Psychotherapy & Counselling
Federation of Australia

PACFA submission to the National Mental Health Commission Review of Mental Health Services

National Mental Health Commission

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EXECUTIVE SUMMARY

The Psychotherapy and Counselling Federation of Australia (PACFA) is a leading peak body for the counselling and psychotherapy profession. In this submission PACFA makes recommendations to address shortcomings in the Better Access Initiative (BAI) and the Access to Allied Psychological Services (ATAPS) programs and identifies alternative models of mental health service delivery.

PACFA submits that the BAI requires serious rethinking as the program has grown exponentially and program expenditure has become unsustainable. There are serious problems with the program design, targeting and implementation, including over-servicing of consumers with mild to moderate mental disorders with specialist psychological treatment and Medicare payments to GPs for Mental Health Plans which are not necessary or approriate for all consumers and are not a cost-effective model of service delivery.

The range of interventions available under both the BAI and ATAPS programs is not adequate to meet consumer needs and is not well informed by research evidence. Client outcomes could be improved by including a range of other evidence-based counselling and psychotherapy treatment models. The BAI also requires better processes for routine data collection and program evaluation in order to improve transparency and accountability for program expenditure and outcomes.

PACFA has contributed to the development of an alternative model of service delivery for Primary Care Counselling which is presented in this submission. This model would require government to rethink the way mental health services are delivered but has the potential to deliver:

- Savings of approximately $100,000,000 (detailed in Appendix 1);
- Capacity for 20% growth in service delivery above current service levels;
- More accessible and affordable services for consumers; and
- A wider range of counselling interventions to meet consumer needs.

Although more people are accessing mental health services since the introduction of the BAI and ATAPS programs, workforce shortages have resulted in waiting lists in some areas, particularly in rural, regional and remote Australia. Counsellors and psychotherapists are 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 as service providers in a range of mental health programs.

Recommendations

Recommendation 1

The design of the BAI program should be responsive to the clinical needs of consumers. The number of treatment sessions available under BAI should be based on research evidence and not limited as a cost-saving measure as this can be detrimental to treatment outcomes.

Recommendation 2

Include registered counsellors and psychotherapists as service providers in the BAI and ATAPS programs. These practitioners are appropriately qualified to provide counselling for consumers with mild to moderate mental health problems and are a cost effective option compared with current program arrangements.

Recommendation 3

Where specialist mental health services are required for severe mental health disorders, these could be provided by PACFA Mental Health Practitioners, in addition to existing service providers under the BAI and ATAPS. PACFA Mental Health Practitioners should therefore be added to the list of providers.

Recommendation 4

GP Mental Health Plans should only be used where a diagnosis of a mental disorder is necessary for effective treatment and where this treatment is to be provided by a specialist Mental Health Practitioner. Consumers with mild to moderate mental health problems should not be diagnosed with a mental disorder or be required to have a Mental Health Plan to access counselling via Medicare.

Recommendation 5

Only GPs who have undertaken the AMA-approved mental health training should be eligible to receive the Medicare Schedule Fee to prepare Mental Health Plans.

Recommendation 6

The BAI should be redeveloped as a more cost-effective and sustainable program that is better targeted to meet consumer needs. Alternatively, it should be replaced with another program that meets these requirements.

Recommendation 7

The National Mental Health Commission should consider whether the BAI could be replaced by a new Primary Care Counselling Program along the lines of the Primary Care Counselling program recommended by PACFA. Alternatively, the BAI could be adapted to include the elements proposed in this alternative model.

Recommendation 8

The range of approved psychological strategies in the BAI and ATAPS programs should be expanded to include other psychotherapy and counselling models with a strong evidence base. This will enable practitioners to select interventions appropriate to client presentations, characteristics and treatment preferences, which is likely to improve service outcomes.

Recommendation 9

Introduce a Minimum Data Set for the BAI and routine data collection using a standardised assessment tool for the BAI and ATAPS programs. This will ensure that both programs gather the data required for ongoing evaluation of service uptake, cost-effectiveness and client outcomes.

Recommendation 10

Increase client access in rural, regional and remote Australia by expanding the mental health workforce to include counsellors and psychotherapists as key allied health professionals to work in government and non-government health services, and to receive referrals as private practitioners.

Recommendation 11

Develop a rural and regional mental health workforce plan. The plan should take a broad definition of the mental health workforce to improve client access, and should include registered counsellors and psychotherapists and PACFA Mental Health Practitioners. Clinical supervision for mental health workers should be emphasised in the plan to improve and maintain service quality.

Recommendation 12

Provide specialised postvention support for the families and friends of suicide victims, with an emphasis on the particular needs of bereaved children and young people.

Recommendation 13

Consumers with severe mental disorders requiring psychotherapy should be able to access long-term psychotherapy from a specialist Mental Health Practitioner. This will help to prevent repeated hospitalisation of these consumers and reduce suicide risks.

Recommendation 14

Peer support should be included in the mental health service mix and where possible, peer support workers should be encouraged and funded to undertake training in counselling and psychotherapy. An assessment process should be used to identify the clients that are suitable for peer support.

BACKGROUND TO PACFA

What is PACFA?

PACFA represents the self-regulating profession of counselling and psychotherapy. Counselling and psychotherapy is a self-regulating in a similar way to the social work profession which is regulated by the Australian Association of Social Workers, in addition to the codes of conduct which are in place for unregistered health professionals in New South Wales and South Australia. PACFA is a federation of twenty-nine Member Associations which represent a range of modalities, including integrative counselling and psychotherapy, family therapy, experiential therapies, psychodynamic psychotherapy and psychoanalysis.

PACFA Register

PACFA has approximately 1,400 practitioners listed on its National Register. Clinical Registrants have completed training in counselling and psychotherapy to at least Bachelors level or equivalent, and must have attained the equivalent of two years' full time practice (950 hours of client contact linked to 125 hours of clinical supervision) and demonstrate that they meet ongoing professional development requirements for renewal of registration. PACFA Registrants are recognised by some private health insurance funds for the provision of counselling services. Registrants are widely distributed and accessible throughout Australia in urban, regional, rural and remote areas.

Mental Health Practitioners

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

Australian Register of Counsellors and Psychotherapists

PACFA has worked in collaboration with the Australian Counsellors' Association (ACA) to establish the Australian Register of Counsellors and Psychotherapists (ARCAP), a national register and credentialing system, to regulate counsellors and psychotherapists within Australia. Practitioners who are listed on the PACFA and ACA Registers are listed on the ARCAP.

