9 March 2009

The Hon. Nicola Roxon MP
Minister for Health and Ageing
Parliament House
Canberra ACT 2600

Dear Minister

Re: MBS Better Access and ATAPS Programs

At our meeting on 12-13 February the Council received a presentation from the Department on the review of ATAPS program and held a discussion on the Better Access Program with a view to providing you with urgent advice on both these programs. Since then I have sought and obtained further information from members of the Council.

Access to Allied Psychological Services (ATAPS)

The Access to Allied Psychological Services (ATAPS) is the only surviving component of the Better Outcomes in Mental Health (BoMH) program introduced in 2001-2 by then Federal Health Minister, the Hon. Dr. Michael Wooldridge.

ATAPS supports GPs and allied health professionals to work together to provide optimal mental health care. This component enables GPs to refer consumers with high prevalence disorders to allied health professionals for six sessions of evidence-based mental health care, with an option of a further six sessions following a mental health review by the referring GP.

This collaborative approach to mental health care is occurring through 108 ATAPS projects being conducted by 114 Divisions of General Practice and progressively funded through four funding rounds. In total, 420,555 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.2. The profile of these sessions has not changed greatly since the ATAPS projects began. Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around four fifths of all sessions. Almost all of these sessions have been delivered to individuals, rather than groups.

The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 44% and 58% of sessions, respectively. The only notable change over time with respect to the sessions of care provided has been in the charging of a co-payment.

The Better Access Program

The Better Access program was introduced in November 2006 as part of the Howard Government's response to the February 2006 commitment by COAG to address the problems with access to mental health care in Australia.

While initially costed at $538m over the five years of the COAG National Action Plan on Mental Health, the program is now costing the Australian Government in excess of $300m per annum. If the current rate of expenditure plateaus, then total spending for the five years will be over $1.4b.

The original estimate of activity under the Program indicated that by 2010-11 almost 960,000 clinical psychology services were expected to be provided and 170,000 GP Mental Health Care plans developed. Within the first two years of the Program alone, over a million GP mental health care plans have been written and the number of sessions of clinical psychology provided under the Program has already exceeded the original five year estimate. (Details on the Better Access program costs, estimates, actuals and trends are included in Attachment 1.)

The NACMH is aware that the Senate Community Affairs Committee also made a number of recommendations regarding the Better Access Program in its September 2008 report which the Government is considering.

Issues with the Better Access Program

The Program represented a significant new investment in primary mental health care by the Commonwealth Government and has been most welcome by all stakeholders. At the time the Program was being designed, several issues of concern were raised with the Howard Government by the Mental Health Council of Australia and others – these issues seem well founded two years on since the Program's commencement. These are outlined briefly here and more fully in Attachment 1.

Uncapped growth of the least proven aspects of the program
A key issue revealed in the data to December 2008 is the natural ceiling reached by Items 2710 and 80010 – the number of services provided by both GPs and clinical psychologists is limited by the number of health professionals available to do the work. It is likely that for these two groups, a saturation point has been reached.

This is not the case for registered psychology. Opening access to the MBS to registered psychology brought a whole new workforce into the mental health service sector. This pool of labour does not have the same restricted ceiling as for clinical psychology (length of training, clinical supervision requirements, etc.).

Inequitable access to services by location etc.
Access to care varies depending on where you live. This is a reflection of workforce distribution with clinical psychology services largely confined to capital cities. It is important to note that the distribution of registered psychologists in rural areas is considerably better than clinical psychologists. The nature of the severity of the clients receiving care under the Better Access Program is unclear although there is some evidence that 81% of referrals to psychology services are assessed as moderate to severe mental illness.

Quality of care
No clear evidence is available yet – the evaluation process is yet to commence. However, it is clear from considerable anecdotal feedback that the quality of care available under the Program varies enormously.

New service options are always welcome in mental health, but they must provide a standard of quality care. On the basis of the available evidence, the quality of care provided by registered psychologists is unclear. Similarly, it is unclear what value GPs add to mental health care in the process of developing the Mental Healthcare Plans.

Workforce
A further consequence of the Better Access Program has been a drift of workers from the public sector to the private sector. The public sector is struggling to provide

psychological care and this particularly impacts on those with severe and persistent mental illnesses and remain in the public sector seeking care.

