

4 Consultations on Training and the Future Mental Health Workforce

This chapter investigates the impact of Better Access on the training (including clinical placements) of the mental health workforce and the implications of this for the future mental health workforce. As indicated in other chapters, separating out the effect of Better Access from that of other initiatives is difficult and this was apparent in the consultations. Not only is Better Access part of broader changes in mental health service provision, but the education and training of the mental health workforce is taking place in the context of even broader changes in population demographics, health system reforms and on changing models of care within and between health workforces.

This chapter examines the training of, interactions between, and future of the Better Access mental health workforce from the perspective of key organisations associated with each of the mental health professions. The information provided is primarily qualitative, with small quantitative components drawn from other surveys. The use of consultations for this aspect of the report provides a means of identifying issues before they become statistically apparent. The results will allow further investigation of some issues, and intervention in others, without waiting for the lag time that exists between a policy initiative and the 4-6 years (minimum) it takes to educate the next generation of the workforce.

The interview schedule (see Appendix C) focussed on investigating stakeholders perceptions of the impact of Better Access on:

- the size, skill level and geographic distribution of the workforce with mental health skills,
- the delivery and take-up of certified training,
- the effectiveness of the interaction between general practice and psychology in expanding access to mental health interventions,
- Regional Training Programs, in particular their capacity to deliver training and their uptake by registrars,
- the capacity of training systems to provide clinical experience to undergraduate and post-graduate doctors and allied health professionals,
- the availability of training places for increasing numbers of medical graduates and how this will interact with other relevant professions, including psychology, occupational therapy and social work, and
- interactions between GPs and psychologists including-
 - reports that GPs find the paperwork in care plans to be cumbersome and use Level D consultations instead, and
 - reports that psychologists complain that GPs are under-utilising care plans.

4.1 Workforce Capacity

In this section a summary is provided for each of the Better Access mental health occupations in relation to the capacity of the current workforce to increase in numbers or service provision.

4.1.1 Psychologists

The APS reports that, since the Better Access initiative, there has been a one-third increase in applications for membership. According to the psychology organisations which took part in the consultations, clinical psychology is, on the whole, fully occupied in practice and has little to no capacity to increase service provision. As with clinical psychology, representatives of the registered psychology workforce describe it as working at capacity but able to keep up with demand as demonstrated by having few waiting lists (APS).

There have been indications in the literature that one of the implications of the introduction of Better Access has been the movement in the psychology workforce away from the public sector and into the private sector (Gleeson and Brewer 2008; Kelly and Perkins 2008; Stokes 2008). Responses from the consultations also highlighted perceptions of the changing structure of the workforce.

In examining this issue, the APS surveyed its members in 2009 (Forsyth and Matthews 2009). A total of 1,167 members of the Australian Psychological Society completed the online survey (it is not a random survey), which revealed that nearly a quarter of those who responded to the question were actively planning to shift working hours to private practice (see Table 4.1). Without data on intentions to move into private practice prior to Better Access, it is difficult to make a definitive statement about the impact of Better Access on intentions. Nevertheless, it was evident from discussions with the APS that there is an assumption that the results can be explained as an effect of the Better Access initiative.

Table 4.1 Intention of APS members to commence or increase private practice

Are you currently actively preparing or planning (e.g. organising premises, Medicare registration) in order to depart from your current employment, or decrease your working hours with the intention of commencing or increasing private practice?	Freq.	%
Yes, actively planning to resign from current role to commence private practice	51	5
Yes, actively planning to reduce my hours of work to increase private practice hours	184	17
No, I am not currently actively planning or preparing to reduce or cease my current employment to commence private practice work	842	78
Total	1077	100

Source: Forsyth and Matthews (2009). Survey of APS members.

Registered psychologists were said to be moving to private practice in a step-wise fashion, reducing public sector hours rather than leaving the public sector altogether, while they establish a private practice (ACCP). According to the accounts provided in the consultations, the Better Access initiative is enabling psychology graduates to set up private practice through the financial incentives that it provides; and the movement of more experienced practitioners into private practice has provided younger psychologists with employment opportunities in public hospitals (APS, ACCP, and APHA). The APS highlighted the need for better support and supervision for these recent graduates in order to enable them to practice safely.

4.1.2 Social Workers

The AASW indicate that the introduction of Better Access has had a substantial impact upon the number of accredited mental health social workers, indicating that they receive five to ten enquiries per week from social workers wanting to register with the Better Access initiative.

It was also noted that mental health is becoming an increasingly popular area of specialisation for undergraduate students and recent graduates. According to AASW, there is spare capacity within the mental health social work workforce and this workforce is, in fact, 'underemployed' or under-utilised. They suggest that this may be a result of a lack of understanding by GPs about the role of social workers in mental health, resulting in fewer referrals than optimum. Some movement of social workers into the private sector was also been noted, although this was not thought to have affected public mental health service provision by social workers. The AASW estimates that approximately one-third of social workers practice in rural Australia.