PACFA SUBMISSION

1. Introduction

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

As PACFA is a federation, this submission represents the perspectives of PACFA's 29 member associations and their members who are counsellors and psychotherapists from diverse locations, disciplines and professional experience around Australia.

In addressing the Terms of Reference of the National Mental Health Commission's review of mental health services, PACFA has focused on two programs with which we are familiar:

- Better Access Initiative; and
- Access to Allied Psychological Services.

In relation to these two programs, PACFA will address the following points from the Terms of Reference:

- The efficacy and cost-effectiveness of programmes, services and treatments;
- Duplication in current services and programmes; and
- Transparency and accountability for outcomes of investment.

Other points from the Terms of Reference are also addressed in this submission:

- Specific challenges for regional, rural and remote Australia;
- Funding priorities in mental health and gaps in services and programmes, in the context of the current fiscal circumstances facing governments; and
- Existing and alternative approaches to supporting and funding mental health care.

1. Better Access initiative

The Better Access Initiative (BAI) is the main Medicare-funded program that provides counselling services to consumers with a diagnosis of a mental disorder. It is also used by some consumers with more severe mental disorders.

1.1 Efficacy and cost effectiveness

The 2011 evaluation of BAI found that, on average, consumers had five sessions of *Focussed Psychological Strategies (*or 6 sessions, depending on the data used) (Pirkis, Harris, Hall & Ftanou, 2011). This is supported by other research which found that six counselling sessions is the optimum amount of counselling required required for effective outcomes for most consumers (Frame, Hanlon, MacLean, & Nolan, 2005), although longer term services are required for severe and long term mental disorders.

The evaluation provided clear evidence that the Better Access initiative has improved access to mental health care. Some features of the evaluation findings are:

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

However, there are significant issues with the program including:

- Exponential growth in program uptake and associated growth in program expenditure;
- The provision of Mental Health Plans by GPs which are not necessary or appropriate for some consumers and are not a cost-effective model of service delivery;
- Over-servicing by psychologists and clinical psychologists of consumers who do not need specialist intervention but simply require primary care counselling;
- Waiting lists for service in some areas, particularly rural, regional and remote areas;

- Continuing difficulties in reaching hard-to-reach individuals and communities;
- Problems with program design such as limiting the service to ten treatment sessions which may not meet the needs of all consumers;
- The prescribed Focused Psychological Strategies offered are too narrow to meet the needs of all consumers, potentially impacting on service effectiveness.

Service uptake

While it has to be acknowledged that BAI has improved assess to counselling services, the BAI evaluation found there were lower levels of service uptake in areas with relatively more socioeconomically disadvantaged people and by consumers in remote locations (Pirkis et al., p. 30)**.**

74% of consumers received one to six sessions through the BAI (Littlefield, June 2011). Successful completions and consumers dropping out of therapy because of dissatisfaction with the service or poor therapeutic alliance with their Mental Health Practitioner are included in this group. This should be of concern to the Department of Health. Attrition in the form of missed appointments wastes the time resources of Mental Health Practitioners who could be offering their services to other clients waiting for appointments, and consumers who drop out do not have their needs addressed. More research is needed on the experience of consumers who receive only one to two sessions through the BAI.

The increased service uptake has come at significant financial cost to Medicare as program expentiure has grown in line with uptake. Prior to BAI commencing, some of the service needs were met by private counselling and pscyhotherapy practitioners. PACFA registered practitioners reported that after the introduction of BAI, there was a noticeable drop in self-referrals for counselling and pscyhotherapy.

Program design and targeting

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

There is a need for Government to clarify the target group intended to receive services under BAI. If the program is to be targeted at consumers where a diagnosis of a mental disorder is appropriate and necessary and where specialist treatment is required, there is no clinical basis for restricting treatment to ten sessions. Indeed, some consumers require long-term psychotherapy and their needs are not currently being met through the BAI (see section 6.2 below).

Although evidence indicates short term therapy is effective for some patients, it is important that clinicians are able to provide treatments that are responsive to consumer needs. Research on consumer engagement with community mental health services demonstrates that "a minimum of 11 to 13 sessions of evidence-based interventions are needed for 50% - 60% of clients to be considered recovered" (Barrett, Chua, Crits-Cristoph, Gibbons & Thompson, 2008, p. 248). For some patients with more long-term or severe mental health challenges, limiting the number of treatment sessions available under the BAI to ten sessions could have a detrimental effect on treatment outcomes.

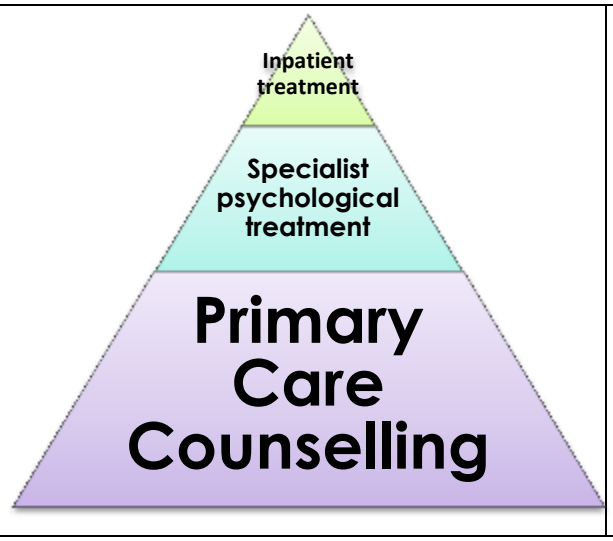
If the target group for BAI is, in fact, consumers with mild to moderate depression and anxiety, which requires only short-term intervention, then BAI is arguably *not* the most appropriate or cost effective service option. Some alternative approaches to service delivery for consumers with mild to moderate depression and anxiety are canvassed in section 7 of this submission.

Recommendation 1
The design of the BAI program should be responsive to the clinical needs of consumers. The number of treatment sessions available under BAI should be based on research evidence and not limited as a cost-saving measure as this can be detrimental to treatment outcomes.

Over-servicing by psychologists and clinical psychologists

One finding in the BAI evaluation was that 47.6% of BAI consumers had severe mental health disorders and 52.4% had mild or moderate disorders (Pirkis et al., p. 36). Despite the wide range of consumer needs serviced through the BAI, consumers using the service accessed on average five sessions of *Focussed Psychological Strategies*. It is difficult to justify Medicare-funded Mental Health Plans prepared by GPs and treatment by specialist practitioners such as clinical psychologists for short-term interventions.

Specialist intervention should be targeted towards consumers who are diagnosed with more severe mental disorders. Based on the above statistics, this would only include 47.6% of consumers accessing BAI services. For the 52.4% of consumers seeking support via BAI for mild to moderate depression and anxiety, alternative models of service delivery should be considered.



