Brigalow Consulting

Trends in Australia's psychological services workforce: some implications for Better Access

Research report prepared for The Australian Counselling Association

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About this report

This research report was commissioned and funded by The Australian Counselling Association (ACA). The ACA provided broad direction for the research. At all times the author was able to exercise independent professional judgement, including on matters relating to analytical methodology, choice of data and interpretation of results.

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About Brigalow Consulting

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Contents

Summary

This research report concerns key demand and supply trends affecting Australia's psychological services workforce delivering treatments under Better Access, which we call psychological services. A key motivator for the research was to analyse the extent to which the main professional groups capable of providing these services could contribute immediately to reducing unmet demand. The underlying rationale was that a lack of appreciation about the psychological services workforce as a whole, beyond those eligible under Better Access, could be impeding consideration of the full gamut of potential workforce solutions.

The evidence presented indicates demand for providers of psychological services is set to remain strong in the short to medium term. Although use of psychological services has declined from the peak in 2020–21, it does not appear to have fallen below levels prevailing immediately before COVID-19 arrived in Australia. This pre-COVID period was characterised by significant unmet demand and service use which, at that time, was historically high. Moreover, per capita use of psychological services under Better Access had been trending up before COVID-19 arrived at an average rate of 4.7% a year over the 10 years to 2021–22. It is not clear what underlying factors might have since changed to reverse this trend.

The current strong demand for psychological services risks further entrenching unmet demand. Job advertisement rates for counsellors and psychologists continue to exceed those prior to the arrival of COVID-19 and 5-year employment growth projections by the National Skills Commission place counsellors and psychologists in the top quartile for all occupations. In rural and remote areas, commentators continue to point to a shortage of service providers.

Calls to address the workforce shortage by increasing the supply of university graduates may have little impact on unmet demand in the short to medium term. The lead times to educate and fully train allied health professionals to meet standards commensurate with MBS eligibility criteria are long, ranging from five years for counsellors and psychotherapists to eight years for clinical psychologists. Further, the likelihood that increased numbers of university graduates would immediately find employment delivering psychological services as independent allied health practitioners appears low.

The report identifies three implications likely to bear on the short- to medium-term effectiveness of Better Access. First, degree-qualified counsellors and psychotherapists constitute an underutilised part of the psychological services workforce. Given their qualifications, training and experience, they could play a more explicit role in a strategy to reduce unmet demand.

Second, the relative scarcity of psychological service providers outside capital cities is likely to be inhibiting access to Better Access. Extending MBS eligibility to appropriately qualified and trained counsellors and psychotherapists has the potential to significantly improve access to psychological services, especially outside capital cities.

Third, the limited choice in service offerings under Better Access may be discouraging some people from seeking support for their mental ill-health. Expanding the range of mental health professionals who are eligible to deliver psychological services would improve the likelihood of people finding a health provider who better matches their care preferences in terms of establishing a good rapport and making them feel safe and comfortable.

1 Introduction

1.1 Background

Australia's mental health sector is struggling to meet universal demand for psychological services. Although demand rose following the introduction of restrictive public health measures to mitigate the spread of COVID-19, issues of unmet demand have been evident for decades. In particular, many people living in rural, regional and remote areas have long suffered from poorer access to psychological services (Burdekin, 1993, vol 2, p. 936; ACIL Allen, 2021 p. 17; Senate Select Committee on Mental Health, 2006a, para. 6.82; 2006b, para. 3.75, reco. 84).

The standard reaction to this issue is to attribute unmet demand for psychological services to a shortage of psychologists. Current estimates using the National Mental Health Service Planning Framework[1] suggest a shortfall of some 7,787 FTE (ACIL Allen, 2021 p. 17). Accordingly, some commentators have canvassed policy reforms aimed at increasing the supply of psychologists. These include calls for additional university places and new funding for supervised placements (APS, 2022b; HODSPA, 2019).

However, there is scope and opportunity to approach this workforce challenge more strategically. Despite a heavy reliance on psychologists, other health professionals have appropriate qualifications, training and experience. For example, most counsellors and psychotherapists routinely provide psychological services in private settings outside the Medicare system (ACIL Allen, 2021 p. 14).

A lack of information about the psychological services workforce has hindered public discourse and impeded workforce planning (ACIL Allen, 2021 p. 21). For instance, it is unclear how decision makers could consider the full gamut of policy solutions without understanding how the existing workforce as a whole could help meet unmet demand.

The purpose of this report is to bridge this information gap by profiling the main health professions that currently deliver psychological services under Better Access,[2] or are capable of deliver them. As such, the focus is on independent practitioners, generally operating in private or group practices, who are likely to have the qualifications and training to deliver psychological services safely and effectively. The report then considers the extent to which each group could contribute to reducing unmet demand in the short to medium term.

1.2 Defining psychological services

Motivating this report was the problem of unmet demand for psychological treatment under Better Access. For this reason, this report uses the term 'psychological services' to mean Better Access services that deliver psychological treatment. These are short-term services aimed at

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1 The National Mental Health Service Planning Framework produces evidence-based targets for the provision of mental health services to meet the needs of people at a population level (University of Queensland, 2019 p. 10).

2 Better Access is the Australian Government's main program for delivering subsidised psychological services for common mental disorders. It is known formally as the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Scheme* initiative, notwithstanding that it involves other allied health professionals (Medicare Australia, 2007 p. 4).

improving mental health outcomes for people with common mental disorders[3] (such as anxiety and depression) and other mental health problems[4] (such as anger and loneliness).

Accordingly, our use of the term excludes Better Access services that are not explicitly therapeutic. These relate chiefly to preparing or reviewing mental health treatment plans. However, an exception is the inclusion of services provided by clinical psychologists that may also include psychological assessment. Although some researchers view assessments as inherently therapeutic (Hanson and Poston, 2011 p. 1056), in any case, data limitations precluded distinguishing treatment and assessment services in such instances.

Most psychological services delivered under Better Access are focussed psychological strategies (FPS). The following FPS are approved for delivery under Better Access:

- psycho-education, including motivational interviewing
- cognitive-behavioural therapy, including behavioural interventions (behaviour modification, exposure techniques, activity scheduling) and cognitive interventions (cognitive therapy)
- relaxation strategies (progressive muscle relaxation, controlled breathing)
- skills training (problem solving skills and training, anger management, social skills training, communication training, stress management, parent management training)
- interpersonal therapy (especially for depression)
- narrative therapy (for Aboriginal and Torres Strait Islander peoples)
- eye-movement desensitisation reprocessing. (DOHAC, 2022a)

Various mental health professionals provide FPS under Better Access under three categories of service offerings.

- 'Focussed psychological strategies' are provided by GPs, other medical practitioners and allied health providers, namely registered and clinical psychologists, occupational therapists and social workers.
- 'Psychological therapies' are provided by clinical psychologists.
- 'Mental health treatment consultations' are provided by GPs and other medical practitioners.

While the category 'focussed psychological strategies' is self-explanatory, in the case of clinical psychologists and GPs, the category name reflects a broader range of mental health service offerings beyond FPS alone. This includes mental health planning and psychological assessments, as mentioned earlier.

The Better Access services that are in scope (therapeutic) and out of scope (non-therapeutic) for the purposes of this report are listed in table 1.1 by their MBS item number.

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[3] A 'mental disorder' is a health problem that significantly affects how a person feels, thinks, behaves and interacts with others. It is diagnosed according to standardised criteria (Productivity Commission, 2020, vol 2, p. 89).

[4] The term 'mental health problem' refers to a combination of diminished emotional, cognitive, behavioural and social abilities, but not to the extent of meeting the criteria for a mental disorder. (Productivity Commission, 2020, vol 2, p. 89).

Table 1.1 **Better Access MBS item numbers: in scope and out of scope**

Provider	*In scope*	*Out of scope*
Psychiatrist		Initial consultation and/or preparation of a written management plan 291, 296, 297, 299, 92435, 92437, 92475, 92477 To review or revise a management plan 293, 92436, 92476
Medical Practitioner	To provide treatment: 279, 283, 285, 286, 287, 371, 372, 941, 942, 2713, 2721, 2723, 2725, 2727, 2729, 2731, 2733, 2735, 91818, 91819, 91820, 91821, 91842, 91843, 91844, 91845, 92115, 92121, 92127, 92133, 93287, 93288, 93291, 93292, 93300, 93301, 93302, 93303, 93304, 93305, 93306, 93307, 93308, 93309, 93310, 93311	To prepare mental health treatment plan or 3 step mental health process 272, 276, 281, 282, 2574, 2575, 2577, 2578, 2700, 2701, 2702, 2704, 2705, 2707, 2708, 2710, 2715, 2717, 92112, 92113, 92116, 92117, 92118, 92119, 92122, 92123, 92124, 92125, 92128, 92129, 92130, 92131, 92134, 92135, 93400, 93401, 93402, 93403, 93404, 93405, 93406, 93407, 93408, 93409, 93410, 93411, 93431, 93432, 93433, 93434, 93435, 93436, 93437, 93438, 93439, 93440, 93441, 93442 To review mental health treatment plan or 3 step mental health process 277, 2712, 2719, 92114, 92120, 92126, 92132, 93421, 93422, 93423, 93451, 93452, 93453
Clinical Psychologist	80000, 80001, 80005, 80010, 80011, 80015, 80020, 80021, 91166, 91167, 91181, 91182, 93312, 93313, 93330, 93331, 93332, 93333, 93334, 93335, 93375, 93376	
Psychologist	80100, 80101, 80105, 80110, 80111, 80115, 80120, 80121, 91169, 91170, 91183, 91184, 93316, 93319, 93350, 93351, 93352, 93353, 93354, 93355, 93381, 93382	
Occupational Therapist	80125, 80126, 80130, 80135, 80136, 80140, 80145, 80146, 91172, 91173, 91185, 91186, 93322, 93323, 93356, 93357, 93358, 93359, 93360, 93361, 93383, 93384	
Social Worker	80150, 80151, 80155, 80160, 80161, 80165, 80170, 80171, 91175, 91176, 91187, 91188, 93326, 93327, 93362, 93363, 93364, 93365, 93366, 93367, 93385, 93386	

Notes: This list of MBS item numbers under the Better Access initiative was current at 30 June 2022. It includes item numbers that have since ceased (for example, temporary phone MBS items to prepare a mental health treatment plan made available in response to the COVID-19 pandemic). Medical practitioners means GPs and other medical practitioners. Item numbers relating to non-directive pregnancy support counselling, chronic pain management and services that are part of Open Arms – Veterans & Families Counselling are out of scope because they are not part of the Better Access initiative.

Source: The Australian Government Department of Health and Aged Care supplied in numerical order a list of MBS item numbers under the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (MBS) initiative (Better Access) current at 30 June 2022 (D James 2022, personal communication, 13 October.

1.3 Defining the psychological services workforce

Given the definition of psychological services adopted in section 0, that is the types of treatment services available under Better Access, there are a number of ways the psychological services workforce could be defined.

- Defined narrowly, it could comprise existing MBS providers who deliver services under Better Access as independent practitioners. This includes a range of professions, predominately GPs and allied health providers (clinical psychologists, registered psychologists,[5] occupational therapists and social workers).
- Defined broadly, it could expand beyond Better Access to potentially encompass a wider range of mental health professionals, both employed and working independently in private practice, including counsellors, psychotherapists, registered mental health nurses, mental health support workers, peer support workers and psychiatrists. For example, some counsellors and psychotherapists in private practice deliver psychological services on behalf of private insurers and government insurance agencies (Bupa, 2019; Medibank, 2022b; SIRA, 2022).

For the purposes of this research, the psychological services workforce is defined as allied mental health professionals who are eligible to deliver psychological services approved under Better Access plus non-MBS providers who are comparably qualified and placed professionally to deliver such services, were that opportunity to arise. For non-MBS providers, being comparably qualified means having at least a bachelor, bachelor honours or master degree in a discipline relevant to the delivery of such services. Comparably placed means working as an independent practitioner in the allied health sector. According to this definition, the main professions were deemed to be:

- counsellors
- GPs (working in the allied health sector)
- occupational therapists
- psychologists (clinical and registered)
- psychotherapists
- social workers.

Not all providers who identify with these professions necessarily provide psychological services. For example, of the more than 11,000 social workers throughout Australia who are represented by the Australian Association of Social Workers, about a fifth (more than 2,200) are accredited Mental Health Social Workers (AASW, 2020b p. 2). Many medical practitioners who prepare mental health treatment plans choose to refer their patients to allied health providers rather than delivering the psychological services themselves. Nevertheless, in considering policy options to address unmet demand for psychological services, the potential range of service providers is broader than those currently operating under Better Access.

[5] All psychologists are registered with the Psychology Board of Australia (PsyBA). However, the profession uses the term 'registered psychologist' when referring to those who hold a general registration and 'clinical psychologist' when referring to those who hold a general registration with a clinical practice endorsement (one of nine areas of practice endorsement created by the PsyBA).

2 Demand for psychological services and for service providers

Key points

- The prevalence of psychological distress that warrants support was historically high just before COVID-19 arrived in Australia in January 2020 and may still be at a similar level in late 2022.
- Demand for providers of psychological services is set to remain strong in the short to medium term.
  - Per capita use of psychological services under Better Access had been trending up before COVID-19 arrived at an average rate of 4.7% a year over the 10 years to 2021–22. It is not clear what factors might have since changed to reverse this trend.
  - Although use of psychological services has declined from the peak in 2020–21, it does not appear to have fallen below levels prevailing immediately before COVID-19 arrived. At that time, per capita service use was historically high and there was significant unmet demand.
  - Job advertisement rates for counsellors and psychologists continue to exceed those prior to the arrival of COVID-19.
  - 5-year employment growth projections by the National Skills Commission place counsellors and psychologists in the top quartile for all occupations.