4.1.3 Occupational Therapists

OT Australia reports having 5,600 members, of whom 250 are registered for the Better Access initiative. Occupational therapists currently require registration in five states, but from 2010 they will be part of the National Registration and Accreditation Scheme and registration will be required nationally.

The consultations indicate that all OTs have mental health training as part of their undergraduate degree, with the expectation that they will increase their skill level on the job. OT Australia has identified some movement into specialising in mental health, and from public to private practice as a result of the Better Access initiative. It was reported that there are two to three enquiries per week from OTs wanting to access the Better Access initiative.

4.1.4 General Practitioners

Information received from AGPT, suggests that GP registrars are increasingly recognising the importance of gaining mental health skills, as are GPs, and this interest in training is leading to an increase in the mental health skill level of both registrars and GPs.

In contrast, the GPMHSC viewed the mental health skill level of GPs as declining as a result of the lack of requirement (at the time of consultations) to undertake continuing professional development under the Better Access initiative. Given the subsequent budget decision (Department of Health and Ageing 2009a) encourages continuing professional development, it is likely that interest in mental health training will again increase.

4.1.5 Psychiatrists

According to the RANZCP, the introduction of Better Access has resulted in some movement of the workforce from the public to the private sector, which they saw was one of the aims of the initiative; however this movement was not viewed as having reduced psychiatrists' ability to attend to other aspects of their role. Better Access was viewed by the RANZCP as a mechanism through which the new referral pathways could increase the capacity of the workforce. The RANZCP suggested that while there are indications that psychiatrists' use of Better Access services has created some capacity within the workforce, it is not yet enough to cater to community needs.

4.2 The Size, Skill Level and Distribution of the Workforce with Mental Health Skills

4.2.1 Workforce Size

Whereas there have been increases in the number of Better Access service providers, as evidenced by the quantitative data, the qualitative data suggest that these increases are not necessarily accompanied by changes in the size of the *overall* mental health workforce or the *capacity* of practitioners to take on extra work. Indeed, the qualitative data suggest that most of the Better Access mental health occupations are already working at their full capacity (except social work, whose representative suggested that social workers have the capacity to further increase their involvement in mental health).

Strategies for increasing numbers in the mental health workforce were discussed in the interviews. Two suggestions were put forward for addressing this issue in the short-term: the re-entry of non-practicing mental health professionals, and moving health professionals between sectors (i.e. from the public to private sector).

4.2.1.1 Re-entry of non-practicing mental health professionals

The re-entry of professionals who were not actively engaged in the workforce has the capacity to increase the overall mental health workforce. The qualitative data indicate that Better Access is unlikely to be the trigger for this due to the proportion of the workload that relates to the Better Access initiative. This is particularly the case for GPs and occupational therapists for whom Better Access is only a small proportion of their overall workload, mostly because their client needs are not primarily related to mental health; or psychiatrists, who mainly use Better Access for new patients, often those with high prevalence, low severity disorders, who make up only a small proportion of their clientele. Re-entry of GPs, occupational therapists and psychiatrists was therefore thought to be unlikely by representatives of these occupations.

The implementation of Better Access was not viewed as having an impact on the numbers of registered psychologists re-entering the workforce, as the financial incentive was considered to be too low to encourage re-engagement, and re-accreditation requires retraining, which is expensive and difficult to access. In contrast, clinical psychologists and, to a lesser extent, social workers were seen to have been encouraged by the Better Access initiative to delay retirement or to continue or extend their (private) clinical hours.

4.2.1.2 Increase in private practice

Better Access provides opportunities for professionals in the allied mental health occupations to increase their participation in private practice. This, however, would not necessarily increase the overall workforce. Participants in the consultations reported that the Better Access initiative has broadened the scope of work for the clinical workforce by encouraging more consultative work for psychiatrists (RANZCP) and supported private practice for allied mental health practitioners (ACCP, APS, OT Australia, and AASW). The move from the public to the private sector for both clinical psychologists and registered psychologists was mentioned in several interviews, but there were also indications that the move to the private sector was occurring among social workers and occupational therapists.

In further examining the impact of the Better Access initiative on the distribution of the workforce across the public and private sectors, responses from the 417 allied mental health professionals who completed the KPMG online questionnaire were examined. Although the sample is non-random and cannot be generalised, these responses provide some insight into the experience of these workers.

Approximately one third of the clinical psychologists and social workers who responded to the survey work in both public and private practice; while the registered psychologists who answered the survey were more likely to work in private practice only (see Table 4.2).

