National Mental Health Commission
July 2022

Feedback on the Better Access initiative first draft interim report

Australian Government
National Mental Health Commission

Feedback on the Better Access initiative first draft Interim report

The Commission commends the overall quality of the draft interim report, its methodology and data. The Commission recommends further work to strengthen the evaluation, through:

- clearer articulation of the purpose and intent of the research
- greater acknowledgement of study limitations and exploration of alternative explanations for data findings
- deeper analysis to include and explore insights gained across studies, particularly from people with lived experience of mental illness
- exploring the impact of recent changes to the Better Access initiative
- more collection and analysis of disaggregated data to better understand differences in access, experience and impact.

About the National Mental Health Commission

The National Mental Health Commission (the Commission) provides cross-sectoral leadership on policy, programs, services and systems that support better mental health and social and emotional wellbeing in Australia. There are three main strands to the Commission's work: monitoring and reporting on Australia's mental health and suicide prevention system; providing independent advice to government and the community; and acting as a catalyst for change.

The Commission's underpinning principle is the Contributing Life Framework. This framework acknowledges that a fulfilling life requires more than just access to health care services. It means that people who experience mental ill health can expect the same rights, opportunities, physical and mental health outcomes as the wider community.

Vision 2030: Blueprint for Mental Health and Suicide Prevention (Vision 2030) is a blueprint for a successful, connected mental health and suicide prevention system to meet the needs of all Australians. As part of the federal Department of Health's 10-year plan, it takes a long term approach to change and improvement.

Vision 2030 takes a whole-of-community, whole-of-life and person-centred approach to mental health; a vision to provide easily navigated, coordinated and balanced community-based services that are offered early to meet each individual's needs and prevent escalating concerns.

Feedback

Thank you for the opportunity to provide feedback on the Better Access Initiative draft interim evaluation report.

In preparing our feedback, the Commission has applied the lens of Vision 2030. That is, we have considered whether the evaluation will help inform the policy decisions and program design required to create a system where people can access care that is accessible, integrated, embedded in their community, meets the full continuum of their needs, and gives them a positive experience.

The Commission commends the overall quality of the draft interim report, its methodology and data. The studies are well designed and the findings are robustly considered. From the Commission's perspective, this evaluation provides a significant opportunity to identify not only for whom the program is working, but for whom it is not and why not. Our overarching feedback is that the evaluation does provide useful direction on the gaps in our knowledge and understanding. However, there are several ways in which the interim evaluation design and methodology could be strengthened to maximise its usefulness for informing future policy and program decision-making.

1. More clearly articulating purpose and intent of the research

The report could clearly define the scope of the evaluation and the purpose and intent of each of the studies undertaken, so it is clear what questions each study seeks to answer.

For example, this could be achieved by revising **Section 2: Evaluation overview** to include:

- A more detailed description of the overarching evaluation approach/methodology and how the approach may support effective utilisation of the findings for future reform of the Better Access initiative.
- A brief overview of what is currently known about the Better Access initiative to explain the value of this evaluation and what new questions the data is able to speak to.
- Identifying the time period in which data was collected for each study to assist in understanding the recency of the data/generalisability of the findings
- Clearly identifying specific research questions and aims for each study, and including a description of how the measures collected address the research questions.

In Stage 2 'Future Reforms', we recommend including more detail about the purpose and utility of "articulating a collective vision", as opposed to simply developing actionable recommendations.

More broadly, we understand (from stakeholder engagement sessions) that the studies aim to answer broader questions related to accessibility, responsiveness, appropriateness, effectiveness and sustainability. This thematic structure could be made more explicit in the report itself, which would also help inform stakeholder feedback on the next stages of the evaluation. It is also unclear if the studies, as currently designed, will provide answers to those higher level questions.

2. Include greater acknowledgement of study limitations and exploration of alternative explanations for data findings

The report would benefit from greater acknowledgement of the limitations of each study and exploration of alternative explanations for data findings. Specifically:

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

- While the results showed that those with more a severe baseline recorded had a greater probability of showing improvement, it is important to note that this could in part be explained by ceiling/floor effects (i.e. those who are relatively less severe at the start of treatment have less room to improve compared with those who are more severe initially). Similarly, while the results suggest that there is a greater likelihood of improvement with a greater number of sessions, another explanation is that those who those who are not experiencing benefits may be less inclined to continue treatment. If the data is

available, the Commission would recommend the evaluators explore this possibility, for example through analysis of number of sessions as well as whether treatment was completed.
- The report concludes that “there was some evidence that older consumers were less likely to show improvement”. It would be useful to know whether such differences still exist when controlling for other factors that may vary across age groups (such as baseline symptom severity).

