Executive Summary

This report addresses Component C of the *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative*. Specifically, it presents an analysis of the allied mental health workforce supply and distribution.

The Better Access initiative increased the number and range of Medicare Benefit Schedule (MBS) Items available to general practitioners (GPs), psychiatrists and allied mental health professionals as a mechanism for increasing access to mental health treatment, streamlining access to mental health services and providing clearer referral pathways for people with high prevalence, non-psychotic psychological disorders. In facilitating changes to the model of care within which mental health care is provided it was anticipated that the Better Access initiative could impact on the workforce and this would therefore require monitoring and evaluation. This report provides baseline data and a review of the findings from the first two full years of the Better Access initiative.

The report has four aims:

1. Describe the characteristics of the Better Access workforce (i.e. GPs, psychiatrists, clinical and registered psychologists, social workers and occupational therapists);

2. Provide an analysis of the extent to which the Better Access initiative has impacted on the supply and geographical distribution of the allied mental health workforce with particular reference to any impact of the Better Access initiative on State and Territory public specialised mental health workforce and the private allied mental health workforce;

3. With specific reference to the Better Access initiative, describe anticipated implications for future workforce trends, for example clinical training;

4. Describe the implications of the Better Access initiative in relation to workforce capabilities and capacity to provide early intervention and treatment of people with mental disorders within a primary care setting.

The report is informed by an analysis of published and unpublished data from a range of sources, and consultations with relevant professional groups and stakeholders.

DATA ISSUES

Comparing disparate data sources which were not developed for the purpose of an evaluation of the mental health workforce meant that there were many areas in which direct concordance was not possible. To make the most of the data available from these sources, we sought to develop ways of interpreting the data so that reasonable comparisons could be made.

It is recommended that the development of a comprehensive database is negotiated with Health Workforce Australia to ensure that data relevant to the mental health workforce are collected. The key issues are:

- Having consistent demographic data across all allied and medical mental health occupations;

- Collecting data on the extent to which mental health professionals work in the private and public sectors, and the mobility between sectors;

- Utilising consistent measures of geographical distribution;

- Identifying a consistent measure of converting numbers (headcount) to full-time equivalence for the occupational groups;

- Having comprehensive data on the private allied mental health workforce. Although the private medical mental health workforce equates (roughly) with the Medicare workforce, this is different amongst allied mental health occupations. More than half of the health professionals in the allied mental health workforce worked in the private sector prior to the implementation of Better Access.

THE BETTER ACCESS WORKFORCE

Psychologists

Psychologists comprised the largest allied mental health occupation in the Better Access allied mental health workforce. It was estimated that in 2006 there were 9,088 psychologists in the potential Better Access workforce. By 2008, there were 8,088 psychologists providing an average of 269 Better Access services per provider, equating to 4 hours 17 minutes per week. Of the two psychology provider categories, clinical psychologists provided an average of 343 services per provider in 2008, equating to 5 hours 37 minutes per week; while registered psychologists provided an average of 200 services per provider in 2008, equating to 3 hours 52 minutes per week. It was noted that in 2008 1,181 clinical psychologists provide both Focussed Psychological Strategies and Psychological Therapy Services.

Between 1995-96 and 2007-08 the public sector psychology workforce more than doubled from 777 to 1741full-time equivalent (FTE) persons. Most of the growth in the public sector psychology workforce was in NSW, Victoria and Queensland, with there being minimal or no change in the remaining states/territories. The average rate of growth in the public sector psychology workforce prior to Better Access was 7.6% p.a., which fell to 4.5% p.a. after the implementation. However, since the implementation of Better Access differences in the extent of growth were noted across states/territories, with Victoria remaining virtually unchanged and decreases recorded in Tasmania and the ACT. The highest rates of growth in the public sector psychology workforce were in SA, Queensland and WA. Notably, by December 2008 Victoria and Tasmania had more deemed full-time equivalent (DFTE) psychologists in the private (Better Access) workforce than in the public sector workforce