This chapter analyses key trends shaping the demand for psychological service providers as defined in section 1.3. It first discusses the link between the demand for psychological services and the demand for service providers. It then analyses trends in the demand for psychological services and considers evidence of unmet need. The chapter concludes by considering indicators of demand for service providers in the short term (trends in job advertisements) and in the medium term (modelled projections of employment growth prospects).

2.1 Demand for services drives demand for providers

Understanding trends in the demand for psychological services is useful for making judgements about the likely demand for service providers and developing workforce plans to ensure adequate supply. As a general proposition, the demand for psychological services drives the demand for service providers. Although government policies and regulations and other labour market forces will influence the pace and extent to which the psychological services labour force responds to changes in demand, we would nevertheless expect to observe some increase in the demand for service providers in response to a sustained increase in the demand for treatment.

Numerous factors can affect the demand for psychological treatment. For individual consumers, factors that can lead to psychological distress include loneliness, job dissatisfaction, traumatic experiences, health issues and interpersonal conflict, especially within families. At a population level, wide-spread crises such as bushfires, pandemics, floods and deteriorating economic conditions heighten psychological distress and increase demand for services.

Other factors affect the extent to which people choose to seek support for mental ill-health. They include self-assessed need, willingness to seek treatment, income, co-payments, prices of alternative therapies (including damaging self-help 'therapies', such as alcohol and illicit drugs), costs to access professional services (travel costs, waiting time, forgone income), preferences over delivery modes and preferences over service offerings available from different mental health professionals. Some of these may also determine whether individuals take steps to obtain the requisite mental health treatment plan in order to receive treatment under Better Access.

Despite an individual's assessed need for treatment and their willingness to receive it, a range of factors may limit the labour force supply response. As with other health services, governments intervene in these markets seeking to balance a mix of policy objectives relating to universal health care, consumer safety and budget allocations. In the case of Better Access, caps on some MBS items limit the number of subsidised services that individuals may receive annually while policy settings over the provision of tertiary education affect the supply of graduates.

2.2 Demand for psychological services

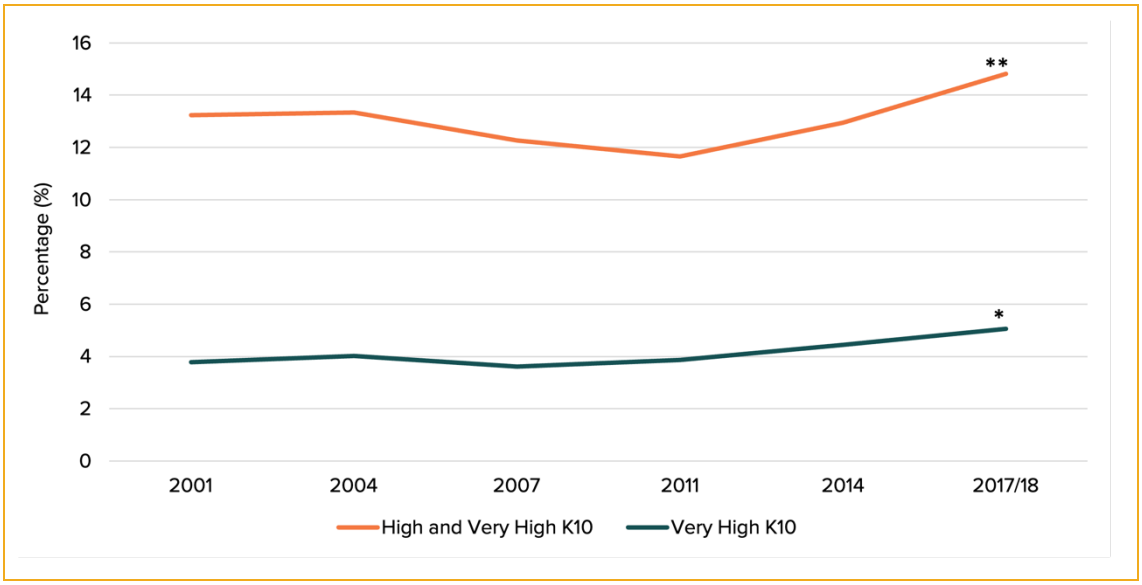
Trends in psychological distress

The prevalence of psychological distress that warrants mental health support was historically high just before COVID-19 arrived in Australia in January 2020 and may still be at a similar level in late 2022. Prior to COVID-19, the prevalence of 'very-high' psychological distress and the combined prevalence of 'high/very-high' psychological distress among Australia's working age population increased significantly over the decade and a half between 2001 and 2017/18 (Enticott et al., 2022 p. 5, reproduced in figure 2.1). Very-high K10 scores are associated with mental health problems meeting diagnostic thresholds in the past year and high/very high scores are indicative of psychological distress (Enticott et al., 2022 pp. 1–2).

Since COVID-19 arrived, the prevalence of psychological distress in Australia has increased due to the pandemic itself and government measures introduced to mitigate its spread (AIHW, 2022a p. 2). The prevalence of severe psychological distress peaked about October 2021 (Biddle et al., 2022 p. 12, reproduced in figure 2.2), but has since trended down. However, there remained more Australians with high levels of psychological distress in August 2022 than in October 2019 (Biddle et al., 2022 p. 25). It is not known whether psychological distress has returned to pre-pandemic levels.

Taken together, the trends evident in figures 2.1 and 2.2 suggest that the prevalence of psychological distress may still be at the historically high levels that prevailed before the arrival of COVID-19. Although the data underpinning the figures differs in terms of Kessler scores (K6 vs K10) and sample populations (working age adults vs all adults), the consistency of the respective methodologies and the slight overlap in time series gives some confidence to this conclusion. In addition, the recent decline in the prevalence of psychological distress is from an unprecedented stressor in the COVID-19 pandemic. There is no apparent reason to believe that the factors driving the overall trend prior to COVID-19 have been addressed.

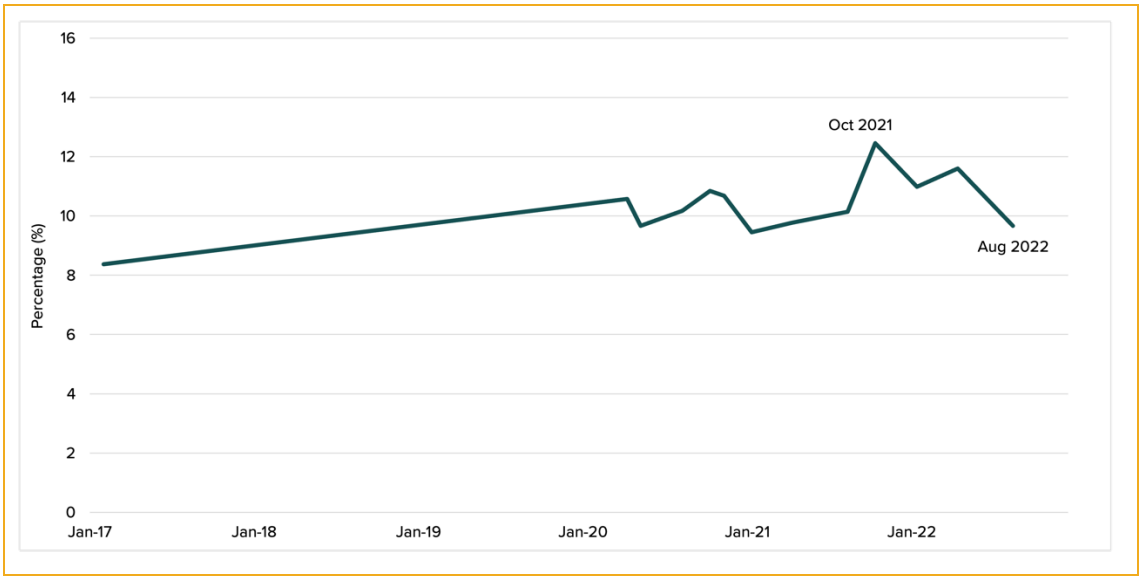
Figure 2.1 **Prevalence of psychological distress (K10) in Australia's working age population, 2001 to 2017/18**



Notes: K10 (Kessler Psychological Distress Scale) age standardized to the 2001 Australian Census. Derived from 78,204 survey participants aged 18–64 years. ** The prevalence in 2017/18 was significantly greater than all previous years ($p < 0.001$). * The prevalence in 2017/18 was significantly greater than 2001, 2004, 2007 and 2011 ($p < 0.01$). Methodology explained in (Enticott et al., 2022).

Source: Figure reproduced from Enticott et al. (2022 p. 5).

Figure 2.2 **Per cent of adult Australians with severe psychological distress (K6), February 2017 to August 2022**



Notes: The K6 (Kessler Psychological Distress Scale) survey data for Australians aged 18 years and over was collected through the Australian National University's COVID-19 Impact Monitoring Surveys.

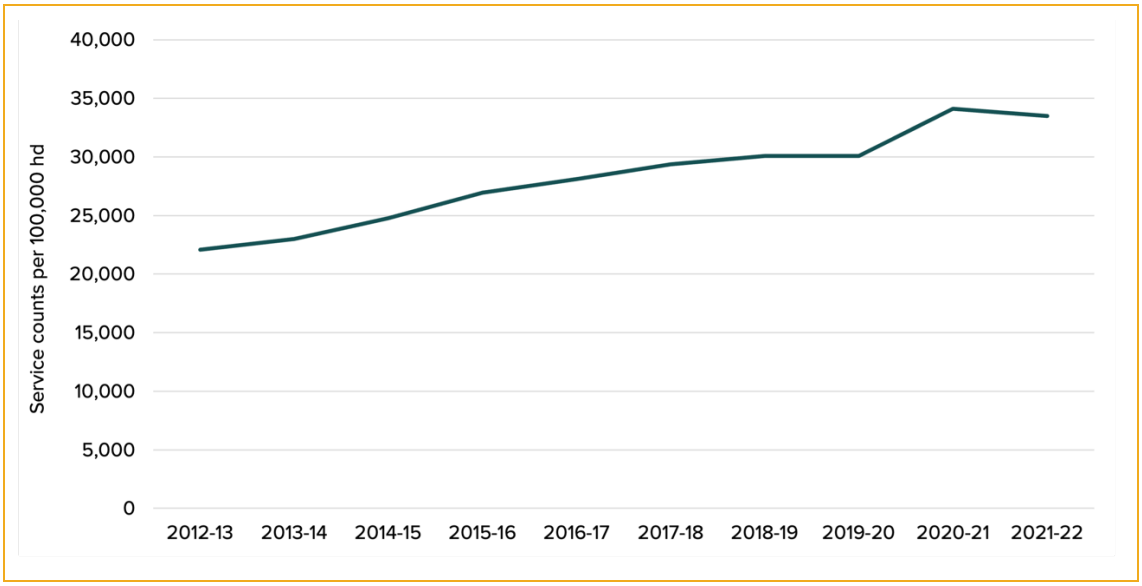
Source: Adapted from Biddle et al. (2022 p. 12).

Use of psychological services

Use of psychological services[6] across Australia has grown steadily over the past decade (figure 2.3). After adjusting for the effects of population growth, growth in service use averaged 4.7% a year over the 10 years to 2021–22.

Peak use occurred in 2020–21, a year in which Australia's COVID-19 case fatality rate peaked (John Hopkins University, 2022) and governments imposed strict quarantine measures and restrictions on people movements.

Figure 2.3 **Use of psychological services under Better Access per 100,000 head of population, 2012-13 to 2021-22**



Notes: The MBS item numbers for psychological services used to compile this figure are listed in table 1.1. They relate to the provision of treatment and not the preparation of mental health treatment plans.

Data source: Services Australia, *Medicare Statistics: Medicare Item Reports*, www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp.

Looking ahead, evidence suggests the use of psychological services per head of population is yet to fall below the historically high levels that prevailed before COVID-19.

First, the prevalence of psychological distress among adult Australians may not have fallen below pre-COVID levels (figure 2.2).

Second, even if it had, growth in the use of psychological services pre-COVID (5.5% a year from 2012–13 to 2018–19) exceeded the 10-year trend (4.7% a year from 2012–13 to 2021–22) (figure 2.3). It is not clear what, if any, endemic factors may have changed over the pandemic period to reverse the upward trend in service use. Were these factors to persist after the effects of COVID-19 have diminished, use of psychological services could potentially remain at relatively high levels.

