# Australian Register of Counsellors and Psychotherapists

# Productivity Commission Submission April 2019

Submission contact details:
Executive Member
Philip Armstrong, FACA
Philip.Armstrong@arcapregister.com.au

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# *Executive Summary*

Our submission aims to provide the Commission with relevant information based on research and evidence. We discuss outcomes being achieved, what works and what doesn't, identify gaps and strengths in current mental health services, provide suggested strategies for improvement, and discuss whether taxpayers are receiving value for money on investment in mental health services.

Our key recommendation relates to the utilisation of Registered Counsellors and Psychotherapists, and how such utilisation will strengthen the mental health system through the delivery of cost-effective, accountable, efficacious mental health services.

We propose that providing Registered Counsellors and Psychotherapists access to the Medicare Benefits Scheme (MBS) through the Better Access Initiative (BAI) will reduce expenditure for mental health services while simultaneously improving the quality of service delivered. Inclusion would also contribute to resolving workforce shortages and waiting times, issues which are presently costing consumers and the nation significantly.

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

Currently, Registered Counsellors and Psychotherapists meet the needs of consumers of mental health services by providing a range of evidence-based psychological strategies. Registered Counsellors and Psychotherapists can work seamlessly in existing mental health services within MBS, NDIS, NGOs, hospitals and the wider health system. They currently deliver psychological therapies in multidisciplinary teams within a range of settings, including state-based work cover programs and Employee Assistance Programs.

Registered Counsellors and Psychotherapists present the opportunity for cost-savings, a bolstered workforce to increase access to treatment for people that have mild or moderate mental illness and disadvantaged groups, but counsellors and psychotherapists are currently under-utilised in the health system.

In a stepped model of care, counsellors and psychotherapists can provide a range of evidence-based psychological strategies, and bolster support in the existing teamwork approaches to client management shared between GPs, psychologists, psychiatrists and other allied health practitioners. There is opportunity to achieve social and economic productivity gains and improving consumer choice by maximising the available workforce potential of Registered Counsellors and Psychotherapists.

# *About ARCAP*

ARCAP is the Australian Register of Counsellors and Psychotherapists. It is the national register and credentialing system established jointly by the Psychotherapy and Counselling Federation of Australia (PACFA) and the Australian Counselling Association (ACA). The ARCAP is made up of qualified counsellors and psychotherapists who are registered with PACFA or the ACA. Counsellors and Psychotherapists who are listed on ARCAP meet the registration requirements of ACA and or PACFA, including relevant qualifications, annual requirements for professional development and supervision, and follow a Code of Ethics. Practitioners registered with ARCAP are distributed throughout Australia in urban, regional and rural areas.

In this submission, the term Registered Counsellor and Psychotherapist is used to refer to practitioners registered with the ACA and PACFA who have completed training to at least degree level and who have completed at least two years full-time practice (a minimum of 750 supervised client hours). These practitioners are competent to provide interventions to support people with their mental health and provide psychotherapeutic interventions for consumers with more serious mental disorders.

The term Vocationally qualified Counsellor is used to refer to counsellors who are trained to Diploma level and are qualified to provide support to clients around their mental health. They make a contribution to early intervention support services.

# *Section 1 – Key themes*

## Social determinants of health

Counselling and psychotherapy can address a range of social determinants by improving education outcomes in school counselling settings, employability through life skills and strategies to find and keep a job, improve the overall mental healthiness of workplaces, support healthy relationships so that vulnerable Australians are kept in housing, and out of the justice system, and work on life skills to keep them out of the welfare system.

Research studies support the central importance of community and social networks, which are accessed through relationships, work and community involvement. One study (Phongsavan, Chey, Bauman, Brooks & Silove, 2006) on social capital and mental health found that having trust in people, feeling safe in the community and having social reciprocity are associated with lower risk of mental health distress. Another study found strong links between social network factors and depression and anxiety outcomes (Levula, Harré & Wilson, 2018). This highlights that value of counselling and psychotherapy to support people with a range of relationships, and in a range of social contexts, as a way to directly address the social determinants of health.

## Supporting increased social and economic participation and contribution

The training of Registered Counsellors and Psychotherapists is relational in nature, making them ideally suited to support individuals and communities around life skills, work,

relationships and community involvement.

Current systems and services do not utilise counsellors and psychotherapists at their full scope of practice to address the changing needs of the Australian population, meet workforce shortages, and improve efficiencies in the health system.

Expanding the counselling and psychotherapy services that are available will benefit the Australian economy and improve productivity by supporting Australians to lead contributing lives by supporting people to explore and resolve life difficulties.

## Early intervention and prevention and need for bolstered workforce

The evidence is clear that the economic impact of youth mental illness is significant and the cost-effectiveness of early intervention is well demonstrated (Access Economics, 2009).

With the Productivity Commission focusing on consumers with mild and moderate mental illness (such as anxiety and depressive disorders) and early intervention approaches, a larger workforce needs to be ready and available to meet recommendations and demand for services.

Given the present shortages in the mental health workforce with limited availability and long waiting times between sessions in metro and low-access areas, Registered Counsellors and Psychotherapists are experienced and able to boost the workforce and provide support in the stepped model of care.

There is strong evidence for the contribution of counselling and psychotherapy models to the prevention and treatment of mental illness, including depression, anxiety and trauma (Cuijpers, van Straten, Smit, Mihalopoulos & Beekman, 2008). Seligman (1995) undertook a large Consumer Reports study to discover the experiences of people who had undergone counselling or psychotherapy. The study concluded that there were substantial benefits for people in psychotherapy; that psychotherapy without medication produces the same effects as psychotherapy and medication; that no one model produces better outcomes than other models; and that psychotherapy is effective regardless of the practitioner's occupation, for example as a psychologist, psychiatrist or social worker. These findings are supported by research into the common factors underlying the effectiveness of counselling and psychotherapy (Duncan, Miller, Wampold & Hubble, 2009; Wampold, 2015) which has found that all types of therapy achieve broadly similar outcomes and the strength of the client-therapist relationship is a key determinant of outcomes.

## Stepped model of care

The stepped care approach emphasises matching the needs of individuals with the intervention they receive (National Mental Health Commission, 2014). The approach focuses on making sure individuals get the right care at the right time and reducing over servicing and under servicing (National Mental Health Commission, 2014). For consumers, this will mean there is a broader range of services available to better target their mental health needs.

By appropriately identifying issues and engaging with the right level of care, particularly for consumers with mild to moderate mental health issues, services will support optimal use of

resources for those cases that are more severe and complex (National Mental Health Commission, 2014).

In Australia, Primary Health Networks are already successfully commissioning services within a stepped care model (National Mental Health Commission, 2016). There are also successful overseas examples of stepped care approaches to mental health service delivery, such as in National Health Service in the UK (National Institute for Health and Care Excellence, 2011).

Stepped care will result in optimal use of resources and will allow specialist mental health treatment for those with severe mental health illness to be delivered by specialist mental health providers (including Registered Counsellors and Psychotherapists).

Registered Counsellors and Psychotherapists can deliver continuous care under each tier in the stepped care model, however, are particularly relevant for consumers with mild to moderate mental health issues.

## Potentially preventable hospitalisations

Potentially preventable hospitalisations can be avoided if timely and adequate primary care is available to the community to prevent the condition occurring and prevent hospitalisation. Counsellors and psychotherapists have a role in identifying, assisting, and triaging patients to avoid hospitalisations.

Preventable hospitalisations are markers of potentially low-value care. In 2015–16, there were an estimated 26.4 potentially preventable hospitalisations per 1,000 people; similar to the rate in 2007–08 (25.8 hospitalisations per 1,000 people) (AIHW, 2018). Moreover, the rate of potentially preventable hospitalisations increased with the rural and remoteness, indicating an ongoing equity and access issue.

Mental health conditions have a significantly higher rate of potentially preventable hospitalisations than non-mental health conditions (Mai, Holman, Sanfilippo & Emery, 2011). There are significant cost-savings from treating a patient in the community in comparison to hospital settings. Therefore, improving primary and secondary prevention will see gains elsewhere in the health system in terms of value-for-money.

Counselling and psychotherapy can keep consumers out of costly, low-value hospital care programs and utilise community care programs. Current services (e.g. Better Access Initiative) are not adequate to achieve this outcome for those with more complex mental health issues.

## Consumer access and choice

ARCAP believes that client choice is very important as people are more likely to seek help if they can consult practitioners that they feel comfortable with and trust. This is supported by research evidence from the United States (Wampold, 2015). In this regard, it is interesting to note research findings that counsellors are more highly accepted by clients than either psychologists or psychiatrists (Sharpley, Bond & Agnew, 2004; Sharpley, 1986) and are seen as more approachable and empathic (Sharpley, 1986).

There is strong evidence that providing services according to client preference improves therapy outcomes (Iacoviello, McCarthy, Barrett, Rynn, Gallop, & Barber, 2007; Lindhiem,

Bennett, Trentacosta, & McLear, 2014; McLeod, 2012).

Consumer choice will be increased when a wider range of mental health professionals are utilised within the current service system, including the Better Access Initiative. Consumers may wish to choose counsellors and psychotherapists because of the relational expertise and scopes of practice that matches the needs of consumers.

## Maximising value and return on investment

The economic cost of not investing in mental health reform would be significant according to research undertaken by KPMG and Mental Health Australia (2018). Conversely, there are significant economic benefits to investing in mental health reform (KPMG and Mental Health Australia, 2018). This research confirms that the current investment in mental health remains below the estimated cost burden. Their Return on Investment analysis is compelling with economic modelling that demonstrates an investment of $2.7 billion would deliver $4.5 billion in saving, and this is based on rolling out the proposed strategies to only 50% of the workforce. (KPMG and Mental Health Australia, 2018, p. 28).

