

EXECUTIVE SUMMARY

1 BACKGROUND

The last decade has witnessed substantial reforms to Australia's mental health care system. These follow the publication of epidemiological evidence of the widespread nature of mental illness in the general population, unexpectedly low treatment rates for these conditions, and the considerable impact of disorders such as depression on individuals' lives and Australia's health burden. Several wide-scoping reviews into the provision of mental health services in Australia have also highlighted the still-pressing need for people with mental illness to have greater access to mental health services, particularly evidence-based treatments by specialist providers such as psychiatrists and psychologists.

In response to these concerns, there have been major reforms to the primary mental health care sector since 2001. A cornerstone of this reform has been the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access)* initiative which commenced on 1 November 2006. *Better Access* was designed to improve access for people with clinically-diagnosed mental disorders (primarily depression and anxiety) to evidence-based treatment from various providers, via a series of new and increased rebates under the Medicare Benefits Schedule (MBS). These modifications to the MBS included the addition of a set of item numbers that enable rebates to be claimed for psychological services delivered by clinical psychologists (these services are known as Psychological Therapy Services), and by general psychologists, and selected social workers and occupational therapists in the community (these services are known as Focussed Psychological Strategies). Referral is required from a general practitioner (GP), psychiatrist or paediatrician. Referrals can be made for up to 12 individual (18 in exceptional circumstances) and 12 group treatment sessions in a calendar year. *Better Access* also provides for a set of item numbers that reimburse GPs for preparing and reviewing mental health treatment plans and providing mental health consultations, and a set of item numbers that reimburse psychiatrists for conducting an initial consultation with a new patient and for providing and reviewing a patient assessment and management plan.

This current report presents findings from an analysis of MBS administrative data, conducted as part of a multi-component evaluation of the *Better Access* initiative commissioned by the Department of Health and Ageing (DoHA).

2 METHOD

The current evaluation was designed to address seven evaluation questions. It uses data obtained from multiple sources. The evaluation questions, and the contribution of each source to addressing each of the questions, are shown in Table i.

Table i Relationship between the evaluation questions and data sources used in the current evaluation

Evaluation questions	Medicare Benefits Schedule data	Pharmaceutical Benefits Scheme data	Australian Bureau of Statistics Census data	Access to Allied Psychological Services projects' minimum dataset	2007 National Survey of Mental Health and Wellbeing
Question 1: To what extent has the <i>Better Access</i> initiative provided access to mental health care for people with mental disorders? Across all of Australia? Across all age groups?	✓		✓		
Question 2: To what extent has the <i>Better Access</i> initiative provided access to affordable care?	✓		✓		
Question 3: To what extent has the <i>Better Access</i> initiative provided equitable access to populations in need? (in particular people living in rural and remote areas, children and young people, older persons, Indigenous Australians, people from culturally and linguistically diverse backgrounds.	✓		✓		✓
Question 4: To what extent has the <i>Better Access</i> initiative provided evidence-based mental health care to people with mental disorders?	✓		✓		
Question 5: To what extent has the <i>Better Access</i> initiative provided interdisciplinary primary mental health care for people with mental disorders?	✓		✓		
Question 6: To what extent has the <i>Better Access</i> initiative impacted on the use of medications commonly prescribed for treatment of mental disorders, in particular antidepressant medications?	✓	✓	✓		
Question 7: To what extent has the <i>Better Access</i> initiative impacted on related MBS (and other) services?	✓		✓	✓	✓

3 KEY FINDINGS

The key findings from the analyses presented in this report are summarised below, organised under each of the evaluation questions addressed. Within each evaluation question, a series of research questions was addressed via targeted analyses.

The ***extent to which Better Access has provided access to mental health care for people with mental disorders*** was examined by profiling the rates of uptake of MBS-subsidised *Better Access* items for the total Australian population, and for key population subgroups. The uptake of the initiative has been substantial, with one in every 19 Australians (5.3% of the population, or 1,130,384 people) receiving at least one *Better Access* service in 2009. The rate of growth of the program accelerated rapidly its first year (increasing by 13.3% per quarter in 2007) but slowed significantly thereafter to 4.6% per quarter (until the March quarter 2010). The initiative appears to be attracting 'new' consumers, i.e. people who have not previously used *Better Access* services. The majority of people who received *Better Access* services in 2008 (68.0%) and 2009 (57.0%) had not previously received these services. When analysed according to provider type, the percentage of new consumers was highest for the Consultant psychiatrist services (92.1% in

2008; 86.9% in 2009), followed by the allied health services (ranging between 73.7% to 79.5% in 2008, and 66.9%-74.5% in 2009), followed by GP services (73.1% in 2008; 62.2% in 2009). In each of 2008 and 2009, the majority of *Better Access* services are used by people who are receiving services for the first time in that year. These findings suggest that *Better Access* is meeting a previously unmet need.

