Psychotherapy & Counselling
Federation of Australia

PACFA submission to the Senate Inquiry into Commonwealth Funding and Administration of Mental Health Services

Senate Community Affairs Committee

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INTRODUCTION

PACFA is an advocate for appropriate, accessible health services to meet the biopsychosocial needs of clients, their carers and families. Counselling and psychotherapy focus on the prevention of mental illness, as well as treatment of symptoms of mental disorders, and actively promote wellbeing and healthy living.

This submission addresses the Terms of Reference of the Senate Inquiry into Commonwealth funding and administration of mental health services. Input into the submission was provided by our Member Associations, therefore it has drawn on diverse locations, disciplines and experiences around Australia.

As a peak body for the counselling and psychotherapy profession, PACFA has focused on the following key issues on which it has expertise:

1. Changes to the Better Access initiative, in particular the rationalisation of the number of allied health treatment sessions available under the Better Access initiative and the impact of this change for patients with mild or moderate mental illness - Terms of Reference point (b).

2. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services (ATAPS) program – Terms of Reference Point (c).

3. Services available for people with severe mental illness and the coordination of those services – Terms of Reference Point (d).

4. Mental health workforce issues, in particular workforce qualifications and training of psychologists (and counsellors and psychotherapists) and workforce shortages – Terms of Reference Point (e).

Recommendations

Arising from this submission, PACFA makes the following recommendations:

Recommendation 1

The maximum number of allied health treatment sessions under the Better Access initiative should be changed back to 12 sessions and the additional funding required allocated accordingly. Access to a maximum of 18 sessions in exceptional circumstances should be continued.

Recommendation 2

The Department of Health and Ageing should undertake research into the number of treatment sessions required for effective outcomes for the range of patients and presentations served by the Better Access initiative. Research should inform government policy on the number of allied health treatment sessions available to patients through the Better Access initiative.

Recommendation 3

The Department of Health and Ageing should develop fact sheets for Access to Allied Psychological Strategies consumers that report on the strengths and limitations of the approved psychological strategies to maximise informed choice for consumers.

Recommendation 4

Practitioners providing psychological strategies through the Access to Allied Psychological Strategies program should be required to match the strategy with the presenting problems of clients, their characteristics and treatment preferences.

Recommendation 5

The range of approved psychological strategies in the Access to Allied Psychological Strategies program should be expanded to include other psychotherapy and counselling models with strong evidence bases as appropriate for client presentations, particularly substance abuse, and treatment preferences.

Recommendation 6

PACFA registered Mental Health Practitioners should be included as service providers in the Access to Allied Psychological Services program. These practitioners are appropriately qualified to provide psychological strategies.

Recommendation 7

Strategies for reducing the stigma associated with being diagnosed with a severe mental illness should be developed and implemented by the Department of health and Ageing.

Recommendation 8

PACFA Registered counsellors and psychotherapists should be included as providers of non-clinical services for severely mentally ill patients receiving Flexible Care Packages.

Recommendation 9

PACFA registered Mental Health Practitioners should be included as service providers in the Better Access initiative. These practitioners are appropriately qualified to provide Focused Psychological Strategies.

BACKGROUND TO PACFA

What is PACFA?

PACFA represents a self regulating profession in a similar way to the Australian Association of Social Workers. PACFA is a federation of thirty-four Member Associations which represent a range of modalities including general counselling, family therapy, experiential therapies, psychotherapy and psychoanalysis.

PACFA Register

PACFA has 1,800 practitioners listed on its Register. Clinical Registrants have completed training in counselling and psychotherapy to at least Bachelors level or equivalent, and must have attained the equivalent of two years' full time practice (950 hours of client contact) linked to clinical supervision (125 hours) and demonstrate they meet ongoing professional development requirements for renewal of registration. Provisional Registrants have completed training in counselling and psychotherapy to at least Bachelors level or equivalent, and must have completed 200 hours of practice linked to 50 hours of supervision and meet ongoing professional development requirements

for renewal of training. Our Registrants are recognised by private health insurance funds for the provision of ancillary health services. Many of our registrants are also qualified in related disciplines such as psychology, social work, occupational therapy, nursing, naturopathy, medicine and psychiatry. Our Registrants are widely distributed and accessible throughout Australia in urban, regional, rural and remote areas.

