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How We Got Here: A Contextual Review of the Better Access Initiative

Adrian Holmes, MCouns, GradCert in Grief and Loss Counselling, BA (Psych)^a, Carol Windsor, PhD^b,
Clint Douglas, PhD, MMedStat, MCLinEpi, BN^c

¹ Queensland University of Technology

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This article presents a contextual review of the literature on mental health policy in the global and Australian settings. The review constitutes an analysis of, firstly, the relevant global literature on mental health policy and practice concepts and, secondly, the Australian literature on mental health policy with a particular focus on the Better Access initiative. Finally, the review offers an analysis of the most recent Better Access evaluation and concludes by considering future directions for the initiative.

This article engages in a contextual review of the literature on mental health policy in the global and Australian contexts, with particular attention given to the Better Access initiative. The article analyses the relevant global literature on mental health policy before delving into the Australian literature on mental health policy, and the Better Access initiative specifically. Key themes are reviewed related to the influences on global mental health policy, namely, deinstitutionalisation and the advent of community care, the dominance of psychiatry and the medical model of care, the literature on the social and cultural determinants of mental health, and the influence of neoliberal capitalism. This leads into a discussion on how such influences have positioned Australia in global mental health policy before turning the focus to the historical context of Australian mental health policy and the Better Access initiative.

From Then to Now—Influences on Global Mental Health Policy Deinstitutionalisation and Community Care

For over three centuries, Western civilisation in Europe, the United Kingdom, and the United States, and later in Australia, confined the “mad” to lunatic asylums (Barham, 1992; Foucault, 1967). Over this time, the focus of

^a Adrian Holmes is a family therapist, supervisor, trainer, and author of *Tools For Hard Conversations in the Helping Professions* (published 2019). He is currently completing PhD research at Queensland University of Technology with the invaluable support and direction of his supervision team Professor Carol Windsor and Professor Clint Douglas in the School of Nursing. This research is due for completion at the end of 2023 and is primarily focused on the Better Access initiative and analysing and critiquing the program design, beneficiaries, and practical outcomes of this policy. To contact Adrian, please email aholmes@skattle.org.au

^b Carol Windsor is a professor and academic lead, post graduate research, in the School of Nursing at Queensland University of Technology. She is also the school research ethics advisor and a faculty member of the University Human Research Ethics Committee. Carol can be contacted at c.windsor@qut.edu.au

^c A clinical academic, Clint Douglas is conjoint professor and nursing chair at Metro North Hospital and Health Service. He can be contacted at c2.douglas@qut.edu.au

incarceration changed from simple confinement to attempts to treat inmates, with varying success (Foucault, 1967). Although the confinement and separation of those experiencing mental ill health is now viewed as barbaric by most in Western cultures, arguments remain that “Western countries have sought new ways to confine the mentally ill in the post-asylum era, namely through the effects of stigma and medicalization. The walls are invisible, when once they were physical” (Teague & Robinson, 2019, p. 1).

Since the commencement of deinstitutionalisation in the 1950s, community-based care has been the centrepiece of policies for most Western nations in caring for those experiencing mental ill health. The hope has been that the “mentally ill” person would leave a hospital setting and rejoin the broader community, gently reintegrating into “normal” society (Barham, 1992). In most Western nations this transition failed because of inadequate and ill-conceived community-based support for people who had been confined in asylums, often for many years, and who had experienced varying degrees of mistreatment during this time (Teague & Robinson, 2019).

There are still many countries around the world that have ongoing programs of institutionalisation and confinement for those experiencing mental ill health, most of which are situated in developing economies (Zhou et al., 2018). In 2014, the World Health Organization surveyed 78 mental health experts representing 42 countries on the “relative usefulness of different methods to expand community-based mental health services, and/or to downsize institution-based care” (World Health Organization, 2014a, p. 12). Named the *Innovation in Deinstitutionalization* survey, its findings identified five key principles for deinstitutionalisation:

- Community-based services must be in place.
- The health workforce must be committed to change.
- Political support at the highest and broadest levels is crucial.
- Timing is key.
- Additional financial resources are needed (WHO 2014a, p. 14).

The above points help to characterise the inherent challenges that the shift from confinement to community care poses; however, they neglect to acknowledge a broader narrative that developed during the deinstitutionalisation process that was both a cause and effect in this transition: that of mental ill health as a medical problem that could only be treated by a medical practitioner, most typically a psychiatrist.