Out of pocket expenses
In April 2008, DoHA released data on the fees, gaps and out of pocket expenses arising from the new Better Access MBS Items (see Table 4 in Attachment 1). As predicted, out of pocket costs to consumers have become significant. The profile of clients using the Better Access Program is not yet clear, however, BEACH data and other information indicate that health care card holders and people on lower incomes are less likely to be receiving the new MBS items.

Position of the NACMH

A consensus position on all the issues associated with the ATAPS and Better Access programs was not possible within the timeframe and other constraints. However, there is a clear majority view from Council members. I have endeavoured to faithfully summarise this as follows. We have also taken in consideration the general direction of primary health care reform outline by you and endeavoured to reflect that in these points.

ATAPS

1. There is strong support for a continuation and indeed expansion of the ATAPS program. The provision of evidence based clinical interventions for common mental health disorders such as anxiety and depression through funded payments has dramatically increased service options and health outcomes for many people. Current levels of funding mean services continue to be rationed to clients.
2. Greater flexibility in access to these ATAPS services could be increased. There is strong support for the expansion of services through telephone and web-based programs. There is also support for:
    a. Funding holding to be available to more than Divisions of GP. Diversity in the identification of fundholders should be seen, in principle, as a desirable objective. The appointment of a fundholder in any region should be based on capability and placement in the community to achieve positive engagement with consumers.
    b. Providing access to clients who do not present to GPs through partnership arrangements with other organisations such as NGOs. Better ways of identifying suitable callers for referral to ATAPS and partnership arrangements to create access pathways for these callers could be developed between NGO's and ATAPS providers and GPs.
3. The Council is unanimous in the view that the program can provide services to targeted populations – rural and remote, indigenous, youth and so on. There is strong support for the program to be available in urban areas not well served by private psychology or GP services.
4. There are some concerns regarding ATAPS administration – specifically with the under-qualified or administrative staff who manage the mental health programs in Divisions of GPs and who are responsible for the selection and monitoring of ATAPS practitioners. Frequently more junior psychologists are selected to provide services as they attract lower salaries and allow funding for the program to go further, but this can put the quality of the service at risk. More expert psychology input is required in the selection and professional/clinical support of staff working under the ATAPS program.

5. Quality of services under both ATAPS and Better Access would also be improved by requiring all service providers to undertake mandatory professional development.
6. Whilst the Department stated that ATAPS was high cost program when compared with Better Access, a view supported by a NACMH member, there is evidence, soon be published, which brings this into question. The evidence from Scott, Naismith et al (in press) shows when costs are calculated on episodes of care as opposed to occasions of service, there is no difference in cost for ATAPS-style collaborative care models and traditional fee-for-service models. This data could not be included here due to publication conditions.
7. It is noted from the ATAPS Review Paper prepared by the Department that "*It is not within the scope of the ATAPS program to consider expanding or extending services to areas of mental illness prevention or support for people with temporary psychological distress*". These are areas are where services, such as Mensline, Lifeline and Kids Helpline, can build pathways to care, and supplement the provision of clinical psychological services, through the provision of crisis/emotional support that may be more appropriate in some circumstances. The linkages between ATAPS and emotional support services could be strengthened.
8. Some suicidal people may not be experiencing diagnosable mental health disorders, and supplementary suicide prevention services should be considered as part of the overall service framework. The ATAPS role in suicide response should be defined around the provision of clinical mental health interventions, where appropriate.

Better Access

1. The majority of the Council see the Better Access program as a provider or supply-driven system. While there is a view that the huge demand and uptake of the services by consumers is evidence that Better Access is a successful initiative, this is not the broad view of the Council and that the program is in its current design unsustainable. Further, the majority view is that the program is not the "best buy" when compared with collaborative care models.
2. it is regrettable that such a significant initiative did not have in place from day one a robust and independent evaluation. This has placed the Government in a difficult position in relation to making informed changes to the program in response to the cost blow-outs and the changed fiscal environment.
3. Changes to the Better Access program should be considered in the context of broader debates and reforms to the Medicare/MBS and primary health care.
4. Based on the views of Members, I am recommending:
    a. The government consider removing Item 2710 (preparation of a GP Mental health Care Plan). The offset costs savings would be considerable given the high MBS rebate.
    b. Provide direct access to clinical psychologists for consumers. The clinical psychologists would be required to notify the consumer's GP regarding the episode of care.
    c. Remove registered psychology items from the Better Access program
    d. Significant expansion of ATAPS to provide improved access to people in urban areas not served by private providers, rural and remote

regions, indigenous populations, youth and men. This can be supported through the use of Service Incentive Payments to providers. Service expansion would include the use of evidence-based telephone and web-based programs, and the provision of services through NGOs and other community organisations best placed to provide the necessary infrastructure.

e. Consideration is given to professional development for as all service providers under the Better Access initiative. Again incentive payments through MBS may be required to achieve higher uptake as opposed to making such professional development mandatory.