Given the consequences of mental ill health, and the opportunities to make significant savings by investing in mental health, counsellors and psychotherapists present an effective, value-for-money option to fill gaps in continuity of care for different demographic groups (KPMG and Mental Health Australia, 2018; Medibank and Nous Group (2013).

## Health workforce

The mental health workforce requires strengthening in a rapidly changing environment that is characterised by growing demand on services, increasingly diverse and complex patients, and divergent demands by both an ageing population and increasing prevalence of youth mental health issues. Full utilisation of an appropriately qualified and skilled workforce, including the utilisation of peer workers, will achieve better outcomes.

Principles that characterise a highly functional health workforce are safe, high-quality, recovery-oriented, trauma-informed, evidence-based, outcomes focused, culturally safe, accessible, and that adaptable to diverse needs of the population.

Investing in the mental health workforce will improve the responsiveness of mental health services, reduce pressure on other health and well-being services, and build a culture of person-centred and recovery-oriented care. ARCAP proposes a flexible, multidisciplinary team approach to mental health workforce shortages. For instance, many counselling and psychotherapy competencies and skills are shared by other professions. Historically in Australia, counselling has been a practice that streamed horizontally across multiple professions (Lewis, 2016). There continues to be an overlap in counselling services provided by counsellors and psychotherapists and services provided by psychologists and mental health social workers. Counsellors and psychotherapists, therefore, share their scope of practice, knowledge and skills, and levels of safe practice with other professions but currently under-utilised under the Better Access Initiative and commissioning bodies such as Primary Health Networks and the NDIS (PACFA, 2018).

## Informal Carers

There is an estimated 2.8 million Australians providing informal care, and 825,000 are primary carers providing the majority of the recipient's care that totals an estimated $60 billion worth of total care (Carers Australia, 2015). Informal carers are effectively part of the mental health workforce, so supporting the carers is essential to ensure they continue to provide support for the people they care for in a sustainable way that ensures they do not develop mental health issues themselves.

Informal carers are a vulnerable group and are at greater risk of negative physical and mental health issues. While some support and counselling services are available for informal carers, greater provision and utilisation of services would increase their economic and social participation and productivity, and of the people, they are caring for.

Counsellors and psychotherapists can support the participation and productivity of carers, and greater utilisation of the available registered workforce will increase overall economic and social productivity in Australia.

## Specific groups in the community

It is essential to address the needs of specific groups in the community who are particularly vulnerable to mental health. Important examples are Aboriginal and Torres Strait Islander peoples, people residing in remote areas, individuals with very low socioeconomic backgrounds, newly arrived migrants, and refugees.

Culturally and linguistically diverse (CALD) clients have historically found it difficult to access culturally sensitive mental health, counselling and psychotherapy services. It is well documented that there are significant barriers for Indigenous people accessing mainstream services. Barriers arise from complex historical impacts of the Stolen Generation, top-down government initiatives, fear and suspicion in Indigenous communities and cultural misunderstandings on the part of service providers (Calma & Priday, 2011; Harms et al., 2011). It is ARCAP's submission that these groups within the community may not be easily able to access private practitioners who offer services under the Better Access Initiative and this is a concern that needs to be addressed in the program arrangements.

An example of good practice is the Transcultural Mental Health Centre in NSW which provides information for referral agents such as GPs on accredited practitioners providing culturally sensitive mental health services. A similar accreditation method could be applied to ARCAP-registered counsellors and psychotherapists to identify those practitioners with expertise in providing culturally safe mental health services. This will contribute to a view on Indigenous and CALD that services are culturally responsive and sensitive.

The counselling and psychotherapy workforce is made up of a large group of professionals who come from specific groups. The counselling and psychotherapy workforce is diverse and multi-cultural. Therefore, in many cases, counsellors and psychotherapists can better understand the unique needs of specific groups.

# *Section 2 – Responses to questions in the Issues Paper relevant to counselling and psychotherapy*

## Contributing components to improving mental health and wellbeing

**Mental health promotion, prevention and early intervention**

Q. *Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs?*

Mental health systems must balance the challenges of caring for people with mental illnesses and helping to prevent mental illness at individual, family and community levels." (Perkins, 2016). ARCAP supports changes to mental illness prevention and early intervention by healthcare providers through a range of evidence-based interventions. For example, telephone counselling is a cost-effective, low-intensity intervention that has been shown to have effective outcomes (Bassilios, Pirkis, King, Fletcher, Blashki & Burgess, 2012).

The Mental Health Commission has suggested that the current system is focused on the needs of providers rather than patients, has been slow to prevent mental health problems and intervene early and that financial payments for providers incentivise activities rather than patient outcomes (NMHC, 2014). By ceasing to silo service delivery by a select group and opening up delivery of services to a broader group of professionals, this will help to improve the population's mental health by increasing access to services and bringing equity to service delivery.

ARCAP proposes the inclusion of Registered Counsellors and Psychotherapists in the class of allied mental health professionals registered to provide Focussed Psychological Strategies under the Better Access program. This would address numerous systemic issues within the mental health and the wider health system, such as workforce shortages and long waiting times for consumers to access and receive mental health services.

Vocationally qualified counsellors who are trained to Diploma level are capable of effectively working with clients in the area of prevention. There are many opportunities for Vocationally qualified Counsellors to work for agencies providing early intervention services.

Tertiary qualified Registered Counsellors and Psychotherapists can be trained within a three-year period (full time) and can be effectively deployed to work effectively with clients in the early stages of mental health illnesses. Research reflects that counsellors get equivalent outcomes when compared to psychologists and social workers (Seligman, 1995; Sharpley, Bond & Agnew, 2004; Sharpley, 1986). Currently, due to restrictions and access to MBS provider numbers clinicians such as psychologists work in this area. This creates a situation where overqualified professionals are paid at a high hourly rate and are over-servicing clients. This takes clinicians away from high need clients and is economically inefficient.

Registered Counsellors and Psychotherapists represent a workforce that is trained in

evidence-based Focussed Psychological Strategies and are competent and well self-regulated, and able to meet the needs of the wider health system. Therefore, the inclusion of Registered Counsellors and Psychotherapists will increase workforce capacity, improve both consumer outcomes and choice, and deliver an improved scale of economy to the wider health system. (Armstrong & Jones, 2019)

The role of a Registered Counsellor or Psychotherapist is to deliver mental health services; in scope, and, of equivalence to other allied mental health practitioners currently utilised to deliver psychological therapies. Including Registered Counsellors and Psychotherapists within existing mental health service/program, configurations provide commissioning bodies significant productivity gains, while still delivering the same level of service and the attainment of the same program outcomes.

Improving access to evidenced-based psychotherapy/counselling is a key driver for stepped care delivery systems (Firth, Barkham & Kellett,2015). Fundamental to the stepped care model is the recognition that there are different treatments for a given disorder, and that these treatments have different levels of intensity associated with a patients' progress, and the frequency and duration of treatment (Bower & Gilbody, 2005; Armstrong & Jones, 2019).

ARCAP's position is that formal diagnosis of a mental disorder is not appropriate or necessary for many members of the community with mild to moderate mental health concerns as recovery is often not aided by being labelled with a mental health diagnosis. The recovery movement in mental health has strongly argued against the disempowerment of consumers as a result of professional practices, including diagnosis, which fails to offer hope (Masterson & Owen, 2006).

**Suicide prevention**

Q. *What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation and productivity?*

Addressing suicide in Australia will go a long way towards reducing the economic burden of mental illness in Australia (Australian Bureau of Statistics, 2012). A KPMG report on the economic cost of suicide in Australia (2013) found the magnitude of the problem was significant. This underscores the importance of the benefits, and the avoided costs, from investing in programs and treatments to reduce the number of suicides in Australia (KPMG, 2013).

Registered Counsellors and Psychotherapists currently deliver a range of community-based suicide prevention workshops and courses. Counsellors also work in multi-disciplinary teams operating in a primary health setting utilising psychotherapy, as identified by the Black Dog Institute LifeSpan system (Lifespan Integrated Suicide Prevention, 2018), which are described below.

"Psychosocial Psychotherapy, such as cognitive behaviour therapy and dialectical behaviour therapy, has been found to be effective in reducing suicidal thoughts and behaviours.

Psychotherapy is particularly effective for high-risk individuals such as those with borderline personality disorder or patients admitted to an emergency department after a suicide attempt.

Evidence-based therapies include cognitive behavioural therapy, and other as clinically indicated are aimed at clients with complex and chronic mental disorders (possibly with co-morbidities such as drug and alcohol problems) (Fletcher, Pirkis, King, Christo, Bassilios, Burgess, Whiteford, Blashki, Littlefield, 2011). Several psychotherapies have been shown to reduce suicidal behaviour including:

- Cognitive behaviour therapy for suicide prevention and mentalisation-based treatment - for adults
- Multi-systemic therapy and group therapies - for adolescents
- Dialectical behaviour therapy - for individuals with borderline personality disorder
- Problem-solving therapy to reduce repeat hospitalisation - for individuals with a history of prior self-harm
- Psychodynamic interpersonal psychotherapy to reduce repeat attempt - for individuals hospitalised for repeat poisoning.

Effective psychotherapies to reduce suicidal thoughts include:

- Collaborative assessment and management of suicidality, cognitive behaviour therapy, and psychodynamic interpersonal therapy - for adults
- Attachment-based family therapy - for adolescents. (Banfield, Freeman, & Suomi, 2017)" (Lifespan Integrated Suicide Prevention, 2018)

Suicidality amongst Aboriginal and Torres Strait Islander communities is a particularly complex issues. One meta-analysis found that evidence suggests having a sense of culture buffers against the negative pathways of suicide, but that there is also a need to engage in culturally relevant activities with respected others in the community (Harder, Rash, Holyk, Jovel & Harder, 2012).

