Evaluating the Better Access initiative: What do consumers have to say?

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Abstract

The Better Access to Psychiatrists, Psychologists and General Practitioners (GPs) through the Medicare Benefits Schedule initiative (Better Access) aims to improve outcomes for people with common mental disorders by encouraging a multi-disciplinary approach to their mental health care. The current paper presents consumers' views on Better Access. A total of 936 consumers completed a structured survey or took part in an interview about their experiences with Better Access. Participants appreciated the fact that Better Access made psychological care affordable. They accessed services because they had high levels of symptomatology, often exacerbated by stressful life events. Most were impressed by the quality of care available through Better Access, and found that the number of available sessions was sufficient to meet their needs. Most importantly, the vast majority experienced significant reductions in symptoms and improvements in coping abilities, and they attributed these changes to the care they received through Better Access. Consumers are the most important stakeholders in any debate about mental health care delivery. Until now, however, they have not been well-represented in discussions about Better Access. Our study gave them the opportunity to air their views, and their first-hand impressions of the initiative were generally very positive.

Key words: Better Access, Mental Health, Medicare

Introduction

Depressive and anxiety disorders are the most common mental health problems worldwide (Moussavi et al., 2007; Somers, Goldner, Waraich, & Hsu, 2006). Global health policies have been concerned with improving access to and providing evidence-based psychological treatment for these disorders (Horton, 2007). To address the gaps in the provision of primary mental health care for these disorders in Australia, one initiative introduced by the Australian Government was the Better Access to Psychiatrists, Psychologists and General Practitioners (GPs) through the Medicare Benefits Schedule initiative (Better Access). This paper describes a study of consumers' experiences of Better Access that was conducted in the context of a broader evaluation that drew on 20 different data sources (Pirkis, Ftanou, Williamson, et al., 2010; Pirkis, Harris, Hall, & Ftanou, 2011; Pirkis, Williamson, et al., 2010).

Better Access

The overarching aim of Better Access was to improve outcomes for people with common mental disorders by encouraging a multi-disciplinary approach to their mental health care. The initiative has seen some modifications since its introduction in November 2006. Initially, the Medicare item numbers associated with the program enabled GPs to refer consumers to recognised allied health professionals (eligible psychologists, social workers and occupational therapists) for a time-limited course of mental health care. The referral involved the GP completing a prescribed mental health treatment plan, and the number of sessions a given consumer could receive was six in the first instance. A further six sessions were available if the referring GP deemed this to be necessary upon review, and an additional six were available in exceptional circumstances. Unexpectedly high uptake of the program and a consequent high cost led to the Australian Government seeking some economies. In 2010, the single Medicare item number for GPs preparing a mental health treatment plan was replaced by two item numbers, so that GPs who spent longer preparing a plan were paid more than GPs who did so in a brief

session. The total number of sessions with an allied health professional available to consumers was reduced from 18 to 10, although this has since been raised again and now sits at 16.

Better Access has been the subject of considerable debate. Firstly, various observers have focused on the unanticipated level of funding required for the program, and have contended that it has not made a difference for the people for whom it was designed (Dunbar, Hickie, Wakerman, & Reddy, 2007; Hickie, Rosenberg, & Davenport, 2011; Rosenberg & Hickie, 2011a, 2011b; Rosenberg, Hickie, & Mendoza, 2009). Our own evaluation of Better Access indicated that in fact it is meeting previously unmet consumer need, making psychiatric care affordable, yielding good consumer outcomes, and fostering collaborative relationships between health professionals (Bassilios et al., 2010; Fletcher et al., 2011; Jorm, 2011; Pirkis & Harris, 2011; Pirkis, Harris, Ftanou, & Williamson, 2011). Secondly, the role of social workers and occupational therapists in delivering services has been the subject of debate. In order to redirect funds to Flexible Care Packages for people with a severe mental illness, in 2010, the Australian Government announced that accredited mental health social workers and occupational therapists would no longer provide services under Better Access. However, due to stakeholder feedback this decision was later retracted and the funding reinstated (Australian Association of Social Workers, 2010; Department of Health and Ageing, 2010).

