

# Mental health funding protests are missing the bigger picture of equity concerns

August 8, 2011 – 2:05 pm, by [Melissa Sweet](#)

Since the May budget, when the Federal Government **announced** that \$1.5 billion in mental health investments over the next five years would be partly funded by a redirection of \$580.5 million from the Better Access program, the cries of outrage have been growing.

Any number of professional groups have been crying foul, including those representing doctors and psychologists, and many community voices have also joined the chorus of concern.

There are now 141 submissions on the website of the **Senate Community Affairs Committee's** inquiry into Commonwealth Funding and Administration of Mental Health Services, and no doubt more in the mail (the full terms of reference for the inquiry are at the bottom of this post).

However, the issues involved are more complex than the "government cutbacks" mantra being waved by many of the protesters, and go to fundamental questions about equity, and the fairness and sustainability of fee-for-service models of care. They also highlight the challenges of meeting the needs of those who often miss out on services, and whose needs therefore are not always at the forefront.

In the article below, **Dr Tim Woodruff**, Vice President of the Doctors Reform Society, provides some of the background to the issues involved, and suggests that if we really care about equity, we should be having a much more wide-ranging look at how health services are funded.

\*\*\*

## **It's time to focus the debate on the systemic issues which contribute to inequity**

*Tim Woodruff writes:*

In the May Budget there was a major mental health funding initiative. There were some small cuts to current programs, and significant expansion of others.

Two of the programs affected are aimed at providing short-term psychological treatment. What do the changes tell us about the direction of Government policy?

The Better Access initiative was introduced in 2006 and finally recognised the importance of psychologists in the treatment of mental health disorders.

Funding is through a fee for service Medicare rebate for each visit to the psychologist at the bequest of a GP who receives a rebate for collating a Mental Health Plan.

Whilst each visit to the psychologist generates a Medicare rebate, it is different from the fee for service arrangement for seeing GPs, or specialists, or having surgery, in that the number of visits with the psychologist

is capped. Ten sessions and it's over. It is very popular and the number of patients involved has been increasing about 20% per year.

Another initiative introduced in 2003 also recognised the importance of psychologists and funded access for short-term psychological treatment. This program (ATAPS) is tiny, less than \$50 million per year compared to Better Access, which costs about \$550 million per year.

Funding for ATAPS is completely different. The money is distributed to Divisions of General Practice (now Medicare Locals) to administer in ways which suit that Division. The amount is largely determined by population. The aim however, has been to provide services to groups which had been identified as not accessing much care at all, ie rural dwellers, young people, and indigenous Australians.

There are significant differences in the programs, which in part reflect the funding mechanism. ATAPS delivers 45% of its services to people in rural and remote Australia. Better Access delivers 25%, similar to the delivery of other Medicare rebate services.

Patient copayments are zero for over 75% of patients in ATAPS and where they do exist, they are between \$5 and \$20. For Better Access however, only 35% of psychology consultations have no copayment and the average copayment is \$35.

Given these figures it is not surprising that use of Better Access is 10% lower for the poorest fifth of the population compared to the richest. That should be of concern as it is well recognised that health status and outcomes are inversely related to socioeconomic status.

One might however, regard the programs as complementary. That is the Federal Government view. Better Access provides the majority access to psychologists and ATAPS picks up the pieces. ATAPS is the safety net for the fundamentally flawed funding mechanism of Better Access.

Fee for service with copayments almost guarantees some patients will not be able to afford the treatment. The capacity to charge fee for service plus copayment contributes to providers staying in areas where they can get copayments, rather than working in poor and rural areas. With continued financial and geographical barriers to access guaranteed, the safety net of ATAPS is crucial.

It all sounds very familiar. General GP and specialist services in the community have been funded that way since Medicare was introduced. Safety nets and targeted programs abound but financial and geographical barriers to access persist. The ABS Patient Survey 2009 showed that 6.4% of average Australians delayed or didn't see their GP because of cost. The Commonwealth Fund Survey of sick Australians showed that 23% didn't see the doctor or get follow up because of cost.

