5 Critically Reflective Analysis of Component C

The aims of Component C of the *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative* were to use existing data to examine the extent to which the Better Access initiative had impacted on the supply and distribution of the allied mental health workforce; and to provide an overview of trends in both the allied mental health and medical workforce, as relevant to the initiative. An analysis of the anticipated future impact of the Better Access initiative on training and service provision within the mental health workforce was undertaken through consultations with key stakeholders.

This chapter brings together the findings from Chapters 2-4 and provides a critically reflective analysis of Component C. It focuses on the implications of the Better Access initiative on workforce capabilities and capacity to provide primary care for people with a mental disorder. Potential areas of improvement of mental health services will be identified and suggestions made where appropriate.

5.1 Delineating the Impact of Better Access

The use of existing data which were not collected for the purpose of evaluating the Better Access initiative meant that there were constraints on the extent to which causal relationships between Better Access and workforce change could be attributed. The only aspect of the supply and distribution of the workforce where this was possible was in evaluating the impact of Better Access on the private (Medicare) allied mental health workforce (Section 3.2). As a consequence, the evaluation has focused on identifying the impact of Better Access on the private (Medicare) allied mental health workforce; providing baseline data about the characteristics relating to the supply and distribution of the mental health workforce; and identifying emerging trends in the Better Access and public sector workforces. With only two full years of post-Better Access data, the analysis provides an excellent basis for ongoing monitoring and development. It is, however, too soon to make definitive statements about the impact of the initiative on the workforce.

To summarise, it was difficult to delineate the impact of Better Access on the supply and distribution of the allied mental health workforce, due to data limitations including:

- The lack of precise data on the size of the potential workforce, requiring estimates to be derived from the available data;
- The need to limit the scope of analysis in the private sector to the private (Medicare) sector, despite this being only a small proportion of the private services provided by the allied mental health workforce;
- The lack of concordance between data sources regarding regional distribution, dates of collection points and measures of fulltime equivalence, requiring estimations to be developed based on the available data;
- The lack of differentiation between clinical and registered psychologists, due to these categories being generated as Medicare provider categories rather than occupational categories;
- Having too few data capture points to detect trends in the potential allied mental health workforce.

Measures were taken to compensate for the first three of these limitations, enabling the most rigorous evaluation of the impact of Better Access possible under the circumstances. It is

anticipated that the establishment of the National Health Workforce Dataset (Health Workforce Australia) will provide a basis for addressing these data issues for future research.[29]

5.2 Characteristics of the Better Access Workforce

The Better Access workforce is comprised of allied (psychologists, social workers and OTs) and medical (GPs and psychiatrists) mental health professionals who meet their professional requirements to practice, but may or may not have provided Better Access services.

One of the more difficult aspects of the evaluation was in finding data that could provide the best estimate of the potential Better Access workforce. In the absence of consistent data across the occupational groups, it was necessary to adopt an eclectic approach in which the best data source(s) for each occupation were used in developing estimates of the broader and potential workforces. Table 5.1 summarises the size of the potential and actual Better Access workforce, and in the following sub-sections a brief overview is provided of selected findings for each occupational group in the Better Access mental health workforce.

Table 5.1 Size of the potential and actual Better Access mental health workforce

	Better Access Allied Mental Health Workforce				
	Broader workforce 2006	*Estimated Potential 2006*[4]	*Actual 2006*[5]	*Actual 2007*	*Actual 2008*
Psychologists	18,547[1]	9,088	3,688	6,858	8,088
Social Workers	12,442[2]	3,981	126	489	646
Occupational Therapists	9,160[1]	6,412	23	115	172
General Practitioners	22,641[3]	n/a	12,064	19,863	21,324
Psychiatrists	2,877[3]	n/a	1,086	1,518	1,608

1. For psychologists and occupational therapists the available Registration Board data was used to weight the ABS Census (2006) numbers. These numbers reflect estimates of the number of current, fully qualified practitioners in each profession.

2. For social workers, the ABS Census (2006) data has been used.

3. Numbers of GPs and psychiatrists in the broader workforce were calculated using Medicare Provider data.

4. Estimates used here are based on the number in the broader workforce in each occupation working in the health industry (excluding residential care and social assistance services). These numbers reflect the size of the potential workforce most likely to provide Better Access services.

