

RESEARCH ARTICLE

Trends in mental health service utilisation by Australia's older population

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Abstract

Objectives: To examine the incidence, trends, and differences between age groups and sex in Medicare Benefits Schedule (MBS)-subsidised mental health service utilisation by older Australians over the past 10 years.

Methods: A cross-sectional cohort study between 1 July 2009 and 30 June 2019 was conducted using publicly available MBS data for older individuals aged ≥ 65 years. Age- and sex-standardised yearly incidence rates of psychological therapy (MBS M06), GP mental health treatments (MBS A20), focussed psychological strategy (MBS M07), and psychiatric attendances (MBS A08) and incidence rate ratios (IRR) estimated using Poisson regression were calculated.

Results: Overall, the rate of utilisation of primary care mental health services by the older population increased over the study period, with psychological therapy claims increasing the greatest from 14.4/1000 older persons in 2009/10 to 38.5/1000 in 2018/19 (IRR 1.11, 95% CI 1.09–1.13), followed by GP mental health treatments increasing from 43.7/1000 (95% CI 43.4–43.9) in 2009/10 to 81.0/1000 (95% CI 80.7–81.3) in 2018/19 (IRR 1.07/year, 95% CI 1.06–1.09). Females aged 65–74 years had the highest use of GP mental health treatments at 123.8/1000 compared to 63.6/1000 in males in 2018/2019.

Conclusions: While utilisation of mental health services by the older population in Australia has increased over the study period, it is important that policymakers and service providers continue to support access and use of these services, which may facilitate well-being and quality of life in the older population.

KEYWORDS

health services, mental health, older people

1 | INTRODUCTION

Mental health conditions pose a significant health burden for older Australians. The recent National Health Survey reports that 17.3% and 22.4% of older men and women,

respectively, aged 65 years and older, suffer from a current long-term mental or behavioural disorder.¹ Older individuals with a mental health condition are more likely to suffer from increased disability and reduced health-related quality of life.² Older people with depression are four times

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more likely to have frailty, and those with frailty are approximately three times more likely to have depression.³

For older people, the provision of adequate primary mental health care can be effective in reducing disability, delaying the transition to high-level aged care services, and improving life expectancy.^{4,5} Older people with a mental health condition have increased use of primary care services,² leading to significantly higher health-care costs.⁶ This may be caused, in part, by the higher prevalence of comorbid mental and physical chronic conditions in the older population.⁷ The Australian government provides access to subsidised primary mental health services through the Better Access initiative.⁸ This initiative allows individuals living in the community to access up to 10 allied mental health services each year that are subsidised under the Medicare Benefits Schedule (MBS). A mental health treatment plan prescribed by a general practitioner (GP) or an assessment and management plan from a psychiatrist is the point of entry to receive these MBS-subsidised services. Once obtained, individuals can access subsidised services from clinical or general psychologists, occupational therapists, and social workers to meet their treatment needs.

The timely diagnosis and treatment of mental health conditions is paramount to healthy ageing. Presently, there is limited evidence on how older Australians use MBS-subsidised primary mental health services to meet their care needs. Understanding how older people use these government-subsidised mental health services provides a foundation to promote increased service use to potentially improve the mental health and well-being for this vulnerable population. Therefore, the current study was undertaken to examine the trends over the past decade in MBS-subsidised mental health service use by older individuals, stratified by age and sex, to inform improvements in policy and practice.

2 | METHODS

2.1 | Ethics

Ethics approval was not required as aggregated, publicly available MBS processing data, downloaded from Medicare Item Reports, Services Australia, Australian Government (http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp), were analysed.⁹

2.2 | Study design, setting, and data sources

A population-based observational study was conducted using aggregated, publicly available MBS data. Monthly counts of Australia-wide mental health service claims

Policy Impact

Utilisation of mental health services by the older population in Australia increased between 2009 and 2019, and is important that policymakers and service providers support continued growth in access and use of these services by the older population.

between 1 July 2009 to 30 June 2019 were accessed from the Services Australia website⁹ for individuals aged ≥ 65 years. Quarterly Australian population estimates for the same periods were accessed from the Australian Bureau of Statistics (ABS).¹⁰

2.3 | Mental health service utilisation

Four groups of mental health services and the specific MBS items for attendances/services within each of the mental health service groups were examined (Table S1). This included psychological therapy services (MBS group M06, eight items), GP mental health treatment (MBS group A20, 15 items), focussed psychological strategies (MBS group M07, 24 items), and consultant psychiatrist attendances (MBS group A08, 21 items).