Indigenous Suicide prevention activities can be facilitated by registered mental health counsellors, trained to deliver Social Emotional Wellbeing (SEWB) programs. They will be able to deliver to Aboriginal and Torres Strait Islander communities within identified culturally safe practices and be benchmarked approved localised cultural competencies when delivering mental health and suicide prevention services for Aboriginal and Torres Strait Islander peoples across a range of primary health settings within a stepped Care model.

A SEWB trained Registered mental health counsellor will be able to operate within a cultural narrative structure, supporting Aboriginal and Torres Strait Islander communities which identifies that families, in particular, are the critical social network required to support the individual, and that service provision must deal with the overall needs of the social network and not just the individual.

There is also a need for specialised postvention support for the families and friends of suicide victims, with an emphasis on the particular needs of bereaved children and young people. In Queensland, there is a Survivors of Suicide Bereavement Support Service which is self-supported and run by volunteers. A practitioner reports that people bereaved by suicide find

this service very useful and they say that only those who have lived through such a loss can really understand their experience.

One research study investigated the grief of children after parental suicide and found that postvention suicide support was only available to one participant and that no support was offered to the other bereaved children apart from support from their families who are also grieving. This lack of intervention resulted in ongoing distressed lives for those bereaved by suicide (Ratnarajah & Schofield, 2008). The children experienced secondary losses such as loss of home, loss of their school and friends, and foreshortened education. Over half of the participants had attempted suicide in adult life and had first degree relatives who made suicide attempts. These suicide attempts resulted in hospitalisation for each of these attempters. There was little or no ongoing support for them unless they sought psychological or counselling support themselves in adulthood. When interviewed (between 5 to 70 years after the suicide of their parent) most could not make meaning of the suicide. Many questions were not answered, and there was an unmet need to speak of the loss (Ratnarajah & Schofield 2008; Ratnarajah & Schofield, 2007).

**Healthcare Reforms**

Q. *What can be done to address health workforce shortages in regional and remote areas? In which areas or circumstances would greater use of technology and telehealth services be suitable? What prevents greater remote provision of services to address the shortages?*

There are significant choke points all around Australia (see Appendix 1) where patients requiring mental health services under the MBS are placed on long waiting lists. For example, patient waiting times (in days) to commence treatment under the Better Access initiative in the Hunter region can be up to 25 days. There is currently over 200 Registered Counsellors and Psychotherapists in the Hunter region who are qualified to deliver services equivalent to Better Access Initiative providers however are not able to do so because they are not able to obtain a provider number under the MBS. Waiting lists in the Armidale region can be up to 41 days. There are over twenty Registered Counsellors and Psychotherapists in that region who could be delivering the equivalent services under Better Access Initiative.

Young people in rural areas experience differential access to Medicare-funded services such as psychological treatment (Fletcher, et al., 2011). They experience significant wait times to access psychological counselling, averaging six days to be assessed with the maximum daily wait time of 23 days, and a commence treatment time averaging 15 days, with the maximum daily wait time of 41 days (HNECC, 2018).

These are just three examples of hundreds where counsellors and psychotherapists are being underutilised at the unnecessary expense of mental health consumers.

Better Access Initiative has lacked consistency and universality across geographical locations since its introduction in 2007. Although Australia is ranked in the middle of the OECD for the proportion of health costs paid for with out-of-pocket fees, in real terms between 2007 and 2014, the out of pocket fees have risen by a quarter (Duckett & Breadon, 2014). However, this burden of cost is not distributed equally across the population; with many poor individuals with the least disposable income experiencing proportionally higher out of pocket

expenses, with one in ten paying up to 20 per cent of their household budget on out of pocket expenses. This has resulted in a sizable minority avoiding health care, with increased potentially preventable hospitalisations through increasingly complex and comorbid conditions (Armstrong & Jones, 2019).

In rural, regional and remote areas, only 4% of psychiatrists and 21.5% of psychologists provide services (Vines, 2011), compared to 28.3% of counsellors and psychotherapists (Schofield, 2008; Schofield & Roedel, 2012). The high demand for MBS services in rural and regional areas could be alleviated by Registered Counsellors and Psychotherapists in rural and regional areas who could deliver *Better Access* services. Research indicates that rural, regional and remote communities continue to struggle to recruit and retain health professionals (Harrison & Britt, 2011; Bourke, Humphreys, Wakerman & Taylor, 2012; Chater, 2008).

One study of a remote community in Queensland demonstrated that medical and allied health services are usually provided by non-resident, visiting specialists (Birks, Mills, Francis, Coyle, Davis & Jones, 2010). While nurses and Aboriginal health workers were predominantly resident in the community, other health professionals, including psychologists, counsellors and psychotherapists, were not, resulting in a lack of appropriate therapeutic skills to support clients with mental health issues. In western NSW, researchers found that the shortage of allied health professionals meant that clinicians located in such communities had to work longer hours with little support from their employers or colleagues (Veitch, Lincoln, Bundy, Gallego, Dew, Bulkeley, Brentnall & Griffiths, 2012).

Psychologists tend to practice in metropolitan areas (Dunbar, Hickie, Wakerman, & Reddy, 2007; Mental Health Council of Australia, 2010) which compounds the issue of wait times and contributes to a limited workforce of trained mental health professionals able to be utilised under the Medicare Better Access initiative.

The inclusion of counsellors and psychotherapists under rebateable programs would increase workforce capacity, which would reduce waiting list periods, put downward pressure on costs (reduction in gap payments), provide consumers with greater choice and increase service access in rural and remote areas.

Counsellors are distributed throughout the country, and therefore make a significant contribution to services in regional, rural, and remote areas, where specialist services are more difficult to access (Gittoes, Mpofu & Matthews, 2011). Australian studies of the counselling workforce have consistently found that approximately one-third of counsellors work in regional, rural, and remote areas (Schofield & Roedel, 2012; Schofield, 2015).

Early intervention and primary care needs are being serviced by expensive highly trained specialists, creating an unintended, costly and inefficient service. Consumers with low-end needs are forced to join long queues for services delivered by clinical service providers who are challenged to meet demands, alongside geographical challenges and provide services at a reasonable cost. In many cases, vocationally qualified Counsellors can service these clients or help manage them until other services become available.

There is no justification for the continuing inequality in service delivery and health outcomes for rural Australians, and this should be addressed as a priority. Disadvantaged people in

underserviced areas require greater access to health services than the well served metropolitan areas due to their greater poverty and lower health status (Schofield, Shrestha & Callander, 2012).

*Q. What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits?*

Registered Counsellors and Psychotherapists have the competency, skills, and experience in delivering evidence-based psychological strategies (ACA, 2016; PACFA, 2018) at an equivalency to other registered allied health professionals registered to receive an item number in the Better Access Initiative. Registered Counsellors and Psychotherapists can meet the need of the primary mental health services within a stepped care approach by providing a range of evidence-based psychological strategies that make the best use of the available counselling workforce within a local region to meet the needs of individual and the population. (Armstrong & Jones,)

Registered Counsellors and Psychotherapists are employed in a diverse range of sectors, including the NGO sector. Opportunities for work in the private sector have broadened with engagements in the private sector. Examples of these are: Employee Assistance Programs, counsellors are now eligible to contract out their services to the top seven EAP suppliers in Australia such as Access EAP, Acacia Connection, Converge International, EUDOXiA and Optum. Registered Counsellors and Psychotherapists are now eligible for provider numbers to offer rebates for Private Health Funds such as Australia's largest two funds, Medibank and BUPA. Registered counsellors are now eligible to sub-contract rehabilitation services under NSW Workcover with several other similar state and territory funds considering counselling.

Additionally, Registered Counsellors and Psychotherapists are employed as school counsellors in independent and private schools in all states, territories, and government schools.

Registered Counsellors are also eligible to provide therapeutic counselling under the National Disability Insurance Scheme.

At present, Registered Counsellors and Psychotherapists are unable to provide psychological therapies that attract a rebate as prescribed under the Health Insurance Act 1973, are unable to deliver evidence-based psychological strategies within a Local Hospital Network in accordance with the National Health Reform Act 2011, or be utilised as an effective workforce within Commonwealth funded programs which utilise evidence-based psychological strategies within the Primary Health Networks; such as the delivery of services within the primary mental health care flexible funding pool, low intensity mental health services for early intervention , primary mental health care services for people with severe mental illness and regional approach to suicide prevention (Armstrong & Jones,2019).

The use of Registered Counsellors and Psychotherapists within the Local Hospital Networks, Primary Health Networks and the Better Access Initiative represents a cost-effective mental health model for service delivery; will improve mental health care sector outcomes and is a

good use of health sector resources.

Registered Counsellors and Psychotherapists have the skills and proficiency in meeting all reporting requirements of the regulations for the provision of the Medicare Benefits Schedule Focussed Psychological Strategies as outlined in the Health Insurance (General Medical Services Table), Regulations 2017.

As a workforce, Registered Counsellors and Psychotherapists generally charge lower fees than psychologists, which in turn reduces the barriers to client participation and an improved cost saving to the health system. The economic evaluation framework Quality-adjusted life-years (QALYs) is used as a cost-utility design tool to model the health benefits and inform treatment decisions within the Australian health system (Mihalopoulos, Magnus, Lal, Dell, Forbes & Phelps, 2015, p 363). QALYs are the most widely used international (World Health Organisation Generalised Cost-Effectiveness Analysis studies) outcome metric in international economic evaluation studies (Chisholm, 2005). Modelling that remains below the $50,000/QALY averted threshold is considered 'good value' (Carter et al., 2008). Applying this model, based on 2014 figures, Registered Counsellors and Psychotherapists would provide highly cost-effective Focussed Psychological Strategies such as cognitive behavioural therapy at $19,000/QALY in adults and $8,900/QALY in children (Mihalopoulos et al., 2015, p 360) with 100 per cent of adults remaining under the $50,000/QALY threshold.