Study 3 – A survey of the experiences and outcomes of consumers recruited through Medicare:
- While the results indicated “overwhelmingly positive experiences/improvements”, this may reflect a self-selection bias among respondents, as those Better Access participants whose mental health has not ‘improved’ may be less likely to self-select to complete a survey.
- Results relating to improvement in outcomes should be interpreted with some caution due to retrospective biases, as participants were asked to think back to how their mental health was before they received treatment through Better Access, and then consider how it was after they had done so.

Study 6 – Qualitative interviews with people with lived experience of mental illness:
- The Commission recommends the limitations of this study be acknowledged, including the small sample size, limited representation of people from different backgrounds and lived experience perspectives (e.g.,. only four male respondents), and recruitment via only two organisations.

Study 7 – A survey of providers and referrers:
- The Commission recommends including information about how many providers were eligible to respond to the survey, or that received reimbursement through Better Access, to give an idea of proportion of providers that responded.

3. Deepen analysis to include and explore insights gained across studies, and particularly from people with lived experience of mental illness

The report findings could be strengthened through analysis that draws the findings of different studies together to triangulate the data or illuminate tensions between different data sources. For example, between relatively high rates of bulk-billing shown in quantitative data and the experiences of cost as a barrier to access services expressed through qualitative data.

For example, the indicative findings from **Study 4 – Consumer characteristics, treatment patterns, and clinical change associated with Better Access treatment services: Re-analysis of data from two randomised controlled trials.** This could be amplified through the other studies to more closely examine the access rates for people aged 56+ years, and the lower improvements for people aged 36-55 years and 56+ years.

A similar approach could be taken across other studies. The Commission recommends expanding and extending **Study 6 – Qualitative interviews with people with lived experience of mental illness**. In particular, we suggest the study seek input from a greater diversity of people with lived experience, including a greater proportion of men and older people, and to seek information about the extent to which the Better Access initiative supported coordinated and collaborative service delivery.

Study 7 – A survey of providers and referrers could also be expanded to seek further information from providers about the benefits and challenges of the initiative in terms of improving access, coordination, quality and continuity of care.

4. Explore the impact of recent changes to the Better Access initiative

In its current form, the evaluation misses the opportunity to understand how recent changes to Better Access have, or have not, improved access. In particular, the Commission recommends the evaluation explore the impact of recent temporary changes/expansions of the Better Access initiative in response to the Black Summer Bushfires and the COVID-19 pandemic on uptake and user experience, including any differences between different cohorts of users.

5. Greater collection and analysis of disaggregated data to better understand differences in access, experience and impact

Wherever possible, the Commission recommends data be analysed to understand differences across gender, age, sexuality, Indigeneity and cultural and linguistic background, geographic location (metropolitan, regional and remote), mode of delivery and service-provider type.

The evaluation could be strengthened by exploring whether Better Access is suited to people whose mental health conditions have been precipitated by the recent natural disasters mentioned above. We note the data is being analysed in aggregated form, which makes a more focussed analysis along these lines challenging. We suggest further stages of the evaluation undertake specific qualitative data collection with populations who may have been disproportionately impacted by natural disasters.

Noting the planned inclusion of **further work to understand Better Access initiative in aged care settings**, the Commission recommends this study go beyond looking only at aged care settings to also more closely examine the emerging data from the existing studies indicating barriers to access and poorer outcomes for older people through the initiative.

Including additional information about the size and geographic distribution and setting (i.e. private, public or not-for-profit) of the mental health workforce who claim (and who are eligible to claim) through Better Access initiative would be helpful to better understand the availability of the initiative and people's access to service providers. Extending this analysis to determine any differences in affordability indicators and consumer outcomes between different types of providers would also be of benefit.

Further, the interim evaluation flags that earlier and current evaluations identify that the program seems to be working best for those with moderate to severe mental health conditions, whereas the intended goal of the program is to*: improve treatment and management for people who have mild to moderate mental health conditions. These are cases where short-term evidence-based interventions are most likely to be useful. https://www.health.gov.au/initiatives-and-programs/better-access-initiative#goals-of-the-initiative.* The evaluators could also consider exploring what this insight is telling us about the relevance and the effectiveness of the program for those with mild conditions (for whom the program was/is in part intended).

Finally, if possible, it would be beneficial for the evaluation to draw out any differentiation between bulk-billing and gap fees for treatment provided (under Better Access funding) by NGOs versus private operators. For example, bulk-billing might be common for programs delivered by NGOs, but those programs will have exclusion criteria and only be available to a subset of people (for example, people accessing Better Access via headspace must be aged under 25 years).