5. Better Access began in November 2006

Source: Tables 2.3, 2.6, 2.9, 2.12, 2.15

5.2.1 Psychologists

The size of the potential Better Access psychology workforce varied depending on the reference data source. The ABS Census data was weighted by using information gained from Registration Board data. We estimated that in 2006 there were approximately 18,547 psychologists of whom

[29] This dataset will not include social workers at this stage.

49% or 9,088 worked in health care (excluding residential care and social assistance services). Registration Board data indicated that the psychology workforce increased by 10% from 2006-2008.

In 2008, psychologists comprised 90.8% of the Better Access allied mental health workforce. Of the 8,088 psychologists providing Better Access services in 2008, 2,284 clinical psychologists provided Psychological Therapy Services, averaging 343 services per provider; and 6,985 registered psychologists provided Focussed Psychological Strategies, averaging 200 services per provider. These figures equate to the DFTE of 1,308 psychologists (471 clinical and 837 registered psychologists) providing Better Access services.

As a whole the psychology workforce is female dominated (around 75%), with registered psychologists being more likely than clinical psychologists to be located outside of capital cities and major metropolitan areas. The proportion of psychologists over the age of 50 years who provided Better Access services in 2008 was 42%, which was higher than that of the broader psychology population at 34%.

5.2.2 Mental Health Social Workers

The size of the social work workforce was calculated using ABS Census (2006) data. Of the 12,442 social workers identified in the Census of Population and Housing (2006), 32% or 3,981 worked in health care (excluding residential care and social assistance services). The Australian Association of Social Workers provided unpublished data on the numbers of accredited mental health social workers. This rose from 150 in 2006 to 839 in 2008. The use of Better Access by accredited mental health social workers is therefore high, ranging from 84% in 2006 to 75% in 2008.

In 2008, social workers were 6.4% of the Better Access allied mental health workforce. There were 646 social workers providing Focussed Psychological Strategies in 2008, providing an average of 159 services per provider. This equated to a DFTE of 61.2 social workers providing Better Access services across Australia.

Similar to other allied mental health occupations, the social work workforce is female dominated (over 80%). The proportion of social workers over the age of 50 years providing Better Access services in 2008 was 57%, which was higher than that of the broader social work population at 30%. More than 25% of social workers provide services outside of capital cities and major metropolitan centres.

5.2.3 Mental Health Occupational Therapists

The size of the potential Better Access OT workforce varied depending on the reference data source. The ABS Census data was weighted by using information gained from Registration Board data. We estimated that in 2006 there were approximately 9,160 OTs of whom 6,412 worked in health care (excluding residential care and social assistance services).

Occupational therapy is the smallest of the Better Access occupations, being just 1.7% of Better Access allied mental health providers (2008). On average, OTs provided 123 Focussed Psychological Strategy services per provider. This equated to a DFTE of 12.1 occupational therapists providing Better Access services across Australia.

With more than 90% of its workforce being women, the OT workforce is the most female dominated of all the mental health occupations. It also has the youngest age profile with just 12% of the broader OT workforce being over 50 years of age (2006). However, 32% of OTs providing Better Access services was aged over 50 years. Approximately 20% of OTs work outside of capital cities and major metropolitan areas.

5.2.4 General Practitioners

In 2006, there were 22,641 GPs registered with Medicare. General practitioners were 93% of the medical mental health workforce in 2008, providing more than 1.37 million services. Despite the relatively high number of GPs providing Better Access services – 21,324 in 2008 – they did so at relatively low levels. In 2008 GPs averaged 64 services per provider, totalling around 24 hours of client contact, over the whole year. This equated to a DFTE of 303 GPs.

GPs are the most widely distributed occupation across rural and remote areas of all the mental health occupations and GPS in these areas appear to be somewhat more likely than their urban counterparts to provide Better Access services. In contrast to the allied mental health occupations, general practice is male dominated (around 60%). However, GPs providing Better Access services are likely to be older, with 47% being over 50 years of age compared to 39% in the broader GP workforce.

5.2.5 Psychiatrists

Psychiatrists offer specialist mental health services and work with the most difficult and complex psychological disorders. In 2006, there were 2,877 psychiatrists registered with Medicare. By 2008, 1,608 psychiatrists provided over 23,000 Better Access services, equating to a DFTE of 44 psychiatrists. The data indicate that this represented only a very small increase on the previous year.

