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access to populational mental health knowledge

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# Improving access to primary service psychotherapy: an Australian experiment

**Jane Pirkis, Ph.D.,** Director, Centre for Health Policy, Programs & Economics, Melbourne School of Population and Global Health, University of Melbourne

**Helen-Maria Vasiliadis, MSc, Ph.D.,** Associate professor, Département des sciences de la santé communautaire, Université de Sherbrooke, and researcher at the Centre de recherche de l'Hôpital Charles-LeMoyne

## Context

The first phase of the Australian mental health reform involved reorganising the specialist mental health sector in order to provide better services to patients with low prevalence disorders (principally psychotic troubles). Over time, there was a change in orientation that allowed more focus on primary mental health care services aimed at people with common disorders and particularly depression and anxiety. In Australia, two main programs were put in place, to facilitate access to psychotherapy in primary care services: *Access to Allied Psychological Services* (ATAPS) (introduced in 2001) and *Better Access* (introduced in 2006).

These programs allowed general practitioners to refer people with common mental health troubles for appropriate treatment provided primarily by psychologists and other mental health professionals. The treatments, essentially cognitive-behavioural therapy, were covered by the Medicare program. The number of visits allowed varies between 6 and 18 for the ATAPS program and between 6 to 10 for *Better Access*.

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The programs operate using different financial models. For ATAPS, the government establishes the funding limit. Local Medicare structures receive a fixed amount to conduct the program activities and to pay providers a set fee. In the case of *Better Access*, the funding provided by the Australian government does not have a fixed limit. Australian Medicare pays the service providers according to the rates established for insurance benefits by health insurance. In both cases, the service provider can ask the patient for a financial contribution.

ATAPS seems to better answer the needs of specific groups, while *Better Access* has a wider-reaching impact (Bassilios B. et al., 2010). In order to offer priority service to high-risk populations, several sub-programs of ATAPS known as 'Tier 2' services have been devoted to perinatal depression, for example, or for specialized services for people at risk of suicide, or children suffering from mental disorders (Reifels et al., 2013).

Between January 1, 2006 and June 30, 2010, some 113,107 people took advantage of the ATAPS program (25,135 per year), of whom 72% had received a diagnosis for depression and/or anxiety and 45% had no history of mental health treatment. Among the individuals consulting the ATAPS program, 82% had six visits or fewer and 69% had received cognitive-behavioural therapy. The results obtained before and after treatment showed significant improvements in both depression and anxiety symptoms according to the Depression Anxiety Stress Scales (DASS 21) and the Kessler 10 (K10) scale (Pirkis J. et al. 2011). More specifically, the patients who showed high or very high levels of psychological distress presented significant improvement with moderate distress scores on the K 10 scale after treatment. Patients who showed moderate or high levels of stress before treatment presented normal or moderate levels of depression, anxiety or stress on the DASS-21 scale in post-treatment.

ATAPS and *Better Access* are complementary programs that have improved access to primary mental health care services for those suffering from common mental health disorders.

During the program's first three years (from 2007 to 2009), some 2,016,495 people received treatment under the *Better Access* program. More than 58% of the patients had never had the benefit of mental health services. The most important factors determining the use of *Better Access* are the diagnosis and the severity of the condition. Approximately 90% of the participants were able to take advantage of cognitive behavioural therapy. They showed statistically significant improvement on the K 10 (Kessler 10; psychological distress) and DASS (depression, anxiety and stress) before and after treatment (Pirkis J. et al, 2011; Harris et al.). One must note however that there was no control group in order to estimate the impact of the program on symptoms evaluated using the DASS-21 and K 10 scales. Before and after evaluations were carried out on the same group of patients.

Tier 2 ATAPS offers specialized services regarding suicide prevention for participants who were suicidal who may or may not have a diagnosis of mental illness. Between October 2008 and June 2011, over 2,070 people took advantage of these services (752 per year). Of this group, 35% had not previously received mental health care and 86% had previously received a diagnosis of a mental health disorder (mostly depression). Of the more than 10,503 sessions given over this period (an average of 5.2 sessions per participant), 43% involved cognitive treatments and 25% involved behavioural treatments. Improvements were noted with the MSSI, the DASS and the K 10 scales (King K. et al., forthcoming). As in the case of the other study, there was no control group.

ATAPS and *Better Access* are complementary programs that have improved access to primary mental health care services for those suffering from common mental health disorders. The two programs use different funding models and systems of service delivery, which may suggest that some of their features may be, applied to different health system contexts.

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## Bibliography


1. Bassilios B. et al. (2010). *The complementarity of two Australian primary mental health care initiatives. Australian and New Zealand Journal of Psychiatry,* 44, 997-1004.
2. Reifels et al. (2013). *Innovations in primary mental healthcare.* Aust. Health Rev. 37, 312-317.
3. Pirkis J. et al. (2011). *Clinical improvement after treatment provided through the Better Outcomes in Mental Health Care (BOiMHC) program: Do some patients show greater improvement than others? Australian and New Zealand Journal of Psychiatry,* 45, 289-98.
4. Harris et al. (forthcoming). *A summative evaluation of the Better Access initiative*.
5. Pirkis J. et al (2011). *Australia's Better Access initiative : An evaluation. Australian and New Zealand Journal of Psychiatry*, 45, 726-39.
6. King K. et al. (forthcoming). *Suicide prevention: Evaluation of a pilot intervention in a primary care context.*