Table 4.2 Public and private work among allied health professionals

Occupation	Sector	Freq.
Clinical Psychologist	Private	85
	Both public and private	44
<i>Sub-total</i>		129
Registered Psychologist	Private	104
	Both public and private	29
<i>Sub-total</i>		133
Occupational Therapist	Private	1
	Both public and private	0
<i>Sub-Total</i>		1
Social Worker	Private	87
	Both public and private	66
<i>Sub-total</i>		153
Grand Total		417

Source: KPMG (2009). "Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative" Online Survey

Table 4.3 shows that, of those respondents to the survey that were in private practice, around 50% had been there for 5 years or less. This loosely corresponds to the period during which allied mental health professionals have had access to MBS Items, initially through Better Outcomes (since July 2004) and then through Better Access (since November 2006). However, allied mental health professionals also work in the private sector by accessing funds from private patients and private health companies and it is unknown whether this result may be related to changes in access to funds from these sources.

Table 4.3 Length of time in private practice for allied health professionals

How long have you been in private practice?	Freq.	%
Less than 2 years	85	21
2 to 5 years	119	30
6 to 10 years	69	17
11 to 20 years	94	23
21 years and over	37	9
Total	404	100

Source: KPMG (2009). "Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative" Online Survey

It is therefore difficult to say whether the shifts into the private sector discussed in the consultations have been a result of the implementation of Better Access or for other reasons.

4.2.2 Skill Level

Overall, the consultations revealed little evidence that the Better Access initiative had a direct impact on the skill level of practitioners. This is unsurprising given that the initiative does not focus on training provision or continuing professional development. However, it was noted that there is an increasing emphasis on the importance of mental health education which will, in turn, have a positive impact on the skill level of practitioners.

It was suggested by the GPMHSC and the AGPT that the focus on common conditions, namely depression and anxiety, created by the Better Access initiative has led to a marginalisation of awareness and skills development for less common, yet important, conditions seen in general practice. There was also concern from the APS that the skills required to manage low prevalence disorders, such as schizophrenia and psychosis, which are treated in the public sector, are being further eroded by the shift of experienced allied health practitioners to private practice.

Psychology organisations also noted that hospitals have been converting psychology positions into general mental health positions to allow other allied mental health professionals to apply for positions, possibly at lower rates of pay (APS). However, they claim that in doing so the role is generalised to the point where no specialist skills are able to be employed by the person in the role. The concern is that this will reduce the overall skill levels among mental health professionals working in hospitals.

4.2.3 Geographic Distribution

The analysis of the MBS data in previous chapters demonstrated that there has been an increase in the number of Better Access service providers in small, rural and remote communities (RRMA 4-7). In this geographic group, the number of psychiatrists claiming Better Access MBS Items has increased from 57 to 83 from its introduction in 2006 to 2008, the number of GPs has increased from 1620 to 2925, the number of psychologists has increased from 407 to 841, the number of occupational therapists has increased from 23 to 46, and the number of social workers has increased from 21 to 89.

Information from the consultations suggest that these increases do not result from any substantial increases in the numbers of practitioners in rural and remote areas but are instead a reflection of the increase in the viability of existing services in these areas (AGPT and APS). This could be indicative of existing service providers in these areas seeing more clients due to increased client access to claims on Medicare. For some organisations, the Better Access initiative was viewed as making services more affordable and more accessible for clients as the provision of services for high prevalence disorders moved from psychiatrists (who have a very small presence in non-metropolitan areas) to psychologists (who have a more substantial presence outside of metropolitan Australia).

4.3 Training

4.3.1 The Delivery and Take-up of Certified Training

Eligibility to register with MBS to provide Better Access services is based on registration through professional bodies. Better Access therefore builds upon the existing professional training

requirements of the professional bodies.²⁸ This was quite different to its predecessor, the Better Outcomes in Mental Health Care initiative (run through the Divisions of General Practice). However, some professional registration bodies (e.g. APS) have compulsory continuing professional development and, as eligibility to register with Medicare for the provision of Better Access Items is based on registration with a professional body, training is indirectly required.

Continuing professional development was primarily influenced by professional association and registration body requirements, as well as the personal interests of the individual practitioner. Each of the professional associations has their own requirements for professional certification and training. This varies from the structured and accredited courses, to the workshops, seminars and case reviews provided as continuing professional education.

The consultations identified the need to extend the content of professional development outside the parameters of the Better Access initiative, and some organisations argued that the professional associations and registration bodies should be maintained as the primary providers of continuing professional development programs.

