Executive Summary

ACA Medicare Rebate Survey

This survey was distributed to ACA members including their networks. Many non ACA counsellors also completed the survey after being made aware of it through their own networks. The survey was conducted from 18th of May 2007 to 24th of May 2007. This summary does not include surveys received after 24th of May 2007, a further updating of this summary will be made available on 30th of May 2007. To ensure the integrity of the survey it was noted in the survey that the term 'counsellor' referred to a non psychologist or social work counsellor.

Aim: The aim of the survey was to ascertain what impact, if any, have the new Medicare Benefits Schedule (Better Access initiative) had on the counselling industry as a whole. The survey was aimed at gathering information from six areas within the industry:

1. Private Practice
2. Students undertaking counsellor training
3. Non-Government Agencies
4. Training Providers from VET and HE sectors.
5. Employers of Counsellors and employed counsellors
6. Member of the public who is not a counsellor

ACA felt it was important to ensure the survey incorporated all aspects of the industry to capture any general patterns as well as any specific patterns in the responses. The results of the survey do indicate that the introduction of the new legislation opening up NHB exclusively to psychologists and social workers to the exclusion of counsellors has had a negative global impact on the counselling industry.

Not all questions in each category were answered. Some returned surveys showed partial responses in multiple areas. Due to this totals are inconsistent with the number of responses in some cases.

Private Practice: **330** responses were received from Private Practitioners. Of these 313 indicated that they had experienced a decline in referrals since the introduction of the new legislation and 17 indicating no decline. Several of those who indicated 'no' clarified this with notations that they had only just started in practice therefore were not able to identify any patterns. 309 of the 330 respondents who identified a decline indicated that they believed the decline was attributable to potential clients being referred to similar services with Medicare rebates. 255 of the 313 respondents indicated that they had been told directly by clients/GPs that they will no longer use the counsellors service because of a lack of access to Medicare services. 213 respondents indicated that they had lost current clients who stated the reason they were changing services was to access Medicare rebates. 145 respondents indicated that would not be able to continue in practice for more than 6 months unless the current situation changed. Of these 44 were already looking for alternative employment and 3 had already closed their doors. 297 claimed that they believed the down turn in business was directly attributable to the new legislation and 303 stated

that their vote at the 2007 Federal election would be influenced by the government's response to this issue. 289 felt this issue was an election issue.

Students undertaking a Graduate or qualification course in counselling: 137 students responded to the survey. 84 indicated they had reconsidered completing there studies as a direct result of exclusion of counsellors to Medicare rebates. 56 indicated they had actually ceased or were seriously considering changing their courses from counselling to social work, 74 indicated they had actually ceased or were seriously considering changing their courses from counselling to psychology and 2 were unsure. 141 believed that exclusion to Medicare rebates would have a direct negative impact on their qualification. 14 respondents had ceased studying as a direct result due to the exclusion of counsellors from Medicare rebates. 12 of the 14 respondents indicated that they had been studying; 1 x PhD, 6 x Masters, 1 x Graduate Diploma, 2 x Advanced Diploma and 2 x Diploma. 123 indicated this was an election issue for them and the outcome would influence how they voted.

Non-Government Agencies: Most respondents disclosed the agency that they worked in, with all the major agencies being named. For confidentiality purposes individual agencies have not been named. 134 surveys were returned from various agencies. 98 of these indicated that they had experienced a significant decrease in client numbers since the introduction of the rebates. 96 of the 98 respondents indicated they attributed the decline to clients being referred to similar private services that offered rebates. 90 respondents indicated that the future of their counselling service was now in danger. 130 of the respondents indicated that the exclusion of counselling services from Medicare rebates was not in the interest of those from low income families.

Training Providers, both VET/HE sectors: 18 providers responded to the survey. 7 indicated that the exclusion of counselling for rebates had a negative impact on enrolments. 15 indicated that they have had students cancel their enrolment as a direct consequence of exclusion from the rebates. 15 indicated that students had shown significant concern about counsellors being excluded from Medicare rebates. All respondents indicated that this was an election issue for them. 12 respondents indicated their training courses would not be commercially viable if counsellors were not given access to rebates. 10 indicated that they believed counsellor training will not be in demand if rebates are not made available to counsellors.

Employed/Employers of Counsellors: 136 responded to this section of the survey. 103 indicated that the introduction of rebates threatened their job security. 110 indicated that it was not viable to hire counsellors because they cannot offer rebates. 105 indicated that there was no future for counselling as an employer/employee without access to Medicare rebates. 102 indicated that there was no future in the counselling industry without immediate access to Medicare rebates.

Members of the public (non counsellors): 303 members of the public responded to this section. 282 indicated they believed that counselling services by counsellors should be made available through Medicare. 300 indicated they would use a counsellor if Medicare rebates were made available.

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Pilot Project for Rebates for Counsellors

About FPCQ: Federation of Psychotherapists and Counsellors of Queensland Inc (FPCQ) is a full foundation member of Australia's largest peak professional body of counsellors, Australian Counselling Association (ACA). FPCQ was incorporated in 2004, after 4 years operating as a Chapter, and founded on democratic principles with an annually elected management committee. FPCQ adheres to the Code of Ethics and Complaints procedure of ACA, this ensures the associations standards remain parallel with National standards set by its peak body. All FPCQ full members are fully registered with ACA. FPCQ was a co-host of the first International Counselling Conference held in Brisbane, Australia in 2006. The conference was attended by academics, researchers and esteemed professionals from over 15 countries.

FPCQ is also involved in the first Asia Pacific Rim International Conference on Counselling to held in 2008 in Hong Kong. FPCQ is involved in the delivery of several community services including the regional counselling service and post natal depression support group. FPCQ was also involved in the Back from the Edge youth program in partnership with Pine Rivers City Council in 2005. FPCQ is the most active state based counselling association in Queensland and involves itself in service delivery, advocacy services as well as being a peak state association. Members of FPCQ have an innate belief that professional bodies are not simply about membership and status, they also have a responsibility to contribute to the community in which they operate and promote employment for counsellors. Regional project is a prime example of this as well as FPCQ directing over $150,000 in less than 2 years into the counselling industry in regional Queensland.

Regional Counselling Project

Since 2005 FPCQ has been working with ACA and the Mental Health Association (Qld) to provide for rebates for members of the public seeking counselling services in regional Queensland. FPCQ is the primary driver of this project and administers all data collection, invoicing and policing the project as well as registering counsellors for this project. Regional Queensland has been identified as having an above average incidence of suicide (particularly in mature aged males), depression and family break downs. It has also been identified that regional Queenslanders do not have ready access to mental health and psychological services to address depression and other issues which are triggered through consequences of the drought, down turns in industries such as the sugar cane industry and cyclone affected areas. FPCQ receives $110,000 per year to offer rebates to registered counsellors. This funding has been extended to 2010 by the Queensland government.

FPCQ holds a database of members who are ACA registered counsellors and meet eligibility criteria to access these rebates. Initially funding provided a rebate of $20 per session for a set of 5

sessions with the clients paying $10 per session to make a total of $30.00 per sessions. The rebate was changed in late 2006 to $40 per hourly session (being made up of two 30 minute sessions each attracting a $20 rebate) with a voluntary contribution by the client of a maximum of $20 per hourly session. This gap payment is capped at $20 however many of the counsellors offer the service with no gap payment. This would be equivalent to bulk billing through Medicare. Interestingly enough we are not aware of any psychological services openly offering bulk billing services through the new Medicare Mental Health Care package.

Medicare rebates for mental health services have had no impact on the demand of this service. This makes for some interesting questions and strengthens the argument that the counselling by registered counsellors should be made available on Medicare. The regional project has found that demand has significantly increased since the introduction of the rebates as opposed to a lessoning in demand. This in itself reflects the current policy of ignoring counsellors for Medicare rebates is counter productive. In August 2005 there were 16 members of the public using the service, in July 2006 84 members of the public were using the service. In November 2006 legislation introduced a rebate for psychological services keeping in mind the Mental Health Care package was also operating at this time. FPCQ thought, logically, that there would be a decrease in the demand for the project given Medicare now had two pathways that offered mental health services to the public. Both were well advertised although the government had discriminated against counsellors in regard to access of the new rebate.

The demarcation of counsellors within this legislation ignores public demand and confidence in counselling services. A research paper called "Why Go to a Counsellor? Attitudes to, and Knowledge of Counselling in Australia, 2002 by Sharpley, Bond and Agnew reflects the ignorance shown in the discrimination of counsellors in the legislation. The following are excerpts taken directly from the research paper:

- 92.5% of the respondents believed that counselling fees should be covered by Medicare
- 83% of the respondents stated that counsellors should be members of a professional organisation
- Respondents were asked to which of the four health professionals they would recommend to a friend in need of help. A counsellor was the preferred choice of 77.9% of respondents, nearly twice as many as a psychologist (40.3%) and a social worker (39.8%) and three times as many as a psychiatrist (23.5%).
- When asked to select health professionals from a given list of four that they would choose to consult for twenty common presenting problems, participants selected counsellors as the most likely to be consulted.
- Counsellors scored the highest when respondents were asked which profession (counsellor, social worker, psychologist and psychiatrist) they would be able to communicate with in a therapeutical relationship.
- Sixty seven percent of the respondents stated that they considered that counsellors were as professional as their psychological colleagues.
- 79% of the respondents thought there should be more counsellors available in the community.
- Of those who would not pay, being unable to afford the fee was the most common response.
- Overall the data collected here indicated that the profession of counselling is highly regarded by this community...

In spite of the new legislation and access to mental health services against Medicare the demand for services in regional areas through the project have risen by nearly 50% since the inception of the legislation in 2006 with 159 individuals accessing the service in March 2007. Due to the dramatic increase in demand the project has now for the first time introduced caps on how many sessions

counsellors can offer and many clients' counsellors can see per month against the project. This is effectively watering down the effectiveness of the project and prohibiting members of the public from accessing the service regardless of the priority of their need.

