
Hunter Rise, Regionally Based Counsellors and Psychotherapists.

Cath Edwards, Master of Social Medicine - Injury Prevention- UNESCO thesis on Alcohol and Crime.

Bruce Llewellyn, M.Acc.

Colleen Wall, Indigenous Elder in Residence.

Damien Jones, MACA.

Grahame Smith, BA Soc Sc (Counselling) (Human Resource Development).

Judith Reader, Australian Counselling Association Supervisor.

Ken Schmidt, B.Theol, B.Couns UNE, RFD PMACA ACACCC ACACOS.

Linda Elsey, M.Couns.

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Submission contact details: Damien Jones

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Executive Summary

This submission discusses how to integrate Counsellors and psychotherapists; as registered clinicians, into the more extensive health system as reflected in the National Standards for Mental Health Services 2010. The Australian Counselling Association and The Psychotherapy and Counselling Federation of Australia have both defined Scopes of Practice which support the professionals operating within the wider health system. Counsellors and psychotherapists who work in mental health services are among the major strengths of the system, essential both to service improvement and to mental health reform, and have a vital role in improving health and social outcomes for the Australian community. Utilising registered counsellors and psychotherapists within the commissioning of additional mental health services creates a flexible, efficient service delivery model by increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improve coordination of care to ensure patients receive the right care in the right place at the right time.

Currently, registered counsellors and psychotherapists can meet the need of the primary mental health services by providing a range of evidence-based psychological strategies that make the best use of the available counselling workforce within a local region and limited resources allocation. Registered counsellors and psychotherapists would be able to seamlessly fit into existing mental health services in primary and secondary care within the wider health system.

Counsellors and psychotherapists as a profession contributes to the broader area of primary mental health, and are essential to the front line of mental health, providing short-term support to consumers and linking them to their supporting networks and assisting them to set goals and relevant activities to achieve those goals.

Registered counsellors can provide responsive interventions for people experiencing a mental health crisis, there psychological interventions are targeted at the prevent or reduce the impact of crisis and relapse. They also have the skills and experience to provide support and treatment for people with long-term mental health problems who have complex needs and who may find it difficult to engage directly with services; and recovery-oriented services which assist people to stay well and engage with their community.

Registered counsellors and psychotherapists can provide responsive interventions for people experiencing a mental health crisis, there psychological interventions are targeted at the prevent or reduce the impact of crisis and relapse. They also have the skills and experience to provide support and treatment for people with long-term mental health problems who have complex needs and who may find it difficult to engage directly with services; and recovery-oriented services which assist people to stay well and engage with their community.

Registered counsellors and psychotherapists have the ability to establish an effective therapeutic relationship and to refer appropriately. With appropriate supervision and support Registered counsellors will have the skills and resilience to respond to the operational constraints of a busy mental health service and adjust to the often-competing demands of program delivery and patient outcomes

The submission concludes with a business case model for incorporating counsellors and psychotherapists into existing services and considers wider systemic issue relevant to service integration. The appendicis introduce the therapeutic modelling of focused psychological services, which are relevant to current mental health service provision, identified wait times for assessment and receiving treatment, and economic modelling the current provisioning of mental health services in New South Wales.

Section One - Background

Defining registered counsellors and psychotherapists practice in Australia

We believe that registered counsellors and psychotherapists can significantly contribute to the strategic vision, purpose, and objective of commissioning bodies for the delivery of timely and relevant psychological services in primary and secondary health settings while being consistent with the priorities and objectives of the Fifth National Mental Health and Suicide Prevention Plan.

Registered counsellors and psychotherapists can provide psychosocial support services to assist people with severe mental illness resulting in reduced psychosocial functional capacity who are not more appropriately supported through other non-clinical psychosocial support services, thereby providing a seamless, high quality and earlier psychosocial supports service which reduce the avoidable need for more intense and acute health services and enhance appropriate/optimal use of the health system.

Registered counsellors and psychotherapists can deliver services targeting identified areas of need such as indigenous health and rural and remote locations, and will provide a dedicated workforce which would significantly increase the service delivery capacity of the mental health sector. Utilising registered counsellors and psychotherapists will improve the effectiveness of mental health services for individuals requiring support by increasing coordination between various sectors, and improving sector efficiency; and improve the effectiveness of mental health services for individuals at risk of suicide and requiring support and treatment by increasing coordination between various sectors, and improving sector efficiency.

Registered counsellors and psychotherapists can meet the standards of service delivery through Primary Health Networks Grant Programme Guidelines for the delivery of mental health, Psychosocial Support and Suicide prevention services, and Primary Mental Health Care and the Indigenous Australians' Health Programme, National Standards for Mental Health Services, and the National Practice Standards for the Mental Health Workforce.

Key priority areas where registered counsellors and psychotherapists can assist include

- Mental Health
- Suicide Prevention
- Alcohol and Other Drugs
- Aboriginal Health
- Children and Families
- Chronic Conditions

Registered counsellors and psychotherapists can support identified target at-risk populations which are underserved, hard-to-reach and at-risk, including:

- Aboriginal and Torres Strait Islander people;
- children and young people;
- people experiencing, or at risk of, homelessness;
- people experiencing perinatal anxiety and depression;
- people with intellectual disability and co-existing mental illness;
- people from culturally and linguistically diverse (CALD) backgrounds;
- people at risk of suicide or self-harm; and
- people who identify as lesbian, gay, bisexual, transgender, and/or intersex
- Older people

- Carers

Key features of the Mental Health Stepped Care Model which registered counsellors and psychotherapists can support include:

Person-centred approach

- Comprehensive assessment with services tailored to the needs of the consumer
- A mix of treatment modalities defined through assessment and supported by the use of clinical staging
- The utilisation of e-health technology as part of a suite of service responses
- A multi-disciplinary team – including credentialed mental health clinicians capable of operating at the top of their scope
- Connection with person's GP as part of the care team
- Ensuring the physical health and wellbeing of consumers forms part of the service response
- Integrated care – particularly for those people with moderate to severe mental health issues including co-morbidities
- Collaborative care planning
- Defined care pathways and linkages to other social care support as required

Services and programs utilising registered counsellors and psychotherapists will achieve significant outcomes, including:

- Improved health outcomes for consumers – improved quality of life, improved consumer pathways
 - Provide evidenced psychological services which improve well-being
 - Able to use quantitative and qualitative measures to rate of consumers using various stepped care services
- Contribute positively to consumer experiences with evidenced psychological services which improve consumers wellbeing, and support with integrated care
- Support system efficiency with a dedicated workforce able to better meet the demands of service integration and management, consumer access, response times, sustainability of service delivery, support improved care pathways, and provide integrated care pathways to other primary and secondary services
- The utilisation of registered counsellors and psychotherapists as a mental health workforce to support more extensive allied health and general practitioner experiences including,
 - Coordinated care capability
 - Integrated collaborative system evidenced by qualitative feedback
 - As meeting the identified need of establishing a broad range of mental health workers within the health system
 - A network of localised Native Title holders and Aboriginal Elders who have the ability to integrate 'on country' cultural practice learnings across the regions that will support practitioners in their work.

Justification, Methodology and Implement Process for regionally based and registered counsellors and Psychotherapists

The transition to a new model of Mental Health Stepped Care as stated by the Commission is still ongoing, and this transition provides opportunities to expand and enhance the stepped care model approach. As already stated what is being proposed as a viable inclusion is the addition of Regionally Registered Counsellors and Psychotherapists. This inclusion fits well into the key stepped care model features, as outlined by the Commission. For example, embedding the cohort of counsellors and psychotherapist into this model has the advantage of this cohort already delivering on the care models stated features, which are described below:

- Person-centred approach
- Comprehensive assessment with services tailored to the needs of the consumer
- A mix of treatment modalities defined through assessment and supported using clinical staging
- The utilisation of e-health technology as part of a suite of service responses
- A multi-disciplinary team – including credentialed mental health clinicians capable of operating at the top of their scope
- Connection with person's GP as part of the care team
- Ensuring the physical health and wellbeing of consumer's forms part of the service response
- Integrated care – particularly for those people with moderate to severe mental health issues including co-morbidities
- Collaborative care planning
- Defined care pathways and linkages to other social care support
- Health outcomes for consumers – improved quality of life, improved consumer pathways
- Improved well-being as evidenced by quantitative and qualitative measures
- Number and rate of consumers using various stepped care services
- Consumer experience – satisfaction and improvement in wellbeing, integrated care
- Satisfaction as evidenced by consumer service and health system experience
- Evidence of % of consumers who have a shared care plan
- System efficiency – better demand management, access, response times, sustainability, improved care pathways, integrated care
- Integrated care pathways as evidenced by formalised partnerships, regional strategies or collaborations (e.g., MOUs)
- Evidence of collaborative care planning
- Practitioner/Clinician experience – capability, utilisation of mental health workforce, satisfaction levels
- Practitioners experience an integrated collaborative system evidenced by qualitative feedback
- Evidence of utilisation of a broad range of mental health workers including clinicians

The bases for this inclusion is demonstrated by Firth et al., 2015 where stepped care service treatments allows patients to be placed at different levels of care based on clearly defined criteria. In this case, it is both proposed and appropriate for such practitioners to provide care at the low to the medium intensity level. As mentioned earlier this proposal centres on the concept of improved targeting of low to moderate intensity psychological services where a clear majority of the population sits, in this case, General adult services, including services for older adults. Thus, incorporating counsellors and psychotherapists in the Stepped Care model will produce a more refined graded service continuum for psychological services. It would commence at Step 3 brief individual therapy for low to low, moderate needs groups, with higher levels of acuity being managed by more senior psychological professionals up to the point where the person may require a blended therapeutic regime in conjunction with a secondary or tertiary clinician. This system creates resource and service efficiency in the use of the flexible funds and refocuses the current Access to Allied Psychological Services (ATAPS) workforce. If you capture and assist this population group and provide interventions at this early stage of mental health and relationship difficulties you significantly improve the chances of these issues not escalating into the expensive medical model and court-based systems with high social costs.

This grouping of practitioners is not mutually exclusive. Some consumers fall into the other four groups; however, most service providers operate across more than one service grouping. Registered Counsellors and Psychotherapists are highly trained in evidence-based service delivery that collectively make up the range of interventions available to consumers within the stepped care system and who currently provide services across more than one grouping.

Section Two – Addressing the Productivity Commissioners Issues Paper 2019

The following are examples of how registered counsellors and psychotherapists can contribute to the broader health system by addressing specific questions within the productivity commissioners' issues paper 2019.

Mental health promotion, prevention, and early intervention

- Q. Should there be any changes to mental illness prevention and early intervention by healthcare providers? If so, what changes do you propose and to what extent would this reduce the prevalence and/or severity of mental illness? What is the supporting evidence and what would be some of the other benefits and costs? (Productivity Commission, 2019, p16)

Improved provision of psychological services - provided by Registered Mental Health Counsellors

Registered counsellors and psychotherapists provide face to face, telephone support and/or online support assisting clients to set goals and relevant activities to achieve those goals. It will require an investment to:

- establish a pool of trained Registered Mental Health Counsellors and psychotherapists
- promote the service in a variety of mediums including online, GPs, community health centres
- monitor and evaluate the effectiveness of the service.
- Operate in conjunction with existing Psychological Therapies Program

It is increasingly recognised that the role of evidence-based mental health therapies which promote wellbeing; such as cognitive-behavioural therapy (CBT) and rational emotive behaviour therapy (REBT), are demonstrated to support the remission and recovery of mental illness and address their underlying risk factors (Armstrong, Jones, p 9).

There are a generic and internationally recognised knowledge base and skill base that each profession of psychology, counselling, psychiatry, social work, mental health nursing, and occupational therapy draw on when training students in the specialty of psychotherapeutic treatment strategies for primary mental health care.

Key texts and resources on best methods of psychotherapeutic intervention and treatment strategies are used in common across all programmes of psychology, counselling, psychiatry, social work, mental health nursing and occupational therapy at both undergraduate and postgraduate levels when focused on training specifically in the area.

Furthermore, ongoing professional development programmes offered around Australia and the world on best methods of psychotherapeutic mental health care and treatment are utilised concurrently by counsellors and psychotherapists, social workers, psychologists, psychiatrists, mental health nurses, general practitioners and occupational therapists who choose to focus in these areas through their chosen disciplines.

Ultimately this means that psychologists, social workers, counsellors and psychotherapists, psychiatrists, mental health nurses, general practitioners, and occupational therapists are all taught from the same pool of research knowledge and evidence-based practice strategies concerning psychotherapeutic treatment approaches for effective primary mental health care. They happen to occupy differently, and often overlapping, sections of that pool.

Nevertheless, against this shared professional background, each specialty also offers a complementary focus of approach whereby each profession contributes to the broader area of primary mental health care with specific nuances and perspectives shaped from the origins of each profession.

Mental Health Promotion

- Q. Which forms of mental health promotion are effective in improving population mental health in either the short or long term? What evidence supports this? (Productivity Commission, 2019, p16)

Indigenous Community Champion Engagement Program

The Community Champion Engagement Program is designed to engage known champions on the broader community and enable the champions to become knowledgeable in the program's objectives and prevention efforts.

Community Champion Engagement Program is the point of contact for community leaders and elders and will support them to facilitate suicide prevention into the broader community. The community champions are involved in recruiting new program users and advocate for suicide prevention activities in their local community. The Community Champion Engagement Program leverages on the strengths of the community and supports resilience and trust with the community and its members, especially the youth.

Community Champion Engagement Program Goals are to:

- Recruit key local advocates and community leaders
- Meet the cultural needs of the community, provide post-vention education, and leverage local resources
- Local Consultation and Support by engaging with local Aboriginal Medical Services to deliver appropriate Mental Health Screening.

Suicide prevention

- Q. What changes do you recommend to healthcare to address the specific issues of suicides and comorbidities among people with a mental illness? What evidence is there to support your suggested actions and what types of improvements would you expect in terms of population mental health, participation, and productivity? (Productivity Commission, 2019, p16)

Mental illnesses has been called 'the chronic diseases of the young (Insel & Fenton 2007) who are most likely to be affected by specific low prevalence; but high severity, conditions including psychotic disorders (such as schizophrenia) and eating disorders, with almost 40 per cent of people with psychotic illness experiencing their first symptoms while in their teens, with very high rates of attempted and completed suicide among people with psychosis (Morgan et al., 2011). To compound the issues faced by people experiencing mental health problems, systemic issues such as what constitutes an acceptable waiting time are not matched by any national benchmarks for wait lists, which seriously contribute to the high persistence rates of mental health issues among the Australian population. (Armstrong, Jones, p 12)

In the past, suicide predominantly occurred in older Indigenous people (Harder, Rash, Holyk, Jovel, & Harder, 2012). However, in recent decades suicide has become more common in youth, particularly between the ages 15–24 (Harder, Rash, Holyk, Jovel, & Harder, 2012). In New Zealand, the suicide rate of Maori people is 1.8 times higher than the non-Maori population. However, the suicide rate for Maori youths is even higher at 2.4 times the rate for non-Maori youths (Ministry of Health, 2015). The rates of suicide among Canada's Inuit youth under the age of 18 was disturbingly high; between 1994 and 2008 rates of suicide were 30 times higher compared to the rest of the under-18 population (Fraser, Geoffroy, Chachamovich, & Kirmayer, 2015).

In Australia between 2001 and 2010, the highest suicide rate of any group was for Aboriginal and Torres Strait Islander males aged between 25 and 29 years (90.8 deaths per 100,000 population) (Australian Bureau of Statistics, 2012). The highest suicide rate for Aboriginal and Torres Strait Islander females was in the 20–24 age group (21.8 deaths per 100,000 population). Although the rates for males are alarmingly high, rates of both male and female Aboriginal and Torres Strait Islander people are significantly different when compared to non-Indigenous Australians, with the age-standardised rate for males four times higher and the female rate five times in the 15–19 years age group (Australian Bureau of Statistics, 2012).

Counsellors and psychotherapists outreach service

Counsellors and psychotherapists would provide an outreach service providing, short-term support to consumers and linking them to their supporting networks (family, friends, carers, community, and service providers).

The objectives of the outreach service are:

- To prevent deaths by suicide by reducing the likelihood of a further attempt or suicide by people who have made a previous suicide attempt
- To provide a service for a currently unmet need in the community
- To successfully engage (and be supported by) consumers, health care professionals and other relevant stakeholders (e.g. Hospital Network Acute Care Team)
- To support individuals to connect with essential services during the period of high risk and vulnerability following a suicide attempt
- To reduce the burden on an individual's supporting network(s) (such as family and carers) following a suicide attempt
- To reduce the burden on existing community healthcare and support services
- To implement a cost-effective service which will provide economic benefits by preventing further suicide attempts

The outreach service will implement protocols and practices that recognise the diverse needs of local communities and populations at higher risk of suicide, with consideration to the demographics of the defined catchment area:

1. Aboriginal and Torres Strait Islanders people;
2. Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI);
3. Older people;
4. Young people;
5. People experiencing a mental health condition; and
6. Particularly men;

Registered counsellors and psychotherapists delivering resilience based mental health and suicide prevention programs

The vision of the Resilience project is to develop resilient students who can identify and direct their education goals and lead as successful citizens in their community. The project enables participating students to engage and develop self-reflection skills and tools supported by their personal narrative developed around their perception of cultural clarity and continuity (Chandler & Lalonde, 2008). Personal development will centre on developing the resilience to operate within a more comprehensive social construct. The project will establish culturally relevant and safe resilience-based strategies, tools and resources enabling students to seek strength-based solutions to their current and emerging needs. The project will assist students to develop depth within their personal identity through examining their personal and collective identity and experiences, learning to reframe their problems into challenges. Objectives are to address students at risk of self-harm, suicide ideation and harm to others through imbedding psychological interventions within student's curriculum content.

The planned outcomes of the project are to reduce the incidence and outcomes of suicide ideation, self-harm and harm to others by engaging students to develop and exercise the cognitive skills essential for navigating complex social situations, by;

- a. Building trust in themselves, their peers and their community
- b. Develop their social, emotional, behavioral and intellectual abilities
- c. Develop lead and Inspire others to participate (is this Develop, Lead and Inspire others?)
- d. Think Critically and Creatively about their challenges
- e. Make sound and timely decisions
- f. Communicate and interact effectively with others
- g. Seek balance, be resilient, and demonstrate a strong spirit
- h. Pursue excellence and continual self-development

The Resilience project is an evidence-based, school-based project utilising Systemic therapies (Pilling, Roth, & Stratton, 2010), and Humanistic therapies (Roth, Hill, & Pilling, 2009) to assist individuals to examine their relationship to others and assist individuals to draw resources from their inner self to address their emotional difficulties and problems in relating to people.

Through reflective practices, the Resilience project examining issues around students cultural and individual identity and using students' own background to develop tools and skills required to addresses emotional difficulties and problems in relating to people and develop a clear personal identity for psychological adjustment (Usborne & Taylor, 2010). Hammack (2008) identified that a clear cultural identity could act as the psychological basis on which personal identity is constructed. Cultural identity clarity is the extent to which beliefs about one's cultural group are perceived to be clearly and confidently defined (Campbell J. D., 1990). Individuals without a clear collective identity might have difficulty developing a clear personal identity, a deficit that translates to poor psychological well-being (Taylor, 2002).

Approaches include Cognitive Behavioural Therapy and Learned Optimism to assist individuals with reframing their worldview, address suicide ideation, self-harm, and harm to others. Research methodology will include three assessment tools to validate the project findings, Cultural Identity Clarity Scale (Usborne & Taylor, 2010) against the Self-Concept Clarity Scale (Campbell, et al., 1996) and The Adolescent Resilience Questionnaire (Gartland, Bond, Olsson, Buzwell, & Sawyer, 2011).