Before the introduction of the Better Access Initiative in 2006, General Practitioners (GPs) readily referred patients to counsellors. With the introduction of the Better Access Initiative counselling as a profession was not recognised in the class of allied mental health professionals (Health Insurance Act 1973, Section 19A) registered to provide Medicare Benefits Schedule items for the provision of Focussed Psychological Strategies (Armstrong & Jones,2019).

The evidence on Registered Counsellors and Psychotherapists delivering mental health interventions such as Focussed Psychological Strategies within a stepped care approach can be shown to address systemic issues regarding mental health outcomes, wider health system planning and design, and workforce continuity. Additionally, this approach effectively supports individuals' remission and recovery and supports their reintegration into the community, thereby realising their individual potential to contribute to workforce participation, productivity, and support wider social cohesion (Armstrong & Jones, 2019).

Q. *What could be done to reduce stress and turnover among mental health workers?*

The mental health system faces considerable challenges in developing and adapting to structural change such as the introduction of new commissioning structures including the Primary Health Networks, the National Disability Insurance Scheme (NDIS), and increased demand in service delivery with an ageing and reduced workforce. The current mental health workforce experiences considerable stress which results in occupational health and safety issues including; the associated demands of an evolving workplace, limited resource allocation, and high community expectations for service delivery. Concerns within the mental health system include the risks of clinician burnout, restricted opportunities to apply specialist skills, reduced job satisfaction, de-skilling, along with the loss of experienced staff from the mental health sector transitioning to private practice.

Practitioner stress and fatigue results in a high turnover of staff and recruitment difficulties, longer wait times, and compromised service continuity and quality of care. Additional issues include reductions in staff and organisational morale, loss of corporate knowledge and practices, and increased demands on remaining staff to fulfil service void while meeting the expectations and needs of consumers.

Much of the stress and turnover within mental health professions is created through an inability to meet the demands of the consumer. Primarily workforce shortages are the issue; this is well documented, current MBS providers are unable to meet the demand of the public. This places significant pressure on providers and can impact on outcomes. Employers can also have an unrealistic expectation of how many clients a therapist can see in a day as demand is usually greater than their capacity to deliver services — workforce shortages impact on all levels creating stress along the whole continuum of service delivery.

The long training requirements for psychologists (six years), also impacts on the ability of the profession of psychology to meet the growing consumer demand. This perpetuates a permanent shortage of professionals to work with clients with low and medium needs. Stress caused by workforce shortages to a large degree is created by the system itself and is self-perpetuating.

In short, stress is created through growing consumer need and workforce shortages, creating long waiting lists, which in turn limits time availability for clinicians to undertake self-care and clinical supervision. This results in higher burnout and reduced efficacy of client outcomes and service delivery. A simple, effective, economical way to remedy this issue would be to bring Registered Counsellors and Psychotherapists into the MBS.

The inclusion of Registered Counsellors and Psychotherapists in the workforce would reduce overall work burden, waiting lists, allow workers more time to engage in self-care strategies, providing an overall healthier and more efficacious workforce. This would also have a long-term positive impact on feeding into the system another stream of mental health professionals to reduce shortages due to long training requirements for psychologists particularly when research does not suggest psychologists get better clinical outcomes than counsellors.

Q. *How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up?*

Current training for counsellors in Australia is high when compared globally. Australian registered counsellors are one the few around the world where professional/clinical supervision is an ongoing mandatory requirement. Countries including the USA and UK do not have a mandatory requirement that practising counsellors undergo supervision once they are licensed and in the workforce.

Australia has one of the best trained and organised workforces of counsellors in the world yet it is very much under-utilised, primarily through exclusion in the MBS system. There is little that could be done to improve training for counsellors at this time in consideration of the high standards currently required for registration. Of all the disciplines in the mental health workforce, registered counsellors are the only ones whose training is specific to the delivery

of therapeutical counselling from end to end. It is not taught as an adjunctive or additive skill to other specialty areas.

Q. *What changes should be made to how informal carers are supported (other than financially) to carry out their role? What would be some of the benefits and costs, including in terms of the mental health, participation and productivity of informal carers and the people they care for?*

Personal Helpers and Mentors Service (PHaMs) provides practical assistance for people aged 16 years and over whose lives are severely affected by mental illness. PHaMs helps people overcome social isolation and increase connections with their community. (PHaMs, 2018)

People are supported through a recovery focused and strengths-based approach that recognises recovery as a personal journey driven by the participant. Potential participants undertake a functionally based assessment with a PHaMs service provider to determine their eligibility for services. (PHaMs, 2018)

As announced in the 2018-19 Budget, the Australian Government will provide Continuity of Support (CoS) for existing PHaMs clients ineligible for the NDIS. CoS will support these clients to achieve similar outcomes to those they were aiming to achieve prior to the introduction of the scheme. From 1 July 2019, existing PHaMs clients who are ineligible for the NDIS will receive CoS through community mental health services delivered through the Primary Health Networks, administered by the Department of Health.

As the NDIS is rolled out across Australia, PHaMs will be progressively phased out. (PHaMs, 2018). Supports provided under the NDIS are holistic and are designed to give people more choice and control over the services and supports they need. Clients will continue to receive supports through PHaMs until their plan is finalised.

“The Government is providing $92.1 million over four years for continuity of support arrangements. This means clients who are ineligible for the NDIS will be supported to achieve similar outcomes, even if the arrangements for doing that change over time.” (Australian Government, Department of Social Services, 2018, p 1)

“Continuity of support was a commitment of the Council of Australian Governments in 2012. It aims to ensure that people with disability currently receiving services are not disadvantaged in the transition to the NDIS.” (Department of Social Services, 2018, p 1)

“There are five different packages of continuity of support which will be implemented from 1 July 2019: 1. Continuity of support for mental health programs 2. Continuity of support for carer programs.” (Australian Government, Department of Social Services, 2018, p 1)

“About 8,800 clients of the mental health programs (Personal Helpers and Mentors, Partners in Recovery and Support for Day to Day Living) who are ineligible for the NDIS will receive continuity of support from community mental health services delivered through the Primary Health Networks. This will be complemented by the Psychosocial Supports measure announced as part of the 2017-18 Budget for new mental health clients who are not eligible for the NDIS.” (Department of Social Services, 2018, p 2)

"About 6,500 clients of the Respite and Carer Support, Respite Support for Carers of Young People with Severe or Profound Disability, and Young Carers Respite and Information Services will receive continuity of support through the new Integrated Carer Support Service." (Department of Social Services, 2018, p 2)

## Social participation and inclusion

Q. *Are there particular population sub-groups that are more at risk of mental ill-health due to inadequate social participation and inclusion? What, if anything, should be done to specifically target those groups?*

***Aboriginal and Torres Strait Islander peoples***

Aboriginal and Torres Strait Islander mental health outcomes are considerably poorer across a range of outcomes than those of non-Indigenous people. In the 2014-2015 ABS National Aboriginal and Torres Strait Islander Social Survey, 33 per cent of adult respondents had high/very high levels of psychological distress, and this was found to be 2.6 times that of as non-Indigenous adults (Australian Government, 2017). Counsellors and psychotherapists provide a bolstered workforce to respond to the high incidence of social and emotional wellbeing problems and mental ill-health. To help ameliorate the intergenerational effects of trauma counsellors and psychotherapists use culturally competent and safe practices, and a wide range of interventions to respond to the cultural diversity of clients, such as Narrative Therapy when working with Aboriginal and Torres Strait Islander clients (Nagel & Thompson, 2007).

Increasing access to culturally appropriate and affordable care will support economic and social participation and lead towards productivity benefits and economic growth over the long term. ARCAP suggests an Indigenous counsellor training program that is integrated into Aboriginal Medical Services as counselling delivered by trained Indigenous counsellors for Indigenous clients has been found to have positive outcomes (Bennett-Levy, Wilson, Nelson, Stirling, Ryan, Rotumah, Budden & Beale, 2014).

***People that are homeless***

The link between homelessness and mental illness is well established, and there is a direct relationship between homelessness and social exclusion. Without access to appropriate mental health and community supports to assist in maintaining accommodation and other essential aspects of daily living such as employment, mental illnesses of people that are homeless can be exacerbated and result in a loss of accommodation and social networks.

Homeless individuals also exhibit high rates of mental illness, trauma, suicide and other issues that lead to premature deaths (Teeson, Hodder & Buhrich, 2004). People that are homeless have a disproportionately higher emergency department visits, inpatient hospital admissions, and longer hospital stays (Fazel, Geddes & Kushel, 2014). People that are chronically homeless have four times the rate of Post-Traumatic Stress Disorder than the general population.

To prevent homelessness and relapse ARCAP proposes a model of care that features a multidisciplinary team in accommodation houses with embedded clinical experts such as registered clinical counsellors and psychotherapists, nurses, and social workers. These

accommodation houses can be scaled up and integrated into a stepped model of care, so that appropriate services can be linked to step up and down as necessary, for example to recovery centres or drug and alcohol programs. This would improve the integration of services and prevent people from falling through the cracks between services.

***Asylum seekers and refugees***

Asylum seekers and refugees are amongst the most vulnerable, socially and economically marginalised people in the Australian community. With many having experienced torture, trauma, and other catastrophic events prior to settlement in Australia, mental ill-health is high. The risk of developing post-traumatic stress disorder, anxiety, or depression is particularly high with this population sub-group.

To achieve settlement a migrant needs to feel independent, secure and accepted in the domains of social interaction, economic engagement, and personal wellbeing. However, mental health literacy and help-seeking amongst refugee populations in Australia is lower than the general population (Yaser, Slewa-Younan, Smith, Olson, Uribe Guajard & Mond, 2016; May et al., 2014). Cultural conceptions of mental health and treatment can present a significant barrier in recognising and addressing mental health issues (Renzaho & Dhingra, 2017).