It is overly obvious the new legislation, in Queensland anyway, is not addressing the needs of the community. By discriminating against counsellors members of the public are denied equity in regard to access and choice. There are far more counsellors in regional areas than psychologists or other mental health workers. Many counsellors live within the communities they service. According to the research undertaken by ACA when profiling counsellors many have a personal investment such as family within the community where they live and practice. Therefore they are not young graduates looking to make significant financial gains by setting up in areas where there are large populations that can afford large gap payments.

There is little financial or professional incentive for psychologists to open private practices in regional and country areas. This brings the burden of delivery of metal services back onto hospitals and government services. With an abundance of counsellors in regional and non regional areas this is necessary and access to Medicare rebates and bulk billing would alleviate this burden on the health system.

It has been suggested that phone counselling services should alleviate demand on current services. Although Lifeline statistics are impressive they are not indicative of preference, region/location or more importantly individuals making multiple calls though out an extended time. This is not to detract from the need of the service or the vital role it plays in the delivery of a much needed confidential service. The point is any argument that the statistics kept by telephone counselling services could be used to suggest they are a valid cost effective replacement for face-to-face services would be nonsense. The majority of telephones counselling services do not offer therapeutic services, nor are the volunteer counsellors in many cases registered or eligible for registration. Also more importantly research has shown that a majority of males would not use telephone counselling services in any case. Effectively alienating a significant portion of the public to counselling services, particularly in regional areas. Research from Advancement of Men's Health (CAHM) taken over a seven period 2000 – 2007 that surveyed 6,500 men with a 65% response rate showed that:

- 62% of the respondents indicated they would not use a telephone counselling service for drought issues with the majority preferring to access a face-to-face counselling service
- 61% of the respondents indicated they would not use telephone counselling services for personal issues
- 79% of these men were married
- 82% of those survey were between 40 to 60 years of age

A detailed research paper on the efficacy of the project by Dr Travis Gee can be read at Appendix 2. Informal results for activities in 207 from January to March can be seen at Appendix 1.

Future: The future of the Regional Project is positive due to the demand for its services growing significantly. Unfortunately the project is not going to be able to meet the demand which is increasing daily as funding has been set until 2010. Current government and private services cannot meet growing community demand with the provision of current mental health services or access through Medicare. Regional Australians are being prejudiced against due to counsellors not being able to offer Medicare rebateable services that would be bulk billed. Sadly thousands of counsellors nationally have been denied access to Medicare. Therefore although a proven in demand service is available to help to meet the needs of the public access to these services is being denied by the majority who cannot afford a full fee paying service. Ongoing funding has been supplied by the Queensland government for this project till 2010, unfortunately the demand is far greater than the project is now able to meet although there is no intention of ceasing this service. Growing demand

for this service does reflect a significant flaw in the present delivery of mental health services that has not been identified by COAG or the Mental Health Council. Whether this is due more to the Regional Project being administered by professionals working at the coal face and being exposed first hand to the real issues is uncertain. However what is certain is the current legislation is preventing access to much needed services to the public.

The future of the Project is even more guaranteed with the introduction of biased and tunnel vision legislation.

Conclusion: The project administrators expected the project to wind up in short time after the introduction of legislation allowing access to mental health services on Medicare. This has unfortunately not alleviated issues such as access with high gap payments demanded by psychologists in private practice and few services being available in regional areas anyways. There has not been an abundance of new private services made available through the private sector in regional and low income areas to address high needs. Access to current services through Medicare has not addressed equity, access or choice issues as the rebates are delivered within a biased system that does not allow counselling services to be delivered through it. In light of the outcomes of the FPCQ Pilot Project it would seem that legislation needs to be changed immediately to incorporate services offered by registered counsellors to address these anomalies. One other interesting question that has been raised through the project, if access in regional areas has been negated by biased legislation and demand is increasing because of this, what is the state of mental health services in more densely populated areas?

FPCQ would like to take this opportunity to thank the Queensland Government for its continued support in funding this project.

Philip Armstrong FACA, AFACHSE
President (FPCQ)

Appendix 1. Regional Counselling Project Report
Appendix 2. Regional Counselling Projects Results, Dr Travis Gee

Appendix 1.

Regional Counselling Project Report for January to March 2007

Number of Clients

January was a quiet month all round the state. We had a number of enquiries from counsellors about the sudden drop in clients. The client numbers picked up again in the following two months. As the number of counsellors using the project increased we have had to limit the number of clients to the counsellors in order to spread the fund around equitably.

Month	Number of Clients	Number of Sessions	Number of Counsellors
January	76	162	10
February	108	271	11
March	159	555	16

Age Range of Clients

The age range was interesting with few children and no adults in their sixties or eighties. The ninety year old's issue was bereavement. The age range male and female is not shown. A number of clients did not complete details regarding their age or gender.

Children	20	30	40	50	60	70	90	Male	Female
3	14	23	20	20	0	2	1	25	38

Reason for Coming

Depression and anxiety continue to be the most common reasons for requiring assistance. These often were linked to relationship issues.

Anxiety	Depression	Bereavement	PTSD	Relationship	Drug & Alcohol
43	30	7	2	23	4

Outcome of Counselling

Fifteen clients expressed relief at being able to talk about their issue. Other outcomes were:

- assistance with making plans for the future.
- Hope for the future
- Coping strategies for the future
- Childhood issues uncovered and resolved
- Return to work

We have thirty three counsellors who meet the requirements of the project in terms of geographical area and current membership. Of these, ten have used the project since the inception in 2005. We have recently attracted another ten by simplifying the client outcomes form.

The requirement now is to complete the form at the final session. Previously the requirements were two pages for every session. This became impractical as we could not find a volunteer willing to enter the complex data. The statistics expert could no longer volunteer time to prepare a report from the statistics. While we appreciate being a part of this project the increasing time required by volunteers to manage this is an ongoing problem. Our Federation does not have funds available to cover this aspect.

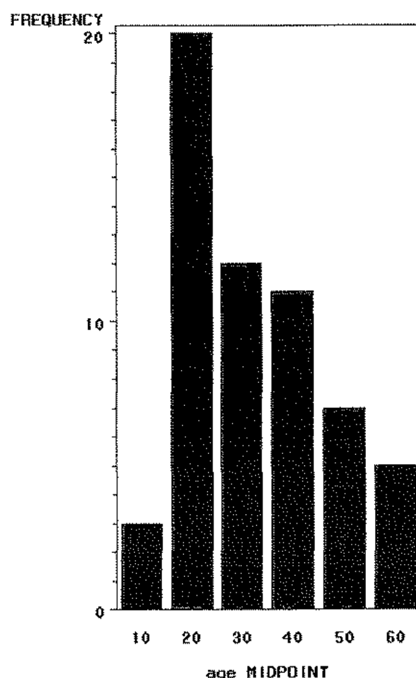
The clients have gained great benefit from this project as otherwise they would not be able to access assistance as they have. The counsellors have also been pleased to be able to offer this service to clients who cannot afford full fees.

Anne Rickett, MFPCQ; MACA (Clinical)
Individual and Relationship Counsellor
Executive Secretary to FPCQ, RCP Co-ordinator

Appendix 2

Regional Counselling Project Results – Preliminary Data by Dr Travis Gee July 2006

Eighty-four unique client ID values were assigned in the database. Of these, sixty-eight participants completed at least baseline data of version 2 of the questionnaire or higher, giving scores on both the K10 and the PPSRS. The average number of sessions attended by clients was 4.5 (sd=2.25). On average these sessions occurred over the course of 32.8 days (sd=32.2), ranging from a single session, to 11 sessions over 163 days. Age data were not consistently available, as a small number of counsellors appear to have declined to collect year of birth information, instead writing in "Mature." At baseline only 47 cases had age information, however, some appears to have been collected at a later date for some cases. For the 58 cases on whom such data are available, the mean age was 31.4 years (sd= 13.8). The distribution is shown in Fig. X, and exhibits some positive skewness.



Among 70 cases on whom data were available for Session #1, two did not have a primary diagnosis coded, and 38 did not have a secondary issue coded. The breakdown of primary diagnosis is in Table X, and secondary diagnosis is in Table X.

Primary Diagnosis	Freq.	Percent
Anxiety	8	11.76
Depression	31	45.59
Life Skills	3	4.41
Sex Abuse	2	2.94
Marital	17	25.00
PTSD	2	2.94
Anger Mgmt.	1	1.47
Bereavement	3	4.41
Eating Disorder	1	1.47

Secondary Diagnosis	Freq.	Percent
Anxiety	11	34.38
Depression	11	34.38
Life Skills	5	15.63
Marital	2	6.25
PTSD	1	3.13
Bereavement	1	3.13
Rehab.	1	3.13

Test Properties and Structure

It should be noted that due to a large number of clients filling out two items of the K10 even when instructed not to do so if they had responded "not at all" to the preceding item, the questionnaire was modified slightly to allow these responses from Version 2 onwards, which includes the present data. Nevertheless, the cross tabulations indicated that individuals who were not apparently nervous did not indicate being excessively nervous (eg., rate the second item as >1), and so with the scoring procedure of assigning a 1 to such cases was moot. The same was true of restlessness.

For the K10, the alpha reliability of the items at baseline was very high (alpha=.90). A similar level was achieved by the five PPSRS variables (alpha=.91) at baseline. Complete test-retest data on the K10 were available for 60 cases. Baseline K10 scores averaged 30.1 (sd=9.12) and changed an average of 11.8 points (sd=9.31; t=-9.8, p< .0001) in the direction of markedly improved scores (effect size=1.29). Age was not significantly correlated with either measure.

The test-retest reliability of the K10 was moderate, with the pre/post correlation being .48 (p<.0001). Test/retest reliability for the PPSRS variables slightly lower (Meaning=.42; Support=.41; Stress=.32; Control=.39; Progress= .36, all p<.01). However, as these were not all taken at the same time (due to highly variable numbers of sessions between pre and post), a variance components method was used to provide another estimate of reliability defined as within-

subject homogeneity. For pre/post scores at all points in time, the ratio of Within Subjects to Total variance was .07 for the K10, but between .40 and .49 for all PPS variables. The Shrout-Fleiss reliability of the K10 for a random set of *k* scores was .63, whereas for the PPSRS variables it ranged between .77 and .84.

