Medicare Benefits Schedule Review Taskforce

ARCAP Response to Report from the Mental Health Reference Group

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Executive Summary

The Australian Register of Counsellors and Psychotherapists (ARCAP) broadly supports the work of the Mental Health Reference Group to update and address flaws in the Medicare Benefits Schedule (MBS) Better Access Initiative (BAI). The key recommendations of the Reference Group present an opportunity to improve access and patient choice relating to mental health providers, and have the potential to increase the overall mental health and well-being of the community.

Registered counsellors and psychotherapists are an under-utilised, high-value, highly skilled workforce that is eager to meet workforce shortages and gaps. However, this workforce is currently ineligible from delivering services under BAI items to the community, including under-serviced groups. In recommending utilisation of counsellors and psychotherapists under BAI, equity of access to groups such as aged persons, people in rural and remote settings, Aboriginal and Torres Strait Islander peoples, newly settled migrants and refugees, families and carers will be achieved.

ARCAP recommends discontinuing differential pricing for different practitioners where practitioners are providing the same service. Psychologists are paid a schedule fee of $84.80 per session compared to other allied health providers who are paid a schedule fee of $74.80 per session. There is no clinical rationale for this differential pricing sturcture as they are providing the same treatments, focused psychological strategies.

In considering recommendations 1 – expanding BAI to at-risk patients and recommendation 2 – increasing the maximum number of sessions per referral, these recommendations will increase pressure on the current mental health workforce with patients experiencing limited availability and long waiting times between sessions in metro and low-access areas. It will therefore necessitate careful consideration of recommendation 4 – reviewing which professional groups can provide services under the BAI.

Incorporating registered counsellors and psychotherapists into eligible professional groups to deliver BAI services will bolster the available workforce and provide substantial cost-savings and efficiency gains.

Matching the needs of patients for timely, efficient care will reduce over and under-servicing and provide a broader range of services available to better target patient needs. In the proposed 3-tiered triage model**,** counsellors and psychotherapists could deliver continuous care under each tier, and simultaneously free up specialist mental health services for those with severe mental health illness to be delivered by a range of specialist mental health providers.

About ARCAP

ARCAP is the Australian Register of Counsellors and Psychotherapists. It is the national register and credentialing system, established jointly by the Psychotherapy and Counselling Federation of Australia (PACFA) and the Australian Counselling Association (ACA). ARCAP is made up of qualified counsellors and psychotherapists who are registered with PACFA or the ACA. Counsellors and Psychotherapists who are listed on ARCAP meet the registration requirements of ACA and/or PACFA, including relevant qualifications, annual requirements for professional development and supervision, and follow a Code of Ethics. Practitioners registered with ARCAP are distributed throughout Australia in urban, regional and rural areas.

In this submission, the term registered counsellor and psychotherapist is used to refer to practitioners registered with the ACA and PACFA who have completed training to at least degree level and who have completed at least two years full-time practice (a minimum of 750 supervised client hours). These practitioners are competent to provide interventions to support people with their mental health and to provide psychotherapeutic interventions for patients with more serious mental disorders.

Feedback on key recommendations

Recommendation	**ARCAP feedback**
Recommendation 1 – Expand the Better Access Program to at-risk patients	• ARCAP supports this recommendation as it is timely and will result in long-term gains in population health outcomes and related long-term productivity gains. • However, it would put added pressure on existing service providers and necessitate the inclusion of additional professional groups that cannot currently provide services under BAI. • See detailed feedback in this submission.
Recommendation 2 – Increase the maximum number of sessions per referral	• ARCAP supports this recommendation in full.
Recommendation 3 – Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness	• ARCAP supports this recommendation as it will result in optimal use of resources and will allow specialist mental health treatment for those with severe mental health illness to be delivered by specialist mental health providers such as clinical psychologists. • Registered counsellors and psychotherapists can deliver care under each tier, particularly for patients with mild to moderate mental health issues. • See detailed feedback in this submission.
Recommendation 4 – Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups	• To meet the rising demands of the population for mental health services and the demands on the workforce, ARCAP recommends action on recommendation 4 to establish a working group.

