Psychotherapy & Counselling
Federation of Australia

Submission to the Senate Inquiry on the Mental Health of Australian Defence Force personnel

Submission to:
Senate Foreign Affairs, Defence and Trade References Committee

24 June 2015

For further information contact:

Maria Brett
Chief Executive Officer
PACFA
03 9486 3077
maria.brett@pacfa.org.au

Contents

Executive Summary

The Psychotherapy and Counselling Federation of Australia (PACFA) welcomes the Senate Inquiry on the mental health of Australian Defence Force (ADF) personnel. With the prevalence of mental illness among returned service personnel being significantly higher than in the general population, the inquiry is important to identify shortcomings in the service system which may be impacting on outcomes for returned service personnel, and to address the growing mental health needs of this client group. PACFA calls on the Inquiry to identify specific recommendations to improve the effectiveness of mental health care for returned service personnel and their families and to promote their mental health and wellbeing through the provision of counselling and psychotherapy services.

Counselling and psychotherapy are interdisciplinary activities provided by a range of professionals, including counsellors and psychotherapists, as well as psychologists, social workers, occupational therapists, nurses, doctors and psychiatrists. Counselling and psychotherapy are not 'owned' by any one of these professional groups. It is therefore surprising that counsellors and psychotherapists have long been overlooked as part of the Department of Veterans Affairs' (DVA) mental health workforce.

With the introduction of a statutory registration system for DVA mental health providers, the workforce has been limited to practitioners with Medicare provider numbers. The Veterans and Veterans' Families Counselling Service (VVFCS) has also limited its workforce of outreach counsellors to psychologists and mental health accredited social workers (VVFCS, 2015). Furthermore, PACFA is not aware of any PACFA-registered counsellors or psychotherapists being employed by the VVFCS as staff counsellors. In PACFA's view there is no valid rationale for these workforce restrictions. Counsellors and psychotherapists are highly trained and skilled, and those registered with PACFA as Mental Health Practitioners are recognised as meeting key mental health competencies.

Access to counselling and psychotherapy for returned service personnel and affected family members is essential for effective service outcomes, particularly as an early intervention strategy; to promote mental health and well-being; and as a treatment option for clients requiring more intensive clinical treatment. There is an abundance of evidence for the effectiveness of counselling and psychotherapy. This evidence holds true when these interventions are delivered by qualified counsellors and psychotherapists. There are also specialist therapies such as family therapy, relationship counselling, art therapy and body-focussed psychotherapy that should be delivered by specialist practitioners in these fields, such as specialist PACFA-registered counsellors and psychotherapists. Additionally, counsellors and psychotherapists are more widely available in rural and regional Australia than psychologists.

Recommendations to the Senate Inquiry and the DVA

1. Include registered counsellors and psychotherapists in the workforce of the VVFCS to broaden VVFCS clients' choices about the practitioners, models, skills and interventions available to them.

2. Develop DVA's purchasing guidelines to enable registered counsellors and psychotherapists, who are skilled and qualified to provide evidence-based interventions, to become DVA providers.

3. Support the extension of Medicare provider numbers to registered counsellors and psychotherapists to enable DVA to use them as providers. This will improve client choice, better match practitioners and interventions with client needs and preferences, and address workforce shortages in rural and regional Australia.

4. Offer specialist interventions, provided by suitably trained practitioners, such as art therapy, body-focussed psychotherapy, family therapy and relationship counselling, to returned service personnel and their families.

5. Increase access to VVFCS programs to strengthen the capacity of spouses, partners, carers and family members to support returned service personnel with help seeking behaviours, healthy lifestyles and recovery.

6. Consult with PACFA, which has research expertise, to help build the evidence base for counselling and psychotherapy as elements of effective mental health care.

Background to PACFA

What is PACFA?

PACFA is the leading national peak body representing the self-regulating profession of counselling and psychotherapy. PACFA is a federation of twenty seven professional associations in the counselling and psychotherapy field covering a range of therapy modalities, including family therapy, relationship counselling, hypnotherapy, integrative counselling, body-focussed psychotherapy, expressive arts therapies, psychodynamic psychotherapy and psychoanalysis.

PACFA advocates for appropriate, accessible health services to meet the bio-psychosocial needs of consumers. Counselling and psychotherapy focus on the prevention of mental illness and the provision of psychotherapeutic interventions for psychological difficulties, while actively promoting the development, mental health and wellbeing of consumers.

What are psychotherapy and counselling?

Counselling and psychotherapy are professional services provided by a range of professionals that utilise the therapeutic relationship to enable people to develop greater understanding of themselves and make positive changes in their lives. Counsellors and psychotherapists work within a clearly contracted, principled relationship to support individuals, couples and families to obtain assistance in exploring and resolving their difficulties.