- Inpatient treatment only for acute care
- Only those who have been assessed as having more severe mental disorders should be accessing specialist psychological treatment via GP Mental Health Plans
- Primary Care Counselling should be an accessible and affordable mental health service for consumers with high prevalence mental disorders such as mild to moderate depression and anxiety

Consumers with mild to moderate depression and anxiety could be effectively assisted by receiving counselling from registered counsellors and psychotherapists, as the evidence-base is clear for the effectiveness of counselling for depression and anxiety. These consumers should not be diagnosed with mental disorders as their recovery is not aided by being labelled with a mental health diagnosis. The recovery movement in mental health has strongly argued against the disempowerment of consumers as a result of professional practices, including diagnosis, which fail to offer hope (Masterson & Owen, 2006).

It is also important to note that psychologists and clinical psychologists are paid higher schedule fees than other allied mental health practitioners, based on the rationale that their training justifies a higher fee. However, under the BAI, the service provided to consumers is *Focussed Psychological Strategies* and the service provided is essentially the same regardless of the discipline of the

practitioner providing the service. If there is to be any price differentiation for services provided, it should be on the basis that a more specialised service is being provided, such as psychometric testing and treatment for more severe mental disorders.

The Government should consider widening the list of practitioners approved for the BAI program to include registered counsellors and psychotherapists for the treatment and symptom reduction of mild to moderate mental illness. These practitioners could also be included in the ATAPS program which offers similar services to consumers. This would improve access to mental health services, as registered counsellors and psychotherapists are widely distributed and accessible throughout Australia in urban, regional, rural and remote areas. The most appropriate and cost-effective practitioner can then be selected according to consumer needs.

Recommendation 2
Include registered counsellors and psychotherapists as service providers in the BAI and ATAPS programs. These practitioners are appropriately qualified to provide counselling for consumers with mild to moderate mental health problems and are a cost effective option compared with current program arrangements.

Specialist intervention is appropriate and necessary where a more serious mental disorder is diagnosed. However, there is no clinical rationale for using only clinical psychologists to deliver these interventions. Where a specialist mental health service is required, this could be provided by existing service providers under the BAI and ATAPS programs or by PACFA Mental Health Practitioners. PACFA Mental Health Practitioners are PACFA Registrants who have demonstrated their mental health competencies. The required competencies meet the skills for Mental Health Practitioners outlined in the Operational Guidelines for ATAPS (Department of Health & Ageing, 2010).

Recommendation 3
Where specialist mental health services are required for severe mental health disorders, these could be provided by PACFA Mental Health Practitioners, in addition to existing service providers under the BAI and ATAPS. PACFA Mental Health Practitioners should therefore be added to the list of providers.

GP Mental Health Plans

Diagnosis of mental disorders should never be a condition of accessing mental health services unless it is necessary for effective treatment. GP Mental Health Plans impose mental health diagnoses on consumers with some significant detrimental effects:

- Adverse impact on employment opportunities;
- Adverse impact on access to insurance;
- Stigma for mental health consumers; and
- Potentially undermining their recovery as a result of stigma and disempowerment (Corrigan, 2005; Masterson & Owen, 2006).

Based on available Medicare data (see Appendix 1), approximately one third of Mental Health Plans are currently prepared by GPs who have not undergone the AMA-recommended Mental Health Training for GPs. This raises serious concerns about the quality of Mental Health Plans.

GPs regularly write other types of referrals without receiving a fee to do so, for example, when referring consumers to specialists such as opthamologists or dermatologists. Why should GPs, especially those who have not been trained in mental health, receive a fee to refer consumers for counselling in relation to mental health?

PACFA recommends that Mental Health Plans should only be provided by GPs who have undertaken the AMA-recommended training in mental health. The GP Mental Health Plan should be a comprehensive mental health assessment to enable referral for intervention by a specialist Mental Health Practitioner. GP Mental Health Plans should not be required for GP referrals for primary care counselling. Rationalisation of the use of GP Mental Health Plans in this way could result in significant savings.

Not only should GP Mental Health Plans only be provided by suitably trained GPs, they should only be provided where the severity of consumers' mental disorder warrants diagnosis and specialised treatment and is demonstrably linked to better outcomes. It is not necessary, appropriate or cost-effective to diagnose a mental disorder, and require a GP Mental Health Plan, for the large number of consumers who experience mild to moderate mental health challenges which can be addressed through short-term counselling and psychotherapy.

Recommendation 4
GP Mental Health Plans should only be used where a diagnosis of a mental disorder is necessary for effective treatment and where this treatment is to be provided by a specialist Mental Health Practitioner. Consumers with mild to moderate mental health issues should not be diagnosed with a mental disorder or be required to have a Mental Health Plan to access counselling via Medicare.

Recommendation 5
Only GPs who have undertaken the AMA-approved mental health training should be eligible to receive the Medicare Schedule Fee to prepare Mental Health Plans.

Waiting lists
Demand for mental health services in regional, rural and remote Australia is high and is not sufficiently addressed by the available pool of BAI providers. This demand could be alleviated by registered counsellors and psychotherapists in these areas who are able to deliver BAI services. For example, in 2011 in Whyalla in South Australia, there was only one psychologist for a population of 22,000 and the waiting time was six months. There were ten registered counsellors practising in Whyalla at this time who could have provided BAI services (based on feedback from practitioners practising in this area).

Recommendation 6
The BAI should be redeveloped as a more cost-effective and sustainable program that is better targeted to meet consumer needs. Alternatively, it should be replaced with another program that meets these requirements.

Recommendation 7
The National Mental Health Commission should consider whether the BAI could be replaced by a new Primary Care Counselling Program along the lines of the Primary Care Counselling program recommended by PACFA. Alternatively, the BAI could be adapted to include the elements proposed in this alternative model.

2. Access to Allied Psychological Services (ATAPS) program

Like the BAI, ATAPS provides *Focussed Psychological Strategies* for consumers with a diagnosed mental disorder. ATAPS is targeted towards particular consumer groups in order to improve service access. Program targeting has enable the ATAPS program to more effectively reach communities who are not otherwise able to access mental health services. Tier 1 and Tier 2 funding also gives ATAPS the flexibility to respond to particular needs identified in the community.

2.1 Efficacy and cost-effectiveness

ATAPS has adopted triage and assessment processes in order to prioritise clients on the basis of highest need and appropriateness when referring them to ATAPS services. Assessment and triage can be completed based on referral documentation or by face to face or telephone assessment if required. The triage approach is supported by PACFA as a way to ensure that consumers most in need are receiving services, while also capping program expenditure.

