Meeting demand for psychological services for people with depression and anxiety: recent developments in primary mental health care

Justine R Fletcher, Bridget Bassilios, Fay Kohn, Lucio Naccarella, Grant A Blashki, Philip M Burgess and Jane E Pirkis

ABSTRACT

Objective: To examine whether there was a reduction in demand for psychological services provided through the Access to Allied Psychological Services (ATAPS) projects after the introduction of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) program, and whether any such reduction was greater in urban than rural areas.

Design and setting: A Division-level correlation analysis examining the relationship between the monthly number of sessions provided by allied health professionals through the ATAPS projects run by Divisions of General Practice, and allied health professional services reimbursed by Medicare Australia under the Better Access program, between 1 November 2006 and 31 March 2007.

Main outcome measures: Uptake of each program, assessed by the number of sessions provided.

Results: Overall, despite dramatic uptake of the Better Access program in the first 5 months after its introduction, the demand for ATAPS services was not reduced. The correlations between the numbers of sessions provided by both programs overall ($r = –0.078$; $P = 0.074$) and in rural Divisions ($r = 0.024$; $P = 0.703$) were not significant. However, there was a significant negative correlation between the numbers of sessions provided by both programs in urban Divisions ($r = –0.142$; $P = 0.019$).

Conclusions: For the first 5 months of the Better Access program, the two programs seemed to operate relatively independently of each other in terms of service provision, but in urban Divisions there was a move towards services provided through the Better Access program. Early indications are that the two programs are providing complementary services and are working together to address a previously unmet need for mental health care.

MJA 2008; 188: S107–S109

Disorders like depression and anxiety are prevalent and disabling,[1] and many people with these disorders do not seek treatment or are not routinely offered treatment by their general practitioners, who are usually the first point of contact.[2]

In recognition of this, the Australian Government has recently instituted primary mental health care reforms. The Better Outcomes in Mental Health Care (BOiMHC) program was introduced in July 2001, followed by the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) program in November 2006. Both programs have a number of components, and both include a mechanism by which GPs can refer patients with disorders such as depression and anxiety to allied health professionals (predominantly psychologists) for six sessions of evidence-based care, with capacity for additional sessions after review by the referring GP.

The BOiMHC program does this through a total of 111 Access to Allied Psychological Services (ATAPS) projects, run by Divisions of General Practice. The Divisions are variously using voucher, brokerage, register and direct referral systems to manage referrals.[3] In contrast, the Better Access program offers a series of new Medicare Benefits Schedule (MBS) item numbers[4] that make patients eligible for a rebate for services of registered allied health professionals if they are referred by their GP. The allied health professionals can directly bill Medicare Australia or can bill the patient, who can then obtain a partial rebate from Medicare Australia.[4]

There has been considerable debate about how the ATAPS projects might coexist with the newer Better Access arrangements. Uptake of both programs has been high,[5-7] but there are questions as to whether Better Access may circumvent demand for the ATAPS projects. The Australian General Practice Network website states that:

> … the new MBS items for psychology and allied health services may … reduce demand for allied health services through ATAPS, although the impact is likely to vary from Division to Division.[8]

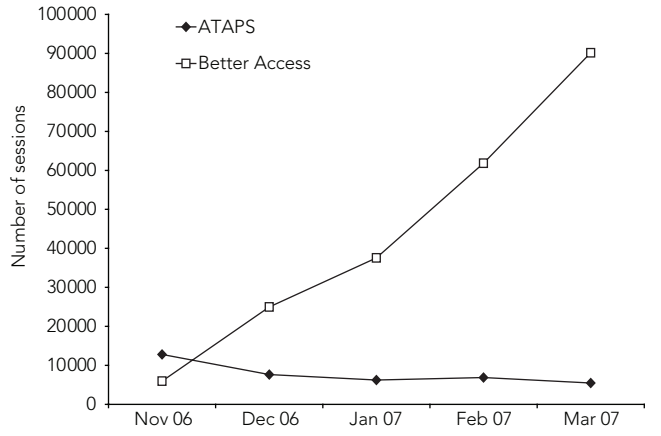
It has been implicitly suggested that demand for ATAPS services in urban areas may be reduced, and that the Better Access program is less likely to meet demand in rural areas where there is a dearth of private providers who are eligible to deliver Medicare-funded services.[9,10]

To date, no empirical analysis has been done to inform these questions of relative demand. Here, we examine whether there was a reduction in demand for services provided through the ATAPS projects after the introduction of the Better Access program and, if so, whether this reduction was greater in urban than remote areas.