Despite concerns from the professional bodies that psychiatrists were leaving the public sector, the data did not indicate that there had been a withdrawal of FTE numbers. In contrast, the public sector psychiatry workforce steadily increased since 1995-96 and the trend has barely changed over the past 14 years. There was no indication that Better Access has had a detrimental impact on the numbers in the public sector workforce, however the statistics may mask internal changes such as the level of turnover or the replacement of senior psychiatrists with those more junior.

5.3 Distribution of the Better Access Workforce

The distribution of the Better Access workforce was examined from the perspective of numbers in the private–public sectors and in urban–rural areas. The extent to which a comprehensive analysis could be undertaken of the distribution of the Better Access workforce was constrained by the limitations of the available data.

5.3.1 Private – Public Distribution

The allied mental health workforce had increased access to MBS Items following the implementation of Better Access. The impact of this on the distribution of each of the allied mental health occupations between the private and public sectors was evaluated. The evaluation was subject to the following limitations:

- It was only possible to evaluate the impact on the private (Medicare) or private (Better Access) workforce due to lack of data about the private workforce more generally. This is particularly pertinent to the allied mental health workforce as it had high levels of participation in the private sector (beyond Medicare) prior to the implementation of Better Access;

- The numbers (headcount) in each Better Access allied mental health occupation were converted to DFTE so that they could be compared to FTE data from the Mental Health Establishments: National Minimum Data Set. The methodology used meant that the FTE /

DFTE numbers were not concordant; nevertheless, the methodology used provided the best basis for comparative analysis.

To provide background for the evaluation of the impact of Better Access on the distribution of allied mental health occupations across the private (Medicare) and public sectors, the MHE: NMDS for the years 1995 – 2008 were used. This placed any developments since the implementation of Better Access in the context of pre-existing trends within the public sector allied mental health workforce.

The following sections discuss the private (Medicare or Better Access) – public sector distribution for each of the allied mental health occupations. Overall, there were considerable differences across states / territories indicating that state / territory policies were likely to have played a role in the distribution of the public-private sector allied mental health workforce. The extent to which state /territory policies had influenced the patterns of distribution could not be ascertained from the available data.

Psychologists

Better Access had an immediate impact on increasing the supply of psychologists into the private (Medicare) sector in all states and across each of the geographic regions. However, two-thirds of all psychologists worked in the private sector prior to the implementation of Better Access (ABS Census 2006). The extent to which Better Access resulted in an increase in the numbers of psychologists in the private sector, overall, could not be ascertained without data on the private sector workforce outside of Medicare. By 2008 there were 1,308 DFTE psychologists in the private (Better Access) workforce and 1,741 FTE psychologists in the public sector workforce.

There has been an increase in the public sector psychology workforce since the implementation of Better Access. At 4.5% p.a., the rate of growth since Better Access was lower than the rate of growth over the preceding 11 years at 7.6% p.a. The rates of growth since the implementation of Better Access varied between states / territories with FTE numbers in the public sector psychology workforce increasing in SA, Queensland, WA, NSW and NT; decreasing in Tasmania and the ACT; and remaining virtually unchanged in Victoria. By 2008, Victoria and Tasmania had more psychologists in the private (Better Access) sector than in the public sector workforce.

The consultations provided a contrasting picture of the public sector psychology workforce. While the numbers of FTE psychologists increased following the implementation of Better Access, the consultations indicated that the number of clinicians available for supervision and training was decreasing. Data from an APS survey suggested that around 22% of psychologists in the public sector were considering reducing their hours. Better Access was viewed as exacerbating, rather than causing, this issue. The discrepancy between the statistical data and information from the consultations could be due to:

- A decrease in the actual number of psychologists (headcount) working in the public sector, creating the situation whereby fewer people are doing more work;
- An expertise drain created by the movement of senior psychologists into the private sector, leaving less experienced psychologists to work in the public sector;
- Instability in the public sector workforce due to high turnover, resulting in an increase in short-term employees.