The PPSRS and the K10 had correlated total scores at baseline ($r=-.70$, $p<.0001$). However, factor analysis of baseline scores (uncontaminated by intervention) of the 10 K10 items and the 5 PPSRS items indicated that there appear to be three fairly distinct constructs measured by them. Initial principal components analysis indicated the presence of three factors with eigenvalues >1, and quartimin rotation produced the factor structure in Table X. The factors were correlated as described in Table X. The first factor appears to be K10 depression, the second K10 anxiety and stress, and the third, the PPSRS variables. The moderate loadings of PPSRS Meaning and Progress on the first K10 factor is the likely reason for the high K10/PPSRS correlation between Factor 1 and 3. This may stabilize as well when more cases have been entered.

Factor Structure (Correlations)

	Factor1		Factor2		Factor3	
K10 Depressed	94	*	28		44	
K10 Sad	89	*	19		45	
K10 Effort	87	*	27		54	
K10 Worthless	82	*	44		40	
K10 Hopeless	79	*	51		57	
K10 Tired	66	*	34		63	*
K10 Restless	34		95	*	31	
K10 SoNervous	36		94	*	29	
K10 Nervous	33		91	*	22	
K10 SoRestless	18		87	*	29	
PPSRS Stress	55		35		91	*
PPSRS Progress	66	*	25		92	*
PPSRS Control	55		42		89	*
PPSRS Support	23		15		70	*
PPSRS Meaningful	73	*	34		82	*

Printed values are multiplied by 100 and rounded to the nearest integer. Values greater than 0.603098 are flagged by an '*'.

Inter-Factor Correlations			
	Factor1	Factor2	Factor3
Factor1	1.00000	.33	0.51
Factor2	0.33	1.00000	.30
Factor3	0.21	0.30	1.00000

A Goal Attainment scale was also constructed for this study. Respondents were asked to indicate at the end of the sessions the extent to which each of four primary goals had been achieved, on a zero-to-ten scale (zero=not at all, to 10=completely achieved). The items were the first four goals that had been identified at the first session, and naturally varied widely from client to client. The four items had an alpha reliability of .994.

Perceived sustainability was evaluated via asking clients to rate how confident they were of being able to manage on a direct zero to ten scale for each of the first four goals identified at the outset. Eighteen respondents completed these items, and a 'confidence' score was taken as the mean of their non-missing responses. Each item had a minimum of 13 respondents, and the Cronbach alpha for all cases with complete data was .95.

Changes

Complete pre/post data were available on the K10 and PPSRS variables for 54 cases. As these variables are highly intercorrelated, a repeated-measures MANOVA in multivariate mode (with no assumptions regarding sphericity) was performed on these cases, and revealed statistically significant effects (Wilks' Lambda=.25, $F_{6,48}$=24.41, p<.0001).

To explore this result further, all available cases were analysed for each outcome measure. For the PPSRS, change scores could be computed for between 71 and 73 cases for each subscale. Meaningfulness scores improved by 2.88 points (sd=2.77; t_{72}=-8.86, p<.0001); Support scores improved by 2.80 points (sd=2.80; t_{71}=-8.80, p<.0001); Stress scores improved by 2.93 points (sd=3.07; t_{71}=-8.04, p<.0001); Control scores improved by 2.45 points (sd=2.97; t_{72}=-7.05, p<.0001) and Progress scores improved by 2.96 points (sd=3.03; t_{72}=-8.34, p<.0001). Taken as a mean across all items, PPS total scores improved by an average of 2.81 (sd=2.72, t_{72}=8.83, p<.0001, effect size=1.36).

Late Starters Excluded

The preceding was an examination that included some 17 cases on whom baseline data from the very beginning of the study had not yet been entered. Thus, their apparent baseline was not the actual beginning of the series of sessions. To understand further the nature of the longitudinal differences across the group, and to account for factor structure, the K10 total score was split into Depression and Anxiety according to the factor structure noted above, and data were analyzed for all cases at all time points up to 10 weeks using a mixed model approach. Times after 10 weeks were excluded as they often involved the 17 cases noted above, which were eliminated because no week 1-5 data have yet been entered for them.

The main effect of session was statistically significant for all seven variables at p<.0001. For this analysis the K10 subscales were reversed and re-scored so they fall on an zero (high distress) to 10 (low distress), to facilitate comparative plotting with the PPSRS variables. These values are plotted

in Fig. X, which shows a consistent pattern of improvement up to week 5, followed by a drop at week 6, then continual improvement to week 10.

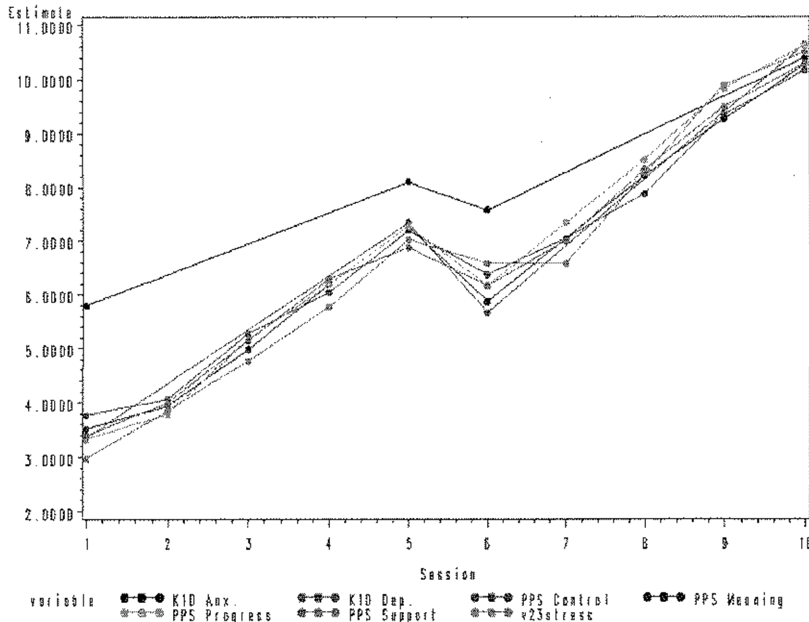
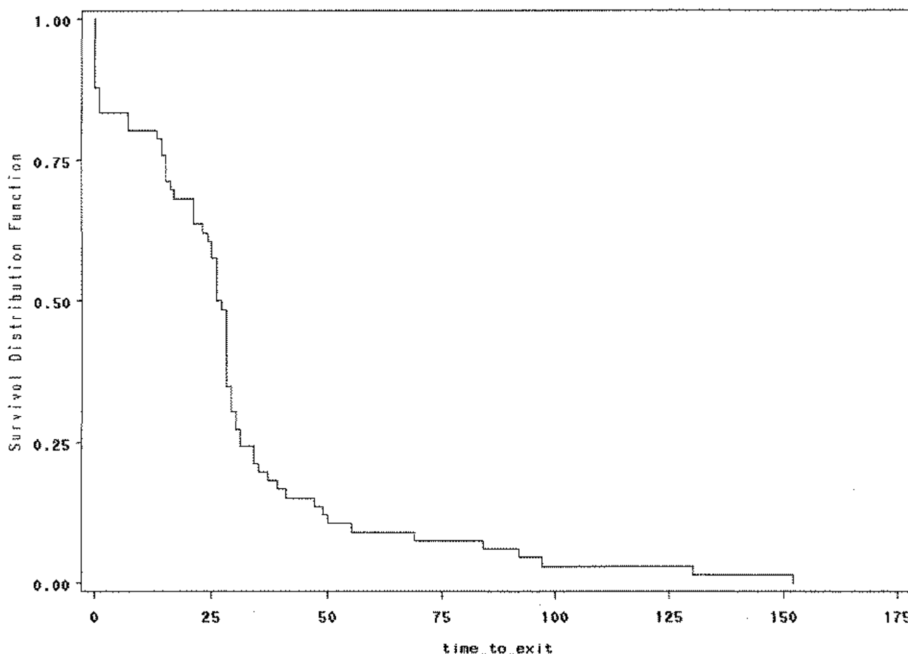


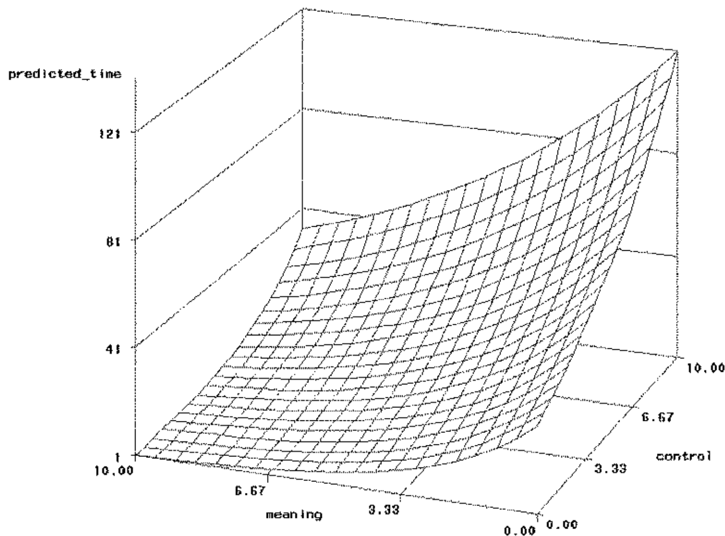
Fig. X: Mixed Model Estimates of Means Over Time (K10 reversed and rescaled).

Predicting Time in Counselling

The baseline measures were also shown to be good predictors of length of time spent in counselling. With the 17 cases on whom no baseline (Week 1) data were available dropped, a survival analysis was performed to test the association between the baseline outcome measures and time to final session. A survival curve (ignoring client gender) is plotted in Fig. X, showing the proportion of cases remaining at a given point in time (time being measured in days). As the log of the survival plot was approximately linear through the origin, an exponential model was deemed to be appropriate.