Mental Health Practitioners

The PACFA Register has a specialist practitioner category of Mental Health Practitioner. Registrants must demonstrate specialist training and practice competencies in the area of mental health to an accrediting panel to be recognised as Mental Health Practitioners.

Australian Register of Counsellors and Psychotherapists (ARCAP)

PACFA has worked in collaboration with the Australian Counsellors' Association (ACA) to establish the Australian Register of Counsellors and Psychotherapists, a national register and credentialing system, to regulate all counsellors and psychotherapists within Australia. Practitioners who are listed on the PACFA and ACA Registers will be listed on the ARCAP Register from August 2011. ARCAP will operate independently of PACFA and ACA yet be accountable to these professional associations through their representation on the ARCAP Board.

PACFA SUBMISSION

1. **Changes to the Better Access initiative, in particular the rationalisation of the number of allied health treatment sessions available under the Better Access initiative and the impact of this change for patients with mild or moderate mental illness**

PACFA is concerned that the decision to reduce the number of allied health treatment sessions from 12 to 10 may have an adverse impact on some clients, particularly those presenting with long standing symptoms of mental illness.

The evaluation of the Better Access initiative undertaken by the University of Melbourne (Pirkis et al., 2011) provides clear evidence that the Better Access initiative has improved access to mental health care. Some features of the evaluation findings are:

- Overall uptake of the initiative has been high and has increased over time for all groups;
- Although some groups had better uptake than others, the Better Access initiative has reached all groups (however data was only available for young people, older people, people in rural and remote areas and those in areas of high socio-economic disadvantage);
- Uptake rates increased most dramatically for those who have been most disadvantaged in accessing mental health services; and
- The Better Access initiative is reaching new consumers who have not previously accessed mental health services (Pirkis et al., 2011).

It is relevant to the rationalisation of number of sessions to note that the Better Access initiative has not only been effective for patients with mild or moderate mental illness, but has also improved service access for significant numbers of people with severe mental disorders. Approximately 80% of Better Access consumers reported high or very high levels of psychological distress at the time of presentation for treatment, compared with 10% in the general population (Pirkis et al., 2011).

The policy decision to restrict treatment under the Better Access initiative to 10 sessions seems intended to ensure that the program is more efficient and better targeted by limiting the number of sessions that patients with mild or moderate mental illness can receive. This was described in the Federal Budget documents as 'rebalancing the number of annual allied health sessions to better align treatment to the needs of people' (Australian Government, 2011). However, this decision assumes that patients using the Better Access initiative have only mild or moderate mental illness, which is clearly not the case.

Although evidence indicates short term therapy is effective for some patients, it is important that clinicians are able to provide treatments that are responsive to patient needs. For some patients with more long-term or entrenched psychological issues, a reduction in the number of treatment sessions available could have a detrimental effect on treatment outcomes.

74% of consumers received 1 – 6 sessions through the Better Access initiative (Littlefield, June 2011). Successful completions and consumers dropping out of therapy because of dissatisfaction with the service or poor therapeutic alliance with the Mental Health Practitioner are combined in this group. This should be of grave concern to the Department of Health and Ageing, as research on consumer engagement with community mental health services demonstrates that 'a minimum of 11 to 13 sessions of evidence-based interventions are needed for 50% - 60% of clients to be considered recovered' (Barrett et al., 2008, p. 248). Attrition in the form of missed appointments wastes the time resources of Mental Health Practitioners who could be offering their services to other clients waiting for appointments. Therefore the rationale for rationalising Better Access services is faulty and more research is needed on the experience of consumers who receive 1 - 2 sessions through the Better Access initiative.