The relationship between counselling and psychotherapy is seen as a continuum rather than a complete demarcation. Counselling focuses more on specific life difficulties such as bereavement and relationships, adjusting to life transitions, and fostering clients' wellbeing, whilst psychotherapy focuses to a greater extent on achieving change in some aspects of the person's self or personality structure to reduce repetitive, maladaptive patterns in work and relationships.

The PACFA Register

PACFA's 1,400 Registrants have completed training in counselling and psychotherapy to at least Bachelor degree level or equivalent, and many are trained at postgraduate levels. Registrants must have attained the equivalent of at last two years' full time practice (950 hours of client contact linked to 125 hours of clinical supervision) and demonstrate that they meet ongoing professional development and supervision requirements. Registrants must practice according to the PACFA Code of Ethics, as well as the Codes of Ethics of the PACFA Member Association to which they belong. Registrants are widely distributed and accessible throughout Australia in urban, regional, rural and remote areas.

PACFA Registrants are also listed on the Australian Register of Counsellors and Psychotherapists (ARCAP), a national register and credentialing system, established jointly by PACFA and our partner the Australian Counsellors' Association (ACA).

Mental Health Practitioners

While all PACFA counsellors and psychotherapists are trained and qualified to work with clients with mental disorders, the PACFA Register also has a specialist practitioner category of Mental Health Practitioner. Clinical Registrants must demonstrate practice competencies in the area of mental health to an accrediting panel to be recognised as Mental Health Practitioners. Mental Health Practitioners are able to provide psychological therapies for clients with more serious mental disorders.

Specialist practitioners

Some PACFA practitioners belong to PACFA Member Associations that focus on certain therapy modalities which are of particular relevance to returned service personnel and their families. Practitioners who specialise in providing these types of supports are identifiable on the PACFA Register by their membership of these associations, as detailed in Table 1.

Table 1: Specialist interventions provided by members of PACFA member associations

PACFA Member Association	Interventions provided
Australian Association of Family Therapy (AAFT)	• Family therapy
Australian Association of Relationship Counsellors (AARC)	• Relationship counselling • Couples counselling
Association of Solution Oriented Counsellors and Hypnotherapists of Australia (ASOCHA)	• Hypnotherapy • Solution-focussed counselling
Australian Hypnotherapists Association (AHA)	• Hypnotherapy
Gestalt Australia New Zealand (GTA)	• Creative arts therapies • Experiential therapy
Melbourne Institute for Experiential and Creative Arts Therapy (MIECAT)	• Creative arts therapies • Experiential therapy
Australian Somatic Psychotherapy Association (ASPA)	• Body-focussed psychotherapy
Music and Imagery Association of Australia (MIAA)	• Music and imagery therapy
Australian Centre for Psychoanalysis (ACP)	• Psychoanalytic psychotherapy
Australian and New Zealand Association of Psychotherapy (ANZAP)	• Psychodynamic psychotherapy
Australian & Aotearoa New Zealand Psychodrama Association (AANZPA)	• Psychodrama

PACFA Response to Senate Inquiry Terms of Reference

PACFA welcomes the Senate Inquiry on the mental health of ADF personnel. With the high prevalence of mental health conditions among ADF personnel who have returned from combat, peacekeeping or other deployment being significantly higher than in the general population, the Inquiry is both timely and necessary. PACFA believes the Inquiry should lead to policies aimed at ensuring more effective mental health care for ADF personnel and their families, and to improve their mental health and wellbeing.

This submission draws on PACFA's submission in 2013 to the Department of Veterans' Affairs (DVA) Consultation on their Draft Mental Health Strategy, in which PACFA identified a number of strategies to support DVA to improve mental health outcomes for returned service personnel and their families.

1. Mental health evaluation and counselling services available to returned service personnel

1.1 Veterans and Veterans' Families Counselling Service (VVFCS)

It is noted that the VVFCS provides a range of services for returned service personnel and their families with the emphasis on counselling, family therapy and group programs. Eligibility to register as a DVA private provider (Outreach counsellor) is limited to psychologists and mental health accredited social workers with Medicare numbers. PACFA presumes employment with VVFCS as Staff Counsellors is similarly limited, as PACFA is not aware of any registered counsellors and psychotherapists being employed by the VVFCS.

The allied mental health service providers used by DVA are principally psychologists and yet, compared with psychologists, counsellors and psychotherapists provide high quality, cost effective counselling and psychotherapy services with lower rates of complaints by consumers. Counsellors and psychotherapists are trained and skilled in providing counselling for trauma, substance abuse and anger management, all of which are key areas of concern for returning servicemen and women. The registration of counsellors and psychotherapists by DVA to provide allied mental health services will provide an affordable treatment option, as PACFA advocates for schedule fees to align with the fees for social workers of $89.45 per session.

