# 1 Introduction

## 1.1 The Better Access Program

The *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative commenced in November 2006. The initiative aimed to improve the treatment and management of mental illness within the community (Dept Health and Ageing, nd), particularly for people with high prevalence mental disorders.

Better Access formed part of the Commonwealth component of the Council of Australian Governments' *National Action Plan on Mental Health 2006-2011* (COAG 2006). It addresses the four outcomes outlined in the Plan, particularly outcomes 1 and 3:

1. Reducing the prevalence and severity of mental illness in Australia;

2. Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;

3. Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and

4. Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

As part of the National Action Plan, the Commonwealth Government undertook to significantly expand its funding in services delivered by private psychiatrists in the community, general practitioners (GPs), psychologists, mental health nurses and other allied health professionals (COAG 2006: 1). In doing this, Better Access introduced new MBS Items for the medical and allied mental health workforce: a total of 26 Items were introduced with another two Items redefined (see Appendix A). Together, these 28 MBS Items provided incentives for:

- General practitioners to participate in the early intervention, assessment and management of patients with mental disorders and to streamline access to appropriate psychological interventions in primary care;

- Private psychiatrists to see more new patients, and expand their role as specialists in backing up the primary health care sector;

- Psychologists, social workers and occupational therapists to be involved in treating patients with mental disorders as part of a coordinated program (via referral pathways) of primary care.

Better Access complements mental health services provided through the Access to Allied Psychological Services (ATAPS). Like ATAPS, Better Access 'supports general practitioners and allied health professionals to work together to provide optimal mental health care' (Fletcher *et al* 2009: 2). The two programs differ, however, in relation to funding mechanisms: ATAPS are funded by the Commonwealth Government through the Divisions of General

Practice; services delivered through Better Access are funded by the Commonwealth Government through the Medicare Benefits Schedule (MBS).

## 1.2 Defining the Better Access Workforce

Generally speaking, a workforce is a pool of labour that is in employment in a particular context – it is equally valid, for example, to speak of an Australian workforce, a health workforce or a skilled workforce. This report focuses on the Better Access workforce, which is a subset of the broader mental health workforce.[2] The Better Access workforce is comprised of six occupational groups: psychologists (registered and clinical), social workers, occupational therapists, general practitioners, psychiatrists and paediatricians. Health professionals in the first five of these occupations can (after meeting eligibility criteria) provide Better Access services, while paediatricians have a referral role within Better Access.[3]

These occupational groups are divided into the Better Access allied and medical mental health workforces:

- The Better Access *allied mental health workforce* is comprised of people working as psychologists, social workers and occupational therapists who provide mental health services.

- The Better Access *medical mental health workforce* is comprised of people working as general practitioners and psychiatrists who provide mental health services and paediatricians who refer into mental health services.

The definition of the ***Better Access workforce*** used in this report is:

- Those members of the allied and medical mental health workforces who meet their professional requirements to practice, but may or may not have provided Better Access services. In essence, this is the broad pool from which Better Access service providers are drawn from. It includes health professionals who may already be registered with Medicare as well as those who could, potentially (after meeting specified requirements), register with Medicare to provide Better Access services. This workforce is also referred to in the report as the *potential* Better Access workforce.

Within the Better Access workforce there is a subset of professionals who provide Better Access services. Throughout the report these are referred to as the *actual* Better Access workforce.

## 1.3 The Better Access Allied Mental Health Workforce

This component of the evaluation focuses on the impact of the implementation of the Better Access initiative on the Better Access allied mental health workforce. Better Access introduced Medicare rebates for services provided by eligible allied mental health

[2] Health professionals within the Better Access mental health workforce include those who are self-employed as well as those employed in the public and private sectors.

[3] As referral providers, paediatricians are out of scope for this evaluation of the Better Access mental health workforce.

professionals. Following referral of a client from a general practitioner, psychiatrist or paediatrician, allied mental health professionals can provide clients with services such as psycho-education, cognitive behaviour therapy, relaxation strategies, skills training and interpersonal therapy. There are two categories of Better Access services:

- *Psychological Therapy Services* which can only be provided by eligible Clinical Psychologists. Clients can access up to 12 individual sessions per calendar year (in exceptional circumstances an additional six services may be provided), and up to 12 group sessions per client per calendar year.