Meaning, Control and Time in Counselling



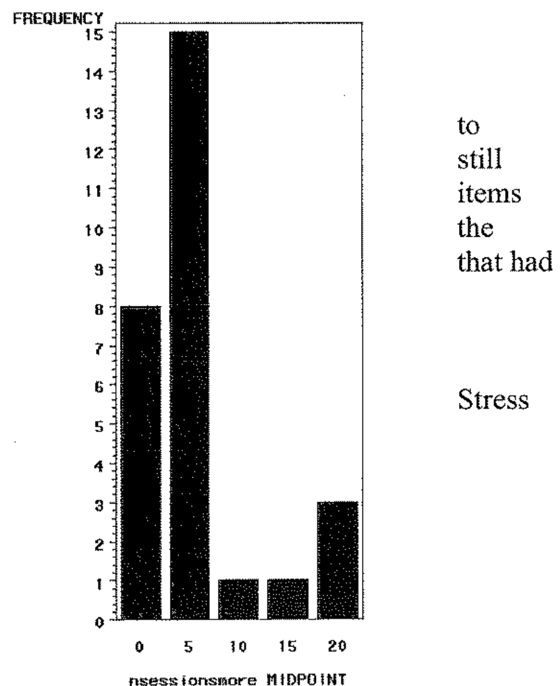
Gender did not predict time in counselling (p=.39, Wilcoxon; p=.50, log rank test). However, with gender included in the model, two of the seven primary baseline outcome measures (K10A, K10D, and PPSRS variables) had significant univariate Wilcoxon tests in a forward stepwise test: PPSRS Meaning (p<.03) and PPSRS Control (p<.0021). Only PPSRS Meaning had a significant univariate relationship with time (p<.0267).

Analysed as a response surface problem, the log of time to exit was predicted from Meaning and Control only. In this instance, of Meaning, Control and the Meaning*Control interaction, Meaning's total contribution was significant (p<.0241) whilst control was marginal (p<.0559). The model accounted for 24% of the variance in time spent in counselling. The full model was statistically significant, however in terms of unique variance, only the linear component was significant (p<.0006). The full response surface of predicted values (a 3-dimensional analog of a regression line) of predicted values of time-in-counselling for the entire range of Meaning and Control is plotted in Fig. X.

This figure indicates that predicted time in counselling is high for those who initially report a great deal of control over relatively meaningless projects, and relatively low for those whose projects are meaningful but relatively out of control.

Achievement of Objectives and Need for More Counselling

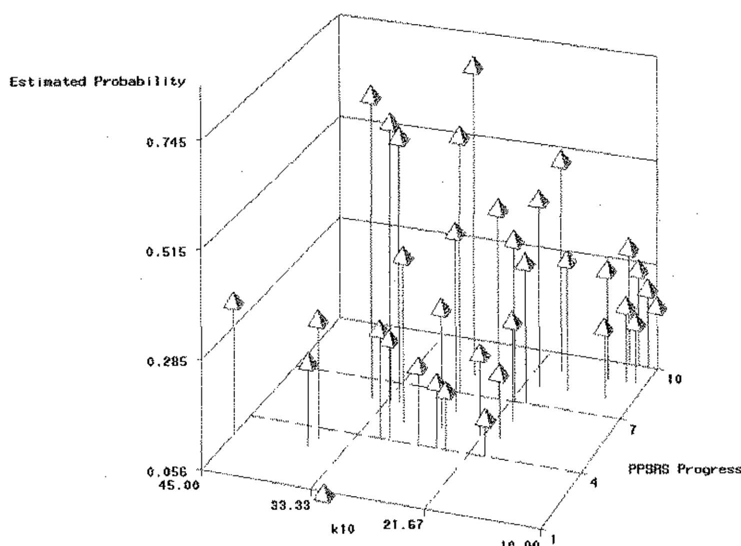
The goal attainment scale noted above was analysed to explore the extent to which clients felt there was still work to do at the last session. Where 3 or more items were available, any missing items were imputed as the mean of the other three, resulting in 42 usable cases that had a mean on the total score scale (range 0-40) of 32.7 (sd=8.5). The total goal attainment score was correlated with the K10 (-.93), Meaning (.95), Progress (.94), Control (.94), Support (.90) and Stress (.95), all r's p<.0001, for N=42 cases.



Twenty-eight cases responded with numeric data to the question of how many more sessions would be needed to achieve their goals. The mean number indicated was 5.8 sessions (sd=5.99). The distribution appears to be Poisson (see Fig. X). Poisson regression analysis to predict this number from the final values of the K10 and PPSRS measures indicated that only PPSRS stress was a predictor of number of sessions that clients felt they needed (chi-squared=35.9, $p<.0001$). As would be expected intuitively, people with more stress at the end of the sessions felt a need for more sessions.

As it was plausible that many people who had made good progress (as evinced by the PPSRS) towards their goals might not even respond to such a question, cases were categorized according to whether they had somehow indicated needing more counselling. Those clearly indicating in words or a number the need for more sessions were coded 1, and those indicating either zero or not answering the question were coded zero. The cases studied were the last ones recorded for each client, as this variable sometimes occurred more than once, due to a second set of funding being approved after it was initially requested.

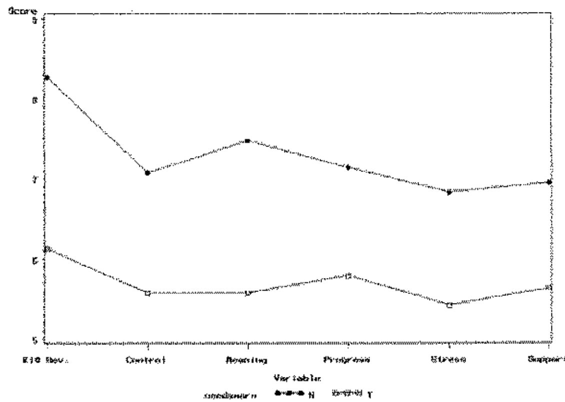
A model was developed using the K10 and PPSRS Progress to predict this variable, using only the interaction term. This was significant (Wald chi-square=4.98, $p<.0256$) and achieved 72.1% accuracy in classification. In Fig. X, the probability that a person would report needing more sessions, based on this model, is plotted against values of PPSRS Progress and the unreversed K10



scale (where distress is indicated by higher values). These are the predicted values from the logistic regression model for the K10 and Progress scores. From the graph it can be seen that the need for more sessions is highest amongst those who see themselves as having made progress, but who are still experiencing moderate levels of distress.

Profile of Those Wanting More

Sixty-two cases were coded as indicating that they wanted more therapy at the end of their sessions. A MANOVA was run to test the differences on the five PPRSRS variables and the K10 (rescaled here for graphical purposes to a 0-10 scale, with 0 indicating high distress). The overall MANOVA was significant ($p<.0005$) as were the individual t-tests for each variable (all at $p<.0012$ or less). The means are plotted in Fig. X. Those not needing more counselling (expressly or implied) have scores averaging above 7 on the zero-to-ten scale, whereas those explicitly indicating that they need more help average 6 or lower on all measures.

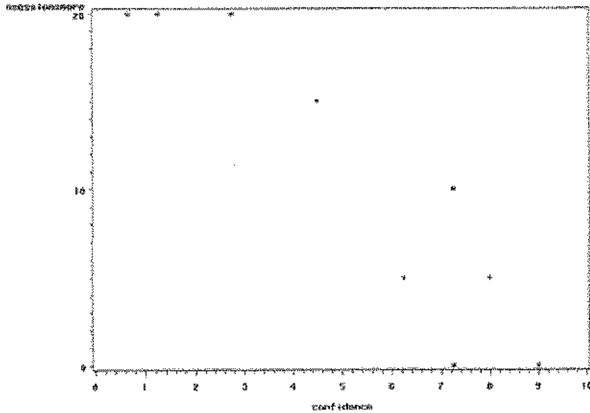


Perceived Sustainability

The overall confidence score on the perceived sustainability scale was 5.9 (sd=2.86), and it was highly correlated with the K10 and PPSRS measures as presented in Table X. Forward stepwise regression indicated that only the K10 contributed significant unique variance (p<.0001).

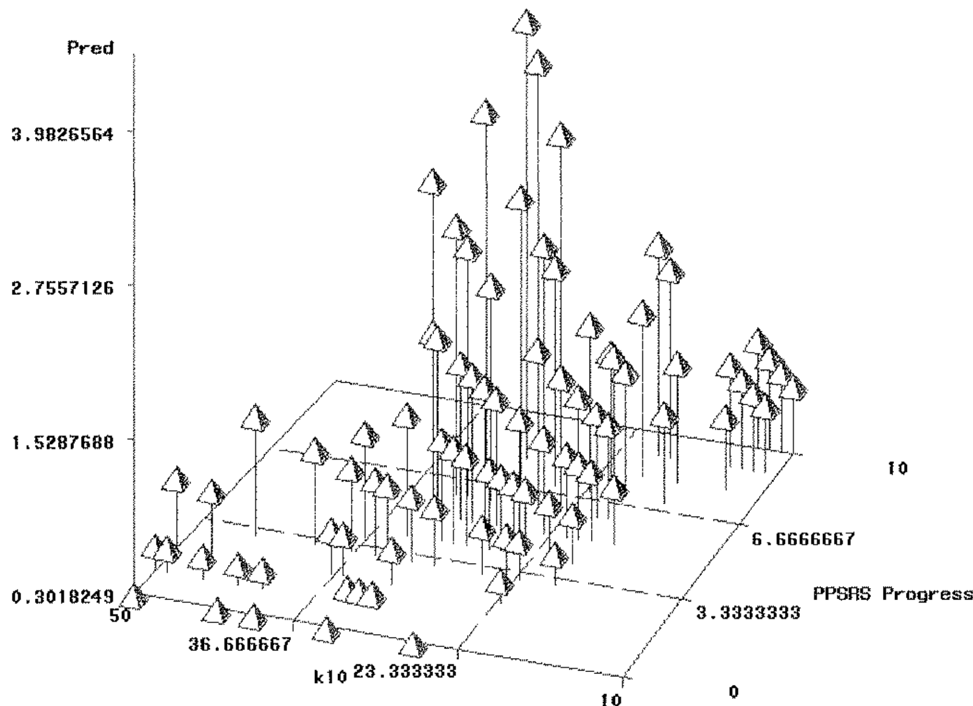
Pearson Correlation Coefficients, N = 18 Prob > |r| under H0: Rho=0							
	confidence	**k10**	**Meaning**	**Support**	**Stress**	**Control**	**Progress**
confidence	1.00000	-0.78141 0.0001	0.56407 0.0148	0.60112 0.0083	0.74506 0.0004	0.63412 0.0047	0.55357 0.0172
k10	-0.78141 0.0001	1.00000	-0.80594 <.0001	-0.80502 <.0001	-0.74781 0.0004	-0.84283 <.0001	-0.71588 0.0008
V23Meaningful	0.56407 0.0148	-0.80594 <.0001	1.00000	0.80523 <.0001	0.40724 0.0935	0.84932 <.0001	0.87996 <.0001
V23Support	0.60112 0.0083	-0.80502 <.0001	0.80523 <.0001	1.00000	0.39623 0.1036	0.77681 0.0001	0.79235 <.0001
V23Stress	0.74506 0.0004	-0.74781 0.0004	0.40724 0.0935	0.39623 0.1036	1.00000	0.63160 0.0049	0.46581 0.0514
V23Control	0.63412 0.0047	-0.84283 <.0001	0.84932 <.0001	0.77681 0.0001	0.63160 0.0049	1.00000	0.87708 <.0001
V23Progress	0.55357 0.0172	-0.71588 0.0008	0.87996 <.0001	0.79235 <.0001	0.46581 0.0514	0.87708 <.0001	1.00000

