The Psychotherapy and Counselling Federation of Australia (PACFA)

Submission to the Australian Senate Community Affairs Committee Inquiry into Mental Health Services in Australia

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SUMMARY

Psychotherapy and Counselling Federation of Australia (PACFA)

The Psychotherapy and Counselling Federation of Australia (PACFA) is a national federation of 40 professional associations representing nearly 4,000 fully qualified practitioners. PACFA has undergone an extensive process of consultation over many years to establish rigorous tertiary level training and professional practice standards specifically for the specialised fields of counselling and psychotherapy. These training standards are considerably higher for the practice of counselling and psychotherapy than those defined by other mental health professional bodies. PACFA represents the majority of tertiary qualified practitioners in the field of counselling and psychotherapy and maintains a voluntary National Register of practitioners who meet rigorous standards and is currently implementing a National Course Accreditation program. PACFA was funded by the Victorian government in 2003 to develop a best practice model for self-regulation of the counselling and psychotherapy profession in Australia, which has led to a strengthening of the self-regulation structures and processes for the profession.

PACFA welcomes the recent mental health reforms which serve to provide greater resources to this chronically under-funded area, and improve access to a wider cross-section of services. PACFA also welcomes the increased recognition of the need for greater consumer-oriented policy and services. The COAG Agreement 2006 was an important milestone in the move towards a fairer and more appropriate mental health service system.

The **key recommendations** in this submission by PACFA are:

1. A greater focus and substantially increased resources are required to address the National Mental Health Strategy objectives of mental illness prevention and early intervention. This can be facilitated by greater inclusion of a more diverse workforce mix in the policy and planning arena. In particular, public health, mental health promotion, and counsellors and psychotherapists have important expertise to address the current imbalance.
2. A systemic shift is still required to achieve a greater consumer-oriented focus in service provision. This shift towards more consumer-oriented and client-centred services needs to begin with the composition of the planning and review committees.
3. A stronger and more broadly coordinated infrastructure to support community-based care is needed. This needs to consider the flow-on impact of current policy initiatives to broader services and policies, such as the impact of national policy on state-based community health and care services, and the damaging impact of the Better Access Medicare rebates on services offered by other professional groups which are not included in this scheme, such as counsellors and psychotherapists.
4. The definition of evidence-based mental health practice needs to be expanded to include a wider range of evidence-based therapies provided by a broad range of well-established and credible psychotherapeutic modalities such as generalist counselling, psychodynamic, psychoanalytic, experiential, family and systems therapies, expressive arts therapies, somatic and integrative psychotherapies (see evidence later in this submission).

5. A significant gap in current policy and action plans is evidenced by the absence of focus on services provided by tertiary-trained counsellors and psychotherapists. This part of the professional workforce has been well recognised and integrated into the health systems of other leading western countries such as the UK, USA, and Canada: Australia is lagging behind. It is therefore recommended that the Federal Government should specifically review the potential role of the counselling and psychotherapy professions in the mental health care plan and develop a coordinated approach to inclusion of counselling and psychotherapy services provided by counsellors and psychotherapists. This may include:
    a. Developing a national registration system for counsellors and psychotherapists, with specialist accreditation of those who specifically meet the National Mental Health Standards. This would facilitate integration of counselling and psychotherapy into the mental health service system.
    b. Supporting development of the National Course Accreditation system for counselling and psychotherapy courses such as the one being implemented by PACFA from 2007.
    c. Providing representation for the profession on mental health policy and implementation bodies to facilitate a more multi-disciplinary and inclusive approach that will better meet consumer needs. PACFA is the national peak body representing over 40 professional associations.
    d. Providing Medicare rebates for registered counsellors and psychotherapists to provide evidence-based prevention, early intervention, and relapse prevention services, as well as services to carers and families affected by mental illness.
    e. Allocating research funds to facilitate investigation of counselling and psychotherapy outcomes in the Australian context and from a broader array of psychotherapeutic interventions. Research funds are also needed for early intervention and prevention of mental health problems, and for the dissemination of research evidence, and upskilling of workforce.