The Dominance of Psychiatry and the Medical Model of Care

Foucault (1967) posited that Sigmund Freud’s most enduring legacy was in solidifying the relationship between “madness” and “unreason”, thereby medicalising common human experiences of distress and struggle. Medicalisation is the process of taking problems and framing them as issues

that require medical intervention (Conrad & Schneider, 1992). Whether intentional or not, by arguing (and convincing many for generations to come) that mental ill health developed as a result of an individual losing their power of reasoning and objectivity, Freud positioned the treatment of “the mad” within the doctor–patient relationship (Foucault, 1967). As Teague and Robinson (2019) stated, “the doctor came to be seen as the sole means by which a patient could be delivered from their suffering, as madness was now a subject for the doctor to decipher” (p. 13). This perspective was to have a significant impact on how people experiencing mental distress were to be viewed and treated by society from this point on.

Psychiatrists—those trained in deciphering the mentally unwell—became all powerful, and the medical model took hold. A recent report by the World Health Organization (2021) confirms:

The predominant focus of care in many contexts continues to be on diagnosis, medication and symptom reduction. Critical social determinants that impact on people’s mental health such as violence, discrimination, poverty, exclusion, isolation, job insecurity or unemployment, lack of access to housing, social safety nets, and health services, are often overlooked or excluded from mental health concepts and practice. This leads to an over-diagnosis of human distress and over-reliance on psychotropic drugs to the detriment of psychosocial interventions—a phenomenon which has been well documented, particularly in high-income countries. It also creates a situation where a person’s mental health is predominantly addressed within health systems, without sufficient interface with the necessary social services and structures to address the above-mentioned determinants. (p.2)

Psychiatry and the dominance of the medical model has not been without its critics over the years. A substantial body of literature questions psychiatry, the validity of the biomedical approach to mental illness, and the benefit of associated therapeutic approaches to mental health treatment (Bracken & Thomas, 2001; Fawcett, 2006; Frances, 2013; Greenberg, 2013; Johnstone, 2017; Pilgrim, 2014; Szasz, 1974; Whitaker, 2010).

Szasz (1974) argued that the “myth of madness” exists to serve the interests of psychiatrists and is “endorsed by society because it sanctions easy solutions for problem people” (p. 2). Szasz was an early proponent of the idea that the majority of mental suffering arises from challenges in life circumstances rather than medical problems with people’s reasoning or brain function. Since this time, concepts such as “critical psychiatry”, “post-psychiatry” and “anti-psychiatry” have evolved to characterise various stances of questioning the validity of the medical model approach.

As a founding member of the Critical Psychiatry Network, Double (2019) helped to define this area by arguing the following:

The essential position of critical psychiatry is that functional mental illness should not be reduced to brain disease. ... there is a need to move beyond a mental health system based on the “disease model”. Functional mental illness is a personal experience that does not have an underlying brain pathology. (p. 61)

Burstow (2019) went further, arguing for the complete abolition of psychiatry. Burstow is among a chorus of academics who have for decades called for a significant shift in how governments approach mental health policy. At the centre of the arguments is the assertion that traditional psychiatry and the medical model has placed too much emphasis on the individual and neglected the social and cultural determinants of mental wellbeing.

Social and Cultural Determinants of Mental Health

Inherent to the medical model approach to mental illness is the individualising of care and treatment for those experiencing mental struggles. The individual is positioned as the problem, and it is the role of the treating doctors with their teams of mental health professionals and the surrounding systems to solve this problem (Guerin, 2021b; Szasz, 1974; World Health Organization, 2014a). Well-meaning or not, the approach discounts two significant factors in the person’s presentation: their social and their cultural experiences of the world. Over the past few decades, this discrepancy has received increasing attention, although translation into how people are treated within mental health care settings has been slow and unwieldy (Guerin, 2021a; Marmot, 2015).

In 2014 and 2021, the WHO published documents on the social determinants of mental health that sought to draw attention to structural factors that influence mental health concerns. The papers offered effective actions to reduce the risk of mental disorders at the community and country level, including environmental, structural, and local interventions (WHO, 2014b, 2021). The publications reflect a powerful and radical message given that the majority of developed countries are deeply entrenched in individualistic, medicalised mental health systems.

The Influence of Neoliberal Capitalism

The final and arguably most significant global mental health policy influence is the role of neoliberal capitalism in dealing with people experiencing mental health struggles. Cummins (2018) drew on Hayek’s (1944) *The Road to Serfdom* when stating:

Two key beliefs are at the heart of neoliberal ideas: the supremacy of the market (as the most effective means established for the distribution of resources), and a belief in liberty (defined here as freedom from state or other interference) as the supreme social and political value. (Cummins, 2018, p. 7).