Apart from problems with access, there are other concerns with Better Access and with fee for service funding generally. The first is the issue of flexibility to meet local needs in innovative ways. It is identified by the report on ATAPS by the Department of Health and Aging

The current ATAPS initiative enables Divisions to utilise a model of service delivery that meets local needs.

Better Access, as with all Medicare subsidised services, offers a universal model (that is the same model for the entire Australian population) and does not have the flexibility to be modified to meet the needs of sub-populations. It is recognised that Better Access mental health services are not always accessible to all consumers'

The second is the issue of over-servicing. This is a potential problem with any professional trained to manage a problem. There is the possibility that such a professional can have more faith in his/her knowledge and skills than the evidence suggests is justified. This can be exacerbated by patient expectations that something should be done. It is compounded by the often-siloed nature of medical practice.

Thus in the United States it has been found that one in every eight non-urgent but quite dangerous and invasive heart procedures for patients at risk of heart attack were not really justified by the evidence. In Australia it's been shown that following a heart attack one is much more likely to get an operation in a private (fee for service) hospital than in a public hospital next door.

The same concerns exist for both the Better Access and ATAPS. The uncapped and siloed nature of the Better Access program combined with the fee for service remuneration for providers makes that even more of a concern when compared to ATAPS.

The May Budget cut Better Access funding in two ways. Firstly it reduced the rebate for the GP assessment, partly because the evidence indicated that the assessment was generally taking much less time than anticipated. Secondly it reduced the number of psychology consultations from 12 to 10, partly because the evidence was that the average need was for only 6 sessions. Clearly these cuts were also about saving money.

In addition, the funding for ATAPS was doubled (still very small). This was recognition that a better safety net was needed. Overall, the changes are minor.

They do move more in the direction of equity and efficiency but there is no underlying aim to achieve equity. The cut to the rebate for the GP assessment ignores the fact that many GPs working in the most difficult areas use this large rebate to cross subsidise the psychologist eg through reduced rental fees for the psychologist. But that is of no concern to a bureaucracy intent on saving money. It also is a further reflection of the flaws in the funding model.

Safety nets are only needed when the basic structure is flawed. Better Access has delivered some great care to many people. Almost every new health funding program will help some people. Even the PHI rebate and the Extended Medicare Safety Net have helped some people access services they would not otherwise have accessed.

But do we want an efficient use of health funds? Or do we want to keep on chasing the gaps in service left by a flawed funding structure?

ATAPS, a fundholding arrangement rather than a fee for service system, delivers to the most needy. It could be expanded slowly to be a major component of our health system.

The allocation of funds could be on the basis of need rather than just population. The resistance to such an expansion will continue from the AMA because it is seen as a potential threat to the independence of doctors. This is despite the fact that health care is increasingly complex and requires the cooperative approach that is facilitated by fundholding and frustrated by siloed practitioners.

The resistance by Government to such an expansion reflects a belief that safety nets and programs are the way to address problems, that targeting the worst is the way to reduce inequity.

It probably also reflects a belief that private provision of services under fee for service, rather than the much more obviously public provision under fundholding, is the right way to go, despite the evidence of the demonstrated failure to achieve equity after over 20 years fiddling trying to address the problems of such total reliance on fee for service funding.

The alternative is to aim for equity. Equity is not equality. It is addressing the preventable causes of inequality. It is not about targeting the most disadvantaged. It is about removing any disadvantage that is due to systemic factors over which we have control.

That is possible, and we can do it by looking at major structural changes to how we fund our health system.

Gradually increasing our use of fundholding and decreasing our dependence on fee for service warrants much more serious consideration than it has been given to date.

