NATIONAL MENTAL HEALTH COMMISSION:

REVIEW OF MENTAL HEALTH PROGRAMMES AND SERVICES 2014

A submission by Australian Counselling Association Inc.

A Peak National Body Representing Australian Registered Counsellors

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Executive Summary

The Australian Counselling Association Inc. (ACA) welcomes this opportunity to submit comments to the National Mental Health Commission (NMHC) on the proposed review of existing mental health services and programmes across the government, private and non-government sectors.

This submission was prepared by review of the Terms of Reference, and of various documents published by the Department of Health, the National Mental Health commission, Department of Health and Ageing, Australian Bureau of Statistics and other relevant documents.

We have provided an overview of the Counselling industry; research literature on the efficacy of counselling services; and the cost effective nature of counselling within the broader context of mental health services. In doing so we have established the proposition that Registered Counsellors can be included in government programs with no reduction in the quality of service; no increase in the risk of harm; rigorous practitioner accountability; yet delivering a substantial budgetary saving.

We have included information on the equivalency of training and supervision standards of Registered Counsellors with their mental health peers; the scope of services competently delivered by Registered Counsellors; as well as industry mechanisms for practitioner accountability.

Our submission aims to provide the Commission with relevant information based on research and factual evidence. We discuss practical evidence regarding outcomes achieved, what works and what doesn’t, identified gaps and strengths in current mental health services, suggested strategies for improvement, and whether we as a nation are receiving value for money based on mental health services provided.

We make several recommendations. Our key recommendation relates to the utilisation of Registered Counsellors, and how this will strengthen the mental health system through delivery of cost effective, accountable, efficacious mental health services. We propose that providing Registered Counsellors access to the Medicare Benefits Scheme (MBS) through the Better Access Initiative (BAI) will reduce expenditure for mental health services with no reduction in the quality of service delivered. Inclusion would also contribute to resolving field force shortages and waiting times.
Overview of the Counselling industry in Australia

The Counselling industry in Australia is mature, robust and growing. There are 41 public and private universities in Australia. Of these, 38 universities and private Higher Education Providers (HEP’s) deliver a Bachelor of Counselling and/or Masters of Counselling.

Counsellor training programs have a strong applied focus, including mandatory training in evidence-based therapies such as Cognitive Behaviour Therapy (CBT) and Solution-Focussed Therapy. By comparison, undergraduate training programs in psychology and social work include little to no training in applied evidence-based therapies, necessitating that these skills be acquired, usually through short-course professional development programs (often online) in order for practitioners to meet the requirements of the Better Access Initiative.

Counsellors have delivered services to the Australian public for several decades. Prior to the introduction of the BAI in 2006, General Practitioners readily referred patients to counsellors.

The Counselling industry is regulated through an inclusive self-regulation model, not dissimilar to the Social Work industry. Whilst there are various membership associations for counsellors; training, supervision, continuing education and ethical standards, meet a uniform minimum standard through listing on the national Counsellor register, Australian Register of Counsellors and Psychotherapists (ARCAP). In this way the industry maintains diversity and inclusiveness, whilst ensuring high minimum training and practice standards. For instance, an ethical breach resulting in delisting by one association results in a delisting from ARCAP, and hence all associations.
Definition of Registered Counsellors

A Registered Counsellor is a Counsellor that meets and continues to meet the minimum standard – training, continuing education, supervision and ethical practice – of an industry association providing a listing pathway to the national Australian Register of Counsellors and Psychotherapists (ARCAP) register. This encompasses some 80% of practicing Australian Counsellors.

In terms of training equivalency, psychology and social work each have a six-year training sequence. For psychology, the six-year sequence comprises: 3-year undergraduate degree + 1-year post graduate (Honours or Graduate Diploma) + 2-years Supervision OR Masters. For social work, the six-years comprises: 4-year undergraduate degree + 2-years FTE post graduate Supervision.

ACA Level 3 (and 4) Members must also attain a six-year sequence through a minimum 3-year undergraduate degree + 3-years Supervised Practice.

