Psychotherapy & Counselling
Federation of Australia

Submission to the Consultation on Improving Mental Health Services in Country Australia

Submission to:

Senator Penny Wright
Spokesperson for Mental Health for The Greens

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Executive Summary

The Psychotherapy and Counselling Federation of Australia (PACFA) welcomes The Greens' consultation paper on Improving Mental Health Services in country Australia. Access to mental health services in rural, regional and remote parts of Australia has long been overlooked by government. PACFA agrees with The Greens' position that it is unacceptable that 30% of Australians have poorer mental health outcomes than other Australians, and lack access to essential mental health services because of where they live.

Distance, geographic isolation and insufficient funding are central drivers for the lack of mental health services in rural, regional and remote areas of Australia, and for the inequality in health outcomes in these areas. Distance and geographic isolation also underpin three other key issues identified by PACFA: workforce shortages, unequal distribution of funding, and the level of stigma associated with mental illness, which can be particularly high in country areas.

A significant issue in country Australia is the shortage of qualified practitioners for the mental health workforce. In this submission, PACFA argues that counsellors and psychotherapists are part of the solution to these workforce shortages, and that our approach aligns with the whole-of-person approach to mental health and wellbeing recommended by The Greens.

PACFA supports The Greens' approach to improving mental health services in country Australia and provides concrete suggestions, supported by evidence, to address gaps in service delivery and to improve mental health outcomes. These include:

- Increasing the capacity of the mental health workforce by including more counsellors and psychotherapists;
- Improving the targeting and effectiveness of existing programs such as the ATAPS program (Access to Allied Psychological Services) and the Better Access Initiative;
- Developing a rural and regional workforce plan, which should include clinical supervision and debriefing for all health and community staff providing services to people at risk of suicide; and
- Investing in suicide prevention training and counselling skills for all front-line workers.

Recommendations

PACFA puts forward four key recommendations which are explained in the full submission:

1. Expand the mental health workforce in country Australia by including counsellors and psychotherapists as key allied health professionals to work in government and non-government health services, and to be referred to as private practitioners.
2. Provide clinical supervision and debriefing to all health and community staff providing services to people at risk of suicide, to ensure the helpfulness of their response, to minimise the risk of detrimental responses and to assist with the emotional burden they are exposed to in their roles as health professionals.
3. Provide suicide prevention and risk assessment training for all staff working in emergency departments and community health services. Such training should include counselling skills. Ideally, this training should be incorporated into the formal education courses for all health and community workers.
4. Include suicide prevention training and counselling skills in training and degree courses for community workers, counsellors, social workers, psychologists, psychiatrists, psychotherapists and mental health nurses.

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-nine member associations which cover a range of counselling and psychotherapy modalities including family therapy, relationship counselling, experiential therapies, expressive arts therapies, hypnotherapy, psychoanalysis, integrative therapy and solution-focussed counselling.

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 activities that utilise an interpersonal relationship to enable people to develop greater self-understanding and to make positive changes in their lives. Professional counsellors and psychotherapists work within a clearly contracted, principled relationship that supports individuals to explore and resolve their difficulties. Evidence for the efficacy of counselling and psychotherapy is included in the appendices to this submission.

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.

Counselling and psychotherapy are interdisciplinary activities provided by a range of professionals, including psychologists, social workers, occupational therapists, nurses, doctors and psychiatrists, as well as counsellors and psychotherapists. Counselling and psychotherapy are not 'owned' by any one of these professional groups.

PACFA Register

PACFA operates a national Register of suitably qualified and experienced counsellors and psychotherapists. PACFA registrants are required to belong to one of the twenty-nine member associations of PACFA as a condition of registration. Registrants must practice according to the PACFA Code of Ethics, as well as the Codes of Ethics of the member associations to which they belong.

PACFA's 1,500 Registrants have completed training in counselling and psychotherapy to at least Bachelor degree level or equivalent, and many are trained at the postgraduate level. They have attained the required level of supervised practice experience and demonstrate that they meet ongoing professional development requirements. Approximately 25% of PACFA Registrants are located outside of the major metropolitan population centres.

