already completed the survey, however, please do not complete it again.

For the purposes of this survey, we refer to people who receive care through Better Access as "consumers".

The survey will take about 15 minutes. Your responses are confidential, and you are free to exit the survey at any stage.

[Questions for all participants]

1.	Have you worked as a clinician in private practice at any time since 1 January 2021? *mandatory	☐ Yes, full time ☐ Yes, part time ☐ No → Exit survey
2.	What is your clinical profession? (Note: If you have qualifications in more than one clinical profession, please indicate your primary clinical profession) *mandatory	☐ GP → Go to Question 7 ☐ Psychiatrist → Go to Question 44 ☐ Clinical psychologist → Go to Question 61 ☐ Psychologist → Go to Question 61 ☐ Social worker→ Go to Question 61 ☐ Occupational therapist → Go to Question 61 ☐ None of the above → Exit survey
3.	How many years have you been working in this profession?	☐ < 1 year ☐ 1-5 years ☐ 6-10 years

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[d] Red text indicates programming instructions for Logicly. Participants did not have to navigate skips themselves – they were automatic.

	☐ 11-15 years ☐ 16-20 years ☐ > 20 years
4. Are you:	☐ Female ☐ Male ☐ Non-binary gender ☐ Prefer not to say
5. What is the postcode of your private practice? (Note: If you work in more than one practice, please indicate the postcode of your primary practice)	______________
6. In your private practice, which of the following conditions do consumers commonly present with? (Tick all that apply)	☐ Anxiety disorders ☐ Depression ☐ Bipolar disorder ☐ Eating disorders ☐ Personality disorders ☐ Post-traumatic stress disorder ☐ Psychotic disorders (e.g., schizophrenia) ☐ Substance use disorders ☐ Childhood behavioural/emotional disorders (e.g., ADHD, conduct disorders) ☐ Other (Please describe) ____ ☐ Unsure

[Questions for GPs]

7. Have you completed the mental health skills training that is recognised through the General Practice Mental Health Standards Collaboration? *mandatory	☐ Yes→ Continue to Question 8 ☐ No→ Go to Question 9 ☐ Unsure→ Go to Question 9
8. What mental health skills training have you completed? (Tick all that apply)	☐ Level 1: Mental Health Skills Training ☐ Level 1 extended: Mental Health Continuing Professional Development ☐ Level 2: Focussed Psychological Strategies Skills Training ☐ Level 2 extended - Focussed Psychological Strategies Continuing Professional Development Continue to Question 9
9. Have you prepared or reviewed Mental Health Treatment Plans under Better Access **at any time since <u>1 January 2021</u>**? *mandatory	☐ Yes → Continue to Question 10 ☐ No → Go to Question 29 ☐ Unsure → Go to Question 29
10. Approximately how many consumers have you prepared or reviewed Mental Health Treatment Plans for under Better Access **at any time since <u>1 January 2021</u>**?	______________
11. Were any of these consumers in residential aged care facilities?	☐ Yes ☐ No

	☐ Unsure
12. Approximately, what proportion of all consumers for whom you prepared a Mental Health Treatment Plan **at any time since 1 January 2021** did you refer to a psychologist, social worker or occupational therapist under Better Access? *mandatory	☐ 100% ☐ 80-99% ☐ 60-79% ☐ 40-59% ☐ 20-39% ☐ 1-19% ☐ 0% → Go to Question 29 ☐ Unsure
13. Approximately, what proportion of all consumers for whom you prepared a Mental Health Treatment Plan **at any time since 1 January 2021** received care from a psychologist, social worker or occupational therapist under Better Access? *mandatory	☐ 100% ☐ 80-99% ☐ 60-79% ☐ 40-59% ☐ 20-39% ☐ 1-19% ☐ 0% → Go to Question 28 ☐ Unsure
14. Which of the above professional groups did you refer these consumers to? (Tick all that apply)	☐ A clinical psychologist ☐ A psychologist ☐ A social worker ☐ An occupational therapist
15. When you make a referral to a psychologist, social worker or occupational therapist, how do you select the individual provider? (Tick all that apply)	☐ I choose them on the basis of their clinical discipline ☐ I choose providers I know ☐ I choose providers who have a good reputation ☐ I try to match their expertise with consumers' needs ☐ They are the only provider(s) available in my area ☐ Other (Please describe) ____________________________________

Thinking about the situations where consumers went on to receive care from a psychologist, social worker or occupational therapist under Better Access, please rate the extent to which you agree or disagree with the following statements.	**1** **Strongly disagree**	**2** **Disagree**	**3** **Neither disagree nor agree**	**4** **Agree**	**5** **Strongly agree**
16. The referral process under Better Access is straightforward	☐	☐	☐	☐	☐
17. Better Access fosters good two-way communication between me and relevant mental health professionals	☐	☐	☐	☐	☐
18. Better Access enables me to refer consumers for appropriate mental health care	☐	☐	☐	☐	☐
19. Better Access enables me to ensure that the referral pathway is smooth	☐	☐	☐	☐	☐