PACFA is concerned, however, that program effectiveness of the ATAPS program may vary depending on the capacity of the Medicare Local overseeing the program. In this regard the government's plan to review Medicare Locals is welcomed. Non-government agencies would be another viable alternative to Medicare Locals for delivery of ATAPS services.

Focussed Psychological strategies

The range of psychological services available to people with a mental disorder in the ATAPS program is not adequate to meet the wide range of needs within the community. This critique also applies to the BAI program which offers similar interventions (*Focussed Psychological Strategies*). Better targeting of interventions to meet client needs could improve consumer outcomes in a cost-effective way.

Researchers emphasise that psychological strategies, including Cognitive Behavioural Therapy (CBT) and Interpersonal Therapy (IPT) have been tested under controlled conditions in university hospitals. These models may not be as efficacious in community settings and with clients who have concurrent conditions, for example depression, risk of suicide, risk of harm to others and substance dependence, as these client presentations are usually specifically excluded from research studies (Margison, Barkham, Evans, McGrath, Mellor Clark, Audin & Connell, 2000; Wampold, 2001). Parker (2006) emphasises that non-specific factors of therapeutic treatments, which are therapeutic interventions not linked to a particular model such as empathy, have not been controlled for in many randomised controlled trials on CBT and IPT.

The Australian National Audit Office's report on the administration of the ATAPS program found that the Department of Health and Ageing did not make informed program design decisions due to lack of information and lack of evidence for the most effective services (2011). This is a concern for PACFA as services may not be meeting consumers' needs.

In the next section, we outline some of the limitations found by researchers on psychological strategies including CBT, IPT and Narrative Therapy. We are also concerned that group treatment is used as a way of rationing resources, and that brief interventions are used when longer term treatment is indicated for mental disorders such as Borderline Personality Disorder. Interventions with a strong evidence base for substance abuse should also be included in the psychological strategies offered in the ATAPS program, and to the strategies offered under the BAI.

Cognitive Behavioural Therapy (CBT)

CBT is the dominant model offered in the ATAPS program. However for some age groups, CBT does not have demonstrated efficacy. A Cochrane review of psychological therapies for Generalised Anxiety Disorder found that older people were more likely to drop out of CBT than other age groups (Hunot, Churchill, Teixeira & Silva de Lima, 2007).

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

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

Interpersonal Therapy

The usefulness of Interpersonal Therapy (IPT), a model developed by researchers in the 1970s to compare antidepressants with a non-specific treatment, has arguably been overstated (Parker, Parker, Brotchie & Stuart, 2006). In developing IPT, researchers drew on outcome research which demonstrates counselling is effective because of common factors across all treatment models, such as the strength of the therapeutic alliance, use of empathy, acceptance and the client's hopefulness about change and openness (Parker et al., 2006). The outcomes of IPT are similar to other models. Additionally, perhaps because IPT developed within a research context rather than the clinical sphere, IPT has not been extensively taught in social work, psychology, occupational therapy and nursing degrees.

Although training in CBT is offered online to allied health practitioners to maintain Medicare provider status via the Professional Development collaboration between the Australian Association of Social Workers, the Australian Psychological Society and Occupational Therapy Australia, training in IPT is not available. Therefore, it can be concluded that currently practitioners approved to offer ATAPS and BAI services are not well trained in IPT.

Narrative Therapy

Narrative Therapy is a relatively new model in counselling and psychotherapy. Its inclusion in the BAI was as an approved psychological strategy for Indigenous people. It is now also included as a psychological strategy in the ATAPS program. The inclusion of Narrative Therapy seems a fairly arbitrary decision. Arguably, as a newer model, its evidence base is the least well-developed of all counselling and psychotherapy models. The application of Narrative Therapy to mental health issues and symptoms is not well developed. Level one and two evidence for Narrative Therapy, meta evaluations and randomised controlled trials, are lacking.

The Dulwich Centre in South Australia hosts the Australian website on Narrative Therapy and lists eight research studies which demonstrate its effectiveness. Seven of these were clinical trials and one study used a control. Most psychologists, occupational therapists, social workers and mental health nurses have not been trained in Narrative Therapy.

Group treatment

The Australian National Audit Office reported that some Divisions of General Practice (now Medicare Locals) offered group treatments to clients in order to reduce the costs of providing services through the ATAPS program (2011). Some research shows better outcomes for individual compared to group treatment for anxiety and depression (Neron, Lacroix & Chaput, 1995). Therefore the use of groups as a resource management strategy should be reconsidered. Client preferences should also be taken into account in offering group treatments. Legitimate concerns such as confidentiality in groups may reduce consumer access to treatment if group programs are the only way that ATAPS services are provided in some regions.

Brief vs. longer term interventions

The brief interventions offered through the ATAPS and BAI programs will not address the needs of people with some forms of mental illnesses. A Cochrane review comparing psychosocial and pharmacological treatments for deliberate self-harm found the most effective treatment for females with Borderline Personality Disorder using self-harm is longer term psychotherapy (Hawton, Townsend, Arensman, Gunnell, Hazell, House & van Heeringen, 1999). This group is at higher risk of completed suicide than the general population.

A PACFA member association, the Australian and New Zealand Association of Psychotherapy, conducted research with this treatment population using longer term psychotherapy and demonstrated its efficacy. The clinical trial with a 5 year follow up (*n* = 150) showed that regular participation in psychotherapy for people with personality disorders reduced the rate of hospitalisation, incidents of self-harm and violence, reduced drug use and improved work history (Stevenson, Meares & D'Angelo, 2005).

See also section 6.2 of this submission for details of the service gap relating to long-term psychotherapy.

Interventions for alcohol dependence

Mental illness is commonly comorbid with substance misuse. For example, misuse of alcohol is common amongst veteran populations experiencing mental illness. Recent systematic reviews have shown that couple counselling and family therapy are more effective than individual treatment for treating substance abuse, and result in increased abstinence, reduced incidence of interpersonal violence, and improved relationship functioning (O'Farrell & Clements, 2011; Ruff, McComb, Coker & Sprenkle, 2010).

The National Audit Office report into the ATAPS program (2011) estimates that 1 in 2 Australians suffer from a mental illness at some point in their lives, the most common being depression, anxiety and alcohol dependence. Evidence-based interventions for alcohol dependence, apart from CBT, are not included in the ATAPS and BAI programs.

Expansion of Interventions Offered

PACFA argues that a wider range of counselling and psychotherapy models should be included in the ATAPS and BAI programs to meet a wider range of client needs and preferences. PACFA's position statement on evidence-based practice is that 'research evidence indicates that, in general, counselling and psychotherapy are effective and that, furthermore, different methods and approaches show broadly equivalent effectiveness' (PACFA, 2011).