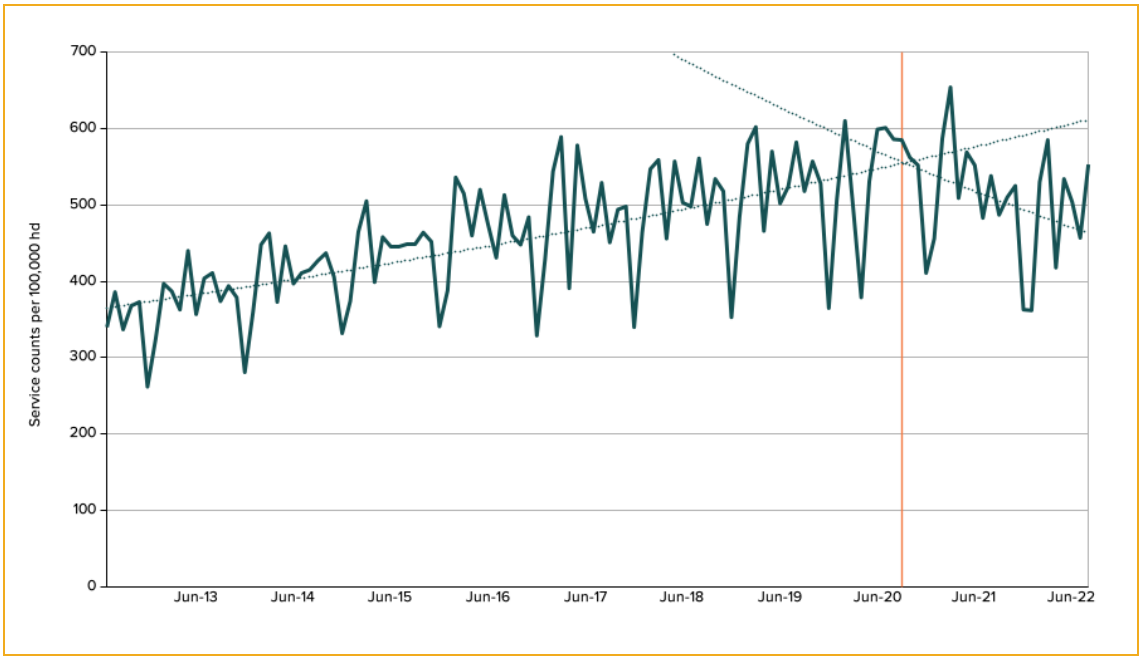
[6] Psychological services means treatment services under Better Access, but excludes services for preparing and reviewing mental health treatment plans or 3-step mental health processes (table 1.1).

Growth in mental health treatment plans

A leading (future) indicator of the use of psychological services is the rate at which mental health treatment and management plans are being prepared. Under Better Access, people require such a plan before accessing subsidised psychological services which are generally delivered over multiple sessions. Since 2006, plans have allowed eligible people to receive MBS rebates for up to 10 individual and up to 10 group sessions each year. Consumers can access additional sessions each year, but those sessions do not attract a rebate. In October 2020, the Australian Government Department of Health (2022) temporarily raised the cap on the number of individual subsidised sessions to 20 in response to the COVID-19 pandemic – a measure which expired in December 2022 (DOHAC, 2022b).

A trend decline in the seasonally adjusted rate of preparation of mental health plans since September 2020 suggests that the use of psychological services could continue to decline in the short run, all other things being equal (figure 2.4). This point coincides with a statistically significant 'break' in the monthly time series data. Up until then, the number of plans per head of population had been growing at an average rate of 5.25% a year. Since then, the rate has declined at about 9.18% a year from September 2020 to August 2022. This finding is consistent with the pattern evident in the use of psychological services between 2020–21 and 2021–22 (figure 2.3).

Figure 2.4 **Rate of preparation of mental health treatment/management plans under Better Access per 100,000 head of population, Jul 2012 to Aug 2022**



Notes: Includes mental health treatment plans prepared by GPs and management plans prepared by psychiatrists. Excludes plans prepared by paediatricians. Appendix B explains the methodology.

Data source: Services Australia, MBS Item Statistics Reports *Medicare Statistics: Medicare Item Reports*, www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp.

Evidence of unmet need

There is a growing body of evidence pointing to unmet need for psychological services across Australia, which includes empirical surveys of citizens and service providers.

- A survey of more than 11,000 adults in April 2022 indicated that a significant proportion (nearly 5%) had been waiting to access mental health support which they had sought during the past six months (Healthengine and Australian Patients Association, 2022 p. 19). Of these, 72% had been waiting more than two months and 59% more than three months.[7]
- A survey of members by the Australian Psychological Society[8] in February 2022 found that 64% of respondents who were able to accept more clients reported worsening wait times, which averaged nearly two months (55 days). Waitlists were significantly more prevalent among psychologists in regional areas (79.2%) compared with those in metropolitan areas (73.5%) (APS, 2022c pp. 4–5).

The recently released Evaluation of Better Access (Pirkis et al., 2022 p. 104) found that indicators of access and wait times had worsened over time for people on low incomes. It concluded that:

> People on low incomes are least likely to use Better Access services, despite having relatively greater levels of need than their high-income counterparts. Those people on low incomes who do use Better Access treatment services typically wait longer than people on high incomes to see a provider once they have a mental health treatment plan. (Pirkis et al., 2022 p. 105)

Unmet need also arises where service offerings do not meet the needs and preferences of consumers. For example, some people may prefer face-to-face therapy, but choose telehealth because it is the only mode available where they live. In other cases where psychological services are available, they may not be able to afford the co-payment. Still others may be unable to locate a service provider with whom they are able to build an effective therapeutic alliance,[9] which significantly affects outcomes (Flückiger et al., 2018 p. 316).

Consumer choice is crucial to the effectiveness of mental health care. People are more likely to seek help if they can consult practitioners with whom they feel comfortable and trust. For example, a survey of adults in northern NSW/southern Queensland (n=226) found that on average, perceptions about ability to communicate with counsellors exceeded that of psychologists, social workers and psychiatrists (Sharpley et al., 2004 p. 104).

Instances of unmet need arise where consumers stop a sequence of treatment sessions before they receive the full benefit, whether that be recovery or prevention of further deterioration. The Productivity Commission (2020, vol 2, pp. 564-565) found this may be because consumers feel:

- attending therapy imposes too great a burden in terms of co-payments, time required (travel, waiting, therapy), transport costs and possibly lost income
- they are not benefiting from the therapy
- establishing the necessary therapeutic rapport with a therapist is not possible. This was a contributing cause for 30% of Better Access consumers who ceased care early (Pirkis et al., 2022 p. 141).

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7 The results were estimated from respondents (n=11,562) who voluntarily participated in an online survey about Australia's health system. The sample was weighted to be nationally representative. (Healthengine and Australian Patients Association, 2022 p. 4)

8 About 5% (n=1456) of APS members completed the survey.

9 The term 'alliance' refers to the holistic collaborative aspects of the client–therapist relationship (Flückiger et al., 2018 p. 317).

2.3 Demand for service providers

Recent comments by industry leaders point to a sustained demand for service providers in the medium term.

- A survey of members by the Australian Psychological Society in February 2022 found that 1 in 3 psychologists were unable to see new clients, up from 1 in 100 prior to the pandemic.[10]
- 'The effects of the pandemic on the mental health of our nation will continue for years to come.' (Dr Zena Burgess, CEO, Australian Psychological Society, as reported by Seyfort, 2022).
- The CEO of The Talk Shop, reportedly Victoria's largest private psychology practice offering bulk-billed appointments, was quoted as saying, 'We have a shortage of registered psychologists in Victoria and the current high demand is unlikely to diminish anytime soon' (Seyfort, 2022).

A variety of empirical data supports industry views about the demand for providers of psychological services remaining strong in the medium term, including trends in job advertisements and empirical modelling of employment prospects.

Trends in job advertisements

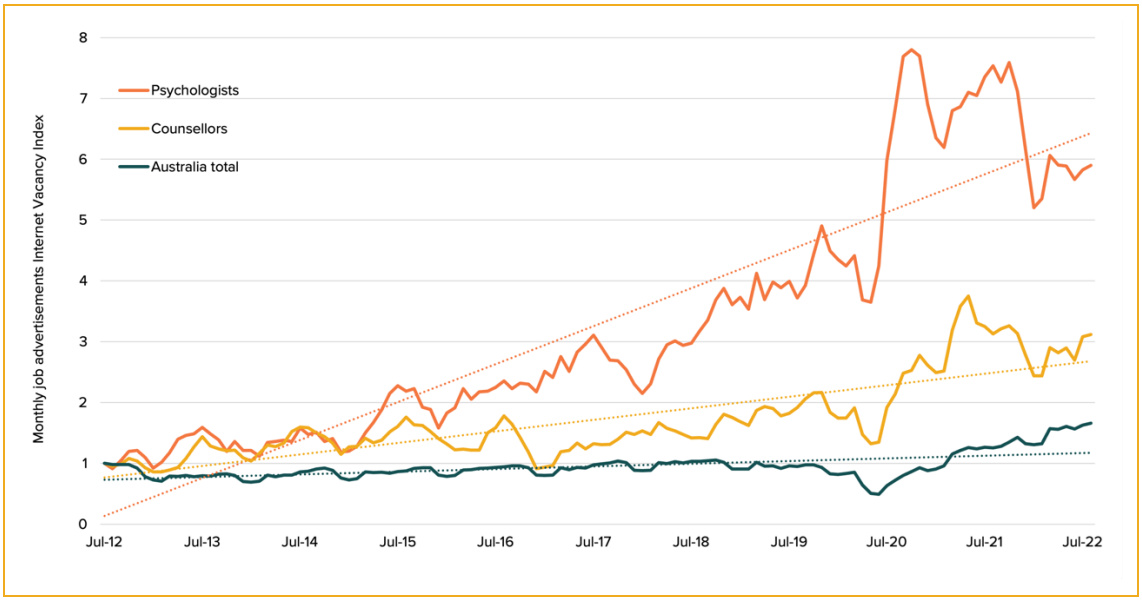
A useful indicator of the expected future demand for service providers is job advertisements. Although decisions to advertise may precede recruitment by only several months or so, they nevertheless reflect employers' longer-term views about demand insofar as recruitment is a form of investment – an upfront cost to secure future revenue streams. Such longer-term views are warranted as the full costs of a recruitment event can be substantial, including costs associated with advertising, recruiting, onboarding and training. There can also be substantial costs involved in trying to break an employment contract.

A national indicator of job advertisements is the monthly Internet Vacancy Index (IVI) produced by the National Skills Commission. The IVI is based on counts of job advertisement newly lodged online by SEEK, CareerOne and Australian JobSearch (NSC, 2022b p. 22). Although the IVI does not include job vacancies advertised in other online forums (such as other online job boards and employer websites) and in newspapers, it is the only national data source that provides consistent monthly time series data by occupation.

Future demand for providers of psychological services appears set to remain historically high based on current trends in job advertisements. Online recruitment activity for counsellors and psychologists, as captured by the IVI, has increased significantly over the past 10 years (figure 2.5). Relative to trend growth for all occupations in Australia, jobs growth as measured by the IVI has been 2.5 times higher for counsellors and 5 times higher for psychologists.

[10] About 5% (n=1456) of APS members completed the survey.

Figure 2.5 **Internet vacancy index for counsellors and psychologists, 3-month moving average, Jul 2012 – Aug 2022**



Notes: For ANZSCO (Australian and New Zealand Standard Classification of Occupations) 4-digit occupation codes 2721 (counsellors) and 2723 (psychologists), as described in appendix A. Coding errors can have large impacts for particular occupations and the degree to which occupations advertise online can vary greatly. Not all positions advertised would necessarily relate to the delivery of psychological services under Better Access.

Data source: National Skills Commission *Internet Vacancy Index*, IVI DATA Detailed Occupation March 2006 Onwards, Labour Market Insights, https://labourmarketinsights.gov.au/our-research/internet-vacancy-index/ (accessed on 5 October 2022).

Employment growth prospects

The growth prospects for the psychological services workforce over the medium term are expected to remain relatively high. Based on its research and modelling, the National Skills Commission has concluded that relative to a majority of other occupations:

- counselling and psychology[11] are resilient occupations (box 2.1), meaning they are among those likely to have strong growth prospects as the economy recovers from the initial impact of the COVID-19 pandemic (NSC, 2022b p. 35)
- counselling[12] is among the top 20 resilient occupations (box 2.1), placing them among occupations likely to have the strongest growth prospects as the economy recovers from the initial impact of the COVID-19 pandemic (NSC, 2022b p. 31)
- employment growth projections for counsellors (14.2%) and psychologists (13.3%) over the five years to November 2026 are in the top quartile for all occupations (NSC, 2022a).

[11] Strictly speaking, the ANZSCO (Australian and New Zealand Standard Classification of Occupations) defines these occupations as 'counsellors' and 'psychologists' (ABS & SNZ, 2006a).

[12] See footnote 11.

Box 2.1 **Occupational resilience**

Occupational resilience can be defined as the employment growth prospects for occupations relative to each other following an economic shock. In volatile labour markets, the concept is used as an analytical framework to help understand the employment dynamics of individual occupations relative to some or all other occupations in an economy.

To help understand the nature of jobs recovery after the COVID-19 pandemic, the National Skills Commission (2022b pp. 25–26) estimated occupational resilience for 358 occupations at the Australian and New Zealand Standard Classification of Occupations (ANZSCO) 4-digit level by combining data on employment growth expectations before COVID-19 with data relating to the employment experience of occupations during the pandemic and early indications of recovery. Each occupation was given a resilience score between 3 and 15, with a score of 11 or more signifying a *resilient occupation*.

The National Skills Commission (2022b p. 35) found that counsellors, with a score of 14, and psychologists, with a score of 12, were resilient occupations. It placed counsellors among the top 20 resilient occupations (NSC, 2022b p. 31), meaning that counsellors were likely to be among those occupations with the strongest growth prospects as the economy recovers from the initial impact of the COVID-19 pandemic.

3 Profile of the psychological services workforce

Key points

- In 2021–22, most (94%) psychological services under Better Access were provided by psychologists and GPs.
- In 2021, psychologists, counsellors and psychotherapists comprised the bulk (96%) of the broader psychological services workforce.
  - This workforce was defined as degree-qualified mental health professionals working as independent practitioners in the allied health sector.
  - The proportion of this workforce outside greater capital city statistical areas (25%) was less than the proportion of the Australian population residing in these areas (33%).
  - The rate of growth per head of population outside greater capital city statistical areas was highest among counsellors (71%), followed by psychologists and social workers (both 54%).