Lastly, certain aspects of our evaluation of Better Access have been criticised by some observers. In particular, these commentators have discounted the findings from a before-and-after study of consumer outcomes that we conducted as part of the evaluation. The study was criticised on the grounds that it was not a randomised controlled trial, that our participating consumers were recruited by providers, and that our sample size was not sufficiently large or representative (Allen & Jackson, 2011; Hickie et al., 2011). We have rebutted these criticisms elsewhere (Pirkis, Harris, Ftanou, et al., 2011), and other independent researchers have acknowledged that our evaluation was conducted as rigorously as

possible in the circumstances (i.e., the universal roll-out of the program precluded a randomised controlled trial (Jorm, 2011).

One of the key features that has been missing from the Better Access debate is the voice of the consumers whom Better Access is targeting. Even a 2011 Senate Inquiry into Commonwealth funding and administration of mental health services (which included an emphasis on Better Access) was predominantly informed by the views of professional bodies and mental health care providers; relatively more submissions came from service providers and professional groups than from individual consumers and carers or the organisations that represent them (Senate Community Affairs References Committee, 2011).

Consumer perspectives can provide useful information about the quality of a service and highlight how services can be improved (Glick, 2009). Despite this, consumers' perspectives are generally scant in evaluations of large national primary mental health care initiatives, particularly compared with evaluations of specialist mental health services and general health services (Lebow, 1983; Simpson & House, 2002; Sitzia & Wood, 1997). There are some exceptions, but these generally rely on survey data and do not have the capacity to collect and analyse in-depth responses from significant numbers of consumers. For example, the *Improving Access to Psychological Therapies* (IAPT) program in the UK which aims to provide services to 900,000 consumers per annum, has built into its evaluation approach a Patient Experience Questionnaire, but has reported qualitative feedback from only 40 participants at a single site (Delgadillo, 2010). In Australia, Divisions of General Practice involved in delivering Access to Allied Psychological Services (ATAPS) projects have conducted various surveys of consumers, but the different survey instruments have made it difficult to analyse qualitative responses to open-ended questions in any systematic way (K. King et al., 2012).

The current study represents the first opportunity for a significant number of consumers to contribute their views about their experiences with the Better Access initiative. It explored consumers'

barriers to seeking care, motivations for seeking treatment, perceptions of the Better Access services they received, positive and negative aspects of their care and the outcomes of their care. As noted, consumers' views were collected as part of a broader evaluation of Better Access which has been described in detail elsewhere (Pirkis, Ftanou, et al., 2011; Pirkis, Ftanou, Williamson, et al., 2010; Pirkis, Harris, Hall, et al., 2011; Pirkis, Williamson, et al., 2010).

Method

The study was approved by the Human Research Ethics Committee at the University of Melbourne.

Participants and Procedures

The study recruited five groups of Better Access consumers: (1) those seen by GPs; (2) those seen by clinical psychologists; (3) those seen by registered psychologists; (4) those seen by social workers; and (5) those seen by occupational therapists (OTs). Respondents in all groups were asked about their experiences with Better Access.

Participating consumers were recruited via providers. The Medical Benefits Division of the Australian Government Department of Health and Ageing (DoHA) identified a random selection of providers who had rendered services under the relevant Better Access item numbers in the 12 months from 1 June 2009, stratified by provider type (GP, clinical psychologist, registered psychologist, social worker, occupational therapist). DoHA provided contact details for these providers and we sent them letters of invitation, plain language statements and consent forms. Those who agreed to participate were then asked to approach English-speaking consumers to invite them to participate (again with letters of invitation, plain language statements and consent forms that we had prepared). Clinical psychologists, registered psychologists and GPs and were asked to approach the next 20 new consumers when they first presented for Better Access-funded services. Participating social workers and occupational therapists were asked to approach the 10 Better Access consumers who had most recently completed treatment. All consumers who agreed to participate in the study were required to return a

consent form to the evaluation team either directly or via their provider. These differences in recruitment instructions related to the fact that consumers seen by GPs and psychologists took part in the above-mentioned study of consumers' outcomes (Pirkis, Ftanou, et al., 2011) which meant that they had to be 'picked up' before they began treatment so that a baseline assessment could be made. Social workers and occupational therapists were initially not included in the evaluation of patient outcomes as it was thought that they provided services to only a small portion of consumers through Better Access and their ongoing role in the initiative was unclear. However, when social workers and occupational therapists were reinstated as Better Access providers, an additional evaluation component examining the experiences of consumers seen by social workers and occupational therapists was developed and implemented.