20. Better Access enables me to refer consumers for mental health care that is accessible	☐	☐	☐	☐	☐
21. Better Access enables me to refer consumers for mental health care that can be delivered in a timely fashion	☐	☐	☐	☐	☐
22. Better Access enables me to refer consumers for mental health care that is affordable	☐	☐	☐	☐	☐
23. Better Access enables me to refer consumers for mental health care that they can benefit from	☐	☐	☐	☐	☐
24. Better Access enables me to refer consumers for mental health care that reduces their symptoms	☐	☐	☐	☐	☐
25. Better Access enables me to refer consumers for mental health care that improves their levels of functioning	☐	☐	☐	☐	☐
26. Better Access enables me to refer consumers for mental health care that addresses their presenting issues	☐	☐	☐	☐	☐
27. Better Access enables me to refer consumers for mental health care that improves their overall mental health and wellbeing	☐	☐	☐	☐	☐

-> If answered Q 12= '100%' Go to Q29

28. In situations where consumers did **not** go on to receive care from a psychologist, social worker or occupational therapist under Better Access, what were the reasons? (Tick all that apply)	☐ The consumer did not require this care ☐ The consumer chose not to take up the referral ☐ The consumer made alternative treatment arrangements ☐ I provided treatment myself ☐ Other (Please describe) ____
29. Have you provided mental health care using the GP Mental Health Treatment Consultation items under Better **at any time since <u>1 January 2021</u>**? *mandatory	☐ Yes → continue to Question 30 ☐ No → Go to Question 32 ☐ Unsure → Go to Question 33
30. Approximately how many consumers have you provided mental health care for using GP Mental Health Treatment Consultation items under Better Access **at any time since <u>1 January 2021</u>**?	______
31. Were any of these consumers in residential aged care facilities?	☐ Yes ☐ No ☐ Unsure
32. If you haven't provided mental health care using the GP Mental Health Treatment Consultation items under Better Access **at any time since <u>1 January</u>**	☐ I didn't see any consumers who required mental health care ☐ I referred all consumers who required mental health care on to other providers

2021, what were the reasons? (Tick all that apply)	☐ I provided mental health care consultations, but I did so using the Focussed Psychological Strategies items under Better Access ☐ I provided mental health care consultations, but I did so using other Medicare item numbers, not the Better Access ones ☐ Other (Please describe) ________________________________
33. Have you provided mental health care using the Focussed Psychological Strategies items under Better Access **at any time since 1 January 2021**? *mandatory	☐ Yes → Continue to Question 34 ☐ No → Go to Question 36 ☐ Unsure → Go to Question 37
34. Approximately how many consumers have you provided mental health care for using the Focussed Psychological Strategies items under Better Access **at any time since 1 January 2021**?	_____
35. Were any of these consumers in residential aged care facilities?	☐ Yes ☐ No ☐ Unsure
36. If you haven't provided mental health care using the Focussed Psychological Strategies items under Better Access **at any time since 1 January 2021**, what were the reasons? (Tick all that apply)	☐ I didn't see any consumers who required mental health care ☐ I referred all consumers who required mental health care on to other providers ☐ I provided mental health care consultations, but I did so using the GP Mental Health Treatment items under Better Access ☐ I provided mental health care consultations, but I did so using other Medicare item numbers, not the Better Access ones ☐ I did not want my services to be contributing to the Better Access session cap for consumers ☐ Other (Please describe) ________________________________ → Continue to Question 37

Thinking about the situations where **you or other GPs** provide mental health care using the Better Access GP Mental Health Treatment Consultation items or Focussed Psychological Strategies items, please rate the extent to which you agree or disagree with the following statements.	**1 Strongly disagree**	**2 Disagree**	**3 Neither disagree nor agree**	**4 Agree**	**5 Strongly agree**
37. Better Access enables GPs to offer consumers appropriate mental health care	☐	☐	☐	☐	☐
38. Better Access enables GPs to provide consumers with mental health care that is accessible	☐	☐	☐	☐	☐
39. Better Access enables GPs to provide consumers with mental health care that is timely	☐	☐	☐	☐	☐

40. Better Access enables GPs to provide consumers with mental health care that is affordable	☐	☐	☐	☐	☐
41. Better Access enables GPs to provide consumers with mental health care that improves their mental health and wellbeing	☐	☐	☐	☐	☐