In the absence of clinical evidence to support the government's decision to reduce the number of treatment sessions from 12 to 10, the impact of this decision on outcomes for Better Access initiative patients is not known. PACFA is concerned that this policy change makes the Better Access initiative less flexible and that treatments will be less responsive to the needs of patients with more severe mental illness.

It is noted that in exceptional circumstances, a further 6 sessions can be provided (up to a maximum of 18 sessions per calendar year). PACFA endorses the continuation of this flexibility in appropriate circumstances where clinical assessment indicates that additional treatment sessions may improve treatment outcomes.

Recommendation 1

The maximum number of allied health treatment sessions under the Better Access initiative should be changed back to 12 sessions and the additional funding required allocated accordingly. Access to a maximum of 18 sessions in exceptional circumstances should be continued.

Recommendation 2

The Department of Health and Ageing should undertake research into the number of treatment sessions required for effective outcomes for the range of patients and presentations served by the Better Access initiative. Research should inform government policy on the number of allied health treatment sessions available to patients through the Better Access initiative.

2. The impact and adequacy of services provided to people with mental illness through the Access to Allied Psychological Services (ATAPS) program

We submit that the range of psychological services available to people with a mental illness in the Access to Allied Psychological Services program is not adequate to meet the wide range of needs within the community. The approved range of psychological strategies includes the following:

- Psycho-education;
- Cognitive Behavioural Therapy (CBT);
- Relaxation;
- Skills training;
- Interpersonal therapeutic strategies, particularly for depression; and
- Narrative Therapy.

Family therapy is also approved for women with perinatal depression.

Researchers emphasise that psychological strategies, including CBT and Interpersonal Therapy, have been tested under controlled conditions in university hospitals. These models may not be as efficacious in community settings and with clients who have concurrent conditions, for example depression, risk of suicide, risk of harm to others and substance dependence, as these client presentations are usually specifically excluded from research studies (Margison et al., 2000; Wampold, 2001). The findings of randomised controlled trial findings for counselling and psychotherapy are limited by high participant dropout rates, lack of compliance with difficult treatment regimes such as Exposure Therapy, and the lack of legitimate comparisons between different treatment models because of differences in paradigms, interventions and length of treatment (Bonchek, 2009; Margison et al., 2000). Parker (2006) emphasises that non-specific factors of therapeutic treatments, which are therapeutic interventions not linked to a particular model such as empathy, have not been controlled for in many randomised controlled trials on CBT and IPT.

The Australian National Audit Office's recent report on the Department of Health and Ageing's administration of the Access to Allied Psychological Strategies program found that the department did not make informed program design decisions due to lack of information and lack of evidence for the most effective services (2011). This is a concern for PACFA. In the next section, we outline some of the limitations found by researchers on psychological strategies including Cognitive Behavioural Therapy, Interpersonal Therapy (IPT) and Narrative Therapy. We are also concerned that group treatment is used as a way of rationing resources, and that brief interventions are used when longer term treatment is indicated for mental health conditions such as Borderline Personality Disorder. Interventions for substance abuse with a strong evidence base should also be included in the psychological strategies offered in the Access to Allied Psychological Strategies program.

Cognitive Behavioural Therapy (CBT)

CBT is the dominant model offered in the Access to Allied Psychological Strategies program. For some age groups, CBT does not have demonstrated efficacy. A Cochrane review of psychological therapies for Generalised Anxiety Disorder found that older people were more likely to drop out of CBT than other age groups (Hunot et al., 2007).

It is interesting to note that information on CBT available to consumers from a good quality consumer website which makes reference to Cochrane reviews and other research, Patient.co.uk, includes a statement on the limitations of CBT:

What are the limitations of cognitive behavioural therapy?

CBT does not suit everyone and it is not helpful for all conditions. You need to be committed and persistent in tackling and improving your health problem with the help of the therapist. It can be hard work. The homework may be difficult and challenging. You may be taken 'out of your comfort zone' when tackling situations which cause anxiety or distress. However, many people have greatly benefited from a course of CBT. (EMIS, 2011).