BACKGROUND

THE IMPORTANCE OF THE COUNSELLING AND PSYCHOTHERAPY PROFESSIONS IN ADDRESSING THE NATIONAL MENTAL HEALTH CRISIS

Psychological health and well-being: A national problem

In the 2001 National Health Survey, more than one third of adults (36%) were classified as having moderate to very high levels of psychological distress, compared with 26% in 1997. One in five (18%) of adults reported using medication for mental wellbeing in past 2 weeks, with high rates of antidepressant use, sleeping tablets and medications for anxiety or nerves.

The majority of Australians experiencing psychological distress will consult their general practitioner, but few gain specialist counselling or psychological services (AIHW, 2006). While the National Health and Medical Research Council (NHMRC, 1997) has published guidelines recommending counselling as the first line of treatment for mild to moderate depression, few general practitioners refer patients suffering from depression to counsellors.

Access to counselling and psychotherapy services is hampered by the lack of current funding for these services. A range of high risk health behaviours have also been associated with poorer mental health including being overweight (Brown, Dobson, & Mishra, 1998), low exercise levels (Brown, Lee, Mishra, & Bauman, 2000), alcohol use and cigarette smoking (Jorm, 1999), suggesting a clustering of risk factors and the need for more wholistic and multi-targeted strategies and approaches. Counsellors and psychotherapists are trained to address the factors that underlie these problems, and thus have potential for a long term improvement in mental health status.

Growing need for broader counselling and psychotherapy services to address the national Mental Health crisis

The very rapid rise in the rates of psychological distress and use of costly medications is also associated with breakdown of couple relationships and family systems, impaired development of children, lost productivity and widespread social problems. The flow-on effects are huge, supporting the view that the current Better Access Initiative may address only a small part of the problem.

Counselling has been shown to be highly effective with a wide range of mental health, social and psychological problems, as evidenced by numerous extensive meta-analyses of psychotherapy versus no treatment (Elliott, 2002; Shadish et al., 1995; Smith, Glass, & Miller, 1980). Lipsey and Wilson (1993) conducted a meta-analysis of 156 meta-analyses where psychotherapy treatments were compared to control conditions, yielding a sample of over 9000 studies and more than one million clients. They concluded that the average effect size (a statistical measure of effectiveness of one group relative to another) was considerably higher than the effectiveness of many common, widely accepted and costly medical treatments such as heart bypass surgery.

More importantly, there is considerable evidence **that no specific form of psychotherapy is superior to other forms**. Meta-analytic studies have shown that:

- Psychotherapy alone is as effective as combining psychotherapy and medication for less severe depression (Thase et al., 1997);
- Psychotherapy and counselling are cost-effective treatments (King et al., 2001);
- A dose-effect relationship has been found between number of sessions and therapy outcome (Howard et al., 1996), suggesting that clients continue to improve with more sessions.
- Psychodynamic treatments are as effective as other treatments and more effective than no treatment (Anderson & Lambert, 1995; Luborsky et al, 1995; Svartberg & Stiles, 1991; Wampold et al., 1997);
- Humanistic therapies showed a high average effect size of around 1.0 (high relative effectiveness) across 99 treatment groups and assessment periods compared with no treatment controls, and no difference in effectiveness from non-humanistic therapies including cognitive-behavioural therapy (CBT) (Elliott, 2002);
- A broad range of therapies with children are effective (Chambless & Hollon, 1998; Weisz et al., 1987);
- As are psychotherapies with the elderly (Scogin & McElreath, 1994).

Who seeks help for psychological distress and who can provide therapy?

A key factor that has prompted mental health reform is the disturbing and consistent finding that the great majority of those who are psychologically distressed receive no mental health care. Among Australian women, only 8.2% of those diagnosed with a mental disorder and 0.7% of women not diagnosed prior to the current Better Access Initiative, reported having consulted a psychologist (McLennan, 1998). The Australian National Mental Health Survey also found that 11.2% of women with a mental disorder (and 1.4% without) had seen a mental health professional (other than psychiatrist or psychologist) for help with a mental health problem in the past 12 months; these included social workers, welfare workers, relationship counsellors and drug and alcohol counsellors.