Each of these issues would result in a decrease in the availability of clinicians for supervision and training, while simultaneously maintaining the FTE numbers / rates of growth in the public sector

psychology workforce. As these have implications for workforce development, the capacity to treat clients with complex needs and the sustainability of the public sector psychology workforce it would be advantageous if more comprehensive data on the public and private sector psychology workforces could be collected.[30] To fully explore the private – public sector distribution of psychologists, there would need to be data about the numbers (headcount) in the public sector workforce; the level of seniority of employees; the proportion of time that clinicians allocate to private and public practice; and the proportion of time spent on clinical supervision and training. To ascertain change over time, this data would need to be longitudinal.

Mental Health Social Workers

Better Access provided mental health social workers with access to MBS Items. It therefore had an immediate impact on increasing the supply of social workers into the private (Medicare) sector in all states and across each of the geographic regions. Just over 50% of all social workers worked in the private sector prior to the implementation of Better Access (ABS Census 2006). The extent to which Better Access resulted in an increase in the numbers of social workers in the private sector, overall, could not be ascertained without data on the private sector workforce outside of Medicare. By 2008 there were 61 DFTE social workers in the private (Better Access) workforce and 1,598 FTE social workers in the public sector workforce.

There has been an increase in the public sector mental health social work workforce since the implementation of Better Access. At 3.3% p.a., the rate of growth since Better Access was lower than the rate of growth over the preceding 11 years at 6.3%p.a. FTE numbers in the public sector social work workforce increased in all states / territories except for NSW and ACT, with Tasmania, WA and the NT recording the highest growth rates.

Mental Health Occupational Therapists

Better Access had an immediate, but relatively small, impact on increasing the supply of OTs into the private (Medicare) sector in all states and across each of the geographic regions. Just over 50% of all OTs worked in the private sector prior to the implementation of Better Access (ABS Census 2006). The extent to which Better Access resulted in an increase in the numbers of OTs in the private sector, overall, could not be ascertained without data on the private sector workforce outside of Medicare. By 2008 there were 12.6 DFTE OTs in the private (Better Access) workforce and 859 FTE OTs in the public sector workforce.

There has been an increase in the public sector mental health OT workforce since the implementation of Better Access. The public sector OT workforce was the only Better Access allied mental health workforce to have increased its rate of growth in the public sector following the implementation of Better Access. At 5.6% p.a., the rate of growth since Better Access was higher than the rate of growth over the preceding 11 years at 4.4%p.a. FTE numbers in the public sector OT workforce increased in all states / territories since 2006, however this varied by year with decreases registered in Queensland and Act in 2006-07, and in Victoria and Tasmania in 2007-08.

5.3.2 Urban – Rural Distribution

The lack of concordance between RRMA (MBS data), non-standard classification (MHE: NMDS) and Section of State (ABS data) meant that it was difficult to assess whether the Better Access mental health workforce was more or less widely distributed, geographically, than the mental

[30] The NSW Psychologist Registration Board conducted a survey of their members in 2009 which covered at least some of these issues. Findings were not available at the time of submitting this report; however they are due for release early in 2010.

health workforce more generally. Given the available data, we estimated that Better Access GPs and allied mental health providers were more likely than health professionals in the broader mental health workforce to work outside of major metropolitan areas. We could not ascertain from the data the extent to which this was the result of demand or supply factors.

GPs were the most widely distributed Better Access workforce with 30% of service providers located outside of capital cities and other metropolitan centres. Better Access psychiatry and clinical psychology services were the least likely to be provided in rural or remote areas, with around 11% of these workforces providing services in rural areas and less than 1.0% in remote areas.

Overall, approximately 20% of psychologists provided Focussed Psychological Strategies outside of capital cities and metropolitan areas. Since the implementation of Better Access the numbers of FTE psychologists in the rural/remote public sector workforce have varied between states. Numbers in rural/remote areas decreased in Victoria and WA, increased in Queensland and remained relatively static in NSW and SA. The workforce in Tasmania, ACT and the NT was too small to analyse.

Approximately 25% of social workers and 20% of occupational therapists also provided Focussed Psychological Strategies in rural areas, with around 1% of social workers and 2% of OTs working in remote areas. Since the implementation of Better Access, the number of FTE social workers in the public sector workforce has increased at a higher rate in areas outside of capital cities; while the number of FTE occupational therapists in the public sector has increased at higher rates within capital cities.