Recommendation	ARCAP feedback
	• The Working group should not be dominated by any particular professional group and should include counsellors and psychotherapists. • See detailed feedback in this submission.
Recommendation 5 – Reduce minimum number of participants in group session	• ARCAP supports this recommendation in full.
Recommendation 6 – Add new group item for therapy in larger groups	• ARCAP supports this recommendation in full.
Recommendation 7 – Enable family and carers to access therapy	• ARCAP supports this recommendation, however this change needs to occur urgently as the only alternative at present is for the family member to get their own mental health plan in order to discuss treament for the patient.See detailed feedback in this submission.
Recommendation 8 – Measure Better Access outcomes	• ARCAP supports this recommendation in full.
Recommendation 9 – Update treatment options	• ARCAP supports this recommendation however ARCAP submits that some focused psychological strategies could be added immediately whilst other recommended treatments may require more work in order to consider their inclusion. See detailed feedback in this submission.
Recommendation 10 – Unlink GP focussed psychological strategy items from M6 and M7	• ARCAP supports this recommendation in full.
Recommendation 11 – Encourage coordinated support for patients with chronic illness and patients with mental illness	• ARCAP supports this recommendation in full.
Recommendation 12 – Promote the use of digital mental health and other low-intensity treatment options	• ARCAP supports this recommendation in full.
Recommendation 13 – Support Access to mental health services in residential aged care	• ARCAP supports this recommendation in full.
Recommendation 14 – Increase access to telehealth services	• ARCAP supports this recommendation. Counsellors and psychotherapists are ideally placed to provide a workforce for the expansion of mental health telehealth services for rural and remote areas. • See detailed feedback in this submission.

Recommendation 1 – Expand the Better Access Program to at-risk patients

ARCAP supports the expansion of BAI to people at-risk of developing mental health issues, who have a high likelihood of developing a mental health disorder in the next 12 months or require treatment to maintain their mental health to prevent relapse (items 2700, 2701, 2715, 2717). This recommendation is timely and will result in long-term gains in population health outcomes and substantial economic savings by investing in early intervention and prevention.

ARCAP also supports enabling the at-risk population to access care without requiring a formal diagnosis as it may reduce stigma and any potential insurance discrimination. It is ARCAP's position that a formal diagnosis is clinically inappropriate and unnecessary for patients presenting with mild to moderate mental health issues. Avoiding a formal diagnosis may also reduce the consequences that a detrimental effect of a diagnosis may have on recovery (PACFA, 2018a; Corrigan, 2004).

Who is at risk of mental illness?

It is estimated that almost half of the adult (16-85) population will experience a mental illness at some point in their lifetime which amounts to approximately 8.5 million people and of these people it is estimated that 1 in 5 (about 3.8 million) of the population will experience a common mental disorder such as anxiety, affective, and substance use disorders in a 12 month period (AIHW, 2019). Almost 1 in 7 (which is equivalent to about 586,000 children and adolescents) aged 4–17 years surveyed in a 2013-14 national household survey were assessed as having mental health disorders in the previous 12 months (AIHW, 2019). The Productivity Commission in an Issues Paper on *The Social and Economic Benefits of Improving Mental Health* has estimated 5.8 million adults and children are at-risk if they had emerging symptoms of a mental illness within the 12-month period, or an episode of mental illness before the 12-month period, or were children of parents with a mental illness (Productivity Commission, 2018).

From an occupational perspective, Safe Work Australia has reported that the occupational groups most at risk of mental illness are: train and tram drivers, police, Indigenous health workers, prison officers, ambulance officers and paramedics (Safe Work Australia, 2018).

Defining the at-risk population depends on the illness or disorder as there many associated risk factors for different illnesses, for instance, in relation to a highly prevalent disorder such as Generalised Anxiety Disorder they can be grouped under sociodemographic, psychosocial, and physical and mental factors.