All counsellors and psychotherapists are qualified and experienced to support clients with high prevalence mental disorders such as depression and anxiety, as well as a range of other life difficulties

such as relationship issues, bereavement, trauma and life transitions. The PACFA Register also includes a specialist category of Mental Health Practitioners. These are Registrants who have been assessed as meeting PACFA's mental health competencies and are therefore skilled to work with clients with more serious mental disorders.

Response to discussion paper

1. Problems or barriers

PACFA has identified four key barriers to achieving equal mental health outcomes for the 30% of Australians living in country Australia:

- Distance and geographic isolation
- Shortages of qualified mental health practitioners
- Unequal distribution of funding between urban and rural health services
- Stigma associated with mental illness which deters country people from accessing health services

1.1 Distance and geographic isolation

Distance and geographic isolation are central drivers for the poor coverage of mental health services in regional, rural, and remote Australia and for the inequality in health outcomes in these areas. Distance and geographic isolation also contribute to other key issues, resulting in insufficient mental health workers located in rural and remote locations, and increased costs of providing health service outside the major metropolitan centres. Living in small, tight-knit rural communities with a culture of stoicism tends to exacerbate the stigma already attached to mental illness. In small communities, people are even more reluctant to seek help.

1.2 Workforce shortages

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). While rural people have stoically coped with the shortage of health services, their health status has fallen below the Australian average (Chater, 2008). In a report on the health workforce in rural and regional Australia, the Department of Health and Ageing (2008) found the supply and distribution of health professionals largely corresponds to the distribution of funding for government-run health services.

The contribution of fly-in, fly-out and drive-in, drive-out (FIFO and DIDO) workers to health services in rural and remote communities is well-known. While FIFO and DIDO services go some way towards relieving unmet health needs in these communities, research has documented the negative effects both socially and on health outcomes. Social effects include the stress on community services and infrastructure, housing availability and affordability, lifestyle and safety issues, and impacts on family cohesion (Morris, 2012). Effects on health outcomes include lack of consumer choice in health services (Guerin & Guerin, 2009); reliance on FIFO and DIDO services at the expense of the development and resourcing of robust local workforces and primary care services (Perkins, 2012; Wakerman, Curry &

McEldowney, 2012); and impacts on the sustainability, productivity and quality of health services (Perkins, 2012).

While there will always be a need for visiting services to remote areas where the population size cannot sustain adequate health services, effective specialist outreach services and outreach arrangements for allied health services depend on well-functioning primary health care services in rural and remote locations (Wakerman et al, 2012).

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).

1.3 Unequal distribution of funding

The funding deficit of $2.1b per year for mental health services needed in country Australia is alarming. Although government has already made funding commitments to increase mental health funding for a range of key programs, no new funding specifically addressing gaps in service delivery in country Australia has been allocated. It is clear that significant investment in country Australia is needed to redress funding inequalities.

While the challenges of delivering mental health services in rural and remotes areas are significant, there is no justification for the continuing inequality in service delivery and health outcomes for rural Australians. Indeed, it is arguable that equity in service delivery will not 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).

2. How we can address gaps in delivery

2.1 Funding commitment from government

It is essential that government rolls out commitments already made to increase mental health service delivery. However, additional funds for mental health, targeted specifically at rural and regional areas, should also be allocated. A further $2.1b per year should be provided for rural, regional and remote mental health services. Funding should be targeted to address local needs. For further details, see section 5.1 below.

2.2 Expand the mental health workforce

An expansion of the mental health workforce is also essential. 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 counsellors and psychotherapists. Counsellors and psychotherapists listed on the PACFA register are highly trained and have attained the required level of supervised practice experience. They also represent a cost-effective alternative to psychologists. There is a large body of evidence supporting the effectiveness of counselling and psychotherapy, as demonstrated in the appendices to this submission.

It is important that *registered* counsellors and psychotherapists are utilised to ensure that the services provided are safe and of a high professional standard. As a self-regulated profession, counselling and psychotherapy have robust processes in place to ensure that practitioners meet expected ethical standards and undertake ongoing professional development.

> ***Recommendation 1***
> Expand the mental health workforce in country Australia by including counsellors and psychotherapists as key allied health professionals to work in government and non-government health services, and to be referred to as private practitioners.