Registered Counsellors are required to undertake training in evidence-based psychological therapies as part of their core training. Typically, education programs in counselling include study and the application of a range of evidence-based therapies such as Cognitive Behaviour Therapy (CBT) and Solution-Focussed Therapy.

Additionally, ACA Members are required to attain a minimum of 25-hours of continuing education per annum, as well as evidence ongoing professional Supervision.
The Role of Counsellors

A counsellor is a trained and experienced professional, who through the use of cognitive, affective, behavioural and systematic interventions, aims to facilitate change in a manner respectful of the client’s values, resources and autonomy (see IRCEP; ACA). A counsellor aims to facilitate client progression towards a solution whilst demonstrating a genuine concern and compassion for the client’s presenting situation.

Registered Counsellors understand the importance of, and utilise an interpersonal relationship to support people to explore and resolve their difficulties and make necessary changes in their lives. The therapeutic alliance is an acknowledged important factor in successful counselling outcomes adjunct to the psychotherapies employed.

The counsellor develops strategies in collaboration with the client. Therapeutic interventions utilised are determined based on client ability and strengths, counsellor knowledge and best practice methodologies.

Counselling aims to:

- Prevent mental illness;
- Provide psychotherapeutic interventions for psychological difficulties;
- Promote mental health and wellbeing;
- Develop resiliency.

Registered Counsellors are well trained and have relevant experience to develop a Mental Health Plan for the client. Thereafter the counsellor constantly evaluates the client’s progress and appropriate outcomes are monitored and recorded by the Counsellor.
Evidenced-based research on effectiveness of Counsellors

There is a large body of international and domestic evidence that counselling is an effective treatment for a range of mental disorders. Counselling skills are an interdisciplinary activity used by a range of professionals, including psychologists, social workers, occupational therapists, nurses, doctors and psychiatrists. Registered Counsellors are specifically trained in the use of advanced counselling skills that include a solid basis in psychological theories.

The counselling process is not ‘owned’ by any one of these professional groups. Therefore there are no valid reasons for government-funded mental health services to be limited solely to psychologists, social workers and occupational therapists, to the exclusion of Registered Counsellors who, as a professional group, specialise in the delivery of counselling services.

In this section, we provide a broad overview of evidence for the effectiveness of counselling and psychotherapy. As these are both ‘umbrella’ terms which cover a range of psychological therapies, the term ‘counselling’ is used here for brevity to encompass the phrase ‘counselling and psychotherapy’ and broader descriptions such as ‘psychological interventions’. We note here that Registered Counsellors, as part of their training, undertake training in a range of evidence-based therapeutic approaches, including Cognitive Behaviour Therapy (CBT) and Solution-Focussed Therapy (SFT).

For more detailed information about specific studies, and further information about different types of research, visit http://bacp.co.uk/research/resources/index.php.

The types of evidence were extracted from the following studies:
- Systematic reviews;
- Randomised Controlled Trials (RCTs);
- Practice-based evidence.

Systematic reviews and meta-analyses

A number of systematic reviews have been conducted which provide evidence that counselling has greater clinical effectiveness compared with usual care (e.g. Bower et al., 2011; Cape et al., 2010; Hill et al., 2008; Rowland et al., 2000), and that clients are highly satisfied with counselling received in primary care (Hill et al., 2008).

Counselling has been demonstrated to be as effective as CBT (Hill et al., 2008), and a review of studies comparing interventions for common mental health problems such as anxiety and depression found no significant differences between CBT, non-directive counselling, and problem solving therapy (Cape et al., 2010). A recent meta-analysis comparing seven interventions for depression – interpersonal therapy; behavioural activation; cognitive behavioural therapy (CBT); problem solving therapy; social skills training; psychodynamic therapy; supportive counselling – reported comparable efficacy, with all interventions being superior to a waitlist control condition (Barth et al., 2013). When compared with usual care, all interventions except for social skills training were significantly more beneficial, and similar results were found in comparison to no treatment (Barth et al., 2013).
Randomised controlled trials

In a comparison of non-directive counselling, Cognitive Behaviour Therapy (CBT) and usual General Practitioner (GP) care in the treatment of depression and mixed anxiety and depression, both psychological therapies reduced depressive symptoms to a significantly greater extent than usual GP care at 4-month follow up (Bower et al., 2000; King et al., 2000). Clients receiving nondirective counselling or CBT expressed more satisfaction with their treatment (King et al., 2000), and there were no significant differences in direct costs between the three interventions (Bower et al., 2000).