The table below outlines some possible factors to consider for a patient at-risk of Generalised Anxiety Disorder (Moreno-Peral et al. 2014). As this illustration makes clear there are a number of factors to consider for the at-risk population for any one disorder.

Sociodemographic factors	**Psychosocial factors**	**Physical and mental factors**
Age	Stressful life events during childhood	Parental history of mental disorders
Gender	Stressful life events during the previous month	Other anxiety or mental health disorders

Sociodemographic factors	Psychosocial factors	Physical and mental factors
Ethnicity	Personality factors such as a level of neuroticism	History of psychological problems or psychiatric care
Marital status	Parental support	Any other chronic conditions
Socioeconomic level	Social support	Any disabilities

Referral and treatment process for new patient cohort

By expanding BAI to include at-risk patients, a new patient cohort will be identified which raises questions of how this patient cohort will be treated and what role General Practitioners (GPs) will have. If an at-risk patient does not require a diagnosis of a mental disorder, a mental health plan becomes inefficient and ineffective. ARCAP acknowledges the importance of GPs central stewardship and acknowledges that GPs are treatment agents in their own right with a crucial role to play in co-morbidities (for example, addictions).

However, a mental health plan and diagnosis is not necessary for a patient at-risk of developing a mental illness and should not be a condition of accessing mental health services. It may be that a referral pathway is created between GPs and practitioners such as counsellors and psychotherapists, by way of referral letter, without the need for a mental health plan. This would off-set costs to treat the at-risk population and provide savings by not creating and reviewing mental health plans.

Counsellors and psychotherapists are highly trained and experienced, and are available to treat the at-risk population but are not currently utilised by the Better Access program. In treating the at-risk population, a larger workforce will be required to reduce pressure points and wait times. Moreover, counsellors and psychotherapists have relational expertise and may be the practitioners of choice for many patients who may not wish to see a psychologist and may wish to see other interventions besides cognitive behavioural therapy (CBT). Counsellors are more highly accepted by clients compared to psychologists or psychiatrists (Sharpley, Bond & Agnew, 2004; Sharpley, 1986) and are seen as more approachable and empathic (Sharpley, 1986).

Consumer access and choice will be increased if a wider range of mental health professionals are eligible to provide services under BAI. Increased patient choice may incentivise providers to deliver services efficiently and in turn may lower costs to patients. There is strong evidence that providing services according to client preference improves therapy outcomes (Iacoviello, McCarthy, Barrett, Rynn, Gallop & Barber, 2007; Lindhiem, Bennett, Trentacosta & McLear, 2014; McLeod, 2012).

Workforce shortages

With the expansion of BAI to at-risk patients, a larger mental health workforce needs to be ready and available. Yet there are currently shortages in the mental health workforce with patients experiencing limited availability and long waiting times between sessions in some metropolitan areas and other areas with low service access, such as rural and regional Australia. This leads to disruption in treatment and increases drop-out rates.

Expanding the workforce will necessitate a consideration of the inclusion of registered counsellors and psychotherapists who currently cannot provide services under BAI. Registered counsellors and psychotherapists provide evidence-based interventions to support mental health and wellbeing.

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). These findings are supported by research into the common factors underlying the effectiveness of counselling and psychotherapy (Duncan, Miller, Wampold & Hubble, 2009; Wampold, 2015) 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.

Case Study: Sophie, 27

Sophie is 27 has recently started work as a high school teacher. She has also ended a relationship with a long-term partner and is experiencing some social and generalised anxiety. She has been encouraged by her close friends to seek some professional mental health support. Her first port of call was her local GP, who created a mental health plan. The GP also provided a list of psychologists in the inner-city Melbourne neighbourhood in which she lives. She found that the psychologists she wanted to see were not taking any more clients or had long waiting lists, so she settled on the psychologist that could see her within the next fortnight. Despite not being a perfect match, she felt relief to have an initial session with the psychologist but was told after the session that the next availability would be in three weeks due to high demand. Subsequent to that there was a month between sessions. Sophie only completed 4 sessions and declined to continue further treatment sessions as interest and momentum was lost.