- 1) The Cultural Identity Clarity (Usborne & Taylor) is positively related to self-concept clarity, self-esteem, and markers of subjective well-being and supports an individual with a clear prototype to construct a clear personal identity and, by extension, achieve self-esteem and well-being.
- 2) The Self-Concept Clarity (Campbell, et al.) reflects the consistency or structure of self-concepts and is distinct yet related to self-esteem or valence of feelings towards the self.
- 3) The Adolescent Resilience Questionnaire (Gartland, Bond, Olsson, Buzwell, & Sawyer) examines the strengths within the adolescent, their family, peer group, school, and community, measuring a youth's ability to reach positive outcomes despite life challenges.

The innovative response targets students at risk of self-harm, suicide ideation and harm to others within the Queensland Department of Education and Training environment, including State High Schools. These services address a wide range of issues within the target audience from participating in concrete educational objectives and goals to reducing juvenile recidivism. Students who disengage from these Education and Training environments jeopardise their ability to participate effectively within society as are exposed to significant risks of harm to themselves and others. A review of the literature identified a number of other suicide risk factors for A&TSI peoples which included lack of cultural continuity (Chandler & Lalonde, 2008), exposure to trauma (Ralph, et al., 2006), alcohol abuse (Hunter & Milroy, 2006), being a young male (Hunter & Harvey, 2002) and suicide clustering (Hunter, et al., 2001). These risk factors, which are disproportionately or exclusively experienced by A&TSI people, illustrate the interconnected relationship between a lack of individual and cultural identity and the significant risk factors that contribute to suicide ideation, self-harm, and harm to others.

The Education Services supports Aboriginal and Torres Strait Islanders (A&TSI) students identified by schools as disengaged from conventional education. The Education Service acknowledges that disengaged A&TSI student require culturally appropriate and safe support to develop resilience tools and skills, enabling them to positively re-engage with their school, home, and community environment.

The project's scope is to respond to the events of suicide and suicide ideation within the Metropolitan Region by developing innovative and sustainable strategies, with support from local and regional partners, drawing on their localised knowledge experience and expertise. Resilience is fostered through the development of the students' personality, thereby supporting their ability to engage effectively with themselves and each other, as well as the wider environment. The project audience encompasses individuals committing harm to self and/or harm to others.

Collaborators engage through a Community Engagement Champion Program. It is designed to engage known champions on the broader community and enable these champions to become knowledgeable in the program's objectives and prevention efforts, leveraging on the strengths of the community, fostering resilience and trust with the community and its members, especially the youth.

Stakeholders engage through a Teacher and School Engagement Program. Designed to engage and inform stakeholders in the program's objectives, prevention efforts, build confidence in their ability to talk about issues that affect resilience, such as depression and suicide.

Indigenous elders peer support engagement program

In addition to the Resilience Project a group of Aboriginal Grandmothers have developed an early intervention program that goes beyond the personal 'self' concept. Called Kid's Identity in Care (KIIC) this program builds the identity of Kids in out-of-home care in a way that focuses on learning one's sense of place in country. Where studies have notionally looked at self-esteem and self-worth or personal value this program works on one's beliefs, emotions and behaviours around one's importance to country. Where children and young people know where they are from and possibly their totemic responsibilities they use their own spiritual connection to country but those who are disconnected from family and country are given 'spiritual' responsibilities when they select a type of country (wetlands) and a member each of the flora and fauna within that country that they are drawn to. Then each one builds a knowledge base around that spiritual grouping in relation to biodiversity or ecosystem that the group belongs too. This takes away from the stress of one's 'self' and moves into one's cultural right to protect and maintain country and its environment. Working from a point of age and ability this process builds respect, responsibility and a resilience in each individual in caring for another or in this case it is one's connection to country and its flora and fauna.

Through learning Aboriginal Grandmother's Law they build a portfolio of knowledge of 'caring for country' which they can take with them where ever they are placed or return to. This process can include a base of horticulture, environmental science, research processes and bush food knowledge.

Health workforce and informal carers

- Q. Does the configuration and capabilities of the professional health workforce need to change to improve where and how care is delivered? If so, how should the workforce differ from current arrangements? How would this improve population mental health, participation and productivity? (Productivity Commission, 2019, p17)

In 2016 the Australian Counselling Association Inc developed and endorsed The Scope of Practice for Registered Counsellors, which defines a consistent and proficient use of counselling interventions to support the consumer and support the integration of Registered Counsellors and psychotherapists as clinicians into the more extensive health system as reflected in the National Standards for Mental Health Services 2010 (Armstrong, Jones, p 9)

Registered counsellors and psychotherapists provide a competent workforce which is trained in evidence-based focussed psychological strategies and can respond effectively to the mental health needs of patients and support the wider health system with potential savings to the Department of Health. (Armstrong, Jones, p 9)

Registered counsellors and psychotherapists level three and four have the skills and proficiency in meeting all reporting requirements of the regulations for the provision of the Medicare Benefits Schedule focussed psychological strategies as outlined in the Australian Government Health Insurance (General Medical Services Table), Regulations 2017. (Armstrong, Jones, p 9)

- Q. What restrictions exist on the scope of practice for different professions, such as GPs, nurses, clinical versus other psychologists, and social workers? Are these restrictions unwarranted and, if so, how could they be addressed and what would be some of the costs and benefits? (Productivity Commission, 2019, p16)

In 2016 the Australian Counselling Association developed and endorsed The Scope of Practice for Registered Counsellors, which defines a consistent and proficient use of evidence based counselling interventions to support the consumer and integrate registered counsellors and psychotherapists as practitioners into the health system as reflected in the National Standards for Mental Health Services 2010 (Armstrong, 2016). The Scope of Practice defines registered counsellors' boundaries of practice and provides a clear framework which informs professionals and patients of the services provided. (Armstrong, Jones, p 11)

- Q. What mental health supports earlier in life are most effective in reducing contact with the justice system? (Productivity Commission, 2019, p24)

Concerns about the high rate of adolescent mental health and the exclusive use of traditional psycho-pharmaceuticals such as Quetiapine as a treatment protocol for mental health issues; such as suicide ideation and youth morbidity and depression have not addressed the significant burden placed on the public health system (Cohen et al., 2008). The treatment of mental health issues within adolescent, and youth populations have significant difficulties such as resistance to; and compliance with, treatment protocols (Flament et al., 2001). Additional factors that need to be considered include patient history (Cromer, Tarnowski, 1989) and poor parenting (Bender et al., 1998), which may be addressed using focused counselling interventions (Huibers et al., 2013). (Armstrong, Jones, p 16)

Across populations, counselling therapies would be considered more effective (Cohen et al., 2008) for the treatment of depression than the use of traditional psycho-pharmaceuticals identified as Quetiapine for the long-term rehabilitation, recovery, and remission of the depression. Counselling therapies allow the clinician and patient to establish the therapeutic alliance (Cohen et al., 2008) which provides an essential opportunity for the patient to identify maladaptive practices and make a strategic adjustment to their cognitive processes. These adaptive changes can be measured with standard tests such as the Depression Anxiety Stress Scales-Short Version (DASS-21) which has been identified as a reliable measure for depression in adolescents (Shaw et al., 2017). The link between the use of Quetiapine for the treatment of depression and its effects on behavioural regulation (Nantel-Vivier et al., 2011) is less clear and need further investigation. Because traditional psycho-pharmaceuticals such as Quetiapine can induce disturbances in patients with complex serotonergic functioning, several psychopathological factors need to be considered, including; any structural changes in the patient's brain (Kjosavik, et al., 2017), the age and gender of the patient, and identifying any environmental risk factors which would mitigate the patients distress. (Armstrong, Jones, p 17)

CBT has also been shown to be useful for anxiety disorders such as generalised anxiety disorder (NCCMH, 2011) and obsessive-compulsive disorder (NCCMH, 2006). However, the delivery and uptake of these well-established treatments are often suboptimal, with the majority of sufferers receiving no treatment (Bower & Gilbody, 2005). Poor uptake of care is associated with many issues including; difficulties in accessing care, reduced efficiency of care, and a limited number of allied health professional trained in evidence-based counselling therapies (Bower & Gilbody, 2005). Poor outcomes over the long term are related to greater complexity and severity of presenting problems at the time of referral, failure to complete treatment irrespective of modality, and the amount of interim treatment during the follow-up period (Durham et al., 2005). (Armstrong, Jones, p 17)

Psychological therapy services need to recognise that anxiety disorders tend to follow a chronic course, and that good outcomes with CBT over the short term are no guarantee of good outcomes over the longer term (Durham et al., 2005). It has been shown that clinicians who go beyond the standard treatment protocols of about ten sessions over six-month periods are unlikely to bring about more significant improvement in the patients presenting mental health issues (Durham et al., 2005). (Armstrong, Jones, p 17)

As part of any early intervention trauma must be considered. Trauma can be physical and usually treated by a doctor in a hospital, or it can be psychological coming from frightening or distressing events. This may show up as a difficulty in coping or functioning normally following a particular event or experience. Most people who experience a potentially traumatic event will recover well with the help of family and friends and will not experience any long-term problems. If

people do develop problems, those problems may appear directly after the traumatic event or they may not emerge until much later.

To put it simply, trauma is a very difficult or unpleasant experience that causes someone to have mental or emotional problems usually for a long time. If we cannot fight or flee, we freeze. Endorphins are released to manage pain and the mind dissociates from the body and from the experience. At this point, the trauma has overwhelmed our resources to cope and causes the mind/body/spirit to shut down. Instead of being stored in words and stories, when this trauma happens our memory of the event is stored in the brain in fragmented pieces of images, thoughts, sounds, smells, physical sensation, and with highly charged emotions.

Unfortunately, many survivors of trauma are unable to talk about their experiences adding to their pain, loneliness and creating an environment where they find it difficult to connect with others. The Adverse Childhood Experience questionnaire (ACE) see page 16..and has thrown considerable enlightenment upon the notion of trauma, showing that trauma can occur at a very early age and not just from adulthood. It has statistically proven links between trauma, drug abuse, and also with anti-social behaviour – specifically in relation to domestic violence. Trauma can lead to seemingly involuntary actions that the sufferer may not otherwise wish to do.

Violence occurs both physically and verbally. Often times, anger is masked by fear leading to vulnerable emotions such as abandonment, rejection, exposure, shame, guilt or helplessness. These can well be regarded as triggers to offences and repeat offences. Any main line evidence based treatment that allows the release of traumatic memories can help prevent people from offending and reoffending, falling a fowl of the justice system.

Information box 1

What is 'trauma-focused psychological therapy'?

There are two types of trauma-focused psychological therapy that we know are more effective than other types of psychological treatment for PTSD: trauma-focused cognitive behavioural therapy (CBT) and eye movement desensitization and reprocessing therapy (EMDR).

When used in PTSD, CBT should have two main components:

1. The cognitive component of therapy should aim to help individuals identify, challenge and modify distorted thoughts
2. The behavioural aspect of therapy should utilise prolonged imaginal and in vivo exposure to confront their memory of the trauma-related events in a gradual and supported manner.

In practice, a course of trauma-focused CBT for PTSD will usually involve the patient being led through a series of exercises in which the traumatic event and its aftermath are imagined and described, with particular focus on the level of negative emotion and arousal generated. As with all CBT, homework assignments allow progress to continue outside of regular session times. Special consideration should always be given to patient safety in the context of imaginal exposure to traumatic events and care taken to ensure that the patient is fully recovered from the experience before leaving the safety of the consulting room.

Eye movement desensitisation and reprocessing (EMDR) is a specific form of treatment for PTSD. During EMDR therapy a patient is asked to repeatedly focus on trauma-related thoughts, experiences and memories while following the movement of a therapist's finger across their field of vision. It is proposed that this dual attention facilitates the appropriate processing of the traumatic event. EMDR therapy has evolved over time and now includes many components that would be considered core aspects of trauma-focused CBT.

Many counsellors or therapists may offer emergency service workers other types of therapy, such as supportive counselling, relaxation therapy or 'tapping therapy'. These may have some temporary benefits, but we know they are not as effective as the two types of trauma-focused psychological therapy described above and they should not be used as an alternative to these evidence-based approaches.

While you were growing up, during your first 18 years of life:			
1	Did a parent or other adult in the household often ... Swear at you, insult you, put you down, or humiliate you? OR Act in a way that made you afraid that you might be physically hurt?	Yes/No If Yes enter 1	
2	Did a parent or other adult in the household often ... Push, grab, slap, or throw something at you? OR Ever hit you so hard that you had marks or were injured?	Yes/No If Yes enter 1	
3	Did an adult or person at least 5 years older than you ever ... Touch or fondle you or have you touch their body in a sexual way? OR Try to or actually have oral, anal, or vaginal sex with you?	Yes/No If Yes enter 1	
4	Did you often feel that... No one in your family loved you or thought you were important or special? OR Your family didn't look out for each other, feel close to each other, or support each other?	Yes/No If Yes enter 1	
5	Did you often feel that... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? OR Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes/No If Yes enter 1	
6	Were your parents ever separated or divorced?	Yes/No If Yes enter 1	
7	Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? OR Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? OR Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?	Yes/No If Yes enter 1	
8	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes/No If Yes enter 1	
9	Was a household member depressed or mentally ill or did a household member attempt suicide?	Yes/No If Yes enter 1	
10	Did a household member go to prison?	Yes/No If Yes enter 1	
Now add up your "Yes" answers: _____ This is your ACE Score			

- Q. Do teachers and other staff in schools and education facilities receive sufficient training on student mental health? Do they receive sufficient support and advice, including on the quality and suitability of different approaches, to adequately support students with mental ill-health? (Productivity Commission, 2019, p26)

Teacher and School Engagement School engagement suicide and self-harm prevention programs

The Teacher and School Engagement Program is designed to engage teachers and administration staff, parents, or community members in the program's objectives and suicide prevention efforts.

The Teacher and Community Engagement Program prepare school administration to plan and implement the Suicide and Self-Harm Prevention through Social and Emotional Well-being program. The program will assist staff to build confidence in their ability to talk to youth about depression and suicide. Participants also learn how to engage and talk to others in their community including school staff, parents and community elders about the signs of depression and suicide. Additionally, the program will assist staff to discuss how and what to do if they are concerned about a student.

The goals of the Teacher and Community Engagement Program are to:

- Ensure program fidelity by sharing best practices in program delivery, discussing lesson learned, and making recommendations
- Responsive to community needs and locally available resources
- Ensure the program objectives are sustainability attained with the buy-in from all staff
- Engage all parts of the school community in suicide prevention efforts by providing complimentary education to students, parents, and school staff
- Bridge communication between schools, parents, students and the wider community

The Teacher and Community Engagement Program will be delivered over two days, disseminate relevant information about the overarching Program implementation and to advocate for suicide prevention programming for all youth.

An example of this is the Brisbane Bayside College which has an Aboriginal dance troupe that 'Learn and display the dances of the Quandamooka people. The Indigenous students perform in Community and school performances, with the inclusion of non-indigenous students at school events held within the Brisbane Bayside College grounds. These events help to address student issues of Suicide and Self-Harm Prevention through Social and Emotional Well-being activities which support students' self-esteem and confidence. Local community organisations and businesses provide financial assistance to support the student performances at National Aboriginal and Islanders Day Observance Committee (NAIDOC) week events. Additional revenue generated from student performances supports the indigenous children attend and perform at special occasions such as the Bangara Dance Theatre, and also have donations from major companies and are taught obligations to their sponsors and dance for the sponsors NAIDOC staff celebrations (<https://www.bangarra.com.au>) performances at Queensland Performing Arts Centre. Students make their own costumes and take on the responsibility of conducting Acknowledgment of Country at school events.

Some private schools have an Elder-in-Residence for their Aboriginal students so the young people can sit and talk to her at any time they need to. This is particularly successful at boarding schools when young ones are away from home and family for some time.

Mentally healthy workplaces

- Q. What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers, and the wider community; and what evidence exists to support your views? (Productivity Commission, 2019, p30)

Both employer and employee experience uncertainty in today's world, with a remarkable change in the workplace culture brought on by Globalization technology and interconnectivity.

Changing the environment and especially the uncertainties lead to workplace stress, affecting an employee's work performance through lowered productivity, increased absenteeism, conflict with co-workers' and presenteeism. Almost all of the costs borne by employers are due to people with mental ill health being absent from work (absenteeism) or having lower productivity when at work (presenteeism). PWC (2014) estimated that absenteeism cost Australian employers \$4.7 billion annually and presenteeism by \$6.1 billion. Solutions to present and persisting mental health issues; Focusing on educating executive leadership, line management and other staff on the benefits of a mentally healthy workforce should focus on identifying and supporting people and employees before mental health issues become acute.

Improved mental health can generate a net financial return for the employer (for workplace initiatives, with the financial return being greater profitability from a more productive workforce. 2017 Australian statistics from several peak organisations including the Workplace Mental Health Institute state:

- Work days lost annually due to workplace stress: 3.2 days per employee
- Annual cost due to stress-related workers' compensation: > \$10 billion each year
- Annual cost to Australian businesses due to not providing early intervention or treatment for employees: \$6.5 billion
- Employee annual turnover directly related to poor mental health support in the workplace: males 44% and females 52%
- Approx. 13,500 workers engage in non-fatal suicidal behaviour each year, approx. 2300 resulting in full incapacity and 11,000 requiring a short absence from work.
- Mental health has been found to affect job involvement, job satisfaction, loyalty, performance, absence, turnover, and physical health.
- Mental health conditions cost Australian workplaces \$4.7 billion in absenteeism, \$6.1 billion in presenteeism and \$145.9 million in compensation claims (PWC).

The benefits of a mentally healthy workforce are numerous, with activities such as identifying wellbeing and building resilience, all essential skills required to support to employees experiencing symptoms mental ill-health and helping them to re-engage work and mitigate presenteeism.