2.3 Improve 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).

2.3 Mental health promotion

Health status statistics indicate that the poorest Australians have the poorest health, and that many of these people live in rural Australia (Allan, Ball & Alston, 2010). Participants in Allan et al.'s study had minimal knowledge, control or choice about the type of interventions they received or the outcomes of services they received. Poor health status was normalised and future health goals were not considered. Thus, those with the most to gain from health promotion and prevention programs are unlikely to benefit from them because they may normalise and accept their poor health status. Mental health promotion messages therefore need to be well targeted and accessible for consumers in rural, regional and remote areas.

3. Appropriate policy responses or solutions

PACFA supports the policy responses suggested by The Greens (see section 5 below).

Additionally, PACFA recommends that counsellors and psychotherapist are recognised as having a contribution to make to mental health in country Australia. Counsellors and psychotherapists are already employed in agency settings and work in private practice outside the capital cities. However, counsellors and psychotherapists are currently under-utilised and undervalued within the mental health workforce. Currently, counsellors and psychotherapists are not recognised by government as providers under the Better Access Initiative, making private counselling inaccessible for most rural clients if they do not have the means to pay for private counselling or psychotherapy.

4. Best practice approaches to suicide prevention

This section is based on PACFA's submission to the Senate Inquiry on Suicide (PACFA, 2009) and expert testimony given to the Senate by PACFA President, Professor Ione Lewis (Commonwealth of Australia, 2010).

On average, 2,600 suicide deaths occur every year in Australia (Commonwealth of Australia, 2001). In 2009, 2,769 people died by suicide (ABS, 2012). Men, adolescents, Indigenous people, the long term unemployed, people living in rural and remote communities, elderly people, lesbian, gay, bisexual and transgender people, international students and people bereaved by suicide are particularly vulnerable for risk of suicide. Suicide accounts for 4% of all Indigenous deaths (Parliament of Australia, 2011). It is noted that the risk of suicide occurs across all social classes, although the extent of the risk increases with social disadvantage and lack of access to support networks (ABS, 2012).

Suicide death in very remote areas is three times higher than in urban areas and 1.5 times higher in outer regional areas (Parliament of Australia, 2011). Male suicides in *very remote* areas are almost three times as prevalent as in *major cities* - for every one suicide in *major cities*, there are 2.89 suicides in *very remote* areas. For *outer regional areas*, suicide is almost 1.5 times greater (Parliament of Australia, 2011).

Targeted prevention and intervention programs are therefore important to address the needs of high-risk groups in regional, rural and remote areas. However, such programs often face difficulties in securing ongoing, sustainable funding. Often, new and successful programs are implemented and then lose their funding. Clients can lose hope, as the funding body appears to have stopped believing in them and positive outcomes are lost.

4.1 Psychiatric consultations

For counsellors and psychotherapists working in private practice, the lack of psychiatric consultants to refer clients who are at risk of suicide is a severe pressure. It is difficult to make urgent psychiatric referrals because appointments are booked out for months in advance. Acutely distressed clients then need to go to hospital emergency departments for triage and assessment, which is often more traumatising. Having accessible psychiatric appointments for acute referrals is imperative in rural and regional areas.

4.2 Health promotion around suicide

There have been varying degrees of success when it comes to public awareness of suicide. While general awareness has increased over time, in the general community there is still fear that speaking about suicide may increase incidence. Health promotion campaigns which speak out about depression reduce the stigma associated with mental illness, such as depression; however suicide is still often a taboo subject. There are restrictions on reporting suicide in the media to avoid increasing suicide attempts and completions (Pirkis & Blood, 2001).

There is little awareness in the community about how to identify and manage suicide risk, despite increased funding of suicide prevention services. In particular, carers and families need access to good quality information on awareness of suicide risk, warning signs, how to talk openly with those at risk of suicide, how to access acute services and the need for follow up after the crisis.

Health promotion campaigns need to provide clear messages on how to communicate about risk of suicide with friends and family and what services can be contacted for professional assistance. More education and community engagement could assist with public awareness. The success of public awareness programs that encourage people to seek help requires services in the public and private sectors to be available and accessible.

It should be noted that the disenfranchised nature of grieving after the suicide of a family member, and theories about suicide that blame the family, do not sit well with some of these health promotion messages.