In order to further probe the impact of the Better Access initiative on the training of mental health professionals, a question about the effect of the Better Access initiative on access to clinical training was included in the KPMG online survey for Component D of the broader *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule initiative* project. A total of 203 medical mental health participants (193 GPs, 2 paediatricians, and 8 psychiatrists) completed this section of the questionnaire. Participants in the survey were asked whether the Better Access initiative had affected their access to clinical training in their discipline. The responses provided by those who answered this question are outlined in Table 4.4. Almost half of the medical mental health workforce who responded to this question believed that the initiative had affected their access to clinical training, and, of these, approximately 80% believed that their access to training had improved as a result of the initiative.

Table 4.4 Impact of Better Access on clinical training in the medical mental health workforce

Has the Better Access initiative affected access to clinical training in your discipline?	Freq.	%
Yes	87	43
<i>Improved</i>	78	90
<i>More difficult</i>	7	8
<i>No response</i>	2	2
No	103	51
No Response	13	6
Total	190	100

Source: KPMG (2009). "Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative" Online Survey

²⁸ During the consultation period a budget decision regarding the inclusion of compulsory training for GPs involved in the Better Access initiative was made, such that those GPs who have completed the GPMHSC accredited training (previously termed 'Level 1' training) will be entitled to claim for a higher rebate than those who have not (Department of Health and Ageing, 2009a).

A total of 418 allied mental health participants (131 clinical psychologists, 133 general psychologists, 153 social workers, and 1 occupational therapist) completed this section of the questionnaire (see Table 4.5). The majority of allied health professionals (64%) reported that the Better Access initiative had no effect on access to clinical training. However, of the 143 respondents who reported that the Better Access had affected their access to clinical training, the majority (90%) said the Better Access initiative had improved access.

Table 4.5 Impact of Better Access on clinical training in the allied mental health workforce

Has the Better Access initiative affected access to clinical training in your discipline?	Freq.	%
Yes	143	34
<i>Improved</i>	136	95
<i>More difficult</i>	7	5
No	268	64
No response	7	2
Grand Total	418	100

Source: KPMG (2009). "Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative" Online Survey

Information from the consultations suggests that the Better Access initiative had, along with a broader emphasis on mental health within the health sector, stimulated interest in the development of mental health related skills amongst professionals (chair of GPMHSC, GPMHSC, and AGPT). To some extent it had also increased the demand for training in mental health disciplines from people wanting to enter the field. The introduction of requirements for the maintenance of continuing professional development (for GPs) since the consultations occurred is likely to further increase the demand for certified professional development training.

The following subsections provide additional information from the consultations regarding the take up of training for each Better Access mental health occupation.

4.3.1.1 Psychologists

Psychology representatives from the APS report that the Better Access initiative has led to an increase in demand for university level training in psychology, particularly for clinical psychology.

It was suggested that this increase in demand for clinical training was most likely to be a result of the higher rebate available for clinical psychologists as opposed to registered psychologists (ACCP). It was noted in the consultations that there is interest from registered psychologists in undertaking further training to enable them to claim the higher rebates. However, given that clinical training either requires postgraduate university studies or 1000 hours of (often unpaid) supervised clinical training subsequent to the completion of a four years of undergraduate and honours level psychology (APS, APAC, and GPMHSC), competition for places and time, as well as monetary constraints preclude this from being a popular course of action (ACCP and APAC).

Concerns were expressed by the APS about the bottleneck caused by the inability of universities to keep up with the demand for psychology training, which is exacerbated by the extra demand for places created through the Better Access initiative. According to the APS, universities report that the high cost of providing post-graduate clinical psychology courses and increasing difficulty in accessing clinical placements hampers their ability to increase the number of positions available. They are, however, adding new courses in psychology and incorporating new clinical training

aspects in old courses in response to the increased demand. The lack of access to clinical placements, which are often in public services and therefore subject to the effects of what clinical psychologists report to be a 15-20% shift of senior practitioners from the public to the private sector as a result of the Better Access initiative, also has implications for the availability of supervised clinical training for those gaining their clinical qualifications in this manner.

The APS requires psychologists to undertake continuing professional development to retain membership and therefore they did not view the Better Access requirement for clinical and registered psychologists to maintain continuing professional development as likely to have an impact on the workforce. One issue they did raise, however, was that the increased interest in clinical training, particularly from rural and regional psychologists, has led to the provision of on-line continuing professional development for practitioners outside of metropolitan regions.

4.3.1.2 Social Workers

The AASW noted that the uptake of continuing professional development for social workers had increased substantially with the introduction of the Better Access initiative. As indicated earlier, many social workers, from students to experienced practitioners, are said to be planning their careers around the capacity to work in private practice as a result of having access to the MBS rebates through the Better Access initiative. Registration for the use of MBS Items is contingent upon the maintenance of professional development and skills, thus participation in certified training has increased (and is expected to continue to do so) as social workers endeavour to maintain their professional development points. Training is predominantly provided locally by branches of the AASW through seminars and workshops.