Of these cases, only 9 provided usable data on how many more sessions would be needed. Nevertheless, the effect is so strong that only 9 were needed to obtain a Pearson r of -.92 (p<.0004). This relationship is plotted in Fig. X, where it appears that each one-point drop on confidence implies an additional two sessions.



How Much More Counselling? An Imputed-Zero Model

If more sessions are needed, then the question is, how many more? As it appears that people who have progressed well and are not experiencing distress are unlikely even to answer the question, a model was set up that imputed a zero for cases where no additional sessions were indicated as being needed. Following the model involving Progress and K10 Distress was run to predict how many more sessions the client felt they needed. In this instance, those who simply noted "lots more" or words to that effect were excluded as there was no way to impute accurately what they meant. A Poisson regression model above was run to predict number of extra sessions needed from the interaction of Progress and the K10. The interaction term was statistically significant (Chi-square=20.4, $p<.0001$) and the predicted values are plotted below in Fig. X.



If we assume that no answering the question, or answering with a zero indicates that the problem is resolved, then of 62 cases who had their last session before or on the fifth session, 71% did not indicate further need, and 29% gave a clear indication that they needed more. Of 22 cases that did receive further sessions beyond the 5, only one (4.6%) indicated that additional sessions would be needed beyond the second batch of five.

Discussion

Overall, these results provide supportive evidence for the hypothesis that the RCP was effective in enhancing several key domains of well-being. The reliability of the K10 and PPSRS measures has been demonstrated once again, and the strong, yet discriminable relationship of the PPSRS factor to the two K10 factors points towards their general validity.

The factor structure that emerged from the measures is much as was expected. Depression, anxiety, and general functioning as indexed by the PPSRS variables appear to be distinct, yet related areas that are central features of mental health. That the Progress and Meaning PPSRS items loaded on depression makes perfect sense in view of Little's (personal communication) meaning/manageability tradeoff, in which pursuit of highly meaningful projects can render many other activities completely unmanageable, whereas a plethora of manageable projects can come to seem utterly meaningless, with both situations leading to depression. Either tail of the catch-22 implies a sense of either meaningless, lack of self-efficacy, or both. This effect is also captured in the sense of loss of control of meaningful projects as a predictor of time to be spent in counselling, and goes to the tractability of different problems. Those who have meaning, it seems, need gentle nudges to find control, whereas those who lack meaning but have a great deal of control need significant work to relax control in the interest of finding meaning.

The lack of significant effect for the K10 in predicting time needed suggests that initial distress is not as good a predictor of level of need as are perceptions of how one fits in with one's local social

ecology, and one's style of managing one's projects. One the one hand, as an outcome measure it performs on par with the PPSRS, if not perhaps slightly better. On the other hand, however, K10 distress does not predict the level of service needed to alleviate it.

The drop at week 6 across all measures is very likely due to the fact that those cases that completed weeks 1 to 5 successfully then dropped out of the study, and the tougher cases that remained for a second series of sessions naturally had lower scores.

While the lack of a control group means that it is impossible to rule out completely the natural regression to the mean that occurs in untreated cases, it is also notable that there is no rapid improvement from session 1 to session 2 or 3, followed by a plateau, which is the shape of curve that would be expected if the effect were attributable entirely to such regression.

The results relating to time spent in counselling point towards the locus of efficacy of counselling, which seems to be a process that can help quickly in providing some sort of order to people whose problems emerge from chaos, but which has slower effect when there is already a good degree of control present.

It is possible to use our measures to identify with reasonable accuracy those who feel they need more help, and those who do not. Where more help is needed and specified, this too is predictable, and expected values range up to about 4 more sessions beyond that which is funded, at least based on these pilot data. Confidence in ability to sustain results is a direct predictor of number of additional sessions perceived by the client to be needed.

From the shape of the two models (logistic and Poisson) of extra time needed, it seems clear that individuals who have attained their goals are unlikely to indicate the need for more sessions, so long as their distress levels are relatively low. However, the need for more sessions increases rapidly, especially for those who have made good progress but in spite of this are still experiencing distress.

Overall, five sessions is a good start for many people, as the great majority benefited within five sessions, and of the more difficult cases, nearly all of them did not indicate a further need after the second set. It appears that the current system of five sessions, followed by a needs assessment and an additional five sessions where required should be highly effective in providing relief to the designated population.

Inquiry into mental health services in Australia

ACA Response 26/3/07

Mental Health: Before I discuss the issue of the current exclusion of counselling from Medicare rebates, I would like to clarify a few issues. In this discussion I will constantly refer to psychologists and by psychologists I am referring to those registered to supply Medicare services. Although the Better Access Initiative is available to other health professionals the Mental Health Council in their report: "An Analysis of the First Six Months" (July 07) stated "*Uptake of the new Medicare items relating to the use of social workers, occupational therapists and mental health nurses is negligible.*" It is reasonable to assume that by far the majority of service providers registered with Medicare to offer the Better Access Initiative are psychologists. When I use the term counsellor I am referring to a counsellor who is registered with ACA or PACFA, the two peak bodies in Australia for Counsellors. The term counsellor does not include psychologists and social workers.

Terms:

Mental health – is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community[1]. 1 The World Health Report. (2001). *Mental Health: New understanding, new hope*. Geneva: World Health Organisation. Retrieved February 5, 2006 from: http://www.who.int/whr/2001/en/.

This is obviously where we would like all Australians to be.

Mental health problems – occur often as a result of life stressors. Mental health problems also have a negative impact on a person's cognitive, emotional and social abilities but may not meet the criteria for an illness. The distinction between mental health problems and mental disorders is not well defined and is made on the basis of severity and duration of symptoms. 2 Commonwealth Department of Health and Aged Care. (2000). *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health.* Canberra, ACT: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.

This is where counselling is most effective, the large majority of Australians who suffer a mental health issue fall into this category. A good example of this is about 20% of people will be affected by depression with 6% experiencing a major depressive illness[8]. 8 SANE Australia. (2005). *Depression*. Retrieved February 5, 2006 from: http://www.sane.org/Information/Factsheets/Depression.html.

Medicare figures show that more than 2.5 million consultations have been claimed under the **mental** health initiative since November 2006.

As part of the program, the former Howard government set aside $538 million for Medicare-funded treatment over five years. But with 450,000 people taking up the scheme in the first year at a cost of $200 million, the budget has blown out. According to the APS web site there are approximately 2000 advertised registered psychologists offering services against the Better Access initiative. This equates to approximately 225 new clients collectively requiring a total 1350 sessions per year per psychologist.

Using depression as an example as it has the highest profile of all mental health issues:

2 out of every 3 people suffering from depression are not suffering from a mental illness SANE Australia. (2005). *Depression.* Retrieved February 5, 2006 from: http://www.sane.org/Information/Factsheets/Depression.html they are suffering from a mental health problem. 2 out of 3 people with depression are able to over come their depression with early intervention through primary care. There is a strong possibility that the rates of major depression that are not biologically based would drop dramatically if early interventions services were made available to the public through counselling services. Counsellors strength is in early intervention as opposed to psychological services which have a strong basis in treatment of mental illness.

To keep this in perspective we need to acknowledge a large proportion of those who suffer from major mental illness suffer from an inherent biological illness that requires medical intervention and psychological treatment. Other issues such as sexual abuse would also fall within the realm of psychological services. You cannot provide early intervention services for a person who is already suffering from a mental illness regardless of its causes. People with mental illness require treatment and support with access to secondary services. It is important that we do not compare apples with oranges, counsellors and psychologists provide two very different key services. To compare a counsellor with a psychologist is like comparing a nurse with a surgeon. Both are just as important but each works at a different end of the spectrum and undergo different training. They may even have

limited overlapping skill levels. However if you take either one of them out of the picture then the system breaks down.

The large majority of people who do not fall into this group and suffer from major depression do not just go to bed feeling great and then suddenly wake up incapacitated, it is generally an accumulative effect caused over time. In a paper written by Emeritus professor Lord Richard Layard in February 2006 "*The case for psychological treatment centres*" he states that in Britain only 1% of the population actually suffer from schizophrenia or bipolar depression, I would suggest these figures would be comparable in Australia.