Relatively lower rates of access were observed among young people, however this not unique to *Better Access*; young people access all mental health services less often than other members of the population. Patterns of access according to geographic location and socio-economic disadvantage were complex. For the GP and Focussed Psychological Strategies items, the level of access was the same in rural centres as it was in capital cities, but it was lower in other rural areas and remote areas. For Consultant Psychiatry and Psychological Therapy Services items, uptake decreased across each category of geographical region from capital cities to remote areas. Uptake rates for Psychological Therapy Services items and, to a lesser extent, Consultant Psychiatry items, decreased as levels of socio-economic disadvantage increased. By contrast, uptake rates for GP Mental Health Treatment and Focussed Psychological Strategies items were markedly lower only for persons residing in the most disadvantaged areas. The growth in uptake between 2007 and 2009 has been greatest for young people aged 0-14 years, compared to all other age groups. Growth in uptake has also tended to be greater for people in remote locations, and for people in more socio-economic disadvantaged areas.

With respect to ***whether Better Access has provided access to affordable care***, analyses revealed that more than half of *Better Access* services delivered were bulk-billed (54% in 2007, 57% in 2008 and 59% in 2009), and the average co-payment was around \$35. There was considerable variation in co-payment rates and average co-payments according to the type of provider who delivered the services. In 2009, only 7% of services delivered under the GP items involved a co-payment by the consumer, whereas up to two thirds of the services delivered under the Consultant Psychiatrist (64%), Psychological Therapy Services (65%) and Focussed Psychological Strategies (57%) items did so. The average co-payment was lowest for GP items (\$20), close to the overall average for Psychological Therapy Services items (\$32) and Focussed Psychological Strategies items (\$37), and highest for Consultant psychiatrist items (\$82). The proportion of services that were bulk-billed increased as the level of remoteness and level of relative socio-economic disadvantage increased. The average co-payment was highest among people in remote areas (\$38) and people in capital cities (\$37) than those in other regions (\$31-\$33). The average co-payment decreased as level of relative socio-economic disadvantage increased (from \$38 to \$33).

The ***extent to which Better Access has provided equitable access to populations in need*** was examined using a modeling exercise that estimated levels of mental health treatment need in areas defined by the boundaries of Divisions of General Practice. It then investigated whether *Better Access* services are being distributed across Divisions according to need. Analyses showed that, at the Division level, rates of total and allied health *Better Access* services used were positively associated with levels of mental health need. However other factors were also found to play a part. Higher rates of total and allied health *Better Access* services used were found in Divisions that had relatively higher rates of GP supply, and Divisions located in Victoria. Lower rates of *Better Access* services used were found in Divisions with relatively more people living in socioeconomically disadvantaged areas and Divisions with relatively more people living in remote locations. More than half the variation in total *Better Access* services used (54.7%) and allied health *Better Access* services used (51.0%) could be explained by these factors. Variables

relating to potential to access services (GP supply, remoteness, state/territory) collectively contributed a slightly larger proportion (approximately 6.5% more) of the variance in total *Better Access* services used than allied health *Better Access* services used. Socioeconomic disadvantage contributed a similar proportion of additional variance in total (8.19%) and allied health (8.17%) *Better Access* services used, after all other variables were taken into account.

Two aspects of ***whether Better Access has provided 'protocol-based' care*** were examined. The first of these related to the patterns of care delivered following a GP Mental Health Treatment Plan. Analyses estimated that less than approximately one fifth of consumers received both a GP Mental Health Treatment Plan and a GP Mental Health Treatment Review, which is perhaps less than ideal. It should be noted, however, that the fact that the GP Mental Health Treatment Review item was not used does not necessarily mean that a review has not occurred. It is possible that other items are being used to capture the content of the session in which the review occurs. In addition, 58% of *Better Access* consumers who received a GP Mental Health Treatment Plan went on to use *Better Access* allied health services; conversely 42% did not. Non-receipt of *Better Access* allied health services following a Treatment Plan was more common among older people aged 65 years or more and among males. Non-receipt of allied health services increased as level of geographical remoteness increased, and as level of socio-economic disadvantage increased. It should be noted, however, that consumers who did not receive *Better Access* allied health services may have received psychological services from other sources, for example: from allied health professionals under the ATAPS program (which is not recorded in the MBS); from their GP, which may be recorded using the *Better Access* GP Mental Health Consultation item (2713) or under another MBS item; or via privately funded services.