Many workplaces especially smaller ones cannot afford Employee Assistant Programs. EAP counselling has proven to be very useful in delivering quality mental health early interventions reducing the risk of issues escalating into crisis, mental illness, and suicide. Millions of dollars are saved through reduced absenteeism and mistake driven work practice. Many registered counsellors and psychotherapists have experienced workplace practitioners and by establishing a funding stream that workplaces can access such services from these practitioners, would create many more mentally healthy workplaces. The Hunter is already rich in having a significant number of such practitioners. Previous research has shown that EAP counselling client satisfaction is generally around 95% (Phillips, 2004; Attridge, 2003) and measured improvements in employee absenteeism, productivity and identified a positive impact on workers compensation costs (Kirk, 2006; McLeod & McLeod, 2001). <http://www.davcorp.com.au/wpdata/files/23.pdf>

Framework to enhance mental health and improve participation and workforce contribution Funding arrangements

- Q. What have been the drivers of the growth in mental health expenditure in Australia? Are these same forces likely to continue driving expenditure growth in the future? What new drivers are likely to emerge in the future? (Productivity Commission, 2019, p36)

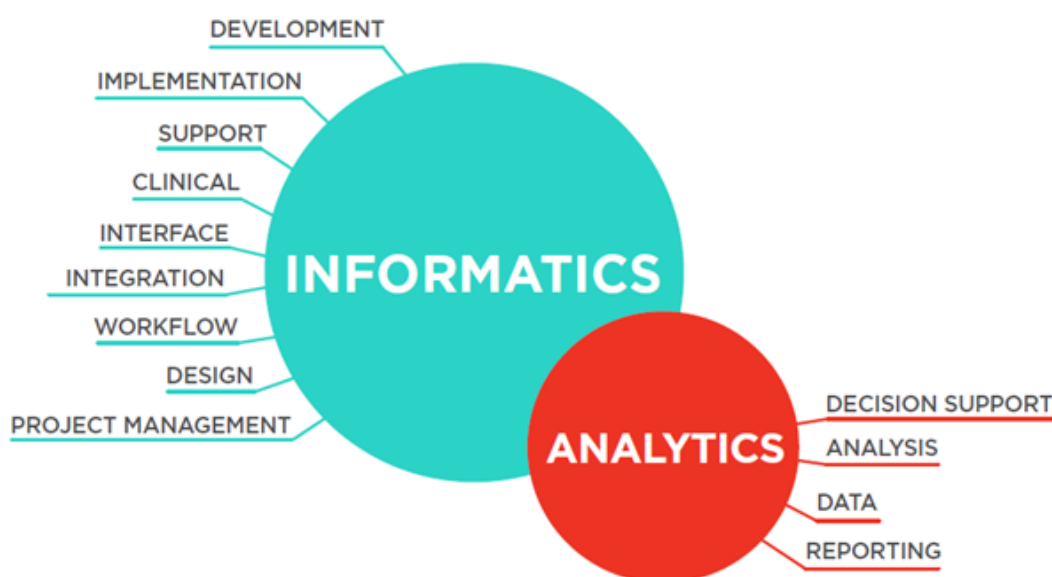
A national framework for recovery-oriented mental health services: Policy and theory (2013), developed by the Australian Health Ministers' Advisory Council has identified several factors that are to inform evidence-based practice. These include, patients lived experience, including greater control over their treatment and person-centred care, and the incorporation of recovery approaches into practitioner and organisational care. Unfortunately at present there are no methodological frameworks in practice in Australia that effectively integrate person centred practices into models of data which effectively embrace person centred practices and produce meaningful data which is matched to current policy outcomes.

An editorial appearing in the Australian and New Zealand Journal of Psychiatry (Jorm, 2011) noted the estimated forward expenditure for the Better Access initiative had tripled over the four-year period and was significantly greater than projected AU \$ 538 million (Allen & Jackson 2011).

The collection and evaluation of evidence-based interventions provided for under the Better Access initiative has to be considered. Currently under the Better Access initiative General Practitioners are unable to evaluate the treatment efficacy and fidelity of the focussed psychological strategies based on current reporting practices. Consumer satisfaction plays a major role in the reporting process, with many patients attribute their improvement to the treatment they have received, with little evidence that the treatment program was effective in addressing the referring issue.

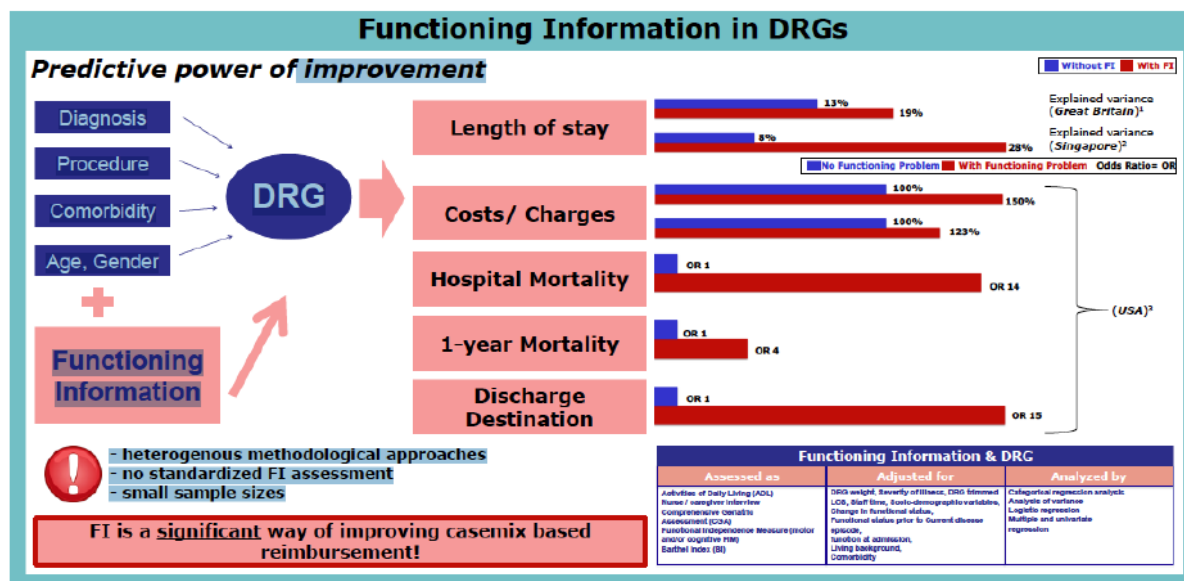
Strategic policy intent is supported by the analysis of information into meaningful outcomes for the consumer, the service provider, and the wider health system. The difference between an output and outcomes illustrates this point in fact. Below is an info-graphic that demonstrates the difference between informatics and analytics;

Diagram 1, Informatics vs Analytics



As an example, the number of services provided to consumers (episodes of care) does not indicate whether the consumer has recovered, been rehabilitated or is experiencing a relapse or remission of their pathological symptoms. International trends towards people-centred, integrative care and support require any measurement of functioning and disability to meet multiple aims. It has long been an ideal to relate the measure of value more to patient outcome than output. Casemix models for funding activity in health care and assessing performance depend on data based on uniformity of resource utilisation. A problem frequently expressed by clinicians is that measures of activity such as Functional Independence Measure (FIM) and Barthel Index scores may not sufficiently represent the aspirations of patients in many care programs.

An Integrative Measure of Functioning (IMF) delivers a person-centred, policy-relevant information for a range of programs, promoting harmonised language and measurement and supporting international trends in human services and public health.



(Hopfe et al. 2011).

Current data collection practices of outcome measures and consumer self-reporting provide opportunities for bias towards overestimating the therapeutic benefits of current practices, and consumers providing a socially appropriate answer based on their perceived evaluation of their episode of care.

For a commonwealth-funded program of such magnitude, the Better Access initiative reliance on self-reporting consumer satisfaction data has been identified as a methodological weakness. The fee for service model that underpins the Better Access initiative allows practitioners to increase their income by charging higher rates by providing the Medicare rebate as well as the consumers' co-payment (Eastley, 2011). Co-payments were intended to be a disincentive for Consumers overuse however have resulted in increased uptake in consumers from socioeconomic advantage backgrounds.

Major methodological weaknesses have been identified within the Better Access initiative including the absence of control or comparison conditions such as control groups, cost-benefit analysis, epidemiological study over time, participants mean regression rates, and outcome measure based on pre and post rate results. Feasible study options that would move towards addressing identified methodological weaknesses include historical (pre-scheme) control samples with baseline measurements prior to treatment (Allen & Jackson, 2011).

As such the lack of methodological data has provided an environment for professional rivalry between mental health disciplines and harmful speculation as to the resultant outcomes of the Better Access initiative. However, the opportunity cost present in addressing identified methodological weakness present in the Better Access initiative will provide a critical step forward in improving systemic, patient and economic outcomes. It has been noted that the self-interest of the “professional groups who are sometimes more interested in protecting their members' access to public funding of their work than they are in making an unbiased evaluation of what might be the best type of mental health system for the Australian community” (Allen & Jackson, 2011).

As an example, an analysis of the Pharmaceutical Benefits Scheme has shown that 70 percent of individuals holding a concession card presenting to GPs receive antipsychotics, with 47 percent of children younger than 15 years of age presenting to a paediatrician receiving antipsychotics (Kjosavik et al., 2017, p 719). GPs initiate and maintain treatment for most adults, with average treatment duration of three years for patients aged under 25 years and four years for those patients between 25-64 years of age (Kjosavik et al., 2017). The prolonged use of these antipsychotics can see patients develop significant side effects including “weight gain, metabolic syndrome and diabetes (Foley and Morley, 2011), brain changes (Fusar-Poli, et al., 2013; Moncrieff and Leo, 2010) and the induction of psychiatric symptoms in patients who are not psychotic (Artaloytia, et al., 2006; Veselinovic, et al., 2011). (Armstrong, Jones, p 16)

An identified area of improvement to mental health outcomes is in the use of factor analysis to support the mental health outcomes. A number of scholarly journals now incorporate findings of clinical significance in their reporting of results, which are used to underpin and support research methodologies and clinical outcomes of evidence based mental health programs (Watson, et al., 2016).

Widely accepted and frequently used approaches toward assessing statistical inference such as the Null hypothesis significance testing (NHST) are used in modern IT Health machine learning are based on quantitative research developed within the financial sector (Thompson, 2002, 2006) and are often criticized for utilising flawed and erroneous methods of determining a statistical event (Cohen, 1990, 1994; Lockett, McWilliams, & Van Fleet, 2014; Norris, 2015).

The greatest criticism of the NHST that it relies on the assumption that the null hypothesis were true where the data indicates this as being extreme or greater and assuming statistical significance being synonymous with practical significance (Watson, et al., 2016).

Essentially, statistical methodology currently utilised in machine learning identify differences in outcome without explaining the noteworthiness of this information; such as magnitude, or how these results relates to improved mental health outcomes.

As such researchers have increasingly turned to alternative indicators of statistical significance, such as effect size (ES) metrics and confidence intervals (CIs) in their research articles (American Psychological Association [APA], 2010; Thompson, 2007). With limited resources and increased public scrutiny evidence-based mental health practices, activities and programs need to be encapsulated into every program. Research supported by factor analysis is essential to the effective delivery of outcome-based activities (Mvududu and Sink, 2013).

Mental health practitioners find themselves either reading a consumer's psychological test results or administering instruments to assess aspects of the consumer's mental health, personality, or psychosocial functioning.

The annexed literature discusses the general uses and major characteristics of factor analysis and how they are directly applied to the development of a mental health related instrument (Mvududu and Sink, 2013). Exploratory factor analysis (EFA) can be used in evidence based mental health programs to understand sophisticated correlational method to locate regularity and trends in a large data set. Confirmatory factor analysis (CFA) allows the researcher to draw causal inferences from information about relationship among variables and factors.

Researchers conducting outcomes-based research within the mental health space can better speak to the practical significance of their findings and help bridge the gap in outcome deliverables between mental health practitioners and program objectives.

- Q. Can you provide specific examples of sub-optimal policy outcomes that result from any problems with existing funding arrangements? (Productivity Commission, 2019, p36)

Mandatory outcome measures could be measured using standardised assessment tools. Data collection would be a requirement for all practitioners providing Primary Care Counselling services. Direct feedback from clients is one of the most informative and accurate ways to measure the effectiveness of the services being provided. There would be requirements for the practitioners to report data collection results to Medicare, enabling administrators the ability to measure the effectiveness of the program over time. However, if mandatory data collection is required, the schedule fee may need to be slightly higher to compensate for the additional work to be undertaken.

Currently, under the Better Access initiative, GPs are unable to evaluate the treatment efficacy and fidelity of the focussed psychological strategies based on current reporting practices (Allen & Jackson 2011). (Armstrong, Jones, p 18)

Evaluative methods which rely on consumer satisfaction play a major role in the reporting process; many patients attribute their improvement to the treatment they have received, with little evidence that the treatment program was effective in addressing the referring issue. Current data collection practices of outcome measures and consumer self-reporting provide opportunities for bias towards overestimating the therapeutic benefits of current practices, with patients providing a socially appropriate answer based on their perceived evaluation of their episode of care (Allen & Jackson 2011, p 698). For a Commonwealth funded program of such magnitude, the Better Access initiative reliance on self-reporting consumer satisfaction data has been identified as a methodological weakness (Allen & Jackson 2011, p 698). (Armstrong, Jones, p 18)

Evidence-based practice is increasingly being adopted as a fundamental principle in mental health care, with the implementation of evidence-based counselling therapies essential to the mental health reform agenda introduced in the 2014 NMHC report Contributing lives, thriving communities. The primary aim of evidence-based practice is to support policy decision makers, clinicians and patients identify and access focused psychological strategies that are matched to outcomes, such as within a stepped care model. Evidence-based practice is a set of strategies designed to harness the basic science of clinical practice and allow the dissemination of reliable and repeatable best practice outcomes within the operational environment and the wider community. (Armstrong, Jones, p 24)

Evidence-based practice integrates and facilitates clinicians' continuous quality improvements and lifelong learning objectives, that include routine information around recent developments in best practice and outcome effectiveness (Rowland et al., 2000). Clinicians, policy makers, and health system administrators should all be involved in critically appraising evidence-based outcomes, where reflective practices can help to demystify the aim and objectives of the evidence-based practice and place it in context to service delivery while meeting the wider health systems intent. (Armstrong, Jones, p 29)

Additional major methodological weaknesses which have been identified within the Better Access initiative including the absence of control or comparison conditions, such as; control groups, cost-benefit analysis, epidemiological study over time, participants mean regression rates and outcome measure based on pre and post rate results (Allen & Jackson 2011). Feasible study options that would move towards addressing these identified methodological weaknesses include historical (pre-scheme) control samples with baseline measurements before treatment (Allen & Jackson 2011, p 698). (Armstrong, Jones, p 18)

Historically, disregarding evidence-based practice and outcomes from a mental health system level has resulted in practices that have largely ignored economic issues, and rather focused exclusively on ideological issues. Practitioners, service managers and commissioning bodies have focused excessively on such issues as reducing risk regardless of opportunity costs; where the optimal reduction in cost exceeds the benefits in terms of reduced risks for patients, which has, in turn, encouraged inefficiencies and unethical use of resources. Practitioners have been ignorant of the evidence-based practices have regarded client welfare above economic and performance considerations, which does not facilitate improvement, and inadvertently places resource constraints on the target population (Rowland et al., 2000). (Armstrong, Jones, p 24)

The practice of evidence-based health care; and the research methods that underpin registered counsellors and psychotherapists practice effectively support policy decisions inform service provision guide professional practice and research, and support client outcomes (Rowland et al., 2000). Registered counsellors and psychotherapists can operate effectively within an evidence-based framework with a variety of focused psychological strategies, with their evidence-based therapies used to inform the purchase, provision, and practice of health care in Australia. (Armstrong, Jones, p 24)

Evidence-based practice needs to operate within a framework that acknowledges finite resources; while meeting the ever-increasing demands placed on the health system, where treatment will benefit certain individuals more than others. Therefore, it is essential to deliver various evidence-based counselling practices that are supported by clinical guidelines that also address the needs of the wider health system. This approach to health system management is desirable, ensuring that appropriate decision-making tools and support are available to clinicians, policymakers, and health system administrators alike. (Armstrong, Jones, p 27)

The lack of methodological data based on evidence-based interventions has provided an environment for professional rivalry between mental health disciplines. This rivalry has fuelled harmful speculation from commentators as to the lack of patient, systemic, and economic outcomes currently achieved by the Better Access Initiative (Allen & Jackson 2011, p 696). However, the opportunity cost in addressing these identified methodological weakness present within the Better Access Initiative will provide a critical step forward in improving patient, systemic, and economic outcomes. It has been noted that the self-interest of the "professional groups, who are sometimes more interested in protecting their members' access to public funding of their profession, than they are in making an unbiased evaluation of what might be the best type of mental health system for the Australian community" (Allen & Jackson 2011, p 698). (Armstrong, Jones, p 18)

Additionally, the existing stepped care literature within the Australian context was limited by a range of shortcomings, such as; the heterogeneity of stepped care interventions tested, the failure to compare stepped care to matched care or other high-intensity interventions, and lack of data about cost-effectiveness (Affairs, 2016). Evidence suggested that stepped care interventions for depression are at least as effective as usual care. However, the clinical and organisational superiority of stepped care is yet to be scientifically verified. The clinical implications of stepped care system designs appear to be effective for treating anxiety and depression, although the specific active components are currently unclear; however, the differential benefits of stepped care may ultimately depend on service quality (Firth et al. 2015). In conclusion, evidence suggested that stepped care systems were at least as effective as usual care systems in a range of contexts and with varying populations. (Armstrong, Jones, p 18)

- Q. How could funding arrangements be reformed to incentivise service providers better to deliver good outcomes, and facilitate coordination between government agencies and across tiers of government? (Productivity Commission, 2019, p36)

We believe that there are significant systemic issues present within the market and regulated spaces for the provision of mental health services, with a diverse range of issues which contrast between urban, regional, rural and remote Australia. Rather than targeting specific issues we outline an objective approach below to investigating the issue regarding resourcing mental health services, which should be incorporated into the Mental Health Needs Assessment of the Primary Health Network commissioning bodies.

Analysis of the current Market

Markets operate through a decentralised decision-making approach and promote freedom of individual choice and a venue for people to develop a sense of efficacy. Markets reduce the need for centralised coordination and free up the capacity of government to manage harder social challenges which are not solved through the aggregation of the private sector actions. Governments often get involved in the centralised allocation of resources where the decentralised market fails to adequately deliver those resources adequately.

Markets always rely upon the government and legislation to determine the underlying rules within the market space. This section will consider the comparative merits of a market versus governmental approach to the resource allocation process. Should the market be left to decentralised actors driven by private motives, or should it be augmented; or even supplanted, by government decision making processes motivated to produce good collective public outcomes? (Mintrom, 2012, p 120)

Government embodies the powers which allow them to make allocation decisions, to direct those decisions be implemented, and to see that those outcomes occur. (Mintrom, 2012, p 120) Government decision making about centralised resource allocations within a localise jurisdiction on behalf of citizens and responds to their identified needs. (Mintrom, 2012, p 120) Government decisions are publicly available.

In contrast to the government, markets allow for a decentralised approach to resource allocation. (Mintrom, 2012, p 121) The decisions are private and are made by individuals and corporations, without the expectation that others will be consulted (such as GPs) before choices are made. (Mintrom, 2012, p 1200)

Markets are driven by individual consumer choice and are characterised by the demands of the consumer and supply of the service provider, where coordination and adjustment are achieved through price signalling mechanisms. (Mintrom, 2012, p 120) Markets facilitate coordination of resource allocation without coercion. (Friedman, 2009)

Discussion on how and when markets are the best choice in response to resource allocation is derived from comparative statistical equilibrium analysis; which is the aggregation of individual demand curves and the derivation of the market supply curve and identifying the market equilibrium. When markets can respond accordingly, it can support coordinated decentralised resource allocation. (Mintrom, 2012, p 120) A clear understanding of complex issues starts with simplification and focus. (Krugman, 1993) It is essential to identify and define the conditions which allow the markets to work well and when markets are the most appropriate mechanism for resource allocation. (Mintrom, 2012, p 120) For example, it is inappropriate and cannot be expected that markets can adequately address issues of the poor and effectively meet their needs without government intervention.

Issues identified within the market analysis will contribute to the discussion on market failure and will identify where government allocation of resources is preferable to the reliance upon markets as an allocation device and identify government policy actions to improve the performance of resource allocation. (Mintrom, 2012, p 121)

By considering possible causes of observed increases in pricing and participation we can start to determine whether government action is necessary and to what kind of action is appropriate.

Analysis of the Market Failure

When markets operate as expected, they are highly effective institutions for the allocation of resources in society. Sometimes markets do not operate as expected; either by responding to challenges in the environment or adequately meet the needs of the consumer, caused by a violation of a critical market assumption resulting in economic inefficiencies. Market failures can provide critical insight into public policy problems and government failures. Often governments take corrective public policy actions within a centralised public-sector approach, to correct identified market failures within the decentralised private sector. Common forms of market failure can serve as a rationale for government action. Markets are an integral institution within society, and their operations and outcomes have implications for most other social and economic activities.