Practice-based evidence

Studies using routine outcome measures, such as Clinical Outcomes for Routine Evaluation (CORE), have reported reliable post-intervention improvement for counselling in three quarters of clients (Mellor-Clark et al., 2001), and demonstrated person-centred counselling to be an effective intervention for clients with common mental health problems (Gibbard & Hanley, 2008).

Research undertaken within Improving Access to Psychological Therapies (IAPT) services has reported counselling and CBT to be equally effective in the treatment of depression, with approximately 40% of people moving to recovery in each intervention (Glover, Webb & Evison, 2010). A meta-analysis of studies on outpatient individual and group CBT in routine clinical practice demonstrated that CBT was effective in reducing depression severity, with post-treatment gains being maintained 6 months after completion of therapy (Hans & Hiller, 2013). In addition, investigations of counsellors’ perceptions indicate that they have perceived clients as having changed in their experience of themselves or of their relationships, and to have benefited from the therapeutic relationship (Howey & Ormrod, 2002).

Comparisons with pharmacotherapy

Research has found that many clients indicate a preference for counselling over antidepressant medication, (e.g. Sharp et al., 2010; Unützer et al, 2003), and patients receiving counselling tend to be more satisfied with their treatment than those receiving CBT or usual care (Hakkaart-Van Roijen et al., 2006). For some specific conditions, such as Obsessive Compulsive Disorder (OCD), psychological therapy has been found to be significantly more effective than pharmacotherapy (Cuijpers et al., 2013). Psychological therapy has also been reported to be significantly more efficacious than specific medications, such as tricyclic antidepressants, in the treatment of depressive and anxiety disorders (Cuijpers et al., 2013). It has been suggested that a combination of psychological therapy and anti-depressant medication may produce the most significant positive outcomes for clients (Baker et al., 2002). For example, interpersonal therapy has been shown to be effective as a combination treatment for depression (Cuijpers et al., 2011), and CBT notably improves outcomes when utilised as an adjunct therapy in acute psychiatric inpatient treatment of depressive disorders (Köhler et al, 2013).

Cost effectiveness

Counselling is reported to be cost-effective compared with standard treatment in primary care (King et al., 2000) and early intervention services (Hastrup et al., 2013). Comparisons of counselling, CBT and usual care have found no significant differences in direct costs between the three interventions (Hakkaart-Van Roijen et al., 2006). Counselling is also reported to be cost-effective in other areas of clinical application, such as for bulimia nervosa (Crow et al., 2013) and postnatal depression (Morrell et al., 2009).
Clinical applications

Research can be a valuable tool in demonstrating the clinical applications of counselling for various presenting issues, and with different client groups. For example, studies of the treatment of personality disorders indicate that dialectical behaviour therapy (DBT) is more effective than treatment as usual for women with borderline personality disorder (Brazier et al., 2006), whilst cognitive analytical therapy (CAT) appears to be effective for a range of personality disorders and superior to treatment as usual (Mulder & Chanen, 2013). Counselling has further been identified as a valid treatment option for anorexia nervosa, with all studies in a systematic review of clinical effectiveness demonstrating an improvement in patients given counselling (Pittock & Mair, 2010). In particular, family therapy was found to be effective, and there was some evidence for the effectiveness of CBT. CBT-based interventions have been shown to have potential use in the management of bulimia nervosa (e.g. Jones & Clausen, 2013; Vaz, Conceição & Machado, 2013), and there is also evidence for therapy-assisted self-help as being an effective first-level treatment in a stepped care approach for bulimia nervosa (Mitchell et al., 2011).

A recent meta-synthesis of qualitative studies investigating helpful and unhelpful aspects of eating disorder treatments found that clients appreciated and valued counselling (Timulak et al., 2013). Furthermore, among specific helpful aspects were interventions that are integral to current empirically-based treatments; clients identified aspects of standard CBT treatments, such as a structured approach, use of monitoring tasks and cognitive restructuring, and behavioural activities (Timulak et al., 2013).