METHODS

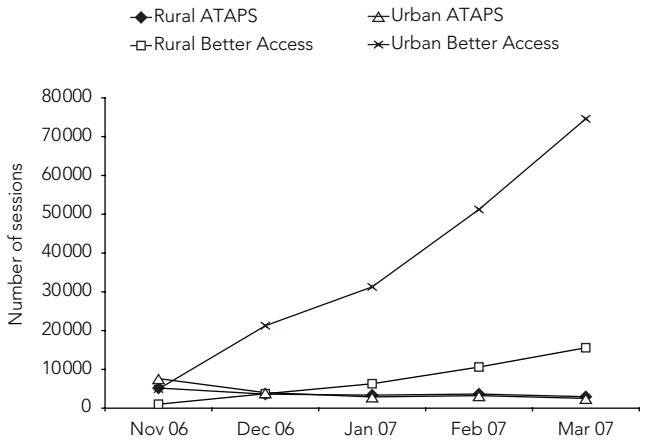
Monthly data on the uptake of ATAPS services were available from a minimum dataset that routinely captures consumer-level and session-level information from the ATAPS projects and is managed by us in the context of an ongoing evaluation exercise. All but one of the ATAPs projects (99%) submitted data to the dataset in the period under analysis. These data were combined with MBS data on services rendered by psychologists under the Better Access program, made available by the Australian Government Department of Health and Ageing. The Department extracted monthly postcode-level session data, aggregated these data so that all of the postcode areas within a given Division were combined for a given month, and provided us with the resulting Division-level data. Data were available from both sources for 105 Divisions from 1 November

1 Overall number of sessions provided through ATAPS projects and the Better Access program, 1 November 2006 to 31 March 2007



ATAPS = Access to Allied Psychological Services. ◆

2 Number of urban and rural sessions provided through ATAPS projects and the Better Access program, 1 November 2006 to 31 March 2007



ATAPS = Access to Allied Psychological Services. ◆

2006 (just before the introduction of the Better Access program) to 31 March 2007.

Pearson's correlation coefficient (r) was used to assess the relationship between the monthly number of within-Division sessions provided through the ATAPS projects and the Better Access program, since the introduction of the latter.

RESULTS

In total, 39 040 sessions were provided through the ATAPS projects in the 5-month observation period, and 220 522 were provided through the Better Access program. Fifty-two per cent of the ATAPS project sessions were provided in urban areas, compared with 83% of the Better Access program sessions.

The overall monthly breakdown of sessions provided under each program is shown in Box 1. Although the monthly number of sessions provided by the Better Access program increased dramatically from the time of its introduction, the monthly number of sessions provided by the ATAPS projects remained fairly constant from 1 November 2006, showing a marginal decrease at most.

A breakdown of sessions by rural and urban areas is shown in Box 2. This shows that the increase in number of sessions provided under the Better Access program was most pronounced in urban areas, where there was an early decrease in the number of sessions provided through the ATAPS projects, which then levelled out. It also shows that the increase in number of sessions provided under the Better Access program was more gradual in rural areas, where the number of sessions provided by ATAPS projects remained relatively constant.

When the relationship between the provision of ATAPS sessions and Better Access sessions was examined within Divisions for each month, there was a negative, non-significant correlation overall ($r = -0.078$; $P = 0.074$). For rural Divisions, the correlation was positive but also non-significant ($r = 0.024$; $P = 0.703$). For urban Divisions, there was a significant negative correlation ($r = -0.142$; $P = 0.019$).

DISCUSSION

Despite dramatic uptake of the Better Access program in the first 5 months after its introduction, the demand for ATAPS services was not reduced. The correlations between the numbers of sessions provided by both programs overall and in rural areas were not significant. However, a significant negative correlation was observed in urban areas.