Mental health is an example of a negative externality, where poor outcomes for the individual have flow-on effects not just for those in their immediate environment, but flow on to affect more comprehensive social and economic outcomes.

Policy instruments need to be regulated and tightened to address negative incentives such as the failure to regulate out of pocket expenses for service, as this distorts the marginal cost of the service provision and effectively allows for additional pricing pressure to be borne by both the consumer and the subsidiser. (Mintrom, 2012, p 163) In the interest of the public good, the development of policy instruments which address negative incentives move the focus from compliance with prescribed procedures and towards the attainment of the desired social outcomes and serve to persuade individuals to embrace a service or behaviour without subjecting them to strong incentives. An example of behavioural issues which can be addressed includes individuals' actions; motivated by self-interest, which produce collectively undesirable outcomes, such as over-consumption or over prescription of a service. (Mintrom, 2012, p 167)

Traditionally, services such as health have been provided as a pure public good, a service which does not exclude or provide an environment for competition. (Mintrom, 2012, p 171) Resource limitations, including the provision of limited public services designated in the interest of pure public good, create a situation where the service is resources as a shared pool. Common pool resourcing identifies a limited allotment of services; each one that is consumed reduces the amount left for others. Effectively, the health system has shifted from a resource intended for the pure public good to a shared pool resource.

There is increased social gain using services and a justification for public funding to support these activities. An efficient policy instrument would identify the set of consumers needing incentivising to undertake the activities which generate positive outcomes.

Government subsidisation; accompanied by regulation, supports individuals to engage in services which deliver identified positive outcomes which are not achieved through the market approach. (Mintrom, 2012, p 163) It is wasteful to incentivise payments for a people to undertake activities which they would undertake of their own accord, and where a market approach has met the identified outcome. (Mintrom, 2012, p 161) Governments sometimes seek to reduce social coordination problems that would otherwise hinder the provision of a service through information provision and social marketing campaigns, which can effect change consumer behaviours and can be undertaken in conjunction to subsidisation or as a stand-alone action. (Mintrom, 2012, p 163)

Analysis of the Government Failure

Markets rely on government and government rely on markets. Institutional structures such as governments and markets promote and support social stability. Markets allow consumers to pursue and resolve their interests in a private, decentralised manner, while governments' resolve coordination problems, ensuring everyone's pursuit of self-interest contributes to good collective outcomes. When discussing government failures, it is essential to stay away from arguments which identify and blame actors or the market; instead, focus on the full range of costs and benefits associated with other institutional arrangements.

The argument for the government to act in a market is when the markets are unable to realise acceptable social outcomes. However, sometimes government actions and public policies can have dynamic effects with unforeseen consequences', which generate adverse effects.

When governments' act; either with regulations, direct service provision or with a social safety net, their actions have transformative effects on both society and the economy. However, there are incidents where government intervention and action, while initially considered beneficial and desirable, produces unexpected results that are worse than the results achieved by the perceived failing market. Often market responses and government intervention are unable to affect the desired outcome and can only be measured in degrees of failure. However, a full solution can be explored and identified by initially considering the problem being addressed within the market by private, decentralised decision makers, and exploring the relationships between decentralised private and centralised public actors. From this perspective, we can identify institutional and societal arrangements that can be designed to meet the allocation of resources better and meet desired outcomes. Where it is unrealistic to rely on resource allocation through the market, government failure is addressed through the redesigning of the current service provision rather than an elimination of a government function.

Addressing government failures focus on achieving the best resource allocation, identifying what combination of government and market response provides the best economical and efficient outcome, with human dignity and equity for the consumer and service provider. When identifying solutions, it is always preferential to identify international evidence of effective and efficient government policies which address similar government failures.

Opportunities for government failure

Provider capture

Regulation of industries within the health profession are taken to protect consumers from harm, and takes on the form of registration with a authority, and takes the form of submitting appropriate and industry relevant qualifications. A market failure occurs where members of a regulated profession exercise their political power to influence the content of those professions and how they are enforced. Inadvertently, the regulations serve as a gatekeeper function, limiting the number of service providers and, driving up the wages for the regulated professions above those levels that would be reasonably be expected in the absence of such regulations.

Perverse incentives

Public policies need to be designed to encourage appropriate alignment between policy goals and individual actions. Sometimes the introduction of public policy results in the introduction of perverse incentives for the relevant actors. Sometimes the presence of government assistance can drive self-interested individuals to direct their efforts towards securing continued receipt of a benefit instead of redirecting their behaviour towards a positive outcome.

Goal Displacement

Goal displacement creates an organisational environment lead by a narrow view of their activities, devoting a majority of their energies towards the measurement of goals rather than resource allocation and the needs of the consumer. Bendor and Miller (1992) address the issue of goal displacement with government policy design which balances the use of broad normative cultural practices such as “this is the way we do things here” with the use of formal, individualised incentives which promote achievement of outcomes and service delivery.

Institutional Inertia

Inadvertently, government actions provide uniform practices which gravitate towards the statuesque, often eliminate incentives for innovation, service delivery and system improvements which are associated with a functioning market process. (Friedman & Friedman, 1962) When organisations are rewarded for goal related practices, they will only be motivated to move once their governing regulations have changed. Incentive-based regulations motivate organisations to provide innovative solutions to resource allocation problems. Another form of inertia can be found through homogenisation of practices and service delivery models, which often result in resistance from administration and practitioners to change, demonising new or different approaches and practices which responsively adapt emerging trends and social changes.

Institutional inertia is most prevalent where there are ongoing programs in specific areas, such as mental health. Implementing change within these conditions is challenging and is often hindered by instructional inertia. Individuals and those operating in organisations become habituated to specific norms which they identify with and which meet their self-interests; any change is a result of incrementalism from these norms is met with resistance. The creation of the market like systems for the allocation and management of resources can assist in addressing these issues.

- Q. Are the current arrangements for commissioning and funding mental health services — such as through government departments, PHNs or non-government bodies — delivering the best outcomes for consumers? If not, how can they be improved? (Armstrong, Jones, page 36)

Given the slow process of reaching agreement on a new classification for mental health services and the expected cessation of national activity-based funding from 2017/18 onwards, many current mental health services are left in confusion and disarray with existing initiatives unable to respond to these recommendations. In theory, the Review of Mental Health Services that is being undertaken through the National Mental Health Commission for the Australian Government is meant to focus on the efficiency and effectiveness of existing mental health services. However, the Australian Government's interest in efficiency is mainly focused on reducing overlap and duplication between the federal and the state governments (Duckett and Willcox, 2015). (Armstrong, Jones, p 10)

Commissioning for outcomes can help ensure cost-effective, high-quality service provision. Routine collection of outcomes data is fundamental to the effective delivery of focused psychological strategies. Collection of outcomes data is as essential for patients' service as it is for clinicians' performance, and administration and policy managers are understanding trends and outcomes within the service and the wider community (CSIP, 2008). (Armstrong, Jones, p 31)

- Q. How does the way the Medicare Benefits Scheme operate impact on the delivery of mental health services? What changes might deliver improved mental health outcomes? (Productivity Commission, 2019, p36)

Primary Care Counselling services would be provided by suitably trained and accredited registered mental health counsellors and psychotherapists. It is not appropriate or necessary for more highly qualified (and expensive) health professionals such as psychologists and clinical psychologists to be delivering primary care counselling services. Counsellors and psychotherapists more appropriately deliver these services. Other suitably qualified practitioners such as social workers and occupational therapists would also continue to be included as providers of Primary Care Counselling. Mandatory bulk-billing for services provided by registered counsellors and psychotherapists. This would ensure there is no gap payment for clients making primary care counselling more accessible for all Australians without an increase in costs to Medicare. A lower fee that is bulk billable would ensure there is no repetition of services being centralised in major cities on the east coast and within pockets of high-income areas as has happened with psychologists. Bulk billing would also act as a check and balance in relation to not attracting a glut of therapists into private practice.

Mental Health Plans can impose mental health diagnoses on consumers with detrimental effects:

- Adverse impact on employment opportunities
- Adverse impact on access to insurance
- Stigmatising for the individuals concerned
- Undermining to their recovery.

Should such a model be implemented, early intervention care would require a maximum of 6 one-hour visits to a counsellor or psychotherapist to deliver Focused Psychological Strategies lasting more than 20 minutes, but not more than 50 minutes, attendance at consulting rooms with a Medicare rebate of \$70.65 per session.

- The introduction of this model; with the supporting Medicare Better Access Initiative rebate, would be cost-effective, free up waiting lists and alleviate GPs workloads to focus on their primary business.
- It would also lessen the burden from the arduous and time-intensive administrative task of writing up Mental Health Care Plans for patients suffering from mental health problems as opposed to patients with mental disorders.
- We believe our proposals can deliver approx. extra 412,000 counselling sessions, provide more accessible and affordable services and improve outcomes for consumers.

Section Three - Developing a business case for registered counsellors and psychotherapists

Below is a proposed business case to assist commissioning bodies, health system managers and administrators to develop a viable business case for the delivery of psychological services within their programs. The business case explores issues around Casemix, resource allocation and service delivery which will address bottle necks, the consumer participation rates and program outcomes.

The business case acknowledges that there are existing allied health practitioners delivering psychological services with the program and that services will need adequate resourcing to execute any changes to their practice.

The purpose of developing a business case is to assist:

- a) Commissioners, service providers and members of allied mental health practice team understand the impact of utilising registered counsellors within their service delivery models, and
- b) Services and practice managers develop a business case for implementing registered counsellors and identify any related practice improvements.

Addressing key concerns from mental health service/program providers

The Business Case provides a framework for the service to address two key questions:

1. How will the use of counsellors within a service directly affect my service costs and revenues?
2. What opportunities does the use of counsellors present for our practice to work differently?

Implications of incorporating registered counsellors to service providers income

The Business Case provides a framework for identifying and assessing the implications of service income, when:

- a) The role of a registered counsellor and Psychotherapists is used for the delivery of mental health services; in scope, and, of equivalence to other allied mental health practitioners
- b) Identifying the associated workforce costs of using a registered counsellor within a practice, and
- c) Considering options for the existing mental health service/program providers to work in different ways that improve health services and the financial position and sustainability of the mental health service/program.

Identified Mental Health Needs Assessment

Draw upon PHN Mental Health Needs Assessments to identify;

- Epidemiology
- Access/utilisation
- Future demand
- Current capacity

Identified costs to the broader health system

Identify current costs to the service/program and the local mental health / wider health system, including defining the;

- Workforce costs
- Time and costs saved by the use of counsellors, releasing other practitioners to fulfil their roles.

Utilising registered counsellors and psychotherapist as a workforce

Identify how the utilisation of a counselling workforce (new arrangements) would support the more comprehensive health system;

- Shortage of workforce
- Exceptionally long waiting times for services
- The cost to the community
 - Economic
 - Social
 - Workforce participation
- The cost to the individual
 - Social
 - Family
 - Health
 - Workforce participation
 - Productivity

Support required to amend the existing mental health system to utilise the uptake of registered Counsellors and Psychotherapists

Opportunities to do things differently

Block funding offers several advantages for mental health services/program to utilise registered counsellors. For example, it provides the opportunity for the practice to receive funding for aspects of the Counsellors and Psychotherapists role that have not previously been directly recognised.

Block funding to support the transition towards registered counsellors

Providing block funding would allow mental health services/programs transition to more effectively utilise registered counsellor workforce which is aligned with the needs of the services/programs and local population needs, rather than the current practice of providing services based on the availability of a particular Medicare Benefits Schedule Item Number.

1. Support for all accredited mental health services/programs to employ a registered counsellor instead of, or in addition to, an existing mental health service provider (Such as registered psychologist, mental health social worker, occupational therapist)
2. Support for practices in urban areas where an area of workforce shortage is identified by:
 - a) Medicare, and
 - b) Aboriginal Medical Services and Aboriginal Community Controlled Health Services to employ a registered counsellor and Psychotherapist as an allied health professional (AHP); instead of, or in addition to an existing mental health service provider; and
 - c) Provide a rural loading based on Australian Standard Geographical Classification - Remoteness Areas (ASGC-RA).

ASGC-RA coding	Geographical Classification	Percentage loading
RA 1	Major City	0%
RA 2	Inner Regional	20%
RA 3	Outer Regional	30%
RA 4	Remote	40%
RA 5	Very Remote	50%

Table 1, rural loading to employ a registered counsellor based on Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA).

3. Provide a one-off \$10,500 incentive to support eligible practices to employ a registered counsellor
4. Provide a loading for Aboriginal Medical Services and Aboriginal Community Controlled Health Services to employ a registered counsellor
5. Where a service provider and or program employees' a registered counsellor and Psychotherapists
 - a. Ensure there are grand-parenting arrangements for the first three years of the program

- b. ensure that mental health services/programs are not financially disadvantaged by the restructuring of their service delivery models and programs design.

Note: receive grandparenting and top-up payments at the identified levels, mental health services/programs must maintain their mental health workforce numbers, and the registered counsellor must continue to work at least the same number of hours as are recorded in the relevant quarter of the historical period.

Number of active full-time client outcome sessions undertaken by mental health services/programs	Minimum number of hours per week required for the full incentive payment	Incentive Amount for a Registered Counsellor/ Psychotherapist Level 3 and 4	Incentive Amount for a Registered Counsellor/ Psychotherapist Level 1 and 2
1,000	12 hours 40 minutes	\$25,000	\$12,500
2,000	25 hours 20 minutes	\$50,000	\$25,000
3,000	38 hours	\$75,000	\$37,500
4,000	50 hours 40 minutes	\$100,000	\$50,000
5,000	63 hours 20 minutes	\$125,000	\$62,500

Table 2, service/program incentivising based on client sessions, a minimum number of client contacts per week and Registered Counsellor Level.

Incentivising accredited mental health services/programs to employ a registered counsellor and Psychotherapist will support services and programs to undertake a broad range of mental health activities which are not well funded under the current financing arrangements, including:

- Preventative health programs and education programs
- Quality mental health management and care coordination
- Increase a dedicated and competent mental health workforce
- Supported self-management of registered counsellors' workforce
- Improved quality and safety, and better mental health services/programs and patient risk management.

Impact of using registered Counsellors and Psychotherapists in current mental health service/programs

The below funding model calculates the difference between current practices and incorporating registered counsellors and psychotherapists, understand the impact of current funding arrangements (assuming the mental health services/programs configuration remains unchanged), when; a) roles and associated costs for delivering mental health services stay the same; b) associated costs for delivering mental health services by registered counsellors and Psychotherapists at their corresponding levels of registration.

Item Description & Item Number	MH services stay the same		Registered Counsellor, Psychotherapists	
	Calculation	Income	Calculation	Income
80102 M7 - Focused Psychological Strategies (Counsellor, Psychotherapist), lasting more than 20 minutes, but not more than 50 minutes, Professional attendance at consulting rooms	1,000/year x \$70.65	\$70,650	1,000/year x \$70.65	\$70,650
80107 M7 - Focused Psychological Strategies (Counsellor, Psychotherapist) lasting more than 20 minutes, but not more than 50 minutes, Professional attendance at a place other than consulting rooms.	1,000/year x \$96.15	\$96,150	1,000/year x \$96.15	\$96,150
80112 M7 - Focused Psychological Strategies (Counsellor, Psychotherapist), lasting more than 50 minutes, These Focused Psychological Strategies Services are time limited, being deliverable in up to ten planned sessions in a calendar year, up to seven of which may be provided via video conference.	1,000/year x \$99.75	\$99,750	1,000/year x \$99.75	\$99,750
81300 M11 - Allied Health Services for Indigenous Australians Counsellor - Psychotherapist, Service is of at least 20 minutes duration, Professional attendance at consulting rooms	1,000/year x \$62.25	\$62,250	1,000/year x \$62.25	\$62,250
80122 M7 - Focused Psychological Strategies (Counsellor, Psychotherapist) lasting for at least 60 minutes duration, GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT	1,000/year x \$25.45	\$25,450	1,000/year x \$25.45	\$25,450
TOTAL items		\$354,250		\$354,250

Table 3, estimates the impact of the changes to comparative service/ program income based on practice configuration.

Note: to arrive at the annual number estimating the number of items in an average or typical week and multiplying by 47 weeks (being the average number of weeks a registered counsellor works over 12 months). These figures are annual amounts, and represent the registered counsellor derived component of revenues, and not total mental health services/programs revenues.

What opportunities does the use of registered Counsellors and Psychotherapists present for services/programs to work differently?

The funding of regionally based and registered counsellors and Psychotherapists within mental health services/programs offers several advantages. For example, it provides the opportunity for the mental health services/programs to receive funding for aspects of the mental health service providers that have not previously been directly recognised. This includes but is not limited to:

Improved targeting of low intensity psychological services - Low intensity coaching (New Access)

1. Establish a pool of trained coaches
2. Promote the service in a variety of mediums including: online, GPs, community health centres
3. Monitor and evaluate the effectiveness of the service.
4. And will be complimentary to existing Psychological Therapies Program

Cross sectorial early intervention for children and young people - Youth mental health services

5. Rural Youth Mental Health Service (RYMHS).
6. Grief, Loss and Trauma Interventions for Children and Young People
 - 6.1. Deliver specialised individual and group counselling for children and young people aged 10-18 years of age.
 - 6.2. Provide training and consultancy to local services working with, or in contact with, the target group.
 - 6.3. Provide education and information sessions to schools.

Address gaps in provision of psychological services to rural and remote and hard to reach populations

7. Support people in rural and remote communities who require access to psychological and other allied health supports to manage their mental health.

Suicide prevention

8. Identify and promote appropriate training and support counsellors and psychotherapists for rural GPs to enable them to better manage suicide presentations, including a focus on pre and post-vention.

Aboriginal and Torres Strait Islander service integration

9. Develop a Social and Emotional Well Being counselling and psychotherapy workforce able to respond to mental health service delivery within aboriginal communities

Stepped care approach

10. Counselling and psychotherapy workforce able to respond to services and interventions as they relate to low, medium and high intensity presentation in primary health settings. The Stepped Care model can also be used to articulate service delivery in the secondary and tertiary care environments. This will support the regional mental health plan,

utilising Stepped Care as the single modality for identifying all services and interventions across the whole spectrum of mental health service delivery.

Regional mental health and suicide prevention plan

11. Counselling and psychotherapy workforce able to respond to services and interventions primary health settings as a key initiative in a regional mental health and suicide prevention plan.

Empowering our communities

12. Counselling and psychotherapy workforce with specialist knowledge in relationship and family counselling able to respond to drought specific, low intensity, support service for individuals and families. The service will be able to offer general support but will have an additional focus of providing assistance for those experiencing relationship/family problems; it will be evidenced based and integrated within a stepped care model to more intense clinical Counselling and psychotherapy services where needed.

Taking advantage of opportunities to use registered counsellors

When the mental health services/program changes its configuration; or the services it offers, the revenues and costs of the practice may also change.

When considering the opportunities presented under the funding of registered counsellors, the following overarching questions need to be addressed:

1. What are the opportunities for our service/program to work differently and more effectively?
2. Which changes are the highest priority for our service/program?
3. How will we implement the changes?
4. How will the changes affect our service/program financially?

When utilising registered counsellors within mental health services/programs consider the roles and functions which can be developed, as well as the flow-on opportunities this creates for other team members to improve the effectiveness of their service/programs overall practice. Ideally, the whole of service should be encouraged to identify opportunities through active internal stakeholder engagement, including front line staff, as well as monitoring the patient experience, asking patients for feedback on areas for services/program improvements through feedback surveys and community consultations.