Indeed, neoliberalism is directly connected with the tenets of capitalism through its link to the free market system. What also distinguishes the concept of neoliberalism from previous incarnations of capitalist thought is the belief that austerity measures designed to reduce government spending are positive. This is where the link between mental ill health and government intervention becomes problematic (Cummins, 2018, 2020; Guerin, 2021b).

The influence of neoliberal ideology has appeared in two distinct ways since deinstitutionalisation and the evolving dominance of the medical model approach:

1. Mental ill health treatment is viewed in economic terms related to concepts of the welfare state (and the desire by many governments to reduce reliance as much as possible, particularly in periods of perceived austerity).
2. Mental ill health treatment is viewed as something to be measured and assessed according to key performance indicators and scientific evidence to ensure the government is getting the best return on investment (Cummins, 2018).

The problem with the above ideology is that it is based on several key assumptions that do not necessarily align with these beliefs: firstly, that mental illness is an individual's problem to solve; secondly, that mental illness can be improved by individualised medical interventions; thirdly, that change in an individual's mental health is measurable; and finally, that the funding invested by governments has any substantial lasting impact when delivered as individualised medical interventions.

Rose (2019) succinctly posed the question:

If it has long been true that people are made sick by the conditions under which they have to make their lives, is there something about our present situation that is driving more and more of us ... into states of anxiety, depression and suicide? What is it in our current “organization of misery” that could be to blame? Could it be because of the rise of policies in so many regions of the world that seek to limit state expenditure ... and—crucially—to promote the ethics of individualism, entrepreneurialism and relentless self-advancement? Is neoliberalism to blame? (p. 51)

Neoliberal ideology has been a key influence on global mental health policies over the past several decades, and the Better Access initiative is an example of neoliberalism at work in Australia. It is important to consider that neoliberal ideology might be contributing to people's experiences of mental ill health rather than providing the solutions its proponents claim. If this is even partially true, greater consideration of its implications for how we might approach mental ill health treatment differently in Australia, and whether such a shift is even possible, is valuable for increased exploration and critique.

Where Are We Now in Global Mental Health Policy Terms?

The global literature suggests that psychiatry and the medical model approach continues to be the dominant response to people experiencing mental distress in Western democracies. This is supported by the enduring belief that mental distress warrants an individualised response that ignores the social and cultural determinants of mental health. The dominant approach is closely tied to neoliberal ideology, which purports that mental health is part of welfare state reliance, which is always to be reduced where possible, particularly at times of perceived need for austerity. All these factors intersect to create a precarious position for those experiencing mental ill health in our current systems across the Western world.

Two notable recent additions to the international literature on global mental health policy were authored by Dainius Pūras (2017, 2020), the United Nations (UN) Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. The Special Rapporteur is a chief authority that reports to the UN, in this instance on health rights matters, and during his tenure, Pūras (who has spent his life working as a child psychiatrist) argued strongly for a complete sea change regarding how mental ill health and the formulation and implementation of treatment options are conceptualised within clinical settings around the world. Pūras's tenure as Special Rapporteur ended in July 2020 after six years in the role.

Pūras stated the following in the 2020 Human Rights Council Report to the UN General Assembly:

Mental health systems worldwide are dominated by a reductionist biomedical model that uses medicalization to justify coercion as a systemic practice and qualifies the diverse human responses to harmful underlying and social determinants (such as inequalities, discrimination and violence) as “disorders” that need treatment. ... How that dominance is overcome requires transformative human rights action. However, action that focuses only on strengthening failing mental health-care systems and institutions is not compliant with the right to health. (p. 4)

Another important recent contribution comes from the Belgian Superior Health Council (the peak health body in Belgium), which released a report entitled *DSM (5): The Use and Status of Diagnosis and Classification of Mental Health Problems* (Superior Health Council, 2019). This is the first and only whole of government report to recommend renouncement of the biomedical model approach to mental illness diagnosis and treatment. To this point, Belgium had shared a similar model of care with most other Western developed nations, in which the medical model approach drives primary mental health treatment. The report is critical of the use of DSM criteria for diagnosis of mental illness and how this can shape the subsequent available treatment interventions. The council argues instead for the focus to shift to

biopsychosocial interventions such as improved housing, social support, and community treatment options that acknowledge the diversity of factors that can influence a person's mental health and overall wellbeing. The report was developed by an expert group of academics and practitioners (importantly including a "service user") that reviewed recent literature and research on mental health rates and treatment options from around the world. One notable quote, taken from a follow up article on the report written by its same authors stated:

Epistemologically, the expert group concluded that mental disorder categories should not be treated as natural kind categories but as constructs that have a causal impact on those who are classified. Sociologically, the group observed that diagnostic classifications tend to legitimize organisational structures and protect psychiatry from pressures to change. The report concluded that common diagnostic categories lack validity, reliability, and predictive power" (Vanheule et al., 2019, p. 726).