Against these low utilisation rates, counsellors have been rated by the public as having higher acceptability than either psychiatrists or psychologists (Sharpley, 1986; Jorm et al., 1997), and as being more approachable and empathic (Sharpley, 1986). Counsellors have been considered by the public to be the most helpful of all the professional groups (including GPs and psychiatrists) when shown a vignette of a person with schizophrenia and second only to GPs for dealing with a person with depression (Jorm et al., 1997). General practitioners also rated counsellors fairly highly for help with depression but psychiatrists far less so. Thus, counsellors and psychotherapists have high acceptability to the public and high perceived effectiveness, suggesting that they have an important contribution to make to provision of more consumer-oriented services.

Impact of 2006 COAG Agreement Initiatives

Since the introduction of the Better Access to Psychiatrists, Psychologists and other Allied Health Practitioners through the MBS initiative, there has been a significant decline in referrals to registered counsellors and psychotherapists, and growing waiting lists for the services of psychologists. The inclusion of registered counsellors and psychotherapists with

mental health training and experience, would increase the available workforce and reduce waiting times – often a critical issue in dealing with acute mental health clients. This would also provide more choice for consumers who have indicated a preference for counsellors.

Counsellors and psychotherapists have in the past, been the preferred professionals for delivery of counselling services: preferred by consumers, by general practitioners and by many government services such as sexual assault and domestic violence services, drug and alcohol services, women's services, youth services, etc. The Better Access Initiative has had a significant impact through providing financial incentives to general practitioners (GPs) to refer mental health clients to psychologists and other allied health practitioners, but not to registered counsellors and psychotherapists.

This has a number of serious consequences:

- It reduces rather than enhances choice for clients/consumers.
- It is leading to longer wait lists for the services of psychologists, and many geographical areas are not serviced at all.
- It leads to increased cost of services in many cases compared with the services previously being provided by counsellors and psychotherapists at a lower cost.
- It leads to significantly reduced viability of NGO services and private practices staffed by counsellors and psychotherapists.
- This in turn will result in a significant loss of expertise, particularly in cases involving complex problems such as childhood abuse and neglect, and severe trauma.
- It requires people suffering relatively common mental health problems to acquire a DSM-IV diagnosis on their permanent health record, in order to gain access to treatment. This has a stigmatizing effect and could result in serious negative financial, work and insurance implications for the individuals concerned.
- It fails to recognise that one of the key barriers to help-seeking for mental health problems is the fear of stigmatization, of being labeled, and the lack of confidentiality associated with diagnostic and system-based approaches.
- It appears from feedback from practitioners, that many people being referred under the MBS scheme are unaware of the implications of being diagnosed with a mental disorder.
- Many clients encounter long delays of a week or more in getting in to see their GP, then are referred to a practice nurse for the Mental Health Care Plan who may only work part-time and thus it can take 2-3 weeks to get the MH Care Plan made up. There can then be a further delay depending on the length of waiting list of the psychologist.

Key Recommendations

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2. A systemic shift is still required to achieve a greater consumer-oriented focus in service provision. This shift towards more consumer-oriented and client-centred services needs to begin with the composition of the planning and review committees.
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    c. Providing representation for the profession on mental health policy and implementation bodies to facilitate a more multi-disciplinary and inclusive approach that will better meet consumer needs. PACFA is the national peak body representing over 40 professional associations.
    d. Providing Medicare rebates for registered counsellors and psychotherapists to provide evidence-based prevention, early intervention, and relapse prevention services, as well as services to carers and families affected by mental illness.
    e. Allocating research funds to facilitate investigation of counselling and psychotherapy outcomes in the Australian context and from a broader array of psychotherapeutic interventions. Research funds are also needed for early intervention and prevention of mental health problems, and for the dissemination of research evidence, and upskilling of workforce.