Limiting the VVFCS workforce to only two professions that are formally trained in a limited range of counselling models limits client choice. There is strong evidence that providing services according to client preference improves therapy outcomes (Iacoviello, McCarthy, Barrett, Rynn, Gallop, & Barber, 2007; Lindhiem, Bennett, Trentacosta, & McLear, 2014; McLeod, 2012). Clients using the VVFCS service will benefit from the expertise of counsellors and psychotherapists, particularly in the areas of trauma counselling, substance abuse counselling, family therapy, relationship counselling, art therapy, and body-focussed psychotherapy. For clients with complex presentations and concurrent conditions, longer-term psychotherapy may be required.

In PACFA's view, there is no valid rationale for the VVFCS to restrict its workforce to psychologists and social workers. The VVFCS and its clients would benefit greatly from inclusion of counsellors and psychotherapists in the VVFCS workforce. DVA should recognise only counsellors and psychotherapists who meet PACFA's registration requirements (see Table 2), or Levels 3 and 4 on the ARCAP register, should they be eligible for recognition as DVA providers or employment by VVFCS.

Table 2: Proposed requirements for counsellors and psychotherapists to be DVA providers

Requirement	Details
Registration with PACFA as a counsellor or psychotherapist	PACFA Registration includes requirements to: • Maintain professional indemnity insurance • Undertake annual supervision and professional development requirements • Comply with PACFA's Code of Ethics and the Codes of Ethics of PACFA member associations to which Registrants belong

Requirement	Details
Competence to provide one or more of the interventions recommended by PACFA for DVA (See Table 3 below)	The interventions recommended by PACFA are all evidence-based interventions which are relevant to returned service personnel and their families

Many counsellors and psychotherapists have previous experience with veterans as people who have served in defence forces around the world already seek counselling. For example, a South American man who fought in the army in his home country as a young man. He witnessed many traumatic acts, before migrating to Australia. He lived and worked here for many years before presenting for counselling with PTSD and excessive drinking after experiencing an assault which triggered previous trauma. He required counselling to reduce his hazardous drinking and to manage the intrusive symptoms of trauma, before being able to discuss his army service, and integrate his past and present trauma.

Recommendation 1
Include registered counsellors and psychotherapists in the workforce of the VVFCS to broaden VVFCS clients' choices about the practitioners, models, skills and interventions available to them.

Recommendation 2
Develop DVA's purchasing guidelines to enable registered counsellors and psychotherapists, who are skilled and qualified to provide evidence-based interventions, to become DVA providers.

1.2 Medicare services

It is acknowledged that returned service personnel may not always seek help when they have a problem with their mental health and that early intervention is important to ensure that services are provided early in the trajectory of a mental health condition. Returned service personnel should be accessing early intervention counselling services upon discharge from active service to ensure appropriate interventions are offered early. For some clients, early intervention can help prevent the development of more complex mental health issues.

For those returned service personnel who are not eligible for free services from the VVFCS, Medicare services are the other main option available for mental health support. Currently General Practitioners and Local Medical Officers can only refer DVA clients to the following mental health practitioners who are registered service providers with Medicare Australia:

- Psychiatrists
- Clinical Psychologists
- Psychologists
- Mental Health Social Workers
- Mental Health Occupational Therapists

PACFA believes clients' ability to choose the most appropriate services and practitioners themselves is very important. Returned service personnel and their families are more likely to seek help if they are able to consult practitioners they trust and feel comfortable with. In this regard, it is interesting to note research findings that counsellors are more highly accepted by clients than either psychologists or psychiatrists (Jorm, Korten, Jacomb, Rodgers, Pollitt, Christiansen, & Henderson, 1997; Sharpley, 1986; Sharpley, Bond & Agnew, 2004) and are seen as more approachable and empathic (Sharpley, 1986). Counsellors are considered by the public to be the most helpful of all the professional groups providing therapeutic services (Jorm et. al., 1997) and general practitioners also rate counsellors fairly high for effectiveness in treating depression (Rodgers & Pilgrim, 1997). As masked depression is

extremely common in the returned service personnel client group, this finding is extremely important for increasing the acceptability of treatment services.

Outcome data for Medicare's Better Access initiative (Bai) indicates that similar outcomes are achieved from the *Focussed Psychological Strategies* offered by the scheme, regardless of whether treatment was provided by psychologists, social workers or occupational therapists. The level of psychological distress decreased from high or very high at the start of treatment to moderate by the end of treatment (Pirkis, Harris, Hall, & Ftanou, 2011), regardless of the occupation of the practitioner delivering the service.

Although more Australians access mental health services since the introduction of the BAi program, workforce shortages have resulted in waiting lists in some areas, particularly in rural, regional and remote Australia. The counselling and psychotherapy workforce is distributed widely across Australia, with 26.2% to 30.7% located in regional, rural and remote areas. Other health professions are less likely to be located outside of capital cities. In rural, regional and remote Australia, only 4% of psychiatrists and 21.5% of psychologists provide services (Vines, 2011), compared to 28.3% (mean) of counsellors and psychotherapists (Schofield, 2008; Schofield & Roedel, 2008). Counsellors and psychotherapists are therefore an overlooked part of the mental health workforce. Current and projected mental health workforce shortages could be addressed by recognising the contribution that counsellors and psychotherapists can make and including them in the BAi.