I am available to discuss this advice further should that be required.

Sincerely

John Mendoza
Chair
National Advisory Council on Mental Health

Attachment 1

Details on ATAPS Program

The Access to Allied Psychological Services (ATAPS) is the only surviving component of the Better Outcomes in Mental Health (BoMH) program introduced in 2001-2 by then Federal Health Minister, the Hon. Dr. Michael Wooldridge.

ATAPS supports GPs and allied health professionals to work together to provide optimal mental health care. This component enables GPs to refer consumers with high prevalence disorders to allied health professionals for six sessions of evidence-based mental health care, with an option of a further six sessions following a mental health review by the referring GP.

This collaborative approach to mental health care is occurring through 108 ATAPS projects being conducted by 114 Divisions of General Practice and progressively funded through four funding rounds.

The ten evaluation report on ATAPS released in 2008 finds:

- The ATAPS projects have established themselves over time as a cornerstone of mental health service provision in Australia.
- The consumer and session profiles have reached a point of consistency. There is good evidence that the projects are achieving positive results for consumers.
- Despite small but noticeable drop offs in the numbers of GPs, allied health professionals, and consumers since the introduction of the Better Access program in November 2006, the number of participants in the projects continues to be substantial. This suggests that Better Outcomes and Better Access programs are complementary in addressing the mental health service needs of Australians.

<u>GP and allied health professional participation</u>

- Between 1 July 2003 and 31 December 2007, 7,776 GPs referred consumers to 2,665 allied health professionals. The numbers of referring GPs rose steadily from 453 in the July-September 2003 quarter to a peak of 2,720 in the July-September 2006 quarter, but showed something of a drop-off after the October-December 2006 quarter. In the last quarter for which reliable data (with minimal data entry lags) were available (July-September 2007), 2,192 GPs referred consumers to 1,050 allied health professionals.

- A similar pattern of participation was apparent for allied health professionals, with the numbers increasing from 135 in the July-September 2003 quarter to a maximum of 1,426 in July-September 2006 quarter, with a reduction beyond this point. The report does not indicate what this reduction was.

- The decrease in quarterly numbers of both GPs and allied health professionals coincided with the introduction of the Better Access initiative. This has provided an alternative referral pathway for GPs and an alternative reimbursement mechanism for allied health professionals.

<u>Patient participation.</u>

- Between 1 July 2003 and 31 December 2007, 100,854 consumers were referred to the ATAPS projects, and 81,372 consumers took up the referrals. On a quarterly basis, the number of referrals rose from 1,190 in July-September 2003 to a peak of 10,328 in July-September 2006. After the introduction of the Better Access program (November 2006) there was a reduction in the number of referrals which had largely levelled out by the July-September 2007 quarter (5,970), the most recent quarter for which reliable data were available at the time of analysis.

- The profile of referred consumers has remained relatively consistent over time, and, in the main, is similar across urban and rural projects. Around three quarters of all consumers are female, and their mean age is approximately 39 years. The majority (around two thirds) are on low incomes. About half have no previous history of mental health care. Of those for whom a diagnosis was made by the referring GP, most have been diagnosed with depression (75%) or anxiety disorders (57%).

About the services provided

- In total, 420,555 sessions of care were provided through the projects, making the average number of sessions provided to consumers 5.2. The profile of these sessions has not changed greatly since the ATAPS projects began. Sessions of 46-60 minutes have consistently been the most popular format over time, accounting for around four fifths of all sessions. Almost all of these sessions have been delivered to individuals, rather than groups.

- The most common interventions provided through these sessions have been CBT-based cognitive and behavioural interventions, delivered in approximately 44% and 58% of sessions, respectively.

- The only notable change over time with respect to the sessions of care provided has been in the charging of a co-payment. Relatively small proportions of sessions were associated with co-payments early on (e.g., 9% in July-September 2003) and more recently (e.g., 13% in July-September 2007), and relatively greater sessions incurring a cost to the consumer in the middle period (e.g., 41% in July-September 2004). The pattern is similar for urban and rural projects, although it is more exaggerated for urban projects, with proportionally more sessions involving a co-payment at each point in time.