Seligman (1995) undertook a large Consumer Reports study to discover the experiences of people who had undergone counselling or psychotherapy. The study concluded that there were substantial benefits for people in psychotherapy; that psychotherapy without medication produces the same effects as psychotherapy and 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 outcomes and the strength of the client-therapist relationship is a key determinant of outcomes.

There is strong evidence for the contribution of counselling and psychotherapy models to the prevention and treatment of mental illness, including depression, anxiety and trauma (Cuijpers, van Straten, Smit, Mihalopoulos & Beekman, 2008). Family therapy has a strong level of evidence for

effective interventions with adolescent anorexia nervosa, for example the Maudsley model which views parents as a resource for recovery (Le Grange, 2005).

The range of psychological strategies should be expanded to include the following treatment models with a high level of evidence for their effectiveness:

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

Recommendation 8
The range of approved psychological strategies in the BAI and ATAPS programs should be expanded to include other psychotherapy and counselling models with a strong evidence base. This will enable practitioners to select interventions appropriate to client presentations, characteristics and treatment preferences, which is likely to improve service outcomes.

3. Program Duplication

There is some duplication between the BAI and the ATAPS program, in that the same *Focussed Psychological Strategies* are offered under both programs. Only 10 sessions are available under BAI whereas 12 sessions are available under ATAPS. Consumers can only access services via one of these programs in a given calendar year, unless their circumstances change during the year.

ATAPS is better targeted at hard to reach and low-income client groups. For Example, ATAPS is providing a high number of services to low income earners, representing 68% of the total number of people receiving ATAP services (DoHA, 2010).

ATAPS has a more sustainable funding model as capped program funds are administered through Medicare Locals which oversee delivery of ATAPS services. This raises the question of whether program costs could be better controlled by putting more funding into the ATAPS model of service delivery and less funding into the BAI model of service delivery.

4. Transparency and accountability

The shortcomings in the 2011 Evaluation of the BAI program were acknowledged in the evaluation report (Pirkis et al., p. 6). The report includes caveats about data limitations and acknowledges the methodological strengths and weaknesses, sample biases and the lack of data from non-English speaking consumers.

This highlights the need to improve data collection processes to enable ongoing program evaluation, in the interests of transparency and accountability for program expenditure. Currently there is very limited data collection undertaken for the BAI. The ATAPS program at least has a Minimum Data Set to collect the data required for reporting purposes, however the Minimum Data Set does not include client feedback and does not attempt to measure client outcomes.

PACFA has therefore recommended that the BAI program should adopt the same Minimum Data Set as the ATAPS program to enable ongoing reporting on service uptake and cost-effectiveness. PACFA also recommends that routine data collection be undertaken using a standardised assessment tool to

measure client outcomes. Direct feedback from clients is one of the most informative and accurate ways to measure the effectiveness of the services being provided.

Recommendation 9
Introduce a Minimum Data Set for the BAI and routine data collection using a standardised assessment tool for the BAI and ATAPS programs. This will ensure that both programs gather the data required for ongoing evaluation of service uptake, cost-effectiveness and client outcomes.

5. Specific challenges for regional, rural and remote Australia

5.1 Gaps in service delivery

The most significant gap in mental health service delivery is the shortage of mental health services in regional, rural and remote areas. There is no justification for the continuing inequality in service delivery and health outcomes for rural Australians and this should be addressed as a priority. Indeed, it is arguable that equity in service delivery will not even be enough to address unequal health outcomes in country Australia. Disadvantaged people and underserviced areas require greater access to health services than the well served metropolitan areas due to their greater poverty and lower health status (Schofield, Shrestha & Callander, 2012).

5.2 Workforce shortages

Shortages of qualified mental health practitioners in rural, regional and remote areas pose a significant challenge. Research indicates that rural, regional and remote communities continue to struggle to recruit and retain health professionals (Harrison & Britt, 2011; Bourke, Humphreys, Wakerman & Taylor, 2012; Chater, 2008; DoHA, 2008).

One study of a remote community in Queensland demonstrated that medical and allied health services are usually provided by non-resident, visiting specialists (Birks, Mills, Francis, Coyle, Davis & Jones, 2010). While nurses and Aboriginal health workers were predominantly resident in the community, other health professionals, including psychologists, counsellors and psychotherapists, were not, resulting in a lack of appropriate therapeutic skills to support clients with mental health issues. In western NSW, researchers found that the shortage of allied health professionals meant that clinicians located in such communities had to work longer hours with little support from their employers or colleagues (Veitch, Lincoln, Bundy, Gallego, Dew, Bulkeley, Brentnall & Griffiths, 2012).

In another study of the health workforce in rural NSW (Smith, Cooper, Brown, Hemmings & Greaves, 2008), which included psychologists and psychotherapists, the female to male ratio was 3:1. The mean age of health practitioners was 43 years, and half of the respondents said they were planning to leave within 5 years. Given that women make up the majority of the health workforce in rural and remote areas, it is important to understand and address the social and working conditions that cause female health practitioners to leave their jobs (Greenwood & Cheers, 2003).

Addressing workforce shortages through the inclusion of counsellors and psychotherapists as recognised providers for the ATAPS and BAI programs would go some way towards improving uptake of these programs in regional, rural and remote areas due to greater geographical spread of counsellors and psychotherapists.

Counsellors and psychotherapists have long been overlooked as an essential part of the mental health workforce throughout Australia. The treatment frequently required for mental disorders, to prevent

mental illness and to support mental health and wellbeing, is counselling and psychotherapy. A range of allied health professionals are trained to provide counselling and psychotherapy, including specialist-trained and registered counsellors and psychotherapists.

Recommendation 10
Increase client access in rural, regional and remote Australia by expanding the mental health workforce to include counsellors and psychotherapists as key allied health professionals to work in government and non-government health services, and to receive referrals as private practitioners.

5.3 Client choice

PACFA believes that client choice is very important as people are more likely to seek help if they are able to consult practitioners that they feel comfortable with and trust. 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, Bond & Agnew, 2004; Sharpley, 1986) and are seen as more approachable and empathic (Sharpley, 1986). Counsellors are considered by the public to be the most helpful of all professional groups providing therapeutic services (Jorm et. al., 1997) and general practitioners also rated counsellors fairly highly for effectiveness in treating depression (Rodgers & Pilgrim, 1997).

