Improving access to psychotherapy delivered through primary care: The Australian experience

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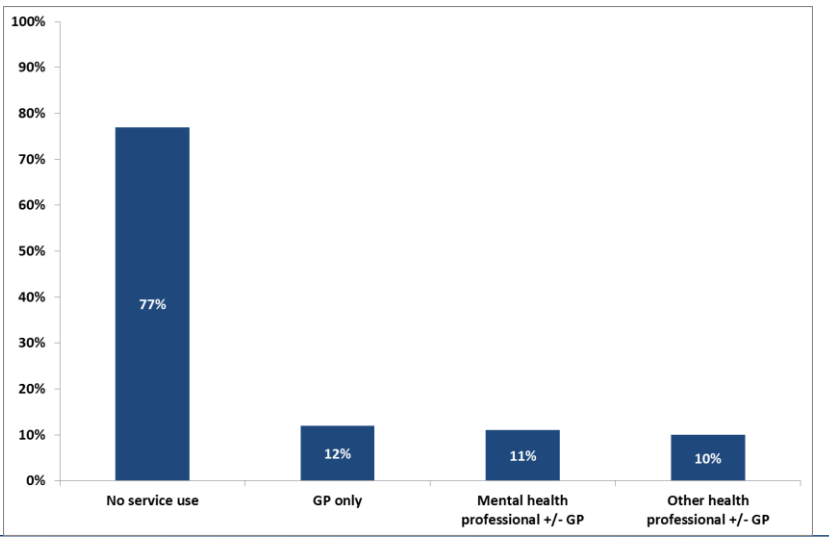
Australian mental health reforms

- Guided by the National Mental Health Strategy for the last 20 years
- Early phase of the Strategy focused on the redesigning the specialist mental health sector to better serve people low prevalence disorders (mainly psychotic disorders)
- As time progressed, however, there was a shift in emphasis to the primary mental health sector and people with common disorders (particularly depression and anxiety)

Catalyst for reform

Service use by people with common mental disorders, 1997



2 main programs

ATAPS

- Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care Program
- Introduced in July 2001

Better Access

- Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative
- Introduced in November 2006

Service delivery models

ATAPS and **Better Access** both enable GPs to refer people with diagnosed common mental disorders for mental health care which is:

- Provided by allied health professionals (predominantly psychologists)
- Free or low cost
- Evidence-based (predominantly cognitive behavioural therapy)
- Time-limited (6-18 sessions for ATAPS, 6-10 sessions for Better Access)

Funding

ATAPS

- Capped funding from the Australian Government
- Medicare Locals* receive funding to run ATAPS projects and pay providers a set fee to deliver services
- Potential for providers to charge consumers a co-payment

Better Access

- Uncapped funding from the Australian Government
- Funding is uncapped
- Providers receive a set rebate from Medicare Australia, through the Medicare Benefits Schedule
- Potential for providers to charge consumers a co-payment

* Primary health care organisations established to coordinate primary health care delivery and tackle local health care needs and service gaps

Complementarity

- **ATAPS** is generally regarded as being better able to meet the needs of at-risk groups than **Better Access**:
  - e.g., 45% of ATAPS sessions are delivered in rural areas compared with 18% of Better Access sessions (Bassilios et al, 2010)
- But **Better Access** has much higher overall reach than **ATAPS**:
  - e.g., ATAPS delivers less than 10% of the number of sessions that Better Access delivers (Bassilios et al, 2010)

ATAPS Tier 2 projects

- ATAPS projects have continued to run alongside Better Access in their original form (now called 'general ATAPS' or 'Tier 1' services)
- Several sub-programs have been introduced that focus on particular at-risk populations and are collectively known as 'Tier 2' services (Reifels et al, 2013):
  - Perinatal depression
  - Telephone cognitive behavioural therapy
  - **Specialist suicide services**
  - Victorian bushfires
  - Aboriginal and Torres Strait Islander
  - Children with mental disorders
  - People experiencing or at risk of homelessness
  - Rural and remote