In Sophie's case, four sessions was inadequate to treat her anxiety, and Sophie has unresolved issues and under-developed coping strategies and mechanisms. Being able to access a counsellor or psychotherapist would improve Sophie's chances of accessing appropriate treatment from a practitioner she feels she can work with.

Value for the health system

With an estimated 5.8 million adults and children at risk of mental ill health (Productivity Commission, 2018) expanding Better Access represents a great opportunity to make an impact towards a mentally healthier population.

Early identification and intervention will derive significant value in preventing deterioration and potentially reduce costs for the health system, particularly for people aged under 25 years, those in rural and remote areas, and people at risk of relapse who do not have access to maintenance care. There will be substantial savings from investing in early intervention and prevention. This will be seen in reduced admissions into emergency departments and potentially preventable hospitalisations. It would reduce total number of sessions used by some patients by addressing symptoms earlier, and may reduce costs in social welfare and other health services.

Patients at-risk of mental illness do not specifically require treatments to be delivered by psychologists or clinical psychologists. By utilising registered counsellors and psychotherapists to meet the demands of the at-risk population, there is a potential for cost-savings to the MBS and the health system as there are efficiencies evident when the cost of services delivered by counsellors and psychotherapists are compared to cost of services delivered by clinical psychologists.

Counsellors and psychotherapists are experienced, skilled, and ready to provide support in a stepped care structure. Refer to the scope of practice for registered counsellors to survey the breadth and depth of the counselling competencies, qualifications, and safe practices within the Australian health system context (PACFA, 2018; ACA, 2016).

Recommendation 3 – Introduce a 3-tiered system for access to Better Access sessions for patients with a diagnosed mental illness

ARCAP supports introducing a 3-tiered triage system to access sessions under BAI for patients with a diagnosed mental illness according to diagnosis, severity and complexity, and progression by patients through each tier. By adopting the efficiencies of the stepped care model patient needs and circumstances will be matched at the appropriate level to reach full recovery.

A bulk of the demand for mental health services is at the level of early intervention and primary care services. A stepped care model which includes registered counsellors and psychotherapists as providers under Better Access would enable better targeting of patient needs with suitable providers. It would also bolster support in the existing teamwork approaches to client management shared between GPs, psychologists, psychiatrists and other allied health practitioners.

Counsellors and psychotherapists are highly skilled and qualified to provide effective, accessible and efficient services, at different levels within the stepped care model for people seeking mental health support and can further guide clients seeking more or less intervention intensity through referral pathways (Firth, Barkham, & Kellett, 2015).

Matching patient needs and optimal use of resources

Matching the needs of patients for timely, appropriate care will reduce over and under-servicing and provide a broader range of services available to target consumer needs. For instance, in the 3-tiered model proposed under recommendation 3, counsellors and psychotherapists could deliver continuous care under each tier, particularly for consumers with mild to moderate mental health issues and those at-risk of developing a mental illness. This will result in optimal use of resources by the available workforce and will allow specialist mental health treatment for those with severe mental health illness to be delivered by a range of specialist mental health providers.

There is no underlying clinical justification for limiting patients to 10 sessions of treatment under BAI. This has resulted in patients who are mentally unwell being unable to access additional services that they need for full recovery. It is essential that as patients progress to higher tiers in the stepped care model that they can access more treatment sessions. ARCAP supports the new suggested caps of 10, 20 and 40 sessions for the three tiers in the stepped care model. Raising the caps in this way for those who require more sessions in order to recover fully will not impact on the vast majority of patients who do not require additional sessions but who are effectively treated by short-term counselling.