Data Collection

Information was sought from all participating consumers after their last session of care, with the exception of a small group who were recruited by clinical psychologists, registered psychologists and GPs and were still in treatment at the end of the study period. Data collection occurred via standardised interview schedules or self-completion surveys, containing identical questions. Participants who were recruited by clinical psychologists, registered psychologists and GPs were initially offered an interview, and a small number for whom an interview was not convenient were asked to complete the survey. The situation was reversed for participants recruited by social workers and occupational therapists; for expediency, these groups were preferentially asked to complete the survey and only a small number took part in an interview. All interviews were conducted over the telephone by a trained member of our study team, and recorded and transcribed. The surveys were returned to the study team in reply-paid envelopes.

Interviews and surveys took 20 to 40 minutes to complete. Participants were asked up to 24 open-ended questions about their experiences of accessing Better Access services, covering topics such as

accessibility of services, barriers to seeking care, satisfaction with care, negative aspects of care and whether they believed that the care was beneficial to them. Consumers were also asked to provide basic demographic information such as age, gender, locality and language spoken at home. This demographic data was used to profile the study consumers against the broader population of Better Access consumers. Participants were asked to complete check-box and free text responses.

Data Analysis

Interview and survey data were analysed using a thematic analysis approach (N. King, 2004). The consumer interview and survey responses were transcribed into Excel spreadsheets and coded for content and themes. Data were initially sorted into seven *a priori* themes informed by the questions that were used for the interviews. These were: barriers to seeking mental health care; prompts to seeking care through the Better Access initiative; sessions attended; experiences of the payment processes; satisfaction with care received; negative aspects of care received; and personal impacts of treatment. Within these seven broad categories of responses, data were then coded into 'sub-themes'. Codes for the sub-themes were developed through an iterative process of data analysis that involved reading and re-reading responses. Between six and eight sub-themes were identified for each of the key theme categories. The criteria for identifying sub-themes were recorded in codebooks to ensure consistency in the way codes were allocated to segments of text and to promote inter-coder reliability. A small number of transcripts were also cross-coded to further ensure inter-coder reliability. Once data had been coded, responses were then quantified to determine how frequently they were nominated. This approach to data analysis generated descriptive (text-based) insights into respondents' experiences of Better Access and enumerated frequency of issues mentioned (calculated as percentages). The findings are presented for the participant group as a whole because no notable differences between groups were observed. In reporting the findings excerpts of text data have been selected to illustrate typical responses.

Results

Profile of Participants

A total of 936 consumers participated in a survey or interview (121 were recruited by GPs, 133 by clinical psychologists, 152 by registered psychologists, 458 by social workers, and 72 by occupational therapists). Table 1 provides a breakdown of the key socio-demographic and clinical characteristics of participants. Wherever possible, comparisons are made between participants and the overall group of Better Access consumers. Participants recruited by each of the five provider groups were broadly similar to all consumers who received Better Access care from these providers in terms of their age and gender. In each case, approximately two thirds of participants were female and three fifths were in the youngest three age groupings. Due to our sampling strategy, there was an over-representation of consumers living in rural areas among the GP-, OT- and psychologist-recruited participant groups; the urban-rural profile of participants recruited by social workers matched those of the general populations of consumers seen by these providers. Consumers from areas of relatively lower socio-economic disadvantage were over-represented in the GP- and psychologist -recruited participant groups but more evenly distributed amongst the social worker- and OT-recruited participant groups. The study design meant that it was not appropriate to explore whether statistically significant differences existed between the consumer groups because the groups were taken from different and unequal time periods. The overall group of Better Access consumers were seen by relevant providers between the 1st of January 2009 and the 31st of December 2009 and the participating consumers received care between the 1st of October 2009 and the 31st of October 2010.

Previous Barriers to Seeking Mental Health Care

Participants were asked about any barriers they had experienced to seeking mental health care in the past. Their responses fell into the categories listed in Table 2. Cost was by far the greatest barrier.