4.3 Indigenous people

Indigenous young people in particular have higher rates of incarceration and mental illness than the general Australian population. Maple (2005) notes that Aboriginal suicide has unique social, cultural and political contexts and that the suicide risk for Aboriginal and Torres Strait Islander young people is considerably higher. An understanding of intergenerational trauma and sociocultural factors are necessary for working successfully with this population. It was noted by practitioners with a role in counselling Indigenous people that positive role models within their communities are necessary for positive outcomes. Working with communities and families, rather than individuals alone, is also very necessary.

PACFA has established an Indigenous Working Party which provides a consultation forum to address the unique needs of Indigenous communities who access counselling and psychotherapy. PACFA is currently reviewing our Training Standards to ensure that counsellors and psychotherapists are better equipped to work with Indigenous clients, to promote opportunities for Indigenous people to train as counsellors, and to ensure that Indigenous counsellors, particularly those in remote areas, can access professional and collegial support and supervision.

4.4 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 family members bereaved by suicide find this service very useful and 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 five to seventy 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 current government for the next five years 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.

5. The Greens' approach to improving mental health services in country Australia

5.1 Increased and more targeted investment

A further $2.1b per year should be provided for rural, regional and remote, mental health services. Increased investment should be targeted at:

- Mental health services in regional centres with good transport links to remote communities;
- Funded counselling positions to work within multidisciplinary health teams in rural communities;
- Funded counselling positions to work within FIFO or DIDO multidisciplinary health teams;
- Counselling programs that will help prevent suicide and provide short and medium term counselling supports to those bereaved by suicide; and
- Mental health promotion programs to reduce the stigma associated with mental illness.

5.2 A whole-of-person approach

This is entirely consistent with the approach of counselling and psychotherapy. The government's current emphasis on the medical model in mental health treatment services, and prioritising of services provided by psychologists over those provided by counsellors and psychotherapists for mild and moderate anxiety and depression, undermines the need to emphasise the whole-of-person approach.

The labelling of mental health conditions can be detrimental and stigmatising for consumers and may have consequences in the future, for example when applying for insurance and in disclosing health conditions to employers. While diagnosis of mental disorders plays a role in access to appropriate services, consumers require a holistic assessment and response that includes areas such as self-esteem, self-efficacy and living skills. Counsellors and psychotherapists do not label mental health conditions but use advanced interpersonal skills to support the client's change processes in the

therapeutic context. This work is based on an ethos of respect for clients, their values, their beliefs, their uniqueness and their right to self-determination.

5.3 Better support

In addition to sub-acute services such as step-up and step-down programs, mental health support needs to be provided through a range of community based programs and existing Medicare-funded services. Medicare-funded programs such as the ATAPS program (Access to Allied Psychological Services), provide another service option. It is essential that these programs are targeted at hard-to-reach clients in rural and remote areas.

High prevalence disorders such as depression and anxiety have a debilitating impact on people living in country Australia and yet take up of Medicare-funded services such as those offered through the Better Access Initiative has been considerably lower in rural and remote areas.

The Evaluation of the Better Access Initiative (Pirkis, Harris, Hall & Ftanou, 2011) found that uptake rates for services under Better Access varied according to geographic region. People residing in capital cities had an uptake of 53.7 per 1,000 population in 2009, compared with other metropolitan centres and regional centres (59.0 and 57.6 persons per 1,000 respectively). However, uptake rates were approximately 12% lower for people in other rural areas (47.3 per 1,000) and approximately 60% lower for people in remote areas (21.5 per 1,000).

Addressing workforce shortages through the inclusion of counsellors and psychotherapists as recognised providers for the Better Access Initiative and the ATAPS program would go some way towards improving uptake of these programs in country Australia and remote areas due to greater geographical spread of counsellors and psychotherapists.

There are significant problems with the design of the Better Access Initiative service delivery model and concerns about the sustainability of the program. PACFA is drafting a proposal for an alternative service delivery model to the government, which will incorporate registered counsellors and psychotherapists, aimed at making the Better Access Initiative more sustainable and more effective at meeting consumer needs. This will potentially create new opportunities for improved service access via the Better Access Initiative in country Australia.

Online counselling is an important option for servicing country Australia, particularly rural and remote areas. Although online counselling is effective in certain situations and is an important way to improve service access, for people with mental illness who already feel disadvantaged by living in a remote location, and who are experiencing significant geographic isolation, online counselling could potentially exacerbate this experience of internal and external isolation as there is no actual face-to-face contact. It is important that people can have the option to consult face-to-face with a practitioner who they feel comfortable with and trust as the strength of the client-therapist relationship is of key importance to therapeutic outcomes. A positive therapeutic relationship, which forms as a result of the highly developed relational and supportive skills of counsellors and psychotherapists, plays a crucial role in treatment effectiveness.