This data is further developed and interpreted in a recent paper (Fletcher et al. Meeting demand for psychological services for people with depression and anxiety: recent developments in primary mental health care. MJA 2008; 188 (12 Suppl): S107-S109.)/

The May 2008 COAG National Action Plan progress report states that, as part of a joint initiative with the BoMH program, DoHA will conduct a trial of telephone based cognitive behaviour therapy interventions in rural and remote areas within the guidelines of the current ATAPS program. The trial is to run for 12 months in about 15 rural and remote DGPs. No data was available at this time on this initiative.

Details on the Better Access Program

Background and Program Estimates, Actuals and Trends

The vast bulk of Commonwealth spending on mental health services is located in two programs; the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Scheme (MBS). Changes to the PBS are not the focus of this paper but will be examined by the NACMH later this year. (This is particularly important given emerging evidence that there is an increase in the numbers of people not filing scripts for anti-depressant medications.)

With regards to the MBS, the main focus of attention is the Better Access Program implemented by the Howard Government on 1 November 2006. The aim of this Program was to provide patients with a mental disorder with better access to psychiatrists, psychologists, GPs and other allied mental health workers.

Analyses of the Better Access program show that the uptake of this program continues to grow much faster than predicted, with no signs of any slowing in demand. The number of services provided under this program has increased by 44% over the 12 months from June 2007 to June 2008. In this time period services provided by GPs grew by 38%, and services provided by mental health professionals (primarily psychologists) grew by 47%

The original budget estimate for the Better Access Program for 2006-11 significantly underestimated demand for these services. Actual costs are now available for 2006-07 and 2007-08 and these are shown at Table 1. Also included is a projected five-year cost to Government, with two scenarios provided, one with no further growth and one assuming continued growth at 15%.

Table 1 – Better Access Program Costs, Estimates, Actuals and Trends

Year	Original Estimated Expenditure $m	Actual Expenditure and Trended Outcome Assuming no Growth $m	Actual Expenditure and Trended Outcome Assuming 15%Growth $m
2006-07	51	124.7	94.6
2007-08	92	321.4	321.4
2008-09	108.6	321.4	396.6
2009-10	130.2	321.4	425
2010-11	156.1	321.4	488.8
Totals	**$538m**	**$1410m**	**$1726m**

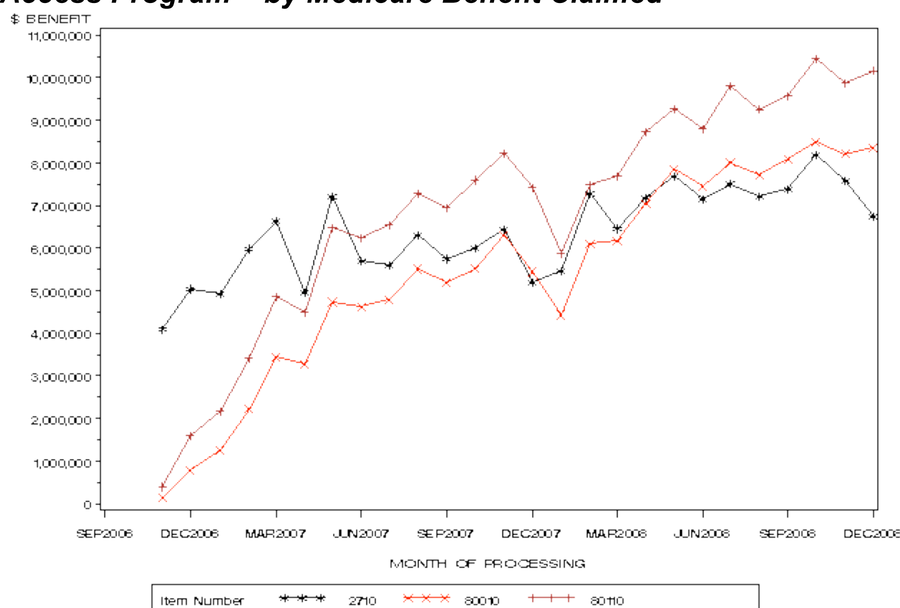
Up to December 2008, the cost to Government of the Better Access Program is $652.3m. Almost 90% of the total revised budget for this five-year program has already been expended in the first 25 months.