This was the first time a country's health system had taken such a stance against the biomedical model of mental health care, and it presents an interesting case study and potential roadmap that reveals the impact on clients and practitioners of adopting a biopsychosocial approach. Such evidence may also be of interest to mental health policymakers in other Western democracies like Australia.

How do These Influences Manifest in Australian Mental Health Policy?

Australia's mental health system is funded and delivered by a mix of the Australian federal government, state and territory governments, and private and non-government organisations (Australian Institute of Health and Welfare [AIHW], 2021). Since the 1990s, policymaking has been guided by the federal government's series of national mental health plans. From 1993 to 2022 there have been five 5-year national mental health plans. On a state level, the Council of Australian Governments' (COAG, 2006) *National Action Plan on Mental Health 2006–2011* overlapped with the national strategy (AIHW, 2021). In December 2012, COAG members agreed to the *Roadmap for National Mental Health Reform* as a guide to federal, state, and territory governments with regard to treatment of mental ill health in Australia over the next decade. [Table 1](#) provides an overview of key dates and milestones that have taken place in Australian mental health policy over the past 30 years.

Inherent to all the milestones, plans, and roadmaps are the influences outlined in the previous section: deinstitutionalisation and the expansion of community care, the dominance of psychiatry and the medical model of care, blaming the individual and discounting the social, and the overarching influence of neoliberal capitalism. These influences and assumptions are apparent in different ways in the Australian context, namely as a marked discrepancy between what the plans and policies state as their objectives and

Table 1. Significant Milestones in Australian Mental Health Policy

Date	Milestone
Mar. 1991	Australian Health Ministers' agreement to Mental Health Statement of Rights and Responsibilities
Apr. 1992	Australian Health Ministers' agreement to National Mental Health Policy implemented through First National Mental Health Plan (1993-1998)
Jul. 1993	National Mental Health Strategy incorporated in 5-year Medicare agreements
Mar. 1994	First National Mental Health Report released
Dec. 1997	Evaluation of First National Mental Health Plan released
Apr. 1998	Australian Health Ministers' agreement to the Second National Mental Health Plan
Jun. 1998	Second National Mental Health Plan (1998-2003) commenced
Nov. 2001	Mid-term review of Second National Mental Health Plan released
2001-2006	Better Outcomes operated as the main policy for dealing with high prevalence disorders
Apr. 2003	Evaluation of the Second National Mental Health Plan released
Jul. 2003	Third National Mental Health Plan (2003-2008) commenced
Jul. 2006	COAG National Action Plan on Mental Health signed
2006-now	Better Access replaced Better Outcomes as main policy for dealing with high prevalence disorders via Medicare funding
Jul. 2008	Third National Mental Health Plan summative evaluation
Nov. 2009	Fourth National Mental Health Plan (2009-2014) commenced
2011	First summative evaluation of Better Access released
Jan. 2012	National Mental Health Commission established
Dec. 2012	Roadmap for National Mental Health Reform (2012-2022) released
Aug. 2017	Fifth National Mental Health and Suicide Prevention Plan (2017-2022) commenced
Dec. 2022	Second evaluation of Better Access released
Dec. 2022	Strengthening Medicare Taskforce Report released

the practical implementation of the plans in service delivery. The following section explores how this discrepancy manifests in Australia's most far-reaching and heavily funded mental health policy to date, the Better Access initiative (Australian Government, 2023).

The Better Access Initiative Literature

The Better Access initiative commenced in 2006 after the COAG *National Action Plan on Mental Health 2006-2011* (2006) was signed by the Commonwealth and state governments. Media reports, as well as a Senate enquiry by the Select Committee on Mental Health (2006) into mental health care in Australia, brought attention to increasing rates of high prevalence disorders such as anxiety and depression in the community (AIHW, 2021), and in response, Better Access (2006) was one of a number of initiatives implemented by governments across Australia. Better Access replaced the 2001-2006 Better Outcomes initiative (Hickie & Groom, 2002).