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APPENDIX
PSYCHOTHERAPY AND COUNSELLING FEDERATION OF AUSTRALIA (PACFA)

The Psychotherapy And Counselling Federation of Australia (PACFA), Inc. a self-regulating peak body comprising a membership of 40 major professional associations for counselling and psychotherapy in Australia. PACFA was established in 1998 following several years of consultation among practitioners, educators and professional associations. This consultative process resulted in the setting of rigorous minimum standards for professional and ethical practice, development of professional accountability and public protection systems through a rigorous process of registration, and transparent and accountable mechanisms to regulate therapeutic practice. PACFA represents several thousand individual practitioners and many different modalities.

PACFA has a Board of Management drawn from institutions of learning and practice from across Australia. PACFA’s minimum professional standards involves a minimum of two years’ postgraduate or three years undergraduate level training in a generalist or specialised area of counselling or psychotherapy, as well as careful selection into training programs, monitoring of suitability throughout and supervised practice requirements for two years after completion of training course. These requirements are equivalent to minimum four years of training required by other professional groups who are recognized as providers of counselling services.

The PACFA National Register of Psychotherapists and Counsellors represents rigorous standards in training, ethical practice and ongoing professional development. It provides a structure for identifying appropriately trained practitioners that supports the functions of government bodies (www.pacfa.org.au). PACFA is in process of implementing a national Course Accreditation program.

The Department of Human Services (DHS) Victoria funded PACFA in 2003 to undertake a substantial study of the profession in Australia towards development of best practice in self-regulation for the profession. It has also undertaken a nation-wide survey of professional members, providing a comprehensive dataset on the practice of professional counsellors.

APPENDIX: PACFA MEMBER ASSOCIATIONS

- Association of Personal Counsellors Inc.
- Association of Solution Oriented Hypnotherapists and Counsellors of Australia
- Association of Soul-Centred Psychotherapists Inc.
- Association of Transpersonal and Emotional Release Counsellors
- Australian and New Zealand Association of Psychotherapy (NSW Branch)
- Australian and New Zealand Psychodrama Association Inc.
- Australian and New Zealand Society of Jungian Analysts
- Australian Association of Buddhist Counsellors and Psychotherapists
- Australian Association of Group Psychotherapists
- Australian Association of Relationship Counsellors
- Australian Association of Somatic Psychotherapists
- Australian Association of Spiritual Care and Pastoral Counselling
- Australian Centre for Psychoanalysis
- Australian College of Psychotherapists
- Australian Hypnotherapists Association
- Australian Psychoanalytic Society
- Australian Radix Body Centred Psychotherapy Association
- Australian Somatic Integration Association
- Christian Counsellors Association of Australia Inc
- Clinical Counsellors Association
- Counselling and Psychotherapy Association Canberra and Region
- Counselling Association of South Australia Inc
- Counsellors And Psychotherapists Association of NSW Inc
- Counsellors And Psychotherapists Association of Victoria Inc
- Dance Therapy Association of Australia
- Gestalt Australia New Zealand
- Hakomi Australia Association
- Institute of Clinical Psychotherapy Inc
- Melbourne College of Contemporary Psychotherapy
- Melbourne Institute of Experiential and Creative Arts Therapy
- Music and Imagery Association of Australia
- NSW Institute of Family Psychotherapy
- Professional Counselling Association of Tasmania
- Psychoanalytic Psychotherapy Association of Australasia
- Psychotherapists and Counsellors Association of WA
- Queensland Association for Family Therapy
- Queensland Counsellors Association Inc
- Society of Counselling and Psychotherapy Educators
- Victorian Association of Family Therapists
- Western Pacific Association of TransactionalAnalysis

Case studies of how counselling services support an inadequate mental health system