Workforce capacity can be built through increased utilisation of the registered counselling and psychotherapy workforce. Current bottlenecks in the health system could be resolved with effective task shifting and interdisciplinary models of team-based care. For instance, a social worker could collect and share the family narratives with the mental health team, while counsellors and psychotherapists can focus on treatment and recovery. This would provide high-quality, cost-effective, and efficient care to more people compared to a general practitioner-centric model.

**Justice and child protection**

Q. *What mental health supports earlier in life are most effective in reducing contact with the justice system?*

Patrick Clark has written extensively on the use of CBT with young offenders, (Clark,2010) with some key points detailed below.

*"Mark Lipsey of Vanderbilt University (Lipsey, Howell, Kelly, Chapman, & Carver, 2010) examined the effectiveness of various approaches to intervention with young offenders. His review analyzed the results of 548 studies from 1958 to 2002 that assessed intervention policies, practices and programs.*

*Lipsey grouped evaluations into seven categories:Counseling, Deterrence, Discipline, Multiple coordinated services, Restorative programs, Skill building and Surveillance.*

*When he combined and compared the effects of these interventions, he found that those based on punishment and deterrence appeared to increase criminal recidivism. On the other hand, therapeutic approaches based on counseling, skill building and multiple services had the greatest impact in reducing further criminal behavior.*

*Lipsey also examined the effectiveness of various therapeutic interventions. In particular, he compared different counseling and skill-building approaches. He found that cognitive behavioral skillbuilding approaches were more effective in reducing further criminal behavior than any other intervention.*

*In a different research review, Nana Landenberger and Lipsey showed that programs based on cognitive behavioral therapy are effective with juvenile and adult criminal offenders in various criminal justice settings, including prison, residential, community probation and parole. Lipsey (Lipsey, et. al., 2010) examined research studies published from 1965 through 2005 and found 58 that could be included in their review and analysis. The researchers found that cognitive behavioral therapy significantly reduced recidivism even among high-risk offenders."*

Whilst the above is only one of many similar articles for the purpose of this submission it is important for the commission to consider that many Registered Counsellors and Psychotherapists are trained in CBT. There is a strong argument that juveniles who undergo counselling or psychotherapy are less likely to re-offend.

**Education and training**

Q. *Do students in all levels of education and training have access to adequate mental health-related support and education? If not, what are the gaps?*

No, they do not. Due to reporting policies and lack of confidentiality in most schools' children resist seeing school guidance officers, who in the most part are psychologists not counsellors in the public-school system. Issues such as stigma and lack of confidentiality/privacy, many counselling rooms are situated in the main admin area close to the principal's office, and where foot traffic is constant, there is a strong reluctance by students to use available services. Students are also aware their files are not confidential; principals and other teaching staff can access files and, in some schools, counsellors must share files and cases with teaching staff who have no training in mental health. Another roadblock for many students is that Guidance Officers (in the main psychologists) will automatically assess and diagnose students against the DSM5 or ICD with a mental illness before entering into a counselling process. This can have lifelong negative consequences.

**Mentally healthy workplaces**

Q. *What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views?*

The following statistics reflect the real financial cost to Australian businesses alone due to poor workplace conditions in which workers do not thrive. The following 2017 statistics are taken from several peak organisations including R U OK and Workplace Mental Health Institute:

- Work days lost annually due to workplace stress: 3.2 days per employee
- Annual cost due to stress-related workers' compensation: > $10 billion each year

- Annual cost to Australian businesses due to not providing early intervention or treatment for employees: $6.5 billion
- Employee annual turnover directly related to poor mental health support in the workplace: males 44% and females 52%
- When looking for a job, 71% of people believe it is important to have a mentally healthy workplace, 34% of employees believe it is essential.
- Around 13,545 workers engage in non-fatal suicidal behaviour each year, with 2303 resulting in full incapacity and 11,242 needing a short absence from work.
- Mental health has been found to affect job involvement, job satisfaction, loyalty, performance, absence, turnover and physical health.
- Mental health conditions cost Australian workplaces $4.7 billion in absenteeism, $6.1 billion in presenteeism and $145.9 million in compensation claims, according to a report by Price Waterhouse Cooper (PWC, 2014).
- It estimated that every dollar spent on effective workplace mental health actions might generate $2.30 in benefits to an organisation — a 2.3 per cent return on investment. (PWC, 2014).
- The median workers' compensation payment for serious mental health claims was $24,500 in the six years up to 2015, compared to $9,200 for physical ones.
- Workers with mental health problems took an average of 14.8 weeks off per year, whereas those with physical injuries took off 5.4 weeks per year?

Employee Assistance Programs (EAP) are generally workers first contact with a mental health professional. The large majority of EAP providers in Australia contract registered counsellors. As the above statistics reflect many Australians will be exposed to counselling services within their work environment. The above figures reflect the high cost to Australian businesses when workplace issues occur, and this emphasises the importance that workplaces have access to counsellors to ensure workers are supported and given assistance until they can go back into the workforce.

Mental health services in many occasions are initiated from the workplace environment through EAPs. The worker if necessary is also guided through the public system should the EAP not be able to address the presenting issues, but more services are required. It is imperative that counsellors are able to provide continuity through the public system. Counsellors are the preferred service provider by many EAPs due to the competitive costs when compared to other similar disciplines. Counsellors need to be able to offer EAP client’s subsidies under MBS and Better Access Initiative to ensure clients who exhaust their access to EAPs can continue treatment without breaking continuity with the counsellor.

## Framework to enhance mental health and improve participation and workforce contribution

### Funding arrangements

Q. *What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future?*

From the commencement of the Better Access Initiative in 2006 to February 2018, around 2,700,000 Australians now have their own individually tailored mental health care plan (MBS Item 2710). Mental illnesses are very common in Australia, as in most parts of the developed world. About one in five Australians aged 16-85 experience anxiety, affective and substance use disorders over a 12-month period (ABS, 2007; Armstrong & Jones, 2019).

Australians are experiencing an increase in the prevalence and early onset of mental health problems, psychological distress and increased medical consultations. This trend has influenced a shift in Commonwealth and state governments' policy towards consumer assess, early intervention and prevention (NHHRC, 2008). A 2011/12 survey (ABS, 2013) reported 8.7 per cent of Australians experienced high levels of psychological distress, with 4.0 per cent experiencing very high levels of psychological distress. Individuals in the very high range would benefit from psychological interventions such as counselling, with research demonstrating a strong association between individuals experiencing high levels of psychological distress and having a diagnosis of anxiety and affective disorders (Andrews & Slade 2001; Armstrong & Jones, 2019).

There is a potential connection between the rise in expenditure and workforce shortages. As long as one discipline is able to monopolise the delivery of services and influence siloing of service deliveries particularly in the tender processes under the PHNs, there is potential for price increases due to operating in a non-competitive environment. Professions who dominate service delivery can control prices and restrict entry by other similar professions to the market place. This has a flow-on effect into other service delivery points such as Better Access Initiative. Market competition is the primary driver that ensures services remain economically viable. When there are supply-side constraints, costs rise. This also impacts on gap fees, as these will also rise without the balance competition brings to the market. This in turn impacts on the availability of services. When siloing of service delivery occurs one way to manipulate costs is by lowering accessibility and shutting out competitors, this generally has a greater impact on low socio-economic groups as they can no longer afford basic services.

This also creates movement in supply as service providers tend to concentrate in higher socio-economic areas where consumers can afford larger gap payments. Those most in need are not able to afford services and are then burdened with the added expense of travel. While services in their geographic area disappear, and they become isolated, increasing their reliance on welfare services, those in the higher economic areas find more services opening in their areas with significant gap payments.

Q. *Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements?*

The Commonwealths' responsibility for primary mental health care and initiatives such as the Better Access Initiative should be expanded to include registered counsellors as a profession able to support the current unmet need of the health system. The Better Access Initiative was initiated as a capped access to some primary mental health care services through GP referrals under a GP mental health care plan to these other primary health care providers. However, the Commonwealth has also introduced multiple additional mental health programs with considerable overlap between Commonwealth services and the care provided by state-funded specialised community mental health teams (Armstrong & Jones,2019).

Current Better Access Initiative services are centralised around the three capital cities on the eastern seaboard, Brisbane, Sydney and Melbourne. They can generally be found in middle to higher income areas. Gap payments are most often required. Lower income regions such as Hunter Valley in NSW have a shortage of service providers and significant waiting lists as a result. The current funding arrangements limit access to lower middle- and lower-income groups. This, in turn, creates workforce shortages in areas where needs are great as well as limiting access to certain socio-economic groups. What was intended to be a subsidised service for low-income earners is now approaching inaccessible to those it was intended for, while high-income earners now have greater access to a glut of subsidised services. To balance access to services and remove waiting lists a broader group of service providers is required to break the monopoly responsible for this scenario. There currently is a workforce of appropriately trained professionals waiting to be deployed to address this situation and bring equity back to help rationalise the economic costs of a broken system, Registered Counsellors and Psychotherapists.

*Q. How could funding arrangements be reformed to better incentivise service providers to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government?*

Bringing balance to tender requirements and opening up Better Access Initiative to counsellors. Currently, those controlling tenders within PHNs are predominantly from one profession and therefore weight requirements in a fashion to ensure certain professions are favoured over others. Tenders are written in such a fashion as to become non-competitive; therefore, continuing siloing of services and perpetuating cost increases and limiting competition within the market, not addressing waiting lists and limiting service delivery to certain groups. There needs to be a balance of professions involved in the allocation of funding arrangements and an acknowledgment that counsellors and other mental health professionals can deliver services with equal outcomes.

Q. *Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved?*

As previously discussed, current arrangements for commissioning and funding mental health services skew funding to select provider groups, thereby creating systemic issues. The current arrangements also perpetuate a bias within certain mental health disciplines, which enable

them to restrict access to the market. Until there is equal representation on boards and committees that control financial arrangements, best outcomes will not be met.