\*\*\*\*

#### **PS from Croakey**

The Terms of reference for the Senate inquiry are:

The Government's funding and administration of mental health services in Australia, with particular reference to:

- (a) the Government's 2011-12 Budget changes relating to mental health;
- (b) changes to the Better Access Initiative, including:
  - (i) the rationalisation of general practitioner (GP) mental health services,
  - (ii) the rationalisation of allied health treatment sessions,
  - (iii) the impact of changes to the Medicare rebates and the two-tiered rebate structure for clinical assessment and preparation of a care plan by GPs, and
  - (iv) the impact of changes to the number of allied mental health treatment services for patients with mild or moderate mental illness under the Medicare Benefits Schedule;
- (c) the impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services program;
- (d) services available for people with severe mental illness and the coordination of those services;
- (e) mental health workforce issues, including:
  - (i) the two-tiered Medicare rebate system for psychologists,

- (ii) workforce qualifications and training of psychologists, and
- (iii) workforce shortages;
- (f) the adequacy of mental health funding and services for disadvantaged groups, including:
  - (i) culturally and linguistically diverse communities,
  - (ii) Indigenous communities, and
  - (iii) people with disabilities;
- (g) the delivery of a national mental health commission; and
- (h) the impact of online services for people with a mental illness, with particular regard to those living in rural and remote locations and other hard to reach groups; and
- (j) any other related matter.

[Comments \(10\)](#) | [Permalink](#)

## 9 Comments


1.  **Mark Thompson**  
Posted August 8, 2011 at 4:14 pm | [Permalink](#)

The erstwhile Dr Tim Woodruff seems to be missing his own point. I note he has been slamming Medicare since 2003 as an inequity vehicle perhaps he could invest time in actually reading the Dept of Health and Ageing's independent evaluation of Better Access and ATAPS 2011 audit. Mental health sufferers are their own disadvantaged group and prior to Better Access uptake of mental health services in Australia languished at approximately 34% of those Australians with a mental health disorder, in 2011 the Better Access program was considered to be a major contributor to an increase in service utilization by approx 47% Australians with a mental health disorder. Epidemiological research by Harris, et al actually showed that demographic and disadvantage population categories were NOT predictors of Better Access usage. In fact, the severity and type of clinical need was the predictor of Better Access usage. Placing that alongside the independent evaluation that Better Access was overwhelmingly seeing Australians with severe and moderate health concerns who had not been seen previously this is a program success story. ATAPS is an important safety net yet this program was seen to exceed 15% admin costs regularly and had session costs ranging from \$53 to over \$1100, with an average cost of over \$200 per session compared with BA overwhelmingly being charged at a smudge over \$80 per session. ATAPS administration also varies and some ATAPS users do pay a gap payment also. In a climate where neither program is means tested cuts to the much larger Better Access program will see compounding of the current problem of area's ATAPS budgets being overwhelmed and rationing of GP referrals or closing books is likely to be exacerbated. All this from a context where Australia is funding mental health at only 7.5% of health budget for mental health despite it's heavy morbidity burden. Critics of universal care please explain how mental health treatment can remain treatment cost efficient and accessible to many within funded and administered program constraints or are you just happy to bar access as Australia has in the past? Not very equitable. The dispersion upon the skills, qualifications and training of mental health workers registered with their national health bodies and audited by Medicare is also unfounded and arrogant. If you are aware of individual practitioners who are not providing evidence based treatment this is a serious breach of professional conduct and this should be reported immediately.

Otherwise it reads like a medico inferring that only the medically trained would provide health treatments of a reputable and consistent quality which I think is profoundly spurious.

2.  **Katrina Walker**  
Posted August 8, 2011 at 5:46 pm | [Permalink](#)

Really Melissa? Is this the best we can do in trying to create Better Access program ambiguity? Mark Thompson above is correct. In the submissions received in the Senate Inquiry into Mental Health Funding and Administration an interested observer could see a submission made by an Australian researcher employed by Orygen Research (group programs include EPPIC & headspace) whose affiliates have been vocal critics of Better Access equity. The Orygen Health researcher submitted that the criticisms of equity have been reasonably answered by the University of Melbourne Public Health Unit Better Access evaluation and even the most resounding ATAPS reviewers concede that funded programs will always leave access barriers and be more expensive to run than Medicare programs. Let's stay with the evidence shall we?

