

# Counselling in Community Health Services: future directions and guidelines for quality counselling

Public consultation draft

# **Counselling in Community Health Services: future directions and guidelines for quality counselling**

Public consultation draft

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## Executive summary

This paper represents the culmination of Stage Two of the counselling review and follows the Stage One paper, *Review of counselling services in community health: discussion paper* (Department of Human Services, 2002a)

Stage One of the review focused on conducting a broad public consultation and establishing a basis for resource allocation. Stage Two focused on the quality of counselling in Community Health Services (CHSs) and their role within the broader primary care system.

### Principles

The following principles will guide the development of counselling services in Victorian CHSs over the next two years:

#### Principle 1. Community health and the National Mental Health Plan

Counselling services in CHSs should be well positioned to contribute to the *National Mental Health Plan 2003–2008*.

#### Principle 2. Social model of health

The social model of health, which underpins counselling services in CHSs, should substantially contribute to the development of primary care mental health policy, planning and services.

#### Principle 3. Effective counselling

The effectiveness and ongoing development of counselling services in CHSs should be assured through improved recruitment, competency development and quality processes.

### Guidelines

The following is a summary of the guidelines for quality counselling services in CHSs:

**Guideline 1.** Counselling services will be underpinned by the principles of the social model of health through their practices and in their relationships with other providers and the community.

**Guideline 2.** Counselling services will ensure continuity of quality care, adapted to the particular needs of the client, from first contact, through assessment, counselling and review to completion.

**Guideline 3.** Demand for counselling services will be managed by a needs-based case allocation and by targeting people who are most likely to benefit, waiting list management and by identifying related client supports.

**Guideline 4.** Counselling services will promote effective practices through care planning and review, and the delivery of evidence-based interventions.

**Guideline 5.** Quality improvement processes will be an ongoing feature of counselling services.

**Guideline 6.** Consumer participation will be a feature of planning and ongoing monitoring of the quality of counselling and mental health promotion.

**Guideline 7.** The competency of counsellors will be assured through the use of minimum qualifications, continuing professional development, workforce planning and clinical supervision.

**Guideline 8.** Counselling services will operate as one part of a continuum of mental health promotion.



# 1. Introduction

## Background

Nearly 40,000 Victorians each year participate in counselling directly funded by the Community Health Program and delivered by more than 300 counsellors working in 100 Community Health Services (CHSs). In addition, CHSs provide alcohol and drug, family and financial counselling. The strength of counselling in CHSs has been in their relevance to their local communities, the quality and commitment of their counsellors and their broad targeting of a wide range of people. Many of the people receiving counselling, including children and adults, individuals, couples, groups and families, are financially and socially disadvantaged and have significant and complex problems of mental and social health.

In Australia, mental disorders were the leading cause of years of 'healthy' life lost due to disability in 1996, and they were the third leading cause of overall burden (after cardiovascular diseases and cancer). Amongst females aged 25–44, mental disorders dominate the burden of disease, depression being the major cause (Australian Institute of Health and Welfare, 2002 pp. 109 and 228).

Recognising the burden of common mental health and social problems, the Victorian Government committed to a program of service expansion and improvement from 2000, directed at increasing the access, profile and effectiveness of these counselling services.

This paper, *Counselling in Community Health Services: future directions and guidelines for quality counselling*, sets new directions for community health counsellors. It specifies the role of community health counsellors and defines the working relationship between counsellors in CHSs and other services in the broader primary care system. The guidelines have been developed after extensive consultation with stakeholders.

## What do counsellors in Community Health Services do?

Community health counsellors need to have mastered a unique range of competencies and skills to fulfil the role of providing a counselling service in a community health setting. The term 'counselling' is used throughout this paper to refer to the role of the community health counsellor, which encompasses care planning, supportive counselling and therapeutic interventions/psychotherapy. Each of these aspects of counselling is crucial in the provision of a comprehensive counselling service in CHSs that requires a social model of health context.