It is essential to consider these impacts to ensure the ongoing sustainability of the mental health services/program and the potential attractiveness of the proposed changes to the commissioning bodies.

Utilising registered counsellors opens opportunities that may not have been considered feasible before, an initial step to identify opportunities would be a brainstorming exercise. This will help to ensure that no possibilities are missed. Follow these rules for effective brainstorming:

- Focus on quantity – generate as many ideas as possible
- Withhold criticism – suspend judgement and provide an environment where participants feel safe making suggestions

- Welcome unusual ideas – encourage the group to look from new perspectives and suspend assumptions
- Combine and improve ideas – extend or add to the ideas suggested by others

Breakdown of proposed practice improvements.

Utilising registered counsellors within a mental health service/program enables the whole practice team to work in different ways, to improve health services as well as the financial position and sustainability of the service/program.

When identifying the proposed practice improvements, consider the following:

1. Identify the potential practice improvement
 - Reduce public waiting lists for treatment
 - Early intervention minimising mental health issues escalating into crisis and mental illness
 - Reduce costs of interventions and providing a grassroots intervention system at the postcode level
2. Objectives/goals
 - Provide a regionally based stepped care process at the postcode level
 - Improve treatment times and collection of evidenced-based data on treatment outcomes
 - Reduce pressure on existing mental health systems by adding to the existing workforce regionally based and registered counsellors and Psychotherapists
3. Description of the proposed new model
 - As described in more detail below, this proposal centres on the concept of improved targeting of low to moderate intensity psychological services where a vast majority of the population sits, in this case, General adult services, including services for older adults. It would commence at Step 3 brief individual therapy for low to low, moderate needs groups
4. Benefits
 - Incorporating counsellors and psychotherapists in the Stepped Care model will produce a more refined graded service continuum for psychological services in regional areas.
5. Assessment of need:
 - 5.1. Epidemiology
 - 5.2. Access/utilisation
 - 5.3. Future demand
 - 5.4. Current capacity
6. Relevant trends in practice and policy – where the sector is heading
7. Alignment to practice strategy, directions, and goals
8. Monitoring and evaluation

Developing a detailed implementation plan for registered counsellors

Drawing from these ideas, a more detailed implementation plan needs can be developed.

High-level implementation plan:

1. Key stages of implementation

2. Implementation tasks at each stage
3. People responsible
4. Indicative time frame

How will the use of registered counsellors and Psychotherapists affect our service/program financially?

Including registered counsellors and Psychotherapists within mental health service/program configurations or the services it offers may also change the revenues and costs of the mental health service/program.

It is essential to consider these impacts to ensure the ongoing sustainability of the mental health service/program and the potential attractiveness of the proposed changes to commissioning bodies.

The business case should detail whether, and how, the proposed service/program changes will affect ongoing revenues – e.g., if the utilisation of registered counsellors frees up GP time, it also reduces patient waiting times and may enable GPs to see other patients, which also generates additional revenues.

Questions to be addressed include;

- Whether, and how, the proposed mental health service/program changes will affect costs
- The net financial impact of the proposed mental health service/program
- Improvement costs and revenues,
- Taking into account any funding changes, such as;
 - Number of bulk billing sessions available, and
 - Any amendments to the Medicare Benefits Schedule Item Numbers.

Impact on mental health service/program costs

Depending on the service/program improvements proposed, there might be an impact on service/program costs, including;

- 1) Any one-off, start-up costs that may be required – e.g.,
 - i) Staff time required for implementing changes;
 - ii) Capital investments such as
 - (a) Amendments to service/program policies, procedure, clinical guidelines and
 - (b) Computer reporting systems
- 2) Ongoing operating costs – the most significant item is likely to be;
 - i) Staff salaries/wages
 - ii) Consumables,
 - iii) Transport,
 - iv) Telecommunications,
 - v) IT support.

Mental health is an all-encompassing term that is akin to the term physical health. Not all aspects of physical health require medical, nursing or current allied health intervention. For example a person who experiences tiredness in the context of alcohol misuse, poor diet and poor exercise may be counselled to alter these aspects of their life. Therefore not all physical health problems are necessarily primary medical problems per se. Common sense and counselling may suffice in these situations. If however, the person continues to experience tiredness they will be counselled to seek medical help.

Likewise not all aspects of mental health require medical, nursing or current allied health intervention. For example a person who experiences a depressed mood in the context of alcohol misuse, poor diet and poor exercise may be counselled to alter these aspects of their life. Therefore not all mental health problems are necessarily primary psychiatric or primary psychological problems per se. As above, common sense and counselling may suffice in these situations. If however, the person continues to experience depression they will be counselled to seek medical help.

Too often and in many areas of Australia the access to primary help is severely limited to just hospital emergency departments and general practices where medical and mental services may be severely limited. Often in these areas people caught in situational crises may need to utilise the social currency of suicidality to access assistance especially in emergency departments that are severely stretched.

The health care counsellor may play the role of the primary health worker. The addressing, acknowledgement and validation of a person's issues may play a major role in the initial therapeutic process. In addition to addressing issues the counsellor may also advocate and assist the person to access other medical, psychiatric and psychological services. In this case the counsellor may be able to address issues that are stigmatised in the community and encourage the person to seek assistance from a GP, for example, to seek psychiatric care or surgical care. Where a counsellor has been trained in certain psychotherapeutic interventions, then they may be utilized, if and only if, the GP (or other specialist) believes this to be an appropriate intervention given the circumstances of health services in that area.

The use of counsellors is not a substitute for appropriate psychiatric assessment and intervention and psychological assessment and intervention, but rather a first line of intervention to have issues addressed, just as counsellors are not a substitute for appropriate neurosurgical, cardiological, oncological, nursing or allied health care assessment and intervention. The counsellors work will be governed by standards of appropriate medical intervention and evidenced based practice through peer reviewed practices subject to strict medical and nursing standards.

An example may suffice. A middle-aged man who is living in a marginalised community in an economic disadvantaged area of Australia has been noted for his alcohol misuse and his contact with the local police services travels to a major city where the alcohol misuse worsens. He refuses to access medical services and has in the past suffered a traumatic admission to an acute psychiatric inpatient unit. A counsellor trained in Aboriginal culture and intervention working in an Indigenous Clinic has been asked to speak to him. The counsellor who is trained in culturally specific interventions is able to draw him into a cultural-specific counselling therapeutic alliance. He notes that the man who has a long history of trauma and depression has a tremor, is unbalanced and is slurring words even when not intoxicated. He also notes a profound loss of weight and jaundice. He encourages and accompanies the man to a GP. They ascertain that he needs medical care. The man will only go to with his counsellor. The diagnoses of alcohol-related neuropathology with an arteriovenous malformation of the brain were uncovered. More disturbingly he is found to have cancer of the pancreas in the context of an alcoholic hepatitis. The cancer of the pancreas manifested with depressive symptoms especially loss of weight as it often does prior to abdominal pain. He had been self-medicating the depression with alcohol. The counsellor stood with this man throughout. Without the counsellor nothing would have been addressed. The counsellor was able to present a culturally bound-health model that was appropriate for this man's culture.

CONCLUSION

Registered counsellors represent a vibrant and competent allied health workforce able to provide relevant and evidenced based focused counselling and primary psychological strategies to meet the current and emerging need of the wider health care system. As a workforce, registered counsellors provide lower out of pocket expenses, which in turn reduces the barriers to client participation and an improved cost saving to the health system. The inclusion of registered counsellors will increase workforce capacity, improve consumer outcomes and choice, and bring an improved scale of economy to the wider health system. Adding counsellors to the Medicare Benefits Schedule items would build workforce capacity and provide proven evidence-based therapies to patients seeking treatment. This submission has demonstrated how registered counsellors meet the needs of the stepped care model for the delivery of focused psychological strategies within:

- The Better Access initiative,
- Commonwealth funded mental health services that provide identifiable benefits to individual patients; and,
- Local Hospital Networks

Registered counsellor training programs have a strong applied focus, including mandatory training in evidence-based therapies such as CBT and solution-focussed therapy. Registered counsellors meet the standard of training, continuing education, supervision and ethical practice equivalent to other registered allied health professional delivering services within the commonwealth health system.

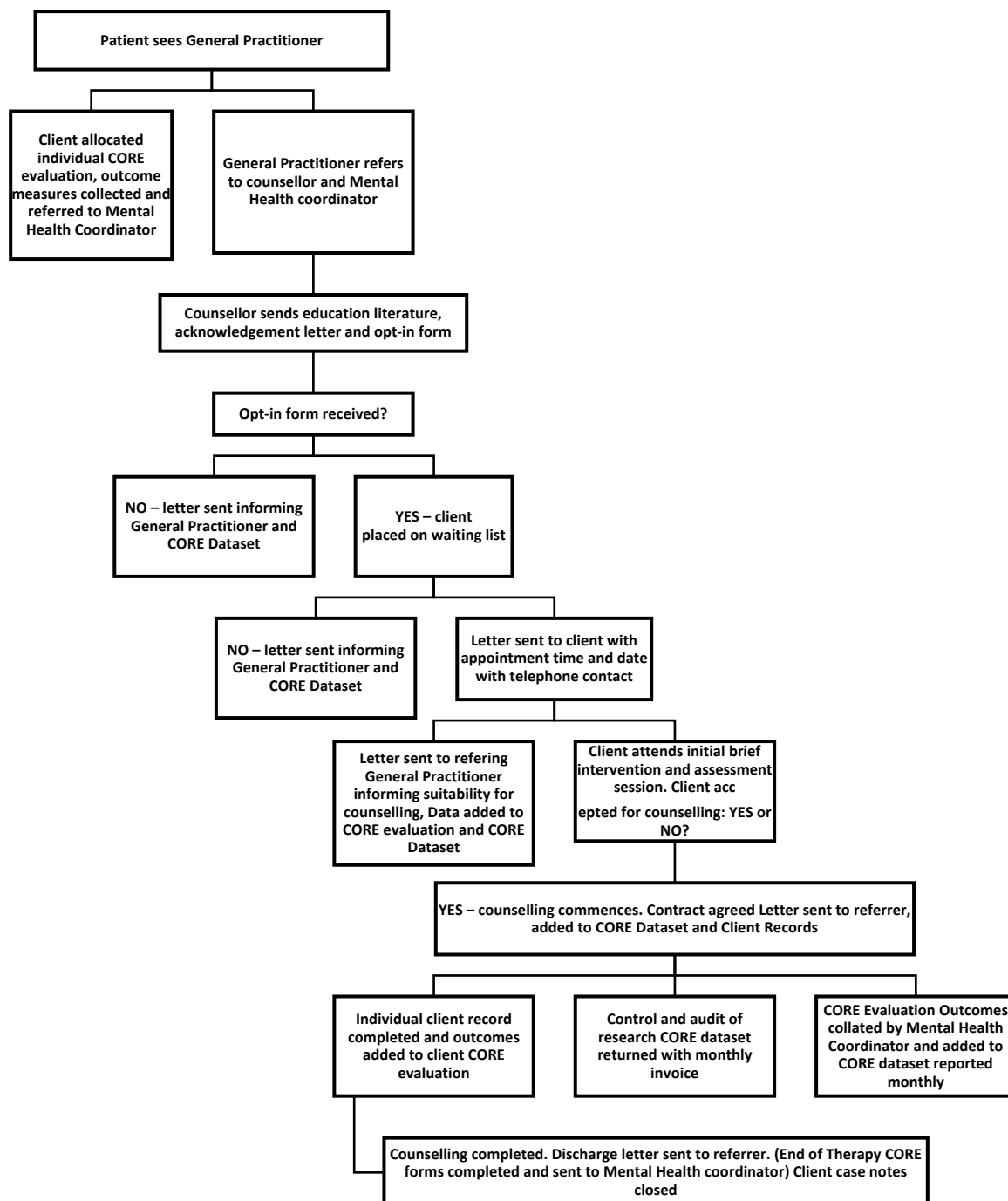
Evidence-based practice is increasingly being adopted as a fundamental principle in mental health care. The practice of evidence-based health care and the research methods that underpin registered counsellors practice effectively support policy decisions, inform service provision, guide professional practice and research, and support client outcomes. Therapeutic interventions delivered by registered counsellors draw upon a proven clinical evidence-base to support service activities with the scope of practice. Evidence-based clinical guidelines for registered counsellors are able to address the key topics of clinical practice, providing a tool for auditing and address areas where clinical decisions are likely to have a significant impact on mental health care. Evidence based practice needs to operate within a framework that acknowledges finite resources, while meeting the ever-increasing demands placed on the health system, where treatment will benefit certain individuals more than others. The counsellor being part of the wider health care system will work within their professional boundaries, being acutely aware of the responsibility and need for further assessment and care by other professionals such as psychiatrists.

Improving access to evidenced-based counselling delivered by registered counsellors' is a key driver for the implementation of the stepped care model. Utilising registered counsellor within a mental health service will support healthcare decision makers to address issues related to the design and implementation of stepped care model within a mental health service. Registered counsellors providing focussed psychological strategies are proven to reduce the burden of disease and improve patient outcomes, with cognitive strategies that support a patients' ability to carry out the activities of their daily life with a freedom from mental disturbance.

Commissioning for outcomes can help ensure cost-effective, high-quality service provision. Mental health services require competent and qualified counsellors to deliver evidence-based treatments within the stepped-care model. Policy makers and commissioning bodies both need to considering how existing primary care services can integrated registered counsellors focused psychological therapies into the stepped-care model and identify what impact these service integrations are likely to have on prescribing costs. Implementing registered counsellors into existing stepped care focused psychological service provision and would reduce the number of people referring to more specialised services, reduce patient waiting times and multiple patient assessments. This would also allow for more specialised service provision to meet the demands of higher needs patients more effectively.

Appendix A - Procedural Flow Chart Primary Care Counselling Service

(Adapted from Foster and Murphy, 2005)



Appendix B - Development of treatment guidelines in line with Stepped Care (taken from Armstrong and Jones, 2018)

What makes a good guideline?

Clinical practice guidelines are primarily advocated as a method to improve the effectiveness and appropriateness of health care (Rowland, et al., 2015). Evidence-based clinical guidelines for registered counsellors are able to address the key topics of clinical practice, provide a tool for auditing and address areas where clinical decisions are likely to have a significant impact on health care. Registered counsellors' clinical guidelines are to be unambiguous about when they are to be used and clearly define specific clinical circumstances, such as application and target patient population. These clinical guidelines are developed through a systematic structured development process to address framework such as a stepped care model, while in consultation with relevant clinicians within the patients' network of care. Registered counsellors' clinical guidelines are based on sound evidence based; whether the guidelines recommendations are based on research evidence or on structured consensus, with the specific evidence base, and strength of evidence for each recommendation clearly identified.

Examples of focused psychological therapies delivered by registered counsellors who meet clinical practice guidelines include:

- Behavioural Couple Therapy (BCT)
- Cognitive Analytical Therapy (CAT)
- Cognitive Behavioural Therapy (CBT)
- Computer Based Cognitive Behavioural Therapy (cCBT)
- Dialectical Behaviour Therapy (DBT)
- Mindfulness-Based Cognitive Therapy
- Rational Emotive Behaviour Therapy (REBT),
- Solution Focused Brief Therapy (SFBT)

An example, 2013 saw the introduction of the Australian guidelines for Post-Traumatic Stress Disorder (PTSD) (Mihalopoulos, et al, 2015), outlining protocols for trauma-focused cognitive behavioural therapy (TF-CBT) and selective serotonin reuptake inhibitors (SSRIs) for the treatment of PTSD in adults and TF-CBT in children.

PTSD is characterised as the “re-experiencing intrusive memories or dreams; avoidance symptoms such as avoiding thoughts, feelings, and places associated with the traumatic event; numbing symptoms such as feeling detached from others; and increased arousal symptoms such as poor sleep, irritability and hypervigilance” (Mihalopoulos, et al, 2015, p 361). PTSD has a high co-morbidity and chronic course if symptoms are left untreated. The clinical guidelines indicate weekly TF-CBT session of 8-12 for adults and 8-10 sessions for children. Guidelines indicate pharmacotherapy using SSRIs is issued and reviewed by the General Practitioner over a 9-month period.

The economic evaluation framework demonstrated that “TF-CBT is highly cost-effective compared to current practice at \$19,000/QALY in adults and \$8900/QALY in children” with 100% of the adult uncertainty iterations falling beneath the \$50,000/QALY threshold (Mihalopoulos, et al, 2015, p 360). The use of SSRI pharmacotherapy is cost effective at \$200/QALY with considerable uncertainty around the long-term cost and benefits of SSRI pharmacotherapy as an exclusive therapeutic option (Mihalopoulos, et al, 2015, p 360). Additional issues noted with SSRI use include a 13% chance in health loss and a 69% probability of costing the health sector additional resources and only a 31% chance of saving health sector dollars, with a minority of patients exceeding the \$50,000/QALY threshold (Mihalopoulos, et al, 2015, p 369).

The use of evidence-based guidelines such as TF-CBT therapists represent a cost-effective model; improve mental health care sector and is a good use of health sector resources. However, there needs to be in place systemic adjustments within commissioning bodies and health administration to include the use of TF-CBT therapists, along with ongoing training and clinical supervision for practitioners (Mihalopoulos, et al, 2015, p 360).

Overcoming the barriers to the implementation of evidence-based practice

Evidence based practice needs to operate within a framework that acknowledges finite resources; while meeting the ever-increasing demands placed on the health system, where treatment will benefit certain individuals more than others. Therefore, it is essential to deliver various evidence-based counselling practices that are supported by clinical guidelines that also address the needs of the wider health system. This approach to health system management is desirable, ensuring that appropriate decision-making tools and support are available to clinicians, policy makers, and health system administrators alike.

Developing clinicians’ skills and experience is an effective way to overcome barriers to the implementation of evidence-based practice. The Australian Counselling Association has developed supervision and professional development requirements that support counsellors to engage in the collecting the information required to develop and maintain evidence-based practice. Registered counsellors have the skills and willingness to engage in a deliberate process to understand their services operational framework and constraints, including reporting and auditing requirements, become informed of any research trials findings and ongoing professional development, which are all regulated by the Australian Counselling Association’s *Scope of Practice for Registered Counsellors*. Additionally, registered counsellors are required to meet annual supervision and ongoing professional development requirements.

The intention of evidence-based practice is to guide and inform rather than being viewed as a tool for mismanagement, used to implement restrictive measures such as service rationing. In such a circumstance where evidence-based practice is not considered, services may be commissioned which are inadequate, with decision based on an incomplete evidence base (Rowland, et al., 2000). Where evidence-based practice is incomplete, health professionals may feel frustrated, and may poorly interpret or abandon the service framework when faced with real life cases. It is essential that evidence-based practice is informative without the practitioner becoming over reliant on the guidance and to not interpreted their practice as prescriptive. Below is a table that illustrates the different therapeutic modalities and their application within a low-intensity or high-intensity environment.