The key difference between the two initiatives was greater scope for general practitioners (GPs) to be both gatekeepers and providers of mental health interventions through the inclusion of more Medicare item numbers and a change in the training that GPs had to undergo to be able to offer mental health interventions. The new Medicare item numbers were accessible when a GP and patient developed a mental health care plan that enabled the patient to access 6-10 rebated sessions with a psychiatrist and/or a psychologist. A few years

later and after much lobbying, social workers, occupational therapists, and mental health nurses were also able to offer services and rebates under Medicare item numbers. From the outset, Better Access was formulated according to medical model notions of what constitutes mental ill health, and the program's design has dictated that clinical diagnosis and development of a treatment plan be the first step before access to a clinical professional is granted by the GP. Consequently, pathways to care under this program design have been limited to the dominant medical model approach, which has left little room for conceptualisation and exploration of other ways of working with people experiencing struggle and distress. The initiative has continued to expand and evolve in the intervening years and is now acknowledged to be the largest federal and state government-funded program aimed at mental health care in Australia (AIHW, 2021).

The following subsections review the literature pertaining to Better Access under four headings that represent the key themes most present in the literature: users' experiences of the Better Access initiative, the views of professionals working within the initiative, the views of those critical of the initiative but supportive of its biomedical program design, and the views of those critical of the Better Access program's design. The section closes with an update on the most recent literature on Better Access today, namely, the release of the second Better Access evaluation (Pirkis et al., 2022) in December 2022.

Users' Experiences of the Better Access Initiative

Foremost in the historical literature on the Better Access initiative is the official summative evaluation conducted in 2011 by Pirkis, Harris et al., a group of research academics from the Centre for Health Policy, Programs and Economics at the University of Melbourne and the School of Population Health at the University of Queensland. These researchers were chosen by the federal government to complete an evaluation of the initiative in its fifth year. The final report was entitled *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners Through the Medicare Benefits Schedule Initiative: Summative Evaluation*.

The evaluation focused on examining improvements between pre- and post-treatment outcomes on psychometric test scores as well as rates of access and uptake to mental health care as a result of Better Access (Pirkis et al., 2011). It was reported that the initiative had been effective in reaching more people with mental health concerns, while simultaneously providing more cost-effective treatments than previous initiatives such as Better Outcomes, the forerunner policy to Better Access (Hickie & Groom, 2002).

The authors reported that "findings suggest that Better Access is playing an important part in meeting the community's previously unmet need for mental health care" (Pirkis et al., 2011, p. 726). Despite being the only formal evaluation conducted over the years since Better Access commenced in 2006, the summative evaluation came under much scrutiny and criticism in the sector based on the reliability of the data analysed (Allen & Jackson, 2011;

Jorm, 2011) and the extent to which it could be accurately evaluated as an improvement compared with previous initiatives given a lack of comparable data (Hickie et al., 2011). The evaluation identified a number of issues.

Several of the co-authors of the evaluation subsequently released peer-reviewed articles that used the same data to explore other elements of Better Access. Ftanou et al. (2014) investigated client experiences and found that of the 936 participants who were interviewed or completed a structured survey, “most were impressed by the quality of care available through Better Access” and “the vast majority experienced significant reductions in symptoms and improvements in coping abilities, and they attributed these changes to the care they received through Better Access” (p. 162). One issue that skewed these positive results was the admission by the authors of a “potential for selection bias” (p. 174) because the mental health providers might have recruited their most satisfied clients to take part in the research. There was a concern that providers, in attempting to support the initiative and continue to benefit the clients and income they received from Better Access, could intentionally or unintentionally choose the people they knew were most satisfied to be interviewed. Participant selection risked misrepresenting the overall experience of users of the initiative. The authors also acknowledged that the numbers of people interviewed or surveyed amounted to only 0.06% of total Better Access users in the calendar year of research.

Professionals’ Views of the Better Access Initiative

Most of the literature evaluating the Better Access initiative privileges the voice of psychologists, despite the initiative providing avenues of care through other professional groups, such as social workers, mental health nurses, and occupational therapists. One example is a survey conducted by a number of the authors of the summative evaluation (Fletcher et al., 2011). The authors interviewed 73 psychologists working in private practice regarding their experiences of operating within the Better Access initiative. Overwhelmingly, the study found that respondents had positive experiences and most reported an increased stability of income and diversity of available work. It was reported that “Better Access is assisting psychologists to meet a previously unmet community need for mental health care” (p. 153). Fletcher et al. (2011) argued that more research should be conducted with a larger sample size of psychologists in the future. It is worth noting, however, that the authors did not refer to the importance of conducting research in this area to offer comparisons with other service professionals and their outcomes beyond the clinical psychological treatments used by the respondents. By including professional groups other than psychologists in research on Better Access, alternative perspectives and assessments could be generated. The reliance on one profession’s viewpoint is a limitation of the extant literature in this area.

