



Letters to the Editor

We still need Better Access

While some have criticised the *Better Access to Mental Health* programme, it is still very much needed here in Australia. The 'Critiques' column by Maurice Vaughan in the May 2012 issue of this journal puts forward the view that the *Better Access* programme was not intended for complex cases, is over-servicing the well-off, and is diverting money away from where it is needed. Although the author raises some important points of concern, the reliance on political rhetoric, and a selective interpretation of the facts and figures, falls short on addressing the genuine difficulties that people who seek psychological treatment face right now in Australia.

It has been claimed repeatedly that the *Better Access* programme was only intended to reach people with mild-to moderate levels of anxiety or depression, but in truth, this view is more of a political construction than a reality, relied on by the current Government to justify cutting services. The COAG statement about the *Better Access* programme identifies people with 'complex' and 'severe' mental health disorders (Council of Australian Governments, 2006). This is mirrored in the words of the Prime Minister when the programme was launched (Howard, 2006). The manual given to GPs states that people should only be referred when it is clinically necessary, and contains a whole section dedicated to managing complex cases (Australian General Practice Network, 2006, p. 34). Likewise, the manual for psychologists and other practitioners lists a number of serious conditions targeted by the *Better Access* initiative,

such as depression, post-traumatic stress disorder, schizophrenia, and bipolar disorder (Australian Psychological Society, 2007). A large-scale evaluation showed that over 80% of patients who used the *Better Access* initiative were found to have serious levels of symptom severity, and typically experienced both depression and anxiety (Department of Health and Ageing, 2011). This matches the results of a survey of over 2000 psychologists working in the *Better Access* initiative, which came to exactly the same conclusion (Giese, Littlefield, & Mathews, 2008). In other words, it is misleading to claim that the *Better Access* initiative targets mild to moderate mental health issues, when it has always served more complex and serious cases, both on paper and in practice.

The critique in the last issue also mischaracterises the people who access psychological therapy in the *Better Access* programme as being white, middle-class, and getting more than their fair share. This assumption appears to be based on a superficial interpretation of figures from the *Index of Relative Socioeconomic Disadvantage* (IRSD). Although some critical newspaper articles from last year took it on face value that the IRSD provides information about the income of an individual, the reality is that it doesn't. What it measures is the relative disadvantage of people who live in a given postcode. Generalisations of this kind cluster people together with all others who share their postcode, regardless of any genuine differences in their situation. It is a skewed perspective to take these figures to mean that those accessing treatment

in the *Better Access* programme are undeserving of care and it is unfair to assume that a person seeking psychological treatment is white-skinned or well-off purely on the basis of their postcode. Evaluation data shows that the most significant barrier preventing people from accessing psychological treatment prior to the *Better Access* programme was the cost (Pirkis, Ftanou, Williamson, Machlin, Warr, Christo, Castan, Spittal, Bassilios, & Harris, 2010).

The uptake of psychological treatment by the public through *Better Access* has been substantial, so the unprecedented success of the programme is the main reason why the costs have exceeded the initial estimates. Criticism that *Better Access* is a drain on the system, draws attention away from the fact that Australia is under-spending on mental health care by a very wide margin. Currently Australia dedicates 7% of the health budget to mental health, whereas mental health represents upwards of 15% of the burden of disease (Begg, Vos, Barker, Stevenson, Stanley, & Lopez, 2007). The proportion we spend is significantly less than the US, New Zealand, and other comparable nations. But despite this, the rate of dependence on medications for anxiety and depression in Australia has dropped from 7.3% to 4.8% since 2001 (Atlantis, Sullivan, Sartorius, & Almeida, 2012). Professor Michael Berk from Deakin University suggests that this may be because the *Better Access* programme has allowed more people to choose psychotherapy rather than medication (Hoffman, 2012). By comparison, other programmes attracting funds that were recently



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The Editorial Advisory Board of *Psychotherapy in Australia* appreciates reader participation through 'Letters to the Editor'. The journal promotes scholarly discussion and debate of psychotherapy practice, and values a diversity of approaches to psychotherapy and counselling. Submitted letters should serve to reinforce these ideals. Letters may be a brief response to an article published in *Psychotherapy in Australia* or a comment on subjects relevant to the journal's scope. All reasonable viewpoints, whether supportive or critical, will be considered.

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diverted away from the *Better Access* programme have been found in practice to favour medication over psychotherapy (Hetrick, Thompson, Yuen, Finch, & Parker, 2012).

The sensible solution to this problem is not to cut therapy via the *Better Access* programme, but rather, to invest a greater proportion of our health budget on expanding services. We cannot afford to trade off our valuable mental health care programmes against one another.

Distressed people who reach out for help need to be given some choices about their preferred treatment, rather than being told that if they don't recover in ten sessions their only option is medication. It may be the case that some only need a few appointments to recover, but if our current research is any indication, only around a third of people will show lasting levels of improvement at the ten session mark (Harnett, O'Donovan, & Lambert, 2010). The system is far from perfect, but expanding the range of options for people to receive psychotherapy is much better than cutting access.

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