Mental health services require competent and qualified therapists to deliver evidence-based treatments within the stepped-care model. Registered Counsellors and Psychotherapists are an important source of workforce supply able to meet the workforce need. Utilising Registered Counsellors and Psychotherapists will allow service provision to be geared to the likely pattern of demand from people accessing services (CSIP, 2008; Armstrong & Jones, 2019).

Q. *How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes?*

The inclusion of Registered Counsellors and Psychotherapists in the class of allied mental health professionals registered to provide Medicare Benefits Schedule items of Focussed Psychological Strategies would be a significant advancement in the Australian mental health sector. Registered Counsellors and Psychotherapists represent a workforce that is specifically trained in evidence-based Focussed Psychological Strategies and are a competent and self-regulated workforce able to meet the emerging needs of the wider health system. The inclusion of Registered Counsellors and Psychotherapists will increase workforce capacity, improve both consumer outcomes and choice, and bring an improved scale of economy to the wider health system (Armstrong & Jones, 2019).

Currently, the present allied health professionals providing Medicare Benefits Schedule items for Focussed Psychological Strategies spend approximately 60 per cent of their time delivering counselling and approximately 30 per cent of their time delivering mental health interventions (National Health Workforce Dataset, 2016). Registered Counsellors and Psychotherapists by definition of their qualifications and professional designation, counsellor, are specialists in counselling as opposed counselling being a subset of skills added onto another discipline. Ironically counsellors are currently disenfranchised from accessing provider numbers through the Better Access Initiative denying mental health consumers to experts in the field of counselling to help them address their issues.

Registered Counsellors and Psychotherapists providing Focussed Psychological Strategies would reduce the burden of disease and improve patient outcomes with cognitive strategies that support patients' ability to carry out the activities of daily life with freedom from mental disturbance (Armstrong & Jones, 2019).

Including Registered Counsellors and Psychotherapists would provide clear advantages to consumers and to government including:

- Capacity for 20% growth in service delivery above current service levels
- Provision of workforce growth in underserved geographic and sociographic areas
- More accessible and affordable services for consumers
- A wider range of counselling interventions to meet the needs of consumers

Including Registered Counsellors and Psychotherapists as Medicare would be in line with other allied mental health providers, would build workforce capacity and provide proven

evidence-based therapies to patients seeking treatment. Registered Counsellors and Psychotherapists currently deliver the same Focussed Psychological Strategies as these allied health professionals within a private practice setting.

**Measurement and reporting of outcomes**

Q. *What does improved participation, productivity and economic growth mean for consumers and carers? What outcomes should be measured and reported on?*

Currently, data collection from Better Access Initiative is limited to demographic data. Better Access Initiative does not require practitioners to collect client feedback to measure treatment outcomes. A review was undertaken by the Centre for Health Policy and Programs at the University of Melbourne in 2011 which outlines that consumers reported positive outcomes (Pirkis, Harris, Hall & Ftanou, 2011). However, there is no ongoing data collection to measure outcomes against standardised measures.

Direct feedback from clients is one of the most informative and accurate ways to measure the effectiveness of the services. Some form of data collection to measure treatment outcomes should be a mandatory requirement of provision of MBS Item Numbers.

Beyondblue has implemented a data collection system, CORE, as part of a pilot program they have developed for low-intensity interventions. CORE is used in the UK as a mandatory data collection requirement for service providers delivering the IAPT (Improving Access to Psychological Therapies) program (Barkham, Mellor-Clark, Connell & Cahill, 2006). This is an example of a successful large-scale data collection system that has been used in the UK to gather direct feedback from clients in order to measure service effectiveness which has been translated into the Australian context.

# *Section 3 – Barriers to achieving increased social and economic participation and contribution*

ARCAP have identified three specific barriers which need to be addressed to support the process of increasing access to therapeutic services and support to be provided by counsellors and psychotherapists.

## GST Exemption not available for counsellors and psychotherapists

Services provided by counsellors and psychotherapists are currently not exempt from GST.

Section 38-10 (1) of A New Tax System (Good and Services Tax) Act 1999 defines 'other health services' for the purposes of GST exemption. Psychology and social work are listed, but counselling and psychotherapy are not.

Counselling and psychotherapy services provided by Registered Counsellors and Psychotherapists are the same as the services provided by Psychologists and Social Workers. The distinction between Psychologists, Social Workers, Counsellors and Psychotherapists in relation to GST exemption for health services is artificial. All are providing counselling and psychotherapy in order to increase the health and wellbeing of the Australian community and prevent and treat mental illness.

It is in the public interest that counselling and psychotherapy services provided by Registered Counsellors and Psychotherapists should be exempt from GST, as is the case for a wide range of other professional health services.

An amendment to the legislation will see reduced costs for consumers and put the full-range of the workforce on an equal footing to ensure that consumer has a choice in the services they access. This will have the impact of increasing access to counselling and psychotherapy services for the community and enabling clients to choose the mental health service most appropriate for their needs.

## Limitations with the Better Access Initiative

ARCAP has serious concerns about the program design and targeting of Better Access Initiative which is not meeting the mental health care needs of the Australian community (Rosenberg, Mendoza & Russell, 2012; Rosenberg & Hickie, 2012).

There has been very little evaluation of the effectiveness of Better Access Initiative. One study of program o outcomes concluded that "The large increase in the use of mental health services after the introduction of the Better Access scheme had no detectable effect on the prevalence of very high psychological distress or the suicide rate". (Jorm, 2018).

To meet the rising demands of the population for mental health services ARCAP supports the Medicare Benefits Schedule (MBS) Review and in particular, the recommendations of the Mental Health Reference Group which have proposed expanding access to, and rebates for, psychological therapies via Better Access Initiative (MHRG, 2018). ARCAP have recommended to the MBS Review that significant changes to current program arrangements are required to improve patient outcomes (PACFA, 2018; ACA, 2018).

However, there are emerging workforce issues with the proposed expansion of Better Access Initiative. ARCAP therefore supports the extension of Medicare provider numbers to Registered Counsellors and Psychotherapists.

## Role of Private Health Insurers too limited

Recent private health reforms are impacting on the role of Private Health Insurers (PHIs) in relation to mental health. These reforms are supported as it is important that PHIs share the burden of the costs on mental health treatment.

Complexities regarding out of pocket expenses are seen within the private health insurance sector. Individuals with private health insurance often consumption all their approved number of sessions through the Better Access initiative during a calendar year before utilising their private insurance. Reasons for this trend include the higher rebate for services accessed through the Better Access Initiative (Armstrong & Jones, 2019).

However, there is a need to find more cost-effective ways to deliver programs to outpatients after hospitalisation to prevent relapse. Costly and inefficient hospital-based programs could be replaced by efficient high-value programs run by counsellors and psychotherapists within the community.

PHIs should utilise the available counselling and psychotherapy workforce for Extras or ancillary services, and this would provide gains in population mental health, which would, in turn, enhance social and economic productivity.

# *Conclusion*

The inclusion of Registered Counsellors and Psychotherapists into wider health care service provision would reduce the number of people being referred to more specialised services, reducing both patients waiting times and the need for multiple patient assessments, and also allow for more specialised service provision to responsively meet the demands of higher needs patients more effectively.

Registered Counsellors and Psychotherapists represent a competent allied health workforce able to provide relevant evidenced based focused psychological strategies to meet the current and emerging need of the wider health care system.

Registered Counsellors and Psychotherapists meet the standard of training, continuing education, supervision and ethical practice equivalent to other registered allied health professional delivering services within the commonwealth health system.

As a workforce, Registered Counsellors and Psychotherapists provide lower out of pocket expenses, which in turn reduces the barriers to client participation and an improved cost saving to the health system. The inclusion of Registered Counsellors and Psychotherapists will increase workforce capacity, improve consumer outcomes and choice, and bring an improved scale of economy to the wider health system, and would provide proven evidence-based therapies to patients seeking treatment.

This submission has demonstrated how Registered Counsellors and Psychotherapists meet the needs of the stepped care model for the delivery of focused psychological strategies within:

- The Better Access Initiative
- Commonwealth funded mental health services that provide identifiable benefits to individual patients
- Local Hospital Networks

Commissioning for outcomes can help ensure cost-effective, high-quality service provision. Mental health services require competent and qualified counsellors to deliver evidence-based treatments within the stepped-care model. Policy makers and commissioning bodies both need to consider how existing primary care services can integrate Registered Counsellors and Psychotherapists into the stepped-care model.

# *Appendix A – Hunter New England and Central Coast Primary Health Network Mental Health Waiting Times*

**Table 1: HNECC Waiting Times January 2018 (HNECC, 2018)**

| Service Location | Waiting Time (days) to assessment | Waiting Time (days) to commence treatment | Provider Name |
|---|---|---|---|
| Armidale | 0 | 41 | Centacare New England North West |
| Barraba | 15 | 15 | HealthWISE |
| Bingara | 0 | 0 | Centacare New England North West |
| Boggabri | 0 | 0 | Centacare New England North West |
| Cessnock | 2 | 25 | Hunter Primary Care Ltd |
| Dungog | 5 | 5 | Life Matters Psychologists |
| Forster | 5 | 5 | Life Matters Psychologists |
| Glen Innes | 0 | 18 | Centacare New England North West |
| Gloucester | 10 | 10 | Life Matters Psychologists |
| Gosford | 14 | 14 | Central Coast Primary Care |
| Gosford | 17 | 17 | Yerin Aboriginal Health Services Inc |
| Gunnedah | 15 | 15 | HealthWISE |
| Guyra | 0 | 33 | Centacare New England North West |
| Inverell | 0 | 8 | Centacare New England North West |
| Lake Macquarie | 2 | 18 | Hunter Primary Care Ltd |
| Maitland | 2 | 18 | Hunter Primary Care Ltd |
| Maitland | 3 | 3 | Life Matters Psychologists |
| Manilla | 17 | 17 | HealthWISE |
| Moree | 0 | 29 | Centacare New England North West |
| Mungindi | 0 | 0 | Centacare New England North West |
| Muswellbrook | 3 | 15 | Hunter Primary Care Ltd |
| Narrabri | 0 | 34 | Centacare New England North West |
| Newcastle | 2 | 15 | Hunter Primary Care Ltd |
| Port Stephens | 2 | 17 | Hunter Primary Care Ltd |
| Quirindi | 20 | 20 | HealthWISE |
| Scone | 3 | 20 | Hunter Primary Care Ltd |
| Singleton | 2 | 15 | Hunter Primary Care Ltd |
| Tamworth | 0 | 18 | Centacare New England North West |
| Tamworth | 23 | 23 | HealthWISE |
| Taree | 15 | 15 | Life Matters Psychologists |
| Tenterfield | 0 | 0 | Centacare New England North West |
| Walcha | 15 | 15 | HealthWISE |
| Warialda | 0 | 0 | Centacare New England North West |
| Wee Waa | 0 | 8 | Centacare New England North West |
| Wyong | 9 | 9 | Central Coast Primary Care |
| Wyong | 17 | 17 | Yerin Aboriginal Health Services Inc |

# *References*


Access Economics (2009), The Economic Impact of Youth Mental Illness and the Cost Effectiveness of Early Intervention, *Report for the Headspace Centre of Excellence in Youth Mental Health*, Canberra.