- *Focussed Psychological Strategies* which can be provided by any of the eligible provider categories in the allied mental health workforce. Clients can access up to 12 individual sessions per calendar year (in exceptional circumstances an additional six services may be provided), and up to 12 group sessions per client per calendar year.

The Focussed Psychological Strategies are differentiated on the basis of provider category. In general, psychologists attend to issues pertaining to the behavioural aspects of mental disorders, social workers to the psychosocial factors relating to mental disorders, and occupational therapists to the functional implications of mental disorders. These differences are elaborated further in the following sections.

### 1.3.1 Psychologists

Psychologists work with individuals (and groups) with the aim of helping people to manage their thoughts, feelings and behaviours. They have particular expertise in

> human behaviour, mental processes, and the way in which these can impact on a person's physical state, mental state, and their external environment (Australian Psychological Society 2007).

Psychology is an evidence-based profession, and as part of their training, psychologists study psychopathology and therapeutic interventions for mental health disorders. Psychology skills are implemented in a range of settings including private practice, education, workplaces, sport, community services and health services (Australian Psychological Society 2007).

Many psychologists specialise in an area of psychology and are members of specialist Colleges within the Australian Psychology Society. Clinical psychologists have specialised training in the assessment and treatment of mental disorders. Their training enables them to treat clients with severe and complex mental disorders, including those with co-morbidities of mental health problems and substance abuse.

Better Access differentiates between registered and clinical psychologists:

- Psychologists within the allied mental health professional category can claim for MBS Items associated with Focussed Psychological Strategies (80100, 80105, 80110, 80115 and 80120). To be eligible to register with Medicare Australia to provide these services, a psychologist must be registered with a Psychologists Registration Board in the State or Territory in which they are practising (Dept of Health and Ageing 2009b).

Within this report, psychologists in this category are called 'registered psychologists'.[4]

- Clinical psychologists can claim for MBS Items associated with the provision of Psychological Therapy Services (80000, 80005, 80010, 80015, and 80020). To be eligible to claim for these services, clinical psychologists must be meet the requirements of membership of the Australian Psychological Society's College of Clinical Psychologists.

### 1.3.2 Mental Health Social Workers

Mental health social workers work collaboratively with clients, carers and other health professionals to resolve psychosocial problems associated with mental health disorders. They have particular expertise in helping clients whose 'mental health difficulties co-exist with other problems such as family distress, drug and alcohol abuse, unemployment, disability, poverty and trauma' (Australian Psychological Society 2007). The focus is therefore on:

> ... the **social context** and **social consequences of mental illness**. The purpose of practice is to promote recovery, restore individual family and community wellbeing, to enhance development of each individual's power and control over their lives, and to advance the principles of **social justice**. (AASW 2010, emphasis in original)

Within Better Access, accredited mental health social workers can provide services associated with Focussed Psychological Strategies and have access to five MBS Items (80150, 80155, 80160, 80165, and 80170). In order to practise as a Mental Health Social Worker, the Australian Association of Social Workers (AASW) accreditation requirements must be met. These are:

- Current membership of AASW;
- Evidence that the *Practice Standards for Mental Health Social Workers* (AASW 2008) have been met;
- Evidence of at least two years of supervised social work practice (post qualifying) in mental health or demonstrably related field;
- Evidence of pre-qualifying, qualifying or post-qualifying education and or recognised professional development of training relevant to working in mental health; and
- Provision of a testimonial from an employer or supervisor (AASW 2010).

The *Practice Standards for Mental Health Social Workers* (AASW 2008) set out the knowledge, skills and values considered to be specific to social work in mental health. These include an emphasis on personhood; valuing the lived experience of individual consumers and family members and carers; affirming the importance of partnership and mutuality; addressing powerlessness, marginality, stigma and disadvantage; and conveying empathy, compassion and hope.

[4] Note that registered psychologists may also include clinical psychologists. The categories are not mutually exclusive but based on the types of Better Access services provided.

### 1.3.3 Mental Health Occupational Therapists

Mental health occupational therapists (OTs) work with clients, their families, carers, schools and workplaces to address the functional implications of mental health problems. They:

> ... work collaboratively with people, who experience distress, illness, disability, and developmental delay, their occupational consequences, and occupational deprivation, as well as with people who desire to further develop their existing skills, and options for occupational development (OT Australia 1999).