Overall, 62% indicated that this had limited their help-seeking behaviour in the past, making comments like: “Mainly the cost” and “I put it [seeking treatment] off because of the cost.”

The availability of services and difficulties in accessing them were also mentioned relatively frequently. Specifically, some participants noted that distance and associated travel time had limited their access in the past and that sometimes they had experienced long waiting times. Typical comments were as follows: “Many specialists are unavailable in my region” and “[it’s] very hard to get appointments because of waiting lists to see any of these professionals.”

Personal factors were another comparatively common obstacle. These included overcoming the anxiety involved in seeking care, fears about “opening up”, lack of motivation, and feelings of “not being ready.” Several participants reported previously believing that they could cope on their own. The following comment exemplifies these responses: “my own idea that I should not have to talk to [someone] other than a GP as I should be able to deal with depression by myself.”

Another commonly-reported barrier was the lack of knowledge about available services. Participants made comments like: “Not knowing who or where to go for help. When [I] finally started seeking [searching for a provider] there was a long waiting list. Help would have been better during [the] crisis” and “I didn’t know exactly who or what type of help I needed or where to start looking.”

Other barriers nominated by a small number of participants included previous negative experiences with mental health services, a lack of recognition that help was required, and stigma.

Prompts to Seeking Care

Participants were asked what prompted them to seek mental health care on this occasion. Their responses fell into the seven sub-themes listed in Table 3.

The most frequently reported reason for seeking care was worsening or unremitting mental health symptoms. Participants mainly described symptoms of anxiety and depression, talking about them in the following ways: “Increasing need due to worsening of anxiety and depression”; “[I] just got sick of

feeling down all the time and wanted to do something about it”; “I felt that it was not worth being here. I lost my self-esteem, my nerves were very bad I worried about having another breakdown”; and “I was struggling with anxiety problems and panic attacks. This was causing an amount of depression.”

Many participants indicated that they had sought specialist mental health care at the recommendation of another health professional, usually a GP: “A referral from a GP. He suggested that I see someone. He believed I was suffering depression and on top of that I went from depression to anxiety. I wouldn't have thought of seeing someone otherwise.”

Stressful life events were also frequently cited as the reason for help-seeking. Experiences such as a relationship break-up, the death of a loved one, loss of employment and the birth of a child often acted as a catalyst. Participants made the following sorts of comments: “My mother had a stroke and I had a bypass and I got very depressed”; “I became a mother fairly quickly after being married. It was a big change of lifestyle and I needed support”; and “My family (husband and son) all suffered the loss of our new baby girl through a very sudden still birth.”

Some participants also indicated that the main trigger for seeking help was their own recognition that they needed treatment. These participants made statements like: “To help me learn to cope with problems in my life” and “I suddenly realised that if I didn't do something that this thing was going to be bigger than me really and was going to just swallow me up.”

Other responses indicated that participants had sought treatment on the advice of family and friends, because of related health problems or addiction problems.

Sessions of Care

Participants were asked about the number of sessions of care they had received. Two-thirds of participants (612 or 65%) reported that they had received treatment for the recommended number of sessions and/or experienced sufficient improvement to cease care, or were still continuing care. Most were satisfied with their number of sessions and made comments like: “We'd had six sessions. I think I

was entitled to 12, but the issues were quite thoroughly, I think, dealt with. It was a very positive outcome”; and “I was doing quite well managing my depression or how I was feeling and coping with things, she'd given me a number of tools and I felt quite safe to not have to rely on her.”

A minority of participants (85 or 9%) had discontinued care before the recommended number of sessions because they were dissatisfied with some aspect of treatment. Reasons for discontinuing included the cost of treatment, lack of rapport with the therapist, difficulty fitting their treatment in around other responsibilities, running out of Medicare-subsidised sessions, and concerns that the treatment was not making any difference. These issues are highlighted in the following comments: “I could not afford to pay the rebate”; I didn't feel she was helping me at all. In fact, she made me feel like my problems were worse than they were. She was extremely unsympathetic to my feelings”; and “I can't get there during the hours that they are open and they don't open after 5pm. I just can't get time off work at the moment to get there.”