Views Critical of the Better Access Initiative, but Supportive of Its Biomedical Program Design

Hickie, Rosenberg and Davenport (2011)—all of whom are influential Australian psychiatrists and academics and had been the primary architects of the original government reporting that helped inform the construction of Better Access—have, over the years, become its key critics. Following the summative evaluation published in 2011, Hickie et al. (2011) released a highly critical report on the lack of credible statistics in the evaluation and challenged whether Better Access was the best investment for mental health services for the Australian public. Hickie et al. were concerned that the scheme was not the best model of care to respond to the growing prevalence of mental illness in Australia and that such insufficient evaluation mechanisms would compromise any future statistical analysis. Unfortunately, these concerns have been borne out in the intervening years.

In 2019, Rosenberg and Hickie released an opinion piece in the *Medical Journal of Australia*, the title of which succinctly captured their assessment of Better Access at its 10-year anniversary—*The runaway giant: Ten years of the Better Access program*. The authors highlighted concerns with the overall quality of treatment under the initiative and the significant funding overruns that the initiative had delivered, and they concluded that Better Access required urgent revisions. Rosenberg and Hickie recommended two significant changes: the first being to establish more specific and far-reaching evaluation mechanisms to enable the scheme to be better monitored regarding its impact on mental illness prevalence and overall value for money, and the second being to transition from the sole practitioner model of care to a more holistic approach to treatment that included practical issues such as employment and housing support. To date, these changes and evaluation mechanisms have not been implemented and the dominant individualised clinical approach discussed in previous sections has persisted.

Over the past decade, Anthony Jorm, a professor at the Melbourne School of Population and Global Health, has also been a significant critic of Better Access and in particular of the 2011 summative evaluation. His work has focused primarily on analysing and critiquing the datasets that the evaluation relied upon and has argued that rates of mental illness have continued to increase each year, which stands in stark contrast to the successes the summative evaluation reported. In his 2018 article, Jorm argued that “despite substantial increases in the provision of mental health services following the introduction of Better Access, there has been no discernible impact on the prevalence of psychological distress in adults or on the suicide rate in the total population” (p. 1060). While Jorm’s work is persuasive in arguing that Better Access needs greater evaluation and critique, his own research has often attracted criticism regarding its analysis process and the inferences that it draws relating to data taken from the summative evaluation.

In relation to the above point, Murray (2019) argued that a lack of improvement for mental health outcomes in Australia cannot be solely attributed to the perceived failures of Better Access because the initiative comprises only approximately 9.5% of total Commonwealth mental health funding (National Mental Health Commission, 2014). Murray (2019) does appear to agree with Jorm (2018) overall in asserting that despite the fact that Better Access has provided much needed psychological services to more Australians, “business as usual appears not to be working at the population level” (Murray, 2019, p. 105) and that the federal and state governments need to do more to bring adequate rigour to the design, delivery, and evaluation of such a large program.

Mihalopoulos (2019), a health economist at Deakin University, also challenged Jorm’s (2018) analysis as “simplistic” and “premature” (Mihalopoulos, 2019, p. 259) and argued the overall health benefits of Better Access cannot be measured solely according to changes in mental illness. Instead, she contended that it was important to address the overall economic value that Better Access has provided, as well as the potential cost if the federal government were not to provide such a service, including hospitalisations, carer costs, and specialised mental health treatment costs (Mihalopoulos, 2019). It is important to note that almost all of the research and commentary focuses exclusively on evaluating the dominant biomedical model of mental health treatment and how this is affecting mental health rates. Mention of other models of care or acknowledgement of the social and cultural determinants of mental health do not appear in any publications regarding Better Access, thereby presenting a significant gap.

Nonetheless, there have also been some criticisms of elements of the Better Access initiative that point to inequities, such as the socioeconomic and geographical disparities in service delivery in rural areas particularly (Crome & Baillie, 2016; Meadows et al., 2015). There is further criticism from Mathews (2018) that the scheme does not go far enough to meet client needs in relation to the number of available sessions and that clinical psychologists are given preference over other specialties, such as counselling psychologists.

Davis-McCabe et al. (2019) explored bias towards clinical psychology within the Better Access initiative by conducting a web-based survey with 346 Australian counselling psychologists recruited via the email lists of the Australian Psychological Society College of Counselling Psychologists and the Association of Counselling Psychologists. The authors concluded that the preferencing of cognitive behavioural therapy (CBT) as the primary model of care has limited client choice of therapeutic modality over the years and that counselling psychologists have been disadvantaged in their career options owing to the two-tiered model of rebates that results in their exclusion from the higher rebate condition because they are not providing CBT. These authors raise important questions concerning the program design of Better Access, but their arguments predominantly focus on the impact for counselling

psychologists rather than clients and do not offer any comparison with other practitioners such as mental health social workers, occupational therapists, or mental health nurses.