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 patient needs. Research on patient engagement with community mental health services demonstrates that “a minimum of eleven to

thirteen sessions of evidence-based interventions are needed for 50% - 60% of clients to be considered recovered" (Barrett, Chua, Crits-Cristoph, Gibbons & Thompson, 2008). For some patients with more long-term or severe mental health challenges, limiting the number of treatment sessions available under BAI to ten sessions could have a detrimental effect on treatment outcomes.

If a patient's access to a higher tier requires a GP review and endorsement, ARCAP recommends that GPs should ideally have completed AMA-approved mental health training to ensure high-quality standards and utility of the GP's central stewardship. Presently, approximately one-third of Mental Health Plans are prepared by GPs who have not completed the AMA-approved mental health training.

Utilising registered counsellors and psychotherapists into existing stepped care focused psychological strategies will increase service capacity for primary care-based mental health services and move towards optimal use of resources. This would allow for a more effective secondary care or specialist services with greater capacity and flexibility to receive patients and meet service loads. This would also reduce inappropriate referrals to secondary mental health care services and reduce secondary care asessment times and patient waiting times.

Recommendation 4 – Establish a new working group or committee to review access to, and rebates for, Better Access sessions delivered by different professional groups

To meet the rising demands of the population for mental health services and the demands on the workforce, ARCAP supports the establishment of a new working group or committee to seek a consensus amongst the professional groups on access to, and rebates for, BAI sessions.

Greater consumer choice and better outcomes may result in reviewing access to and rebates for BAI by different professional groups. Patients may prefer to choose registered counsellors and psychotherapists because of the relational expertise, training, and scope of practice that more closely match their needs.

The working group or committee must be balanced, have a focus on patient needs, unbiased and with no interest groups dominating, and with a mandate to provide best value for the health system and consumers. Therefore, we recommend that membership to this committee be very carefully considered. It is essential that counsellors and psychotherapists are included as they have been excluded from BAI in the past.

Access to, and rebates for BAI items for patients within the MBS has been an ongoing issue for counsellors and psychotherapists as the present arrangement disadvantages patients who seek the services of registered counsellors and psychotherapists. The full range of professional mental health practitioners has never been available to manage mental illness in the community.

This critical issue impacts patient choice, as choice in providers will be increased when a wider range of mental health professionals are eligible to provide services under BAI.

Opportunity to meet the needs of under-serviced groups

There is an opportunity to meet the needs of sectors of the community that have been under-serviced or unable to access services. For example, under-serviced groups such as family and carers of people with mental illness may benefit more from family therapy or relationship counselling where counsellors and psychotherapists are highly experienced and have expertise in the sector. Increasing services to groups such as aged persons, people in rural and remote settings, Aboriginal and Torres Strait Islander peoples, newly settled migrants, and refugees, requires a larger and more diverse workforce.

For instance, Aboriginal and Torres Strait Islander mental health outcomes are considerably poorer across a range of outcomes than those of non-Indigenous people. In the 2014-2015 ABS National Aboriginal and Torres Strait Islander Social Survey, 33 per cent of adult respondents had high/very high levels of psychological distress, and this was found to be 2.6 times that of as non-Indigenous adults (Australian Government, 2017). Registered counsellors and psychotherapists would provide a bolstered workforce to respond to the high incidence of social and emotional wellbeing problems and mental ill-health. Further, to help ameliorate the intergenerational effects of trauma, registered counsellors and psychotherapists use culturally competent and safe practices, and a wide range of interventions to respond to the cultural diversity of clients, such as Narrative Therapy when working with Aboriginal and Torres Strait Islander clients (Nagel & Thompson, 2007).

Service access issues in rural and regional areas

The current MBS model also has substantial issues catering to the demand for mental health services in regional and rural Australia. Demand is high and is not being met by the current pool of MBS providers. In rural, regional and remote areas, only 4% of psychiatrists and 21.5% of psychologists provide services, compared to almost one third of counsellors and psychotherapists (Vines, 2011). The high demand for MBS services in rural and regional areas could be alleviated by registered counsellors and psychotherapists who could deliver BAI services.