There is evidence supporting the efficacy of counselling in substance misuse disorders, with research demonstrating that mindfulness-based interventions can reduce consumption of various substances, as well as being associated with a reduction in craving (Chiesa & Serretti, 2013).

A systematic review of prevention and intervention strategies for populations at risk of engaging in violent behaviour identified small to moderate effects for CBT and for all counselling interventions combined (Hockenhull et al., 2012). Existing research into interventions for children and young people has provided some support for the use of solution focused brief therapy (SFBT) and parent training programs as interventions for child behaviour problems (e.g. Bond et al., 2013; Leijten et al., 2013). A systematic scoping review of the evidence for counselling for children and young people identified CBT and play therapy as particularly effective interventions for anxiety and conduct/behavioural problems (McLaughlin et al., 2013). A range of therapeutic approaches, including CBT, interpersonal psychotherapy, psychodynamic and family therapies emerged as efficacious in the treatment of adolescent depression (McLaughlin et al., 2013). Research with this particular client group has also identified strong evidence of the effectiveness of self-care support interventions for children and young people with long-term physical health conditions such as cystic fibrosis, asthma and diabetes (Kirk et al., 2013).

This current compelling international research evidence indicates that counselling can be an effective intervention for a range of presenting issues, from common mental health problems, to personality disorders, substance misuse, and long term health conditions, and that it can be utilised successfully with various client groups. Different counselling interventions are reported to have comparable treatment efficacy, and can have greater clinical effectiveness than usual care and other forms of treatment such as pharmacotherapy. Counselling is also demonstrated as being a cost effective intervention when compared with alternative treatments.
Evidence from the United States show that the counselling profession can help alleviate shortages in mental health providers; the Bureau of Labor Statistics predicts 30% growth in the number of mental health counsellors between 2006 and 2016. (Institute of Medicine, 2008). Evidence from the United States strongly favours letting clients select a psychological treatment that makes sense to them and permitting therapists to be consonant with the attitudes, values, and culture of the client, rather than having third-party payers or health maintenance organizations mandate a particular type of treatment. (Wampold, B. E, 2000).

A study by the Texas Department of Insurance found that a state law requiring insurers to reimburse for the services of licensed professional counsellors did not significantly increase coverage costs. Claims costs for services provided by licensed professional counsellors accounted for less than .1% of total claims for the insurers surveyed. A similar survey conducted by the State of Virginia found that, in 1996, claims for counsellors’ services amounted to .26% of insurers’ total claims. (Texas Department of Insurance. 1998).

Overall, these studies provide ample evidence that counselling is effective in prevention and treatment of mental disorders, and is inexpensive.
Utilising Counsellors to deliver cost effective efficacious mental health services

Counsellors are well educated, self-regulated, mental health practitioners. They are well regarded in the community, having delivered services to the Australian public for decades. In this section we demonstrate significant cost savings to government for the inclusion of Registered Counsellors in the Better Access Initiative.

The Better Access Initiative (BAI) was introduced in 2006 by the then Howard government. It is currently the primary Medicare-funded program that provides evidence-based treatment to persons with a clinically-diagnosed mental disorder.

The 2011 Evaluation of BAI found that, on average, consumers had 5 sessions of focussed psychological strategies (or 6 sessions, depending on the data used).

Entrenched within BAI are several challenges and assumptions, including:

- Growth in consumer numbers/services delivered and associated unsustainable increase in costs;
- Difficulties servicing hard-to-reach individuals and communities;
- Lack of data collection to demonstrate efficacy and outcomes;
- ‘Profession-based’ rebate allocation that assumes efficacy;
- The Focused Psychological Strategies offered are too narrow to meet all consumers’ needs.