2.4 | Statistical analysis

Summary statistics were calculated to describe the overall study population. Yearly incidence rates per 1000 older persons (aged ≥ 65 years from ABS quarterly population statistics) and 95% confidence intervals (CIs) were calculated, analyses were stratified by sex and age groups (65–74 years, 75–84 years and ≥ 85 years), and overall rates were age- and sex-standardised. Poisson models were used to estimate incidence rate ratios (IRRs) of mental health services group utilisation between 2009/10 and 2018/19. Heteroscedasticity and autocorrelation consistent (HAC) standard errors were used to account for potential autocorrelation in the regression models. Models were estimated separately for each mental health service type. Additionally, the proportion of individual item claims that contributed to the total group claims were calculated to determine the use of each item within their respective groups (see Table S1 for all items in each group). The reporting of this study is done in accordance with the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement.¹¹ All analyses were conducted using Stata 15.1.

3 | RESULTS

In 2009/10, there were $n = 2,963,692$ (accounting for 13.6% of total Australian population, $n = 21,788,088$) individuals aged ≥ 65 years, and in 2018/19, there were $n = 4,008,474$ (15.7% of total Australian population, $n = 25,472,266$).¹⁰ The distribution of sex and older age groups remained relatively stable over the study period (Table 1).

Over the study period, the use (per 1000 older individuals) of all mental health services examined increased (Figure 1, Table 2, Table S2). GP mental health treatments had the highest utilisation by 2018/19, increasing from 43.7/1000 (95% CI 43.4–43.9) in 2009/10 to 81.0/1000 (95% CI 80.7–81.3) in 2018/19 (IRR 1.07/year, 95% CI 1.06–1.09). Psychological therapy claims increased from 14.4/1000 (95% CI 14.2–14.5) in 2009/10 to 38.5/1000 (95% CI 38.3–38.6) in 2018/19 (IRR 1.11/year, 95% CI 1.09–1.13). Focussed psychological strategy claims increased from 29.9/1000 (95% CI 29.7–30.1) in 2009/10 to 55.7/1000 (95% CI 55.4–55.9) in 2018/19 (IRR 1.08/year, 95% CI 1.07–1.08), and psychiatric attendances had the smallest increase from 48.3/1000 (95% CI 48.1–48.6) in 2009/10 to 56.8/1000 (95% CI 56.6–57.0) in 2018/19 (IRR 1.02/year, 95% CI 1.02–1.03) (Figure 1, Table 2, Table S2).

The utilisation of mental health services by sex and age groups are shown in Figure 2 and Table 2. Females aged 65–74 years had the highest utilisation of mental health services, which increased over the study period, for all groups examined (Figure 2, Table 2). The greatest increase was observed for psychological therapy claims, increasing from 27.0/1000 (95% CI 27.0–27.0) in 2009/10 to 68.5/1000

(95% CI 68.5–68.5) in 2018/19 (IRR 1.10, 95% CI 1.08–1.12). While males aged ≥ 85 years had the lowest utilisation of mental health services, they had the greatest increase in the rates of use over the study period. For example, GP mental health treatments increased from 13.2/1000 (95% CI 13.2–13.3) in 2009/10 to 38.0/1000 (95% CI 38.0–38.1) in 2018/19 (IRR 1.13/year, 95% CI 1.10–1.17).