3.  **Thembi Soddell**  
Posted August 8, 2011 at 6:16 pm | [Permalink](#)

Something really needs to be done to stop the misinformation spreading about the cutbacks to Better Access. The reduction in sessions is from 18 down to 10, not 12 down to 10. Tim Woodruff write that "Overall, the changes are minor", but for people using the full 18 sessions the changes aren't minor at all! That's a 44% reduction of possible psychological treatment per year. For anyone who can't afford to make up the difference (which is highly likely for people with chronic mental illness who need longterm psychological treatment, who are often out of work or in low income brackets) these changes are dramatic; these changes will negatively affect their mental health and daily functioning, and lead to an increased suicide risk. ATAPS, even with increased funding, isn't yet equipped to handle all these people. Even if it is determined that ATAPS is a better way to deliver service, treatment available through Better Access can't be reduced until an alternative has been offered that is equally as effective. The new budget does nothing to achieve this.

This article asks us to look at the bigger picture, but the problem with this is the implication that the "smaller picture" is irrelevant. The smaller picture, as I see it, is the direct effect these cutbacks will have on people who use and need Better Access—particularly those with chronic conditions who need the most support. There are a lot of people speaking out about how much Better Access has improved their mental health, particularly people with chronic mental health problems that need ongoing support. There is no evidence that people with chronic mental illness will miraculously get better after 6 (or 10) sessions. There is only evidence that people, on average, were using around 5-6 sessions through Better Access. This doesn't tell us anything about what constitutes effective treatment. This doesn't mean the people who were using the full 18 sessions were being over-served. More likely, they are different people with different needs, and those using the full 18 sessions needed them. And there were over a quarter of a million of these people over three years!

Mental illness keeps getting lumped into one category, like there is one treatment that works for every illness and disorder out there. This is not true. Evidence show that some disorders require intensive long term psychological treatment—and not just CBT (DBT is a good example). Other disorders require much less. None of this is factored into Better Access (or ATAPS), although the additional six sessions in 'exceptional circumstances' did something to counteract this by providing extra treatment to those most in need. Yet these are the sessions that have been cut, and these are the sessions that are not even getting a mention in the media when cutbacks are discussed. When they are discussed, their importance is often minimised. Yet these are the sessions most integral to people with more serious mental health concerns! These are the sessions that often make all the difference.

As for people moaning about "government cutbacks" (said as though people need to realise there have not been cutbacks), it is important to note that even if the budget for mental health has increased, the budget for psychological services has significantly decreased. Once again, I see the media lumping mental illness into one big category as though everyone with a mental illness has the same needs. But people who require longterm psychological treatment have missed out, whereas people who need medication are getting more service—and those who would be better off with psychological treatment will be forced to use medication. There is another huge issue going on here that is not getting enough attention at all: medical vs. psychological treatment, which does Australian need more? I would think the massive budget blow-out for Better Access suggests the latter.

My own protest to the new budget is mainly based on the fact that we need serious evidence-based alternative to medications because medications can cause serious (even deadly) side-effects. Many are unaware of these side-effects, or when they're discussed they are minimised as though they're no big deal. As someone who has experienced some of these I can guarantee they are a big deal! And I am sickened by the thought of the new budget increasing young Australians' use of these medications without offering sufficient alternatives for those that may benefit otherwise. Until somebody can prove there has been a \*significant\* amount of research into the safety of psychiatric medication (particularly in the longterm) I will remain opposed to overemphasising the importance of this approach to treatment.