Registered Counsellors represent an underutilised, yet equally competent, available workforce. The following rates apply under the BAI MBS Schedule, 2012:

<table>
<thead>
<tr>
<th>MBS Item No.</th>
<th>Description</th>
<th>Unit Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>80100</td>
<td>Focused Psychol. Strategies by Psych. (&lt;50 mins)</td>
<td>$60.10</td>
</tr>
<tr>
<td>80105</td>
<td>Focused Psychol. Strategies by Psych. (&lt;50 mins) other location</td>
<td>$60.10</td>
</tr>
<tr>
<td>80110</td>
<td>Focused Psychol. Strategies by Psych. (&gt;50 mins)</td>
<td>$84.80</td>
</tr>
<tr>
<td>80115</td>
<td>Focused Psychol. Strategies by Psych. (&gt;50 mins) other location</td>
<td>$106.55</td>
</tr>
<tr>
<td>80120</td>
<td>Group therapy by Psych. per patient (&gt;60 mins)</td>
<td>$21.65</td>
</tr>
<tr>
<td>80125</td>
<td>Focused Psychol. Strategies by Occ. Therapist (&lt;50 mins)</td>
<td>$52.95</td>
</tr>
<tr>
<td>80130</td>
<td>Focused Psychol. Strategies by Occ. Therapist (&lt;50 mins) other location</td>
<td>$74.55</td>
</tr>
<tr>
<td>80135</td>
<td>Focused Psychol. Strategies by Occ. Therapist (&gt;50 mins)</td>
<td>$74.80</td>
</tr>
<tr>
<td>80140</td>
<td>Focused Psychol. Strategies by Occ. Therapist (&gt;50 mins) other location</td>
<td>$96.35</td>
</tr>
<tr>
<td>80145</td>
<td>Group therapy by Occ. Therapist per patient (&gt;60 mins)</td>
<td>$19.00</td>
</tr>
<tr>
<td>80150</td>
<td>Focused Psychol. Strategies by Soc. Worker (&lt;50 mins)</td>
<td>$52.95</td>
</tr>
<tr>
<td>80155</td>
<td>Focused Psychol. Strategies by Soc. Worker (&lt;50 mins) other location</td>
<td>$74.55</td>
</tr>
<tr>
<td>80160</td>
<td>Focused Psychol. Strategies by Soc. Worker (&gt;50 mins)</td>
<td>$74.80</td>
</tr>
<tr>
<td>80165</td>
<td>Focused Psychol. Strategies by Soc. Worker (&gt;50 mins) other location</td>
<td>$96.35</td>
</tr>
</tbody>
</table>
Proposed Schedule Items for Registered Counsellors:

<table>
<thead>
<tr>
<th>Description</th>
<th>Unit SAVING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focused Psychol. Strategies by COU. (&gt;50 mins)</td>
<td>$65.00</td>
</tr>
<tr>
<td>Focused Psychol. Strategies by COU. (&gt;50 mins) other location</td>
<td>$80.00</td>
</tr>
</tbody>
</table>

The cost saving per MBS Item Number for services delivered by a Registered Counsellor would be:

<table>
<thead>
<tr>
<th>MBS Item No.</th>
<th>Description</th>
<th>Unit SAVING</th>
</tr>
</thead>
<tbody>
<tr>
<td>80110</td>
<td>Focused Psychol. Strategies by Psych. (&gt;50 mins)</td>
<td>$19.80</td>
</tr>
<tr>
<td>80115</td>
<td>Focused Psychol. Strategies by Psych. (&gt;50 mins) other location</td>
<td>$26.55</td>
</tr>
<tr>
<td>80120</td>
<td>Group therapy by Psych. per patient (&gt;60 mins)</td>
<td>$21.65</td>
</tr>
<tr>
<td>80135</td>
<td>Focused Psychol. Strategies by Occ. Therapist (&gt;50 mins)</td>
<td>$9.80</td>
</tr>
<tr>
<td>80140</td>
<td>Focused Psychol. Strategies by Occ. Therapist (&gt;50 mins) other location</td>
<td>$16.35</td>
</tr>
<tr>
<td>80160</td>
<td>Focused Psychol. Strategies by Soc. Worker (&gt;50 mins)</td>
<td>$9.80</td>
</tr>
<tr>
<td>80165</td>
<td>Focused Psychol. Strategies by Soc. Worker (&gt;50 mins) other location</td>
<td>$16.35</td>
</tr>
</tbody>
</table>