5.4 Development of a rural and regional workforce plan

The rural and regional mental health workforce plan to be developed should take a broad definition of the potential mental health workforce for country Australia. Currently this workforce is seen

principally as psychiatrists, mental health nurses and psychologists. As detailed in recommendation 1, the mental health workforce for country Australia should be inclusive of counsellors and psychotherapists.

It is reported that clinical supervision and debriefing for workers in frontline and community settings remains minimal. 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 2

Provide clinical supervision and debriefing to all health and community staff providing services to people at risk of suicide, to ensure the helpfulness of their response, to minimise the risk of detrimental responses and to assist with the emotional burden they are exposed to in their roles as health professionals.

5.5 Greater investment in training and education

PACFA supports The Greens' proposal for greater investment in training and education around mental health and suicide prevention.

Community health and community settings provide an important response to people at risk of suicide and in the aftermath of a suicide attempt when the risk of a repeated attempt is four times greater. The quality of the response to a person at risk of suicide depends on the skill level of practitioners. Many practitioners working in community health settings and front line work feel they are not adequately trained and resourced to support clients who are severely depressed and at risk of suicide.

Although in most of these settings, suicide prevention training is provided for front-line workers, access to more short courses is needed. Most commonly the training available is the Applied Suicide Intervention Skills Training (ASIST), a suicide intervention program by LivingWorks, Lifeline, ASSERT and Mental Health First Aid. There is now refresher training for practitioners who have completed the ASIST program. TAFE and other institutions also offer specialised mental health courses, for example Certificate IV in Mental Health.

Many mental health professionals have not been trained in counselling skills and this should also be included in suicide prevention training. It is noted that although these courses are seen as very worthwhile, they cost money. It is recommended that all training and degree courses for counsellors, psychotherapists, community workers, social workers, psychologists, psychiatrists and mental health nurses should include suicide prevention training and risk management.

Recommendation 3

Provide suicide prevention and risk assessment training for all staff working in emergency departments and community health services. Such training should include counselling skills. Ideally, this training should be incorporated into the formal education courses for all health and community workers.

Recommendation 4

Include suicide prevention training and counselling skills in training and degree courses for community workers, counsellors, social workers, psychologists, psychiatrists, psychotherapists and mental health nurses.

Appendix 1

Evidence for the efficacy of counselling and psychotherapy

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'.

In 1977, Smith and Glass published a meta-analysis of studies that compared outcomes for people who had received psychotherapy interventions with those who had not. They found a consistent, positive and substantial treatment effect, regardless of treatment approach or client group. While controversial at the time, these core conclusions have survived a further 45 years of research and continue to be supported in recent reviews of the effectiveness of counselling and psychotherapy.

We also have more than 20 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 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 client outcomes and that the strength of the client-therapist relationship is a key determinant of therapy outcomes.

Recently, outcome data for Medicare's Better Access initiative indicates that similar outcomes are achieved from the counselling and psychotherapy services provided under 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 et. al.2011), regardless of the occupation of the practitioner delivering the service.

Counselling and psychotherapy have been demonstrated to be efficacious treatments for health in a number of ways. The contribution they make to health is both remedial and preventative.

Mental health

There is widespread evidence for the contribution of counselling and psychotherapy - of various orientations - to the effective treatment of mental illness. A pertinent example is the provision of counselling services for high prevalence disorders such as depression and anxiety. Where aspects of

personality functioning are a factor in mental health, psychotherapy has a particular role to play. There is also strong evidence for the contribution of counselling and psychotherapy to the prevention and treatment of mental illness, including depression, anxiety and trauma (Cuijpers, van Straten, Smit, Mihalopoulos&Beekman, 2008).

Once mental illness develops and becomes severe, specialised clinical services, hospitalisation and a higher level of case management are required. 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. There is evidence from an Australian clinical trial with a 5 year follow up (*n* = 150) 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).

Family therapy also 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 evidence indicates that family therapy is more effective in the treatment of adolescent eating disorders than individual therapy.

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).