## Counselling initiatives 2000–2004

The counselling initiatives undertaken by the Community Health Program in 2000–2004 included:

- projects for increasing the access and quality of counselling provided in rural areas
- increased funding for counselling, allocated according to the burden of common mental health problems in each region
- regional forums and statewide focus groups to engage and seek the views of counselling practitioners and service managers
- consulting with a range of organisations with related interests, including the Victorian Health Promotion Foundation, Victorian Hospitals Association and university counselling training programs
- an independent consultancy to review the features, strengths and weaknesses of community health assessment and counselling
- improved policy coordination between specialist mental health services, primary mental health teams and community health counselling
- as part of the community health policy framework, positioning counselling services as a significant and credible part of mental health promotion in primary care
- development of guidelines (Chapter 7) for assuring the quality of counselling is consistent with the department's *Service quality framework* (Department of Human Services, 2002d)

- minor works grants with a focus on improving the physical infrastructure of counselling facilities in CHSs
- leadership initiatives operating in all regions to encourage sustained change in counselling practices through building local networks and improving the quality of counselling practice and service provision
- development of the policy paper, *Foundations for primary care mental health treatment services in Victoria* (Department of Human Services, 2004) , to improve coordination and collaboration between state and Commonwealth departments with responsibility for primary mental health initiatives
- development of a monograph and a web-based resource guide about the use of evidence-based approaches for counsellors in CHSs
- a training program about single session work for community health counsellors
- piloting a brokerage model to assist people in rural areas to access appropriate counselling.

## Review of counselling in Community Health Services

The *Review of counselling services in community health – discussion paper* (Department of Human Services, 2002a) was published as Stage One of the review of counselling and was widely disseminated in February 2002. In Stage Two of the review, written submissions and focus group feedback on the findings in the Stage One report were considered and issues identified. Initiatives to address these issues have been developed in consultation with a wide range of stakeholders both within and external to the Department of Human Services.

While the Stage One review identified much good work in community health counselling, certain shortcomings were evident, such as:

- lack of explicit targeting of services
- inconsistent waiting list management and mechanisms for managing client demand
- the need for minimum qualifications and competencies for counsellors
- the need for standards for approaches to service delivery
- the need to enhance evidence-based interventions
- counselling is mainly delivered to adults, greater focus is needed on children, young people and families
- external credibility requires development
- insufficient record keeping of client problem types and social disadvantage.

The review of counselling in CHSs identified the following:

- Counselling in CHSs already caters for the needs of people with the most common mental health and social problems, such as anxiety and depression, and is experiencing increased demand as a consequence of increased community awareness and government focus on these mental health problems.
- Counselling in CHSs is well placed to contribute to the implementation of Australia's *National Mental Health Plan 2003-2008* in primary care. However, the existing and possible future contributions of community health counselling to meeting the needs of people with the most common mental health and social problems has not been sufficiently recognised by either the government or service sector.
- Partnerships of specialist mental health, CHSs and general practice will improve primary care mental health services.
- The social model of health, which underpins CHSs and acknowledges the substantial evidence linking mental health to social disadvantage, supports the effectiveness and acceptability of the present approaches to primary care mental health policy and service planning.

- Quality assurance of counselling in CHSs falls short of that in most other government funded counselling services and fails to meet recommendations in evidence-based guidelines for effective psychosocial interventions.
- Formalised guidelines for quality counselling in CHSs are required, together with the associated structures and processes to support minimum qualifications, quality assurance, ongoing competency development, physical infrastructure, evidence-based practice and evaluation.

## Future directions for counselling in Community Health Services

This paper builds on the initiatives mentioned above and the review findings by bringing together the relevant existing policies (Table 1) and evidence to support a future direction for counsellors in CHSs.

### The purposes of setting new directions in counselling are to:

- actively contribute to the National Mental Health Plan 2003–2008 with a clearly identifiable role for counselling in CHSs, a policy context and a range of new initiatives
- give CHSs a profile as a credible primary care mental health provider and an influential advocate of the social model of health and wellbeing
- provide greater access for people with common mental health and social problems to effective counselling of an assured quality
- lead to improved recognition, support and retention of counsellors in community health.

## Principles

The following principles will guide the development of counselling services in Victorian CHSs over the next two years:

### Principle 1. Community health and the National Mental Health Plan

Counselling services should be well positioned to contribute to the National Mental Health Plan 2003–2008.

### Principle 2. Social model of health

The social model of health, which underpins counselling services, should substantially contribute to the development of primary care mental health policy, planning and services.

### Principle 3. Effective counselling

The effectiveness and ongoing development of counselling should be assured through improved recruitment, competency development and quality processes.