So while I welcome a review of Better Access to make it more effective, it's a huge problem to be reducing sessions for those who need them most. ATAPS is not currently a suitable alternative. All I see is a budget for mental health "reform" that gives no options to people who need longterm psychological treatment. I won't argue that the mental health system needs a significant overhaul, but this is not the way to do it!



4.

**Ben Mullings**

Posted August 8, 2011 at 6:18 pm | [Permalink](#)

The above article is an ideologically driven piece against the fee-for-service model. It uses a lot of rhetorical language that goes with politically driven articles of this kind, with reference to silo effects and the usual bogus claims that psychological services are being delivered to people who don't need them. It is ironic that the writer claims that critics of the planned cuts to psychological services are not seeing the

bigger picture, when in fact, the article completely fails to mention the serious impact these cuts to services are going to have on people that desperately need them. Let me explain...

First, we know that the people service by the Better Access system are in over 80% of cases people who are experiencing moderate to severe levels of psychopathology – and not those with ‘mild to moderate’ levels of distress. Clearly they have a serious need for mental health care. It is not helpful at all for the writer of the above article, or indeed any other writer, to trivialise the needs of these people for psychological services. To do so is stigmatising and discouraging for those who are distressed and contemplating reaching out for help.


Second, there are scientific problems with the idea that a mental health disorder can be fixed in just 10 sessions. All of the controlled research worldwide, has repeatedly demonstrated that 15 to 20 sessions of psychological therapy are required for the most common mental health disorders like depression and anxiety. Research was published here in Australia just last year about the Medicare system, showing that around 50% of people would be left in the lurch if they were only offered 10 sessions of treatment. To cut public access to programs that are cost-effective and have been shown to deliver positive treatment outcomes for people who need help, is not only lacking in basic human care, but is also ignorant of the scientific evidence.

Third, the above article implies that the Better Access program is not flexible, but the truth is that it provides the most flexible way of delivering psychological services – which is precisely why centres like Headspace and others have been able to employ psychologists through the Better Access scheme. The current Better Access system allows clients to access their preferred mental health practitioner and lets local service providers offer services either inside or outside their consulting room, as required to meet the needs of their clients. By contrast, the ATAPS program has a fixed model of service delivery in each geographic region and limited boundaries of access, such that if a person seeks services from a GP who is not in their region, then they cannot access those services. Under the ATAPS scheme, the client is also restricted in the choice of care packages that are available in that region. They will not simply be able to work through their problems with a psychologist if the Medicare Locals area they are in only provides case managed programs.


In addition, the ATAPS system is plagued with the problem of cost blowout. A recent review by the Department of Health and Ageing reports that frequently the administrative costs of the ATAPS scheme are as high as 25% of the budget. In human terms, that amounts to one person missing out on psychological services out of every four who reach out for help. The recent review also found that sometimes these cost blowouts result in a single consultation with a mental health professional costing as much as \$635 per consultation in the ATAPS scheme. This is in stark contrast to the fee-for-service arrangement in Better Access, where the taxpayer only funds the delivery of legitimate psychological services. Most rational people would take the obvious position that this represents far better value for money to the Australian taxpayer, when it comes to the limited mental health funding we have available.



So whilst it is certainly true that there are some niche areas of special need, it is certainly not warranted to redirect such an enormous amount of funding away from the Better Access program and into the ATAPS Scheme. There is absolutely no need to force the overwhelming majority of people who have depression and anxiety into heavily case managed programs that do not serve their interests in the first place. Those opposed to the cuts to services welcome new investment in the ATAPS scheme, but not at the cost of the Better Access program.