PACFA is lobbying the federal government to extend access to Medicare provider numbers to registered counsellors and psychotherapists. This essential step needs to be taken by government to enable better access to services, including counselling services for returned service personnel and their families, and to better meet client preferences for interventions and choice of practitioners.

Recommendation 3
Support the extension of Medicare provider numbers to registered counsellors and psychotherapists to enable DVA to use them as providers. This will improve client choice, better match practitioners and interventions with client needs and preferences, and address workforce shortages in rural and regional Australia.

2. Adequacy of mental health support services provided by DVA

Counselling and psychotherapy are important elements of the mental health support service already provided by the VVFCS. Counselling is particularly important as an early intervention for those experiencing mental health concerns, to support returned service personnel and their families with self-management, and to promote mental health and well-being. Longer-term psychotherapy treatment may be required for complex presentations, in coordination with treatments being provided by other mental health professionals.

Research evidence shows that effective outcomes can be expected from one to twelve sessions of counselling or psychotherapy. Sixty to 65% of people attending counselling experience significant reduction in their presenting issues after one to seven sessions (Miller, Duncan, Brown, Sorrell, & Chalk, 2006).

There is clear evidence for the contribution of counselling and psychotherapy to the prevention and treatment of mental illness, including depression, anxiety and trauma (Cuijpers et al., 2008). Where aspects of personality functioning are a factor in mental health, psychotherapy can make a particular contribution to treatment.

The whole of person approach advocated in the DVA's Mental Health Strategy (DVA, 2013) aligns with the person-centred emphasis of counselling and psychotherapy, which place clients firmly at the centre of our approach to therapeutic intervention. The training of counsellors and psychotherapists emphasises the centrality of the therapeutic relationship and counsellors and psychotherapists have highly developed relational skills to work in a client-centred way.

While the services provided by DVA are extensive, there are still gaps in service reach and failures in treatment outcomes. There are areas for possible improvement and expansion, particularly in relation to specialist interventions that could be offered, and broadening the VVCFS workforce to include registered counsellors and psychotherapists.

2.1 Posttraumatic Stress Disorder

For returned service personnel who experience significant trauma, effective trauma-informed treatment is required. Trauma counselling requires great skill and care, and a strong therapeutic relationship based on trust, to ensure the client is not re-traumatised and to manage and reduce the symptoms of Posttraumatic Stress Disorder (PTSD).

Therapists working with PTSD require skills to support clients who experience a high level of distress, are likely to use alcohol and other substances to manage intrusive symptoms, and to display anger and irritability in their relationships. The highly developed relational and supportive skills of counsellors and psychotherapists play a crucial role in treatment effectiveness. A positive therapeutic relationship and the client's expectations about treatment are positively associated with treatment outcome (Australian Centre for Posttraumatic Mental Health, 2007).

There is a variety of evidence-based counselling and psychotherapeutic treatments for PTSD (Schottenbauer, Arnkoff, Glass, Gray & Hafter, 2006; Sherman, 1998). Counsellors and psychotherapists are trained in one of more of these approaches:

- trauma-focused cognitive-behavioural therapy
- eye movement desensitization and reprocessing
- psychodynamic psychotherapy
- supportive counselling
- art therapy
- body-focussed psychotherapy
- exposure therapy (for single incidents of trauma)
- dialectic behaviour therapy
- hypnotherapy
- psychological debriefing.

Case study 1: Counselling for Posttraumatic Stress Disorder

An ex-army client was referred to a counsellor by his GP for counselling with symptoms of trauma following a neighbourhood dispute. He had recently been diagnosed with a terminal illness which had re-triggered traumatic experiences incurred while serving with the army. He had been involved in bomb disposal but had no trauma symptoms during service, having been protected by being part of a close knit team during service. He attended counselling for twenty sessions to reduce the intrusive PTSD symptoms. The counselling drew on techniques of: affect regulation, distraction from negative feelings, having daily positive experiences to enrich his life, problem solving about relationships, motivational interviewing to reduce alcohol, and conflict resolution. The intrusive symptoms of trauma settled and the client was more able to reflect on the meaning of his life and to prepare for end of life without being re-traumatised.