Our study has some strengths and weaknesses that should be noted before considering how these findings might be interpreted. Its main strength is that it is the first study to systematically investigate the relationship between demand for services provided through the ATAPS projects and through the Better Access arrangements. However, its main weakness is that it examines only the first 5 months in which the two programs were operating in tandem, rather than a longer period extending beyond the early establishment phase of the Better Access program. We attempted to update our preliminary analyses reported here (originally conducted for an earlier report), but were unable to access further MBS data in the form required (ie, Division-level rather than aggregated) for a repeat analysis of a longer time period.

Patterns of uptake of either or both initiatives may have varied after the initial "settling in" period of the Better Access program. However, our data suggest that, for the first 5 months of the Better Access program, the two programs seemed to be operating relatively independently of each other in terms of service provision, but that in urban Divisions there was something of a move towards services provided through the Better Access program.

Overall, the findings suggest that there was a strong demand for both programs during the 5-month observation period, presumably because there was pre-existing demand for psychological services that could not be met by the ATAPS projects alone. This interpretation is consistent with a high level of unmet need previously observed in the community.[11] It is also consistent with the fact that ATAPS projects were implementing demand management strategies before the introduction of the Better Access program,[12] and suggests a need for ongoing monitoring of such strategies as they are made operational by both programs during the current climate of mental health reform.

These preliminary findings suggest that the ATAPS projects and the Better Access program should continue to coexist in a complementary fashion. The ATAPS projects have an established history of successful

service delivery,[13,14] have brought many GPs and allied health professionals "on board",[13,14] and may more easily attract allied health professionals in areas where private providers are scarce, because they can offer the certainty of salaried positions or formalised contractual arrangements. In addition, their budgets are capped, rendering their overall associated expenditure predictable. On the other hand, the Better Access arrangements may be seen as providing greater ease of referral for GPs, increased flexibility for allied health professionals, and a reimbursement mechanism that is congruent with the broader private specialist service system. The two programs are thus well placed to work together to provide access to primary mental health care. Anecdotally, some Divisions are already supporting GPs wishing to refer patients through the Better Access program, and some allied health professionals are providing services through both programs.

Of course, there are questions over and above those related to the complementarity of the two programs that should inform decisions about their future directions. For example, additional evaluation will be necessary to compare the appropriateness and effectiveness of each program. Our own research suggests that the ATAPS projects are reaching the consumers for whom they were originally designed (ie, people with anxiety and depression who may previously have had difficulty accessing services),[13,15] and that they are achieving improvements in patients' mental health, as assessed by various standardised outcome measures.[16] Similar evaluative efforts are required to assess the appropriateness and effectiveness of the Better Access program.

Evidence will also need to be sought regarding the optimal number of psychological services required to meet community need, and the affordability of these services. Using epidemiological data, cost-effectiveness studies and expert advice, a recent report estimated that optimal treatment with optimal coverage would require 4.9 million psychological services per year and would be affordable.[17] According to aggregated data from the ATAPS minimum dataset and the MBS website, by December 2007 the ATAPS projects and the Better Access program had provided a total of 1 954 283 sessions of care (423 530 and 1 530 753, respectively) since each program's inception. Even with discounting for publicly funded, state-based services, this suggests that the number of services being provided is neither too many nor unaffordable.

Ongoing monitoring will be required to determine whether our preliminary findings are consistent over time, and additional evaluation evidence will be required to help shape future program delivery. However, early indications are that the two programs are providing complementary services and are working together to address a previously unmet need for mental health care.

ACKNOWLEDGEMENTS

This work was funded by the Australian Government Department of Health and Ageing, which also made available the MBS data for the Better Access program. The authors would like to express their gratitude to Strategic Data Pty Ltd for developing the minimum dataset, and the Divisions of General Practice for managing the ATAPS projects.

COMPETING INTERESTS

None identified.