5.  **David Short**  
Posted August 8, 2011 at 6:52 pm | [Permalink](#)


Actually it isn't quite how Mark Thompson and Katrina Walker suggest it is with Better Access. It is better. World Health Organisation mental health studies inform our study of statistics of mental health service uptake. Acknowledging both that a problem exists and that help is needed can be more problematic for certain people over others, this isn't a broken leg scenario. The traditional groups seen to have inequity within mental health utilisation are known to have some differences in awareness and preparedness to seek help such as within men, rural, socially disadvantaged and the like. The Better Access program as is seen by WHO with large-scale primary public health programs has seen INCREASED uptake in the traditionally hard to reach groups over the successive years of Better Access than more traditionally accessed sub-groups adding to some of the unexpected costs critics complain about. Young people, rural people, men and socially disadvantaged have been the fastest growing sub-sections as the program matures so we have some early indication via the independent reviews that an increased awareness of mental health and reduced stigmatization has resulted in more equity in mental health.

6.  **linda holland**  
Posted August 9, 2011 at 8:55 am | [Permalink](#)

Its such a shame that some very educated men and women appear not to have all the facts when denigrating the Better Access system particularly when many of the points that are made address issues that BA already successfully manages. Sessions have been cut from 18 to 10, this is a vital point for you all to recognise. Hard to reach groups have under the present system much more access to the Mental Health treatment that was .difficult for them to find in the past. Most of these people, the elderly, young, the disadvantaged both economically and socially have full access to mental health treatment at present. This treatment in a majority of the cases is free to them, a majority of practitioners bulk bill for their sessions meaning these disadvantaged groups have no gap payment, no outlay at all. They are able to attend to the same therapist and continue to develop a relationship with an empathetic and caring professional. They always have someone to call on when in need, this will change if these cuts are allowed to be implemented.

Understand how difficult it is for some people who have already been either maligned by society or feel maligned to reach out and tell their story to someone, when they do, they now will need to change practitioners and try to do it all again after the 10 sessions. How many do you think will make that change, they wont, they will drop off and discontinue treatment. This saddens me, as Psychologists and other mental health professionals have worked tirelessly to open up the Mental Health Problem, to

reduce the stigmatization as David Short states, and we have made some amazing inroads into this problem with Better Access.

7.  **Tim Woodruff**  
Posted August 10, 2011 at 3:41 pm | [Permalink](#)

Thank you all very much for your constructive criticisms of my article. Firstly I do apologise for my mistake regarding the numbers of psychology sessions previously available. My source was the press release from Nicola Roxon about the budget changes. I'm delighted to explain my ideological bent. It is based on the principle of equity. For health that means constructing a system which aims to remove all preventable systemic causes of health inequalities. Fee for service funding is quite probably a very reasonable way of funding acute care in the community. For dealing with chronic disease however, it leads to financial barriers and contributes to geographical barriers to access. As the main means of funding community care ie GPs, psychologists, specialist services, it is inequitable. It is indeed inequitable that those with mental health disorders have unequal access. They are one of the largest single disadvantaged group. Better Access has helped them and has reduced inequity. It has reached out to some hard to reach groups. But it's not perfect according to Professor Jane Pirkis, the lead author of the evaluation on Better Access. On the ABC's Health Report on 21st March 2011 she said, 'It's certainly true that people in the lowest socio economic areas and in remote areas received proportionally fewer services than those in more affluent city areas..... I think it is true that equity is an issue and I guess it's important to remember that Better Access is part of a suite of primary mental health care reforms.' In addition the evaluation report does not claim to have been able to evaluate everything well. It states 'The evaluation was also unable to examine issues of access for groups who are often disadvantaged in terms of their access to mental health care, including Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.' It's also worth noting that the first two authors of the evaluation wrote in the MJA (2011) 'Better Access is part of a suite of mental health care reforms that received attention in the Budget. Many of the others complement Better Access by reaching groups that may not be best served by a fee-for-service approach. We believe the Budget reforms have struck an appropriate balance between retaining the core features of a program that appears to be working well while at the same time providing additional resources for important existing and new initiatives.' My article is about the bigger picture however because it is the bigger picture which is continually given little attention (except for costings). Instead, programs and projects are continually introduced, expanded, modified, or abandoned on the basis of stakeholder pressure and politics, heavily influenced by budgetary considerations. Sometimes such decisions use evidence to support changes but evidence is not the main factor. When modifications to programs occur, there are almost always patients who will be disadvantaged. The hope is that in the long term such modifications will lead to an overall improvement in the health system. The Better Access cuts are redirected in an expanded mental health budget. Whilst it is very reasonable to debate whether the redirection is better for patients, if we fail to modify programs because there will be some losers, we will not progress. Most of the money saved from Better Access