Mental Health OTs have a view of mental health that is broader than clinical diagnosis, and takes account of personal functioning, opportunities, resources and suffering (OT Australia 1999). As stated in the APS *Better Access Orientation Manual* (2007: 38), OTs 'are evidence based specialists, whose academic training includes broad based education in physical and psychological components of mental health and wellbeing.' Mental health OTs work both independently and in multi-disciplinary teams.

Within Better Access registered mental health OTs can provide services associated with Focussed Psychological Strategies and have access to five MBS Items (80125, 80130, 80135, 80140 and 80145). To provide services under the Better Access Initiative, occupational therapists apply through their professional association, Occupational Therapy Australia for registration. To be eligible, OTs must:

- Be a current member of OT Australia;
- Provide evidence that the *Australian Competency Standards for Occupational Therapists in Mental Health* (OT Australia 1999) have been met; and
- Provide evidence of at least two years of supervised social work practice (post qualifying) in mental health or demonstrably related field (OT Australia 2009).

## 1.4 Methodological Considerations

The evaluation of the Better Access initiative required drawing upon several data sources. Comparing disparate data sources which were not developed for the purpose of an evaluation of the mental health workforce was difficult because there were many areas in which direct concordance was not possible. To make the most of the data available from these sources, we sought to develop ways of interpreting the data so that reasonable comparisons could be made. We discuss the methods used in developing measures that could be compared across data sets, occupational categories, public-private sectors, and regions in this section. Despite enhancing the comparability of the data, throughout the report we urge caution in drawing generalisable conclusions where data are particularly problematic.

### 1.4.1 MBS and Medicare Provider Data

The Department of Health and Ageing provided unpublished data from the Medicare Benefits Schedule for Items associated with Better Access, and associated data from the Medicare Providers database (2004-2008).

MBS data for services provided between November 2006 and December 2008, inclusive, provided information about the *actual* Better Access workforce. Information from the Medicare Providers database informed calculations of estimates for the *potential* Better Access workforce, although these estimates were supplemented with information from other data sources (see below for details).

Medicare data were used in two sections of the report. In chapter 2, the data were split into calendar years (January – December) and analysed for each occupation in relation to the required characteristics for 2006, 2007 and 2008. The collation of data into calendar, rather than financial, years meant that there were two full years of Better Access to analyse,[5] with a further 2 months (9 weeks) of data for 2006. In chapter 3, Medicare data were used to examine the supply and distribution of health professionals in each of the allied mental health provider categories.

The following information relates to our use of the MBS data:

- The analysis in chapters 2 and 3 primarily used numbers of people (headcount) in each category.

- The headcount in each provider category using Better Access Item numbers were identified using the service providers' 'provider number'[6]. These figures, although the most reliable available, only give an approximate number of service providers as it is possible for individual providers to have more than one provider number (particularly if an individual provides services in multiple locations or across more than one state/territory). The numbers of service providers registered with Medicare Australia were also provided, for each of the relevant provider categories.

- Service provider categories were derived from use of occupationally specific MBS Items. For example, all service providers using MBS Items 2710, 2712 and 2713 were defined as General Practitioners. See Appendix A for the Item numbers associated with each occupation.

  Given that a criterion for registration with Medicare is registration with a professional body, the use of occupationally specific MBS Item numbers provides reliable data for the standard defined occupational categories – general practitioner, psychiatrist, psychologist, social worker, OT.

  However, the use of MBS Items to differentiate between clinical psychologist and registered psychologist, within the broader psychologist occupational category, distinguishes between types of services rather than occupations. Hence, clinical psychologists can provide services for MBS Items allocated to registered psychologists. For example, 297 psychologists provided both Psychological Therapy Services and Focussed Psychological Strategies in 2006. This number rose to 1096 in 2007 and 1181 in 2008 (MBS data 2006-2008). When based on MBS Items, the occupational demarcation between clinical and registered psychologists is therefore less clear. For the purposes of this report, clinical and registered psychologists are

[5] Although collation into financial years would have enabled concordance of collection points with the NMHS- MHE data, it would have only provided one full year of comparison (July 2007 – June 2008).

