

Productivity report Submission
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Version 2

Adam Finkelstein

Occupational Therapist, Mental Health Clinician
Occupational Therapy Australia (OTA) Member
Accredited Better Access to Mental Health provider

To whom it may concern,

I am registered occupational therapist with clinical mental health experience, practicing throughout Australia's public and private mental health sectors. My career in mental health has included working the Northern Territory and Victoria, at the levels of a specialist public tertiary psychiatric service and community mental health private practice. I am currently working as an allied health Better Access to Mental Health provider operating in private practice and also providing care coordination under the NDIS and MACNI programs at a private psychology organisation in Melbourne.

I have reviewed the Productivity Commission's Draft Mental Health Report and am providing a brief submission to contribute to the development of the final report. The focus of my submission calls for further consideration regarding the mental health workforce and productivity issues associated with this.

I have detailed a variety of workforce issues which contribute to systemic inefficiency and poor clinical outcomes from our mental health system.

1. Remuneration Disparity under the MBS:

a. Background information

Under the current MBS Better Access to Mental Health scheme, a patient's GP refers those living with a mental illness for evidenced based treatment (focused psychological strategies) by a registered Medicare Better Access provider of their choosing, enabling 10 yearly Medicare funded sessions.

Several different professions provide services focused on treating patients with mental health concerns under the MBS under the Better Access scheme. With the aim of improving treatment and management of mental illness in the community, Better Access relies heavily on mental health professionals from a range of professional backgrounds to provide appropriate services to meet these needs.

Each discipline's professional body (APS, AASW, OTA) governs its own eligibility standards to permit Better Access provider endorsement. To be eligible to apply to be an endorsed Better Access provider, *occupational therapists* are required to meet the following stringent OTA criteria:

- Registered to practice with the Occupational Therapy Board of Australia (requiring current AHPRA membership);
- Be a full (full-time or part-time) member of Occupational Therapy Australia;
- Have a Medicare Australia Provider Number;

- Have a minimum of 2 years full time (or equivalent) supervised practice as a qualified occupational therapist working in mental health with recency of BAMH relevant practice (at least 6 months full time equivalent in the last 5 years). Specifically, this needs to be post-graduate experience. Undergraduate placements and pre-graduation volunteer work are not be considered in the application.
- Satisfy all domains of competency as set out in the Occupational Therapy Board of Australia (Registration requirements are included in the Competency Standards);
- Meet the National Practice Standards for the Mental Health Workforce 2013.
- Demonstrate an appropriate level of Mental Health practice experience (i.e. advanced psychotherapy and psychiatric treatment training) to be eligible to apply for Better Access Mental Health endorsement, as decided by OTA.

Upon meeting the relevant professional requirements and obtaining Better Access endorsement, providers are permitted to treat mental health conditions prescribed by a patient's referring GP Mental Health Treatment Plan, using focused psychological strategies (including CBT, IPT, MI). There are currently no restrictions or guidelines that regulate the diagnostic presentations that can be treated by each professional group. This means that all endorsed Better Access providers, including social workers, clinical psychologists, general psychologists and occupational therapists, are able to provide focused psychological strategies for any clinical concern, as referred by a GP.

Each Better Access provider is remunerated by the MBS for their service, according to a billing schedule linked to their relevant disciplinary registration. The MBS pay scale is solely based on professional title, irrespective of a provider's level of seniority, practice experience, professional development, clinical skillset or clinical outcomes.

This current billing system is problematic and inefficient on a number of levels. I have outlined these concerns outlined below.

b. Unacknowledged Clinical Experience:

MBS item rates are based on professional title, not clinical experience. A senior generalist psychologist, social worker or occupational therapist, perhaps with advanced psychotherapy training, experience with diverse clinical presentations and a wealth of practice experience, is paid at a lower rate (MBS item 80135, \$75.95 per session) than any clinical psychologist (MBS item 80010, \$126.50 per session) – even if the clinical psychologist is a recent graduate or unexperienced with the presenting diagnostic issue.

While I am aware of the historical context and current rationale for this disparity in pay among the allied health professions (with APS lobby being a prominent voice in this discussion), I am curious about the economic consequences of this MBS funding schedule and its broader ripples throughout the mental health system. As discussed below, I am particularly interested in the Medicare spending per professional group, how this payment matches to clinical expertise and the detrimental impacts of pay discrepancy within mental health sector.