Process of Receiving Care Through Medicare

Participants were asked about their experiences of the Medicare rebate process. Five hundred and fifty nine (60%) indicated that they found the process straightforward, using adjectives like “good”, “easy” and “helpful”. Two hundred and forty eight (26%) explicitly noted that Better Access had lowered costs. These sentiments are exemplified in the following quotations: “Excellent – was a big help financially and was easy to process rebate”; and “Medicare refund made service easier to obtain so the process was good in that it helped provide access to the service.”

A small number of participants (62 or 6%) reported that the process was “poor”. These participants were often critical of bureaucratic aspects such as the referral requirements, the paperwork and the bulk billing process. They felt that these were unnecessarily cumbersome and time-consuming and that the out-of-pocket expenses were high. The following responses summarise their concerns: “It was annoying to have to go through the mental assessment at the GP just to be able to get the refund”; and

It was good except for the fact that I had to have the money, and instead of paying the gap I had to pay the whole amount and then get the refund. Sometimes I did not have the \$100. If you just had to pay the gap fee it would be a far more accessible system.

Satisfaction with Care Received

A large majority of participants (889 or 95%) reported being satisfied with the care they received. In particular, participants were satisfied with providers' attributes and competency, the qualities of their interactions with providers and the usefulness of the advice, strategies and guidance that they received. Typical responses included: "She was insightful, experienced, very good and non-judgemental, compassionate and really objective which is what I was seeking"; "Skills to manage anxiety. Support to get back into the community"; "My condition has improved dramatically. I valued my existence at 1/10 when I sought help, now I feel 7/10. The breathing techniques, positive thinking strategies and learning new ways to communicate were good aspects"; and "I went to a psychologist and I did cognitive behavioural therapy and it was mainly just good because it's just teaching you really practical things. Really useful things."

Negative Aspects of Care

Participants were asked what aspects of care were unsatisfactory. Six hundred and fifty nine (70%) either explicitly reported that there were no negative aspects of their care, or did not comment. Two hundred and seventy seven (30%) reported negative aspects of care, and 242 of these consumers could articulate them. The negative aspects of care they mentioned are outlined in Table 4.

Some participants who reported negative aspects of care focused on the restricted number of sessions, the time allocated for sessions and the waitlists. The following responses exemplify their comments: "Sometimes the time is too short. Half hour session is too short"; "Limited to 12 sessions under mental health care plan"; and "Timelines. It was difficult waiting so long for an appointment."

Others focused on features of the therapeutic process, rather than the service itself. This was usually because they were unfamiliar or uncomfortable with counselling processes or they had to revisit painful experiences. They recognised, however, that this was part of the recovery process. For example one participant said: “In the beginning it was about talking about the trauma and reliving that was re-traumatizing.”

Some were ambivalent about the usefulness of treatment, or felt uncomfortable with or misunderstood by their provider. One participant put it this way: “I feel that she was trying to provide practical solutions to my problems but not really trying to work out emotionally what was going on for me.”

Some consumers identified difficulties with payments (e.g., having to pay a co-payment and/or to pay up front, and having to pay a cancellation fee) and affordability as negative aspects of care. These participants made comments like: “Still costly at \$45 per session after rebate” and “not being able to see her more often because I can't afford the sessions.”

Changes in Wellbeing

Participants were asked whether their general wellbeing had changed since seeing their provider, and nearly all felt that it had. Table 5 summarises the kinds of changes participants observed.

Most commonly, participants spoke of improvements in their mental health. They discussed reductions in their symptoms, and commented on the strategies they had learnt to modify maladaptive thought patterns and change negative behaviours. They made comments like: “Much better control of anxiety”; and “Yes, my suicidal tendencies are far less.”

Many reflected on more general improvements (e.g., increased confidence, improved outlook on life, better attitudes), and some discussed improvements in their physical health, lifestyles and ability to return to work. Examples of these responses include: “Got back on my feet, and was able to survive my job. I fell apart when I first went in and now I'm feeling pretty strong and capable”; and “Resolved

severe emotional pain that I have had all my life. Slept much better. Changed negative thinking. Increased self-esteem. Loss of weight. Increased enjoyment of life – best I have ever been. More insight into myself”.

Less frequently, participants noted reductions in unhealthy behaviours and few participants discussed that although symptoms had improved their underlying problem still remained. They made comments like: “I can be very up and down. However, I have found that it has been very helpful when I have been in the right headspace, and haven't been having a meltdown.”