Views Critical of the Better Access Program Design

King penned an opinion piece in the *Psychotherapy in Australia* journal in 2013, suggesting that Better Access compromised the “critical role of the client as an active agent in therapeutic change” (p. 38) by privileging supposedly evidence-based treatments such as CBT. He argued these treatments have no therapeutic superiority over other models of care and run the risk of minimising or even removing a therapist’s professional capacity to match interventions to individual clients. King also argued that there is no quality assurance in place for Better Access and that significant sums of money are being spent on a largely unevaluated policy program. In conclusion, King was highly critical of the biomedical formulation of Better Access and argued that the program required greater scrutiny to ensure it was delivering the best service for clients. It is important to note that this article has received few citations since its publication date in 2013, highlighting the paucity of critical review of Better Access since its inception.

In the second publication that questioned the overall program design of Better Access—the only one from a discipline external to psychology—Papadopoulos and Maylea (2020) from the Social and Global Studies Centre at RMIT University in Victoria focused on the particular impact of Better Access on social work practice in Australia. The authors argued that the Better Access scheme has directly influenced social work practice since its inception by minimising the distinction between social work and the dominant biomedical models. They called on accredited mental health social workers to articulate more directly how social work as a profession should advocate for change if “social work is to retain a sense of professional autonomy, independence, and a focus on the underlying causes of social issues” (p. 2). While their article is one of only two published that directly address Better Access’s program design, it focuses primarily on the impact of the program on social workers and does not extend its critique to examining the initiative at a broader level.

It is evident from this review of the literature on Better Access that research to date has focused on measuring and analysing how effective the initiative has been at providing value for money and meeting program objectives, while mostly avoiding critique of its biomedical formulation and focus on clinical diagnosis and treatment. To the best of the current author’s knowledge, King (2013) and Papadopoulos and Maylea (2020) are the only two studies to have offered such a critique, and even these have been limited in the ways outlined above.

Better Access Today

In December 2022, a major evaluation of the Better Access initiative was released (Pirkis et al., 2022). This represents only the second evaluation completed since the initiative commenced in 2006, the last summative evaluation having been published in 2011 (as detailed earlier in this contextual review) (Pirkis et al., 2011). Overwhelmingly, this most recent evaluation found that Better Access has positive impacts on Australians' mental health. Those who use services through Better Access Medicare rebates generally improve their mental wellbeing in at least the short term. The evaluation found that disparities in geographical access continue to be a problem, as do a significant increase in the co-payments charged by psychologists and the overall capacity to meet increased demand over the past two years in particular. The lack of any mechanisms for long-term comparable data capture and routine outcome measurement tools was acknowledged, alongside a significant discussion about the merits of increasing the maximum number of sessions from 10 to 20 sessions during the COVID-19 pandemic. It is relevant to note that the federal government (under Prime Minister Scott Morrison at the time) commissioned the same university and the same group of academics to complete this most recent evaluation as those who had completed the evaluation back in 2011. These academics were also influential in the original formulation of Better Access in 2006. This raises concerns regarding the level of meaningful critique offered within these evaluations.

According to the 2022 evaluation of the Better Access initiative (Pirkis et al., 2022), one in every 10 Australians received at least one Better Access service in 2021, and one in 20 received at least one session of psychological treatment through the initiative in the same year. The total cost to Australian taxpayers for Better Access services was \$1.2 billion in 2021, representing a 4% increase since 2018. Co-payment rates increased significantly in 2021, that is, 47% of all Better Access services incurred a co-payment—a figure that is up from 36% in 2018. The median co-payment for Better Access services was relatively stable at around \$74 per session between 2018 and 2021 but increased markedly to \$90 per session in the first half of 2022.

Affordability of the scheme was one of the chief concerns raised by the consumers and providers who contributed to the evaluation, and it was noted that increases in utilisation over time disproportionately favour people on relatively higher incomes in major cities (Pirkis et al., 2022). This contributes to concerns about not only the overall cost of access but also the limits that affect certain geographical areas. The general impression given is that those professionals who offer services that attract Medicare rebates are more likely to set up in wealthy inner-city locales than in rural and remote areas where psychological services are stretched and the need is greater, but the capacity of local people to make significant co-payments is less. It was a consistent finding that those on the lowest incomes are least likely to access services owing to these types of challenges. Despite the reach of Better Access continuing to expand, and more than 10% of the Australian population receiving a Better

Access service in 2021, this figure should be considered in the context of 21% of the adult population experiencing a DSM-defined “mental disorder” in the same period (Pirkis et al., 2022). This disparity indicates there are many people who would benefit from Better Access but are not accessing it or, more likely, cannot access it.