Approximately 65% of all psychologists worked in the private sector in 2006, just prior to the implementation of Better Access (ABS Census 2006). Psychologists have had access to Medicare since July 2004, and there were already 1,429 psychologists registered in the private (Medicare) workforce before the implementation of Better Access. The growth rate in the numbers of psychologists registering for Medicare increased from a monthly average of 2.4% prior to Better Access to 3.4% thereafter. There were differences between the two psychology provider categories. While there were more registered psychologists, the proportion of psychology services they provided fell from 82.5% in November 2006 to 70.2% by November 2008. Clinical psychologists in the private (Medicare) workforce grew at a rate of 6.2% per month over this period, compared to 3.1% for registered psychologists.

Since the implementation of Better Access the number (headcount) of psychologists providing Better Access services increased from 3688 (December 2006) to 8088 (December 2008). This equated to an increase from 214 to 1,308 DFTE psychologists. There was an increase in the private (Better Access) psychology workforce in every state and territory, with the highest rates of growth being in SA, ACT and WA.

Changes in the geographic distribution of the public and private (Better Access) psychology workforce working in capital cities and non-capital city areas varied across states. Since the implementation of Better Access, the public sector psychology workforce decreased outside of capital city areas in Victoria and WA; and increased outside of capital city areas in Queensland. Changes in NSW and SA were relatively evenly distributed across geographical categories, while the workforce in Tasmania, ACT and NT was too small to comment.

The main issue raised in the consultations was the lack of supervisors for the number of clinical placements required by universities and for the retraining of general psychologists. The consultations indicated that there had been a withdrawal of senior clinicians from the public sector in response to the Better Access initiative and that their replacement by junior psychologists was impacting on the availability and quality of supervision. As stated in Chapter 3, decreases in the FTE numbers of psychologists from the public sector in 2007-08 were limited to Victoria and WA and there was an overall increase in the FTE psychologists in the public sector workforce. Although there appears to be a discrepancy between the findings from the data analysis and the perceptions of stakeholders from the consultations, it may well be that both are true. For example, it is possible that there has been:

- 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.

The available data did not allow an investigation of these possibilities. In future it would be useful to incorporate data on the hours spent in service provision in the public and private sectors, as this distribution has workforce planning and development implications.

Social Workers

Social workers had an estimated 3,981 professionals in the health workforce in 2006. However data provided by the Australian Association of Social Workers indicated that the number of accredited mental health social workers was 150 in 2006, rising to 839 by 2008. In 2008, the 646 social workers providing Better Access workforce had an average of 159 services per provider; this equated to 2 hours and 29 minutes per week.

Between 1995-96 and 2007-08 the public sector social work workforce doubled, increasing from 798 to 1592 FTE persons. The increase in the public sector social work workforce occurred in all mainland states, with Tasmania, ACT and NT remaining relatively static. The average rate of growth prior to the implementation of Better Access was 6.3% p.a., which fell to 3.3% p.a. after the implementation. Since the implementation of Better Access differences in the extent of growth were noted across states/territories with Tasmania, WA and NT

recording the highest growth rates; and NSW and ACT experiencing an overall decline in the number of FTE social workers in the public sector.

Approximately 53% of the social work workforce was in the private sector prior in 2006, just before the implementation of Better Access (ABS Census 2006). In contrast to psychologists and OTs, social workers could not register with Medicare until the Better Access initiative. The private (Medicare) workforce is therefore the same as the private (Better Access) workforce. Since the implementation of Better Access the number of social workers in the private (Better Access) workforce has increased from 126 (Dec 2006) to 646 (Dec 2008). This equated to an increase from 5 to 61 DFTE social workers. Increases were recorded in every state and territory, with the highest rates of growth being in Victoria, SA and Tasmania.

Changes in the geographic distribution of the public and private (Better Access) social work workforce indicated that it increased at a higher rate in non-capital city areas than it did in capital cities.