Posttraumatic Stress Disorder

In 2012, PACFA published a resource for practitioners working with clients suffering from posttraumatic stress disorder (Knauss & Schofield, 2009c). The resource reviews recent research on the effectiveness of a range of psychotherapeutic interventions for the treatment of PTSD, finding that there is substantial empirical support for effectiveness (Schnyder, 2005). Meta-analyses covered in the resource indicate high success rate from psychotherapeutic interventions and significant reduction in symptomatology (Bradley, Greene, Russ, Dutra & Westen, 2005; Sherman, 1998).

Therapists working with PTSD require skills to support clients experiencing a high level of distress. The highly developed relational and supportive skills of counsellors and psychotherapists therefore play a crucial role in treatment effectiveness. A positive therapeutic relationship and the client's expectations towards the treatment were found to be positively associated with treatment outcome (Australian Centre for Posttraumatic Mental Health, 2007b).

Substance abuse

Mental illness is commonly comorbid with substance misuse, particularly alcohol, 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). Couple therapy also has a strong evidence base for treating posttraumatic stress disorder in returning service personnel and veterans (Monson, Fredman & Adair, 2008).

Relationship difficulties

The nexus between fulfilling and rewarding personal relationships and both physical and mental health is well documented by research. For example, a large Canadian population study showed that 12% of people who separate become depressed, and adult males in particular were six times more likely to become depressed after a relationship breakdown than men who remain married (Rotermann, 2007). Research supports counselling and psychotherapy as the indicated treatment for relationship difficulties and adjustment to separation.

Physical health and disease

It is recognised that the response of patients to interventions aimed at ameliorating or healing various physical conditions will be influenced by emotional and psychological factors. Examples include treatments for cancer, chronic conditions involving a degree of impaired functioning, and immune disorders including HIV/AIDS. Counselling and psychotherapy have a growing role as an adjunct to medical interventions in these situations.

There is also evidence that many physical ailments have a psychological component and vice versa. For example, recent research from the Australian Institute of Health and Welfare (2010) found that 1.8 million people experiencing back problems in 2007 to 2008 were 2.5 times more likely to experience mood disorders such as depression, 1.8 times more likely to suffer from anxiety and 1.3 times more likely to report a substance use disorder, compared with people without back problems. The provision of short term counselling and psychotherapy is a sound, evidence-based response to concurrent physical and mental conditions.

References

Allan, J., Ball, P., Alston, M. (2010). "What is health anyway? Perceptions and experiences of health and health care from socio-economically disadvantaged rural residents." *Rural Society*, 20: 85-97.

Australian Bureau of Statistics (ABS) (2012). 4125.0 Gender Indicators, Australia. *Suicide: Key Series*. ABS. Retrieved from http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by+Subject/4125.0~Jan+2012~Main+Features~Suicides~3240.

Australian Centre for Posttraumatic Mental Health (2007b).*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.

Australian Institute of Health and Welfare.(2010). *When musculoskeletal conditions and mental disorders occur together.* Bulletin 80. Cat. no. AUS 129. Canberra, ACT: AIHW.

Birks, M., J. Mills, Francis, K., Coyle, M., Davis, J., Jones, J. (2010). Models of health service delivery in remote or isolated areas of Queensland: A multiple case study. *Australian Journal of Advanced Nursing* 28(1): 25-34.

Bourke, L., Humphreys, J., Wakerman, J. & Taylor, J. (2012). Understanding rural and remote health: A framework for analysis in Australia. *Health & Place* 18: 496-503.

Bradley, R., Greene, J., Russ, E., Dutra, L., &Westen, D. (2005). A multidimensional meta analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162*, 214-227.

Chater, A. B. (2008). Looking after health care in the bush. *Australian Health Review,* 32(2): 313-318.

Commonwealth of Australia (2001). *Life - Living is for everyone: A framework for prevention of suicide and self harm in Australia.* Commonwealth Department of Health and Ageing.

Commonwealth of Australia (2010). *Proof Committee Hansard, Senate, Community Affairs References Committee: Suicide in Australia*. Canberra, 25 March 2010.

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.

DoHA (2008). Report on the audit of health workforce in rural and regional Australia, April 2008. Department of Health and Ageing. Canberra, Commonwealth of Australia.

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.