4.3.1.3 Occupational Therapists

OT Australia indicated that the popularity of occupational therapy as an occupation has increased in recent years, and this has resulted in a substantial increase in the number university occupational therapy courses being offered. However, there was some concern about the impact of the movement of skilled mental health practitioners away from the public sector on the capacity to train the increasing number of undergraduates entering university courses.

At present, the primary method by which occupational therapists acquire advanced skills is through on the job supervision by a senior occupational therapist, although continuing professional development events are also available for and undertaken by occupational therapists. While there is currently no requirement for accredited continuing professional development for occupational therapists, OT Australia identified that this is in the process of change and that they will be increasing professional development resources, either by increasing the resources provided by the association or by facilitating access to external resources for members, to cater for the anticipated growth in participation in continuing professional development.

4.3.1.4 General Practitioners

The AGPT and the ACRRM identified the increased visibility of mental health in the community as contributing to the increased demand for mental health care amongst their clients. This increase in the demand for services is driving an increase in the number of GPs attending continuing professional development sessions in mental health. Consumer representatives suggested that an area of focus for professional development in GPs needs to be the development and implementation of care plans. This has been echoed in the consultations with GP organisations, who have also acknowledged the need for increased resources to enable GPs to audit their own care plans in order to ensure that they are providing a high level of care (chair of GPMHSC).

The consultations with GP organisations highlighted one area of concern around the lack of regulation of training through the Better Access initiative: the role of training provided through the Better Outcomes in Mental Health Care initiative in reducing the prevalence of drug-company sponsored, drug therapy focussed professional development programs. There was some concern from the GPMHSC that, without this regulated training, professional development may revert to drug-company funded training. However, this issue may have been addressed in the budget statement released after the consultations were conducted.

4.3.2 Training Provision

The information provided from the consultations suggest that the introduction of the Better Access initiative has increased the demand for mental health training, and that this is stimulating a rethink in how and who provides training to the mental health workforce. The challenge from the perspective of the training organisations that were consulted was viewed as being the ability to expand training opportunities for the workforce within the current training provider framework, while still maintaining the quality of the training.

On the whole, however, the consultations indicated that professional bodies across each of the occupations were making attempts to increase the size of the training workforce, either by introducing more staff (as reported by the MHPN) or by exploring other sources of training providers (i.e. the use of Level 2 GPs with expertise in mental health as trainers as suggested by AGPT). The use of on-line training was discussed by the APS and the ACRRM as a means by which they are delivering continuing professional development opportunities for non-metropolitan practitioners.

One area of concern highlighted in the interviews was the report from the GPMHSC that there has been a reduction in the number of trainers applying for accreditation due to the perception that the Better Access initiative encourages GPs to handball patients to other practitioners rather than to gain mental health skills themselves.

4.3.3 Training Places for Medical Graduates

One question that this evaluation sought to address was whether Better Access had impacted on the availability of training places for increasing numbers of medical graduates and how this interacts with other relevant professions, including psychology, occupational therapy and social work

The consultations revealed that it was not possible to determine whether Better Access had an effect on the availability of training places for medical graduates, as this was influenced by numerous factors. It was suggested by Universities Australia that the increase in numbers of medical graduates was viewed as having little impact on the allied mental health workforce because, given that each profession teaches its own students and provides its own clinical experience, there is no competition among the professions for clinical placements.

There was, however, an interest in multidisciplinary training to increase inter-professional understanding and the effectiveness of referrals. This interest was expressed in consultations with representatives from GP, occupational therapy, and psychology organisations.

There was some concern, particularly among GP organisations, that there will be not enough medical educators to teach the increased number medical graduates. However, Universities Australia reported that the Council of Australian Governments' commitment to inject \$1.5 billion (UA) to a range of clinical education and training initiatives will enable the expansion of the range of education providers.

4.3.4 Clinical Training

The consultations sought to understand whether Better Access had impacted on the capacity of training systems to provide clinical experience to undergraduate and post-graduate doctors and allied health professionals

According to the APS, AASW and OT Australia, the Better Access initiative has *indirectly* had a negative impact on the capacity of training systems to provide clinical experience to students and trainees. In particular, these organisations identify the withdrawal of senior clinical and registered psychologists, occupational therapists and social workers from the public sector, along with the marginalisation of teaching as the core business of the public hospital system, as contributing to the reduction of the skilled workforce available for supervision and the training of junior staff.

Representatives from the medical mental health workforce did not describe this same shift away from the public sector, nor was there any impact upon access to clinical placements as a result of the Better Access initiative.