The greatest disparity between male and female mental health utilisation was observed for the 65–74 age group. In 2018/2019, females aged 65–74 years claimed psychological therapy services at a rate of 68.5/1000 (95% CI 68.5–68.5) compared with males of the same age at 33.9/1000 (95% CI 33.9–33.9) and GP mental health treatments therapy at a rate of 123.8/1000 (95% CI 123.8–123.9) compared with males 63.6/1000 (95% CI 63.5–63.6) (Figure 2, Table S2).

Next, we examined the individual types of attendances and services contributing greatest to overall mental health service utilisation within each group (Table S1). Within psychological therapy services (M06), attendances by a clinical psychologist to provide psychological assessment and therapy for a mental disorder lasting at least 50 min (MBS item 80010) comprised 93% of the services in 2009/10 and 95% in 2018/19. For GP mental health treatments (A20), professional attendance by a GP in relation to a mental disorder and when treatment, advice, or referral were required (MBS item 2713) comprised 59% in 2009/10 and 62% in 2018/19 of the total claims. Preparations and review of GP mental health treatment plans were the next most-commonly claimed services across the study period. For the focussed psychological strategies group (M07), attendances by a general psychologist to provide focussed psychological strategy services for an assessed mental disorder lasting more than 50 min (MBS item 80110) comprised 82% in 2009/10 and 78% in 2018/2019 of total claims. Within the consultant psychiatric attendances (A08) group, professional attendances by a consultant physician lasting between 30 and 45 min (MBS item 304) comprised 35% in 2009/10 and 37% in 2018/2019 of the total claims, followed by professional attendances lasting between 45 and 75 min (MBS item 306; 31% in 2009/10 and 33% in 2018/19), and professional attendances lasting between 15 and 30 min (MBS item 302; 20% in 2009/10 and 13% in 2018/19).

TABLE 1 Study cohort: older Australians aged ≥ 65 years, 2009/10 and 2018/19

	2009/10 $N = 2,963,692$	2018/19 $N = 4,008,474$
	N (%)	N (%)
Sex		
Female	1,608,527 (54.3)	2,131,636 (53.2)
Male	1,355,165 (45.7)	1,876,838 (46.8)
Age groups (years)		
65–74	1,596,639 (53.9)	2,268,983 (56.6)
75–84	984,223 (33.2)	1,226,450 (30.6)
≥ 85	382,830 (12.9)	513,041 (12.8)
Sex * Age (years)		
Female 65–74	810,088 (27.3)	1,160,698 (29.0)
Female 75–84	545,710 (18.4)	653,911 (16.3)
Female ≥ 85	252,729 (8.5)	317,027 (7.9)
Male 65–74	786,551 (26.5)	1,108,285 (27.6)
Male 75–84	438,513 (14.8)	572,539 (14.3)
Male ≥ 85	130,101 (4.4)	196,014 (4.9)

4 | DISCUSSION

This large population-based study shows that the use of primary mental health services by the older population in Australia has increased over the last 10 years. The use of psychological therapy claims, GP mental health treatments, focussed psychological strategies, and consultant psychiatrist services all significantly increased across the study period. Given that the prevalence of common mental