The provision of training for the rural and remote mental health workforce was identified as being an issue. Although some web-based training has been developed and delivered, concern was expressed in the consultations about the capacity to provide good quality mentoring to health professionals in rural and remote areas. Given the accreditation process for allied mental health professions requires evidence of supervision in mental health practice; this may be an issue that requires addressing.

5.4 Meeting Better Access Workforce Objectives

Aspects of Component C can inform the analysis of whether the Better Access initiative is improving the workforce's capabilities and capacity to provide primary care for people with a mental disorder. Five workforce objectives were associated with Better Access:

- Encourage more GPs to participate in early intervention, assessment and management of patients with mental disorders
- Streamline access to appropriate psychological interventions in primary care
- Encourage private psychiatrists to see more patients and expand their role as specialists in backing up the primary health care sector
- Provide referral pathways for appropriate treatment of patients with mental disorders
- Support GPs and primary care service providers with education and training to better diagnose and treat mental illness

As discussed earlier, it is difficult to state definitively whether changes in workforce capabilities and capacities are a direct result of the introduction of the Better Access initiative or stem from

broader policy changes, including other mental health initiatives. However, analysis of the available data indicates that each of the workforce objectives is being achieved to some degree and that the Better Access initiative is likely to have contributed to these achievements.

5.4.1 Increase GP Participation in Mental Health Care

A high proportion of GPs provided Better Access services. Of the 24,953 GPs registered with Medicare in 2008, 87% provided mental health care plans and services associated with Better Access. Despite the widespread provision of Better Access services, the data suggest that GPs have a relatively low level of usage per provider: the average use per provider was 1.2 services per week (64 consults per year) in 2008. This totalled approximately 47 minutes of GP billing time. Although this was a slight increase of 6 minutes from the previous year, only future analysis of data from subsequent years will provide an indication of whether there is a trend toward increasing GP participation at the service provider (individual) level.

The reasons for this low level of usage per provider cannot be determined from the research undertaken for Component C. It may be that this reflected the level of demand for these services from GPs. It is also likely that there will be geographical differences in the levels of use given that 85-90% of Better Access services in remote centres and other remote areas are provided by GPs.

5.4.2 Streamline Access to Appropriate Psychological Interventions

To fully assess whether Better Access has contributed to meeting this objective an analysis of client data would need to be undertaken to examine treatment pathways. This was out of scope for Component C. From the analysis of MBS and Medicare Provider data, one issue was identified that may influence whether Better Access is meeting this objective.

As indicated in the report, by 2008, 1181 clinical psychologists were providing both Psychological Therapy Services and Focussed Psychological Strategies. This suggests that the triaging of clients to ensure that they are being treated by health professionals with the most appropriate skills may have the capacity for improvement.

Triaging takes place within Better Access when a GP (or other Better Access referral provider) develops a care plan, makes an assessment of client needs and then either treats the client themselves, or refers them to an allied mental health professional. The referral process depends on the GP diagnosis, the level of psychological intervention required, and the availability of different allied mental health professionals within the GPs' professional networks. While GPs are referring to allied mental health professionals, it is difficult to determine whether referrals are made to the *most appropriate* allied mental health professional for the required psychological intervention. This may be better addressed in other Components of the evaluation. From the data and literature analysed in Component C, we are suggesting that it is possible that the streamlining may not be as efficient as it could be, given that clinical psychologists are using Focussed Psychological Strategies.[31]

There are workforce implications if triaging is not working efficiently. In effect, it means that there is a mismatch between the skills and capacities of clinical psychologists and their utilisation by Better Access. Clinical psychologists have the capacity to deal with the more severe or complicated psychological disorders. If they are providing services to clients with relatively straightforward

[31] There is no indication that clients were receiving inappropriate psychological interventions; or that the MBS Items were being used inappropriately. The issue is whether the appropriate service provider is being utilised.

psychological disorders, then they cannot use that time to provide services to clients with more complex needs.

5.4.3 Encourage Private Psychiatrists to see More Patients

An estimated 51% of psychiatrists used Better Access Items in 2008. The most used MBS Item by psychiatrists was 296 (initial consult with a new patient, in rooms), which accounted for 77% (78,008) of services provided. Items 297 and 299, also for consults with new patients, accounted for a further 10.4% (10,559) of services provided. There is evidence then, that psychiatrists are using Better Access Items when consulting new patients. Items 296, 297 and 299[32] alone indicate that psychiatrists have seen 183,825 new patients over the life of Better Access.