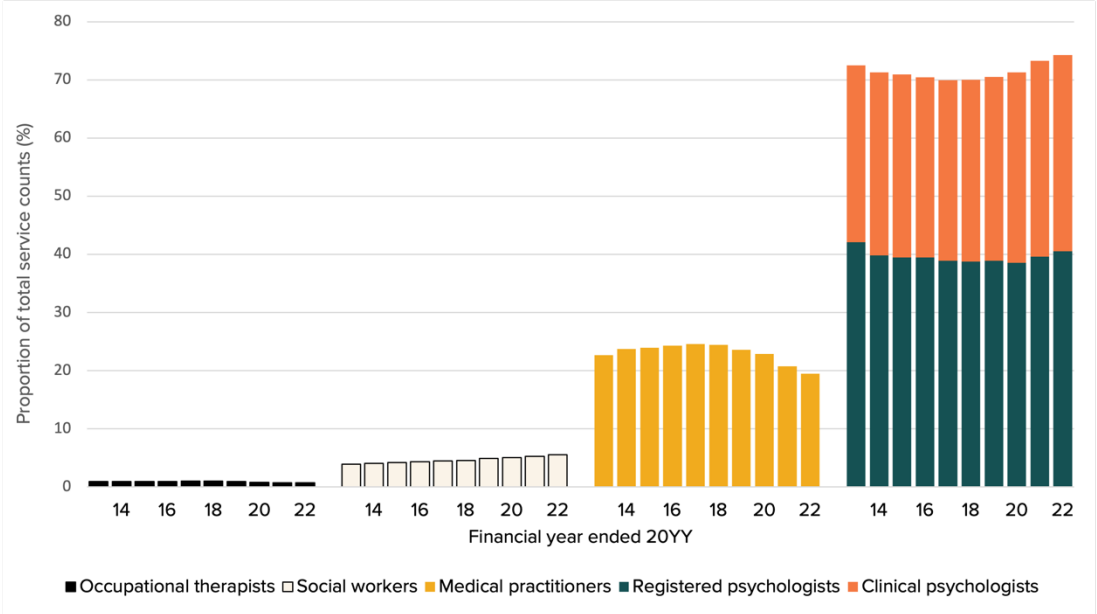
This chapter profiles the psychological services workforce, analysing its professional composition, geographical distribution and age structure. It focuses on the main allied health practitioners who provide most psychological services: psychologists (clinical and registered), counsellors and psychotherapists, and social workers.

Section 3.1 profiles the Better Access workforce while section 3.2 profiles the broader psychological services workforce in the allied health sector.

3.1 Better Access workforce

In 2021–22, psychologists provided the majority (74.3%) of psychological services under Better Access, followed by medical practitioners (19.4%) and social workers (5.6%) (figure 3.1). Over recent years, the provision of services has become more concentrated in the psychology profession. Since 2017–18, a significant share of total treatment sessions has shifted from medical practitioners (down 5.0%) and occupational therapists (down 0.3%) to psychologists (up 4.3%) and social workers (up 1.0%) (figure 3.1).

Figure 3.1 **Share of psychological services delivered under Better Access by type of service provider, 2012–13 to 2021–22**



Notes: The Better Access MBS item numbers deemed 'in scope' for this analysis are listed in table 1.1. Medical practitioners includes GPs and other medical practitioners.

Source: Services Australia, *Medicare Statistics: Medicare Item Reports*, www.medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp.

3.2 Broader psychological services workforce

This report defines the broader psychological services workforce as degree-qualified providers of psychological services working as independent practitioners in the allied health sector. They could be providing these services under Better Access or as private providers outside of Medicare (section 1.3). The main professions are counsellors (including psychotherapists), GPs (working in the allied health sector), occupational therapists, psychologists (clinical and registered) and social workers.

This section does not profile the contribution made by occupational therapists as it is not possible to use census data to confidently identify those delivering mental health treatments. Including all occupational therapists working in allied health would distort assessments about their scope to further contribute to reducing unmet demand. To illustrate the potential for distortion: although a relatively large number of occupational therapists work in allied health (about six times the number of social workers in 2021), Medicare data indicate they provided about eight times fewer services than social workers in 2021–22. The decision to forgo analysing occupational therapists was made easier by the fact that their share of Better Access treatment sessions is small (0.7%) and declining (figure 3.1).

Questions about the size and professional composition of the broader psychological services workforce can be addressed by examining applicable census data.

About 13,830 psychologists, counsellors (including psychotherapists), social workers and GPs who hold a bachelor, master or doctoral degree worked in allied health in 2021 (table 3.1). About 75% were psychologists, 22% counsellors and psychotherapists, 3% social workers and 1% GPs.

Table 3.1 **Number of degree-qualified psychologists, counsellors, social workers and GPs working as independent practitioners in allied health by place of work, 2021**

	Place of work						
Occupation	*Capital cities*		*Rest of Australia*		*Total*		*Proportion of total*
	No.	%	No.	%	No.	%	%
Psychologists	7,670	75	2,550	25	10,220	100	74
Counsellor and Psychotherapists	2,270	75	740	25	3,010	100	22
Social Workers	300	67	150	33	450	100	3
General Practitioners (in allied health)	80	53	70	47	150	100	1
Total	**10,320**	**75**	**3,510**	**25**	**13,830**	**100**	**100**

Notes: Psychologist means Australian and New Zealand Standard Classification of Occupations (ANZSCO) unit group 2723; counsellor means unit group 2721; social worker means unit group 2725; and General Practitioner means unit group 2531. Psychotherapists (ANZSCO occupation 272314) were deducted from psychologists and added to counsellors to reflect professional eligibility under Better Access. Allied health means Australian and New Zealand Standard Industrial Classification industry class 8539 'Other Allied Health Services'. Degree-qualified means holding a bachelor, master or doctoral degree under the Australian Standard Classification of Education narrow level of education codes 31, 12 and 11 respectively. The ABS has made small random adjustments to avoid the release of confidential data. Cell counts have been rounded to the nearest '10' to reflect this.

Source: Australian Bureau of Statistics, *Occupation (OCCP) by Non-School Qualification (QALLP) by Industry of Employment (INDP) by Greater Capital City Statistical Areas Place of Work (GCCSA POW)* [Census TableBuilder Basic, 2021 Census of Population and Housing – Employment, Income and Education], accessed 6 January 2023.

Most of these service providers were likely to have been providing psychological services because they met multiple selection criteria closely aligned with those services (there being no data field specific to the provision of psychological services). While a single criterion may offer some confidence in some instances, that likelihood increases with the number of independent selection criteria. All of these providers met criteria relating to industry, occupation and qualification.

- Working in the 'Other Allied Health Services' industry class meant they were mainly engaged in providing health care and treatment services (appendix A).
- The occupations of counsellor, psychologist or social worker working in allied health is consistent with the provision of health care and treatment services relating to mental health given the likely nature of their mental health training (section 4.1). It is difficult to envisage other types of health care and treatment services these occupations could deliver beyond mental health related services.
- Holding a bachelor, master or doctoral degree constitutes a professional eligibility criterion under Better Access (section 4.1). It helps to distinguish those in the census data who are likely to be capable of providing psychological services to a quality standard commensurate with eligible service providers. This is particularly useful in the case of counsellors and social workers, where anyone can adopt these appellations. In 2021, the proportion of service providers in allied health who held a bachelor or postgraduate degree was: psychologists (90%), counsellors and psychotherapists (76%), and social workers (80%) (table 3.2).

Table 3.2 **Proportion of psychologists, counsellors and psychotherapists, and social workers in allied health whose highest non-school qualification is a bachelor degree or postgraduate degree, 2021**

Highest non-school qualification	*Psychologists*	*Counsellors and Psychotherapists*	*Social Workers*
	%	%	%
No degree	10	24	19
Degree	90	76	80
bachelor	18	35	46
postgraduate	72	41	33
Total	100	100	99

Notes: Psychologist means Australian and New Zealand Standard Classification of Occupations (ANZSCO) unit group 2723; counsellor means unit group 2721; social worker means unit group 2725. Psychotherapists (ANZSCO occupation 272314) were deducted from psychologists and added to counsellors to reflect professional eligibility under Better Access. Allied health means Australian and New Zealand Standard Industrial Classification industry class 8539 'Other Allied Health Services'. Highest qualification was obtained using the ABS Census variable QALLP – describes the level of a person's highest completed non-school qualification (ABS, 2021b). Degree-qualified means holding a bachelor, master or doctoral degree under the Australian Standard Classification of Education narrow level of education codes 31, 12 and 11 respectively. Excludes those whose QALLP was coded as not applicable, not stated or inadequately described, which was less than 5% for all occupations. No degree means certificate, advanced or graduate diploma. Column totals do not equal 100% as the ABS has made small random adjustments to avoid the release of confidential data.

Source: Australian Bureau of Statistics, *Occupation (OCCP) by Non-School Qualification (QALLP) by Industry of Employment (INDP) by Greater Capital City Statistical Areas Place of Work (GCCSA POW)* [Census TableBuilder Basic, 2021 Census of Population and Housing – Employment, Income and Education], accessed 27 January 2023.

Geographical distribution

There is a significant imbalance between where the psychological services workforce is physically located and where Australians usually reside. In 2021, three-quarters (75%) of the psychological services workforce worked in greater capital city statistical areas ('capital cities') and a quarter (25%) worked outside these areas (table 3.1). In comparison, the proportion of the Australian population who usually resided in capital cities was 67%, while 33% resided outside these areas.

The psychological services workforce in the allied health sector has grown substantially more than the Australian population in recent years, especially outside capital cities. Between 2016 and 2021, the number (per head of population) of allied health practitioners (psychologists,[13] counsellors and social workers) who held a bachelor, master or doctoral degree, and who worked in the allied health sector grew 42% in capital cities and 55% outside these areas (figure 3.2).

[13] In this instance, psychologists includes psychotherapists while counsellors does not. See notes to figure 3.2.

Figure 3.2 **Growth in the population-adjusted number of psychologists, counsellors and social workers with a bachelor, master or doctoral degree working in the allied health sector by place of work, 2016 to 2021**

Notes: Psychologist means Australian and New Zealand Standard Classification of Occupations (ANZSCO) unit group 2723; counsellor means unit group 2721; and social worker means unit group 2725. Psychologists includes psychotherapists while counsellors does not as TableBuilder Basic could not identify psychotherapists within 2016 census data. The allied health sector means Australian and New Zealand Standard Industrial Classification (ANZSIC) industry class 8539 'Other Allied Health Services'. Bachelor, master and doctoral degree means Australian Standard Classification of Education narrow level of education codes 31, 12 and 11 respectively. The ABS has made small random adjustments to avoid the release of confidential data.

Source: Australian Bureau of Statistics, *Occupation (OCCP) by Non-School Qualification (QALLP) by Industry of Employment (INDP) by Greater Capital City Statistical Areas Place of Work (GCCSA POW), Greater Capital City Statistical Areas Usual Residence (GCCSA UR)* [Census TableBuilder Basic, 2016 and 2021 Census of Population and Housing – Employment, Income and Education], accessed 9 January 2023.

Outside capital cities, growth in the number of counsellors (excluding psychotherapists)[14] per head of population between 2016 and 2021 was 71%, significantly exceeded that of psychologists (including psychotherapists) and social workers, both 54% (figure 3.2).

Age structure

Monitoring changes in the age structure of the labour force[15] is important for detecting emerging skill shortages due to population ageing. This is especially true for the psychological services sector, which is already experiencing a skill shortage (section 1.1). Industry sectors most likely to be affected by population ageing are those with a 'high proportion of workers who are aged 45

[14] Psychologists includes psychotherapists while counsellors does not. See notes to figure 3.2.

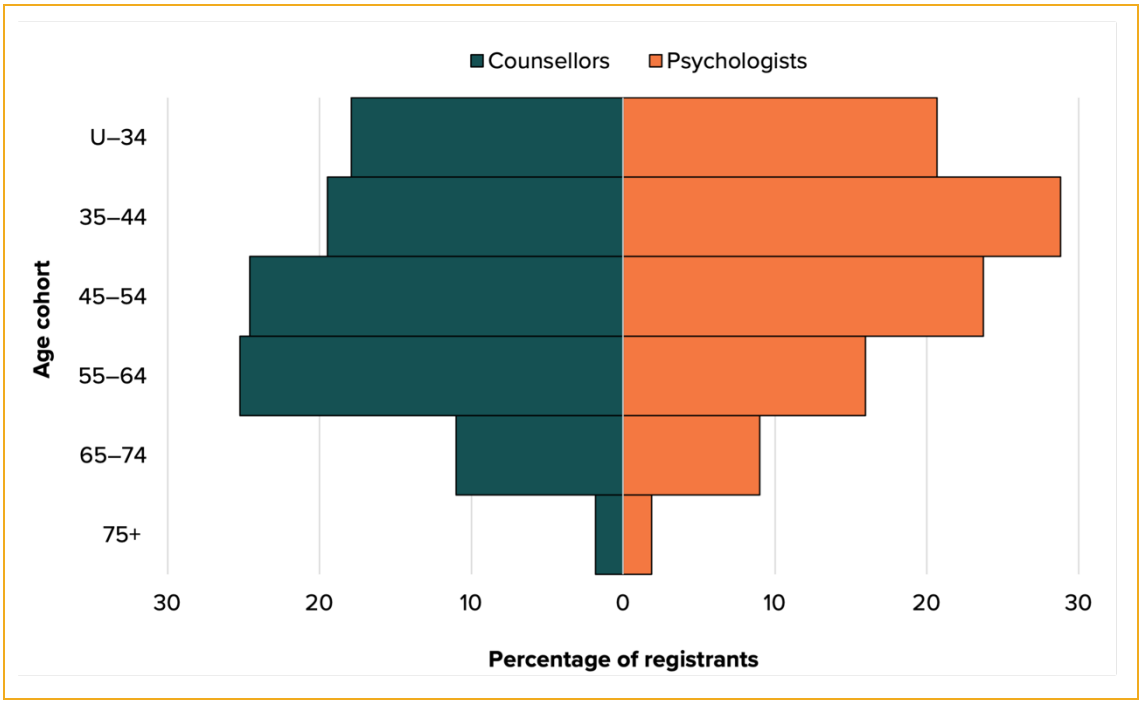
[15] The labour force comprises persons who are employed and those who are unemployed but actively looking and immediately available for employment (ABS, 2018 p. 5). The workforce can be defined as that part of the labour force in employment.

years and over, and have recorded large increases in mature-age workers[16] in recent years' (DEWR, 2005 p. 11).