5.4 Rural and Regional Mental Health Workforce Plan

A Rural and Regional Mental Health Workforce Plan should be developed to address current and projected workforce shortages in the rural and regional areas. The Plan should take a broad definition of the potential mental health workforce. Currently this workforce is seen principally as psychiatrists, mental health nurses and psychologists. As detailed in Recommendation 11, the mental health workforce for country Australia should be inclusive of counsellors and psychotherapists and PACFA Mental Health Practitioners.

The workforce plan should include the provision of clinical supervision for the mental health workforce. Clinical supervision is an important quality assurance mechanism for professionals working with people at risk of suicide.

Recommendation 11
Develop a rural and regional mental health workforce plan. The plan should take a broad definition of the mental health workforce to improve client access, and should include registered counsellors and psychotherapists and PACFA Mental Health Practitioners. Clinical supervision for mental health workers should be emphasised in the plan to improve and maintain service quality.

6. Funding priorities in mental health and gaps in services & programs

Aside from gaps in service in rural and regional areas which are addressed elsewhere in this submission, some service delivery gaps and funding priorities have been identified.

6.1 People bereaved by suicide

There is a great need for specialised postvention support for the families and friends of suicide victims, with an emphasis on the particular needs of bereaved children and young people. In Queensland there is a Survivors of Suicide Bereavement Support Service which is self-supported and run by volunteers. A

practitioner reports that people bereaved by suicide find this service very useful and they say that only those who have lived through such a loss can really understand their experience.

One research study investigated the grief of children after parental suicide and found that postvention suicide support was only available to one participant and that no support was offered to the other bereaved children apart from support from their families who are also grieving. This lack of intervention resulted in ongoing distressed lives for those bereaved by suicide (Ratnarajah & Schofield, 2008). The children experienced secondary losses such as loss of home, loss of their school and friends, and foreshortened education. Over half of the participants had attempted suicide in adult life and/or had first degree relatives who made suicide attempts. These suicide attempts resulted in hospitalisation for each of these attempters. There was little or no ongoing support for them unless they sought psychological or counselling support themselves in adulthood. When interviewed (between 5 to 70 years after the suicide of their parent) most could not make meaning of the suicide. Many questions were not answered and there was an unmet need to speak of the loss (Ratnarajah & Schofield 2008; Ratnarajah & Schofield, 2007).

Despite the allocation of Commonwealth funding for people bereaved by suicide by the previous government to the Standby Suicide Bereavement Response Service, the response is currently limited to telephone crisis support and referral. Most people bereaved by suicide in Australia still do not receive any intervention.

Recommendation 12
Provide specialised postvention support for the families and friends of suicide victims, with an emphasis on the particular needs of bereaved children and young people.

6.2 People requiring long-term psychotherapy

Clients requiring long-term psychotherapy have very limited opportunities to access the treatment they require. These are clients with more serious mental disorders such as Borderline Personality Disorder which is frequently related to unresolved trauma. These clients often present with dual diagnosis such as drug or alcohol dependence and are at risk of self-harm and suicide. For research evidence, see section 2.1 on *Brief vs longer term interventions*.

One of the few options available to these clients is therapy provided by a psychiatrist under Medicare, but this is at significant cost to the health care system. PACFA submits that long-term psychotherapy treatment does not need to be provided by psychiatrists but could be provided by qualified, registered psychotherapists. The BAI program would need to include the option of long-term psychotherapy for consumers requiring this type of treatment, and PACFA Mental Health Practitioners, who are suitable providers to provide long-term psychotherapy, would need to be added as providers under the BAI program.

Recommendation 13
Consumers with severe mental disorders requiring psychotherapy should be able to access long-term psychotherapy from a specialist Mental Health Practitioner. This will help to prevent repeated hospitalisation of these consumers and reduce suicide risks.

7. Alternative approaches to supporting and funding mental health care

PACFA has contributed to the development of a new model of Primary Care Counselling aimed at meeting the growing needs in the Australian community for mental health services. This has been

developed through our ARCAP partnership (The Australian Register of Counsellors and Psychotherapists) with the Australian Counselling Association.

The proposed model of Primary Care Counselling could be a new Medicare-funded program or could be incorporated within an existing program such as the BAI. Introducing a better targeted, more affordable, Primary Care Counselling model through Medicare would address the needs of the majority of people in the community who currently access services through BAI.

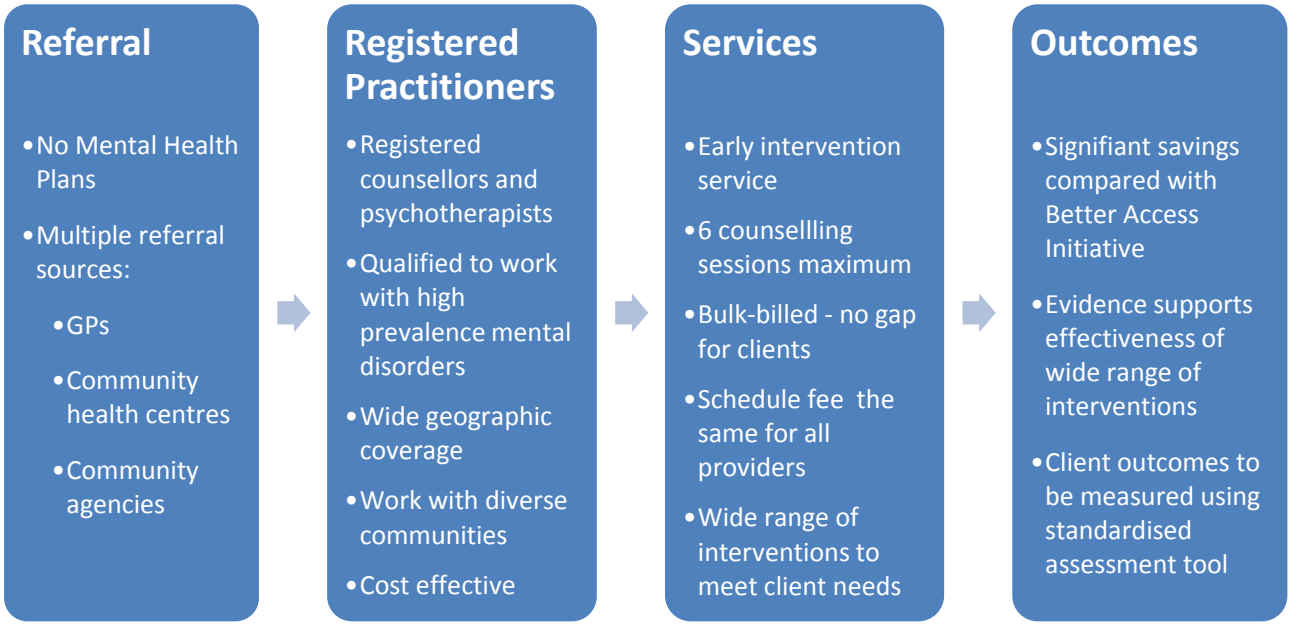
7.1 An alternative model of Primary Care Counselling

A new Primary Care Counselling model, such as that proposed by ARCAP, would provide clear advantages including:

- Savings of approximately $100,000,000 (see Appendix 1 for detailed costings);
- Capacity for 20% growth in service delivery above current service levels;
- More accessible and affordable services for consumers;
- Better targeted services for hard to reach consumers and communities; and
- A wider range of counselling interventions to meet the needs of consumers.