2.2 Specialist interventions

Specialist counsellors and psychotherapists have a contribution to make, both as allied health providers and as part of the workforce of the VVFCS. Table 3 shows interventions which can be provided by counsellors and psychotherapists and which are appropriate supports for DVA clients and their family members

Table 3: Counselling and psychotherapy interventions recommended for returned service personnel

Therapy intervention	**Details**
Art therapy	Support to work through trauma, avoids re-traumatisation
Brief therapy	Support to find solutions to specific problems
Body-focussed psychotherapy	Support with complex presentations including trauma
Cognitive-behavioural therapy	Support to change dysfunctional thoughts and behaviours and reinstitute adaptive behaviours
Couples therapy	Support with the primary relationship with a spouse or partner
Family therapy	Support to improve relationships with family members and carers
Group therapy	Support to develop and improve social and communication skills with peer support
Hypnotherapy	Support to increase motivation or change behaviour using hypnosis
Integrative counselling	Support for a wide range of client presentations, using a range of counselling interventions selected according to client needs and preferences
Mindfulness-based therapies	Support to develop awareness and acceptance of present experience
Motivational interviewing	Support to build motivation for behaviour change, for example substance abuse, reduce resistance to change and prevent relapse
Person-centred counselling	Support to develop a stronger sense of self and make life changes
Psycho-education	Support to develop a wide range of psychosocial skills
Psychodynamic psychotherapy	Support with complex presentations including trauma, suicide risk and personality disorders
Relationship counselling	Support to improve relationships with family members, carers, friends and colleagues
Solution-focused counselling	Strengths-based support to assist clients to find solutions for specific problems and develop positive self-identity
Supportive counselling	Support with all aspects of functioning

Art therapy

Psychotherapists working in inpatient and outpatient settings in health services may provide art therapy for returned service personnel. This therapy modality requires specialist psychotherapy training that psychologists and social workers generally do not have, unless they have undertaken additional training outside of their discipline. Hospitals are not restricted to employing psychologists and social workers, but are able to employ skilled and qualified art therapists, who may be psychotherapists. Art therapists also work with returned service personnel in private practice.

Collie, Backos, Maichiodi and Spiegel (2006) reviewed studies on the effectiveness of art therapy for PTSD and concluded that art therapy is effective for hard-to-treat symptoms of combat-related PTSD. They found that externalisation of traumatic experiences, using art therapy to create images and objects, helps traumatised clients take an observational stance and relate to traumatic material with emotional distance. Whereas talking therapy may cause re-experiencing of the trauma, which may result in re-traumatisation, working through trauma using art significantly reduces this risk.

Johnson, Lubin, James and Hale (1997) found that art therapy, compared with another 14 treatments including group therapy, drama therapy, community service, anger management, and journaling, produced the greatest benefits for returned service personnel with severe PTSD symptoms. Returned service personnel were able to tolerate war-zone content during art therapy in a way that they couldn't during other activities.

Case study 2: The perspective of an art therapist working with returned service personnel
In working with ex-servicemen who are still suffering the haunting daily consequences of conflicts and war, I found many men don't want to talk about it, and others want to talk a lot. For those who are deeply affected, it takes a long time to break through. This is where art therapy and the non-verbal therapeutic modalities help. Art therapy enables veterans to give a voice to the experience through visual expression and allows them to capture the vulnerability of their experiences, initially through non-verbal communication. By working with art, they are then able to explore their experiences verbally, which in turn enables them to connect with their emotional experience.

It is important that art therapy is provided by a suitably qualified registered psychotherapist. Psychotherapy is a creative experience and art therapy is one of the tools. Psychotherapists are the conduit by which those tools are used to assist clients.

Body-focussed psychotherapy
Research indicates body-focussed psychotherapy is effective for a wide range of presenting issues (Bloch-Atefi & Smith, 2014). Studies show positive treatment outcomes for depression, anxiety, somatisation and psychosomatic disorders (Röhricht, 2009), chronic depression (Röhricht, Papadopoulos, & Priebe, 2013) and suicide prevention (Allmer et al., 2009).

A study by Gordon et al. (2008) investigated the effects of mind-body interventions such as meditation, biofeedback, autogenic training, guided imagery, movement, and breathing techniques, and found significant positive treatment outcomes. There is also a considerable body of research that has validated acupoint simulation as an efficacious treatment for several conditions including PTSD, anxiety, and depression (Church, 2013; Feinstein, 2012).

Of particular relevance to returned service personnel is the finding that body-focussed interventions offer promising additional psychotherapeutic tools in areas where traditional talking psychotherapies seem to fail, including PTSD (Gordon et al., 2008; Röhricht, 2009).

Recommendation 4
Offer specialist interventions, provided by suitably trained practitioners, such as art therapy, body-focussed psychotherapy, family therapy and relationship counselling, to returned service personnel and their families.

3. Support available for partners, carers and families of returned service personnel who experience mental ill-health and PTSD

3.1 Family therapy and relationship counselling

As DVA would be well aware, family relationships are impacted where returned service personnel are living with trauma or other mental health problems related to their military service. Family therapists and relationship counsellors have a particularly important role to play in supporting couples and families to address relationship and family stresses arising from military service. Specialist family therapists and specialist relationship counsellors are recommended for the provision of these services.