Proportion aged 45 years and over

The proportion of the labour force[17] aged 45 years and over is higher for the psychological services labour force than for Australia's labour force as a whole. In 2021, 40.1% of Australia's labour force was aged 45 years and over; this proportion being lower (34.5%) for those holding a bachelor or postgraduate degree.[18] In contrast, about 62.2% of counsellors and 50.5% of psychologists with general registrations were aged 45 years and over in 2022 (figure 3.3). The higher proportion of counsellors aged 45 years and over compared with psychologists reflected a flatter age structure and less attrition among older cohorts (figure 3.3).

Figure 3.3 **Age distribution of counsellors and psychologists, 2022**



Notes: Counsellors who were Level 3 or Level 4 members of the Australian Counselling Association as at 12 September 2022. They typically had a bachelor or master degree in counselling. Psychologists who had general registrations, including non-practising registrants (but excluding those with provisional registrations) for the reporting period 1 April 2022 to 30 June 2022.

Sources: The Australian Counselling Association (per comm 9 December 2022); (PsyBA, 2022, table 5.1, p. 10)

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16 The Department of Employment and Workplace Relations (2005 p. 8) defined mature-age persons as those aged 45 years and over.

17 The labour force is defined here as including people employed (full-time or part-time), away from work or unemployed but looking for work (full-time or part-time).

18 Median ages calculated using ABS, *Labour Force Status (LFSP) and 1-digit level HEAP Level of Highest Educational Attainment by Age in Five Year Groups (AGE5P)* [Census TableBuilder Basic, 2021 Census of Population and Housing – Employment, Income and Education], accessed 13 December 2022.

Changes in the proportion of mature-age workers

The age structure of Australia's workforce of psychologists is relatively static and does not appear to be ageing. An ageing workforce has been raised as an issue among psychologists (Crowe, 2012 p. 35), as it has for the health workforce more broadly (Treasury, 2004; DEWR, 2005). However, over the decade to 2022, the proportion of practising psychologists with general registration aged 45 years and over has remained relatively constant at about 50.5% (figure 3.4).

Figure 3.4 **Proportion of practising psychologists with general registration by major age cohorts, 2013–2022**

Source: Estimates based on June quarter registration statistics for practising psychologists with general registration published by the Psychology Board of Australia from 2013 to 2022, available at https://www.psychologyboard.gov.au/About/Statistics.aspx.

Conclusions

There is little evidence to suggest that population ageing is affecting the psychological services workforce. Although the proportion of psychologists aged 45 years and over is relatively high, it has not increased significantly in the past decade. Insofar as psychologists comprise about three-quarters of the psychological services workforce in the allied health sector, population ageing does not yet appear to be inducing any skill shortages.

A related question that could arise is whether there are service-quality implications in relying on a workforce that comprises a relatively high proportion of mature-age workers. This issue is sometimes framed through the lenses of experience and expertise or, more technically, in terms of formation of therapeutic relationship and/or adherence to empirically supported treatments.

- Evidence about the importance of therapist age on the formation of a therapeutic relationship is variable (Stubbing and Gibson, 2022; Anderson et al., 2009). Some studies have found that therapist age is moderately or very helpful in forming a strong therapeutic alliance (Simpson and Bedi, 2012 p. 352). In other studies, the evidence has been mixed (Clark et al., 2018 pp. 6, 8).

- There is opposing evidence about the relationship between therapist age and adherence to empirically supported treatments. In a narrative systematic review of 10 studies, Speers et al. (2022) found an array of evidence – for negative correlation (sometimes referred to as 'therapist drift'), positive correlation and no significant relationship. They concluded that further research was necessary to settle this issue because a precise reason to explain therapist drift has not been identified.

In summary, the literature is unclear about the effect that therapist age may have on the quality of psychological services. However, the literature does point to the importance of maintaining professional accreditation, and continuing professional development in particular. As Karson (2021) concluded, while some older therapists incorrectly claim greater expertise for experience, those who adhere to ongoing professional improvement and critical self-assessment will be more expert, all other things being equal.

4 Graduate entry into the psychological services workforce

Key points

- In the short term, increasing access to bachelor or master degree places to alleviate the current shortage of allied health workers delivering psychological services may have little impact on unmet need.
  - The lead times to educate and fully train allied health professionals to meet standards commensurate with MBS eligibility criteria are long, ranging from five years for counsellors and psychotherapists to eight years for clinical psychologists.
  - The likelihood that increased numbers of university graduates would immediately find employment delivering psychological services as independent allied health practitioners appears low. The vast majority of recent graduates (95%) from relevant degree programs who were available for employment reported that their careers were beginning elsewhere.
- In the long term, increasing access to degree programs would be expected to expand the psychological services workforce to the extent that allied health professionals who have gained experience elsewhere subsequently move into independent practice.

A potential strategy for addressing the workforce shortage is to increase the supply of university graduates entering the psychological services sector. This approach could target university education programs linked to professions that are already under Better Access and/or those that may become part of it. While changes in policy settings could take several years or more to have an impact, their inclusion within a broader health workforce planning strategy would help reduce reliance on overseas-trained health care workers. In 2010, World Health Organization members adopted the voluntary *WHO Global Code of Practice on the International Recruitment of Health Personnel*, which encourages member states to:

> … strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel. (WHO, 2010, article 3.6, p. 5)

This chapter considers the scope to expand the psychological services workforce through policy changes aimed at influencing enrolment decisions by students and employment decisions by graduates. It first considers the education and training requirements necessary to meet MBS eligibility criteria before analysing graduate employment intentions.

4.1 Education and training requirements

This section summarises the minimum education and training that allied health professionals need to complete to become eligible[19] to deliver MBS subsidised psychological services under

[19] To maintain eligibility, registered health professionals typically need to complete continuing professional development each year, among other requirements.

Better Access or, in the case of counsellors and psychotherapists, need to be professionally registered at a commensurate level. The Australian Government determines MBS eligibility using the *Health Insurance Act 1973* (Cth) and related regulations (Services Australia, 2021). For Better Access, determinations are made under the *Health Insurance (Allied Health Services) Determination 2014* (Cth). Although these determinations involve a range of criteria, this section focuses on two criteria that critically affect the rate at which Australia's psychological services workforce grows: education and training.

Descriptions are provided for the four main fields of education relevant to the delivery of psychological services (counselling, occupational therapy, psychology, social work) and for medicine because GPs provide a substantial proportion of psychological services delivered under Better Access. Two conclusions can be drawn from the descriptions.

- The quantum of course content in bachelor degrees that is broadly relevant to the delivery of psychological services varies considerably across fields of education, ranging from minimal (medicine) to maximal (counselling, psychology, psychotherapy).
- The lead times to fully educate and train allied health professionals to meet standards commensurate with MBS eligibility criteria are long, ranging from 5 years (counsellors, psychotherapists) through 6 years (occupational therapists, registered psychologists, social workers) to 8 years (clinical psychologists).

Counsellors and psychotherapists[20]

It takes a minimum of five years to educate and train a counsellor or psychotherapist ('counsellor') to a level commensurate with the eligibility criteria applying to other allied health professionals who deliver focussed psychological strategies (FPS) under Better Access.

A Bachelor of Counselling is typically a 3-year program. Students complete units in counselling skills, FPS, human development and behaviour, and counselling theories. The vast majority of university lecturers who teach FPS courses are registered psychologists. It is common for student counsellors and student psychologists to be attending the same counselling classes, at the same time, listening to the same educators. In addition, many counsellors enter the profession via a master degree program.[21]

University programs directed at educating and training counsellors differ from those for psychologists or social workers because the focus is on learning counselling skills, rather than learning counselling skills as part of a broader set of skills and knowledge in other areas of expertise. Thus, while most other mental health practitioners move into mental health as a secondary or specialist pathway, the primary pathway for counselling students from day one is counselling. In many cases, counsellors go on to complete post-graduate qualifications in specialist areas, such as families and relationships, eating disorders, autism and trauma.

A further two years of supervised clinical practice is mandatory (among other criteria) for registration with the Australian Register of Counselling and Psychotherapy through upper-level membership of the ACA (Australian Counselling Association) or PACFA (Psychotherapy and Counselling Federation of Australia). A minimum of 750 hours of post-qualifying client contact and 75 hours of clinical supervision completed over a minimum 2-year period is requisite for Level 3 or 4 membership of the ACA (2021 p. 14) or for Clinical Membership of PACFA (2020 p. 2).

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[20] Much of the information on counsellors and psychotherapists was provided by Dr Philip Armstrong (CEO, Australian Counselling Association).

[21] Master degree qualifications are held by 65% of Level 3 and 4 members of the Australian Counselling Association who do not hold 'legacy' qualifications, compared with 35% who hold bachelor degrees.

Many registered counsellors deliver FPS services to full fee-paying clients, including through private health insurers and state government insurance agencies, despite not being eligible under Better Access. For example, BUPA and Medibank cover their members who receive care from counsellors whom they recognise (Bupa, 2019; Medibank, 2022b). Both insurers recognise members of the ACA and PACFA as ancillary health care providers because they meet the requirements under rule 10 of the *Private Health Insurance (Accreditation) Rules 2011* (Cth) (Bupa, 2022; Medibank, 2022a).

Occupational Therapists

It takes a minimum of six years to educate and train an occupational therapist to become eligible to deliver FPS health services under Better Access. The legislated eligibility requirements are registration with the Occupational Therapy Board of Australia (OTBA), and accreditation with Occupational Therapy Australia (OTA) as having a minimum two years experience in mental health and as having undertaken to observe the 'Australian Competency Standards for Occupational Therapists in Mental Health' (OTA, 2019).[22] Registration with the OTBA requires completion of a 4-year bachelor or a 2-year master degree program, or equivalents (DOHAC, 2021 p. 3). Although the amount of program content devoted to education and training in psychological services is not specified, OTBA approves entry-level programs that meet the World Federation of Occupational Therapists Standards, which requires at least 10% of the content to focus on 'knowledge supporting an understanding of body structures and functions, biomedicine, psychological and sociological concepts' (OTC, 2018 pp. 3–4; WFOT, 2016 p. 46).

Psychologists

It takes a minimum of six years to educate and train a psychologist to become eligible to deliver a 'focussed psychological strategies health service' under Better Access. The legislated eligibility requirement is general registration with the Psychology Board of Australia.[23] To be eligible for general registration, the Board (PsyBA, 2016 p. 2) requires completion of a 4-year sequence of study in psychology plus either one year of postgraduate study followed by a 1-year internship or two years of postgraduate study (or completion of equivalent qualifications).

For clinical psychologists, who are able to deliver 'psychological therapy health services' under Better Access[24] in addition to FPS services, the time required for education and training is a minimum eight years. Beyond the 4-year sequence of study in psychology required for general registration alone, it requires completion of a master degree in clinical psychology, plus two years of supervised practice or a doctorate in clinical psychology, plus one year of supervised practice (APS, 2022a). Completion of these additional requirements enables the Psychology Board of Australia to endorse a psychologist's general registration to permit them to practise in the area of clinical psychology.

Social Workers

It takes a minimum of six years to educate and train a social worker to become eligible to deliver FPS services under Better Access. The legislated[25] eligibility requirements are membership of the

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22 *Health Insurance (Allied Health Services) Determination 2014* (Cth) sch 1 s 7(c).

23 *Health Practitioner Regulation National Law Act 2009* (Cth) s 35; *Health Insurance (Allied Health Services) Determination 2014* (Cth) sch 1 s 7(a).

24 *Health Insurance (Allied Health Services) Determination 2014* (Cth) sch 1 s 16.

25 *Health Insurance (Allied Health Services) Determination 2014* (Cth) sch 1 s 7(b).

Australian Association of Social Workers (AASW) and certification by the AASW as meeting its *Practice Standards for Mental Health Social Workers* (AASW, 2014).

Membership of the AASW requires completion of either: a 4-year Bachelor of Social Work degree program that includes at least one year of studies in the social and behavioural sciences; or a 2-year Bachelor of Social Work degree program following a minimum of two years of a relevant undergraduate degree that includes at least one year of studies in the social and behavioural sciences (AASW, 2021 p. 15). Psychosocial health and wellbeing is a core curriculum area of all degree programs accredited by the AASW. Its purpose is to equip students with the 'skills, values and attitudes required for the effective translation of knowledge and understanding into professional performance' (AASW, 2021 p. 8). Degree programs must also ensure students complete 1000 hours of supervised placement time, of which 500 hours must be undertaken in a direct practice role that enables them to apply their professional interpersonal skills (AASW, 2021 pp. 10, 22).