ATAPS Specialist suicide services

- Piloted in 19 Divisions of General Practice (precursor to Medicare Locals) from July 2008 to June 2011; now available in all Medicare Locals
- Targeted consumers at risk of suicide with or without a diagnosis of a mental disorder
- Initial referral could come from a hospital (usually via an emergency department) or community mental health service, although a referral from a GP was required within a week
- The allied health professional had to make contact with the consumer within 24 hours and provide first session within 72 hours
- Therapeutic support more intensive than that for Tier 1 services, and occurred within a 2 month timeframe through an unlimited number of sessions
- A centralised after-hours telephone support service was also available

Evaluation

ATAPS

- Conducted alongside the program more-or-less since its inception
- Relies on a purpose-designed minimum dataset which collects information on consumers (e.g., demographic, clinical and outcome data) and sessions (e.g., data on session duration and treatment delivered)
- Also draws on one-off surveys, interviews and focus groups

Better Access

- Conducted at a single point in time (2009-2011)
- Drew on 20+ data sources, including:
  - Studies of consumers and their outcomes
  - Analyses of Medicare Benefits Schedule data
  - Analysis of workforce data
  - Stakeholder consultations
  - Evaluation of education and training projects
  - Analyses of the National Survey of Mental Health and Wellbeing
  - Analysis of data from the Bettering the Evaluation and Care of Health (BEACH) program
  - Relevant documentation (e.g., DoHA records, Post-implementation review)
  - Surveys of providers and consumers

ATAPS – general

Individuals seen between Jan 1st 2006 and June 30th 2010

- 113,107 (i.e., 25,135 per year)

Demographic profile

- 70% female
- 43% aged 25-44
- 66% on low income

Clinical profile

- 45% had no previous history of mental health care
- 72% had a diagnosis of depression and/or anxiety

Treatment profile

- 82% had 6 sessions or fewer
- 69% received cognitive behavioural therapy

Outcomes

- Pre- and post-treatment outcome data available from nine different outcome measures for 16,700 (15%)
- Statistically significant improvements on all outcome measures

Pirkis et al (2011)

ATAPS – Specialist suicide services pilot

Uptake (October 2008 to June 2011)

- 2,312 referrals (predominantly from GPs)
- 2,070 individuals took up services (752 per year) – 63% female, mean age 33 years, 58% on low income, 35% had no previous history of mental health care, 86% had a diagnosis of a mental disorder (most commonly depression)

Treatment

- 10,503 sessions of care provided (an average of 5.2 per consumer) – 69% 46-60 minutes, 100% individual, 91% face-to-face, majority involved CBT (43% cognitive interventions, 25% behavioural interventions)

Outcomes

- Pre- and post-treatment data available for 328 consumers (14%)
- 245 assessed with Modified Scale for Suicidal Ideation (MSSI) – improvement of 8.6 points* on total score
- 128 assessed with the Depression, Anxiety and Stress Scales (DASS) – improvement of 8.1 points* on the Anxiety scale, 14.4 points* on the Depression scale and 10.7 points* on the Stress scale
- 102 assessed with the Kessler 10 (K-10) – improvement of 11.5 points* on total score

King et al (submitted)

Better Access

Reach

- 2,016,495 consumers received services in the first three years of Better Access – one in every 30 Australians in 2007, one in every 23 in 2008, and one in every 19 in 2009 (Medicare data)
- Reaching new consumers – 42-58% of those receiving Better Access services have not previously received any form of mental health care (Study of consumers and their outcomes)
- 90% of Better Access users have a diagnosis of depression and/or anxiety, and 80% report high or very high levels of distress on the K-10 (Study of consumers and their outcomes)
- Strongest predictors of Better Access use are diagnosis and severity of illness, not region of residence, socio-economic disadvantage, education level or employment status (Analysis of NSMHWB data)

Treatment

- 2.7 million services in 2007, 3.8 million in 2008, 4.6 million in 2009 (Medicare data)
- Around 90% of consumers receive cognitive behavioural therapy (Study of consumers and their outcomes)

Outcomes

- Consumers experience statistically significant improvements in K-10 and DASS scores from pre- to post-treatment (Study of consumers and their outcomes)

Pirkis et al (2011), Harris et al (submitted)

Conclusions

- ATAPS and Better Access operate in a complementary fashion
- They appear to have improved access to primary mental health care for people with common mental disorders and, as best can be judged, have benefited many of those receiving care
- The fact that they operate under different funding models and within different systems of service delivery would suggest that many of their features might be applicable in other contexts

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