AUTHOR DETAILS

Justine R Fletcher, BPsych, MPsych, Research Fellow[1]
Bridget Bassilios, BSc, GradDipPsych, DPsych, Research Fellow[1]
Fay Kohn, DEd, MA, GradDipTESOL, Research Fellow[1]
Lucio Naccarella, BSc(Hons), GradDipMHS, PhD, Research Fellow[2]
Grant A Blashki, MB BS, MD, FRACGP, Senior Research Fellow[2]
Philip M Burgess, MA, PhD, FAPS, Professor[3]
Jane E Pirkis, MPsych, MAppEpid, PhD, Associate Professor[1]

1 Centre for Health Policy, Programs and Economics, School of Population Health, University of Melbourne, Melbourne, VIC.
2 Department of General Practice, University of Melbourne, Melbourne, VIC.
3 Queensland Centre for Mental Health Research, School of Population Health, University of Queensland, Brisbane, QLD.

Correspondence:
justine.fletcher@unimelb.edu.au

REFERENCES

1 Andrews G, Hall W, Teesson M, Henderson AS. The mental health of Australians. Canberra: Commonwealth Department of Health and Aged Care, 1999.
2 Andrews G, Sanderson K, Slade T, Issakidis C. Why does the burden of disease persist? Relating the burden of anxiety and depression to effectiveness of treatment. *Bull World Health Organ* 2000; 78: 446-454.
3 Pirkis J, Burgess P, Kohn F, et al. Models of psychological service provision under Australia's Better Outcomes in Mental Health Care program. *Aust Health Rev* 2006; 30: 277-285.
4 Australian General Practice Network. Better Access to Mental Health Care Initiative. http://www.primarymentalhealth.com.au/site/index.cfm?display=15129 (accessed May 2008).
5 Fletcher J, Pirkis J, Kohn F, et al. Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program. Tenth interim evaluation report — progressive achievements over time. Melbourne: Program Evaluation Unit, School of Population Health, University of Melbourne, 2007.
6 Medicare Australia. Medicare Benefits Schedule (MBS) item statistics reports. http://www.medicareaustralia.gov.au/statistics/dyn_mbs/forms/mbs_tab4.shtml (accessed Jan 2008).
7 Department of Health and Ageing. Better Access to Mental Health Care — questions and answers. Canberra: Department of Health and Ageing, 2006.
8 Australian General Practice Network. Better Outcomes in Mental Health Care Initiative. http://www.primarymentalhealth.com.au/site/index.cfm?display=15130 (accessed Jan 2008).
9 Dunbar JA, Hickie IB, Wakerman J, Reddy P. New money for mental health: will it make things better for rural and remote Australia? *Med J Aust* 2007; 186: 587-589.
10 Hickie IB, McGorry PD. Increased access to evidence-based primary mental health care: will the implementation match the rhetoric? *Med J Aust* 2007; 187: 100-103.
11 Meadows G, Burgess P, Fossey E, Harvey C. Perceived need for mental health care: findings from the Australian National Survey of Mental Health and Well-being. *Psychol Med* 2000; 30: 645-656.
12 Naccarella L, Morley B, Pirkis J, et al. Evaluating the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program. Ninth interim evaluation report — demand management strategies. Melbourne: Program Evaluation Unit, School of Population Health, University of Melbourne, 2006.
13 Pirkis J, Morley B, Kohn F, et al. Improving access to evidence-based mental health care: general practitioners and allied health professionals collaborate. *Prim Care Psychiatry* 2004; 9: 125-130.
14 Pirkis J, Stokes D, Morley B, et al. Impacts of Australia's Better Outcomes in Mental Health Care program for psychologists. *Aust Psychol* 2006; 41: 152-159.
15 Hickie IB, Pirkis JE, Blashki GA, et al. General practitioners' response to depression and anxiety in the Australian community: a preliminary analysis. *Med J Aust* 2004; 181 (7 Suppl): S15-S20.
16 Morley B, Pirkis J, Sanderson K, et al. Better outcomes in mental health care: impact of different models of psychological service provision on patient outcomes. *Aust N Z J Psychiatry* 2007; 41: 142-149.
17 Andrews G, Tolkien II Team. Tolkien II: a needs-based, costed stepped-care model for mental health services. Sydney: World Health Organization Collaborating Centre for Classification in Mental Health, 2006.

(Received 5 Dec 2007, accepted 15 Apr 2008) ❑