AIHW, (2006). Psychology Labourforce 2003, catalogue number HWL 34, Canberra; AIHW (2010).

AIHW, (2018). *Selected potentially preventable hospitalisations*. Retrieved from https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/indicators-of-australias-health/selected-potentially-preventable-hospitalisations

Andrews, G., & Slade, T., (2001). 'Interpreting scores on the Kessler Psychological Distress Scale (K10)', *Australian and New Zealand Journal of Public Health* 25(6): 494–7.

Armstrong, P., & Jones, D. (2019). *Proposal for counsellors to deliver stepped care focused psychotherapies within better access*. Grange, Brisbane: Australian Counselling Association Inc.

Australian Bureau of Statistics, (2007). *National Survey of Mental Health and Wellbeing: summary of results, 2007*. Canberra: ABS, 2007. (ABS Cat. No. 4326.0.). 2007; Available from http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0

Australian Bureau of Statistics, (2013). *Australian Health Survey: Updated Results, 2011–2012*, Cat No. 4364.0.55.003, Canberra: ABS.

Australian Bureau of Statistics. (2012). *Suicides Australia Catalogue 3309.0*. Canberra: ABS.

Australian Counselling Association, (2016). *Scope of Practice for Registered Counsellors*. Newmarket, Queensland: Author. Retrieved from https://www.theaca.net.au/documents/ACA%20Scope%20of%20Practice%20for%20Registered%20Counsellors%202016.pdf

Australian Government (2017). *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*. Retrieved from https://www.pmc.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf.

Australian Government, (2015). *Health Insurance Act 1973*, No. 42, 1974 §

Australian Government, (2017). *Health Insurance (General Medical Services Table) Regulations 2017.* Health Insurance Act 1973, Compilation No. 1. Retrieved from http://www.legislation.gov.au/Details/F2017C00567/Download

Australian Government, Department of Social Services. (2018, August). *Continuity of support for clients of Commonwealth disability programs*. Department of Social Services. Retrieved March 25, 2019, from https://www.dss.gov.au/publications-articles/corporate-publications/budget-and-additional-estimates-statements/continuity-of-support-for-clients-of-commonwealth-disability-programs

Banfield, M., Freeman, B., & Suomi, A. (2017). Framework for the engagement of people with a lived experience in program implementation and research. Canberra Australia: Centre for Mental Health Research, Australian National University.

Barkham, M., Mellor-Clark, J., Connell, J., & Cahill, J., (2006). A core approach to practice-based evidence: A brief history of the origins and applications of the CORE-OM and CORE System. *Counselling and Psychotherapy Research*, *6*(1), 3–15.

Bassilios B., Pirkis J., King, K., Fletcher, J., Blashki, G, & Burgess, P., (2012). *Evaluation of an Australian primary care telephone cognitive behavioural therapy pilot*. Australian Journal of Primary Health 20: 62-73.

Bennett-Levy, J., Wilson, S., Nelson, J., Stirling, J., Ryan, K., Rotumah, D., Budden, W., Beale, D. (2014). Can CBT be effective for Aboriginal Australians? Perspectives of Aboriginal practitioners trained in CBT. *Australian Psychologist*, *49*(1), 1–7.

Birks, M., J. Mills, Francis, K., Coyle, M., Davis, J., & Jones, J. (2010). Models of health service delivery in remote or isolated areas of Queensland: A multiple case study. *Australian Journal of Advanced Nursing, 28*(1), 25-34.

Bourke, L., Humphreys, J., Wakerman, J., & Taylor, J. (2012). Understanding rural and remote health: A framework for analysis in Australia. *Health & Place, 18,* 496-503.

Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency: Narrative literature review. *The British Journal of Psychiatry, 186*, 11-17.

Burgess, P., J. Pirkis & T. Coombs., (2006). 'Do adults in contact with Australia's public sector mental health services get better?' *Australian and New Zealand Health Policy* 3: 9.

Burgess, P., Pirkis, J., Buckingham, B., et al., (2002*).* Mental health needs and expenditure in Australia. Canberra: *Mental Health and Special Programs Branch*, Commonwealth Department of Health and Ageing.

Calma, T. & Priday, E. (2011). Putting Indigenous human rights into social work practice. *Australian Social Work, 64*(2), 147-155.

Carter R, Vos T, Moodie M, et al. (2008). Priority setting in health: Origins, description and application of the assessing cost effectiveness (ACE) initiative. *Expert Review of Pharmacoeconomics and Outcomes* 8: 593–617.

Chater, A.B. (2008). Looking after health care in the bush. *Australian Health Review, 32*(2), 313-318.

Chisholm, D. (2005). Choosing cost-effective interventions in psychiatry: results from the CHOICE programme of the World Health Organization. *World Psychiatry: Official Journal of The World Psychiatric Association* (WPA) 4: 37–44.

Clark, P., (2010). Preventing Future Crime With Cognitive Behavioral Therapy. *National Institute of Justice Journal* No. 265, April 2010. Retrieved from https://www.nij.gov/journals/265/pages/therapy.aspx.

Council of Australian Governments (COAG) Health Council, (2017). *Fifth National Mental Health and Suicide Prevention Plan.* Australian Govenrment.

Cuijpers, P., Van Starten, A., Smit, F., Mihalopoulos, C., Beekman, A., (2008). Preventing the onset of depressive disorders: a meta-analytic review. *American Journal of Psychiatry*; 165:1272 - 1280.

DSS (Department of Social Services), (2018). Continuity of support for clients of Commonwealth disability programs. *2018 Budget*. Retrieved from https://www.dss.gov.au/publications-articles/corporate-publications/budget-and-additional-estimates-statements/continuity-of-support-for-clients-of-commonwealth-disability-programs

Duckett, S., & Breadon, P., (May 2014). *Out-of-pocket costs: hitting the most vulnerable hardest.* Grattan Institute, Australia.

Dunbar, J. A., Hickie, I. B., Wakerman, J., & Reddy, P. (2007). New money for mental health: Will it make things better for rural and remote Australia? *Medical Journal of Australia*, 186(11), 587–589.

Duncan, B.L., Miller, S.D., Wampold, B.E., & Hubble, M.A. (Eds.), (2009). *The heart and soul of change: Delivering what works in therapy.* (2nd ed.). San Francisco, CA: Jossey-Bass.

Fazel, S., Geddes, J. R., & Kushel, M., (2014). The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet, 384*(9953), 1529-1540.

Firth, N., Barkham, M., & Kellett, S., (2015). The clinical effectiveness of stepped care systems for depression in working age adults: A systematic review. *Journal of Affective Disorders*, 170, 119–130.

Fletcher, J., Pirkis, J., King, K., Christo, J., Bassilios, B., Burgess, P., Whiteford, H., Blashki, G., Littlefield, L., (2011). Psychologists' Experiences with the Better Access Initiative: A Pilot Study. *Australian Psychologist*, *46*(3), 153–162.

Gittoes, E., Mpofu, E., & Matthews, L. R., (2011). Rehabilitation counsellor preferences for rural work settings: Results and implications of an Australian study. *The Australian Journal of Rehabilitation Counselling*, *17*(1), 1–14.

Harder, H. G., Rash, J., Holyk, T., Jovel, E., & Harder, K., (2012). Indigenous youth suicide: a systematic review of the literature. *Pimatisiwin Journal of Aboriginal and Indigenous Community Health, 10*(1), pp.125-42.

Harms, L., Middleton, J., Whyte, J., Anderson, I., Clarke, A., Sloan, J., Hagel, M. & Smith, M., (2011). Social work with Aboriginal clients: Perspectives on educational preparation and practice. *Australian Social Work, 64*(2), 156-168.

Harrison, C., & H. Britt., (2011). General practice workforce gaps now and in 2020. *Australian Family Physician*, *40*(1/2), 12-15.

Hunter New England and Central Coast Primary Health Network (HNECC), (2018). *HNECC Mental Health Waiting Times January 2018.* (Available from;

https://www.hneccphn.com.au/media/14542/mental-health-waiting-times-01012018-to-31012018.pdf)

Iacoviello, B. M., McCarthy, K. S., Barrett, M. S., Rynn, M., Gallop, R., & Barber, J. P., (2007). Treatment preferences affect the therapeutic alliance: Implications for randomized controlled trials. *Journal of Consulting and Clinical Psychology, 75*(1), 194–198.

Jorm, A.F., (2018). Australia's 'Better Access' scheme: Has it had an impact on population mental health? *Australian & New Zealand Journal of Psychiatry*, *52*(11), 1057–1062.