Certification by the AASW as meeting its mental health practice standards follows a credentialing process which, among other criteria, includes having completed two years of post-qualifying social work experience in a mental health setting that was formally supervised (AASW, 2022; 2020a).

Medical practitioners

It generally takes at least six to seven plus years to educate and train a GP to the level of registrar. To become eligible to deliver FPS health services under Better Access, they need to complete the mental health training standards for GPs. Depending on the training pathway, this takes about 26 hours plus the time necessary to complete pre- and post-training components.

Bachelor degree programs in medicine typically take five to six years, but may contain relatively little practical training in mental health therapeutic interventions. Under the accreditation standards for medical programs, universities are to ensure that, on entry to professional practice, graduates are able to:

- perform a full and accurate physical examination, including a mental state examination, or a problem-focused examination as indicated
- describe the principles of care for patients at the end of their lives, avoiding unnecessary investigations or treatment, and ensuring physical comfort including pain relief, psychosocial support and other components of palliative care (Australian Medical Council, 2012 pp. 2–3, domains 2.3 & 2.13).

To be eligible to provide FPS under Better Access, GPs need to have completed Level 1 and Level 2 training under the mental health training standards for GPs (GPMHSC, 2022). A person is able to complete Level 1 and then Level 2 training once they become a registrar,[26] that is, following formal study and a 1-year internship.

- Level 1 Mental Health Skills Training is designed to equip GPs to be able to undertake mental health assessments for common mental illnesses in the context of general practice, and to develop and review GP mental health treatment plans. There are two possible pathways:
  - the primary pathway requires completion of an e-learning or face-to-face course (minimum 6 hours), relevant predisposing components (e.g. prereading and pre-course surveys) and relevant reinforcing components (e.g. discussions and follow-up surveys)

[26] A. Smith, The Royal Australian College of General Practitioners Ltd, personal communication, November 15, 2022).

  - the modular pathway requires completion of one core module (minimum three hours) and one clinical enhancement module (minimum four hours) (GPMHSC, 2022 p. 13).

- Level 2 training is designed to enable GPs to provide cognitive behavioural therapy or interpersonal therapy to patients who are eligible for treatment in the context of general practice. GPs must complete course contact time (minimum 12 hours), an additional interactive structured learning course (minimum 8 hours), a predisposing component and a reinforcing component (GPMHSC, 2022 pp. v, 12–17).

4.2 Scope to increase supply of university graduates

The number of university graduates who have become available for employment as independent allied health practitioners delivering psychological services, or who are in training to deliver these under supervision, is estimated in appendix C. More particularly, it estimates the number of graduates who, in recent years, were available for full-time or part-time employment at about four to six months after graduating. Being available for employment means being either employed, about to start employment or looking for employment (SRC, 2021 p. 43).

This report suggests that new policy proposals, which aim to significantly increase the number of university graduates available to work as independent allied health practitioners delivering focused psychological therapies, are best considered a medium to long-term solution to current shortages in the psychological services workforce. More specifically, the results indicate that new policy proposals designed to increase access to bachelor or master degree places are likely to have little impact on the volume of psychological services delivered in the short run, all other things being equal.

- The minimum time required to fully educate and train allied health professionals to a level commensurate with Better Access eligibility criteria ranges from five years (counsellors, psychotherapists) to eight years (clinical psychologists).

- The vast majority (95%) of university graduates with a bachelor or master degree in the main fields of education do not appear to begin their careers as independent allied health practitioners delivering psychological services.

However, in the long term, increasing access to degree programs would be expected to swell the psychological services workforce as practitioners who have gained experience elsewhere choose to move into private practice as independent allied health practitioners.

Accordingly, new policy proposals to address the shortage of independent allied health practitioners delivering psychological services would likely need to factor in:

- the relatively long lead times to fully educate and train allied health practitioners

- the likelihood and timing of such additional graduates actually entering the allied health sector as counsellors and psychologists versus other employment opportunities

- the extent to which increasing access to master degree programs, were this a viable option, could delay appropriately qualified bachelor degree graduates from becoming available for employment

- constraints to training allied health practitioners, in particular, in-course training placements and post-qualification training placements.

5 Some implications for Better Access

Key points

- Degree-qualified counsellors and psychotherapists constitute an underutilised part of the psychological services workforce. Given their qualifications, training and experience, they could play a more explicit role in a strategy to reduce unmet demand for psychological services under Better Access.
- The relative scarcity of psychological service providers outside capital cities is likely to be inhibiting access to Better Access. Extending MBS eligibility to appropriately qualified and trained counsellors and psychotherapists has the potential to significantly improve access to psychological services outside capital cities.
- The limited choice in service offerings under Better Access may be discouraging some people from seeking support for their mental ill-health. Expanding the range of mental health professionals who are eligible to deliver psychological services would improve the likelihood of people finding a health provider who better matches their care preferences in terms of establishing a good rapport and making them feel safe and comfortable.

The aim of Better Access is 'to encourage more people to seek support for their mental ill-health' (DOHAC, 2022b). However, the preceding chapters reveal two workforce issues that curb its effectiveness. First, the relative scarcity of providers outside capital cities limits access to services and thus contributes to unmet need. Second, the predominance of professionals trained in the medical model has the potential to dissuade clients who have a service usage preference for a more holistic, non-pathologizing service.

This chapter considers these issues through the lens of a third workforce issue – that a potentially large pool of degree-qualified counsellors and psychotherapists ('counsellors') is ready to address unmet demand under Better Access but is not eligible to do so. This issue is discussed first, followed by the issues relating to the relative scarcity of providers in rural and remote areas, and the limited choice in service offerings.

5.1 Underutilised counsellors and psychotherapists

Degree-qualified counsellors constitute an underutilised part of the psychological services workforce and could play a greater role in reducing unmet need under Better Access. Unlike areas of the psychology profession (section 0), it is difficult to find evidence of capacity constraints affecting the counselling profession's ability to take on new clients. Further, the entirety of training of counsellors and psychotherapists is preparing them as practitioners who deliver psychological services (ACA, 2012 pp. 6–7; PACFA, 2022 pp. 9–10).

Moreover, they constitute a sizeable proportion of allied health providers with mental-health related qualifications (table 3.1). In 2021, they numbered about 3,010 of which about 25% (740 counsellors) were working in regional, rural and remote areas. Not all of them would have been engaged entirely in providing mental health services. For example, rehabilitation counsellors are allied health providers who offer career counselling to people experiencing injury and/or disability, among a range of services including mental health management (AHPA, 2023). Nonetheless, a large proportion would likely have been engaged in providing mental health

services given the high prevalence of mental disorders[27] and thus the extent to which counselling in allied health is largely mental health counselling.

Counsellors could play a more explicit role in a strategy to reduce unmet demand for psychological services under Better Access, given their qualifications, training and experience. Counsellors who hold a bachelor, master or doctoral degree represent a sizeable share of the broader psychological services workforce and constitute an underutilised resource for reducing unmet demand for psychological services. Allowing appropriately qualified, trained and regulated counsellors to provide focused psychological strategies could improve the effectiveness of Better Access by enabling more people to access or continue with support.

A key policy question is the extent to which the Better Access workforce may increase, were the Australian Government to widen the set of MBS eligible occupations to include counsellors.

In the first instance, counsellors represent an immediate qualified workforce. The opportunity would likely interest many of the 3,010 degree-qualified counsellors already working in the allied health sector, given their qualifications, training and experience.

However, over the long term, many factors would ultimately affect the size of the Better Access workforce. These include factors affecting decisions by:

- counsellors to pursue MBS eligibility (including those outside the allied health sector who might choose to refocus their scope of practice)
- GPs to refer consumers to counsellors
- consumers in choosing their preferred provider of focussed psychological strategies
- other allied health providers considering any impacts on their business models
- government through its funding and regulatory roles
- students considering entering the mental health sector.

5.2 Scarcity of providers in rural and remote areas

The relative scarcity of service providers in rural and remote areas is a persistent problem for mental health generally and Better Access more specifically (Cleary et al., 2020 p. 7; Meadows et al., 2018; Pirkis et al., 2022 p. 12; Productivity Commission, 2020 pp. 30, 457, 749). Universal access remains a goal of Medicare, but achieving this requires improved access to services, especially for those living outside capital cities (MBS Review Taskforce, 2020 pp. 9, 27). In fact, this challenge may be growing. According to a diverse sample[28] of stakeholders, people living in regional, rural and remote areas have been finding it increasingly difficult to access Better Access (Pirkis et al., 2022 p. 12). Moreover, all survey participants 'agreed' or 'strongly agreed' with the statement: 'The relative scarcity of providers in rural and remote areas must be addressed' (Pirkis et al., 2022, figure 11.9, p. 274).

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[27] In 2022, about 1 in 5 Australians aged 16–85 had experienced symptoms of a mental disorder within the previous 12 months (AIHW, 2022b).

[28] The Evaluation of Better Access used a modified Delphi method to identify collective views about the main issues and reform priorities from a diverse group of 104 stakeholders. The group comprised representatives from 55 service providers (35 eligible Better Access providers, 18 ineligible providers and two First Nations providers), 20 consumers and people with lived experience, 10 carers, eight representatives from advocacy organisations, six health systems experts and five policy makers (Pirkis et al., 2022 p. 262).

Although the widespread adoption of telehealth has 'proved popular' and 'improved access' (Pirkis et al., 2022 pp. 323, 328), this mode of service delivery may also discourage some people from seeking support or continuing to receive care. As is so often the case, several reasons explain why 'one size does not fit all'. In the first instance, connectivity difficulties can render telehealth sessions unsatisfactory (Pirkis et al., 2022 pp. 214–215). That aside, many (if not most) users prefer face-to-face sessions as this mode makes it easier to develop rapport and establish trust with the service provider (Pirkis et al., 2022 pp. 10, 93, 213).

A preference for face-to-face sessions significantly affects patterns of service use. Compared with existing users, new users are much less likely to receive services via telehealth and more likely to continue receiving face-to-face services only (Pirkis et al., 2022 pp. 5, 328). Moreover, while some people may find telehealth an 'acceptable second-best option' (Pirkis et al., 2022 p. 214), others reported it as the least helpful influence on their health and wellbeing (Pirkis et al., 2022 pp. 229–230).

Part of the challenge stems from difficulties in recruiting and retaining providers to work in rural and remote areas (Cleary et al., 2020 p. 5; Pirkis et al., 2022 p. 323). Although recent growth in the mental health workforce in these areas has been stronger than in capital cities (section 3.2), scarcity still persists.

However, extending MBS eligibility to appropriately qualified and trained counsellors has the potential to significantly improve access to psychological services outside capital cities. It would have the immediate effect of opening access to a large pool of experienced and degree-qualified counsellors who are already practising in those areas. In addition, this initiative could serve to further narrow the city–country disparity insofar as practising outside greater capital city areas appears to be more attractive to counsellors than psychologists. The average annual growth rate in the number of allied health practitioners working outside capital cities was higher for counsellors[29] (12.2%) than psychologists and social workers (both 10.0%) between 2016 and 2021 (calculated from the data in table 3.1). Moreover, the higher growth in the number of counsellors working outside capital cities occurred without the advantage of MBS eligibility.

5.3 Limited choice in service offerings

The limited choice in service offerings under Better Access may be discouraging some people from seeking support for their mental ill-health.

The extent to which Better Access encourages greater support seeking depends on having 'a good rapport and feeling safe and comfortable with the mental health professional' (Pirkis et al., 2022 p. 232). A substantial body of research confirms that the behaviour and style of individual therapists can affect the therapeutic alliance and, in turn, outcomes of mental health care (Ryan et al., 2021 pp. 1, 15). Further, evidence suggests that outcomes could be improved by focusing on matching clients to counsellors, as much as matching treatments to diagnoses (Schirmer, 2018; Blow et al., 2007; Boswell et al., 2017). So far as this primary enabler is necessary for Better Access to be effective, its absence would, logically, prevent people from receiving the support they need.

Recent evidence raises doubts about the extent to which Better Access inherently promotes greater support seeking. A survey of Better Access consumers who had ceased mental health care early revealed that a substantial proportion (30.4%) reported their dislike for a 'mental health professional's manner or approach' as a reason for ceasing that care (Pirkis et al., 2022 p. 141). Although this may have been one reason among several for some participants, the importance of ensuring rapport, safety and comfort, together with the magnitude of the survey response, mean this issue requires closer scrutiny.

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[29] These were counsellors holding a bachelor, master or doctoral degree.

In interpreting this result, it is not reasonable to assume that all negative experiences are due solely to differences *within* the entire pool of Better Access providers to the exclusion of differences *between* individual professions. In other words, dismissing these concerns simply on the ground that there will always be providers whose manner and approach is liked by some and not by others risks overlooking the possibility that some consumers might have continued with their care had they begun with a different style of service offering. The Better Access workforce already reflects some diversity in professional service offerings across GPs, occupational therapists, psychologists and social workers. By extension, the possibility of a more effective consumer–provider match would likely increase if the Better Access workforce was more professionally diverse.