The consultations did not identify any difficulties regarding the capacity of the profession to meet the training or supervision required for accreditation. However, the consultations did reveal that the social work mental health workforce is perceived to be underemployed and underutilised.

Occupational Therapists

Occupational therapists were the smallest of the allied mental health occupations that actually provided Better Access services. However, at 6,412 the estimated potential workforce (2006) was larger than that of social workers. By 2008, 172 occupational therapists were providing Better Access services, averaging 123 services per provider. This equated to 1 hour and 54 minutes per week.

Between 1995-96 and 2007-08 the public sector occupational therapy workforce gradually increased from 498 to 859 FTE persons. Growth in this workforce was strongest in Queensland, NSW and Victoria. The average rate of growth prior to the implementation of Better Access was 4.4% p.a., which rose to 5.6% p.a. thereafter. The occupational therapy workforce was the only allied mental health occupation in the public sector to increase its rate of growth following the implementation of Better Access. The overall trend in the public sector occupational therapy workforce has been one of growth since the implementation of Better Access. The increase in FTE persons did, however, fluctuate over the two years with Queensland and ACT having negative growth in the first year and Victoria and Tasmania having negative growth in the second year.

Approximately 54% of the occupational therapy workforce was in the private sector in 2006, just prior to the implementation of Better Access. Occupational therapists have had access to Medicare since July 2004, and there were 209 persons registered in the month prior to the implementation of Better Access, growing to 457 persons by December 2008. During this time NSW and Victoria increased their proportion of occupational therapists in the private (Medicare) workforce.

Since the implementation of Better Access the number of occupational therapists in the private (Better Access) workforce increased from 23 in December 2006, to 172 in December 2008. This equated to an increase from 0.4 to 12.6 DFTE occupational therapists. The increase was recorded across all states and territories.

Changes in the geographic distribution of the public and private (Better Access) occupational therapy workforce indicated that it grew at a higher rate in capital cities compared to non-capital city areas over the two year period.

The consultations indicated that there has been a minor increase in interest in mental health training among occupational therapists. Some concern was expressed about the impact of Better Access on the number of occupational therapists in the public sector, and that this could impact on training. As stated in Chapter 3, there is no indication that Better Access has had a negative impact on numbers of occupational therapists in the public sector; however, internal dynamics may be masked in the available data.

Medical Mental Health Workforce

In calculating the size of the potential Better Access medical mental health workforce, Provider data from Medicare was used. By 2008, approximately 53% of psychiatrists were providing Better Access services. The 1,688 psychiatrists in the actual Better Access workforce in 2008 provided an average of 63 services per provider, equating to 54 minutes per week. The consultations indicated that Better Access was not viewed as having an impact on the training or future supply of psychiatrists.

Approximately 87% of general practitioners registered with Medicare provided Better Access services in 2008. Although there was wide engagement with Better Access, the extent to which individual general practitioners provided services was much lower than that of any of the allied mental health occupations. On average, general practitioners provided 64 services per provider in 2008, equating to 28 minutes per week.

The consultations revealed contradictory evidence about the demand for mental health training from general practitioners. In rural areas, web-based training was now available. Following the consultations, measures to promote the training of general practitioners in mental health treatment and care were announced in the budget.

The consultations explored the effect of Better Access on interactions between GPs and psychologists. The following issues were raised:

- Unfamiliarity with each other's professional protocols around client management, although a shared literacy was said to be developing. It was suggested that a set of feedback standards would help to overcome this issue.

- The variability in the quality of care plans. Some GPs were seeking training on how to use care plans more effectively. Difficulties were related to the unfamiliarity of the paradigm of mental health embodied in the care plans; and to the lack of time if clients did not request a long enough appointment.

- Concerns about the forms used to develop care plans include: the inability to 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.

- Level D consultations tended to be used when there is a concern about labelling clients, privacy and the implications for clients in having a mental health diagnosis.

SUMMARY OF KEY FINDINGS

The key findings from Component C of the *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule Initiative* are:

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.