The second aspect of 'protocol-based' care was the number of psychological services delivered by allied health professionals per person per calendar year (which should not exceed 30 per person in a calendar year). Around 75% of consumers received between one and six allied health professional services, 20% received between 7 and 12, and 5% received between 13 and 18. This suggests that the protocol is being interpreted appropriately by providers.

The ***extent to which Better Access users received interdisciplinary care*** was examined by profiling the use of various grouping of *Better Access* MBS items. Overall, 55% of *Better Access* users received some combination of interdisciplinary care, most commonly from combinations of GPs and allied health professionals. The remainder received GP care alone. Rates of interdisciplinary care were the same other metropolitan areas as they were in capital cities, and only slightly lower in rural centres, but they were 15% lower in other rural areas and 33% lower in remote areas (as compared to the average across all *Better Access* consumers). Rates of interdisciplinary care also decreased as level of socio-economic disadvantage increased. Specifically, in metropolitan areas rates of interdisciplinary care were 13% lower among people from the most disadvantaged areas, compared to the average across all *Better Access* consumers.

Analyses of the ***impact of Better Access on the use of medications commonly prescribed for the treatment of mental disorders*** found that the rate of persons using PBS-subsidised antidepressant medications increased significantly (0.9% per quarter, on average) in the three years after the introduction of *Better Access*. The rate of PBS-subsidised scripts supplied for antidepressant medications also increased significantly (1.5% per quarter, on average) post-*Better Access*. In contrast, rates of PBS-subsidised anxiolytic use were stable over the pre- and post-*Better Access* periods. A positive association was also found between *Better Access* uptake

and medication use at a Division level. That is, the rate of persons within a Division using PBS-subsidised antidepressant medications, and the rate of scripts supplied, increased as the rate of persons using *Better Access* increased. This was also true for anxiolytic medications. Taken together, these findings would tend to suggest that *Better Access* has had the effect of increasing consumers' access not only to the non-pharmacological treatments that underpin it, but to pharmacological therapies which have also been shown to have good evidence of effectiveness.

Finally, the ***impact of Better Access on existing related programs*** was considered. Analyses revealed that the rate of uptake of non-*Better Access* MBS mental health items at a Division level was the same in the two years after the introduction of *Better Access* as it was in the two years prior to *Better Access*. In addition, a positive association was found between the uptake of *Better Access* MBS items and non-*Better Access* MBS mental health items at a Division level. The picture with the uptake of psychological services provided under the Access to Allied Psychological Services (ATAPS) projects was more complex. ATAPS had experienced substantial growth prior to the introduction of *Better Access*. This growth has continued, but has slowed since the introduction of *Better Access*. ATAPS has proportionally greater penetration into rural and remote regions than metropolitan regions (whereas the reverse is true for *Better Access*). This pattern was not affected by the introduction of *Better Access*. In metropolitan Divisions, higher population uptake of *Better Access* was associated with higher uptake of ATAPS, but in rural/remote Divisions higher uptake of *Better Access* was associated with lower uptake of ATAPS. These findings suggest that *Better Access* is filling a gap in the mental health service delivery system that was not previously being met by other related services. However, the introduction of *Better Access* does not appear to have negated the need for these other services, particularly in rural/remote areas.

4 CONCLUSIONS

The current analysis of MBS and related data has shown that *Better Access* has improved access to evidence-based, multi-disciplinary mental health care for Australians. These improvements have occurred for people irrespective of their age and socio-economic status, and regardless of where they live. However, young people, people in the lowest socio-economic stratum, and people in small rural and remote areas have not been as well served as their older, more affluent, urban counterparts. Over half of the sessions of care provided through *Better Access* are bulk-billed, although – like other Medicare-funded services – the proportion of bulk-billed services is higher for GPs and lower for specialists (e.g., psychiatrists and psychologists). Those with greatest levels of financial need are the biggest beneficiaries of bulk-billed services. High levels of uptake of *Better Access* services have not led to commensurate reductions in the use of other relevant mental health services or prescribing of antidepressant or anxiolytic medications. In fact, the opposite is true, which suggests that *Better Access* is a crucial piece in the web of Australian primary mental health care reforms, and is helping to meet previously-unmet need. Before this conclusion can be definitively drawn, however, further work is required to profile the mental health status of people using *Better Access* services, and the outcomes of *Better Access* care. The study of consumers and their outcomes, which is being conducted as part of the current evaluation, will be helpful in this regard.