[6] Provider numbers were randomised by Medicare Australia to ensure privacy.

called provider categories rather than occupational categories. Due to these data issues, clinical and registered psychologists were grouped under the category of 'psychologist' when data was compared across data sets, and separately when the MBS data was used in isolation.

- Information about educational attainment and country of birth were provided by the Department of Health and Ageing but did not comply with standard (ABS) classifications and were not used. It was assumed that all providers met Medicare eligibility standards for their occupation, including qualification.

- Deemed full time equivalent (DFTE) numbers have been calculated for each of the provider categories using MBS data. This information is reported in chapter 3. The DFTE was calculated by converting the hours billed against the MBS for Better Access Items to an estimated fulltime equivalent. This involved several steps:

    - Calculating the number of billed hours: for each Better Access MBS Item number, the recommended consultation time for the Items was allocated to produce a conservative estimate of the number of hours spent by providers on Better Access services. As the standard by which time was recommended was not uniform across the various MBS Items, we have based our calculations on the following:

        - Using the minimum recommended time where this is the only time provided;

        - Using the midpoint recommended time if a time range was specified;

        - Where no recommended time was specified (e.g. for MBS Items 2710 and 2712), BEACH data[7] was used to estimate an average consultation time of 25 minutes.

    - The average number of billed hours per occupation per year was then divided by the number of working weeks in the year. Allowing for annual and sick leave, it was estimated that there were 46 working weeks per calendar year in the private sector, equating to 8 weeks in 2006 (Nov-Dec only). This figure provided an indication of the average number of hours per week that each allied mental health occupation worked on Better Access services.

    - To estimate how many fulltime health professionals it would take to deliver the number of Better Access hours billed, a conversion factor was used. This conversion factor took account of the difference between hours worked and hours billed (or claimed via MBS). Using information from various sources including the Australian Institute for Health and Welfare (AIHW), the Mental Health Establishments: National Minimum Data Set and consultations with the Australian Psychological Society, it was estimated that approximately 85% of time worked was billed. From the information available we therefore estimated that the allied mental health workforce would claim 30 hours per week, while a full time medical mental health professional would claim 33 hours per week.

[7] Data provided by the Department of Health and Ageing (9/11/2009) from the BEACH (Bettering the Evaluation and Care in Health) dataset, The Family Medicine Research Centre, University of Sydney.

- The average number of hours per week spent on MBS Items for each occupational group was then divided by the conversion factor to produce the deemed fulltime equivalent (DFTE) for each group.

- The MBS database provided Rural, Remote and Metropolitan Areas (RRMA) categories of geographical classification, based on population density, to describe the geographical distribution of service providers.[8] In section 3.2, these regions have been grouped into urban and rural based on the categories in Table 1.1:

**Table 1.1 Comparison of the RRMA and non-standard geographical categories**

| Non-standard | RRMA |
|---|---|
| Urban areas | Capital cities and large metro areas<br>Other metro areas |
| Rural areas | Large rural areas<br>Small rural centre<br>Other rural centre<br>Remote centre<br>Other remote centre |

### 1.4.2 ABS 2006 Census of Population and Housing

For the purpose of this evaluation, the ABS 2006 Census of Population and Housing (ABS Census) provided information on both the estimated numbers and the demographic, geographic and labour market characteristics of the *potential* Better Access workforce, for each occupational category. The ABS Census is the largest survey in Australia. Involving a complete enumeration of the population, rather than of a population sample, it does not suffer the sampling problems of other surveys and allows the analysis of small or highly specific groups to be targeted. Furthermore, the collection of information for the ABS Census occurred in August 2006, only a few months before the Better Access initiative was implemented.

The ABS has policies to reduce collection and processing errors occurring in the Census. In 2006, the ABS Census Post-enumeration Survey (PES) indicated that there was a net undercount of 549,486[9] Australians (approx. 2.7% of the estimated population). While this may slightly under-estimate the numbers for each occupational category, the size of the ABS Census and the sampling technique used ensures that the underlying characteristic distributions are a true reflection of the population. With a 97.3% response rate, the ABS Census was therefore considered to be the most accurate and comprehensive data source for the discussion of the characteristics of occupations in the Better Access workforce. It was the only data source that provided consistent data about workforce characteristics across all occupational groups. The required data was purchased from the ABS specifically for this project and is primarily used in Chapter 2.