Defining intervention intensity (*Adapted from CSIP, p 28, 2008*)

Interventions	Therapy
Low-intensity	• Computer based CBT • Pure self-help (such as books on prescription where there is on direct support in the use of the materials based on CBT principles) • Guided Self Help (That is facilitated and based on CBT principles) • Behavioural activation • Structural exercises • Psychoeducational groups • Other therapies such as narrative therapy
High-intensity	• CBT • Interpersonal Therapies • Counselling • Couples therapy • Other therapies such as ERBT

Central to the practice of registered counsellors is the process developing and maintaining the therapeutic alliance between the clinician and the patient. Practitioners need to rely on their clinical judgment to identify that available treatment best suits the patient's needs and the objectives of the mental health service. It is also acknowledged that the therapeutic alliance may interfere with evidence collection and bias research outcomes. Additional issues that need to be addressed include practitioner and researcher allegiance to preferred models of therapy and delivery. A pluralistic approach to evidence-based practice needs to be considered within a commissioning environment, to identify and address bias, explore a variety of beneficial therapies, and to generate new information about patient recovery and service performance from both quantitative and qualitative methods, and supported by the reductionist and phenomenological paradigms that underpin and are informed by the evidence-base. Additionally, these opportunities will enable administrators and clinicians to address cultural issues around research, therapeutic practice and innovation (CSIP, 2008).

Evidence based practice integrates and facilitates clinicians' continuous quality improvements and lifelong learning objectives, that include routine information around recent developments in best practice and outcome effectiveness (Rowland, et al., 2000). Clinicians, policy makers, and health system administrators should all be involved in critically appraising evidence-based outcomes, where reflective practices can help to demystify the aim and objectives of the evidence-based practice and place it in context to service delivery while meeting the wider health systems intent. Below is a table that illustrates the Principles and benefits of Evidence based practice as it relates to outcomes within a management environment (CSIP, 2008).

Principles	Benefits
<i>The primary purpose of outcomes measurement is to improve people's experience of and benefits from the service and is part of ongoing, collaborative service evaluation, with feedback from patients at its heart</i>	People chart their progress towards recovery and see at what point their psychometric score falls within the normal range. If the goal is to reduce or stop medication, this can help decide the right time
<i>Sessional outcomes feedback to clinicians helps improve the quality of their interventions</i>	People set their own goals for therapy, and give ongoing feedback on whether therapy is working and that elements are helpful or unhelpful
<i>Regular outcomes feedback to supervisors supports case reviews and collaborative treatment planning</i>	If people wish, they can ask their carers (loved ones, family or friends) to help with setting goals, step-by-step changes, and giving additional feedback on progress
<i>Routinely collected outcomes data helps managers monitor and improve overall service performance</i>	Therapists and supervisors, and the clinical team, can also chart progress, and can adjust treatment plans if the feedback indicates that the current plan is not working. Likewise, clinicians can check performance against their peers, to keep their skills in good shape
<i>Service performance data informs managers who set national standards to aim for</i>	GPs and clinicians doing initial assessments for therapy can engage patients and work collaboratively. For example, if getting back to work is what the patient wishes, they will be encouraged to take responsibility for this as part of their therapeutic outcome
<i>Intelligent use of aggregate outcomes data by experts aims to define best practice models of service delivery</i>	Service managers can use the outcomes framework to manage performance and improve quality, that also helps commissioners ensure that contracts and the funding of services are providing good value for money
<i>Ask fewer questions and get more answers. The requirement for data collection should be proportionate to the treatment being offered and integrated with clinical priorities. The utility of data is enhanced if a complete set of minimum data is obtained for each intervention</i>	Local, regional and national leads will benefit from having accurate, comprehensive outcomes data being fed in to the policy-making system, that can help drive up standards by setting benchmarks and establishing league tables. Whole-system care pathways can be improved by using high-quality practice-based data. Future resource planning will also be improved

Commissioning for outcomes can help ensure cost-effective, high-quality service provision. Routine collection of outcomes data is fundamental to the effective delivery of focused psychological strategies. Collection of outcomes data is as important for patients' service as it is for clinicians' performance, and for administration and policy managers understanding trends and outcomes within the service and the wider community (CSIP, 2008).

Mental health services require competent and qualified therapists to deliver evidence-based treatments within the stepped-care model. Registered counsellors are an important source of workforce supply able to meet the capacity and capability needs of the health system. Utilising registered counsellors within will allow service provision to be geared to the likely pattern of demand from people accessing services (CSIP, 2008).

Considering how existing primary care counselling services can be integrated into stepped-care psychological therapies services and what impact these services are likely to have on prescribing costs. Services may have difficulty meeting the reporting demands of the collection of outcomes data. One way to meet the demands of commissioning data requirements is for service providers and managers need to ensure that patients who are experiencing high needs within a stepped care model are allocated and monitored appropriately. High-intensity treatment is an essential component of a stepped-care psychological service although the service will cost more and treat fewer patients, but sufficient high-intensity resource is needed to prevent waiting lists building up. Below are three tables that illustrates registered counsellors' delivering focussed psychological strategies, including the;

1. Management of patients within the stepped care model
2. Patient workflow within the stepped care model; and,
3. Schematic flow chart of the steps taken in the stepped care model.

Step 1: Primary care service

Action	Intervention
<i>Recognition of an issue or problem</i>	Assessment/watchful waiting

Step 2: Low-intensity service

Disorder	Intervention
<i>Depression – mild to moderate</i>	Computer based CBT, guided self-help, behavioural activation, exercise
<i>Panic disorder – mild to moderate</i>	Computer based CBT, guided self-help, pure self-help
<i>Generalised Anxiety Disorder (GAD) – mild to moderate</i>	Computer based CBT, guided self-help, pure self-help, psychoeducational groups
<i>PTSD</i>	n/a
<i>Social phobia</i>	n/a
<i>Obsessive Compulsive Disorder (OCD) – mild to moderate</i>	Guided self-help

Step 3: High intensity service

Disorder	Intervention
<i>Depression – mild, moderate & severe</i>	CBT, IPT, behavioural activation
<i>Depression – mild to moderate</i>	Counselling, couples therapy
<i>Panic disorder</i>	CBT
<i>Generalised Anxiety Disorder (GAD)</i>	CBT
<i>Social phobia</i>	CBT
<i>Post-Traumatic Stress Disorder (PTSD)</i>	CBT, eye movement desensitisation and reprocessing (EMDR)
<i>Obsessive compulsive disorder (OCD)</i>	CBT

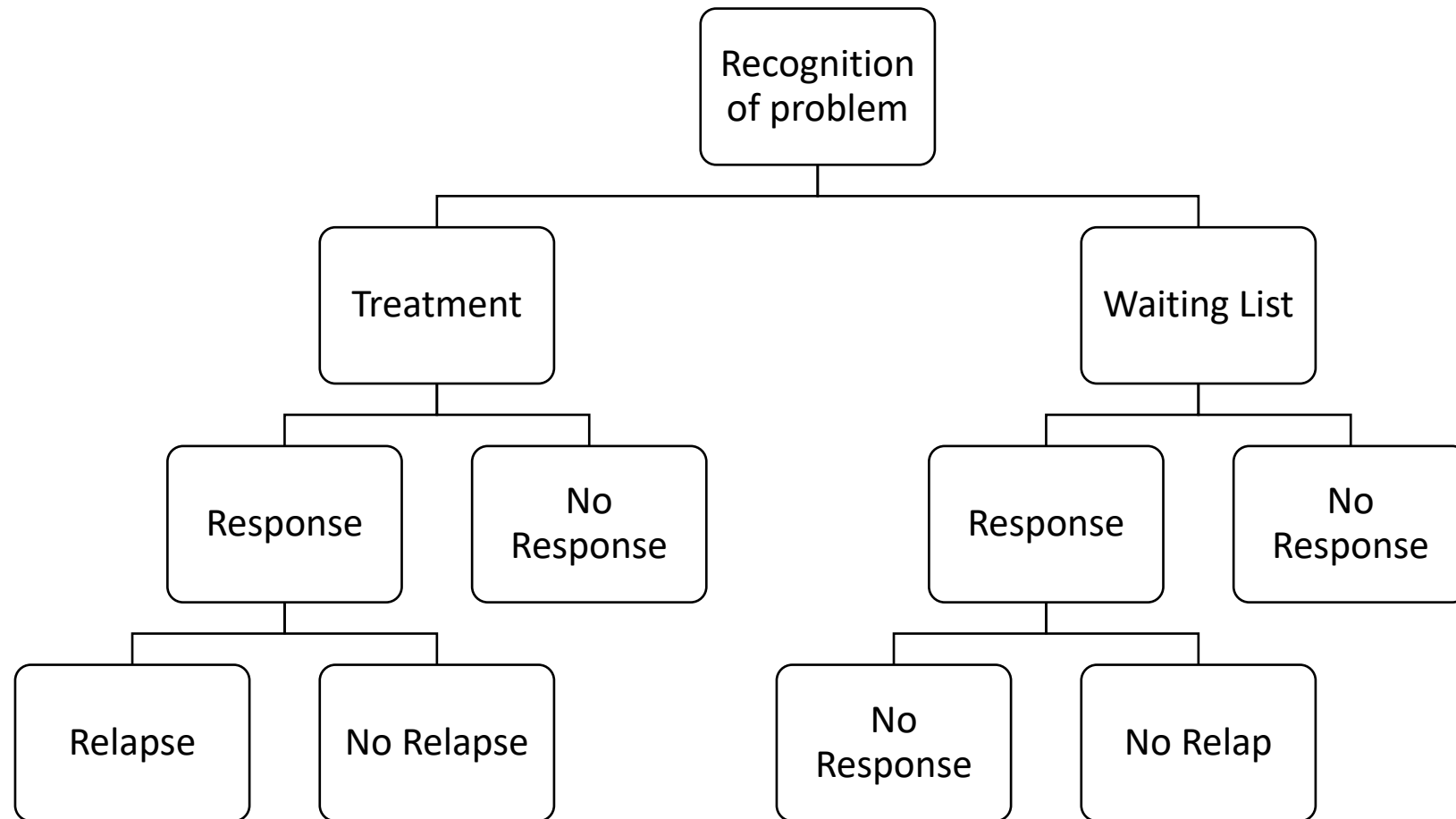
Step 4: Complex treatment service

Disorder	Intervention
<i>Depression – mild, moderate & severe</i>	CBT, IPT, behavioural activation

Example Stepped Care Workflow for registered counsellors delivering Focussed Psychological Strategies (Adapted from NCCMH, 2010)

	<u>STEP 1:</u>	<u>STEP 2</u>	<u>STEP 3</u>	<u>STEP 4</u>
Focus of the intervention	All known and suspected presentations of Mental Health Issue	Diagnosed Mental Health Issue that has not improved after education and active monitoring in primary care	Diagnosed Mental Health Issue with inadequate response to step 2 interventions or marked functional impairment	Complex treatment-refractory of Mental Health Issue and very marked functional impairment, such as self-neglect or a high risk of self-harm
Nature of the intervention	Identification and assessment; education about Mental Health Issue and treatment options; active monitoring	Low-intensity psychological interventions: pure self-help, guided self-help and psychoeducational groups	Choice of a high-intensity psychological intervention (cognitive behavioural therapy/ applied relaxation) or a drug treatment	Highly specialist treatment, such as complex drug and/or psychological regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care

Appendix C - Example Schematic flow chart of Stepped Care Model for registered counsellors delivering Focussed Psychological Strategies (NCCMH, 2010)



Registered counsellors at a level three and four have received training in more specialist psychological therapies (such as high-intensity interventions or CBT) in order to provide the range and depth of therapeutic skills needed to deliver focused psychological strategies under the Better Access Initiative. Registered counsellors are accredited against courses based on revised standards; linked to the CBT competencies, with supervision by appropriately trained and experienced therapists.

Counsellors delivering low-intensity interventions will also be essential within a stepped care model, where services experience high-volume crisis care case management. Registered counsellors are trained to delivering low and high-intensity focused psychological therapies to an appropriate and coherent standard required to offer effective interventions.

Implementing registered counsellors into existing stepped care focused psychological therapies will increase service capacity for primary care-based mental health services. Mental health services should review the current roles within their provision to better understand service gaps that can be effectively serviced by registered counsellors. This would allow for a more effective secondary care service that allows for greater capacity and flexibility to receive patients and meet service loads. This would change mental health care pathways and reduces inappropriate referrals to secondary mental health care services and reduce secondary care assessment times.

The integration of counsellors into a stepped care service provision would allow reduce the number of people being referred to more specialised services, reducing both patient waiting times and the need for multiple patient assessments, and also allow for more specialised service provision to responsively meet the demands of higher needs patients more effectively.

Appendix D - Medicare Benefits Schedule Item Numbers for Registered Counsellors and Psychotherapists

Referral to Registered Counsellors (for new and continuing patients)

(As interpreted from the Medicare Benefits Schedule 2018 page 77, source [http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/B0C8AEE172E74F74CA25823A0004BFB2/\\$File/201803-MBS.doc](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/B0C8AEE172E74F74CA25823A0004BFB2/$File/201803-MBS.doc)).

The purpose of the 8 Medicare benefits payable items is to increase;

- The available clinical treatment options to psychiatrists and paediatricians,
- Efficient and timely options for patients with an assessed mental disorder

Patients will receive a total of ten individual services of focused psychological strategies delivered by registered counsellors for in a calendar year.

Referrals from psychiatrists and paediatricians to a registered counsellor must be made from eligible Medicare services. For specialist psychiatrists and paediatricians these services include any of the specialist attendance items 104 through 109. For consultant physician psychiatrists the relevant eligible Medicare services cover any of the consultant psychiatrist items 293 through 370; while for consultant physician paediatricians the eligible services are consultant physician attendance items 110 through 133.

Within the maximum service allocation of ten services, the registered counsellor can provide one or more courses of treatment relevant to Focused Psychological Strategies which include;

- Educational
- Interpersonal Therapies
- Skills Training
- Behavioural Intervention Therapies

A comprehensive breakdown of Focused Psychological Strategies can be found in Appendix B.

For the purposes of these services, a course of treatment will consist of the number of services stated in the patient's referral (up to a maximum of six in any one referral). These services should be provided, as required, for an initial course of treatment (a maximum of six services but may be less depending on the referral and patient need) to a maximum of ten services per calendar year.

On completion of the initial course of treatment, the registered counsellor must provide a written report to the referring medical practitioner, which includes information on:

1. assessments carried out on the patient;
2. treatment provided; and
3. recommendations on future management of the patient's disorder.

A written report must also be provided to the referring medical practitioner at the completion of any subsequent course(s) of treatment provided to the patient.

Appendix E - Focused psychological strategies delivered by registered Counsellors & Psychotherapists

(from the Medicare Benefits Schedule 2018 page 113-114, source [http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/B0C8AEE172E74F74CA25823A0004BFB2/\\$File/201803-MBS.doc](http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/B0C8AEE172E74F74CA25823A0004BFB2/$File/201803-MBS.doc)).

The Medicare Benefits Schedule currently recommended the delivery of psycho-education, and cognitive-behaviour therapy in addition to other evidence-based therapies; such as interpersonal therapy, which may be used if considered clinically relevant (Medicare Benefits Schedule, 2018, p. 1126). Below is a list of focused psychological strategies matched to the current Medicare Benefits Schedule items for allied mental health (items 80100 to 80171). These focused psychological strategies are currently provided by eligible psychologists, occupational therapists and social workers.

Focused Psychological Strategies	Subset Focused Psychological Strategies ->>>	Educational strategies Interpersonal Therapies Skills Training	Behavioural Intervention Therapies
• Psycho-education • motivational interviewing • Cognitive-behavioural Therapy • Behaviour modification • Activity scheduling • Cognitive interventions • Cognitive therapy • Relaxation strategies • Progressive muscle relaxation • Controlled breathing • Skills training • Problem solving skills and training • Anger management • Social skills training • Communication training • Stress management • Parent management training • Interpersonal Therapy • Narrative therapy (for ATSI populations)		• Socratic questioning • Guided discovery • Examine evidence • De-catastrophising • Challenge negative thoughts • Problem solving • Cognitive rehearsal • Identify core beliefs • Schema inventories • Schema advantages verses disadvantage	• Vegetative routines (e.g. sleep) • Behaviour activation • Activity scheduling • Graded task assign • Breathing retraining • Thought stopping • Imaginal relaxation • Exposure therapy • Graded exposure plan • Imaginal exposure • In vivo exposure • Skill acquisition • Social & communication skills • Relapse prevention • Dev coping strategies • Manage risk

Appendix F - Therapeutic treatment guidelines for the delivered of focused psychological strategies by Registered Counsellors and Psychotherapists

Below is a list of recommended treatment guidelines for the delivery of focused psychological strategies delivered by registered counsellors.

Depression

- Target daily activities
- Monitor/increase activity frequency
- Improve social and communication Skills
- Increase adaptive behaviours
- Decrease negative life events
- Change negative thoughts
- Social problem solving

Bipolar disorder

- Emphasise negative thought patterns (self-statements, dysfunctional beliefs)
- Focus on mood fluctuations & vegetative routines (e.g. sleep wake cycles)
- Psychoeducation
- Behavioural activation
- Cognitive restructuring

Anxiety and panic

- De-catastrophize
- Exposure therapy
- Elicit and test maladaptive beliefs about body sensations
- Identify more adaptive beliefs and evaluate

Obsessive compulsive disorder

- Compulsions equal safety behaviours, therefore repeated exposure to obsessional cues + suspension of compulsive rituals to get use to anxiety response and extinguish safety behaviour
- Socratic questioning to identify, then evaluate, then alter problematic belief
- Exposure and ritual prevention
- Relapse prevention

Social phobia

- Exposure
- Social skills training
- Target negative beliefs about self

Post-traumatic stress disorder

- Exposure imagery
- Socratic questioning to identify, then evaluate, then alter problematic belief
- Examine evidence

Generalised Anxiety Disorder

- Psychoeducation
- Relaxation
- Exposure imagery/in vivo
- Behavioural activation
- Recognise anxious thoughts then find helpful alternatives then test alternatives

Specific phobia

- Classical conditioning
- Exposure imagery/in vivo

Bulimia nervosa

- Cognitive behavioural techniques to replace dietary restraint with normal eating pattern
- Address dysfunctional attitudes about body shape, weight, self.

Anorexia nervosa

- Operant conditioning in inpatient settings (e.g. reinforcer for each 0.5kg gained)
- CBT patients better than control groups but still under weight.

Schizophrenia/schizoaffective

- Reinforcement schedules
- Stimulus control
- Social modelling
- Social skills training
- Target medical compliance, recognising relapses, developing a relapse plan, coping with symptoms, avoiding drugs/alcohol
- CBT for positive symptoms:
 - Delusions (identify beliefs, examine evidence, modify)
 - Hallucinations (address dysfunctional beliefs e.g. voice is powerful/do what the voice says)

Substance abuse

- Classical or operant conditioning
 - Classical (antecedent conditions to day after use paired with day after use produce conditioned response that encourages further day after use)
 - Exposure extinguishes conditioning
- Target beliefs, identify thoughts/feelings/behaviours that precede and follow day after use
- Restrict cues associated with day after use
- Find alternative strategies for dealing with negative affect
- Coping skills training (CBT)

Somatoform

- Reduce attention to distressing sensations
- Correct misinformation/exaggerated beliefs
- Identify and modify distorted perceptions
- Interrupt critical self-thoughts
- Exposure to anxiety provoking situations
- Practice response prevention
- Relaxation training, activity scheduling

Paranoid personality disorder

- Social skills training (group therapy)
- Anxiety management (cbt)
- Antipsychotic medication if overtly psychotic

Schizoid

- Supportive therapy aimed at resolution of crisis
- Insight orientated therapy
- Increase coping, social interaction, communication, self-esteem
- CBT to encourage gradual social involvement
- Group therapy to build social skills & relationships

Schizotypal

- Supportive relationships to counter cognitive distortions
- CBT
- Highly structured educational groups for social skills

Antisocial

- Core beliefs schema therapy
- Confrontation by peers e.g. jail, military

Borderline

- Dialectic Behavioural Training to identify triggers and assess which coping skills to apply:
 - Risk assessment
 - Therapy contract
 - Therapist assumes crises, self-destructive behaviour will occur
 - Decrease suicidal behaviour
 - Increase behavioural skills
 - Improve self esteem and specific behaviour targets
- Behaviour therapy to reduce self-destructive behaviours

Histrionic

- Psychodynamic:
- Patient aware self esteem is maladaptively based on ability to attract attention

Narcissistic

- Individual psychotherapy:
 - Convey empathy for patient's sensitivities and disappointments

Avoidant

- Supportive techniques and gentle interpretation of defensive use of avoidance

Dependent

- Individual psychotherapy:
 - Explore fear of independence
- Use transference to explore dependency, increase self esteem, effectiveness, assertiveness, functioning

Obsessive-compulsive personality disorder

- Focus on feelings patient usually avoids
- Cognitive techniques to reduce need for control and perfection

Appendix G - Medicare Benefits Schedule Item Numbers for Registered Counsellors and Psychotherapists – 80102; 80107; 80112; 80122; 81300.