The 2022 evaluation (Pirkis et al., 2022) raised the need for serious consideration to be given to whether expanding the range of eligible providers could help to address capacity issues in meeting consumer needs. A survey of psychologists in 2022 (Pirkis et al., 2022) showed that one-third were unable to take on new consumers, an increase from one-fifth in 2021 and a major leap from one in one hundred before the pandemic. This significant increase in capacity issues might now force the dominant member lobby groups, such as the Australian Psychological Society, to support expansion of Better Access to include other eligible providers, such as counsellors and psychotherapists.

Since the evaluation has been released, the Minister for Health Mark Butler has announced a reduction in maximum funded sessions from 20 to the pre-pandemic number of 10 sessions. This move was in consideration of current budget strain and pandemic conditions such as regular lockdowns now being a thing of the past. There has been much debate on this point, but it is important to remember that most people do not access nearly this number of sessions, and there are no consistent findings that more sessions necessarily produce better outcomes for consumers.

Of participants in the evaluation, 92% supported expanding the range of therapies from the dominant CBT approach to other models that might better meet consumers’ mental health needs. Feedback was in favour of including evidence-based therapies and consulting people with lived experience perspectives to drive the inclusion of other helpful therapeutic approaches. This is a significant step away from the dominance of the CBT approach and opens the door for the myriad of other therapeutic approaches to be included that can support people better and offer greater diversity of choice.

The ongoing problem of how outcomes are measured was also noted in the evaluation. Despite being established for over 15 years, routine outcome measurement tools have never been adopted. These kinds of tools would help measure whether Better Access is achieving its goals and monitor what changes might be necessary to ensure the best outcomes for consumers and practitioners alike. Many of the contentious points in the evaluation would be much easier to assess if measurement tools were in place that acknowledge the complexity of measuring more than just economic figures when assessing outcomes for consumers.

The recommendation and subsequent announcement of \$7.5 million in funding to create two lived experience peak bodies comprising organisations and individuals dedicated to including the voices of people who have experienced mental ill health were well received following the release of the evaluation. As Dr Sebastian Rosenberg from the Brain and Mind Centre at the University of Sydney stated (Barrett, 2023):

The launch of the peaks (peak bodies for people with lived experience) represents a tremendous opportunity to establish new direct reporting from mental health system users not just about the cost of services or access issues, but about their quality and impact on people's lives. As was recently said in relation to the Aboriginal Voice, it is one thing having a voice, it is another being listened to. Was the service you received delivered in the way you wanted it? Did it help you go back to work, go back to school, rejoin your life? This could be game changing.

Finally, as mentioned above, it is worth noting that this most recent evaluation was conducted by the same university and authors that offered the 2011 summative evaluation and that were also influential in the original formulation of Better Access in 2006. In the context of research that offers a meaningful critique and holistic view of policies such as Better Access, this should be considered an issue. There is no suggestion that motives and intentions were anything but pure; however, this current contextual review forms part of a wider research effort seeking to critique the overall biomedical-inspired program design of Better Access, so in line with this effort attention must be given to the inherent bias that these authors might bring to the evaluation and the impact this might have on the outcomes and recommendations they advise.

Conclusion

As demonstrated in this contextual review, significant historical precedents, both locally and globally, have led to programs such as Better Access, and their inherent bias towards individualised and clinical approaches to working with people experiencing distress and struggle. In the literature, little attention is paid to whether the dominant medical model influences the approach of policymakers and service providers to client interventions and preferred outcomes in the formation of Better Access. Much of the current literature regarding Better Access is remiss in acknowledging or exploring how the inclusion of other models or modalities of intervention might be helpful to client outcomes, for example, a less medicalised approach to mental health care. The aim of future research efforts should be to form a fuller picture of how Better Access could deliver a more equitable service to Australians experiencing mental ill health, and to explore other policy ideas that might help to serve Australians with mental ill health better outside of the dominant medical model approach interventions. There is increasing acknowledgement around the world that the clinical response is no longer considered the most helpful for those who are significantly unwell, so logically this would be an inappropriate response for those suffering from normal human responses to distress and struggle such as the high prevalence disorders that Better Access is designed to address. We should not continue to do the same thing over and over and expect a different result (which, ironically, is the simplest definition of mental illness). By delving into other key areas that are not addressed in the

current literature, such as the significant influence of social and cultural issues on people's mental health, future research and commentary might offer a more balanced view and consider other ways of approaching these complex issues that acknowledge broader definitions of wellbeing and therapy, encompassing counselling, psychotherapy, and Indigenous healing practices.

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