**Table 1: Policies and resources relevant to community health counselling**

<b>Australian Government</b>
• <i>National Mental Health Plan 2003–2008</i>
• <i>National Action Plan for promotion, prevention and early intervention for mental health, 2000</i>
• <i>National standards for mental health services, 1997</i>
• <i>National practice standards for the mental health workforce, 2002</i>
<b>Victorian Government</b>
• <i>Community health services – creating a healthier Victoria, Public consultation draft, 2004</i>
• <i>Primary Care Partnerships strategic directions 2004–2006</i>
• <i>Towards a community health policy framework – discussion paper, May 2002, Objective 3. Primary mental health and promotion of psychosocial wellbeing</i>
<b>Other resources</b>
• <i>New directions for Victoria’s mental health services: the next five years, 2002</i>
• <i>Department of Human Services quality framework, 2002</i>
• <i>Review of counselling services in community health: discussion paper, February 2002,</i>
• <i>Framework for counselling casework: a stronger primary health and community support system (PHACS Information Resource 2), 1999</i>
• <i>Foundations for primary care mental health treatment services in Victoria, 2004</i>

(see References for full details)

## Quality counselling guidelines and initiatives

The Quality counselling guidelines (Chapter 7) have been prepared in consultation with counsellors in Victoria’s CHSs. They will support the implementation of the key goals of this paper.

The guidelines are to be used by CHSs delivering counselling services, funded by the Community Health Program, previously termed ‘counselling casework’ and now called ‘counselling’. The counselling guidelines emphasise:

- improved operational processes to ensure that priority is given to people most in need and who will most benefit from counselling
- improved access for children and young people
- more effective practices based on evidence and an outcome orientation
- upgraded entry qualifications and ongoing competency development
- improved integration of counselling with mental health promotion and wellbeing efforts both within and external to the CHS
- promotion of research and development.

Successful implementation of the guidelines will further raise the profile, credibility and impact of these established and valued services with consumers, other service providers and the community.

## 2. The mental health and wellbeing of Australians

This chapter outlines the nature of Australians' most common mental health and social problems and the present role of community health counsellors in addressing these needs.

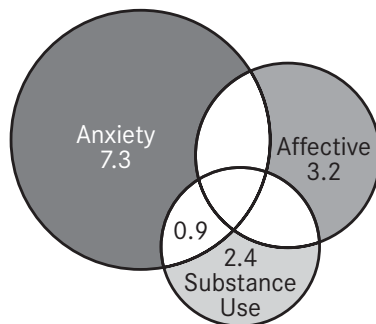
During 1997–98, the Australian Bureau of Statistics (ABS) conducted several large-scale community household surveys designed to describe, for the first time, the community prevalence of mental health problems. The National Survey on Health and Wellbeing (NSHMW) (ABS, 1998a) described the nature and frequency of the range of anxiety, affective and substance use disorders, and service use in Australian adults aged 18+ years. Data specifically relating to the Victorian population (ABS, 1998b) and a report on the mental health problems of Australian adolescents and children (ABS, 1999) have also been released.

The NSHMW found that in the Australian community 18 per cent of the adult population had a mental disorder in the previous 12 months. Young adults aged 18–24 years had the highest prevalence of mental disorder (27 per cent), declining to 6.1 per cent in those aged 65 years and over. As shown in Figure 1, there are distinct gender trends, with substance use problems being more common in men and anxiety and depression more common in women. Around 40 per cent of these men and women also have chronic problems of physical health, including cardiac and respiratory disorders and arthritis.

**Figure 1: Prevalence of single and co morbid anxiety, affective and substance use disorders amongst Australian adults in the past year**

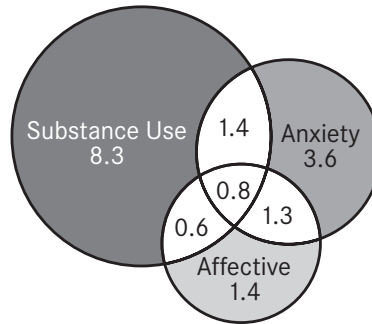
### Females

**Prevalence (%) of Single and Comorbid Affective, Anxiety and Substance Use Disorders Amongst Australian Females in the Past Year**



### Males

**Prevalence (%) of Single and Comorbid Affective, Anxiety and Substance Use Disorders Amongst Australian Males in the Past Year**



Source: Andrews, Hall, Teeson and Henderson 1999, p. 34

In Australian children and adolescents, 14 per cent are reported as having mental health problems of the kind outlined in Table 2. Broadly, these problems can be divided into internalising problems – bodily (somatic) complaints, being withdrawn, anxious and depressed – and externalising problems of aggressive and delinquent behaviour.