'More work for less pay': For example, Better Access providers from a social work or occupational therapy registration, with proven clinical experience background and training in treating psychosis, would claim MBS item 80135, \$75.95 per individual session of focused psychological intervention when working with client with psychotic and depressive disorders. However, all clinical psychologists are paid at MBS item 80010, \$126.50 per session, while they may not necessarily have the specific clinical experience or the professional skillset to treat complex presentations, and instead could

treat less complex clients, i.e. mild adjustment disorder, while being paid significantly more from MBS.

This situation encapsulates the 'more work for less pay' concept. Those paid at a lower rate who are also equipped to treat complex clients are also required to complete additional unbillable tasks when working with complexity (i.e. mass correspondence with external supports, crisis management, client contacts, regular no shows, etc.).

If the Medicare system is unable to effectively utilise, fund, acknowledge and attract a skilled workforce, clients with specialist needs will remain unsupported and staff will continue to opt of providing much needed services under the medicare scheme.

c. Relocation of skilled staff from the sector

Due to the issues with MBS pay remuneration described above ('more work for less pay'), there is a steady flow of highly capable and skilled allied health staff who choose to not engage with this unfair and unbalanced Medicare system. Not only is this a missed opportunity for Victoria's public to access good mental health supports, however this adds further strain on the existing mental health avenues and MBS Better Access providers. This contributes to longer waitlists for patients and a flow-on effect including increased risks due to longer durations of untreated mental health symptoms.

2. Staff turnover, poor retention and unable to attract a strong workforce:

It is well documented that Australia's mental health workforce is understaffed and unfit to meet the community's mental health care needs. A major issue that underpins our mental health system's poor functioning is the current and projected nationwide skills shortage in the mental health sector. The workforce issues relate to both a fundamental undersupply of mental health professionals and shockingly poor retention of competent staff.

There are many factors that contribute to the mental health sector's poor staff retention and these are well understood, documented and researched (i.e. emotional labour, excessive workloads, burnout, compassion fatigue, poor clinical outcomes, bureaucracy, vicarious trauma, poor working environments, toxic team culture, limited resources, low remuneration rates compared to other employment opportunities, etc.). Disappointingly, despite this knowledge, these issues continue to effectively remain unaddressed and corrosive to our already failing mental health system.

The cost to services of managing high employee turnover is substantial in terms of recruitment, training and loss of organisational knowledge. With the overbearing acumination of the workforce issues listed above, it is easy to comprehend the time-limited nature of these roles. Significant organisational costs are incurred in the ongoing recruitment processes and orientation of new staff, not to mention the subsequent damages to clinical outcomes during this learning process. As a case manager at a public mental health service in Victoria, I was amazed to witness the revolving door of staff leading to chronic understaffing, continuous orientation and trainings for new team members, prior to their inevitable departure from the service after being overworked, burnt out and poorly paid – given the emotional weight, workload and stress associated with these roles.

I strongly recommend investigation into workforce turnover and staff retention, illuminating its impact on the sector's productivity and providing recommendations to address this issue.

3. Increased occupational therapy involvement in mental health care:

Occupational therapists provide evidence based and outcome oriented services to improve mental health and wellbeing, and to help a person access meaningful every functioning in life. Within mental health, occupational therapists are often employed in generic roles. Although well suited to these roles, the profession was under-represented in these transdisciplinary teams.

In December 2016, there were 4,627 occupational therapists with general registration in Victoria, while only 1,924 practiced in mental health settings. Drawing a greater occupational therapist workforce to the mental health sector is a feasible strategy to improve understaffing issues and the associated inefficient systemic productivity. However, attraction to the sector remains limited due to negligible understanding of potential for occupational therapists in mental health and poor recognition for the discipline (i.e. psychology saturated space due to rumination rates). This could be supported through increased mental health focus in a university curriculum, improved communication and recognition about existing evidence for interventions available to occupational therapists and other allied health staff (i.e. CBT, Substance use interventions, case management, family therapy, other forms of psychotherapy), more consistent opportunity for visible research projects and greater remuneration for these important clinical positions.

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