The following projected savings are based on the percentage of services delivered by Registered Counsellors:

<table>
<thead>
<tr>
<th>% COU services</th>
<th># Sessions</th>
<th>MBS Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>5%</td>
<td>299,080</td>
<td>$26,964,847</td>
</tr>
<tr>
<td>10%</td>
<td>59,8160</td>
<td>$53,929,694</td>
</tr>
<tr>
<td>15%</td>
<td>89,7240</td>
<td>$80,894,541</td>
</tr>
<tr>
<td>20%</td>
<td>119,6320</td>
<td>$107,859,388</td>
</tr>
</tbody>
</table>

As demonstrated, the introduction of Registered Counsellors into the Better Access Initiative will provide substantial budgetary savings. These savings come with no loss to the efficacy of service provided, or risk associated with the accountability of the service provider. It is expected that inclusion of Registered Counsellors would also reduce waiting times and improve access, including access in non-metropolitan areas and within indigenous communities.

Field force expansion, without budgetary expansion

As the General Practitioner (GP) remains the referral conduit, it is not anticipated that the introduction of Registered Counsellor to the BAI would increase the number of services delivered or the associated gross cost of BAI. As the GP remains the conduit through which services flow, it would simply reduce waiting times and provide greater choice of providers – to GP’s and patients.
Recommendations

Our recommendations for the subject review are as follows:

**Efficacy and cost-effectiveness of existing programs, services and treatments**

Efficacy of mental health services delivered under programs such as BAI is largely assumed. We suggest that practitioners delivering mental health services under rebated programs provide outcome measurements for services delivered. This will enable the government to capture data regarding the efficacy of services, and ensure practitioners provide measurable outcomes. **Registered Counsellors** in practice utilise systems such as Clinical Outcomes in Routine Evaluation software (CORE), which provides measurement tools that improve clinical effectiveness and allow for clinical reporting of services delivered. By reporting outcome measures, the government can have confidence that its investment in mental health treatment is directed to effective services and effective service providers, rather than funding professional groups with assumed efficacy.

**Recommendation 1**: Link rebates to treatment outcomes rather than focusing on professional groups with assumed efficacy.

Our review indicates that the government is paying an unnecessary premium for services provided by some mental health professional groups.

**Recommendation 2**: Registered Counsellors be provided access to BAI at the threshold schedule rates identified above.

There is substantial research indicating that investment in the prevention and early intervention of mental illness is more fiscally effective than investment in treatment of mental illness.

**Recommendation 3**: That Registered Counsellors be funded to provide early intervention services. These services could be delivered to patients presenting to the General Practitioner with issues likely to advance to a clinically-diagnosed mental disorder. These services would be cost effective to deliver and would serve as a stop-gap to issues advancing to a clinically-diagnosed mental disorder, which is substantially more complex and costly to remedy. The current system is porous in the context of these early-intervention candidates being referred by GP’s and subsequently being ‘over-serviced’ by psychologists or social workers. This comes at substantial cost to government. A specific program/facility to deal with these persons would reduce over-servicing and reduce cost to government.

*The appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services and how outcomes could be better regulated*

As expressed in **Recommendation 1**, it is our recommendation that funding be directed based on **treatment outcomes** rather than funding professional groups with assumed efficacy. Treatment providers should be providing measured outcomes on services delivered, with funding/rebates linked to patient outcomes.
Funding priorities in mental health and current gaps in services and programmes in the context of the current fiscal circumstances facing governments

It is our contention that the inclusion of Registered Counsellors in BAI will assist close gaps (field force challenges and waiting lists), whilst reducing the budgetary burden of the current BAI construct.

Enabling an early intervention treatment scheme, inclusive of Registered Counsellors, would assist stem the onset of clinically-diagnosed mental disorders. The fiscal disparity between early intervention and clinical treatment would provide further budgetary benefits.

Specific challenges for regional, rural and remote Australia

There is an acknowledged higher prevalence of mental health disorders amongst persons living in rural and remote areas (particularly men) as compared to metropolitan areas. Mental health services are also recognised as being less available, and less accessed.

