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The cuts to the Better Access program are not supported by the findings of the Better Access Review.

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Whilst the Australian Federal Government has acknowledged the large burden of mental ill-health on individuals, families, and the community by providing some new funding into this area, they have done this at the cost of a highly successful and cost effective program – the Better Access program. The Federal Government commissioned a large independent review of the Better Access program and a major report was written and released in 2011 (Pirkis et al, 2011). It would be reasonable to anticipate that the evidence from this review would be used to guide and support Federal policy making with regards to the funding of this program. It can only be concluded after the announcements in the May 2011 Budget however, that this unfortunately is not the case. Equally concerning is the apparent lack of use of research evidence to determine the number of sessions required in order to effectively and reliably treat patients reporting moderate to severe distress with their mental health problems. This is especially problematic given that approximately 80% of patients accessing psychological services in this program reported high or very high levels of psychological distress, as assessed by a GP given questionnaire at referral point (Prikis et al., 2011). These figures are supported by several independent studies of the Better Access services which found the majority of referred patients had severe levels of distress with their mental health disorders (National Survey of Mental Health and Wellbeing 2007; Giese, et al, 2011).

It is reasonable to expect that the Federal Government would want to invest in treatment protocols which provide a high likelihood of positive mental health outcomes for the Australian community. However, the Federal Government decided in its May budget to reduce funding to the Better access program in number of significant ways. The main changes included reducing the number of sessions supported by Medicare for people to access a Psychologist from 12 sessions (with a possible extension to 18 sessions) per calendar year, down to 6 sessions (with a possible extension to 10) per year; reducing the rebate to GPs and changing the guidelines regarding mental health care plans and reviews.

Some of the main findings, taken directly from the review, are that:

- the Better Access initiative significantly increased access to affordable mental health services in the primary care sector
- it serviced a significant number of patients who previously could not afford these services, thereby meeting a previously unmet need
- services provided by Psychologists provided significant positive outcomes for people with moderate to severe levels of distress with common psychological disorders such as depression and anxiety
- that the MBS is the most effective and efficient means of providing this service and
- that although some groups had greater levels of uptake of Better Access than others, Better Access did reach all groups, and increased most dramatically for those who had been disadvantaged in the past. For example, the review found that children aged 0-14yrs and people in rural and remote areas had lower uptake than other groups, but had greater percentage increases in uptake than other groups. The study additionally found that the pattern was also consistent for those in the most socio-economically disadvantaged groups. This is possibly the result of the relatively high level of bulk

billing or reduced fees charged by Psychologist for people in socio-economically disadvantaged groups.

The review concluded that the Better Access program provides good value for money in terms of MBS costs to the Government. **It is important to emphasize that the decision to cut funding to this program, especially to cut the number of treatment sessions, was NOT recommended by the Better Access review, nor was this change discussed with treating professionals who are responsible for therapy outcomes.**

It appears that such positive outcomes would indicate that the Government was on the right track to use the MBS as a cost effective and efficient way to provide the community with the much needed psychological health care it required. It therefore appears to be very disingenuous when the Federal Government claims it wishes to support and expand services which are cost-effective and therapeutically effective in the mental health area, and it then reduces funding to a highly successful program.

Cost effectiveness of this program also needs to be considered in terms which may not have been measured by the Review, such as in early intervention occurring when a patient presents to their GP with distress, especially when compared with highly difficult to access state public services. Timely access may have flow on effects such reducing the likelihood of an escalation of distress requiring expensive crisis care in hospital, reducing productivity loss in the workplace and school systems, and most importantly, reduced suffering of individuals and families.

One of the main areas of concerns with the Budget is the reduction in the number of sessions for psychological treatment. There is considerable research evidence to show that effective psychological treatment for psychological disorders with moderate to severe levels of distress or disability requires approximately 20-25 sessions, especially to prevent relapse and the need for continuing care. For example, an Australian study by Harnett, et al., (2010) aimed to estimate the number of sessions of psychotherapy needed for clients suffering from psychological disorders (the majority were patients diagnosed with depression, anxiety, or adjustment disorders), to return to a normal state of functioning and for this to be reliable improvement. It was found that it would take about 8 sessions for 50% of clients to show **reliable improvement** and 21 sessions for about 85% to meet this criterion. **Recovery** however, took more treatment, with 50% of clients estimated to recover after 14 sessions and 70% requiring 23. They concluded that "**The current (Government) policy appears to be suitable for only about one-third of clients who carry the burden of psychological illness",** and this was before the number of sessions were cut in the current budget.

If the Federal Government reduces the number of sessions, it will significantly increase the likelihood that people cannot get access to complete treatment, leading to poor mental health outcomes. Reducing the number of Medicare supported sessions also jeopardises the integrity of psychological treatment protocols, something which would not be tolerated in any area of medicine. It becomes very dangerous for patients when Government policy dictates treatment and clinical management, especially when this is based on fiscal policy needs.

One of the justifications Minister Butler has used to reduce the number of treatment sessions supported by Medicare is that the Better Access review found during 2007 and 2008 that a large percentage of patients only claimed between 1 to 6 services from the MBS. What he has not been clear about is the comments made in the review which state the low claiming rates could be attributed, at least in part, to patients who commenced a mental health care plan towards the end of the calendar year and only claimed some of their rebated services within that calendar year. At the very least, claims on the MBS indicate that there is no over-servicing occurring by psychologists in the program and there it begs the question why this program needs to be cut. Why not allow the small percentage of people who require more sessions to have them?

If the Federal Government wants to reduce its spending in the mental health area, (which would be a major disappointment to most mental health sectors), then it at least needs to consider measures which do not impact directly on clinical outcomes and place patients at risk of not recovering and/or relapsing. For example, the Better Access review suggested examining the value of mental health care plans (MHCP), especially in the light of the findings that there were a significant percentage of patients not receiving mental health services subsequent to a MHCP and this percentage increased as the patient's location became more rural and remote. Specifically, of the urban patients who received a MHCP during 2007, 33.8 % did not receive follow up MBS mental health services in the immediate subsequent 12 months, and 37.7 % of patients in rural and 48.9% in remote locations did not receive MBS mental health services.

Lastly it would be good to underscore the comments made by the President of the AMA (Dr. Hambleton) on ABC radio in September 2011, where he acknowledged that many GPs greatly appreciate the ability to refer their patents with mental health care needs to psychologists under this scheme. Indeed, the writing of a mental health care plan and/or making a referral by GPs (and Paediatricians and Psychiatrists) to psychologists, is a strong indicator of the willingness of the medical profession to collaborate with other professionals in mental health care, to get the best outcomes for their patients.

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