cuts has gone to programs other than ATAPS. Better Access psychology was clearly not designed to treat all patients with mental illness. It was designed to give limited access to psychologist to those patients whom it was thought would benefit from that limited access. The rules were set in Canberra on advice from both professionals and from bureaucrats counting money. The rules have been reset partly on the basis that the evaluation showed the average number of visits was six and partly because it was more expensive than anticipated. Those patients who need more treatments will miss out. Those patients who needed more than eighteen sessions were already missing out. The program does not have the flexibility to rely on the professional to decide if more should be funded. Most programs across the health system and including ATAPS are similarly restricted by the central bureaucracy. Professionals are not to be trusted to think about cost efficiency so rules must be imposed. We can do better. We can create a structure which returns responsibility for treatment decisions to the professionals at the coalface, working in teams, with proper consumer and citizen involvement, supported by evidence, guided by nationally audited data, with funding allocated to regions on the basis of need. ATAPS is nowhere near that vision but it is closer to it than Better Access and has some of the core ingredients to realise that vision.



8. **Ben Mullings**

Posted August 10, 2011 at 5:16 pm | [Permalink](#)

Hello Tim:

You cut out the middle of that quote from Jane Perkis there – and it’s pretty clear to see why. For the benefit of others, here is the rest of what she had to say (cited at <http://www.abc.net.au/rn/healthreport/stories/2011/3167686.htm>):

Jane Pirkis: It’s certainly true that people in the lowest socio economic areas and in remote areas received proportionally fewer services than those in more affluent city areas. But in absolute terms the number of services received and the number of people receiving services in those traditionally more disadvantaged areas were still quite high. So for example in 2009 150,000 people in the most disadvantaged areas across Australia received services which is far more than were receiving similar services pre Better Access.

It is also worth adding here that traditionally disadvantaged people have been taking up services in the Better Access program at an increasing level. As you probably know Tim, one of the main reasons for this is because of socio-demographic factors that make certain groups in society less likely to take up health services in general, including issues around the stigma of accessing mental health services. The Better Access program has gone a long way to breaking down those barriers. We know this because in the evaluation, mental health consumers said this loud and clear. The increasing proportions of disadvantaged people taking up mental health services in the Better Access program with each year it has been running are testament to that fact.

Nobody I know has a problem with ATAPS getting more funding to support niche areas of special need. The problem however is when policy-makers dismantle programs that are working extremely well and are servicing a much broader spectrum of mental health problems that people battle with in the general community. For all the talk about showing greater care, it seems rather ironic to be slashing psychological services down to levels that are below scientific standards of minimal treatment.



9. **Jillian Horton**

Posted August 10, 2011 at 7:36 pm | [Permalink](#)

I fully agree with Ben and the other comments about the Better Access initiative, on how well Better Access has been in providing services to the community. It is really quite problematic when Ministers make major budget decisions about length of therapy when it is not supported by independent research evidence. Will the Government take legal and ethical responsibility for those who only get half treated and don't recover? Another aspect of this issue is that community members have very inequitable access to the non-drug therapies vs drug therapies, when Medicare provides significant subsidies to psychiatry services (at double the rate to psychologists) for 50 sessions per year compared with the now 6 to 10 sessions with a psychologist! How has this been decided? Maybe its time to realise that people in the community want direct and open access to psychological services because they actually work and there is a highly trained and skilled workforce available to provide it.