While the Better Access Program listed some 26 new billable items under Medicare, the vast majority of activity occurs under only three MBS Items (Items 2710, 80010 and 80110). The most recent full year data on the Program is from December 2007-December 2008. This data reveals that the cost to Government for just the three major MBS items alone was in fact just under $300m, as shown in Table 2.

Table 2 - Three Major MBS Items Under the Better Access Program – Full Year Expenditure Dec 2007-Dec 2008

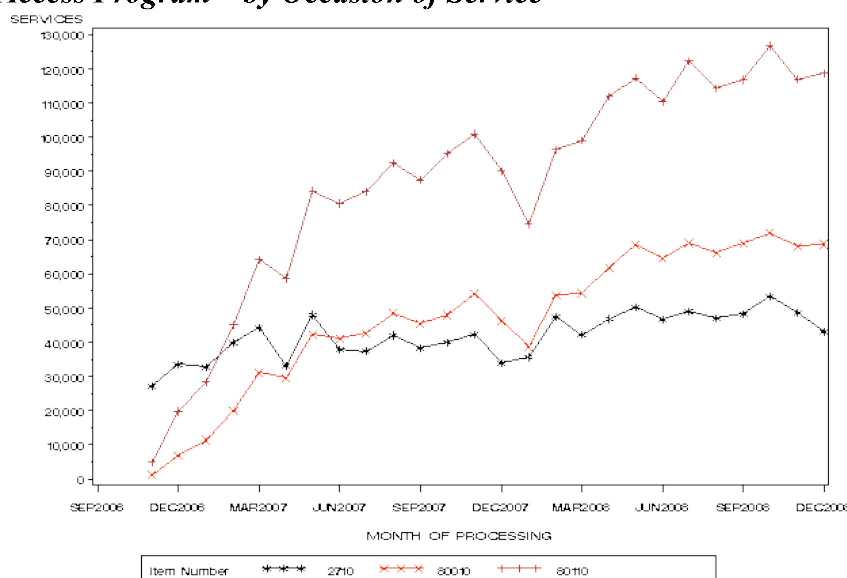
Item No	Description	MBS $ Benefit Paid Dec 2007 –Dec 2008
2710	Preparation of a GP Mental Health Care Plan for a patient	$91m
80010	Session of service from Clinical Psychologist 50mins+	$93m
80110	Session of service from Registered Psychologist 50mins+	$114m
Total		**$298m**

Figure 1 – Demand Trend Lines for Three Major MBS Items Under the Better Access Program – by Medicare Benefit Claimed



While there are rules regarding how many sessions of psychological care can be provided to an individual in each calendar year, they allow for monthly repeat billing. Figure 2 shows the trend for the same three items but by occasion of service.

Figure 2 – Demand Trend Lines for Three Major MBS Items Under the Better Access Program – by Occasion of Service



Considering the three major items since the Program's inception in November 2006, the take-up has been dramatic, as shown in Table 3.

Table 3 - Three Major MBS Items under the Better Access Program Nov 2006-Dec 2008

Item No	Description	No. of Occasions of Service 11/06 – 12/08	MBS $ Benefit Paid 11/06 –12/08
2710	Preparation of a GP Mental Health Care Plan for a patient	1,088,577	$165.6m
80010	Session of service from Clinical Psychologist 50mins+	1,223,992	$141.2m
80110	Session of service from Registered Psychologist 50mins+	2,261,139	$180.5m
Total		**4,573,708**	**$487.3m**

The original estimate of activity under the Program indicated that by 2010-11 almost 960,000 clinical psychology services were expected to be provided and 170,000 GP Mental Health Care plans developed. Within the first two years of the Program alone, more than six times as many GP mental health care plans have been written than were originally estimated to occur over the full five years. The number of sessions of clinical psychology to be provided under the Program has already exceeded the original five year estimate.

Issues with the Better Access Program

Several concerns regarding the design of the Better Access program were raised with the Howard Government in July and August 2006 by the mental Health Council of Australia and others. These concerns seem well justified on the available evidence

two years on since the introduction of Better Access. Some additional issues have also become evident.

Uncapped growth of the least proven aspects of the program
The key issue revealed by Figures 1 and 2 above is the natural ceiling reached by Items 2710 and 80010 – the number of services provided by both GPs and clinical psychologists is limited by the number of health professionals available to do the work. It is likely that for these two groups, a saturation point has been reached, past which workforce and time constraints preclude significant numbers of new clients being added to the system.