A Specialist trained counsellor

A 22 year old male was found trying to jump off a roof by police on a Friday night. He wouldn't come down but was eventually brought down and taken to the local hospital. Even though he was suffering from mental health problems, the hospital couldn't cope with him and the local mental health team was not available on the weekend to deal with him. He was released from hospital and found again on Sunday trying to commit suicide. He was referred to a private practice counsellor who contained him by phone and saw him on the Monday. The counsellor tried to contact the local mental health team, but they couldn't offer an appointment before Thursday. Given the urgency, the counsellor worked with the client immediately, liaised with a local private psychiatrist to see him, and continued working with him therapeutically. The counsellor and client have formed an effective and supportive therapeutic alliance and collaboratively developed a therapeutic contract to prevent further suicide attempts and clear contact arrangements. The suicidal attempts have stopped and the client is more stable but requiring longer-term supportive therapy in conjunction with psychiatric monitoring.

B Specialist trained counsellor

A professional woman in her early 30's became agoraphobic, had to give up her job, was living on a disability pension, and completely unable to take public transport. She had previously been put on medication and was seeing a Psychiatrist but with no real change in her symptoms. She was referred for counselling to a postgraduate trained generalist counsellor and in 12 months worked through a wide range of the underlying causes and is now a home owner, working full time, and in a committed relationship. She has not had a relapse in 5 years.

C Specialist family therapist and integrated multidisciplinary team

A young 21 year old woman had spent most of her adolescence struggling with a complex presentation of mental health issues including very lengthy and repeated hospitalization. She was eventually referred to a family therapist in private practice. A committed treatment team was assembled and provided a combination of medication, individual and family therapy. Over time she has stabilized in her use of hospital based care, medication and she is successfully living in a Community Care Unit with a growing connection to the community. She works part time in a community service, holding a position of responsibility. She belongs to two local community organisations, is in regular contact with her parents and wider family, manages her everyday living needs, and is planning additional activities. Currently she is struggling with nightmares and flashbacks of the trauma she experienced while hospitalized. This progress is a result of the formation of an integrated treatment program which combines elements of the traditional mental health system and the individual counselling and family therapy services from the private sector. The integrated program was instigated and coordinated by the private family therapist, as a result of previous lack of coordinated care which exacerbated the problems.

D Effective integration of services for treating complex mental health problems

A young woman had been a high demand client of an area mental health service. Her service needs were extensive in relation to her serious episodes of attempted suicide, her extensive self harm behaviour and her eating disorder (severe and chronically life threatening). The client had been regularly admitted to inpatient units, but was often not contained within these units due to her level of eating disorder, psychosis and/or self harm. She did not fit into either category of eating disorder specialty, adult mental health or Borderline Personality services and used a range of services in an uncoordinated way. A specialist family therapy centre became involved due to the need for family therapy, the desperation of the client, the overloaded mental health service situation, the need for across-service liaison, and the particular skills of the director-psychiatrist in the area of family work with eating disorders. This Therapy Centre sits between sectors, has a relationship with the various arms of the state mental health service and takes a systemic view of mental health care. The Centre undertook direct family work which involved the client's family in the context of extensive sexual and psychological abuse issues and systemic consultation with other service providers to work toward achievable goals.

This client had severely tested the capacity of the service system to be responsive and to be persistently compassionate and optimistic. Workers in the mental health system were being traumatised by the crises that constituted the care of this client, for example when the client cut her own throat. Due to bed pressure and the client's destructive behaviours, it was often difficult for services to respond in a manner that did not, in the process, exacerbate the client's triggers for self-destructiveness. The different arms of the services were able to meet specific needs but had difficulty when they overlapped, for example when the client was self harming in the eating disorders unit or when she needed intensive support after hours.

The turning points for this work appeared to have been the capacity of the family therapy centre to both engage the family and to maintain a long-term relationship with both the family and their other service providers as part of a systemic approach to mental health care This alliance has been able to hold a consistent position in relation to working slowly toward a recovery position rather than crisis management and using inpatient services strategically. Although there is a long way to go, the client has been able to sustain placements in specialist clinics, has remained in therapy for treatment of trauma and has changed her home/family dynamics even moving into an independent flat. This last effect has been the result of particularly careful and systemic intervention with the family and the education/support of the spouse.