Psychologists and medical practitioners dominate the delivery of psychological services under Better Access (section 3.1). Because this dominance implies that service offerings are almost entirely based on the medical model, it risks increasing the incidence of service provision that is 'unhelpful and even harmful for people accessing services' (Mayers and Agnew, 2019 p. 2). Mayers and Agnew (2019 pp. 2–4) explain potential shortcomings of the medical model for providing psychological services.

> The medical model of mental health is founded upon the assumption that an individual's distress is a form of pathology, with unidentified biological signs which link to 'symptoms' … In aligning itself with psychiatry and the medical model, psychology has adopted associated constructs such as 'symptoms', 'diagnosis' and 'treatment' ([as cited in] Johnstone, 2000) … [B]y medicalising and individualising distress, clinicians risk ignoring the need to address the social, relational and political factors which may have caused their distress in the first place and inappropriately blaming clients' personal characteristics and cognitions for their problems (citing Johnstone, 2000).

A key shortcoming of the current Better Access workforce is that it limits consumer choice in mental health care to the medical model (Northern Territory Government Department of Health, 2021 p. 3). In addition to knowledge about mental health and its treatment, the counselling profession emphasizes the need to assess clients' needs holistically and contextually, leading to a whole-of-person approach. Notwithstanding efforts by mental health practitioners to apply the medical model in more person-centred ways, compared with psychologists for example, 'counsellors adopt a more person-centred approach' which emphasises listening and discussing goals first (Snell 2022, as cited in Deakin University, 2022). As such, it is difficult for many consumers to access counsellors who offer MBS-subsidised services founded on a recovery approach.

> Recovery approaches are viewed by the consumer movement as an alternative to the medical model with its emphasis on pathology, deficits and dependency. There is no single description or definition of recovery, because recovery is different for everyone. However, central to all recovery paradigms are hope, self-determination, self-management, empowerment and advocacy. Also key is a person's right to full inclusion and to a meaningful life of their own choosing … (AHMAC, 2013 p. 17)

Empirical research indicates that the general public holds diverse preferences for different types of mental health professionals. For example, when a sample (n=226) of adults in northern NSW/southern Queensland were asked to state which professionals (counsellors, psychologists, psychiatrists or social workers) they would prefer to consult about specific problems, the proportion stating 'counsellors' (including those providing multiple responses) varied among participants, it being 19% for mental health, 49% for anxiety and 53% for depression (Sharpley et al., 2004 p. 105).

Expanding the range of service providers under Better Access could make the initiative more effective. For the reasons outlined above, consumers will generally benefit most from psychological services delivered by professionals whom they feel comfortable with and who match their preferences. Further, to the extent that some consumers hold negative perceptions about particular types of mental health professionals, a wider range of service offerings would serve to lower an obvious and avoidable hurdle. An added advantage of expanding the range of provider types is likely to stem from enhanced opportunities for self-determination through greater choice in their own care. Greater choice in and of itself can lead to improved mental health outcomes (Stanhope et al., 2013 pp. 192, 199).

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A Relevant ABS occupations and industries

Much of the empirical analysis in this report relies on ABS Census data, which was downloaded using Census TableBuilder Basic, the ABS's free online self-help tool (ABS, 2020).

Data about the main service providers was drawn from the Census employment, income and education dataset by selecting industries and occupations that closely reflected their professional skills and the nature of the activities that characterised their work environment. Relevant industries and occupations were identified using the descriptions in the Australian and New Zealand Standard Classification of Occupations (ANZSCO) and the Australian and New Zealand Standard Industrial Classification (ANZSIC) and (ABS & SNZ, 2006a; 2006b).

Relevant industries

ANZSIC provides an industry classification framework for organising data about businesses that carry out similar activities (ABS & SNZ, 2006b).

There is a range of industry (4-digit) classes under ANZSIC division Q Health Care and Social Assistance to which private businesses that provide psychological services could reasonably be classified.

- 8500 Medical and Other Health Care Services, nfd: This code captures survey/census responses that fit within the scope of subdivision 85 Medical and Other Health Care Services, but do not contain sufficient information to unequivocally assign to specific ANZSIC 4-digit industry categories (ie 8511, 8512, 8520, 8531, 8532, 8533, 8534, 8539, 8591, 8599).
- 8510 Medical Services, nfd: This code captures survey/census responses that fit within the scope of group 851 Medical Services, but do not contain sufficient information to unequivocally assign to specific ANZSIC 4-digit industry categories (ie 8511, 8512, 8599). This group consists of business units mainly engaged in the independent practice of general or specialised medicine who generally operate private or group practices in medical clinics or centres.
- 8511 General Practice Medical Services: This class consists of business units mainly engaged in the independent practice of general medicine. These units consist of registered medical practitioners who generally operate private or group practices in medical clinics or centres. It includes primary activities such as: general medical practitioner service, general practice medical clinic service and rural general medical practice service, but excludes units mainly engaged in providing services of specialist medical practitioners, among other things.
- 8530 Allied Health Services, nfd: This code captures survey/census responses that fit within the scope of group 853 Allied Health Services, but do not contain sufficient information to unequivocally assign to specific ANZSIC 4-digit industry categories (ie 8531, 8532, 8533, 8534, 8539).
- 8539 Other Allied Health Services: This class consists of business units mainly engaged in providing allied health care services not elsewhere classified. These units consist of independent allied health practitioners not elsewhere classified that are mainly engaged in providing health care and treatment services. It includes business units whose primary activity is a clinical psychology service or occupational therapy service.

- 8590 Other Health Care Services, nfd: This code captures survey/census responses that fit within the scope of group 859 Other Health Care Services, but do not contain sufficient information to unequivocally assign to specific ANZSIC 4-digit industry categories (ie 8591, 8599).
- 8599 Other Health Care Services nec: This is a collection of distinct industry classes that fit within the scope of subdivision 85 Medical and Other Health Care Services, but which do not exceed the minimum threshold to justify being in separate 4-digit classes. It includes business units whose primary activities are health assessment service or health care service nec, among others, such as blood bank operations.

The industry most relevant to this report is industry class 8539 (Other Allied Health Services), which is classified under Division Q (Health Care and Social Assistance), Subdivision 85 (Medical and Other Health Care Services), Group 853 (Allied Health Services). While including other industry classes in the analysis would boost the number of providers counted, it would also increase the number who are less comparable with existing allied health practitioners who eligible to provide Better Access Services as independent practitioners in private practice.

Business units in class 8539 consist of independent allied health practitioners who are mainly engaged in providing health care and treatment services. This class includes business units whose primary activity is, for example, a clinical psychology service or occupational therapy service, but excludes business units engaged in providing medical services, which are included in classes 8511 (General Practice Medical Services) and 8512 (Specialist Medical Services).

This report refers to class 8539 simply as 'allied health' without ambiguity. Other classes listed within the industry group titled Allied Health Services (industry group 853) have no relevance, namely: Dental Services (8531), Optometry and Optical Dispensing (8532), Physiotherapy Services (8533), and Chiropractic and Osteopathic Services (8534) (ABS & SNZ, 2006b p. 63).

Relevant occupations

ANZSCO is a skill-based classification used to categorise all occupations and jobs undertaken for profit in the Australian and New Zealand labour markets (ABS, 2021a). Each occupation is defined by its primary task.

It was important to select for industry and occupation jointly in order to extract data relevant to the psychological service providers of interest. This is because a single occupation may be specific to a particular industry, or common to multiple industries or sectors (ABS & SNZ, 2006a p. 2). In deciding which occupation best suits a survey response, the ABS places primary importance on the occupation title, but also makes extensive use of the main tasks performed in a job, skill level and skill specialisation (ABS & SNZ, 2006a pp. 2, 4).

Under ANZSCO, there are four unit groups of occupations that relate to the provision of psychological services to assist with mild to moderate mental disorders: counsellors, occupational therapists, psychologists and social workers.

Counsellors (unit group 2721)

Unit group 2721 comprises counsellors who, among other things:

> ... provide information on vocational, relationship, social and educational difficulties and issues, and work with people to help them to identify and define their emotional issues through therapies such as cognitive behaviour therapy, interpersonal therapy and other talking therapies. (ABS, 2022b)

The tasks undertaken by counsellors include:

- assessing client needs in relation to treatment for drug and alcohol abuse
- conducting counselling interviews with individuals, couples and family groups
- assisting the understanding and adjustment of attitudes, expectations and behaviour to develop more effective interpersonal and marital relationships
- presenting alternative approaches and discussing potential for attitude and behaviour change. (ABS, 2022b)

While no occupations within unit group 2721 have descriptions explicitly linked to mental health counselling, there are several that are likely to be in scope and relevant (ABS & SNZ, 2006a).

- 272100 Counsellors, nfd:[30] This code captures survey/census responses that fit within the scope of unit group 2721, but do not contain sufficient information to unequivocally assign to specific ANZSCO 6-digit occupation categories.[31] Typically, these would be survey responses of simply 'counsellor' with no additional information to enable specific classification to a 6-digit existing category.
- 272112 Drug and Alcohol Counsellor: Provides support and treatment for people with drug and alcohol dependency problems, develops strategies which assist them to set goals and affect and maintain change, and provides community education. May work in a call centre.
- 272114 Rehabilitation Counsellor: Assists physically, mentally and socially disadvantaged people to reintegrate into work and the community.
- 272199 Counsellors nec:[32] This is a collection of distinct occupations that fit within the scope of unit group 2721, but which do not exceed the minimum threshold of 300 employed persons in Australia to justify being in separate 6-digit categories. It includes the occupations Gambling Counsellor, Grief Counsellor, Life Coach, Sexual Assault/Abuse Counsellor and Trauma Counsellor.

Extraction of occupation data at the 4-digit unit group level was justified on the grounds that, in combination with the allied health filter (industry class 8539), it captured counsellors providing mental health services. As with social workers, there are other industries in which counsellors would likely appear, such as unit group 879 (Other Social Assistance Services). In any case, most counsellors falling into occupation unit group 2721 and industry unit group 8539 would likely have a transferable skill set that could usefully assist with delivering psychological services, especially as a data filter requiring a degree qualification was always applied.

Occupational Therapists (unit group 2524)

Unit group 2524 includes occupational therapists who:

> … assess functional limitations of people resulting from illnesses and disabilities, and provide therapy to enable people to perform their daily activities and occupations. (ABS, 2022a)

Although ANZSCO does not distinguish occupational therapists engaged in tasks specifically relating to mental health issues, it includes tasks such as:

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30 The ABS uses 'nfd' (not further defined) to code vague survey responses which cannot be allocated at a particular level of classification and 'nec' (not elsewhere classified) to code clear responses that fall below minimum counts for individual classification, thus ensuring statistical classification is exhaustive.

31 272111 Careers Counsellor, 272112 Drug and Alcohol Counsellor, 272113 Family and Marriage Counsellor, 272114 Rehabilitation Counsellor, 272115 Student Counsellor and 272199 Counsellors nec.

32 See footnote 30.

- assessing clients' emotional, psychological, developmental and physical capabilities using clinical observations and standardised tests
- providing advice to family members, carers, employers and teachers about adapting clients' home, leisure, work and school environments (ABS, 2022a).

Unit group 2524 contains one occupation 252411 – Occupational Therapist.

Psychologists (unit group 2723)

There are several occupations within unit group 2723 that are likely to include psychologists who provide psychological services to assist with mild to moderate mental disorders (ABS & SNZ, 2006a).

- 272300 Psychologists nfd:[33] This code captures survey/census responses that fit within the scope of unit group 2723, but do not contain sufficient information to unequivocally assign to specific ANZSCO 6-digit occupation categories (ie 272311, 272312, 272313, 272314 or 272399).
- 272311 Clinical Psychologist: This occupation comprises clinical psychologists who consult with individuals and groups, assess psychological disorders and administer programs of treatment. It includes three specialist occupations: Forensic Psychologist, Health Psychologist and Neuropsychologist.
- 272314 Psychotherapist: This occupation comprises psychotherapists who provide diagnosis and treatment of mental and emotional disorders using psychotherapeutic methods such as behavioural therapy, biofeedback, relaxation therapy and other techniques.
- 272399 Psychologists nec:[34] This is a collection of distinct occupations fitting within the scope of unit group 2723, but which do not exceed the threshold of 300 employed persons to justify being in separate 6-digit categories. It includes the occupation Counselling Psychologist.

All of these occupations were deemed to be in-scope and relevant to this report.

However, where possible, data relating to the occupation Psychotherapist was deducted from the unit group Psychologists and added to the unit group Counsellors. This was done to produce analytical results that reflected the current eligibility arrangements for allied health professions under Better Access.

Social Workers (unit group 2725)

Unit group 2725 includes social workers who:

> … assess the social needs of individuals, families and groups, assist and empower people to develop and use the skills and resources needed to resolve social and other problems, and further human wellbeing and human rights, social justice and social development. (ABS, 2022c)

Although ANZSCO does not distinguish social workers engaged in tasks specifically relating to mental health issues, it includes tasks such as:

- conducting individual and family case interviews to identify the nature and extent of clients' problems
- assisting clients to understand and resolve problems by providing information, acting as a mediator and referring them to community and self-help agencies (ABS, 2022c).

Unit group 2725 contains one occupation 272511 – Social Worker.

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[33] See footnote 30.

[34] See footnote 30.