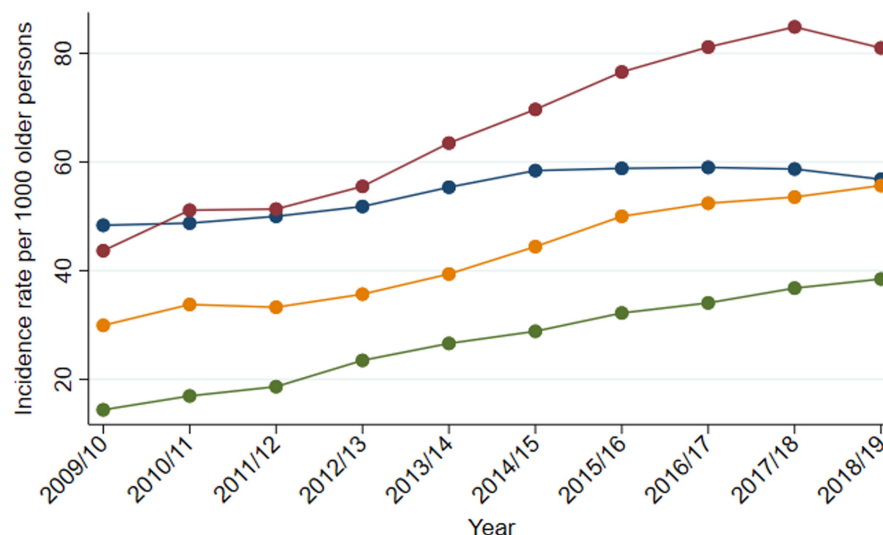


FIGURE 1 Age- and sex-standardised yearly incidence rates in mental health service utilisation by individuals aged ≥ 65 years between 2009/10 and 2018/19. —, Psychological therapy services (M06); —, GP mental health treatment (A20); —, Focussed psychological strategies (M07); —, Consultant psychiatric services (MBS Group A08).

TABLE 2 Incidence rate ratio (IRR) of change in utilisation of Medicare-subsidised mental health care services between 2009/10 and 2018/19, overall, and by age and sex

	Psychological therapy services (M06) IRR (95% CI)	GP mental health treatment (A20) IRR (95% CI)	Focussed psychological strategies (M07) IRR (95% CI)	Consultant psychiatric services (A08) IRR (95% CI)
Overall (≥ 65 yrs) ^a	1.11 (1.09–1.13)	1.07 (1.06–1.09)	1.08 (1.07–1.08)	1.02 (1.01–1.03)
Female 65–74	1.10 (1.08–1.12)	1.07 (1.05–1.08)	1.06 (1.06–1.06)	1.02 (1.01–1.03)
Female 75–84	1.13 (1.12–1.14)	1.09 (1.07–1.10)	1.10 (1.09–1.11)	1.03 (1.03–1.04)
Female ≥ 85	1.12 (1.11–1.13)	1.11 (1.09–1.13)	1.15 (1.09–1.21)	1.05 (1.03–1.06)
Male 65–74	1.11 (1.09–1.13)	1.07 (1.06–1.09)	1.07 (1.07–1.08)	1.02 (1.01–1.03)
Male 75–84	1.12 (1.10–1.14)	1.07 (1.06–1.09)	1.09 (1.09–1.10)	1.03 (1.02–1.03)
Male ≥ 85	1.13 (1.12–1.13)	1.13 (1.10–1.17)	1.14 (1.08–1.20)	1.07 (1.05–1.09)

Abbreviations: CI, confidence intervals; IRR, incidence rate ratio.

^aOverall models are age- and sex-standardised.

health conditions has remained stable over recent years,¹² the increased trend in mental health service utilisation observed in the current study is likely to be a reflection of a growing recognition of the need to improve to mental health treatment access.¹³ However, despite increased utilisation, there is still an imperative for increased access and use of these services to improve the health and well-being of the older population. Importantly, in 2020 (although after our current study period), Australia's Better Access scheme, by which access to subsidised primary mental health services is supported by the Australian government, was extended to include people living in residential aged care facilities (RACFs).⁸

Our findings that those aged ≥ 85 years use the least amount of mental health services may reflect how older people now living in RACFs were previously ineligible to access some of the examined mental health services that

are specific to residential aged care. Additionally, older individuals who do not have mental health conditions are more likely to have increased survival¹⁴ and require fewer mental health services. It is likely that the associations between increased age, better mental health, and lower mortality may be partly attributed to a number of factors across the lifespan, including utilisation of health care, compliance with treatments, and number and severity of comorbidities.¹⁵

The disparity observed between males and females accessing mental health services, especially for those aged between 65 and 74 years, aligns with the past research, indicating that males are less likely to seek help for mental health issues.¹⁶ Males may seek help less because of increased levels of stoicism, feelings of perceived stigma related to mental health issues, and lower levels of openness to experience compared with females.¹⁷ In addition, males are more likely to present with atypical symptoms when