While these figures appear to indicate that Better Access is meeting this objective, it is difficult to know how many of these new patients would have been seen by psychiatrists had the Better Access initiative not been implemented. That is, the extent to which psychiatrists are seeing more new patients *because* of Better Access is unknown. To evaluate this objective, data is required that can compare the number of new patients seen by psychiatrists who do use Better Access with those who do not to see if there is a difference in the rates in consultations with new patients.

5.4.4 Provide Referral Pathways

The development of formal referral pathways between GPs and allied mental health professionals, especially psychologists, began in 2004 with the Better Outcomes initiative's ATAPS program. Better Access expanded this by providing selected allied mental health occupations with access to MBS Items based on the implementation of referrals from medical mental health professionals.

Better Access provides referral pathways for the delivery of mental health services in which referrals are made by GPs, psychiatrists or paediatricians to clinical psychologists for Psychological Therapy Services; or to registered psychologists, social workers and occupational therapists for Focussed Psychological Strategies. As referral data was out of scope for the analysis undertaken in Component C, the extent to which we can inform discussion of this objective is limited.

From the implementation of Better Access until Dec 20008, GPs developed 1,093,891 mental health care plans, many of which would have had referrals to allied mental health professionals. The data suggests that the number of referrals each year is likely to be increasing. For example, the number of mental health care plans developed by GPs increased by 18% between 2007 and 2008, the first two complete years of the Better Access initiative.

As part of Component C we were asked to investigate concerns that mental health care plans were not being utilised effectively. This issue was explored in the consultations where the perception was that the quality of the plans varied greatly between individual GPs and issues were exacerbated by:

- The incorrect use of referral pathways which resulted in the lack of time during initial consultations to fully ascertain client needs
- Clients skipping steps in the referral process

[32] Psychiatrists can also claim for Items 291 and 293 (consults with referred patients). As these Items were available prior to the implementation of Better Access, they are not included in this discussion. In 2008, these two Items accounted for 12.6% of services provided by psychiatrists.

- The forms lacking the flexibility to capture the nuances and detail required for effective communication between health professionals

- The lack of evidence regarding whether/how the quality of a care plan affects the outcome

- The need for benchmarks in good practice

The consultations also investigated why GPs were using level D consultations in lieu of Better Access for some clients. The response to this line of inquiry indicated that this was not a reflection of the amount or type of administration associated with Better Access, but a concern about the impact of a mental health diagnosis on a client's capacity to get employment or insurance.

Consultations with representatives of groups from each of the allied mental health professions also indicated that GPs may require clearer information about the role of each profession within the patient pathway. As outlined in Chapter 1, clinical psychologists, registered psychologists, social workers and occupational therapists each have a different approach and field of expertise within mental health care. There are indications that referral pathways between GPs and psychologists are improving due to the development of a shared literacy forming a stronger basis for communicating across disciplinary / professional boundaries. This does not appear to have occurred to the same extent between GPs and social workers and OTs. The AASW, in particular, indicated that one of the reasons that social workers are under-utilised within Better Access is that the lack of understanding about their role in mental health care impacts on their likelihood of receiving referrals.

5.4.5 Education and Training for GPs and Primary Care Service Providers

From the available data, it was difficult to determine the extent to which Better Access has *supported* GPs and primary care service providers with education and training to better diagnose and treat mental illness. There is evidence however, that Better Access has stimulated interest in mental health training by social workers and, to a lesser extent, occupational therapists and psychologists, by providing pathways for allied mental health workers to develop a more financially viable practice in mental health.

Data from a small survey conducted for Component D of the evaluation (comprised of 264 psychologists, 153 social workers and one OT) indicated that 32.5% thought that Better Access had improved their access to training. For social workers this is evident from the increase in the number of accredited mental health social workers: from 150 in 2006 to 839 in 2008 (by 2009, this had further increased to 1054). Although a proportion of these social workers would have attained their mental health accreditation based on experience and training prior to the implementation of Better Access, the sustained rate of increase suggests that Better Access is encouraging mental health training by social workers. In contrast, Better Access appears to have had a marginal impact on mental health training by OTs (consultations).