[8] Although available in other categories of geographical classification, RRMA data was provided by Medicare for the purpose of this evaluation.

[9] ABS, Census of Population and Housing – Details of Undercount, August 2006, Cat. no. 2940.0

The ABS and MBS databases differ across some categories and, in using the analysis of these databases, the following should be noted:

- In the ABS Census, occupations are defined according to the ABS Australian and New Zealand Standard Classification of Occupations (ANZSCO). The relationship between the ABS and MBS occupations are shown in Table 1.2. The occupation information collected in the ABS Census is self-enumerated, applicable only to those employed and aged 15 years and over. The ABS Census asks individuals to provide the 'full title of' and the 'main tasks undertaken in' the occupation of their 'main job' held in the 'last week'.[10] This information is then categorised by the ABS. This method of self-reporting (and subsequent coding) of occupations may result in slightly under/over-estimate of the numbers for each occupation category. In determining numbers of the potential Better Access workforce, the ABS Census is therefore used in conjunction with other data sources.

**Table 1.2 Comparison of occupational categories, ABS and MBS**

| ANZSCO code | ABS Occupational Category | MBS Provider Category |
|---|---|---|
| 272300 | Psychologists* | Clinical Psychologists **<br>Registered Psychologists |
| 272511 | Social Workers | Social Workers |
| 252411 | Occupational Therapists | Occupational Therapists (OTs) |
| 253111 | Generalist Medical Practitioners | General Practitioners (GPs) |
| 253411 | Psychiatrists | Psychiatrists |
| 253321 | Paediatricians | Paediatricians |

* Note: The ANZSCO Major Group (6-digit) occupation categories include: Clinical Psychologist (272311), Educational Psychologist (272312), Organisational Psychologist (272313), Psychotherapist (272314), and Psychologists nec (272399).

** Note: In consultation with the Department of Health and Ageing, the more detailed ANZSCO Major Group (6-digit) 'Clinical Psychologist' (272311) occupation was not selected as a comparison to clinical psychologists in the MBS data. The ANZSCO definition does not appropriately reflect the level of qualification or experience required by the Australian Psychological Society (APS) or Medicare Australia.

- The ABS uses the Australian Standard Geographical Classification (ASGC) based on either population size or remoteness from services, to describe the geographical distribution of health professionals. The lack of concordance between RRMA and ASGC meant that direct comparison of the geographic distribution of the actual and potential Better Access workforce was limited. Instead, comparisons of distribution as discussed in chapter 2 have been estimated based on broad delineation of metropolitan and rural (includes rural, remote areas) as per Table 1.3.

[10] ABS, Census Dictionary, 2006 (Reissue), Cat. no. 2901.0.

**Table 1.3 Comparison of ASGC, RRMA and non-standard geographical categories**

| ASGC (ABS) | RRMA (MBS) | Non-standard |
|---|---|---|
| Major urban | Capital cities and large metro areas | Metropolitan |
| Other urban | Other metro areas | Rural |
| Bounded locality | Large rural areas | |
| Rural balance | Small rural centre | |
| Migratory | Other rural centre | |
| | Remote centre | |
| | Other remote centre | |

### 1.4.3 Mental Health Establishments: National Minimum Data Set

A collection of Mental Health Establishments data is conducted on behalf of the Department of Health and Ageing annually as at June 30.[11] It collects information from *specialised mental health services* that are managed or funded by the state and territory governments. The services are publicly funded and are therefore outside of the MBS system (although there are 5-6 private hospitals with publicly funded services). Health professionals in the public mental health workforce may also work in the private sector or may transition between the two. In effect, the public mental health workforce is part of the broader Better Access mental health workforce. The Mental Health Establishments: National Minimum Data Set (MHE NMDS) was used to examine whether Better Access had impacted on the distribution of health professionals across the Medicare and public health sectors. This is discussed in Chapter 3.