Recommendation 4: As per our Recommendation 2, we recommend the inclusion of Registered Counsellors in BAI to expand field force availability of mental health services. Whilst studies have not specifically, to date, identified why, on a proportionate basis, mental health services are accessed less (mostly by men) in non-metropolitan areas, we contend that expanded field force availability to services will serve to break down stigma’s and result in greater parity between metropolitan and non-metropolitan access.

Specific challenges for Aboriginal and Torres Strait Islander people

The challenges of Aboriginal and Torres Strait Islander people are well documented. It is a complex situation that requires a multi-faceted approach. It is our opinion that much support needs to precede and underpin mental health services.

Specifically focussing on mental health service delivery, Registered Counsellors are required to undertake training in Counselling/Working with Diversity. Counsellors regularly work with diverse and marginalised groups with social divisions such as race, gender, ethnicity, age, sexuality and ability. Their training explores barriers in the application of appropriate counselling interventions and they are encouraged to explore their own values, beliefs and assumptions in relation to marginalised groups. Registered Counsellors are able to reflect on cultural awareness in work practice; accept cultural diversity as a basis for effective workplace and professional relationships; communicate effectively with culturally diverse persons; and resolve cross-cultural misunderstandings.

Recommendation 5: As per our Recommendation 2, including Registered Counsellors in BAI will expand field force availability in regions of low-access to mental health services.

Recommendation 6: ACA has Professional Colleges in areas of specialty practice. The Board of ACA has already been exploring the possibility of establishing a Professional College specifically for Aboriginal and Torres Strait Islander Counsellors. This Professional College would focus on issues specific to the community. ACA would welcome a government supported program that would assist ACA develop the competencies of the College and expand on the number of Aboriginal and Torres Strait Islander Counsellors, whom would serve in their community.
Transparency and accountability for outcomes of investment

We have discussed earlier our opinion on the importance of results orientated investment in mental health services; as opposed a ‘profession-based’ approach. We believe significant advancements could be made on the quality outcomes achieved in the mental health system if an outcome-based approach was implemented, which was inclusive of diverse, accountable professional groups.

**Recommendation 7:** As per our Recommendation 1, introduce outcome-based investment in mental health service delivery, which is inclusive of Registered Counsellors.
Conclusion

In conclusion, we applaud the initiative by the Australian Government in undertaking this review and requesting submissions from stakeholders on how to improve upon our mental health system. ACA believes this is a necessary and important review.

In this submission, we have defined a *Registered Counsellor* and the valuable work they have contributed to the community for several decades. We have established the parity in training standards between Registered Counsellors and their mental health counterparts; and provided research-based evidence as to the efficacy of counselling services. We have also expressed how, as an industry, the Counselling industry establishes and maintains the quality and accountability of its practitioners and members.

Importantly, we have provided a model that provides demonstrable cost savings to government with no reduction in the quality of outcomes to patients; expands on the existing field force; will reduce waiting lists; and addresses cultural-specific challenges within the Aboriginal and Torres Strait Islander communities.

We have also proposed a model that makes recipients of government rebates accountable to the efficacy of their service. This model dispels the notion that a subset of mental health providers, or specific ‘professions’ as a whole, is more competent than another, instead accepting the broader wealth of resources within the professional groups. The model of accountability and transparency will allow practitioners of quality from whichever profession – psychology, social work, occupational therapy or counselling – to provide rebated services; ensuring government investment is well served for the community.

We look forward to further discussion with you and your feedback on our submission.

Thank you.