B Estimation of breakpoint in preparation of mental health treatment plans

A leading indicator of likely future use of psychological services is the number of mental health treatment plans prepared by medical practitioners and other mental health plans prepared by psychiatrists delivered using the following MBS item numbers:

- medical practitioners, for the preparation of a mental health treatment plan or 3-step mental health process: 272, 276, 281, 282, 2574, 2575, 2577, 2578, 2700, 2701, 2702, 2704, 2705, 2707, 2708, 2710, 2715, 2717, 92112, 92113, 92116, 92117, 92118, 92119, 92122, 92123, 92124, 92125, 92128, 92129, 92130, 92131, 92134, 92135, 93400, 93401, 93402, 93403, 93404, 93405, 93406, 93407, 93408, 93409, 93410, 93411, 93431, 93432, 93433, 93434, 93435, 93436, 93437, 93438, 93439, 93440, 93441, 93442
- psychiatrists, for an initial consultation and/or preparation of a written management plan: 291, 296, 297, 299, 92435, 92437, 92475, 92477.

Monthly data on MBS service counts per capita were collected from the Medicare Statistics portal[35] of Services Australia for each of the abovementioned MBS item numbers from July 2012 to August 2022. A plot of monthly totals constructed by aggregating service counts across all relevant item numbers revealed an increasing trend followed by a decreasing trend, and a strong seasonal pattern (figure B.1).

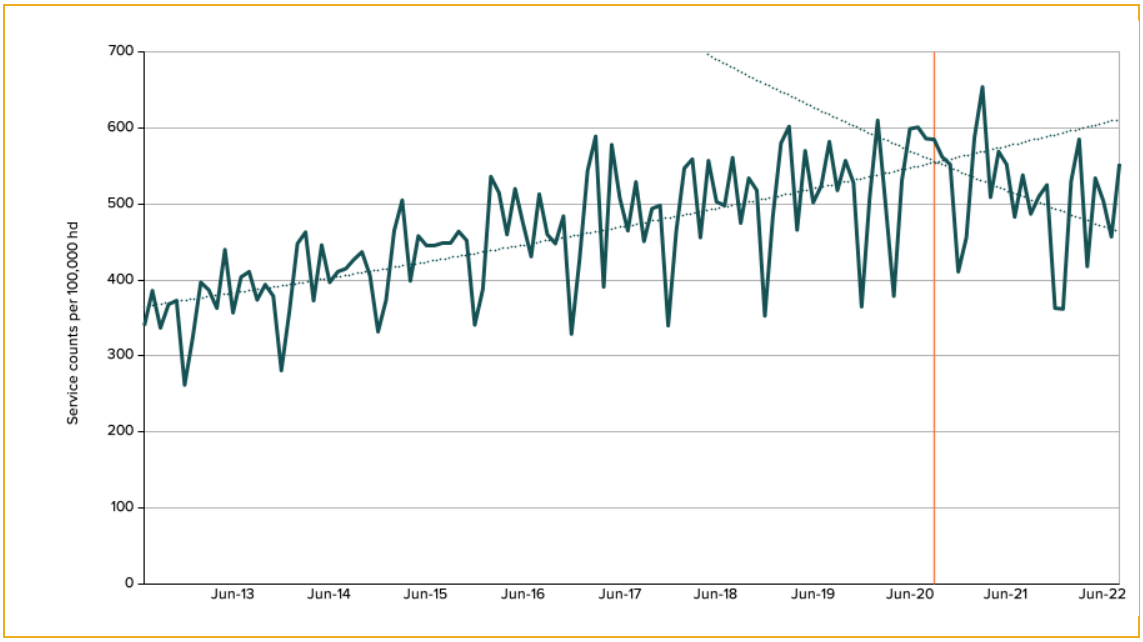
Insight Business Analytics[36] tested the data to see if a statistically significant breakpoint was present. A piecewise exponential function was fit to the data. This employed a similar approach to that in Hayward & Randal (2008). Specifically, this analysis consisted of the following steps:

- A log-transform was applied to the number of service counts.
- A piecewise linear function was fit to the data (while ignoring the seasonality). This employed the 'segmented' function in the 'segmented' package in R.
- A seasonal pattern was fit to the residuals. It is noted that this seasonal pattern was not sinusoidal in shape, and so the seasonal pattern was modelled as an independent value for each month throughout the average year.
- A piecewise linear function was fit to the original data once the seasonality had been removed (using the 'segmented' function).
- An updated seasonal pattern was fit to the residuals.
- A piecewise linear function was fit to the original data once the updated seasonality had been removed.

35 http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp.

36 www.insightrsa.com.

Figure B.1 **Counts of services to prepare mental health treatment/management plans under Better Access per 100,000 head of population, Jul 2012 – Aug 22**



This was an iterative procedure alternating between improving the piecewise linear function and the seasonal model. It converged after two iterations and no further iterations were conducted.

Models with one and two breakpoints were considered. There was only a minimal improvement in model fit (according to the Bayesian Information Criterion) for two breakpoints, so one breakpoint was considered sufficient.

The breakpoint was predicted to be at 30 September 2020 (with a 95% confidence that it was between 21 May 2020 and 8 February 2021). Across the first time segment (2012 to 2020) there was an exponential increase of 5.25% per year in the number of service counts ($P < 0.001$). Across the second time segment (2020 to 2022) there was an exponential decrease of 9.18% per year in the number of service counts ($P < 0.001$).

C Graduate employment intentions

This appendix estimated the average number of university graduates who became available for employment as independent allied health practitioners delivering psychological services or training in their delivery under supervision over the six years 2016–2021. More particularly, it pertains to graduates who were available for full-time or part-time employment at about four to six months after graduating. Being available for employment means being either employed, about to start employment or looking for employment (SRC, 2021 p. 43).

The estimation methodology used data collected by the Social Research Centre[37] through the Graduate Outcomes Survey (box C.1) and followed three steps:

1. counting graduates with relevant qualifications
2. filtering those who were not independent practitioners in the allied health sector
3. filtering those who did not deliver psychological services as their primary activity.

Box C.1 **About the Graduate Outcomes Survey**

The Graduate Outcomes Survey (GOS) is an annual survey of graduates of Australian higher education institutions conducted by the Social Research Centre (SRC). It is one of several surveys comprising the Quality Indicators for Learning and Teaching (QILT) surveys which the SRC, a subsidiary of the Australian National University, conducts on behalf of the Australian Government Department of Education. The SRC is the independent administrator of the QILT surveys and is responsible for their design and development, sample selection and processing, survey deployment and reporting on survey outcomes (SRC, 2022b).

The GOS measures short-term employment outcomes including skills utilisation, further study activities and graduate satisfaction (SRC, 2022a). The SRC conducts the GOS about four to six months after graduates finish their studies. This entails three rounds of surveys each year, beginning in November, February and May.

The 2021 GOS attracted 127,827 valid responses representing a response rate of 40.4% (SRC, 2021 p. 1). It was conducted primarily online among 127 higher education institutions, including all 41 universities. Graduates of undergraduate and postgraduate coursework and research programs were encouraged to participate through a broad range of promotional materials, an email invitation, nine reminder emails, up to two SMS reminders and telephone reminder calls (SRC, 2021 p. 33).

Step 1 – Counting graduates with relevant qualifications

Over the six years 2016 to 2021, an average 5,327 graduates with a bachelor or master degree in a field of education relevant to the provision of psychological services reported they were available for employment each year (table C.1). The majority (59%) of these graduates held degrees in psychology; the balance comprised graduates with degrees in social work (21%), occupational therapy (12%) and counselling (8%).

[37] www.srcentre.com.au.

Table C.1 **Availability for employment reported by university graduates with a bachelor or master degree by field of education, average 2016–2021**

ASCED Field of Education Classification		*Step 1*		*Step 2*		*Step 3*	
		Avail. for empl.		*Avail. for empl. 'Other Allied Health Services'*		*Avail. for empl. 'Other Allied Health Services' AND occupation counsellor or psychologist*	
			(%)		(%)		(%)
090513	Counselling	447	8.4	38	0.7	22	0.4
061703	Occupational Therapy	628	11.8	248	4.7	0	0.0
090701	Psychology	3,121	58.6	340	6.4	218	4.1
090501	Social Work	1,132	21.2	53	1.0	9	0.2
	Total	5,327	100.0	679	12.7	249	4.7

Notes: ASCED means Australian Standard Classification of Education. Available for employment means being either employed, about to start employment or looking for employment in the week before the survey. 'Other Allied Health Services' is class 8539 of the Australian and New Zealand Standard Industrial Classification.

Data source: Quality Indicators for Learning and Teaching Graduate Outcome Survey, data request supplied by the Social Research Centre, Melbourne.

This step of counting graduates with relevant qualifications is likely to have led to an underestimate in two ways, although the impact appears minimal.

First, it excluded graduates with other qualifications suitable for professional registration. For example, a Doctor of Psychology degree is a valid path to general registration as a psychologist. Such graduates were excluded on the assumption that many with this advanced research qualification might not have engaged in delivering psychological services as their primary activity upon graduation. Their inclusion would therefore have unreasonably inflated the estimate.

Second, also excluded and for a similar reason were graduates from other potentially relevant fields of education: Behavioural Science (nfd and nec[38] – ASCEDs 090700 and 090799) and Human Welfare Studies and Services (nfd and nec – ASCEDs 090500 and 090599). Although including them would have increased the estimate by about 10% (549), it would have unreasonably inflated the estimate as relatively few (less than 3%) reported being available for employment in 'Other Allied Health Services' (data supplied by the Social Research Centre).

Step 2 - Graduates reporting working in allied health

The proportion of relevant graduates who are likely to immediately embark on a path towards independent practice in allied health may be estimated as the proportion reporting availability for work in ANZSIC class 8539 'Other Allied Health Services'. This industry class comprises independent allied health practitioners who are mainly engaged in providing health care and treatment services. For example, it includes business units whose primary activity is a clinical psychology service or occupational therapy service.

Of the 'gross pool' of relevant graduates, a significant proportion (about 13%) reported being available for employment in allied health (table C.1). There was, however, considerable variation across fields of education, ranging from 5% for social work to 41% for occupational therapy

[38] See footnote 30.

(table C.1). The proportion with degrees in counselling and psychology were more comparable, being 8% and 11% respectively.

Subsetting to class 8539 alone was also likely to understate the true number of graduates heading towards independent practice in allied health. Six other industry classes could potentially include relevant graduates.[39] However, including all seven risked introducing disproportionately high numbers of non-relevant graduates. Their descriptions suggested they would likely attract graduates well beyond the four main fields of education listed in table C.1. In addition, whatever bias may have resulted from excluding them, it may not be significant. For example, in the 2021 ABS census, the six other classes accounted for 7% of all psychologists, of which a still smaller proportion could have been delivering psychological services as independent practitioners.

Step 3 – Graduates reporting their occupation as a counsellor or psychologist

Step 3 aimed to retain only those step 2 graduates who were delivering psychological services (including being trained in this role). It did this by applying a third filter that discarded graduates not reporting their occupation as a counsellor or psychologist. This approach made a strong assumption that graduates whose primary activity was delivering psychological services would report their occupation as counsellor or psychologist irrespective of their professional affiliation.

About 249 graduates (that is, 4.7% of graduates with a bachelor or master degree in one of four main fields of education) reported they were available for employment in allied health as a counsellor or psychologist (table C.1). It is reasonable to assume that most were delivering psychological services given that over 95% held a counselling or psychology degree.

An upper bound estimate

In each of the three methodological steps, assumptions were made that consistently led to a conservative or lower bound estimate. However, this conservative approach could have unduly underestimated the true number of recent university graduates who had become available for employment as independent allied health practitioners delivering psychological services or training in their delivery under supervision.

An upper bound estimate was calculated that reversed key lower bound decisions that:

- excluded doctorate degrees in step 1. These graduates were assumed to be 2.95%, which is the proportion of postgraduate research graduates (which would include some master research graduates) relative to the sum of undergraduate and postgraduate coursework graduates across all fields of education (SRC, 2021, table 21, p 39).
- excluded Behavioural Science and Human Welfare Studies and Services graduates in step 1. Data supplied by the Social Research Centre indicated they averaged about 549 graduates a year, of which 2.8% reported being available for employment in allied health. It is further assumed that the proportion that delivered psychology services was the same as that for social work graduates available for employment in allied health.
- excluded ANZSIC classes in step 2 (appendix A). Data supplied by the Social Research Centre indicate these classes (beyond class 8539) represent an additional 15.8% of psychology graduates. For the purposes of estimating an upper bound, the estimates for all fields of education were inflated by 15.8%.

[39] 8510 (Medical Services nfd), 8511 (General Practice Medical Services), 8530 (Allied Health Services nfd), 8590 (Other Health Care Services nfd) and 8599 (Other Health Care Services nec).

- assumed only graduates reporting their occupation (primary activity) as counsellor or psychologist would be delivering psychological services in step 3. It is possible some occupational therapy and social work graduates whose primary activity was delivering psychological services may have reported their occupation as being their professional affiliation rather than that of counsellor or psychologist. For the purposes of the upper bound estimate, the number of occupational therapy and social work graduates assumed to be delivering psychological services was calculated pro rata using the ratio of Better Access services delivered by psychologists relative to occupational therapists and social workers between 2016 and 2021 (80 times and 15 times respectively, figure 3.1).

Following these adjustments, the upper bound estimate was calculated at 312 graduates. This estimate represented 5.2% of the pool of relevant graduates, 90% of whom were from four main fields of education: counselling, occupational therapy, psychology and social work.

Conclusion

About 250 to 310 university graduates a year between 2016 and 2021 were estimated to have been employed, about to start employment or looking for employment as independent allied health practitioners delivering psychological services some four to six months after graduating. They represent about 5% of the total pool of (relevant) graduates who were available for employment; the balance (95%) being available for employment in other industries.