Recommendation 3

The Department of Health and Ageing should develop fact sheets for Access to Allied Psychological Strategies consumers that report on the strengths and limitations of the approved psychological strategies to maximise informed choice for consumers.

Interpersonal Therapy

The usefulness of Interpersonal Therapy (IPT), a model developed by researchers in the 1970s to compare antidepressants with a non-specific treatment, has arguably been overstated (Parker et al., 2006). In developing IPT, researchers drew on outcome research which demonstrates counselling is effective because of common factors across all treatment models, such as the strength of the therapeutic alliance, use of empathy, acceptance and the client's hopefulness about change and openness (Parker et al., 2006). The outcomes of IPT are similar to other models.

Additionally, perhaps because IPT developed within a research context rather than the clinical sphere, IPT has not been extensively taught in social work, psychology, OT and nursing degrees. Training in CBT is offered online to allied health practitioners to maintain Medicare provider status via the Professional Development collaboration between the Australian Association of Social Workers, the Australian Psychological Society and Occupational Therapy Australia. Training in IPT is not available. Therefore, it can be concluded that currently practitioners approved to offer Access to Allied Psychological Strategies are not well trained in IPT.

Narrative Therapy

Narrative Therapy is a relatively new model in counselling and psychotherapy. Its inclusion in the Better Access initiative was as an approved psychological strategy for Indigenous people. It is now included as a psychological strategy in the Access to Allied Psychological Strategies program. The inclusion of Narrative Therapy seems a fairly arbitrary decision. Arguably, as a newer model, its evidence base is the least well-developed of all counselling and psychotherapy models. The application of Narrative Therapy to mental health issues and symptoms is not well developed. Level 1 and 2 evidence for Narrative Therapy, meta evaluations and randomised controlled trials, are lacking. The Dulwich Centre in South Australia hosts the Australian website on Narrative Therapy and lists 8 research studies which demonstrate its effectiveness. 7 of these were clinical trials and 1 study used a control. Most psychologists, occupational therapists, social workers and mental health nurses have not been trained in Narrative Therapy.

Group treatment

The Australian National Audit Office reported that some Divisions of General Practice (soon to become Medicare Local companies) offered group treatments to clients in order to reduce the costs of providing services through the Access to Allied Psychological Strategies program (2011). Some research shows better outcomes for individual compared to group treatment for anxiety and depression (Neron et al., 1995). Therefore the use of groups as a resource management strategy should be reconsidered. Client preferences should also be taken into account in offering group treatments. Legitimate concerns such as confidentiality in groups may reduce consumer access to

treatment if group programs are the only way that Access to Allied Psychological Strategies services are provided in some regions.

We argue that a wider range of counselling and psychotherapy models should be included in the Access to Allied Psychological Strategies program to meet a wider range of client needs and preferences, including family therapy for client presentations in addition to perinatal depression. Family therapy has a strong level of evidence for effective interventions with adolescent anorexia nervosa, for example the Maudsley model which views parents as a resource for recovery (Le Grange, 2005). Couple therapy, experiential therapies, counselling and brief psychotherapy should also be provided. PACFA's position statement on evidence-based practice is 'that the overwhelming research evidence indicates that, in general, counselling and psychotherapy are effective and that, furthermore, different methods and approaches show broadly equivalent effectiveness' (PACFA, 2011).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 et al., 2008).

Brief vs. longer term interventions

The brief interventions offered through the Access to Allied Psychological Strategies program will not address the needs of people with some forms of mental illnesses. A Cochrane review comparing psychosocial and pharmacological treatments for deliberate self-harm found the most effective treatment for females with Borderline Personality Disorder using self-harm is longer term psychotherapy (Hawton et al., 1999). This group is at higher risk of completed suicide than the general population. A PACFA member association, the Australian and New Zealand Association of Psychotherapy, conducted research with this treatment population using longer term psychotherapy and demonstrated its efficacy. The clinical trial with a 5 year follow up (*n* = 150) showed that regular participation in psychotherapy for people with personality disorders reduced the rate of hospitalisation, incidents of self-harm and violence, reduced drug use and improved work history (Stevenson et al., 2005).