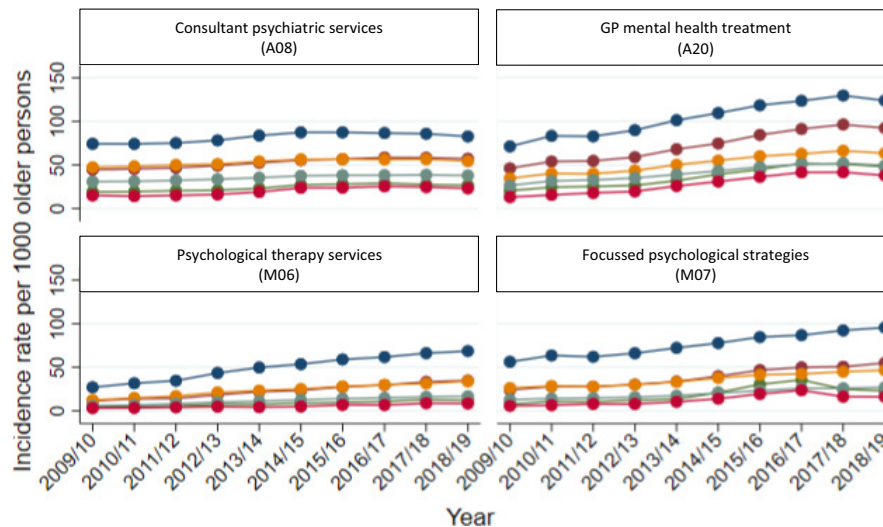


FIGURE 2 Yearly incidence rates in mental health service utilisation by age groups and sex between 2009/10 and 2018/19. —●—, Females 65–74; —●—, Females 75–84; —●—, Females 85+; —●—, Males 65–74; —●—, Males 75–84; —●—, Males 85+.

suffering from depression, such as an increase in somatic complaints and externalised symptoms such as anger, alcohol misuse, or risk-taking, potentially impacting on an appropriate diagnosis.¹⁸ Similar to our observed findings, the gender gap in mental health attenuates in advanced older age.¹⁹

4.1 | Strengths and limitations of the study

This study provides a comprehensive population-based overview of the use of federal government-funded mental health services in Australia by older people over a 10-year period. In addition, overall rates were age- and sex-standardised, allowing for meaningful comparisons over the 10-year study period.

The publicly available data used for our analyses are limited to primary mental health services subsidised by the MBS and do not include private services, services provided by non-government organisations, hospitals (such as outpatient services), community services, or those covered by the Department of Veterans' Affairs. Second, these data are an aggregate of service claims from Australia and are not individual level records and therefore do not provide us with demographic or other important psychosocial or clinical information such as dementia that may influence service use by older people. This limitation, however, is offset by the fact that these data are representative of the whole older Australian population. Furthermore, these data are contemporary as Services Australia publishes claims information monthly and data were examined up to 2019. This means that immediate high-level insights can be gained quickly

from these data avoiding the delays of sometimes years that can accompany unit-level administrative linkage data. This study only focused on those aged ≥ 65 years and did not examine changes in the utilisation of mental health services for younger age groups; therefore, we are not able to comment on overall trends in the utilisation of mental health services over the study period. Future research should examine the effects of the observed increased utilisation of mental health services on health outcomes, especially mental health outcomes.

5 | CONCLUSIONS

This study has shown an increased utilisation of primary mental health services over the past 10 years. However, given the high prevalence of mental health conditions in the older population, these services are likely under-utilised. These findings are of particular importance to policymakers and coordinators of primary mental health-care provision as these findings can inform national resource allocation to facilitate the continued access of these services by the older population. It is important to prioritise access to GPs and mental health services for older individuals as these services are central to healthy ageing for Australia's growing older population.

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CONFLICTS OF INTEREST

Dr Andrew Kellie is a practicing general practitioner. The authors have no other conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Data is available publicly from Services Australia.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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