As terrible as these conditions are we have to keep in context that in my submission I am talking about how we can effectively help the majority who suffer from mental health problems not illness. It is also important to acknowledge that these issues if left untreated will in many cases develop into a mental illness. There are a myriad of reviewed studies that show early intervention through primary care, in this case counselling, will in the majority of cases resolve mental health problems preventing them from developing into more embedded problem.

There are four issues that I believe need addressing with the current system:

Access: The Mental health Council of Australia in its report "Mental Health and the new Medicare Services: An Analysis of the First Six Months" identified that the large majority of Medicare registered psychologists were to be found concentrated in 3 cities, Melbourne, Sydney and Brisbane. Within these cities they were more likely to be found in upper middle class suburbs. There was also a higher usage of these services in these areas. There is no evidence to show there has been any increase in the provision of psychological services since the introduction of the initiative through the opening of new practices in high needs areas situated in lower socio economical areas. There is also no evidence to show extra services have become available in regional and country areas either. Waiting times and list have actually increased in regional and country areas as demand has increased as the public has become aware of a rebateable service. A good example of this would be the Hunter Valley in NSW where late last year the waiting list was in excess of 12 weeks to see a psychologist. This would be more than enough time for a Mental Health problem to develop into a mental health illness or for a person in crisis to attempt to self harm to either access treatment or to suicide. In the NT there are no clinical psychologists outside of Darwin. Therefore the chances of

mental health problems developing into mental illness would high unless you had the resources to travel or relocate. This is a similar problem in many regional areas in South Australia, Tasmania and Western Australia and to a lesser extent Queensland.

One Queensland farmer I spoke to last year told how he had to drive over 300 kilometres to access the only psychological service in his region. He could tell you where every large tree between his home and the service provider was. This was because he contemplated driving into each one of them every time he made the drive. The time it took him to get to and from each visit, basically a whole working day, depressed him to the point where visits became a burden not a relief. He also told me of three of his close friends all farmers who were depressed and who had either been involved in single vehicle accidents or had committed suicide in 2007. The irony behind this story is he had lived within 40 minutes of a counselling service that had since closed due to the local GP referring all patients to Medicare services that did not exist locally.

To demonstrate that access for anyone outside a major capital city is significantly restricted in access to Medicare rebateable services I have researched where the majority of psychologists can be found. According to the APS web site of advertised Medicare registered psychologists it states "access over 2000 Medicare psychologist" We can only assume this means there are approximately 2000 psychologists on the system. I have based my final totals on this amount. Regardless of whether there may be a few more than 2000 I am sure these totals will still shock you.

According to the APS web site there are:

State	Clin Psychs	Psychs	Total	10 kilometre radius of
Qld	45	155	200	Brisbane
WA	74	103	177	Perth
Tas	11	19	30	Hobart
Vic	179	535	714	Melbourne
NSW	183	455	638	Sydney
NT	2	6	8	Darwin
SA	40	75	115	Adelaide
Total	534	1348	1882	

Of these 1882 advertised Medicare registered psychologists, combined there are 1352 situated in practices within a 10 kilometre radius of Melbourne and Sydney, this is out of approximately 2000 nationally. According to the NSW Department of State and Regional Development in June 2006, Melbourne and Sydney had a combined population of 8028752. Australia's population is just over 21 million. This would equate to on the above figures approximately 38% of Australia's population is serviced by 67% of its Medicare registered psychologists. This would also beg we ask the significant question as to who is looking after the indigenous populations that are primarily situated outside of these cities.

Over 51% of ACA registered counsellors offer services in regional and country areas through out Australia. Not one of them can offer a medicare rebateable service.

I think this just about makes my point in regards to access, it also supports my next issue equity.

Equity: Clearly from what I have just shared with you there is little equity in regards to services primarily outside of Sydney and Melbourne and to a lesser extent outside of Brisbane, Perth, Hobart or Adelaide. Currently most psychologists are charging anything from $30 to $80 gap fees. Most clients are being asked to pay full fees up front and then apply for the rebates through Medicare. I am not aware of any bulk billing services, if they do exist they are rare.

Therefore a client needs to have anything from $110 to $180 in the hand. The CBA bank does supply a HICAPS terminal facility whereby a client can swipe their Medicare card and the rebate is directly deposited into the psychologists account and the client simply pays the gap fee. However, after discussing with the Brisbane CBA representative what the percentage of psychologists that have taken up this facility he stated the take up rate has been low so far. Therefore in many cases, unless a client has access to well over $100 in cash and can wait until they get their Medicare rebate back services are only available to those with the ability to have access to cash. With mortgage, petrol, food and utility increases over the last 12 months only those in the higher middle income bracket are able to afford these types of services. This also has a negative impact on those in lower income

brackets who are forced to use credit cards to be able to pay for these services. Credit cards and mental health issues are not a good mix.

Over servicing: To date for a member of the public to access mental health services through Medicare rebates they need to have a referral from a GP. The referral is based on a diagnosis by the GP usually using a tool such as the K10 questionnaire. Once this has been done the GP will refer the patient to a psychologist with a mental health care plan. In many cases as I have pointed out these patients are statistically more likely to be suffering from a mental health problem than a mental illness. A registered counsellor is more than capable and qualified to treat this type of client. The system is forcing people to seek services from specialists whose skills are well above that necessary to help with the problem. With no choices as to what type of service they refer to GP's cannot even begin to ensure that the service is appropriate to the issue. This has the potential to cause several behaviours to develop, GP's may eventually only see mental health as an illness and psychologists will develop a monopoly mentality believing their services are the only ones that are appropriate. These behaviours are already starting to develop roots in several areas. The ability to develop a hierarchal cost effective and multi-disciplinary mental health system will be lost. Over servicing will become the norm.

With counsellors being excluded from the Better Access Initiative the choice for GP's is simple and also some what financially rewarding. The $150 incentive to write up a mental health care plan is a financial bonus when accessing this initiative. Traditionally many GP's did refer many clients to counsellors prior to November 2006. Since the introduction of this financial incentive the number of referrals to counsellors has declined significantly. Interestingly I have heard arguments from the AMA and psychologists declare that the payment is not a financial incentive and actually GP's find the plan time consuming and that their time is not adequately compensated for. I can only say 450,000 plans have been written in just over 14 months at $150 each, this would not reflect that this is such a great burden. The question as to why GP's have stopped referring to counsellors when in the past they did has not been satisfactorily answered. The option to refer to a counsellor still exists, although does not attract a $150 dollar bonus, and in many cases is far more convenient for the patient in regard to travel and access. It would seem the road to early intervention is no longer as attractive as treatment.

In medicine it has been found that by using vaccines the cost of treatment and the need for many years for the training of specialists to react to outbreaks is significantly decreased. The cost in money and resources to produce a vaccine and train a person to administer it is also cost effective. Specialist are used when the vaccine does not work to treat a victim of the disease. This also decreases the need of the community to experience sickness and the associated debilitating consequences to individuals, families, workplace and the economy. In medicine there exists a tiered system of paramedics, nurses, GPs and then specialists/surgeons. This system works well as each operates within their own capacity and skill level ensuring the higher skilled professional is not underutilised. A bandaid becomes very expensive when it is applied by an oncologist whose hourly rate is several hundred dollars if a paramedic is available at $40 an hour.

When trade is restricted (and the current legislation could be in contravention of the Health Professionals and National Competition Policy as quoted at the end of this document) because one organisation is given a financial incentive that is not available to similar organisations and could result in the formation of a monopoly action can be taken as this type of business is not encouraged in Australia. It is also bad for the economy. Ironically in mental health in Australia we have such a scenario and it is government legislation that has created this uneven playing field by giving one profession financial incentives whilst the other is slowly strangled as it becomes uncompetitive. Instead of developing a multidisciplinary system a monopoly has been created and is sustained through arguments of standards and training. Words such as early intervention and primary care have no place in this argument.

As I have already pointed out just looking at depression alone which is the most prevalent form of mental health issue only 1 in 3 sufferers require treatment at a level that would require the skills of a psychologist. There is not much we can learn from our brethren in the UK in regards to cricket but we have a lot to learn about mental health services. In the UK counselling is accessible on the NHS and training standards for counsellors are parallel to those in Australia. There are plans to have a counsellor placed in every GP practice in Britain, many already do. Any arguments that there is no place for Medicare rebates for counsellors in Australia just do not stand up when compared to overseas practice.

If there are no rebates for accessing counselling through primary care in the form of preventative services and fees for psychologists ranging from $140 upwards it could be seen by many that being ill is the cheaper option when the utilisation of a preventative service (a vaccine) is not considered. Low wage earners or one wage families or simply those struggling financially the option to seek early intervention services through a full fee paying service is not a real option. The alternative is to bite the bullet and pray the condition does not develop into a full blown mental illness that has the potential to cause family break downs, loss of jobs, self harm or harm to others but does carry the advantage of finally being able to access help through a Medicare service.

Counsellors have traditionally been a cheaper and more appropriate option in the delivery of early intervention services. An option many GP's in the past have embraced. The lack of equity and access is forcing people with mental health problems to seek services from psychologists purely to access rebates. Psychologists are being overwhelmed with people seeking their services. Many of these clients require early intervention services not psychological treatment. For every person seeing a psychologist unnecessarily there are others in crisis contemplating self harm to get to the front of the queue. In November 2007 the average waiting list was in excess of several weeks. Whilst psychologists service clients whose issues could be resolved through a counsellor clients with mental illnesses are forced to wait weeks before accessing help. This is the result of a system whereby early intervention services are not supported by the health system. We are having bandaids applied by specialists who cost Medicare from $75 to $110 an hour. Over servicing is rampant in mental health due to the exclusion of primary services offering early intervention strategies that create a vaccine effect. This over servicing is also creating a potential financial drain on Medicare due to not adopting a tiered system of services.

Cost: The one argument that has been used over and over to justify the exclusion of an entire profession to Medicare is the potential added cost. In Queensland the Federation of Psychotherapists and Counsellors of Queensland have been running a regional counselling project that has been funded through a partnership of the Mental Health Association of Qld and the Department of Health (Qld). This project has enabled counsellors in regional and country Queensland to offer a rebates to local communities. These rebates have in most cases not carried a gap payment.