Interventions for alcohol dependence

The National Audit Office report into the Access to Allied Psychological Strategies program (2011) estimates that 1 in 2 Australians suffer from a mental illness at some point in their lives, the most common being depression, anxiety and alcohol dependence. Evidence-based interventions for alcohol dependence, apart from CBT, are not included in the program. The range of psychological strategies should be expanded to include the following treatment models with a high level of evidence for their effectiveness (NSW Department of Health, 2008):

- Brief Interventions (for assessment and education about risky substance abuse);
- Motivational Interviewing (for clients ambivalent about changing substance abuse);
- Dialectical Behaviour Therapy; and
- Psychodynamic Therapy.

Recommendation 4

Practitioners providing psychological strategies through the Access to Allied Psychological Strategies program should be required to match the strategy with the presenting problems of clients, their characteristics and treatment preferences.

Recommendation 5

The range of approved psychological strategies in the Access to Allied Psychological Strategies program should be expanded to include other psychotherapy and counselling models with strong

evidence bases as appropriate for client presentations, particularly substance abuse, and clients' treatment preferences.

Inclusion of PACFA Mental Health Practitioners in the Access to Allied Psychological Strategies program

The discussion paper on Flexible Care Packages for People with Severe Mental Illness released by the Department of Health and Ageing in 2011 recommended expansion of the Access to Allied Psychological Services program. The Federal Government should widen the practitioners approved by this program to include PACFA registered Mental Health Practitioners for the treatment and symptom reduction of mental illness.

PACFA Registrants must demonstrate that they have Mental Health competencies to a panel of practitioners with Medicare Provider numbers to be listed as Mental Health Practitioners on the PACFA Register. The required competencies meet the skills for Mental Health Practitioners outlined in the Operational Guidelines for Access to Psychological Strategies Component of the Better Outcomes in Mental Health Program (Department of Health and Ageing, 2010).

Inclusion of PACFA Registered Mental Health Practitioners in the Access to Allied Psychological Strategies program will improve access to mental health services, as they are widely distributed and accessible throughout Australia in urban, regional, rural and remote areas.

Recommendation 6

PACFA registered Mental Health Practitioners should be included as service providers in the Access to Allied Psychological Services program. These practitioners are appropriately qualified to provide psychological strategies.

3. Services available for people with severe mental illness and the coordination of those services

Where severe mental illness is diagnosed, the associated stigma can restrict consumers' access to housing, employment and health care and negatively impact upon their relationships and social networks. There is Australian evidence that people living with severe mental illness have reduced physical health status (Connolly & Kelly, 2005) and face considerable social exclusion (Huxley & Thornicroft, 2003). Access to adequate housing is a form of social exclusion experienced by many Australians living with a severe mental illness (Robinson, 2003). The new funding measures for non-clinical support in the Flexible Care Packages component of the Better Access initiative may lessen social exclusion in the areas of housing, participation in social networks and employment.

Recommendation 7

Strategies for reducing the stigma associated with being diagnosed with a severe mental illness should be developed and implemented by the Department of Health and Ageing.

Non clinical services covered in Flexible Care Packages should include PACFA Registered counsellors and psychotherapists. Counselling and psychotherapy, as adjuncts to psychiatric and psychological services, can be successful in symptom reduction and increasing the social functioning of consumers. There is a shorter and more effective journey through treatment for consumers as a result of access to counselling and psychotherapy.

Recommendation 8
PACFA Registered counsellors and psychotherapists should be included as providers of non clinical services for severely mentally ill patients receiving Flexible Care Packages.