KPMG and Mental Health Australia, (2018). *Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform*.

KPMG, (2013). *The Economic Cost of Suicide in Australia,* Report prepared for Menslink.

Levula, A., Harré, M., & Wilson, A., (2018). The Association Between Social Network Factors with Depression and Anxiety at Different Life Stages. *Community Mental Health Journal*, *54*(6), 842–854.

Lewis, I., & Meteyard, J., (2015, November). Australian Counselling and Psychotherapy Survey Update. *PACFA eNewsletter*, pp. 6-8. Retrieved from *http://www.pacfa.org.au/wpcontent/uploads/2014/03/eNews-November-2015.pdf*

Lifespan Integrated Suicide Prevention, (2018). *Evidence-based treatment for suicidality, NSW trial sites, Central Coast Local Health District, Hunter New England Local Health District, Murrumbidgee Primary Health Network*. Retrieved from https://www.blackdoginstitute.org.au/docs/default-source/lifespan/lifespan-strategy-summaries-research-summaries/lifespan_evidence_based_treatment_research_summary.pdf?sfvrsn=6

Lindhiem, O., Bennett, C. B., Trentacosta, C. J., & McLear, C., (2014). Client preferences affect treatment satisfaction, completion, and clinical outcome: A meta-analysis. *Clinical Psychology Review, 34,* 506-517.

Lipsey, M. W., Howell, J. C., Kelly, M. R., Chapman, G., & Carver, D., (2010). *Improving the Effectiveness of Juvenile Justice Programs*. Georgetown University: Center for Juvenile Justice Reform.

Mai, Q., Holman, C. D. A. J., Sanfilippo, F. M., & Emery, J. D., (2011). The impact of mental illness on potentially preventable hospitalisations: a population-based cohort study. *BMC psychiatry*, *11*(1), 163.

Masterson, S., & Owens, S., (2006). Mental health service user's social and individual empowerment: Using theories of power to elucidate far-reaching strategies. *Journal of Mental Health, 15*(1), 19-34.

May, S., Rapee, R. M., Coello, M., Momartin, S., & Aroche, J. (2014). Mental health literacy among refugee communities: differences between the Australian lay public and the Iraqi and Sudanese refugee communities. *Social Psychiatry and Psychiatric Epidemiology*, 49(5), 757–769.

McLeod, J., (2012). What do clients want from therapy? A practice-friendly review of research into client preferences. *European Journal of Psychotherapy, Counselling and Health, 14*, 19-32.

Medibank and Nous Group, (2013). *The Case for Mental Health Reform in Australia: A Review of Expenditure and System Design, Detailed Expenditure Calculations.* Medibank, Australia.

Mental Health Council of Australia, (2010). *Mental health fact sheet: Analysis of the Better Access scheme.* Canberra, ACT: Mental Health Council of Australia.

Mental Health Reference Group, (2018). *Report from the Mental Health Reference Group*. Australian Government, MBS Review. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/58EFEA022C2B7C49CA2583960083C4EA/$File/Report%20from%20Mental%20Health%20Reference%20Group.pdf

Mihalopoulos, C., Magnus, A., Lal, A., Dell, L., Forbes, D., & Phelps, A., (2015). Is implementation of the 2013 Australian treatment guidelines for posttraumatic stress disorder cost-effective compared to current practice? A cost-utility analysis using QALYs and DALYs. *Australian & New Zealand Journal of Psychiatry*, 49(4). 360–376.

Nagel, T., & Thompson, C., (2007). AIMHI NT 'Mental Health Story Teller Mob': Developing stories in mental health. *Australian E-Journal for the Advancement of Mental Health, 6*(2), 1-6. 31. Retrieved from www.lowitja.org.au/aimhi-nt-mental-health-story-teller-mob-developingstories-mental-health

National Health and Hospitals Reform Commission, (2008). *A healthier future for all Australians: Interim Report*, Canberra: NHHRC.

*National Health Reform Act 2011,* No. 9, 2011 § (2012).

National Health Workforce Dataset, Space Time Research, (NHWD, STR), (2016). *Local Government Area and Primary Health Network by Year, Professions and Job Area Counting: Number of Psychology Practitioners,* Australian Government.

National Institute for Health and Care Excellence, (2011). *A stepped-care approach to commissioning high-quality integrated care for people with common mental health disorders*.

National Mental Health Commission, (2014). *Contributing Lives, thriving communities: Report of the National Review of Mental Health Programs and Services Summary*. Canberra, Australia: Commonwealth of Australia. Retrieved from http://www.mentalhealthcommission.gov.au/media/119896/Summary%20%20-%20Review%20of%20Mental%20Health%20Programmes%20and%20Services.PDF

National Mental Health Commission, (2016). *PHNs and Stepped Care, Case Study*, Available from http://www.mentalhealthcommission.gov.au/our-reports/our-national-report-cards/2016-report/case-studies.aspx

National Mental Health Commission, (2018). *Monitoring Mental Health and Suicide*

*Prevention Reform: National Report 2018*, Sydney.

Department of the Prime Minister and Cabinet. (2017). *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023.* Australian Government.

Perkins, D., (2016). Stepped Care, System Architecture and Mental Health Services in Australia. *International Journal of Integrated Care*, 16(3).

Personal Helpers and Mentors Service, (PHaMs). Department of Social Services, Australian Government. (2018, December). Retrieved March 25, 2019, from https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability/personal-helpers-and-mentors-service-phams

Phongsavan, P., Chey, T., Bauman, A., Brooks, R., & Silove, D., (2006). Social capital, socio-economic status and psychological distress among Australian adults. *Social Science & Medicine (1982)*, *63*(10), 2546–2561.

Pirkis, J., Harris, M., Hall, W. & Ftanou, M.. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative: a Summative evaluation.* Melbourne: Centre for Health Policy, Programs and Economics.

Psychotherapy and Counselling Federation of Australia, (2018). *Scope of Practice for Registered Counsellors.* Melbourne, Australia: Author. Retrieved from: https://www.pacfa.org.au/wp-content/uploads/2018/09/Scope-of-Practice-for-Registered-Counsellors-2018.pdf

PWC, (2014). *Creating a Mentally Healthy Workplace: Return on Investment Analysis,* Melbourne.

Ratnarajah, D., & Schofield, M.J., (2007). Parental suicide and its aftermath: A review. *Journal of Family Studies, 13(*1), p. 78 (17 pages).

Ratnarajah, D., & Schofield, M.J., (2008). Survivors' narratives of the impact of parental suicide. *Suicide & Life-Threatening Behaviour, 38*(5), p. 618 (13 pages).

Renzaho, A.M.N., and Dhingra, N., (2016). *Addressing the needs of Syrian and Iraqi refugees in the Nepean Blue Mountains region: a formative assessment of health and community services needs.* Penrith: Wentworth Healthcare Limited.

Rosenberg, S., J. Mendoza and L. Russell, (2012). Well meant or well spent? Accountability for $8 billion of mental health reform. *Medical Journal of Australia* 196(3): 159–61.

Rosenberg, S.P., & Hickie, I.B., (2012). Better Outcomes or Better Access — which was better for mental health care? *The Medical Journal of Australia*, *197*(11), 619–620.

Schofield, D., Shrestha, R., & Callander, E., (2012). Access to general practitioner services amongst underserved Australians: a microsimulation study. *Human Resources for Health,* 10(1), 1.

Schofield, M. J., (2015). Counseling in Australia. In T. H. Hohenshil, N. E. Amundson, & S. G. Niles (Eds.), *Counseling Around the World* (pp. 333–347). Alexandria, VA:

American Counseling Association.

Schofield, M.J., (2008). Australian counsellors and psychotherapists: A profile of the profession. *Counselling and Psychotherapy Research, 8*(1), 4-11.

Schofield, M. J., & Roedel, G., (2012). *Australian psychotherapists and counsellors: A study of therapists, therapeutic work and professional development.* Melbourne, Australia: La Trobe University and PACFA. Retrieved from http://www.pacfa.org.au/wp-content/uploads/2012/10/Australian-Psychotherapists-Counsellors_Schofield-Roedel-2012_Final-Research-Report.pdf

Seligman, M.E.P., (1995). The effectiveness of psychotherapy: The consumer reports study. *American Psychologist, 50*(12), 965–974.

Sharpley, C.F., (1986). Public perceptions of four mental health professions: A survey of knowledge and attitudes to psychologists, psychiatrists, social workers and counsellors. *Australian Psychologist, 21,* 57-67.

Sharpley, C.F., Bond, J.E., & Agnew, C.J., (2004). Why go to a counselor? Attitudes to, and knowledge of, counseling in Australia, 2002. *International Journal for the Advancement of Counseling, 26,* 95-108.

Teesson, M., Hodder, T., & Buhrich, N., (2004). Psychiatric disorders in homeless men and women in inner Sydney. *Australian & New Zealand Journal of Psychiatry*, *38*(3), 162-168.

Veitch, C., Lincoln, M., Bundy, A., Gallego, G., Dew, A., Bulkeley, K., Brentnall, J., & Griffiths, S., (2012). Integrating evidence into policy and sustainable disability services delivery in western New South Wales, Australia: The 'wobbly hub and double spokes' project. *BMC Health Services Research*, 12(70): 1-8.

Vines, R., (2011). Equity in health and wellbeing: Why does rural, regional and remote Australia matter? *InPsych.* Retrieved from http://www.psychology.org.au/Content.aspx?ID=3960

Wampold, B. E., & Imel, Z. E., (2015). *The great psychotherapy debate: the evidence for what makes psychotherapy work (Second edition).* New York: Routledge.

Yaser, A., Slewa-Younan, S., Smith, C. A., Olson, R. E., Guajardo, M. G. U., & Mond, J., (2016). Beliefs and knowledge about post-traumatic stress disorder amongst resettled Afghan refugees in Australia. *International Journal of Mental Health Systems,* 10(1).