42. What barriers do GPs experience in relation to Better Access? (Tick all that apply)	☐ The number of available sessions from relevant mental health professionals is too restrictive ☐ The fact that Better Access is designed to serve consumers who meet certain diagnostic criteria means that some consumers miss out ☐ 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 adequately 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 timing of reviews can present challenges ☐ Consumers do not always know whether they already have a Mental Health Treatment Plan ☐ There are long waiting lists for the mental health professionals who provide treatment under Better Access ☐ The list of mental health professionals who are eligible to provide treatment under Better Access is too limited ☐ In some areas, insufficient numbers of mental health professionals are available ☐ Other (Please describe) ________________________________
43. What things act as facilitators for GPs in relation to Better Access?	☐ Good communication with relevant mental health professionals ☐ Good documentation from relevant mental health professionals to inform reviews ☐ The ability to refer consumers for care that is tailored to their needs ☐ The ability to refer consumers for care that is affordable ☐ Other (Please describe) ________________________________

→ Continue to Question 79

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[Questions for psychiatrists]

44. Have you prepared or reviewed a Psychiatrist Assessment and Management Plan or conducted an initial consultation with a new consumer under Better Access **at any time since <u>1 January 2021</u>**? *mandatory	☐ Yes → Continue to Question 45 ☐ No → Go to Question 60 ☐ Unsure → Go to Question 79
45. Approximately how many consumers have you prepared or reviewed a Psychiatrist Assessment and Management Plan for or conducted an initial consultation with under Better Access **at any time since <u>1 January 2021</u>**?	_______________
46. Were any of these consumers in residential aged care facilities?	☐ Yes ☐ No ☐ Unsure
47. Approximately, what proportion of these consumers did you refer for treatment **<u>in 2021</u>**? *mandatory	☐ 100% ☐ 80-99% ☐ 60-79% ☐ 40-59% ☐ 20-39% ☐ 1-19% ☐ 0% → go to Question 49 ☐ Unsure
48. If you referred consumers for treatment, who did you refer them to? (Tick all that apply)	☐ A GP ☐ A nurse practitioner ☐ A psychologist ☐ A social worker ☐ An occupational therapist ☐ Another psychiatrist ☐ A paediatrician, consultant physician or other medical specialist ☐ Other (Please describe) _______________________________________

Thinking about the different ways in which you might see consumers under Better Access, please rate the extent to which you agree or disagree with the following statements.	**1 Strongly disagree**	**2 Disagree**	**3 Neither disagree nor agree**	**4 Agree**	**5 Strongly agree**
49. The processes of preparing and reviewing Psychiatrist Assessment and Management Plans and conducting initial consultations under Better Access are straightforward	☐	☐	☐	☐	☐
50. Better Access fosters good two-way communication between me and other providers	☐	☐	☐	☐	☐

51. Better Access helps me to ensure consumers get appropriate mental health care	☐	☐	☐	☐	☐
52. Better Access helps me to ensure that referral pathways for consumers are smooth	☐	☐	☐	☐	☐
53. Better Access helps me to ensure consumers get accessible mental health care	☐	☐	☐	☐	☐
54. Better Access helps me to ensure consumers get timely mental health care	☐	☐	☐	☐	☐
55. Better Access helps me to ensure consumers get affordable mental health care	☐	☐	☐	☐	☐
56. Better Access helps me to ensure that consumers get mental health care that reduces their symptoms	☐	☐	☐	☐	☐
57. Better Access helps me to ensure that consumers get mental health care that improves their levels of functioning	☐	☐	☐	☐	☐
58. Better Access helps me to ensure that consumers get mental health care that addresses their presenting issues	☐	☐	☐	☐	☐
59. Better Access helps me to ensure that consumers get mental health care that improves their overall mental health and wellbeing	☐	☐	☐	☐	☐ → Go to Question 79

60. If you haven't prepared or reviewed an assessment or management plan or conducted an initial consultation with a new consumer under Better Access **in 2021**, what were the reasons?	☐ I didn't see any consumers for whom this was appropriate or necessary ☐ I provided the equivalent of these services, but I did so using other Medicare item numbers, not the Better Access ones ☐ Other (Please describe) ______________________________ → Go to Question 79

[Questions for clinical psychologists, psychologists, social workers and occupational therapists]

61. Have you provided Psychological Therapy Services or Focussed Psychological Strategies under Better Access **at any time since 1 January 2021**? *mandatory	☐ Yes → Continue to Question 62 ☐ No → Go to Question 76 ☐ Unsure → Go to Question 77
62. Approximately how many consumers have you provided Psychological Therapy Services or Focussed Psychological Strategies for under Better Access **at any time since 1 January 2021**?	______________
63. Were any of these consumers in residential aged care facilities?	☐ Yes ☐ No ☐ Unsure
64. Did you provide any of these Psychological Therapy Services or Focussed Psychological Strategies in group sessions? *mandatory	☐ Yes → Go to Question 66 ☐ No → Continue to Question 65 ☐ Unsure → Go to Question 66