Registered counsellors and psychotherapists are distributed throughout the country, and therefore make a significant contribution to services in regional, rural, and remote areas, where specialist services are more difficult to access (Gittoes, Mpofu & Matthews, 2011). Australian studies of the counselling workforce have consistently found that approximately one third of counsellors work in regional, rural, and remote areas (Pelling, 2005; Schofield & Roedel, 2012; Schofield, 2015).

Allowing registered counsellors and psychotherapists to deliver MBS items for the provision of focused psychological strategies, in line with other allied mental health providers, would build workforce capacity and provide proven evidence-based therapies to patients seeking treatment. Registered counsellors and psychotherapists currently deliver the same focused psychological strategies as other allied health professionals working within a private mental health practice setting.

Focused Psychological Strategies are poorly targetted

BAI targets consumers inefficiently with the services being provided by a range of practitioners who are paid different fees despite providing the same service. Psychologists are paid a schedule fee of $84.80 per session (Item Number 80110) and clicnical psychologists $125.50 compared to other allied

health providers who are paid a schedule fee of $74.80 per session (Item Numbers 80135 and 80160). This price differential privileges one profession over others, even though all of the providers are essentially delivering the same interventions.

Table 2: Comparison of fees paid to different practitioners that are providing the same service

Item No	Description	Current Fees	No of services (2012)	Cost
80160	Focussed Psychol. Strategies by Soc. Worker (>50 mins)	$74.80	168,529	$12,605,969
80135	Focussed Psychol. Strategies by Occ. Therapist (>50 mins)	$74.80	31,662	$2,368,318
80110	Focussed Psychol. Strategies by Psych. (>50 mins)	$84.80	1,936,034	$164,175,683
80010	Assessment and Treatment by Clinical Psych. (>50 mins)	$124.50	1,418,542	$176,608,479
			TOTAL	$355,758,449

The majority of consumers who have mild to moderate depression and anxiety do not specifically require intervention from psychologists or from clincial psychologists. These consumers could be effectively assisted by receiving counselling from a registered counsellor or psychotherapist, or from a social worker or an occupational therapist.

The higher schedule fees paid to psychologists to deliver focused psychological strategies, and to clinical psychologists for assessment and treatment, is an inefficient use of resources. There is no clinical rationale for paying more to providers based on their training and no evidence that the higher fees paid to psychologists result in better treatment outcomes. Services could be provided by a range of suitably qualified practitioners, including counsellors and psychotherapists, at the lower rate of $74.80 per session.

Recommendation 7 – Enable family and carers to access therapy

ARCAP supports allowing family members and carers to participate in treament sessions for the patient. However ARCAP is concerned that because this recommendation is being considered as a future change, family members, guardians, and carers will not be to attend therapy sessions immediately in order to support the treatment of the patient.

There is a need for this change to take place urgently as the only alternative at present is for the family member, guardian or carer to get their own mental health plan in order to participate in discussions about the the care of the patient. This is not an appropriate use of mental health plans.

Recommendation 9 – Update treatment options

ARCAP supports updating treatment options, however, we are concerned about the implications of putting this recommendation in “longer-term recommendations.” There is an urgent need to expand the focused psychological strategies allowed under BAI to reflect the wide range of interventions for which there is a strong evidence-base. Based on available evidence, some interventions could be added to the definition of focused psychological strategies immediately. Other interventions with a strong evidence base may require more time to be added to the list of acceptable interventions as a credentialing system would be needed to identify which practitioners are suitably qualified to provide those interventions. For example, family therapy has a strong evidence base for effectiveness for

eating disorders, however, only those with specific training in family therapy can provide these interventions.

Ongoing review of the evidence for different psychological therapies is also necessary. Confining clinical treatments limits the opportunity clients have to access treatments that are effective for their particular presenting issues and preferences. There are a number of interventions with proven clinical effectiveness that should be incorporated into MBS Item Numbers. For instance, systematic reviews have shown that couples counselling and family therapy can be more effective than individual treatment for treating substance abuse (O'Farrell & Clements, 2011).