The lack of concordance between the MHE: NMDS and MBS data in collection points, the unit of analysis and geographic distribution, meant that there were difficulties in making comparisons between occupational groups in the two sectors. In particular, each of the datasets has different collection points: the MBS is collected monthly and was reported on per calendar year; and the MHE: NMDS is collected annually on a financial year basis. There was no concordance in the timeframes across the data sources. We did, however, develop measures to make the MHE: NMDS and MBS data more comparable. This involved:

- Reporting on estimates of full-time equivalent numbers in each of the data sources. The MHE: NMDS reports on the number of fulltime equivalent (FTE) places in each occupation. The MBS data was converted to provide numbers of deemed fulltime equivalent (DFTE) places in each occupation (explained above). While this has allowed a better comparison across the two sectors, the different methodologies in achieving these figures mean that caution is required when interpreting the results. In effect, there is still a lack of concordance between the datasets. Despite this lack of

[11] This data set includes both the Mental Health Establishments: National Minimum Data Set (2005-08) and the National Survey of Mental Health Services (1995-2006). In this report the combined data is referred to as the Mental Health Establishments: National Minimum Data Set (MHE: NMDS).

concordance, it was important to gain an understanding of the trends in the allied mental health workforce following the implementation of Better Access. The use of FTE and DFTE provided a better method to quantify the workforce than simple head counts, because the headcount method does not control for differences in part-time/full-time status.

- Converting non-concordant geographical categories to the more simplified capital – non-capital categories of analysis. In consultation with the Department of Health and Ageing, the MHE: NMDS (2004-2008) was manually coded according to a non-standard geographic category based on whether an establishment was located in a 'capital city' or 'outside a capital city'. This provided a simple mechanism for examining whether Better Access has influenced the supply of the allied mental health workforce outside of capital cities. To make this comparable to the MBS data, which uses RRMA, the 'capital cities and large metro areas' was equalised to the 'capital city' non-standard category, with all other RRMA categories equalised to the 'not capital city' non-standard category.

### 1.4.4 Registration Boards and Administrative Data

Registration Board and administrative data from professional associations were used as auxiliary information in estimating the numbers of health professionals in the potential Better Access allied mental health workforce. Part of the issue for acquiring data relating to the allied mental health workforce was that there were no consistent national registration requirements or administrative bodies that collect the data required.[12] Table 1.4 summarises the jurisdictions for which data were publicly available.

**Table 1.4 Availability of registration board and administrative data for psychologists, occupational therapists and social workers, 2006-2008**

| State/Territory | Psychologists | | | Occupational Therapists | | | Social Workers | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2006 | 2007 | 2008 | 2006 | 2007 | 2008 | 2006 | 2007 | 2008 |
| **NSW** | ✓ | ✓ | ✓ | n.a. | n.a. | n.a. | ✓ | ✓ | ✓ |
| **VIC** | ✓ | ✓ | ✓ | n.a. | n.a. | n.a. | ✓ | ✓ | ✓ |
| **QLD** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **SA** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **WA** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **TAS** | ✓ | ✓ | ✓ | n.a. | n.a. | n.a. | ✓ | ✓ | ✓ |
| **ACT** | ✓ | ✓ | ✓ | n.a. | n.a. | n.a. | ✓ | ✓ | ✓ |
| **NT *** | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | ✓ | ✓ | ✓ |

Note: for psychologists, occupational therapists and social workers, the collection of data varied from the end of the financial year and the end of the calendar year.

[12] From 1 July 2012, psychologists and occupational therapists will be joining the Australian National Registration and Accreditation Scheme, which will provide consistency in the data. However social workers will continue to be self-regulating.

* Note: Administrative data from the Northern Territory Psychologists Registration Board or the Northern Territory Occupational Therapists Registration Board were not publicly available.

To estimate the potential number of social workers, membership data was provided by the Australian Association of Social Workers (AASW).[13] For psychologists and OTs, publicly available state/territory registration board administrative data were used to estimate potential numbers. The registration board data included members licensed/registered to practice, where required by state/territory legislation.[14] In contrast to the ABS Census data, registration board data includes those (i) not employed (i.e. retired, on leave, unemployed or not in the labour force), (ii) employed, but not as a psychologist or occupational therapist, (iv) interstate or overseas. Due to the limitations of the information publicly available it is not known how many of the psychologists and OTs registered with their boards, were active practitioners. However, using South Australian data, from 2006 to 2008, it was estimated that approximately 7-8% of psychologists and 16-17% of OTs were not employed, 4-6% of psychologists and 2-3% of OTs resided interstate, and 2-3% of psychologists and 4-3% of OTs resided overseas.