Attribution of Change

Participants were asked to consider the extent to which they would attribute any changes they had noticed to having seen their given provider. Four hundred and seventy five participants (51%) “totally” attributed their observed changes to their provider, and 301 (32%) “partially” did so. A small number (49, or 5%) did not attribute changes to the provider at all, and 111 (12%) did not respond to this question.

Discussion

Overall, consumers in our study were very positive about Better Access. They appreciated the fact that Better Access had made psychological care affordable; only a small minority appeared to be experiencing difficulties with up-front fee payments and the administrative demands of claiming their rebate. These consumers were accessing services because they had high levels of symptomatology, often exacerbated by stressful life events. Most were impressed by the quality of care available through Better Access, and found that the number of available sessions was sufficient to meet their needs. Most importantly, the vast majority experienced significant reductions in symptoms and improvements in coping abilities, and they attributed these changes to the care they have received through Better Access. A minority of consumers felt misunderstood by providers, were unfamiliar with the therapy process and felt that they were not given a sufficient number of sessions to meet their needs.

The positivity of consumers towards the Better Access initiative is consistent with research regarding consumer experiences of health services more broadly. Research has found that consumer perceptions of health services are generally favourable and can be influenced by factors such as politeness, appreciation of accessing a service and hesitancy in reporting negative aspects (Glick, 2009). In this case, however, consumers' positive views were consistent with other indicators of service quality, including the objectively-measured improvements in mental health outcomes found in the broader evaluation. (Pirkis, Ftanou, et al., 2011).

Our study had a number of limitations. We deliberately used providers as intermediaries in our recruitment of consumers, because we had no other way of identifying consumers who had received services from these providers. An alternative might have been to issue a general call (e.g., via the *beyondblue* website) inviting anyone who had received such services to take part in the survey or interview, but this would have introduced systematic biases (resulting in an over-representation of people with a history of mental health service use). In addition, our previous experience suggests that consumers do not always know the profession of the provider from whom they have received care, so it is likely we would have inadvertently recruited consumers who had seen other types of providers. Ultimately, our samples of consumers were fairly representative of the groups from which they were drawn but we acknowledge that there may have been a potential for selection bias resulting in providers recruiting more satisfied consumers to take part in the research.

Some comment must also be made about the numbers of consumers in our study. A sample of 936 participants is relatively large in comparison those in other studies of this kind (Delgadillo, 2010; Lebow, 1983). Our response rates for consumers who were recruited by social workers and occupational therapists were 38% and 33%, respectively. We could not calculate precise response rates for consumers recruited by GPs and psychologists because we were not privy to how many consumers each provider approached, but they were likely to be respectable. It is acknowledged, however, that in

absolute terms our numbers represent 0.06% of all consumers seen by GPs, clinical psychologists, registered psychologists, social workers and occupational therapists through Better Access in the reference year. Importantly, we found that our interview and survey rapidly reached a point of “saturation” where participating consumers were not adding any new perspectives. This suggests that we elicited a comprehensive range of views, and that increasing our sample size would not have altered our findings.

It is also acknowledged that our consumer groups were of discrepant sizes. Participating consumers who were seen by social workers dominated (accounting for 1.62% of all consumers seen by these providers), and consumers seen by occupational therapists were also relatively well represented (1.41%). We explicitly looked for differences in responses across groups, but found none of note. We are confident, therefore, that our findings were not “swamped” by data from these proportionally larger consumer groups.

Consumers who did not speak English were “out of scope.” This decision was made for resourcing reasons; we did not have the capacity to translate the interviews/surveys into other languages, or to make use of interpreters. We acknowledge, however, that this strategy introduced a systematic bias. The characteristics of Better Access consumers from culturally and linguistically diverse backgrounds may be different from those of their English-speaking peers, as may their clinical outcomes. They may also have different experiences of receiving care through Better Access.

Like any survey- or interview-based study, the current study relied on self-report. It examined the experiences of consumers, so there were no right or wrong answers, but participants that completed the surveys/interviews may have given socially desirable responses. There may also have been some biases in their likelihood of recalling particular experiences. For example, participants who got better may have been more likely to recall positive experiences with Better Access and those who did not have

positive experiences with the initiative may have also chosen to decline to participate in the qualitative part of the evaluation.