4. Mental health workforce issues, in particular workforce qualifications and training of psychologists (and counsellors and psychotherapists) and workforce shortages

Concerns that the introduction of the Better Access initiative would lead to workforce shortages in public sector mental health services appear not to have been born out. Department of Health and Ageing data indicates that there is no evidence that the Better Access initiative has reduced the size of the public sector mental health workforce (Pirkis et al., 2011). In fact, there has been a steady growth in mental health professionals working in the public sector since 1995 - 1996.

PACFA's concerns relate to the workforce issues amongst counsellors and psychotherapists in private practice who have experienced a significant loss in clients since the introduction of the Better Access initiative. This is despite the fact that prior to the Better Access initiative, counsellors and psychotherapists were successfully providing effective, evidence-based treatment for a diverse range of clients experiencing mental illness.

While there is no data specifically on the distribution of workforce of providers for the Better Access initiative and Access to Allied Psychological Strategies programs, we do have data (in the Better Access initiative Evaluation) on uptake of the Better Access initiative by different groups within the community. This data shows there is some variation in the uptake of services amongst different groups (Pirkis et al., 2011), although there is a complete lack of data relating to service uptake by patients from Indigenous and Culturally and Linguistically Diverse (CALD) backgrounds.

Culturally and linguistically diverse 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 such as the Northern Territory Intervention, fear and suspicion in Indigenous communities and cultural misunderstandings on the part of service providers (Calma & Priday, 2011; Harms et al., 2011). It is PACFA's submission that these groups within the community may not be easily able to access private practitioners who offer Better Access and Access to Allied Psychological Strategies services, and this is a concern that needs to be addressed in the program arrangements.

The Transcultural Mental Health Centre in NSW 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 Mental Health Practitioners to identify those practitioners with expertise in providing culturally safe mental health services. This will contribute to a view in Indigenous and CALD communities of the Better Access and Access to Allied Psychological Strategies programs being culturally responsive and sensitive.

PACFA will not comment on the workforce qualifications and training for psychologists, however the inclusion of PACFA Mental Health Practitioners as providers for the Better Access initiative and Access to Allied Psychological Strategies program would make a significant contribution to service access amongst CALD, Indigenous, remote and rural communities by expanding the available workforce of providers for these programs. Practitioners come from diverse backgrounds, live in all parts of Australia and have experience providing a wide range of evidence-based treatments.

Outcome data for the Better Access initiative indicates that similar outcomes were achieved regardless of whether treatment was provided by psychologists, social workers or occupational therapists. The level of psychological distress decreased from high or very high at the start of treatment to much more moderate at the end of treatment (Pirkis et al., 2011). Counsellors and psychotherapists achieve positive treatment outcomes with clients with high levels of psychological distress in the same way that psychologists, social workers and occupational therapists do.

Recommendation 9
PACFA Registered Mental Health Practitioners should be included as service providers in the Better Access initiative. These practitioners are appropriately qualified to provide Focused Psychological Strategies.

CONCLUSIONS

PACFA's recommendations (pages 2-3) are aimed at addressing the concerns highlighted in this submission relating to Commonwealth funding and administration of mental health services.

PACFA has submitted that the reduction in the number of allied health treatment sessions under the Better Access initiative may be detrimental to patient outcomes. Government policy on the number of treatment sessions available needs to be evidence-based and the program needs to be flexible enough to be responsive of the wide range of consumers using the scheme, including people with more severe mental illnesses who access the scheme in significant numbers. Research on the reasons for consumers dropping out of treatment with Mental Health Practitioners should be conducted to inform decisions on the number of treatment sessions needed for full recovery.

The range of psychological services available to people with a mental illness through the Access to Allied Psychological Strategies program is not adequate to meet the wide range of needs within the community and is not well informed by research evidence. This program could be strengthened and client outcomes improved by including a range of counselling and psychotherapy treatment models selected according to the clients' presenting issues and treatment preferences.

Uptake of the Better Access initiative in rural and remote communities and amongst patients of Indigenous and CALD backgrounds could be improved by including PACFA Mental Health Practitioners as providers under this scheme. The same applies to improving access to mental health services under the Access to Allied Psychological Strategies program.

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