This is not the case for registered psychology as shown in Figure 2. Opening access to the MBS to registered psychology brought a whole new workforce into the mental health service sector. This pool of labour does not have the same restricted ceiling as for clinical psychology (length of training, clinical supervision requirements, etc.) and given the capacity to keep training new psychologists, has the potential to continue to expand. Almost every university in Australia offers undergraduate psychology courses. The spiralling cost demands on the MBS in future years seem certain should the current access to the Better Access Program remain unaltered.

Inequitable access to services by location etc.
Access to care varies enormously depending on where you live. This is a reflection of workforce distribution with clinical psychology services largely confined to capital cities. It is important to note that the distribution of registered psychologists in rural areas is considerably better than clinical psychologists. The Better Access Program provides no incentive to target vulnerable groups, such as young people, Aboriginals or those from non-English speaking backgrounds. The nature of the severity of the clients receiving care under the Better Access Program is unclear.

Quality of care
Two years into the Better Access Program, an evaluation process is finally starting with the Department of Health and Ageing (DoHA). However, it is already clear from considerable anecdotal feedback that the quality of care available under the Program varies enormously.

New service options are always welcome in mental health, but they must provide a standard of quality care. On the basis of the available evidence, the quality of care provided by registered psychologists is unclear. Similarly, it is unclear what value GPs add to mental health care in the process of developing the Mental Healthcare Plans. There is some evidence that some GPs see these plans as a well paid referral process to enable patients to claim psychological rebates.

There is evidence to suggest that collaborative care is not only better than individual therapy in terms of patient outcomes, but also in terms of joint professional accountability. The implementation of Better Access removed the requirement for mental health training as a pre-requisite for GP participation in the claims system (as had existed under the Better Outcomes Program), and there is no assessment or review of the quality of the care plans.

Workforce
A further consequence of the Better Access Program has been a drift of workers from the public sector to the private sector. The public sector is struggling to provide psychological care and this particularly impacts on those with severe and persistent mental illnesses who are less likely to use the Better Access Program and instead remain in the public sector seeking care.

The Better Access Program has seen the Commonwealth Government fund the establishment of many individual small psychology businesses with all the incumbent costs. The evidence shows that the vast majority of care provided under the Program occurs by individual practitioners working from their own rooms. This may not be the best buy when it comes to the allocation of Commonwealth resources in mental health.

Out of pocket expenses
In April 2008, DoHA released data on the fees, gaps and out of pocket expenses arising from the new Better Access MBS Items (see Table 4 below).

Table 4 – Fees, Gaps and Out of Pocket Costs – Main Better Access Items

Item No	Description	Schedule Fee	MBS Rebate	Gap	Average Capital City Co-payment
2710	Preparation of a GP Mental Health Care Plan for a patient	$153.30	$153.30	$0	$16.48
80010	Session of service from Clinical Psychologist 50mins+	$132.25	$112.45	$19.80	$28.61
80110	Session of service from Registered Psychologist 50mins+	$90.15	$76.65	$13.50	$34.81

As predicted in 2006, out of pocket costs to consumers have become significant. The profile of clients using the Better Access Program is not yet clear, however, BEACH data and other information indicate that health care card holders and people on lower incomes are less likely to be receiving the new MBS items. There is the real prospect that the new items best serve those with the resources to pay these out of pocket costs. Clients most at risk seem least likely to access care under the new items.

Other Relevant Data

Better the Evaluation and Care of Health (BEACH) data on GP consultations

- In 2006–07, 10.4% of all GP encounters reported for the BEACH data were encounters at which a mental health-related problem was managed. There were an estimated 10.7 million encounters where at least one mental health-related problem was managed, plus another 2.3 million (estimated) additional encounters where a psychologically-related management procedure, treatment, counselling, referral or medication was provided.

- The proportion of GP encounters that were mental health-related has shown an average annual increase of 1.2% between 2002–03 and 2006-07.

- In 2006-07 there were 0.6 million MBS-subsidised specific mental health services provided by GPs and other mental health professionals. The MBS mental health items introduced on 1 November 2006 as part of the Better Access to Psychiatrists, Psychologists and GPs through the MBS initiative (item nos. 2710, 2712, and 2713) represented 2% of MBS items recorded by GPs in 2006–07. A further 0.2% were other mental health-specific MBS items.

- Over 12 million estimated GP mental health-related encounters did not involve in claims for mental health-specific MBS items.