The proposed model has four key elements:

- Making referrals more accessible and cost effective through new referral mechanisims;
- Including registered counsellors and psychotherapists as Medicare Providers;
- Providing time-limited early intervention counselling services that are affordable and better targetted to meet consumer needs; and
- Measuring service outcomes to ensure effectiveness.



Mental Health Plans

Mental Health Plans from GPs should only be required for specialist psychological treatment.

- The average number of sessions accessed through BAI is 5 sessions making it difficult to justify Medicare-funded Mental Health Plans prepared by GPs.
- Only GPs who have undergone AMA-approved mental health training would be able to prepare Mental Health Plans and to offer other MBS items relating to mental health.

- Where it is appropriate to make a mental health diagnosis, the GP Mental Health Plans should involve a comprehensive mental health assessment and referral for specialist intervention.

Referral routes

There should be multiple referral routes for consumers to access Primary Care Counselling:

- For mild to moderate mental health conditions not requiring formal diagnosis or specialist treatment, GPs could still make referral to counselling but without Mental Health Plans.
- Health professionals working in other settings such as Community Health Centres and non-profit agencies should also be able to make referrals for Primary Care Counselling.

Early intervention Primary Care Counselling

An early intervention counselling service to be funded through Medicare to address high prevalence mental disorders and to prevent more serious mental disorders. This could be an amended BAI program or a new program to replace BAI.

- Consumers could access up to 6 counselling sessions as an early intervention.
- If more intensive specialist treatment is required, a GP Mental Health Plan would be required for referral to a psychologist, clinical psychologist or other qualified Mental Health Practitioner.
- The Schedule Fee should be in line with fees currently paid for treatment by social workers and occupational therapists.
- The possibility of mandatory bulk-billing should be considered. This would ensure there is no gap payment for clients and making Primary Care Counselling accessible for all Australians.
- A wide range of evidence-based interventions would better meet consumer needs. Service should no longer be limited to *Focussed Psychological Strategies*.

Service Providers

The service providers delivering Primary Care Counselling should be appropriate for the consumers accessing services, that is, those with mild to moderate mental health issues.

- Primary Care Counselling services could be provided by suitably qualified and experienced counsellors or psychotherapists.
- Other suitably qualified practitioners such as social workers, occupational therapists and psychologists would also continue to be included as providers of Primary Care Counselling.
- However, it is not appropriate or necessary for more highly qualified (and expensive) health professionals such as clinical psychologists to be delivering Primary Care Counselling services. These services are more appropriately delivered by counsellors and psychotherapists.
- Fees should not vary based on the professional background of the service provider. All practitioners are providing the same counselling interventions.

Data collection and service evaluation

Outcomes could be measured using a standardised assessment tool to enable program evaluation to measure client outcomes.

- Data collection should be a mandatory requirement for all practitioners providing providing Primary Care Counselling services. The schedule fee may need to be slightly higher to compensate for the additional work to be undertaken by practitioners.
- This would enable Medicare to measure the effectiveness of the program over time.
- Direct feedbak from clients is one of the most informative and accurate ways to measure the effectiveness of the services being provided.

Treatment Interventions

A wide range of evidence-based interventions should be offered to better meet consumer needs.

- The current list of *Focussed Psychological Strategies* is too narrow and ignores other evidence-based interventions that may better meet the needs of some consumers.
- Counsellors and psychotherapists undertake evidence-based practice which is the 'the integration of the best available research evidence with clinical expertise in the context of patient characteristics, culture and preferences' (American Psychological Association, 2005), which is endorsed in PACFA's Evidence-Based Practice Statement.

Recommendation 7

Government should consider replacing the BAI program with a new primary Care Counselling Program along the lines of the program recommended by PACFA. Alternatively, the current BAI program could be adapted to include the elements proposed in this alternative model.

7.2 The Stepped approach to Mental Health Care

A recent Reachout.com report, *Rethinking the Mental Health System* (Hosie, Vogl, Hoddinott, Carden & Comeau (2014) acknowledges the growing service demand, high service costs and the growing workforce shortages and urges government to make the mental health system more sustainable.

Reachout.com recommends a significant proportion of the services being delivered by peer workers. PACFA supports the inclusion of peer support in the mix of service options but we urge government to ensure that there is a clear evidence base for the effectiveness of this model of intervention. Peer support workers could benefit greatly by undertaking training in counselling or psychotherapy and this training is strongly encouraged by PACFA. An assessment process should be used to triage clients suitable for peer support and those requiring referral for a clinical service.

Recommendation 14

Peer support should be included in the mental health service mix and where possible, peer support workers should be encouraged and funded to undertake training in counselling and psychotherapy. An assessment process should be used to identify the clients that are suitable for peer support.

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Appendix 1

Program Costings – Primary Care Counselling

Current program costs under BAI (2012)	$539,296,940
Projected program costs under new program (future)	$434,597,572
Including extra sessions (20% growth)	$ 411,868
Savings	**$104,699,368**