65. What was your reason for not providing group sessions? (Tick all that apply)	☐ Group sessions are not as helpful for consumers as individual sessions
	☐ Consumers have told me they would prefer individual sessions
	☐ Group sessions are hard to arrange
	☐ I do not feel confident running group sessions
	☐ I can provide better treatment if I do it individually
	☐ Group sessions have particular complexities (e.g., group dynamics)
	☐ Group sessions have been particularly hard to run during the COVID-19 pandemic
	☐ Other (Please describe) ____________________________________

→ Continue to Question 66

Thinking about the situations where you provided Psychological Therapy Services or Focussed Psychological Strategies under Better Access, please rate the extent to which you agree or disagree with the following statements.	**1 Strongly disagree**	**2 Disagree**	**3 Neither disagree nor agree**	**4 Agree**	**5 Strongly agree**
66. Better Access enables me to offer consumers appropriate mental health care	☐	☐	☐	☐	☐
67. Better Access enables consumers to access my services through a smooth referral process	☐	☐	☐	☐	☐
68. Better Access enables me to provide consumers with mental health care that is accessible	☐	☐	☐	☐	☐
69. Better Access enables me to provide consumers with mental health care that is timely	☐	☐	☐	☐	☐
70. Better Access enables me to provide consumers with mental health care that is affordable	☐	☐	☐	☐	☐
71. Better Access enables me to provide consumers with mental health care that they can benefit from	☐	☐	☐	☐	☐
72. Better Access enables me to provide consumers with mental health care that reduces their symptoms	☐	☐	☐	☐	☐
73. Better Access enables me to provide consumers with mental health care that improves their levels of functioning	☐	☐	☐	☐	☐
74. Better Access enables me to provide consumers with mental health care that addresses their presenting issues	☐	☐	☐	☐	☐
75. Better Access me to provide consumers with mental health care that improves their overall mental health and wellbeing	☐	☐	☐	☐	☐

→ Go to Question 77

76. If you haven't provided Psychological Therapy Services or Focussed Psychological Strategies under Better Access **at any time since 1 January 2021**, what were the reasons? (Tick all that apply)	☐	I didn't see any consumers who required Psychological Therapy Services or Focussed Psychological Strategies
	☐	I provided Psychological Therapy Services or Focussed Psychological Strategies, but I did it through other programs or funding mechanisms
	☐	Other (Please describe) ______________________________________
77. What barriers do psychologists, social workers and occupational therapists experience in providing Psychological Therapy Services or Focussed Psychological Strategies under Better Access? (Tick all that apply)	☐	The number of available sessions is too restrictive
	☐	The fact that Better Access is designed to serve consumers who meet certain diagnostic criteria means that some consumers miss out
	☐	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 adequately 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 (e.g., case conferences between providers)
	☐	Other (Please describe) ______________________________________
78. What things act as facilitators to psychologists, social workers and occupational therapists providing Psychological Therapy Services or Focussed Psychological Strategies under Better Access? (Tick all that apply)	☐	Good communication with referrers
	☐	Well-documented Mental Health Treatment Plans from referrers
	☐	Timely reviews by referrers
	☐	The ability to offer care that is tailored to consumers' needs
	☐	The ability to offer care that is affordable
	☐	Other (Please describe) ______________________________________

[Questions for all participants]

Thinking about the overall Better Access program, please rate the extent to which you agree or disagree with the following statements.	**1 Strongly disagree**	**2 Disagree**	**3 Neither disagree nor agree**	**4 Agree**	**5 Strongly agree**
79. Better Access enables providers to meet the needs of consumers	☐	☐	☐	☐	☐
80. Better Access allows providers to offer services that are accessible and affordable	☐	☐	☐	☐	☐
81. The type of care that providers can offer through Better Access is comprehensive	☐	☐	☐	☐	☐
82. The rules around Better Access make sense	☐	☐	☐	☐	☐
83. The administrative processes associated with Better Access are straightforward	☐	☐	☐	☐	☐
84. Better Access has decreased inequalities in mental health care	☐	☐	☐	☐	☐
85. Better Access fosters good coordination of care	☐	☐	☐	☐	☐
86. Better Access has led to opportunities for professional development and training	☐	☐	☐	☐	☐
87. Better Access has enhanced the viability of private practice for some providers	☐	☐	☐	☐	☐
88. Better Access has improved outcomes for consumers	☐	☐	☐	☐	☐
89. Is there anything else you would like to tell us about Better Access? Please write your comments here:					

Thank you for completing this survey