For psychologists, Better Access was viewed as exacerbating existing issues relating to the lack of availability of supervisors in the public sector workforce. Alternative options for clinical training, such as virtual training and simulations were being implemented in some areas; however, there was some concern about the ability to achieve the same quality of training as had previously been available through face-to-face supervision.

Since July 2009, GPs have been financially rewarded through access to higher schedule fees for acquiring accredited mental health training. GPs without the training can provide Better Access services but will only be able to access the lower schedule fee (Department of Health and Ageing, 2009c). In a survey conducted for Component D of the evaluation, approximately half of the

medical mental health workforce indicated that Better Access had affected their access to training, with over 90% of these respondents indicating that it had improved their access.

Some gaps in mental health education and training were identified. In a recent survey of OTs using Better Access, respondents identified three areas in which additional resources are required to support them to provide Better Access services: clinical practice, business skills, and an organised peer support system (OT Australia, 2008). In the consultations GP organisations identified the need for training and resources in the use of care plans and the development of benchmarks, and in the area of multi-disciplinary communication and working.

5.5 Conclusion

This chapter concludes with a summary of the key issues identified in the critically reflective analysis, including those that could lead to the improvement of mental health services.

1. Concordance between data sources relating to mental health services could be improved in the areas of occupational definitions, demographic data, regional categories, estimations of fulltime equivalence and the level of private-public service provision. The new National Health Workforce Dataset provides a unique opportunity to collect the types of data that would be beneficial to the mental health workforce.

2. Each of the mental health workforce objectives have been met to some degree and the Better Access project is likely to have contributed to these achievements, although causal relationships could not be established. These objectives are:

    a. Encouraging more GPs to participate in early intervention, assessment and management of patients with mental disorders;

    b. Streamlining access to appropriate psychological interventions in primary care;

    c. Encouraging private psychiatrists to see more patients and expand their role as specialists in backing up the primary health care sector;

    d. Providing referral pathways for appropriate treatment of patients with mental disorders;

    e. Supporting GPs and primary care service providers with education and training to better diagnose and treat mental illness.

3. The provision of Better Access services entails a relatively small amount of time per week for any of the allied mental health workforces, indicating a level of spare capacity to increase the provision of Better Access mental health services.

4. Better Access allied mental health service providers were older than the mental health workforce more generally. The reason for this could not be determined from the data, but it could have workforce planning implications.

5. Better Access allied mental health service providers were more likely to work in rural and remote areas than the allied mental health workforce more generally.

6. At the national level, there have been increases in the numbers of allied mental health professionals (FTE/DFTE) in each of the occupational groups in both the private (Medicare) and public sectors since the implementation of Better Access. State / territory differences in the distribution between the private (Medicare) and public sectors indicate

that the specific policy context in each jurisdiction was likely to have influenced the outcome.

7. Data indicated that the public sector psychology workforce had increased (especially in Queensland, NSW and SA) since the implementation of Better Access, however the rates of growth have slowed and there are state / territory differences. The data could not determine why the public sector psychology workforce in Victoria decreased in 2007-08 and is now smaller than the private (Better Access) workforce.

8. To expand the social work and occupational therapy Better Access allied mental health workforces, a more inclusive use of referral pathways may be required. This would involve clarifying the roles of social workers and occupational therapists in mental health service provision; promoting their role to GPs, creating opportunities for a shared literacy to develop across mental health paradigms; and the pro-active development of broader GP professional networks.

9. Concerns about the lack of clinical supervision and training in the public sector psychology workforce may be due to issues that could not be evaluated using data on FTE/DFTE numbers. For example, there may be a decrease in the number (headcount) of psychologists in the public sector; a shift in the demographic structure of the workforce; or an increase in the turnover. To assess the reasons for the shortages, data related to these issues would need to be collected.

10. Trends toward the provision of remote supervision of GPs and allied mental health professionals may assist with professional development in rural and remote areas and in some outer metropolitan clinical practices. This needs to be associated with quality assurance measures that equal the standards imposed on face-to-face models of supervision.

11. Areas of additional training required were identified including:

    a. GPs: use of care plans, including benchmarking; multi-disciplinary communication practices; and multi-disciplinary networking.

    b. Occupational therapists: clinical practice; business skills; and peer support.