Spare capacity for the delivery of undergraduate clinical training was identified in the private hospital system, however the supporting infrastructure in terms of governance, systems, quality assurance and the availability of trainers is not currently in place (Universities Australia). Another measure for overcoming shortages in the availability of clinical placements that was discussed in the consultations is the introduction of simulation centres, which are being rolled out by the Health Workforce Agency (Universities Australia). These centres would still require students to work with real patients, but they would ease the demand on resources, particularly in regional areas.

4.3.5 Regional Training Programs

The incorporation of mental health into Regional Training Programs for GPs is especially important due to the high level of demand that the ACRRM has observed from both its members and from patients who increasingly expect that rural GPs will be competent in mental health. Regional Training Programs provide not only the equivalent of Level 1 mental health training that is required as part of the RACGP and the ACRRM curriculum, but also extend to the provision of Level 2 mental health training (by providers such as the ACRRM), mental health sessions at conferences (i.e. the ACRRM conference), and workshops (by providers such as the MHPN).

There are differing views in the accounts provided through the consultations as to the impact of the Better Access initiative upon Regional Training Programs. While the AGPT reported that the Better Access initiative has had no impact upon Regional Training Programs, the ACCRM reported that the initiative has increased interest in mental health training from registrars to such an extent that they now lack the capacity to keep up with demand.

As a result of this increased demand, Regional Training Programs have to use their resources effectively to maximise the extent of training being provided to rural GPs and this has resulted in innovations in training. For example, the ACRRM has piloted web-based Level 2 mental health training for rural doctors, with the pilot funded under the Better Access initiative. They are now developing on-line continuing professional development for these GPs to maintain their mental health skills. This reduces the time and travel requirements for the GPs involved and also for training staff.

According to the GP organisation representatives (chair of GPMHSC, GPMHSC, and AGPT), despite time constraints registrars do take up mental health training through Regional Training Programs. It was noted that registrars understand the importance of mental health training, and

that they understand the financial benefits of being able to access the Better Access MBS Items, especially because they are able to use the Better Access Items for clients whilst they are still a registrar.

4.4 Effect of Better Access on Interactions Between GPs and Psychologists

4.4.1 Expanding Access to Mental Health Interventions

General practice and psychology organisations agree that the Better Access initiative has expanded access to mental health interventions, particularly as psychologists are more financially accessible now that their clients can claim the Medicare rebate (chair of GPMHSC, GPMHSC, AGPT, APS, and ACCP). They report that the Better Access initiative has been successful in expanding access for common disorders, but attention is still required for the young, elderly, poor, Indigenous, and marginalised with mental health care needs (AIPA and chair of GPMHSC).

The APS reports that the effect of the Better Access initiative has been very positive in promoting collaboration between general practice and psychology and good clinical outcomes. They suggest it has fostered a collaborative approach to treatment which is in the best interests of the client. Similarly, GP organisations (ACCRM, and GPMHSC) report an increasing awareness of the clinical role of allied health practitioners resulting, at least in part, from the Better Access initiative. GP organisations such as the GPMHSC believe that the Better Access initiative has improved the ability of doctors to link their patients with psychological services, particularly for doctors who do not provide mental health treatment themselves.

There is concern among rural doctors from the ACRRM that the shift of allied mental health practitioners from the public sector into the private sector will further restrict access to public mental health services, especially for Indigenous and other disadvantaged populations who rely on public services.

4.4.2 Interactions Between GPs and Psychologists

The impact of Better Access on the effectiveness of the interaction between general practice and psychology in expanding access to mental health interventions was explored in the consultations.

According to the chair of the GPMHSC, the referral process consists of the GP examining the patient, diagnosing the patient, and referring to a psychologist (or other allied health professional) if appropriate. The GP then expects the psychologist to acknowledge the referral, return the patient to the GP for primary care, and detail treatment, which is the process that occurs in medical referrals. The chair of the GPMHSC noted that psychologists are not familiar with this model of treating the client and then returning management of the client back to the GP and prefer to maintain management of the client themselves. It is thought that this 'conflict' may be exacerbated by the strict confidentiality requirements for psychologists. However, both GP and psychologist representatives acknowledge that the occupational groups appreciate the collaborative care process, and individuals are developing processes for getting around these difficulties (APS, ACCP, and AGPT): the GPMHSC suggested that a set of feedback standards, developed and endorsed by the RACGP and the APS, would help to manage the quality of the communication between GPs and psychologists.

There was some concern from both GP organisations and the APS about the clarity of the role of each profession within the patient pathway. Currently both GPs and psychologists view their role as providing a diagnosis and that this repetition of tasks often creates conflict between the two occupations. GP organisations also report that the lack of knowledge that the two occupations have about each others' roles can have a negative impact on the client when assumptions are made

about what tasks have or have not already been completed, and when the lack of knowledge about other occupations roles in mental health impacts upon decisions about where to refer clients (AGPT).