Item Number	Group	Duration	Service type	Location	Fee <i>for each patient</i>	Benefit <i>for each patient</i>	Extended safety net cap <i>for each patient</i>	Explanation
80102	M7 - Focused Psychological Strategies (Allied Mental Health)	lasting more than 20 minutes, but not more than 50 minutes	INDIVIDUAL THERAPY	Professional attendance at consulting rooms	\$70.65	85% = \$60.10	\$211.95	Professional attendance for the purpose of providing focused psychological strategies services for an assessed mental disorder by a registered counsellor registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

Item Number	Group	Duration	Service type	Location	Fee <i>for each patient</i>	Benefit <i>for each patient</i>	Extended safety net cap <i>for each patient</i>	Explanation
80107	M7 - Focused Psychological Strategies (Allied Mental Health)	lasting more than 20 minutes, but not more than 50 minutes	INDIVIDUAL THERAPY	Professional attendance at a place other than consulting rooms.	\$96.15	85% = \$81.75	\$288.45	Professional attendance for the purpose of providing focused psychological strategies services for an assessed mental disorder by a registered counsellor registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 20 minutes, but not more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

Item Number	Group	Duration	Service type	Location	Fee <i>for each patient</i>	Benefit <i>for each patient</i>	Extended safety net cap <i>for each patient</i>	Explanation
80112	M7 - Focused Psychological Strategies (Allied Mental Health)	lasting more than 50 minutes	INDIVIDUAL THERAPY	These Focused Psychological Strategies Services are time limited , being deliverable in up to ten planned sessions in a calendar year, up to seven of which may be provided via video conference.	\$99.75	85% = \$84.80	\$299.25	Professional attendance for the purpose of providing focused psychological strategies services for an assessed mental disorder by a registered counsellor registered with Medicare Australia as meeting the credentialing requirements for provision of this service - lasting more than 50 minutes - where the patient is referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.
80122	M7 - Focused Psychological Strategies (Allied Mental Health)	lasting for at least 60 minutes duration	GROUP THERAPY with a group of 6 to 10 patients, EACH PATIENT	These Focused Psychological Strategies Services are time limited , being deliverable in up to ten planned sessions in a calendar year, up to seven of which may be provided via video conference.	\$25.45	85% = \$21.65	\$76.35	Professional attendance for the purpose of providing focused psychological strategies services for an assessed mental disorder by a registered counsellor registered with Medicare Australia as meeting the credentialing requirements for provision of this service, lasting for at least 60 minutes duration where the patients are referred by a medical practitioner, as part of a GP Mental Health Treatment Plan or as part of a shared care plan; or referred by a medical practitioner (including a general practitioner, but not a specialist or consultant physician) who is managing the patient under a referred psychiatrist assessment and management plan; or referred by a specialist or consultant physician in the practice of his or her field of psychiatry or paediatrics.

81300	81300 M11 - Allied Health Services for Indigenous Australians Who Have Had A Health Check	Service is of at least 20 minutes duration	INDIVIDUAL THERAPY	Professional attendance at consulting rooms	\$62.25	85% = \$52.95	\$186.75	ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE provided to a person who is of Aboriginal and Torres Strait Islander descent by an eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner if: (a) either: (i) a medical practitioner has undertaken a health assessment and identified a need for follow-up allied health services; or (ii) the person's shared care plan identifies the need for follow-up allied health services; and (b) the person is referred to the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner by a medical practitioner using a referral form that has been issued by the Department or a referral form that substantially complies with the form issued by the Department; and (c) the person is not an admitted patient of a hospital; and (d) the service is provided to the person individually and in person; and (e) the service is of at least 20 minutes duration; and (f) after the service, the eligible Aboriginal health worker or eligible Aboriginal and Torres Strait Islander health practitioner gives a written report to the referring medical practitioner mentioned in paragraph (b):
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Item Number	Group	Duration	Service type	Location	Fee <i>for</i> <i>each</i> <i>patient</i>	Benefit <i>for each</i> <i>patient</i>	Extended safety net cap <i>for each</i> <i>patient</i>	Explanation
								(i) if the service is the only service under the referral - in relation to that service; or
								(ii) if the service is the first or the last service under the referral - in relation to the service; or
								(iii) if neither subparagraph (i) nor (ii) applies but the service involves matters that the referring medical practitioner would reasonably be expected to be informed of - in relation to those matters

Appendix H - Hunter New England and Central Coast Primary Health Network Mental Health Waiting Times

Table HNECC Mental Health Waiting Times January 2018. (Available from; <https://www.hnecphn.com.au/media/14542/mental-health-waiting-times-01012018-to-31012018.pdf>)

HNECC Mental Health Waiting Times January 2018

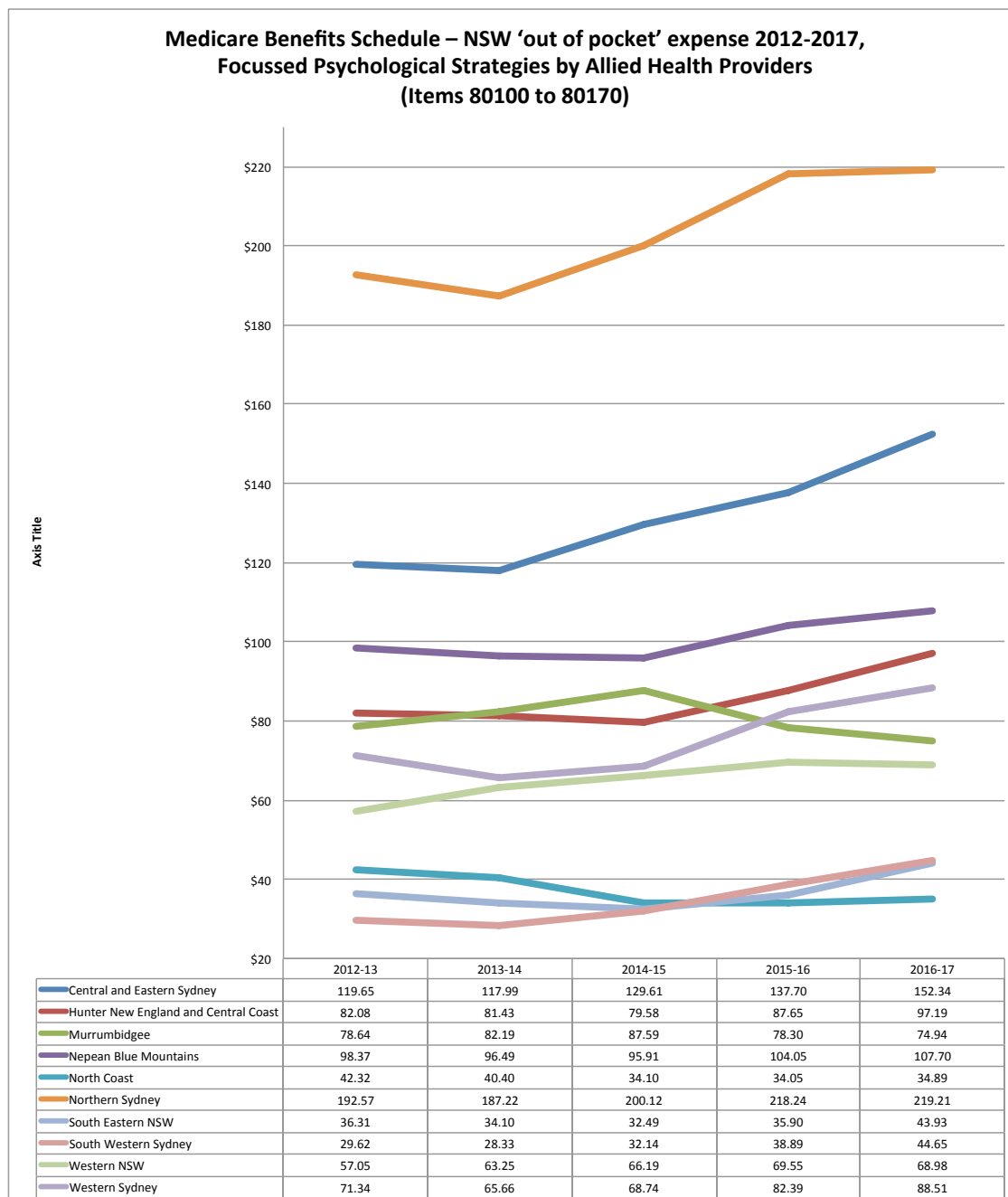
Service Location	Patient Waiting Time (in days) to assessment	Patient Waiting Time (in days) to commence treatment	Provider Name
Armidale	0	41	Centacare New England North West
Barraba	15	15	HealthWISE
Bingara	0	0	Centacare New England North West
Boggabri	0	0	Centacare New England North West
Cessnock	2	25	Hunter Primary Care Ltd
Dungog	5	5	Life Matters Psychologists
Forster	5	5	Life Matters Psychologists
Glen Innes	0	18	Centacare New England North West
Gloucester	10	10	Life Matters Psychologists
Gosford	14	14	Central Coast Primary Care
Gosford	17	17	Yerin Aboriginal Health Services Inc
Gunnedah	15	15	HealthWISE
Guyra	0	33	Centacare New England North West
Inverell	0	8	Centacare New England North West
Lake Macquarie	2	18	Hunter Primary Care Ltd
Maitland	2	18	Hunter Primary Care Ltd
Maitland	3	3	Life Matters Psychologists
Manilla	17	17	HealthWISE
Moree	0	29	Centacare New England North West
Mungindi	0	0	Centacare New England North West
Muswellbrook	3	15	Hunter Primary Care Ltd
Narrabri	0	34	Centacare New England North West
Newcastle	2	15	Hunter Primary Care Ltd
Port Stephens	2	17	Hunter Primary Care Ltd
Quirindi	20	20	HealthWISE
Scone	3	20	Hunter Primary Care Ltd
Singleton	2	15	Hunter Primary Care Ltd
Tamworth	0	18	Centacare New England North West
Tamworth	23	23	HealthWISE
Taree	15	15	Life Matters Psychologists
Tenterfield	0	0	Centacare New England North West
Walcha	15	15	HealthWISE
Warialda	0	0	Centacare New England North West
Wee Waa	0	8	Centacare New England North West
Wyong	9	9	Central Coast Primary Care
Wyong	17	17	Yerin Aboriginal Health Services Inc
Overall	6	15	

Times listed are in average days

All data provided by Service Providers for previous calendar month

Appendix I - New South Wales - Provision of Focussed Psychological Strategies Services by Allied Health Providers - (Items 80100 to 80170)

New South Wales 2012 – 2017 - Provision of Focussed Psychological Strategies Services by Allied Health Providers - (Items 80100 to 80170);

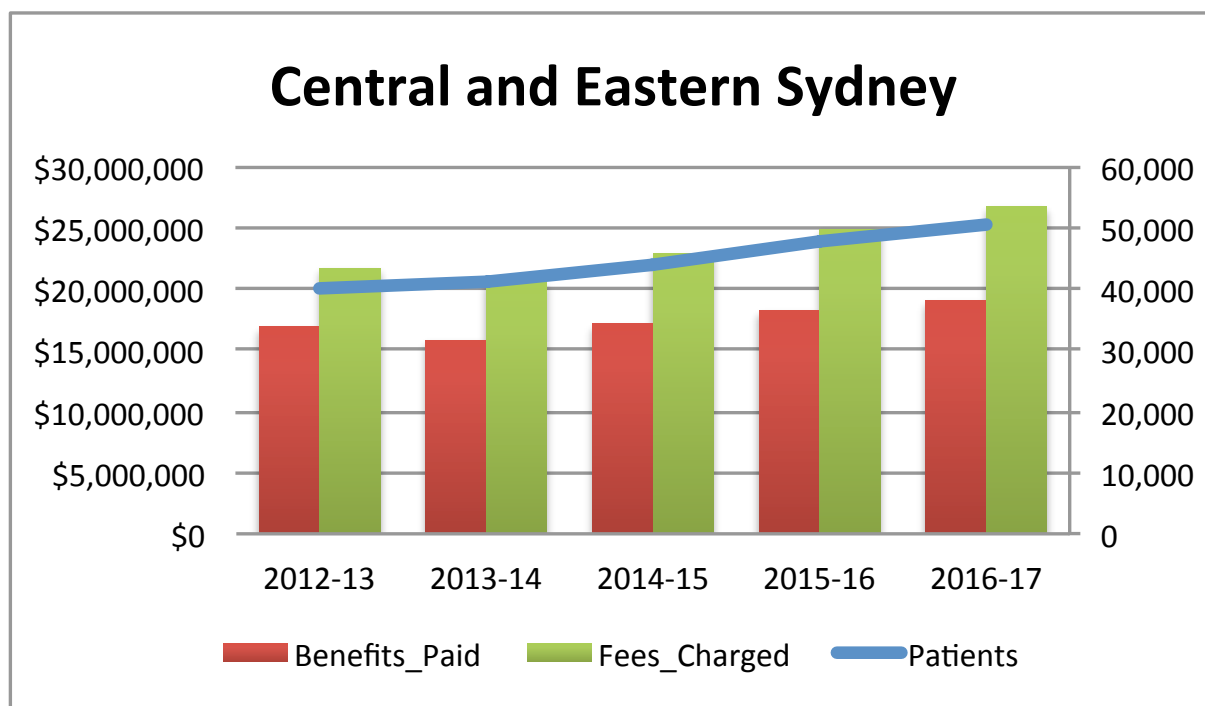


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Central and Eastern Sydney 2012 – 2017 - Provision of Focussed Psychological Strategies
Services by Allied Health Providers - (Items 80100 to 80170)

Central and Eastern Sydney	Providers	Patients	Benefits Paid	Fees Charged	Average 'out of pocket expense' per Provider
2012-13	1,341	39,945	\$16,890,194.53	\$21,669,430.80	\$3,565.21
2013-14	1,355	41,187	\$15,811,485.40	\$20,671,042.38	\$3,586.36
2014-15	1,397	44,064	\$17,155,590.18	\$22,866,915.96	\$4,086.93
2015-16	1,468	47,834	\$18,238,338.09	\$24,824,849.54	\$4,486.17
2016-17	1,508	50,561	\$19,028,932.82	\$26,731,392.04	\$5,108.58
<i>Total</i>	7,069	223,591	\$87,124,541.02	\$116,763,630.72	\$4,192.87

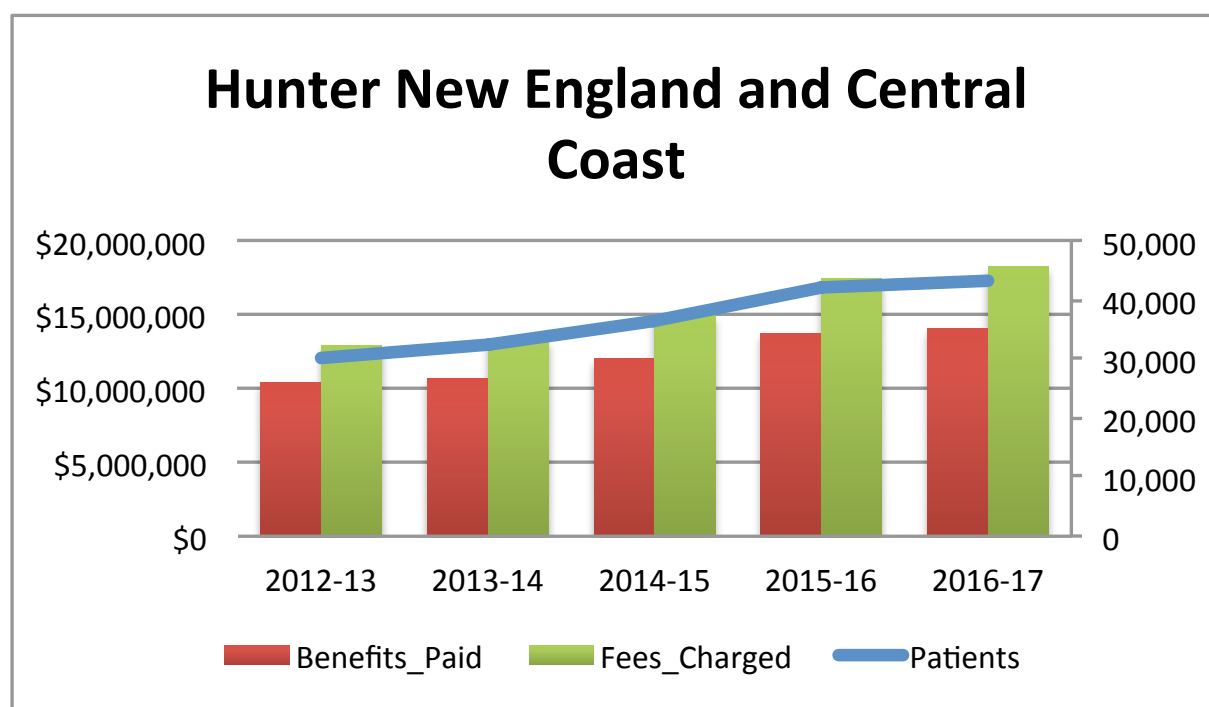


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Hunter New England and Central Coast 2012 – 2017 - Provision of Focussed Psychological Strategies Services by Allied Health Providers - (Items 80100 to 80170)

Hunter New England and Central Coast	Providers	Patients	Benefits Paid	Fees Charged	Average 'out of pocket expense' per Provider
2012-13	723	30,123	\$10,439,657.25	\$12,912,096.18	\$3,419.27
2013-14	772	32,305	\$10,681,266.15	\$13,311,896.98	\$3,406.67
2014-15	828	36,613	\$12,014,259.85	\$14,927,985.91	\$3,518.91
2015-16	889	42,005	\$13,753,866.95	\$17,435,815.10	\$4,140.14
2016-17	874	43,243	\$14,051,433.55	\$18,254,077.11	\$4,808.41
<i>Total</i>	4,087	184,289	\$60,940,483.75	\$76,841,871.28	\$3,891.05