Conclusions

Notwithstanding the above limitations, our findings add an important consumer perspective to the debate around Better Access. Better Access is filling an important gap in mental health care delivery for these consumers; it has reduced the costs associated with accessing primary mental health care for them and has resulted in significant improvements in their mental health and wellbeing. Many of these consumers come from the very groups that Better Access critics would argue are being let down by the initiative (Dunbar et al., 2007; Hickie et al., 2011; Rosenberg & Hickie, 2011a, 2011b; Rosenberg et al., 2009). They are not the group that has been pejoratively called “the worried well”; they are people who are experiencing significant psychological problems and major life stressors. They are not all residents of wealthy metropolitan suburbs; many come from areas of lower socio-economic status and rural areas. The broader Better Access evaluation indicated that many of these consumers were also experiencing significant psychiatric morbidity and were first time users of mental health services (Pirkis, Ftanou, Harris, & Williamson, 2010).

The findings from the study have a number of implications for Better Access providers, policy makers and researchers. When delivering Better Access services, providers should ensure that barriers to participation such as out-of-pocket expenses and waiting lists are considered. They should also acknowledge and address the specific needs of consumers and ensure that they are competent, compassionate, objective and non-judgemental. Policy makers could consider addressing barriers to care such as lack of knowledge of available services, accessibility of services in remote areas and cost of services. Researchers designing evaluation studies for primary mental health care programs should consider incorporating a consumer evaluation component and recognise that randomised control trials

are not always possible and other techniques such as collecting data from a variety of sources and triangulation may be required.

The voice of consumers accessing primary mental health initiatives is critical to the assessment of service quality and identification of potential service improvements. Policy makers and researchers need to include consumer participation early on in the development of new initiatives and build in a routine evaluation using a standardised measure of patient experience, as the IAPT program has done. Finally, the Better Access initiative would benefit from ongoing consumer evaluation studies, including a more detailed examination of the experience of people with English as a second language and consumers under the age of 16 years to identify any unique access, policy and service implications for these groups.

Consumers are the most important stakeholders in any debate about mental health care delivery. Until now, however, they have not been well-represented in discussions about Better Access. This is the first evaluation of Better Access to include consumers and it gave consumers the opportunity to share their views, and their first-hand impressions of the initiative were generally very positive. Their perspective should certainly be taken into account in future planning around Better Access and other primary mental health care programs.

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Table 1: Socio-demographic characteristics of Better Access consumers

		Consumers seen by GPs				Consumers seen by clinical psychologists				Consumers seen by registered psychologists				Consumers seen by social workers				Consumers seen by occupational therapists			
		Participating consumers ¹ (n=121) ³		All consumers ² (n=971,836) ³		Participating consumers ¹ (n=133) ³		All consumers ² (n=100,434) ³		Participating consumers ¹ (n=152) ³		All consumers ² (n=348,417) ³		Participating consumers ² (n=458) ³		All consumers ² (n=28,276) ³		Participating consumers ² (n=72) ³		All consumers ² (n=5,103) ³	
		Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%	Freq	%
Gender	Male	33	27%	351,621	36%	48	36%	69,254	37%	45	30%	124,498	36%	92	20%	8,806	31%	17	24%	2,437	49%
	Female	86	71%	620,215	64%	83	62%	120,164	63%	107	70%	223,919	64%	361	80%	19,470	69%	55	76%	2,666	52%
Age	<30	11	9%	308,421	32%	30	23%	672,36	35%	21	14%	117,374	34%	73	16%	5,372	19%	15	21%	1,174	23%
	30-39	21	17%	216,330	22%	30	23%	43,092	23%	29	20%	79,070	23%	113	25%	4,806	17%	15	21%	970	19%
	40-49	36	30%	195,278	20%	20	15%	37,392	20%	35	23%	71,964	21%	116	26%	5,089	18%	14	19%	970	19%
	50-59	25	21%	139,853	14%	32	24%	26,095	14%	43	29%	49,607	14%	92	20%	4,806	17%	15	21%	868	17%
	60-69	21	17%	71,977	7%	9	7%	11,530	6%	18	12%	22,470	6%	43	9%	4,524	16%	8	11%	612	12%
	>69	3	2%	39,977	4%	5	4%	4,073	2%	5	45%	7,932	2%	16	4%	3,676	13%	4	6%	510	10%
Region⁴	Metropolitan	40	33%	717,817	74%	42	32%	157,569	83%	51	34%	260,651	75%	263	71%	19,427	69%	28	49%	4,040	79%
	Rural	46	38%	243,158	25%	48	36%	30,929	16%	58	39%	85,561	25%	99	26%	8,676	31%	25	44%	1,032	20%
	Remote	-	-	10,853	1%	6	5%	916	0%	4	3%	2,203	1%	7	2%	173	1%	4	7%	31	1%
Socio-economic disadvantage⁵	Quintile 5 (Least)	9	10%	247,452	26%	22	23%	67,343	36%	24	22%	93,188	27%	137	37%	7,667	27%	18	25%	1,647	33%
	Quintile 4	25	29%	211,256	22%	17	18%	41,567	22%	23	20%	80,727	23%	80	22%	5,798	21%	6	8%	1,050	21%
	Quintile 3	27	32%	199,709	21%	32	34%	35,733	19%	28	25%	69,447	20%	72	20%	5,498	20%	16	22%	969	19%
	Quintile 2	17	20%	172,162	18%	14	15%	23,903	13%	27	25%	58,931	17%	49	13%	5,525	20%	13	18%	799	16%
	Quintile 1 (Most)	8	9%	130,682	14%	10	11%	18,346	10%	10	9%	42,897	12%	28	8%	3,470	12%	4	6%	595	12%