The issue with the introduction of the additional interventions is not whether there is an evidence-base for their effectiveness as the evidence for all of these interventions is strong. ARCAP notes that some interventions (Table 3 below) could be allowed immediately, whereas the specialist interventions (Table 4) may require more work before introduction.

Table 3: Suggestions for Focussed Psychological Strategies to be added immediately

Intervention	Presenting issues
Solution-focused therapies	Substance misuse, depression
Motivational interviewing	Substance misuse, problem gambling
Supportive counselling	Depression
Exposure treatments	Phobias, anxiety disorder, OCD
Couples counselling	Depression, generalised anxiety, post-traumatic stress disorder, substance misuse
Humanistic-experiential therapies	Depression, anxiety, relationship / interpersonal distress

These interventions are supported by a range of research studies as detailed in this submission, and by PACFA literature reviews on depression (Knauss & Schofield, 2009a), post-traumatic stress disorder (Knauss & Schofield, 2009b), anxiety (Knauss & Schofield, 2009c), eating disorders (Knauss & Schofield, 2011), supportive counselling (Jacobs & Reupert, 2014) and experiential psychotherapy (Mullings, 2017). Table 3 also considers the findings in *Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review* (Australian Psychological Society, 2018).

Wide numbers of practitioners are trained and competent to provide these interventions so there is no clinical reason to delay adding them to the list of accepted focused psychological strategies. No specialist credentialling is required for the practitioners providing these interventions.

Table 4: Suggestions for interventions to be added in the future

Intervention	Presenting issues
Psychodynamic psychotherapy	Depression, generalised anxiety disorder, social anxiety, substance use disorders, anorexia nervosa
Eye movement desensitisation and reprocessing	PTSD and anxiety disorders
Emotion-focused therapy	Depression, trauma, binge eating disorders

Intervention	Presenting issues
Mindfulness-based cognitive therapy	Depression, generalised anxiety, , borderline personality disorder, ADHD, sleep disorders, panic disorder, obsessive complusive disorder
Acceptance and commitment therapy	Depression, generalised anxiety disorder, social anxiety disorder, obsessive-compulsive disorder, binge eating disorder, chronic pain, borderline personailty disorder
Dialectical behaviour therapy	Depression, Borderline personality disorder, bulimia nervosa, anorexia nervosa, binge eating disorder, ADHD
Family therapy	Anorexia nervosa, substance use disorders
Creative arts therapies	Depression, post-traumatic stress disorder
Somatic psychotherapy	Post-traumatic stress disorder, trauma

These interventions are supported by a range of research studies as detailed in this submission, including the PACFA literature reviews on psychodynamic psychotherapy (Gaskin, 2012), creative arts therapies (Dunphy, Mullane & Jacobsson, 2013) and body-oriented psychotherapy (Bloch-Atefi & Smith, 2014) and the findings in *Evidence-based Psychological Interventions in the Treatment of Mental Disorders: A Literature Review* (Australian Psychological Society, 2018).

As these are more specialist interventions, further work is required to determine whether specialist credentialing is required for the practitioners providing these interventions.

Recommendation 14 – Increase access to telehealth services

ARCAP supports increased access to tele-health services to meet rural and remote area needs. Registered counsellors and psychotherapists are ideally placed to provide a workforce for the expansion of mental health telehealth services for rural and remote areas. Counsellors and psychotherapists represent higher value to the health system to provide these services compared to other mental health service providers such as psychologists and clinical psychologists.

Optimal utilisation of the counselling and psychotherapy workforce will result in improved assess and efficiencies. For example, we envision a digital health-based counselling support gateway for people in rural and remote areas, particularly Aboriginal and Torres Strait Islander and rural farmer populations who are unable to travel great distances for in-person appointments.

Registered counsellors and psychotherapists have training in online work to ensure ethical and safe practice and provide a cost-effective solution for telehealth services. Counsellors and psychotherapists are experienced in this mode of service delivery.

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