Supporting and sustaining the family relationships of returned service personnel will go a significant way towards preventing and ameliorating mental illness in this client group. The nexus between fulfilling, rewarding personal relationships and physical and mental health is well documented in the research. For example, a large Canadian population study showed that 12% of people who separate become depressed, and adult males in particular are six times more likely to become depressed after a relationship breakdown than men who remain married (Rotermann, 2007). Research supports counselling and psychotherapy, and in particular couple therapy, as the indicated treatment for relationship difficulties and to promote adjustment to separation.

Substance abuse

Mental illness, in particular PTSD, is commonly comorbid with substance abuse, particularly alcohol, amongst veteran populations experiencing mental illness. Recent systematic reviews have shown that couple counselling and family therapy can be more effective than individual treatment for treating substance abuse, and result in reduced use, reduced incidence of interpersonal violence, and improved relationship functioning (O'Farrell & Clements, 2011; Ruff, McComb, Coker & Sprenkle, 2010). Couple therapy also has a strong evidence base for treating PTSD in returning service personnel and returned service personnel, as spouses and partners can develop secondary trauma symptoms (Monson, Fredman, & Adair, 2008).

Treatment of alcohol abuse is particularly important, as it is likely to be the first psychological disorder to develop in returning service personnel (McKenzie, Creamer, Kelsall, Forbes, Ikin, Sim, & McFarlane, 2009).

Case study 3: Family therapy during active service

A woman sought assistance from a family therapist for anxiety. She was married to a serving member of the army deployed in Afghanistan. They had a ten year old daughter. The client experienced anxiety about her husband's safety and distress about his last period of leave. She said he seemed hyperactive and unable to sit and talk with family without drinking alcohol. He had difficulty sleeping and nightmares, which he didn't want to discuss. The family therapist used techniques such as relaxation, focusing on the breath, and distraction to reduce her anxiety. In the next few months the daughter also showed heightened symptoms of anxiety about her father. The family therapist saw mother and daughter together for three sessions and the distress settled. On the next period of leave, the couple came to therapy and were able to institute positive activities that enriched their family life. A session of family therapy was also provided and the father was more willing to spend time with his daughter doing activities they enjoyed. In the next period of service, the family coped with the separation without high levels of anxiety, and the father maintained more frequent contact with his daughter.

3.2 Other supports for partners, carers and family members

The range of services offered to partners, carers and family members of returned service personnel by the VVFCS is welcomed. However, it is noted that ADF personnel and family members who are not eligible to access VVFCS services (based on the VVFCS eligibility criteria), or those who require mental health services that are not provided by the VVFCS, are not able to access the services they need through DVA. This means some family members may be missing out on access to valuable individual and family treatment services and group programs because of the eligibility criteria. These programs are valuable not only for spouses, partners, carers and family members themselves, but as a way to build their capacity to support returned service personnel with help seeking behaviours, re-establishing healthy lifestyles and recovery.

The services offered via Medicare under the *Better Access initiative* are *Focussed Psychological Strategies*, which do not include family therapy and relationship counselling. Group programs like those offered by VVFCS are not available through the BAi. PACFA has long advocated for the restrictive list of *Focussed Psychological Strategies* to be expanded to include other evidence-based interventions including family therapy and relationship counselling. This would go some way towards improving access to family therapy and relationship counselling for returned service personnel and their family members. DVA could consider lobbying the Department of Health to expand coverage under BAi.

The DVA could also consider improving access to its group programs to more family members, partners and carers of returned service personnel by reviewing the eligibility criteria.

Recommendation 5
Increase access to VVFCS programs to strengthen the capacity of spouses, partners, carers and family members to support returned service personnel with help seeking behaviours, healthy lifestyles and recovery.

4. Any other related matters

4.1 Building the evidence base

There is a strong evidence base for the efficacy of psychotherapy and counselling. PACFA endorses the American Psychological Association's definition of evidence-based practice as "the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preferences" (APA, 2006, p. 273).

We now have more than twenty years of knowledge concerning client experience of counselling and psychotherapy. A 1990 study by Scott and Freeman compared GP treatment, psychologist treatment, medication, and counselling treatment provided by social workers. All treatments achieved similar results for similar costs, however clients rated counselling more highly as the social workers spent more time with their clients.

Seligman (1995) undertook a large Consumer Reports study to discover the experiences of people who had undergone counselling or psychotherapy. The study was in effect a consumer satisfaction study of the kind that might be conducted with respect to any product or service. He concluded that there were substantial benefits for people in psychotherapy; that psychotherapy without medication produces the same effects as psychotherapy with medication; that no one model produces better outcomes than other models; and that psychotherapy is effective regardless of the practitioner's occupation, for example as a psychologist, psychiatrist or social worker.