The rebate offered is for two thirty minute sessions at $20 each, effectively a $40 one hour session. Over 2700 sessions have delivered by counsellors in regional Queensland over the last 2 months. Clients are asked to fill in questionnaires prior to their first session and they are also required to fill in feedback sheets every 3 sessions. This has enabled significant data to be collected in regard the project. The outcome of this service was researched by Dr Travis Gee who at that time was a researcher for Medical Services in Queensland University and he published a paper on the efficacy of these services in a peer reviewed journal in 2007.

Not only did Dr Gee find them to be effective but it was also apparent all the clients would have been eligible for access to the Medicare rebates had they seen there GPs for referrals. Although this is not mentioned in the report by Dr Gee as it was not part of the study, intake forms bare this out. In total had these clients used the Better Access Initiative it would have cost over a 12 month period Medicare a minimum of $202,500.00.to a maximum of $297,000.00 if these clients had seen clinical psychologists. This does not include the $67,500.00 that would have gone to the GP's to write up a health care plan. The cost to the Queensland government was $110,000 for 12 months. There was no loss to quality or standards to these services. In many cases there were no psychological services close to where the clients lived and worked. A simple $50 rebate against Medicare would save our health system millions annually if this project is any indication of how counselling and psychological services can work in tandem to deliver appropriate services at the appropriate level. Every counsellor seen for early intervention services would be saving Medicare over $65 per session in comparison to a clinical psychologist. This would also ease waiting lists and release psychologists to treat mental illness cases more efficiently. It would also resolve the issue of a lack of services in many regional and country areas.

The possibility that indigenous counsellors could also offer their communities services could go along way to resolving indigenous alcohol and domestic violence issues.

There is also a negative cost if the current situation is not turned around and not just in delivery issues. The exclusion of counselling to the Mental Health Access Initiative has been expensive to Medicare with a budget blow out within the first six months of its introduction. The potential cost to the economy as counsellors

close their doors followed by the TAFES, Universities and private providers ceasing counsellor training could possibly see thousands of Australians out of work looking for new careers. It would also set Australia back may years in the eyes of our Asian neighbours and western allies if Australia was the first country to effectively see the end of the provision of professional counselling services.

In conclusion: The key priority in mental health should be the need to have a greater consumer-oriented and client-centred focus on primary care and prevention as a central component in mental health service provision. To this end it is vital to make the best use of limited mental health resources by early diagnosis and stronger and more broadly accessible professional services. To this end, I request this enquiry to enable a wider field of allied health professional services to act as a screening system that picks up early signs of mental health problems before they become embedded forms of mental illness. I would also strongly place emphasis on the damaging impact on counsellors not being available across the nation as GPs do not have access to these services under the Better Access initiative. The Senate might give higher priority to emotional wellbeing and increased social inclusion as indicative positive outcomes rather than focus on post-mental illness return to work or reduced institutional care days.

HEALTH PROFESSIONALS AND NATIONAL COMPETITION POLICY.
In 1995, all nine Australia Governments agreed that in order to stimulate economic growth and job creation a co-ordinated approach to market reform was required.
As a result, all Governments undertook to implement, on an ongoing basis, a package of reforms to be known as the National Competition Policy.
In its simplest form, 'competition' in a marketplace is about choice and exists when a number of businesses strive against each other to attract customers and sell their goods and services.

Competition generally will foster production efficiency and innovation and thus generate lower prices, greater choice and better levels of service for consumers.

One of the most important National Competition Policy undertakings is that each Government will review and reform all laws that restrict competition unless the benefits of the restriction to the community as a whole outweigh the costs.

In line with this policy, anti-competitive restrictions and regulations for health professionals must be comprehensively reviewed by the Commonwealth and all State and Territory Governments and reformed if they are found not to be in the public interest.

WESTERN AUSTRALIA

	ACA	PACFA	PACWA	APS
<u>Lower Western Australia</u>				
Population 277,650 (2006) 49.9% male; 50.1% female, indigenous 2.3% Median Age = 39 years				
Bunbury	2	1	2	1
Albany	5	0	1	1
Armadale	2	0	0	1
Palmyra	3	0	0	0
<u>Remainder Balance Western Australia</u>				
Population 230,375 (2006) 52.2% male; 47.8% female, indigenous 13.4% Median Age = 34 years				
Broome	3	1	0	1
Karratha	1	0	0	0
Geraldton	3	0	0	1
Exmouth	1	0	0	0
Kalgoorlie	1	0	0	2
TOTAL	**21**	**2**	**3**	**7**

QLD PACFA Regional Members

Name	Suburb	Postcode	ACA	PACFA
Ms Christine Perry	Beerwah	4519	5	1
Heather Sinclair	Brinsmead	4870	27	6
Robin Wileman	Broadbeach	4218	12	1
Monique Anderson	Bundaberg	4670	23	2
Richard Johnson	Bundaberg	4670	*	*
Dinah Stern	Bungalow	4870	*	*
Colleen Gray	Cairns	4870	*	*
Ken Warren	Cotton Tree	4558	13	3
Janette Berry	Cotton Tree	4558	*	*
Lesley Newman	Edgehill	4870	*	*
Christine Rose	Jimboomba	4280	5	1
Christine Andrade	Maleny	4552	10	3
Juliette Kaliefa	Maleny	4552	*	*
Jenny Jones	Maleny	4550	2	1
Brenda Howarth	Manunda	4870	*	*
Yvonne Chalice	Maroochydore	4558	*	*
Helyna Burton	Noosa	4567	10	2
Lynn Cameron	Petrie	4502	3	1
Dorothy Ratnajah	Point Vernon	4655	25	1
Iona Abrahamson	Southport	4215	18	1
Jean Tulloch	Sunshine Beach	4567	*	*
Margaret Hill	Surfers Paradise	4217	10	1
Terry Skidmore	Tivoli	4305	26	1
Patricia Quinn	Toowoomba	4350	35	2
Judith Dawson	Toowoomba	4350	*	*
Christine Perry	Warner	4500	8	1
Denis Hay	Warwick	4370	4	1
Esther Pockrandt	Witta	4552	*	*
Naomi Wilson	Woree	4870	*	*
			ACA	**PACFA**
		Total	236	29
			900 WS	**29 WS**

NSW PACFA Regional Members

Name	Suburb	Postcode	ACA	PACFA
Leonie Allsopp	Alstonville	2477	6	1
Terence McBride	Arncliffe	2205	0	1
Erica Pitman	Bathurst	2795	15	1
Peter Hurley	Blaxland	2777	7	4
Sandra Kondos	Blaxland	2777	*	*
Robyn Grace	Byron Bay	2481	5	1
Jacqueline Burns	Campbelltown	2560	14	1
Jan Wernej	Caringbah	2229	11	1
Catherine Vines	Coffs Harbour	2450	18	1
Katie Hansen	Deniliquin	2710	3	1
Suzanne Paton	Erskine Park	2759	5	1

Margaret Hutchings	Grafton	2460	8	2
Mardi Dunbar	Grafton	2460 *	*	
Kate van Barneveld	Grays Point	2232	7	4
Dr John James	Hartley Vale	2790	6	2
Hilary James	Hartley Vale	2790 *	*	
Rosemary Weir	Kariong	2250	26	1
Joss Bennett	Katoomba	2780	9	2
Jeanene Ecob	Kirrawee	2232 *	*	
Jillian Lynch	Leura	2780 *	*	
Stephen Said	Lidcombe	2741	0	1
Steve Gunther	Lismore	2480	23	1
Rody Myers	Morriset	2264	6	1
Catroina Roberston	Murwillumbah	2484	7	1
Barbara Shelley	Ruse	2560	14	1
Jeffrey Lucas	South Windsor	2756	3	1
Jacinta Frawley	Sutherland	2232 *	*	
Christina Del Medico	Sutherland	2232 *	*	
Raymond Andrews	Toormina	2452	1	1
Lisa Frese	Wagstaffe	2257	6	1
Peter Hurley	Winmalee	2777 *	*	
Peter Periera	Winmalee	2777 *	*	
Catherine McGrath	Wollongong	2500	10	1
Margaret Hutchings	Yamba	2464	4	1

	ACA	PACFA
Total	214	34
	993 WS	**34 WS**

NT PACFA Regional Members

Name	**Suburb**	**Postcode**		
Barbara Curr	Alice Springs	1843	0	1
Anna Bower	Samford	4520	5	1

	ACA	PACFA
Total	5	2
	5 WS	**2 WS**

SA PACFA Regional Members - Individual and whole state P/Codes

Name	**Suburb**	**Postcode**		
Dr John Ashfield	Tumby Bay	5605	0	1

	ACA	PACFA
Total	0	2
	111 WS	**2 WS**

TAS PACFA Regional Members - No individual P/Codes, whole state number

Name	**Suburb**	**Postcode**

None for PACFA				35	0
				ACA	**PACFA**
		Total		35	0
				35 WS	**0 WS**

VIC PACFA Regional Members - Individual and whole state P/Codes

Name	**Suburb**	**Postcode**			
Shirley Briggs	Bairnsdale		3875	3	1
Penny Lakey	Ballarat		3350	19	2
Heather Roche	Ballarat		3350 *	*	
Helen Martin	Bendigo		3550	7	1
Heather Battersby	Berwick		3806	19	1
Kerry Bergin	Camberwell		3214	1	1
Lorraine Gittings	Cardigan		3352	5	1
Elisabeth Southall	Geelong		3220	11	1
Dr Elizabeth Arthur	Hamilton		3300	2	1
Annette Lowe	Middle Park		3206	10	1
Rhonda Andrews	Narre Warren		3804	5	1
Dr Shelagh Wilken	Silvan		3795	1	1
Tracy Horner	Wodonga		3690	7	1
				ACA	**PACFA**
		Total		90	13
				548 WS	**13 WS**