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Philip Armstrong
Chief Executive Officer,
Australian Counselling Association.
### Definitions used in the submission

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Australian Counselling Association (ACA)</strong></td>
<td>Australian Counselling Association Inc. is a leading industry Association for qualified Counsellors.</td>
</tr>
<tr>
<td><strong>ATAPS</strong></td>
<td>Access to Allied Psychological Services (ATAPS). ATAPS enables GPs to refer consumers to ATAPS mental health professionals who deliver focussed psychological strategies services. ATAPS mental health professionals include psychologists, social workers, mental health nurses, occupational therapists and Aboriginal and Torres Strait Islander health workers with specific mental health qualifications. ATAPS does not currently include registered counsellors or psychotherapists.</td>
</tr>
<tr>
<td><strong>Better Access Initiative (BAI)</strong></td>
<td>An Australian Government program aimed at improving treatment and management of mental illness in the community, through better access to mental health practitioners through Medicare.</td>
</tr>
<tr>
<td><strong>Consumer/Client/Patient/Person with a mental disease</strong></td>
<td>These terms are used to interchangeably to describe a person who uses or has used a mental health service.</td>
</tr>
<tr>
<td><strong>Carer</strong></td>
<td>A person who has a significant role caring for someone with a mental health issue or mental illness. A carer may be a family member, friend or colleague and may be paid or unpaid. The role of such a carer is not necessarily static or permanent, and may vary over time according to the needs of both consumers and carers.</td>
</tr>
<tr>
<td><strong>Registered Counsellor</strong></td>
<td>A Counsellor or Psychotherapist currently registered with ACA and/or PACFA, and listed on ARCAP.</td>
</tr>
<tr>
<td><strong>Mental illness</strong></td>
<td>A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional and/or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases.</td>
</tr>
<tr>
<td><strong>Early detection</strong></td>
<td>The discovery of a disorder or condition as early as possible in its course so as to minimise its negative impact on the individual or group of individuals exposed to the disorder/condition/agent.</td>
</tr>
<tr>
<td><strong>Early intervention</strong></td>
<td>The management of a mental health issue or mental illness, early in life or early in the course of the disorder, so as to reduce the risk of its escalation.</td>
</tr>
<tr>
<td><strong>Disadvantage</strong></td>
<td>A social relationship in which the position of one person is worse because the position of another person is relatively better. People may be disadvantaged in many ways in relation to poverty, availability to opportunities, isolation and marginalization and distribution of powers.</td>
</tr>
<tr>
<td><strong>Psychotherapy and Counselling Federation of Australia Inc. (PACFA)</strong></td>
<td>An umbrella body for industry Associations in the disciplines of Counselling and Psychotherapy.</td>
</tr>
</tbody>
</table>
| **Serious Mental Illness (SMI)** | A diagnosable mental disorder that substantially
<table>
<thead>
<tr>
<th><strong>Mental health services</strong></th>
<th>Services in which the primary function is to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allied Health Professionals Australia (AHPRA)</strong></td>
<td>A professional stakeholder based organisation which represents allied health professions and their representative bodies. Collectively, organisations within AHPA represent about 50,000 health professionals. AHPA’s membership comprises a number of allied health professional associations including audiologists, chiropractors, dieticians, exercise physiologists, occupational therapists, orthotists, orthotists and prosthetics, osteopaths, hospital pharmacists, podiatrists, psychologists, sonographers, social workers and speech pathologists.</td>
</tr>
<tr>
<td><strong>Prevention</strong></td>
<td>An activity or approach that assists in maintaining positive mental health through pre-emptively addressing factors that may lead to mental health issues or mental illnesses. These can be aimed at increasing protective factors, decreasing risk factors or both, as long as the ultimate goal is to maintain or enhance mental health and wellbeing.</td>
</tr>
<tr>
<td><strong>Primary mental health care</strong></td>
<td>The first level of care within the formal health system. Essential services at this level include early identification of mental health issues or mental illnesses, treatment of common mental illnesses, management of stable psychiatric patients, referral to other levels where required, attention to the mental health needs of people with physical health problems, and mental health promotion and prevention.</td>
</tr>
<tr>
<td><strong>Whole-of-government</strong></td>
<td>Whole-of-government denotes public agencies working across portfolio boundaries to achieve shared goals and an integrated government response to particular issues. Approaches can be formal and informal. They can focus on policy development, program management and service delivery.</td>
</tr>
</tbody>
</table>
References


14. (Sharpley, Bond and Agnew,(2002) “Why Go to a Counsellor? Attitudes to, and Knowledge of Counselling in Australia”.