However, both GP and psychology organisations report that there is improved communication between GPs and psychologists resulting from the increase in referrals under the Better Access initiative (APS, AGPT, and chair of GPMHSC). It has also been reported that a shared literacy is developing between the professions that is improving communication between GPs and psychologists.

4.4.3 Care Plans

GP organisations (including the chair of GPMHSC, AGPT, ACRRM, and GPRA) and the APS both reported that the quality of the use of mental health care plans varies greatly between individual practitioners. According to the accounts provided, some practitioners find the care plans to be a useful tool for patient care because it helps to engage the patient in the care process, and they complete the plans carefully; conversely, other practitioners view the plan as not necessarily useful to their client and complete only the minimum requirements. This variability in the quality of mental health care plans, as reported by the GP organisations that took part in the consultations, is of concern (chair of GPMHSC, AGPT, ACRRM, and GPRA). The chair of GPMHSC indicated that there are no benchmarks for good practice in developing a care plan and that GPs want training and support in this aspect of the Better Access initiative. One suggestion that arose through the consultations is that the development of care plans for mental health does not fit comfortably with the paradigm under which GPs are accustomed to working.

This is supported by the high degree of interest in outcome measures and in evidence that mental health care plans actually improve the client experience in the accounts provided by GP representatives.

There was also an almost unilateral concern amongst GP organisations that the quality of mental health care plans is compromised when the referral pathway is used incorrectly. GP representatives described a pattern in which clients are referred from psychologists to the GP in order to obtain a mental health care plan so that their treatment can be billed to Medicare (AGPT, GPRA). However, a lack of communication means that patients are not requesting the longer appointments required for developing a mental health care plan and GPs are forced to develop a plan without sufficient time or knowledge of the patient. One example of how GPs successfully deal with this situation is the use of the shorter session to explain the process and to provide the patient with fact sheets and homework to ensure their understanding of the process, before scheduling the patient for an extended appointment for developing the mental health care plan. This process has the benefit of empowering the patient and involving them in the care process. However, it also appears that there are problems with clients skipping stages in the referral pathway (AGPT, GPRA, and ACPM), suggesting a need for further information dissemination both to psychologists and to the general public about the referral process and GP requirements for the initial consultation and development of the mental health care plan.

The consultations sought information about whether GPs find the paperwork involved in care plans to be cumbersome and unhelpful and that they are instead using Level D consultations to provide mental health care to their patients. The accounts provided by the GP representatives indicated that paperwork was not popular with GPs (AGPT and GPMHSC).

According to the chair of the GPMHSC, the forms used in the mental health care plans are inflexible and restrictive in that they do not take co-morbidities into account. Although some GPs have reported that the care plans enable them to conduct a more thorough exploration of the

patient's mental health status than would be possible through a normal GP consultation (GPRA). The following concerns were identified with the forms:

- the patient's illness has to be framed entirely from a mental health perspective, and separate care plans must be developed for subsequent co-morbidities, effectively doubling (or more, depending on the number of co-morbidities) the work for the GP,
- the forms do not allow for nuances to be recorded,
- the forms place the GP in a 'tick the box' mode rather than allowing them to engage in quality patient care,
- given the complexity of the system and the multiplicity of referral pathways (of which Better Access is but one), GPs find it confusing matching the form to the correct referral pathway, and
- there is no evidence that the quality of the mental health care plan has a positive effect upon patient pathways or satisfaction, which makes them reluctant to take on the extra work involved in completing the forms.

However, despite GPs' apparent dislike of paperwork, GPs have indicated to their organisations that the major driver to use a Level D consultation is not the paperwork involved in developing a care plan, but concern about labelling clients, privacy, and the implications for patients of having a mental health diagnosis. According to GP representatives from ACRRM and AGPT, GPs are concerned that diagnosis with mental illness has stigma attached and may exclude patients from employment, or may prevent them from obtaining insurance. The emphasis on depression and anxiety in the Better Access initiative, which can lead to over-diagnosis of these conditions in order to meet referral requirements, is another reason cited by GPs for using Level D consultations rather than the Better Access Items.

4.5 Summary

This chapter investigated a range of issues associated with the impact of Better Access on the future mental health workforce. Consultations with key stakeholder organisations were undertaken to assess current workforce capacity and the ability to provide adequate training and supervision. An additional component of the consultations reviewed the effect of Better Access on the relationship between psychologists and GPs.