**Table 1.5 Selected categories of license/registration for psychologists and occupational therapists, by state/territory.**

| | Psychologists | Occupational Therapists |
|---|---|---|
| **NSW** | Fully registered | - |
| | Fully registered (temporary) | - |
| **VIC** | General registration | - |
| | Specific registration | - |
| **QLD** | General registrants | General |
| | Provisional general registrants | Provisional general |
| | Deemed general registrants | Deemed |
| | Deemed provisional general registrants | - |
| **SA** | Full registration | Full registration |
| | Limited registration | Limited registration |
| | Deemed registration | Deemed registration |
| **WA** | Fully registered | General |
| | Specialist title | - |
| | Mutual recognition | - |
| **TAS** | Registered | - |
| **ACT** | Registered | - |
| **NT *** | - | - |

* Note: Administrative data from the Northern Territory Psychologists Registration Board and the Northern Territory Occupational Therapists Registration Board were not publicly available.

[13] Social Workers do not have a registration board, although accredited social workers do need to be members of the Australian Association of Social Workers.

[14] OTs are not required to register in all states/territories

For both the psychologists' and OTs' registration board data, the definitions and standards in licensing varied between the state/territory jurisdictions. In consultation with the department of Department of Health and Ageing, the licenses that reflect fully-trained psychologists (clinical and other) and OTs have been selected for analysis. Table 1.5 summarises the selected licenses for psychologists and OTs by state/territory used in this report.

For social workers, the AASW membership administrative data includes both unaccredited and accredited mental health social workers. Unlike the psychology and OT registration boards, the AASW is self-regulating and there are no state/territory legislative requirements for social workers accreditation. However, social workers must be a member of the AASW and have attained accreditation to register with Medicare and be able to utilise MBS Better Access Items. Specific data was acquired from AASW providing the numbers of accredited mental health social workers. Similar to the registration board data, the AASW membership data includes social workers (i) not employed (i.e. retired, on leave, unemployed or not in the labour force), (ii) employed, but not as a social worker (unaccredited and accredited), (iv) interstate or overseas. It is not known how many of the social workers (unaccredited and accredited), registered with the AASW, were active practitioners.

### 1.4.5 Consultations

In examining the anticipated implications of the Better Access initiative for future workforce trends, consultations were held with representatives from key organisations associated with the Better Access workforce. The consultations were conducted in June, prior to the 2009-10 Budget release (Department of Health and Ageing 2009a), and therefore responses do not consider changes introduced at this time. The findings from the consultations are discussed in chapter 4.

The purpose of the consultations was to identify issues that may not yet have been apparent from the quantitative data due to the relatively short time frame (just over two years) between the implementation of the Better Access initiative and the evaluation. It would be difficult, for example, to assess the impact of Better Access on the capacity of training systems through the collection of quantitative data given that training systems typically have a lag time of more than two years depending on the occupation.

Speaking directly to key stakeholders provided an opportunity to canvass issues raised by the Department of Health and Ageing in relation to the impact of Better Access on training, and the effectiveness of referral pathways. The consultations therefore investigated the perceptions of key stakeholders about the impact of Better Access on different occupational groups.

As negotiated with the Department of Health and Ageing, stakeholders representing the Better Access occupations were invited to participate in the consultations. These representatives were primarily sourced from the peak medical/allied health associations and colleges and training providers, with two individuals participating. Table 1.6 identifies participants in the consultation component of this study.

**Table 1.6 Participants in the consultations**

| Organisations consulted, including the acronyms used in the report |
|---|
| Australian College of Rural and Remote Medicine (ACRRM) |
| Australian Association of Social Workers (AASW) |
| General Practice Registrars Australia (GPRA) |
| Overseas Trained Doctors Association (OTDA) |
| Australian Indigenous Psychologists Association (AIPA) |
| Australian College of Clinical Psychologists (ACCP) |
| Universities Australia |
| Australian Psychological Society (APS) |
| Royal Australian and New Zealand College of Psychiatrists (RANZCP) |
| General Practice Mental Health Standards Collaboration (GPMHSC) |
| Chair of GPMHSC |
| Australian General Practice Training (AGPT) |
| Australian Private Hospital Association (APHA) |
| Occupational Therapy Australia (OT Australia) |
| Mental Health Professionals (MHPN) |
| Royal Australian College of General Practitioners (RACGP) |
| Australian Psychology Accreditation Council (APAC) |
| Royal Australian College of Physicians (Paediatrics) (RACP (Paediatrics)) |
| **Individuals Consulted** |
| Overseas trained doctor |
| Consumer representative |

