Were the budgetary reforms to the Better Access to Mental Health Care initiative appropriate? — No

Mental health policy expert Sebastian Rosenberg and psychiatrist Ian Hickie want more change

NO The Australian Government had little option but to reform the Better Access to Mental Health Care initiative in the federal Budget. The surprise is their timidity. The changes reduce some of the bureaucracy and waste while promoting more targeted services for those in greatest need.

Better Access was the largest single component of the Council of Australian Governments' 2006 National Action Plan on Mental Health, and has been likened to a runaway giant,[1] already costing more than three times its initial 4-year estimate of $538 million, or more than $10 million each week.

The focus of the federal government's changes are GP Mental Health Care Plans. Under pressure from doctors, Better Access removed the requirement for the collaborative, interdisciplinary approach embodied in the earlier Better Outcomes in Mental Health program, despite repeated positive evaluations.[2] The professions championed shifting their role in primary mental health care to fee-for-service, a model of payment shown to be ineffective in generating collaborative care.

The Better Access program suggests that, after several sessions of psychological therapy, patients return to their general practitioners for review of their mental health care plans. Latest data indicates that this is happening for only one in every three plans written. Consumers are not receiving a full episode of care. The number of GP Mental Health Care Plans prepared by GPs (Medicare Item 2710) has also declined significantly over the past 12 months. Twenty per cent of all Better Access clients are now having their mental health managed through their GP using Medicare Item 2713 — the GP Mental Health Care Consultation — alone.[3]

GPs have allowed their role in Better Access to dwindle to that of glorified referrers. No wonder the government is now backing better value services. The Budget's support for the Access to Allied Psychological Services (ATAPS) program is an admission that better ways to engage GPs productively as key players in the delivery and management of primary mental health care do exist.

The government did not choose to make significant changes to psychological services, which continue their unbridled growth. The Budget trims subsidised sessions of cognitive behaviour therapy (CBT) from 12 to 10 per year. On average, people are receiving five sessions, though ironically, the government's most recent evaluation of the Better Access program indicated that health outcomes were optimised after six.[4]

Better Access has generated controversy within the psychology profession, with clinical psychologists arguing it devalues their specialised skills. Consumers lack the information to differentiate clinical from other psychologists.

Better Access service users have frequently reported receiving psychoeducation and non-specific counselling rather than the evidence-based CBT programs. This type of inadequate treatment was one of the main reasons that the Better Outcomes and Better Access initiatives were supported by most health professionals.[5]

The minimalist Budget changes leave key issues unaddressed.

The significance of out-of-pocket expenses (around $30 for each session of CBT) associated with the Better Access program has been noted.[3] There is considerable evidence to indicate that the program is failing to reach people aged less than 15 years, men, and people living in areas of high socioeconomic disadvantage and non-urban areas.[3] Analysis of Medicare data shows that Queenslanders receive clinical psychological services at half the rate of Tasmanians. There are as many clinical psychology services provided in the Australian Capital Territory as in the whole of New South Wales!

In 2008, 68% of people using the Better Access program were using it for the first time. In 2009 this figure had dropped to 57%. An initiative originally designed to offer short, focused regimens of CBT may be becoming a program of continuing care instead.

Although the 2011 Budget makes only minor changes to the most obvious deficits in the current Better Access to Mental Health Care program, it does clearly indicate that it is now a major problem that will be monitored closely for value, efficiency and equity, particularly in comparison with more attractive and collaborative alternatives.

There is a clear role for GPs in coordinating genuine primary mental health care. At present, that role is largely vacant. The timing is right for the professions to abandon self-interest and argue for a planned, evidence-based overhaul of the Better Access program.

Competing interests: Ian Hickie is a board member of *headspace*: Australia's National Youth Mental Health Foundation and a member of the clinical reference group for the BUPA Australia group. He has also been a member of the National Advisory Council on Mental Health.

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