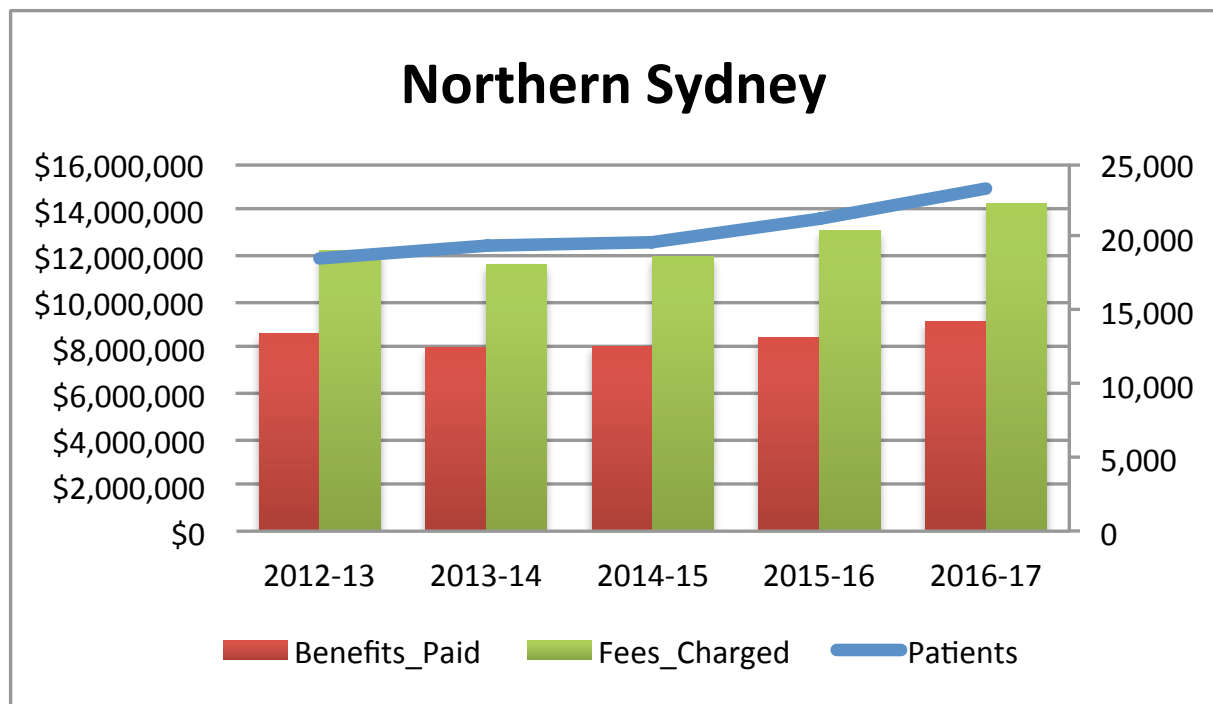


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Northern Sydney 2012 – 2017 - Provision of Focussed Psychological Strategies Services by Allied Health Providers - (Items 80100 to 80170)

Northern Sydney	Providers	Patients	Benefits Paid	Fees Charged	Average 'out of pocket expense' per Provider
2012-13	754	18,556	\$8,626,602.43	\$12,199,946.84	\$4,741.45
2013-14	775	19,320	\$7,990,578.05	\$11,607,649.60	\$4,668.27
2014-15	776	19,726	\$8,029,788.28	\$11,977,356.44	\$5,088.45
2015-16	792	21,329	\$8,436,005.75	\$13,090,768.89	\$5,880.49
2016-17	840	23,313	\$9,141,426.50	\$14,251,899.04	\$6,083.10
<i>Total</i>	3,936	102,244	\$42,224,401.01	\$63,127,620.81	\$5,310.89

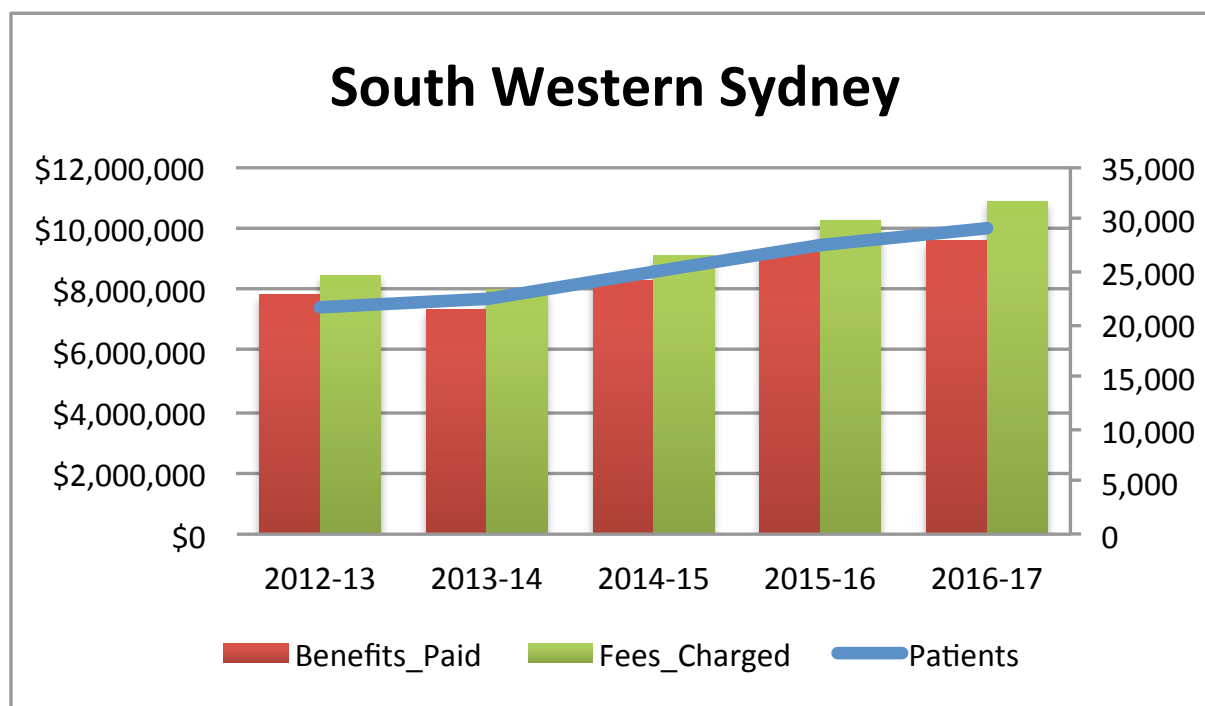


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South Western Sydney 2012 – 2017 - Provision of Focussed Psychological Strategies Services by Allied Health Providers - (Items 80100 to 80170)

South Western Sydney	Providers	Patients	Benefits Paid	Fees Charged	Average 'out of pocket expense' per Provider
2012-13	400	21,595	\$7,808,362.65	\$8,447,924.75	\$1,598.47
2013-14	419	22,489	\$7,345,855.05	\$7,982,892.94	\$1,521.98
2014-15	432	24,810	\$8,287,613.85	\$9,085,067.83	\$1,847.58
2015-16	461	27,612	\$9,177,937.30	\$10,251,871.39	\$2,331.50
2016-17	464	28,959	\$9,567,688.60	\$10,860,776.12	\$2,789.71
<i>Total</i>	2,174	125,465	\$42,187,457.45	\$46,628,533.03	\$2,042.41

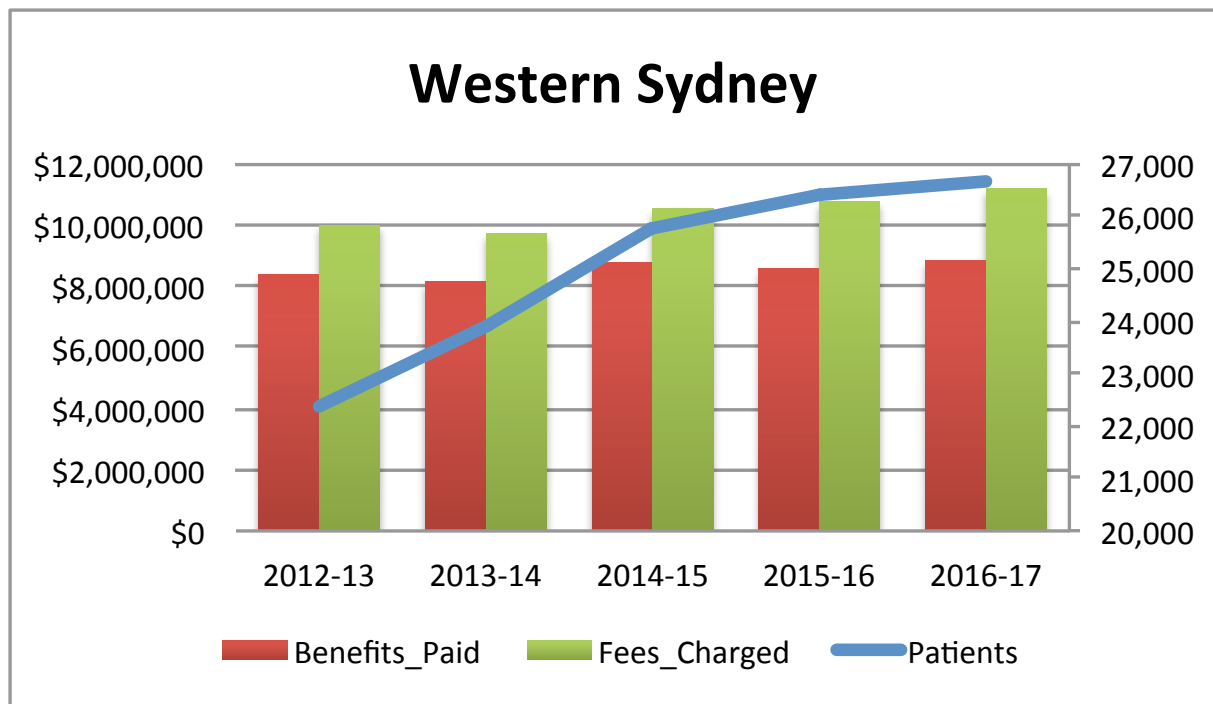


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Western Sydney 2012 – 2017 - Provision of Focussed Psychological Strategies Services by Allied Health Providers - (Items 80100 to 80170)

Western Sydney	Providers	Patients	Benefits Paid	Fees Charged	Average 'out of pocket expense' per Provider
2012-13	442	22,356	\$8,383,092.00	\$9,977,929.55	\$3,610.60
2013-14	469	23,919	\$8,127,170.65	\$9,697,696.11	\$3,347.10
2014-15	494	25,781	\$8,749,708.98	\$10,521,983.51	\$3,584.99
2015-16	505	26,421	\$8,560,653.35	\$10,737,478.24	\$4,311.57
2016-17	489	26,637	\$8,819,811.50	\$11,177,554.54	\$4,826.10
<i>Total</i>	2,399	125,114	\$42,640,436.48	\$52,112,641.95	\$3,948.87



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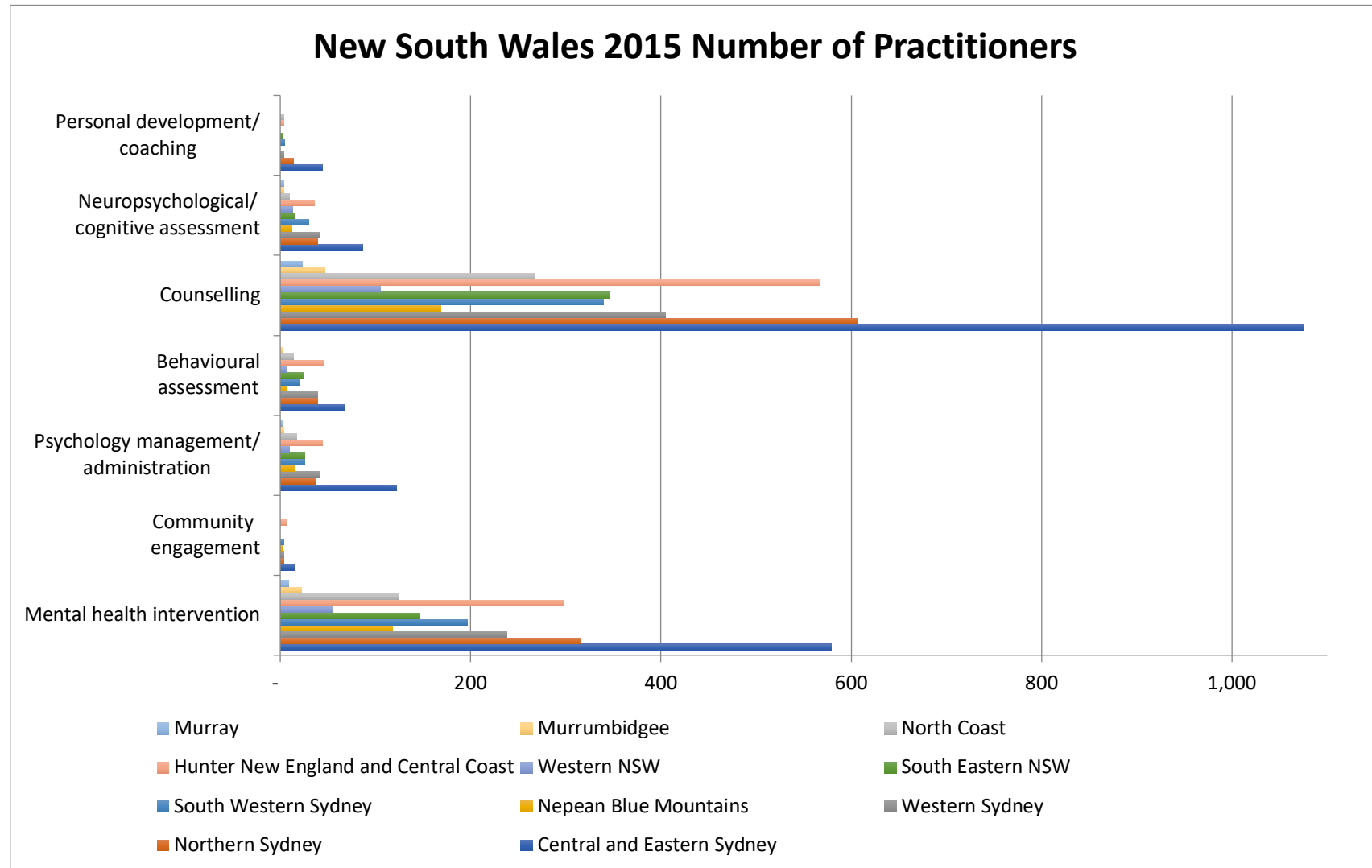
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Appendix J - Number of Practicing Psychologists and Job Area in New South Wales, 2015.

National Health Workforce Dataset, © Space Time Research 2016, (source <http://hwd.health.gov.au/>)

Year	2015	2015	2015	2015	2015	2015	2015	2015	2015
Professions	Psychologists	Psychologists	Psychologists	Psychologists	Psychologists	Psychologists	Psychologists	Psychologists	Medical Practitioners
Job Area	Mental health intervention	Community engagement	Psychology management / administration	Behavioural assessment	Counselling	Neuropsychological / cognitive assessment	Personal development/ coaching	Psychologists Total	General practitioner (GP)
Central and Eastern Sydney	579	15	122	68	1,076	87	44	1,991	2,026
Northern Sydney	315	4	38	39	606	39	14	1,055	1,165
Western Sydney	238	4	41	39	405	41	4	772	1,038
Nepean Blue Mountains	118	3	16	6	169	12	-	324	369
South Western Sydney	197	4	26	21	340	30	5	623	929
South Eastern NSW	147	-	26	25	346	16	3	563	711
Western NSW	55	-	10	7	105	13	-	190	333
Hunter New England and Central Coast	297	6	44	46	567	36	4	1,000	1,420
North Coast	124	-	17	14	268	10	4	437	687
Murrumbidgee	22	-	4	3	47	4	-	80	211
Murray	9	-	3	-	23	4	-	39	55
New South Wales Total	2,101	36	347	268	3,952	292	78	7,074	8,944

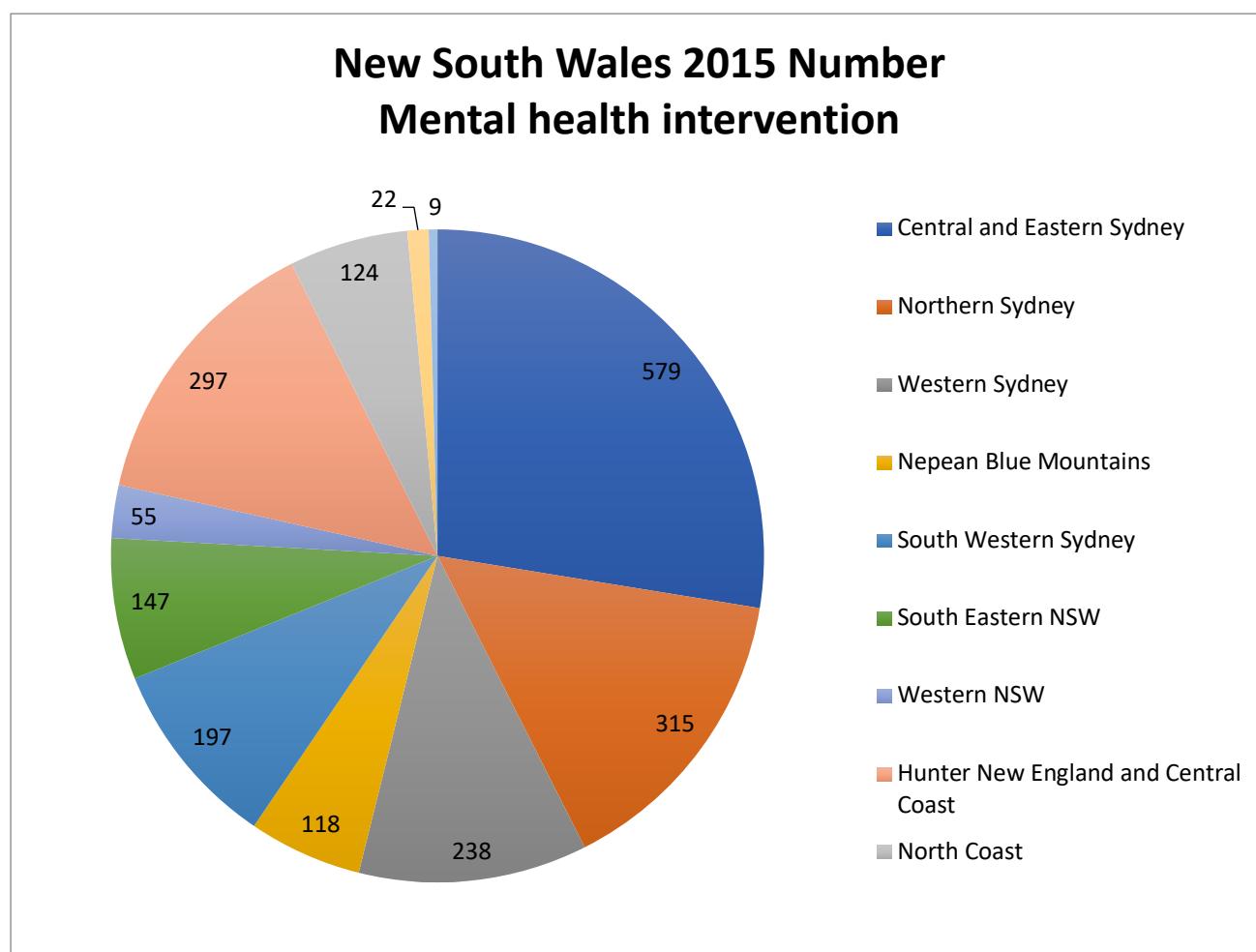
Appendix K - Table of Job Area of Practicing Psychologists in New South Wales, 2015



National Health Workforce Dataset, © Space Time Research 2016, (source <http://hwd.health.gov.au/>)

Appendix L - Mental health intervention in New South Wales, 2015

National Health Workforce Dataset, © Space Time Research 2016, (source <http://hwd.health.gov.au/>)



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