A qualitative interview schedule (see Appendix C) was designed and tailored to each organisation participating in the consultation. Ethics approval for this component of the evaluation was acquired from Monash University Standing Committee on Ethical Research in Humans. Nineteen interviews and a group discussion with the Board of the General Practice Mental Health Standards Collaboration were conducted. Except for the group discussion, each consultation consisted of a semi-structured interview of approximately 35 minutes duration. Each interview was digitally recorded and transcribed. The transcriptions were entered into the NVivo qualitative research analysis programme and analysed by coding responses thematically.

As with each of the data sources, there were limitations in the information gained through the consultations:

- The sample of organisations from which the consultations were drawn was small and targeted. The aim was to get as broad a sample as possible with the available resources, covering each of the key stakeholder groups. This meant that the analysis covers a range of issues, but could not verify the extent to which they were widespread. For example, the discussion of the psychology workforce is based on consultations with four psychology organisations. Quantifying the responses to assess veracity was therefore not appropriate.

- The consultations were primarily with representatives of groups. Sometimes these groups were large (e.g. Australian Psychology Association with over 20,000 members), while others were relatively small (e.g. Universities Australia with less than 50 members). In two instances, consultations were undertaken with individuals. No effort has been made to weight the responses according to the size of the organisation represented.

- The participants did not have the benefit of the quantitative data upon which to make comments. Discussions therefore focused on their *perceptions* of what was happening for members of their particular organisation. Although this method enables the early identification of issues and could be viewed as a strength of the approach, it also means that the information provided was based on experience and observations which has limited generalisability.

**Supplementary material**

The information collated through the consultations was supplemented by:

- Material provided by some of the organisations that took part in the consultations, including:

    - Forsyth, C. and Matthews, R. (2009). Survey of members providing services under the Better Access and Better Outcomes initiatives, *InPsych, 30-33*.

    - General Practice Mental Health Standards Collaboration (2010). Retrieved Sept 2009 from www.racgp.org.au/gpmhsc

- Personal correspondence from a representative from the School of Behavioural Science at the University of Melbourne and the Director of the University of New South Wales Psychology Clinic.

- KPMG survey questions: in collaboration with KPMG, who conducted Component D (consultations with stakeholders) of the broader *Evaluation of the Better Access to Psychiatrists, Psychologists and GPs through the Medicare Benefits Schedule initiative*, questions concerning access to clinical training were included in an internet based survey of mental health stakeholders (see Appendix D). Please note that KPMG also interviewed many of the organisations listed above.

## 1.5 Scope of the Report

The National Institute of Labour Studies was commissioned to address Component C of the evaluation of the Better Access Initiative by providing a detailed analysis of any changes in the supply and distribution of the allied mental health workforce across Australia following the introduction of the Better Access initiative and to provide an analysis of the associated workforce implications.

The report proceeds as follows:

**Table 1.7 Outline of tasks for Component C of the evaluation**

| Task | Data Source | Chapter |
|---|---|---|
| Methodology and Scope of Report | | 1 |
| Describe the characteristics of the Better Access workforce (i.e. GPs, psychiatrists, clinical and registered psychologists, social workers and occupational therapists) | ABS (2006 Census)<br>MBS<br>Registration Boards and Professional Association | 2 |
| Provide an analysis of the extent to which the Better Access initiative has impacted on the supply and geographical distribution of the allied mental health workforce with particular reference to any impact of the Better Access initiative on State and Territory public specialised mental health workforce and the private allied mental health workforce | MBS<br>MHE NMDS | 3 |
| With specific reference to the Better Access initiative, describe anticipated implications for future workforce trends, for example clinical training; | Consultations | 4 |
| Describe the implications of the Better Access initiative in relation to workforce capabilities and capacity to provide early intervention and treatment of people with mental disorders within a primary care setting | Critical evaluation of data | 5 |