These findings are supported by research into the common factors underlying the effectiveness of counselling and psychotherapy (Duncan, Miller, Wampold, & Hubble, 2009) which has found that all types of therapy achieve broadly similar client outcomes, and that the strength of the client-therapist relationship is a key determinant of therapy outcomes.

It is important to continuously improve treatment services by building the evidence base for effective treatments. There is the opportunity to build the evidence base for effective counselling and psychotherapy through liaison and collaboration with peak bodies. In this regard, PACFA is available for consultation based on our research expertise. Through its Research Committee, PACFA has an ongoing research agenda to build the evidence base for the effectiveness of counselling and psychotherapy.

Recent achievements include establishing the Psychotherapy and Counselling Journal of Australia (PACJA), and publishing literature reviews on therapy modalities (Evans, Turner & Trotter, 2012; Gaskin, 2012 & 2014; Bloch-Atefi & Smith, 2014; Jacobs & Reupert, 2014; Kennedy, Macnab & Ross, 2015) and practice resources for those working with common presenting issues, such as trauma, depression and anxiety (Knauss & Schofield, 2009a; 2009b; & 2009c).

Recommendation 6
Consult with PACFA, which has research expertise, to help build the evidence base for counselling and psychotherapy as elements of effective mental health care.

References

Allmer, C., Ventegodt, S., Kandel, I., & Merrick, J. (2009). Positive effects, side effects, and adverse events of clinical holistic medicine: A review of Gerda Boyesen's nonpharmaceutical mind-body medicine (biodynamic body-psychotherapy) at two centers in the United Kingdom and Germany. *International Journal of Adolescent Medicine and Health, 21*(3), 281-297.

American Psychological Association (APA). (2006). Evidence-based practice in psychology. *American Psychologist, 61(*4), 271–285. Retrieved from http://www.apa.org/practice/resources/evidence/evidence-based-statement.pdf

Australian Centre for Posttraumatic Mental Health (2007). *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder.* Melbourne, VIC: ACPMH. Retrieved from http://www.nhmrc.gov.au/guidelines/publications/mh13-mh14-mh15-mh16.

Bloch-Atefi, A., & Smith, J. (2014). *The effectiveness of body-oriented psychotherapy: A review of the literature.* Melbourne: PACFA. Retrieved from http://www.pacfa.org.au/wp-content/uploads/2012/10/PACFA_LitReview_Body-Oriented-Psychotherapy_Final.pdf.

Church, D. (2013). Clinical EFT as an evidence-based practice for the treatment of psychological and physiological conditions. *Psychology*, *4*(7), 645-654.

Collie, K., Backos, A., Malchiodi, C., & Spiegel, D. (2006). Art therapy for combat-related PTSD: Recommendations for research and practice. *Art Therapy: Journal of the American Art Therapy Association*, 23(4), 157-164.

Cuijpers, P., van Straten, A., Smit, F., Mihalopoulos, C., & Beekman, A. (2008). Preventing the onset of depressive disorders: A meta-analytic review of psychological interventions. *American Journal of Psychiatry, 165*(10), 1272-1280.

Department of Veterans' Affairs (DVA). (2013). *Veteran mental Health Strategy: A ten year framework 2013 – 2023*. Canberra, Australia: Commonwealth Government. Retrieved from http://at-ease.dva.gov.au/veterans/resources/dva-mental-health-strategy/

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

Dunphy, K., Mullane, S., & Jacobsson, M. (2013). *The effectiveness of expressive arts therapies: A review of the literature.* Melbourne, Australia: PACFA. Retrieved from http://www.pacfa.org.au/research.

Evans, P., Turner, S., & Trotter, C. (2012). *The Effectiveness of Family and Relationship Therapy: A Review of the Literature*. Melbourne, Australia: PACFA. Retrieved from http://www.pacfa.org.au/research.

Feinstein, D. (2012). Acupoint stimulation in treating psychological disorders: Evidence of efficacy. *Review of General Psychology*, *16*(4), 364-380.

Gaskin, C. (2012). *The effectiveness of psychodynamic psychotherapy: A systematic review of recent international and Australian research.* Melbourne, Australia: PACFA. Retrieved from http://www.pacfa.org.au/research.

Gaskin, C. (2014). *The effectiveness of psychoanalysis and psychoanalytic psychotherapy: A literature review of recent international and Australian research*. Melbourne, Australia: PACFA. Retrieved from http://www.pacfa.org.au/research.

Gordon, J. S., Staples, J. K., Blyta, A., Bytyqi, M., & Wilson, A. T. (2008). Treatment of posttraumatic stress disorder in postwar Kosovar adolescents using mind-body skills groups: A randomized controlled trial. *Journal of Clinical Psychiatry*, *69*(9), 1469-1476.

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

Jacobs, N. & Reupert, A. (2014). *The effectiveness of supportive counselling, based on Rogerian* principles*: A systematic review of recent international and Australian research.* Melbourne, Australia: PACFA. Retrieved from http://www.pacfa.org.au/research.