Better Access Initiative Costs - January to December 2012

MBS Item No.	Description	Unit Price	Occasions of Service Jan-Dec 2012	Total Cost to Medicare Jan-Dec 2012
2700	MH Plan by untrained GP (20 mins)	$70.30	134,909	$9,484,103
2701	MH Plan by untrained GP (40 mins)	$77.65	66,484	$5,162,483
2712	Review of Mental Health Plan by GP (20 mins)	$52.75	320,767	$16,920,459
2713	GP Mental Health attendance (20 mins)	$70.30	1,056,344	$74,260,983
2715	Mental Health Plan by trained GP (20 mins)	$89.25	415,414	$37,075,700
2717	Mental Health Plan by trained GP (40 mins)	$98.60	196,450	$19,369,970
80000	Specialist treatment by Clinical Psych. (<50 mins)	$84.80	14,988	$1,270,982
80005	Specialist treatment by Clinical Psych. (<50 mins) other location	$106.00	883	$93,598
80010	Specialist treatment by Clinical Psych. (>50 mins)	$124.50	1,418,542	$176,608,479
80015	Specialist treatment by Clinical Psych. (>50 mins) other location	$145.65	23,591	$3,436,029
80020	Group therapy by Clinical Psych. per patient (>60 mins)	$31.65	9,882	$312,765
80100	Focused Psychol. Strategies by Psych. (<50 mins)	$60.10	32,252	$1,938,345
80105	Focused Psychol. Strategies by Psych. (<50 mins) other location	$60.10	3,809	$228,921
80110	Focused Psychol. Strategies by Psych. (>50 mins)	$84.80	1,936,034	$164,175,683
80115	Focused Psychol. Strategies by Psych. (>50 mins) other location	$106.55	98,970	$10,545,254
80120	Group therapy by Psych. per patient (>60 mins)	$21.65	15,275	$330,704
80125	Focused Psychol. Strategies by Occ. Therapist (<50 mins)	$52.95	3,255	$172,352
80130	Focused Psychol. Strategies by Occ. Therapist (<50 mins) other location	$74.55	1,012	$75,445
80135	Focused Psychol. Strategies by Occ. Therapist (>50 mins)	$74.80	31,662	$2,368,318
80140	Focused Psychol. Strategies by Occ. Therapist (>50 mins) other location	$96.35	7,782	$749,796
80145	Group therapy by Occ. Therapist per patient (>60 mins)	$19.00	1,408	$26,752
80150	Focused Psychol. Strategies by Soc. Worker (<50 mins)	$52.95	2,057	$108,918
80155	Focused Psychol. Strategies by Soc. Worker (<50 mins) other location	$74.55	538	$40,108
80160	Focused Psychol. Strategies by Soc. Worker (>50 mins)	$74.80	168,529	$12,605,969
80165	Focused Psychol. Strategies by Soc. Worker (>50 mins) other location	$96.35	19,913	$1,918,618
80170	Group therapy by Soc. Worker per patient (>60 mins)	$19.00	853	$16,207
	Total		**5,981,603**	**$539,296,940**

Projected costs - Future

MBS Item No.	Description	Unit Price	Occasions of Service Future	Total Cost to Medicare Future
2700	MH Plan by untrained GP (20 mins)	$70.30	0	$0
2701	MH Plan by untrained GP (40 mins)	$77.65	0	$0
2712	Review of Mental Health Plan by trained GP (20 mins)	$52.75	160,384	$8,460,230
2713	GP Mental Health attendance by trained GP (20 mins)	$70.30	528,172	$37,130,492
2715	Mental Health Plan by trained GP (20 mins)	$89.25	207,707	$18,537,850
2717	Mental Health Plan by trained GP (40 mins)	$98.60	98,225	$9,684,985
80000	Specialist treatment by Clinical Psych. (<50 mins)	$84.80	7,494	$635,491
80005	Specialist treatment by Clinical Psych. (<50 mins) other location	$106.00	442	$46,799
80010	Specialist treatment by Clinical Psych. (>50 mins)	$124.50	709,271	$88,304,240
80015	Specialist treatment by Clinical Psych. (>50 mins) other location	$145.65	11,796	$1,718,015
80020	Group therapy by Clinical Psych. per patient (>60 mins)	$31.65	4,941	$156,383
80100	Specialist treatment by other MH specialist (<50 mins)	$60.10	16,126	$969,173
80105	Specialist treatment by other MH specialist (<50 mins) other location	$60.10	1,905	$114,460
80110	Specialist treatment by other MH specialist (>50 mins)	$84.80	968,017	$82,087,842
80115	Specialist treatment by other MH specialist (>50 mins) other location	$106.55	49,485	$5,272,627
80120	Group therapy by other MH specialist (>60 mins)	$21.65	7,638	$165,352
80125	Primary Care Counselling by Occ. Therapist (<50 mins)	$52.95	3,255	$172,352
80130	Primary Care Counselling by Occ. Therapist (<50 mins) other location	$74.55	1,012	$75,445
80135	Primary Care Counselling by Occ. Therapist (>50 mins)	$74.80	31,662	$2,368,318
80140	Primary Care Counselling by Occ. Therapist (>50 mins) other location	$96.35	7,782	$749,796
80145	Group therapy by Occ. Therapist per patient (>60 mins)	$19.00	1,408	$26,752
80150	Primary Care Counselling by Soc. Worker (<50 mins)	$52.95	2,057	$108,918
80155	Primary Care Counselling by Soc. Worker (<50 mins) other location	$74.55	538	$40,108
80160	Primary Care Counselling by Soc. Worker (>50 mins)	$74.80	168,529	$12,605,969
80165	Primary Care Counselling by Soc. Worker (>50 mins) other location	$96.35	19,913	$1,918,618
80170	Group therapy by Soc. Worker per patient (>60 mins)	$19.00	853	$16,207
New	Primary Care Counselling by Counsellor/Psychotherapist (>50 mins)	$74.80	1,777,113	$132,928,052
New	Group therapy by Counsellor/Psychotherapist (>60 mins)	$19.00	9,044	$171,836
New	Program growth of 20% over current service levels	$74.80	402,824	$30,131,265
	Total		**5,197,591**	**434,597,572**

Assumptions:

1. Delete MBS Items 2700 and 2701 for GPs not trained in Mental Health. GP Mental Health Plans should only be provided by GPs who undertake AMA-approved mental health training.
2. Reduce by half the number of Mental Health Plans provided by trained GPs as Mental Health Plans will only be provided for consumers requiring specialist treatment.
   - MBS items 2712, 2713, 2715 and 2717 numbers all reduced by half.
3. Reduce by half the number of services provided by psychologists and clinical psychologists to stop over-servicing.
   - Amend MBS Items 80005, 80010, 80015, 80020 to be “Specialist Treatment by Clinical Psychologist”
4. Provide specialist psychological treatment only to consumers who require it.
   - Amend MBS Items 80100 to 80120 to be “Specialist treatment by other Mental Health Specialist”.
5. Services provided by Occupational Therapists and Social Workers would be Primary Care Counselling instead of Focused Psychological Strategies.
   - Amend MBS Items 80125 to 80165 to be “Primary Care Counselling”.
7. Primary Care Counselling services provided by Counsellors and Psychotherapists to be added with multiple referral routes available and no GP Mental Health Plan required.
8. Program growth of 20% is growth in primary care counselling over current service levels based on:
   - Previous levels of service provided by Social Workers and Occupational Therapists; and
   - Half of the services previously provided by Psychologists and Clinical Psychologists (which would be provided instead by registered Counsellors/Psychotherapists).