Better Access was seen to have had the most impact on the psychology workforce. Both clinical and registered psychology workforces were said to be working to capacity, although waiting lists for registered psychologists were said to be shorter than that for clinical psychologists. Of most concern to stakeholders in the psychology workforce was how the increased demand for clinical placements due to increased enrolments in university courses and the retraining of registered psychologists (who wanted to be eligible for the higher rebates associated with clinical accreditation) was going to be managed. Some of this increased demand was said to be due to Better Access. The concern was that the demand for clinical placements was occurring at a time when Better Access was making it more attractive for psychologists to work in the private sector. The withdrawal of senior clinical psychologists from the public sector meant that either supervision was not available or it was more likely to be provided by junior psychologists who had yet to develop the clinical experience or skills required for supervision. To provide some perspective on the extent of this problem, data from an APS survey indicated that approximately 5% of the public sector psychology workforce was considering moving into the private sector, while another 17% were considering increasing the number of hours consulting in the private sector.

Better Access was said to have increased the numbers of social workers seeking mental health accreditation, with mental health becoming an increasingly popular area of specialisation. The social work workforce was the only one where current spare capacity for increasing the levels of mental health workload was identified, with comments suggesting that the social work mental health workforce was underutilised by GPs.

For the occupational therapy workforce, Better Access was viewed as having only a marginal impact, with some increased interest being expressed in mental health specialisation. There is currently no accredited pathway for occupational therapists to work in mental health, although this will be changing in the near future. Some concern was expressed about the withdrawal of occupational therapists from the public mental health sector, and the impact this might have on training.

For GPs, the impact of Better Access was less clearly defined. It was not viewed as impacting on the availability of training places for medical graduates; and there was some capacity within the GP workforce to increase their provision of Better Access services. However, on one hand it was suggested that Better Access had increased the level of skills and interest in mental health training; on the other hand, it was suggested that because Better Access did not require GP training (at the time of the consultations), it had decreased GP engagement in mental health. Contrasting views were also evident in consultations about the impact of Better Access on Regional Training Programs for GPs with one suggesting that it had no impact, and another suggesting that there had been such an increase in interest that they were unable to keep up with training. Web-based training was now available for rural continuing professional development.

Better Access was seen to have created some capacity for psychiatrists to see new patients, but that it was still insufficient to meet demand. Better Access was not viewed as impacting on the workforce shortage of psychiatrists, or their training, more generally.

Overall, Better Access has increased the demand for mental health training and continuing professional development for the allied mental health and GP workforces. Professional bodies were attempting to meet this demand through increasing the size of the training workforce and using online modes of delivery. Another, related, area that was identified as experiencing increased demand was in multi-disciplinary training to increase inter-professional understanding and the effectiveness of referrals. With respect to clinical training for the allied health workforce, Better Access was viewed as having an indirect impact by making it more attractive for senior clinicians to work in the private sector and therefore reducing the availability and perhaps standard of clinical supervision. In addressing this issue, some capacity for expanding clinical supervision in the private hospital system was identified, but this would require supporting infrastructure; and the use of simulation centres, especially in rural centres, was being explored.

The second aim of this chapter was to review the impact of Better Access on the relationship between psychologists and GPs. Better Access was seen as having successfully expanded access to mental health interventions for clients with high prevalence, non psychotic disorders, but did little for clients with more serious psychological disorders or who could not afford to access private services. In expanding access to mental health interventions, the Better Access initiative promotes collaboration between GPs and psychologists and the quality of this relationship is likely to impact on the efficacy of care provided.

Several factors were identified that were impacting on the quality of interactions between psychologists and GPs. This includes unfamiliarity with each others' professional protocols around client management; the lack of clarity about their respective roles, which was viewed as having overlap especially in diagnosis; and the confusion caused by the incorrect use of referral pathways where psychologists refer patients to GPs for a care plan so that the client can then access the

Better Access rebates. Despite these difficulties, both GP and psychology organisations indicated that a shared literacy is developing and that issues are being attended to as they arise (for example, the development of a set of feedback standards to help manage the quality of communication). Many of the issues raised in the consultations reinforce the findings in Chapters 4 and 5 about the relationship between the medical and allied mental health workforces.

Finally, this chapter investigated GPs' use of care plans. The consultations indicated that the quality of care plans differs between individual GPs. Some GPs were seeking training on how to use them more effectively; others found them difficult to use because of the differences in approaches to mental health. There were some indications that clients were not requesting long enough appointments in which to fully develop the care plans, and that this may be a matter of providing more information about how the system works. Concerns were raised about the forms used, including the inability to adequately cater for co-morbidities or nuances in care; the complexity of the form; and the lack of an evidence base for the impact of care plans. Despite these issues, the major driver to use a Level D consultation in lieu of Better Access is concern about labelling clients, privacy and the implications for patients having a mental health diagnosis (including the over-diagnosis of conditions such as depression in order to meet referral requirements).