Johnson, D. R., Lubin, H., James, M., & Hale, K. (1997). Single session effects of treatment components within a specialised inpatient posttraumatic stress disorder program. *Journal of Traumatic Stress*, *10*(3), 377-390.

Jorm, A., Korten, A. E., Jacomb, P. A., Rodgers, B., Pollitt, P., Christiansen, H., & Henderson, S. (1997). Helpfulness of interventions for mental disorders: Beliefs of health professionals compared with the general public. *British Journal of Psychiatry*, *171,* 233-237.

Kennedy, G. A., Macnab, F. A. & Ross, J. J. (2015). *The effectiveness of spiritual/religious interventions in psychotherapy and counselling: a review of the recent literature.* Melbourne: PACFA. Retrieved from http://www.pacfa.org.au/research.

Knauss, C., & Schofield, M. J. (2009a). *A resource for counsellors and psychotherapists working with clients suffering from anxiety.* Melbourne, Australia: PACFA. Retrieved from http://www.pacfa.org.au/research.

Knauss, C. & Schofield, M. J. (2009b). *A resource for counsellors and psychotherapists working with clients suffering from depression.* Melbourne, Australia: PACFA. Retrieved from http://www.pacfa.org.au/research.

Knauss, C., & Schofield, M. J. (2009c). *A resource for counsellors and psychotherapists working with clients suffering from posttraumatic stress disorder.* Melbourne, Australia: PACFA. Retrieved from http://www.pacfa.org.au/research.

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

McKenzie, D. P., Creamer, M., Kelsall, H. L., Forbes, A. B., Ikin, J. F., Sim, M. R., & McFarlane, A. C. (2009). Temporal relationships between Gulf war deployment and subsequent psychological disorders in Royal Australian Navy Gulf war returned service personnel. S*ocial Psychiatry Epidemiology, 45*(8), 43–852.

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

Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R., & Chalk, M.B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy, 5*(1), 5-22.

Monson, C. M., Fredman, S. J., & Adair, K. C. (2008). Cognitive-behavioural conjoint therapy for posttraumatic stress disorder: Application to operation enduring and Iraqi Freedom returned service personnel. *Journal of Clinical Psychology: In Session, 64*(8), 958-971. DOI: 10.1002/jclp.20511

O'Farrell, T. J., & Clements, K. (2012). Review of outcome research on marital and family therapy in treatment for alcoholism. *Journal of Marital and Family Therapy*, *38*(1), 122-144. doi: 10.1111/j.1752-0606.2011.00242.x.

PACFA (2013). *Submission on the Department of Veteran Affairs Draft Mental Health Strategy 2013.* Melbourne, Australia: PACFA. Retrieved from http://pacfa-org-au.cloud.hosting-toolkit.net/wp-content/uploads/2014/03/PACFASubmission_Returned service personnelAffairs_15Feb2013.pdf.

Pirkis, J., Harris, M., Hall, W., & Ftanou, M. (2011). *Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation.* Melbourne, Australia: Centre for Health Policy, Programs and Economics. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-eval-sum.

Röhricht, F. (2009). Body oriented psychotherapy. The state of the art in empirical research and evidence-based practice: A clinical perspective. *Body, Movement and Dance in Psychotherapy*, *4*(2), 135-156.

Röhricht, F., Papadopoulos, N., & Priebe, S. (2013). An exploratory randomized controlled trial of body psychotherapy for patients with chronic depression. *Journal of Affective Disorders*, *151,* 85-91. doi.org/10.1016/j.jad.2013.05.056

Rodgers, A., & Pilgrim, D. (1997). The contribution of lay knowledge to the understanding and promotion of mental health. *Journal of Mental Health*, *6*(1), 23-35.

Rotermann, C. (2007). Marital breakdown and subsequent depression. *Health Reports, 18*(2), 33-44. .

Ruff, S., McComb, J. L., Coker, C. J., & Sprenkle, D. H. (2010). Behavioral Couples Therapy for the treatment of substance abuse: A substantive and methodological review of O'Farrell, Fals-Stewart, and colleagues' program of research. *Family Process, 49*(4), 439-456.

Schottenbauer, M. A., Arnkoff, D. B., Glass, C. R., & Gray (2006). Psychotherapy for PTSD in the community: Reported prototypical treatments. *Clinical Psychology & Psychotherapy, 13*, 108-122.

Scott A. I., & Freeman C. P. (1992). Edinburgh primary care depression study: Treatment outcome, patient satisfaction, and cost after 16 weeks. *British Medical Journal, 304*(6831), 883-887.

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

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

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

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

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

Sherman, J. J. (1998). Effects of psychotherapeutic treatments for PTSD: A meta-analysis of controlled clinical trials. *Journal of Traumatic Stress, 11*, 413-435.

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