WA PACFA Regional Members - Individual and whole state P/Codes

Name	**Suburb**	**Postcode**			
Dr Patricia Sherwood	Boyanup		6237	0	1
Mary Tunnecliffe	Broome		6725	3	1
Sylvia Ballantyne	Bunbury		6230	7	1
Dr Linda Gregory	Erskine		6210	24	1
				ACA	**PACFA**
		Total		34	4
				128 WS	**4 WS**

WHOLE STATE	**ACA / PACFA COMPARISON**
QLD	**900 / 29**
NSW	**993 / 34**
NT	**ACA 5 - PACFA 2**
SA	**111 / 2**
TAS	**35 / 0**
VIC	**548 / 13**
WA	**128 / 4**

*Postcodes for regional areas are selected as anything above 200 eg. 4201, 5201 etc

QUEENSLAND

	ACA	PACFA	QCA	APS

Regional Areas (not Brisbane)

Population 2,128,597 (2006)
49% male; 51% female, indigenous 4.5%

Darling Downs

Population 213,754 (2006)
49.2% male; 50.8% female, indigenous 3.1%
Median Age = 37 years

	ACA	PACFA	QCA	APS
Ipswich	9	0	2	10
Warwick	6	1	0	2
Goondiwindi	0	0	0	1

South West

Population 24,777 (2006)
51% male; 49% female, indigenous 11%
Median Age = 35 years

	ACA	PACFA	QCA	APS
Tara	0	0	0	0
St George	2	0	0	0
Toowoomba	28	2	4	4

Far North

Population 231,151 (2006)
50.5% male; 49.5% female, indigenous 14.3%
Median Age = 35 years

	ACA	PACFA	QCA	APS
Cairns	7	1	1	4
Atherton	3	0	0	1
Manunda	2	1	0	0

Gold Coast North

Population 51,996 (2006)
49.6% male; 50.4% female, indigenous 2.5%
Median Age = 34 years

	ACA	PACFA	QCA	APS
Beenleigh	8	0	0	2
Oxenford	3	0	0	1
Hope Island	3	0	0	0

Gold Coast South

Population 430,322 (2006)
49.1% male; 50.9% female, indigenous 1.0%
Median Age = 38 years

Mermaid Beach	3	0	0	1
Coolangatta	2	0	0	1
Currumbin	7	0	0	0

Central West

Population 10,853 (2006)
50.8% male; 49.2% female, indigenous 6.6%
Median Age = 37 years

Blackall	1	0	0	0
Longreach	0	0	0	0
Augathella	1	0	0	0

Fitzroy

Population 188,402 (2006)
51% male; 49% female, indigenous 4.7%
Median Age = 35 years

Yeppoon	2	0	0	0
Rockhampton	6	0	0	2
Blackwater	1	0	0	0

Mackay

Population 150,176 (2006)
51.9% male; 48.1% female, indigenous 3.6%
Median Age = 35 years

Mackay	9	0	0	3
Sarina	1	0	0	0
Andergrove	1	0	0	0

North West

Population 30,942 (2006)
52.9% male; 47.1% female, indigenous 22.7%
Median Age = 30 years

Mount Isa	4	0	0	0
Kelso	3	0	0	0
Kirwan	9	0	0	0

Northern

Population 196,670 (2006)
50.3% male; 49.7% female, indigenous 6.6%
Median Age = 34 years

Proserpine	1	0	0	0
Townsville	6	0	0	6
Rosslea	1	0	0	0

Sunshine Coast

Population 276,266 (2006)
48.7% male; 51.3% female, indigenous 1.2%
Median Age = 41 years

Caloundra	5	0	1	5
Coolum	6	0	0	1
Mooloolaba	5	0	0	3

West Moreton

Population 68,630 (2006)
50.0% male; 50.0% female, indigenous 2.4%
Median Age = 39 years

Boonah	0	0	0	0
Esk	2	0	0	0
Laidley	3	0	0	0

Wide Bay - Burnett

Population 254,662 (2006)
49.6% male; 50.4% female, indigenous 3.3%
Median Age = 42 years

Bundaberg	20	2	1	6
Maryborough	13	0	0	1
Hervey Bay	7	0	0	0
TOTAL	**190**	**7**	**9**	**54**

TASMANIA

	ACA	PACFA	APS
Regional Areas (not Hobart)			
Population 240,151 (2006) 49% male; 51% female, indigenous 4.5%			
Mersey - Lyell			
Population 106,129 (2006) 49.2% male; 50.8% female, indigenous 5.1% Median Age = 40 years			
Queenstown	1	0	0
Smithton	1	0	0
Devonport	3	0	0
Northern			
Population 134,021 (2006) 49.0% male; 51.0% female, indigenous 2.6% Median Age = 39 years			
Burnie	4	0	0
Elliott	1	0	0
Launceston	1	0	2
TOTAL	**11**	**0**	**2**

VICTORIA

	ACA	PACFA	VAFT	CAPAV	APS

<u>Regional Areas (not Melbourne)</u>

Population 1,333,435 (2006)
49.2% male; 50.8% female, indigenous 1.2%

<u>All Gippsland</u>

Population 239,648 (2006)
49.2% male; 50.8% female, indigenous 3.1%
Median Age = 41 years

	ACA	PACFA	VAFT	CAPAV	APS
Lakes Entrance	1	0	0	0	0
Sale	4	0	4	0	2

<u>Barwon - Western District</u>

Population 357,867 (2006)
49.1% male; 50.9% female, indigenous 0.8%
Median Age = 39 years

	ACA	PACFA	VAFT	CAPAV	APS
Warrnambool	10	0	0	0	2
Geelong	12	1	4	1	6

<u>Central Highlands - Wimmera</u>

Population 190,654 (2006)
48.9% male; 51.1% female, indigenous 0.9%
Median Age = 39 years

	ACA	PACFA	VAFT	CAPAV	APS
Horsham	16	0	0	0	0
Ballarat	15	2	4	0	10

<u>Goulburn - Ovens - Murray</u>

Population 287,825 (2006)
49.6% male; 50.4% female, indigenous 1.5%
Median Age = 39 years

	ACA	PACFA	VAFT	CAPAV	APS
Shepparton	13	0	0	0	0
Wodonga	9	1	1	0	3
Albury	8	0	3	0	3

<u>Loddon - Mallee</u>

Population 257,439 (2006)

49.1% male; 50.9% female, indigenous 1.5%
Median Age = 39 years

Swan Hill	2	0	1	0	0
Bendigo	4	1	0	0	10
Mildura	7	0	0	0	3
	101	**5**	**17**	**1**	**39**

NEW SOUTH WALES

	ACA	PACFA	CAPA	APS

Regional Areas (not Sydney)

Population 2,419,813 (2006)
49.3% male; 50.7% female, indigenous 3.9%

Central West

Population 170,899 (2006)
49.8% male; 50.2% female, indigenous 4.5%
Median Age = 38 years

	ACA	PACFA	CAPA	APS
Orange	8	0	0	2
Cowra	3	0	0	0
Bathurst	8	1	3	2

Far West - North Western

Population 133,307 (2006)
49.9% male; 50.1% female, indigenous 12.2%
Median Age = 38 years

	ACA	PACFA	CAPA	APS
Bourke	1	0	0	0
Brewarrina	0	0	0	0
Broken Hill	4	0	0	0

Hunter Valley

Population 95,773 (2006)
50.2% male; 49.8% female, indigenous 3.2%
Median Age = 41 years

	ACA	PACFA	CAPA	APS
Muswellbrook	1	0	0	0
Singleton	5	0	0	0
Moore Creek	1	0	0	0

Newcastle

Population 493,466 (2006)
49.0% male; 51.0% female, indigenous 2.5%
Median Age = 38 years

	ACA	PACFA	CAPA	APS
Newcastle	7	0	4	10
Waratah	2	0	0	1
Hamilton	14	0	1	6

Illawarra

Population 99,727 (2006)
48.9% male; 51.1% female, indigenous 2.1%
Median Age = 45 years

Ulladulla	6	0	0	0
Batemans Bay	3	0	0	0
Kiama	2	0	0	2

Nowra - Bomaderry

Population 30,956 (2006)
48.6% male; 51.4% female, indigenous 5.8%
Median Age = 38 years

Nowra	1	0	0	5
Bomaderry	1	0	0	0
Culburra Beach	2	0	0	0

Wollongong

Population 263,535 (2006)
49.3% male; 50.7% female, indigenous 1.8%
Median Age = 37 years

Wollongong	4	1	0	12
Figtree	2	0	0	0
Albion Park	3	0	0	0

Mid-North Coast

Population 284,676 (2006)
48.9% male; 51.1% female, indigenous 4.3%
Median Age = 43 years

Kendall	1	0	0	0
Port Macquarie	12	0	1	5
Coffs Harbour	15	1	4	9

Murray - Murrumbidgee

Population 257,819 (2006)
49.8% male; 50.2% female, indigenous 3.4%
Median Age = 38 years

Queanbeyan	5	0	0	2
Burra	1	0	0	0
Ainsley	1	0	0	0

Northern

Population 172,395 (2006)
49.4% male; 50.6% female, indigenous 7.9%
Median Age = 38 years

Glen Innes	3	0	0	0
Armidale	13	0	0	3
Tamworth	12	0	0	2

<u>Richmond - Tweed</u>

Population 219,328 (2006)
48.8% male; 51.2% female, indigenous 3.3%
Median Age = 42 years

Tweed Heads	5	0	0	2
Richmond	14	1	0	2
Lismore	11	1	1	4

<u>South Eastern</u>

Population 197,943 (2006)
49.9% male; 50.1% female, indigenous 2.5%
Median Age = 41 years

Bega	1	0	0	1
Bradbury	4	0	0	1
Campbelltown	9	1	0	9
TOTAL	**185**	**6**	**14**	**80**

NORTHERN TERRITORY

Regional Areas (not Darwin)

Population 85,004 (2006)
50.9% male; 49.1% female, indigenous 50.9%
Median Age = 28 years

	ACA	**PACFA**	**APS**
Alice Springs	13	1	0
Durack	3	0	0
Humpty Doo	4	0	0
TOTAL	**20**	**1**	**0**