⁽¹⁾ Received care through Better Access between 1 Oct 2009 and 31 Oct 2010; ⁽²⁾ Received care through Better Access between 1 Jan 2009 and 31 Dec 2009; ⁽³⁾ Cells do not always sum to the total n due to some missing data; ⁽⁴⁾ Region based on Rural, Remote and Metropolitan Areas (RRMA) classification. RRMA classifies geographical areas in to 7 categories (2 metropolitan, 3 rural and 2 remote) based on statistical local areas; ⁽⁵⁾ Socio-economic disadvantage based on Index of Relative Socio- Economic Disadvantage (IRSED) classification. IRSED was developed by the Australian Bureau of Statistic (ABS) to provide a measure of determining and comparing levels of social and economic disadvantage of geographical areas. It is based on Australian postcodes.

Table 2: Previous barriers to seeking care^{1,2}

	Freq	%
Costs	576	62%
Availability and difficulty accessing services	135	14%
Personal factors	116	12%
Lack of knowledge regarding services	62	7%
Stigma	50	5%
Previous negative experience with mental health services	40	4%
Not recognising that they needed support	46	5%

⁽¹⁾ n=936

⁽²⁾ Multiple and non-responses permitted

Table 3: Reasons for seeking care on this occasion^{1,2}

	Freq	%
Referral by health professional	301	32%
Symptoms worsening/mental health	359	38%
Traumatic event	252	27%
Perceived need	169	18%
Encouragement by family/friends	81	9%
General health problems	48	5%
Addiction problems	13	1%

⁽¹⁾ n=936

⁽²⁾ Multiple responses permitted

Table 4: Negative aspects of care received^{1,2}

	Freq	%
Practical difficulties (waitlists, session times and limits)	85	9%
Unfamiliar or uncomfortable to talk about personal issues or other personal factors	61	7%
Not comfortable with the provider (e.g., no rapport, judgemental)	27	3%
Uncertain about the value or usefulness of the treatment	24	3%
Cost or payment difficulties	45	5%

⁽¹⁾ n=936

⁽²⁾ Multiple responses permitted

Table 5: Types of positive change noticed^{1,2}

	Freq	%
Improvements in mental health (e.g., symptoms or feelings improved, have learnt strategies for managing distress and symptoms)	442	48%
Generalised improvement	328	35%
Improvements in physical health/lifestyle/sleep patterns	75	8%
Return to work, coping better at work or seeking work	52	6%
Some improvements but underlying causes are still present	31	4%
Reduced unhealthy behaviours	31	4%

(1) n=936

(2) Multiple responses permitted

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