Greenwood, G. & Cheers, B. (2003).Doctors and nurses in outback Australia: Living with bush initiatives. *Rural and Remote Health*, 2 Online: 1-9.

Guerin, P. and B. Guerin (2009)."Social effects of fly-in fly-out and drive-in drive-out services for remote Indigenous communities." *The Australian Community Psychologist,* 21(2): 7-22.

Harrison, C. and H. Britt (2011). General practice workforce gaps now and in 2020. *Australian Family Physician*, 40(1/2): 12-15.

Hawton, K.K.E., Townsend, E., Arensman, E., Gunnell, D., Hazell, P., House, A. & van Heeringen, K. (1999).Psychosocial and pharmacological treatments for deliberate self harm. *Cochrane Database ofSystematic Reviews*, *3.*Retrieved from http://www2.cochrane.org/reviews/en/ab001764.html.

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.

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

Le Grange, D. (2005). The Maudsley family-based treatment for adolescent anorexia nervosa. *World Psychiatry, 4*(3), 142–146.Maple, M.J. (2005).*Parental portraits of suicide: Narrating the loss of a young adult child.* PhD Thesis, University of New England.

Miller, S.D., Duncan, B.L., Brown, J., Sorrell, R., & Chalk, M.B. (2006). Using F=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 Iraqui Freedom veterans. *Journal of Clinical Psychology: In Session, 64*(8),958-971. DOI: 10.1002/jclp.20511

Morris, R. (2012) *Scoping Study: Impact of Fly-in Fly-out/Drive-in Drive-out Work Practices on Local Government*. Australian Centre of Excellence for Local Government, University of Technology, Sydney.

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 (2009). *Psychotherapy and Counselling Federation of Australia Submission to the Senate Inquiry into Suicide.* Melbourne, VIC: PACFA. Retrieved from http://www.pacfa.org.au/news.

Parliament of Australia (2011). *Suicide in Australia.* Department of Parliamentary Services. Retrieved from http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/BN/2011-2012/Suicide.

Perkins, D. (2012). "Editorial: Fly in Fly out and Drive in Drive out - useful contribution or worrying trend?" Australian Journal of Rural Health 20(5): 239-240.

Pirkis, J. and Blood, R.W. (2001). *Suicide and the Media: A Critical Review.* Canberra: Commonwealth Department of Health and Ageing. Retrieved from http://peu.unimelb.edu.au/__data/assets/pdf_file/0013/32314/pirkis_blood_2001.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, VIC: Centre for Health Policy, Programs and Economics. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-eval-sum.

Ratnarajah, D. and Schofield, M.J. (2007). Parental suicide and its aftermath: A review. *Journal of Family Studies, 13(1);* p.78 (17 pages).

Ratnarajah, D. and Schofield, M.J. (2008).Survivors' Narratives of the Impact of Parental Suicide. *Suicide & Life - Threatening Behaviour*, 38(5); p.618 (13 pages).

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.

Schnyder, U. (2005). Why new psychotherapies for posttraumatic stress disorder? *Psychotherapy and Psychosomatics, 74*, 199-201.

Schofield, D., Shrestha, R., Callander, E. (2012), Access to general practitioner services amongst underserved Australians: a microsimulation study. *Human Resources for Health.*10(1), 1.

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.

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.

Smith, T., Cooper, R., Brown, L., Hemmings, R. & Greaves, J. (2008).Profile of the rural allied health workforce in Northern New South Wales and comparison with previous studies. *Australian Journal of Rural Health,* 16(3): 156-163.

Smith M.L., & Glass G.V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist, 32*(9)*,* 752-760.

Stevenson, J., Meares, R. & D'Angelo, R. (2005).Five-year outcome of outpatient psychotherapy withborderline patients. *Psychological Medicine, 35*, 79–87.

Veitch, C., Lincoln, M., Bundy, A., Gallego, G., Dew, A., Bulkeley, K., Brentnall, J., Griffiths, S. (2012). Integrating evidence into policy and sustainable disability services delivery in western New South Wales, Australia: The 'wobbly hub and double spokes' project. *BMC Health Services Research*, 12(70): 1-8.

Wakerman, J., R. Curry, McEldowney, R. (2012). "Fly in/fly out health services: The panacea or the problem." *Rural and Remote Health,* 12(2268): 1-4.