**Table 2: Prevalence of children's mental health problems in specific areas**

Prevalence (%) of mental health problems in specific areas					
CBCL Scale	All Children	4 - 12 years		13 - 17 years	
		Males	Females	Males	Females
Somatic Complaints	<b>7.3</b>	7.2	5.6	10.6	6.8
Delinquent Behaviour	<b>7.1</b>	7.4	7.8	6.4	5.9
Attention Problems	<b>6.1</b>	7.4	6.2	4.8	4.6
Aggressive Behaviour	<b>5.2</b>	5.9	5.2	5.0	4.0
Social Problems	<b>4.6</b>	6.5	3.9	3.8	3.0
Withdrawn	<b>4.3</b>	5.4	2.9	4.8	4.2
Anxious/Depressed	<b>3.5</b>	4.1	2.9	3.6	3.6
Thought Problems	<b>3.1</b>	3.2	2.7	3.4	3.1

Note: CBCL = Child behaviour checklist

Source: Commonwealth Department of Health and Aged Care 2000

While not all adults and children with mental health problems will seek counselling services, these prevalence estimates are important in planning counselling services, including the priority to be given to each kind of mental health problem, the respective sizes of the target groups by age and gender, and the competencies in assessment and intervention skills likely to be required of practitioners. Physical co-morbidities, such as back pain, headache and chronic illness, coexist with each of the mental health problems.

The NSHMW (ABS 1998a) also describes what services people with mental health problems use (expressed need) and whether these services have met their needs in the last 12 months. These data, therefore, set a baseline for how people with mental health problems use services to address their needs.

Of adults with high prevalence/common mental health problems, more than a third sought help for these problems in the last year and the majority of these received counselling that they felt met their needs. Of those adults with mental health problems who did not seek help, only about one in five expressed an interest in counselling. Around 4 per cent of the adult population without mental health problems significant enough to have a diagnosis, sought help for mental health problems. Most of these adults also received counselling with good effect.

Of that third of adults who sought help for their common mental health problems, about half consult with their general practitioner (GP) for assistance with these problems. The other half consult with a health professional, mental health professional, psychologist or psychiatrist. About 40 per cent of these people consult more than one of these in a year. For children and adolescents with mental health problems, 25 per cent attended at least one service for help in the past year.

### 3. Community health counselling – the context

The NSMHW (ABS 1998a) indicated that four out of five people who attended a psychiatrist in the previous year reported that the psychiatrist was not the sole mental health provider. This was more pronounced in disadvantaged areas of cities and remote areas. Most mental health care is, therefore, shared care and all providers need to be mindful of the need to communicate with others providing care (Meadows, Singh, Burgess & Bobevski, 2002). This chapter looks at community health counselling in the context of other mental health services in the community.

#### A four level schema for primary care mental health services

Service planners, providers and consumers would benefit from better understanding and communication about the roles of GPs, CHSs and specialist mental health services in providing primary care mental health services. In this section, a four level schema is described to provide some guidance to services and practitioners in identifying the target populations and the roles of general practice, community health and specialist mental health services.

The schema (Table 3) illustrates the roles and relationships between counsellors in CHSs, specialist mental health services and GPs. It recognises that there is substantial overlap in the functions of these services. The schema is designed to support clearer communication. It is not intended to be prescriptive; it will require flexible adaptation to be relevant in metropolitan, urban fringe and rural settings and across practitioners with varying knowledge and skills to deliver effective interventions. It acknowledges the complex work undertaken in community health counselling.

The first three need levels are related to the severity and complexity of mental health problems. The three related intervention levels are of increasing skill. All of the three intervention levels include the common activities of problem identification, assessment, referral, care planning, review and feedback and follow-up.

Level 4 refers to specialist consultation, training and support services provided to practitioners to ensure the optimal quality and effectiveness of services they deliver at Levels 1–3. These Level 4 activities are critical to the successful development of the primary care mental health initiatives.

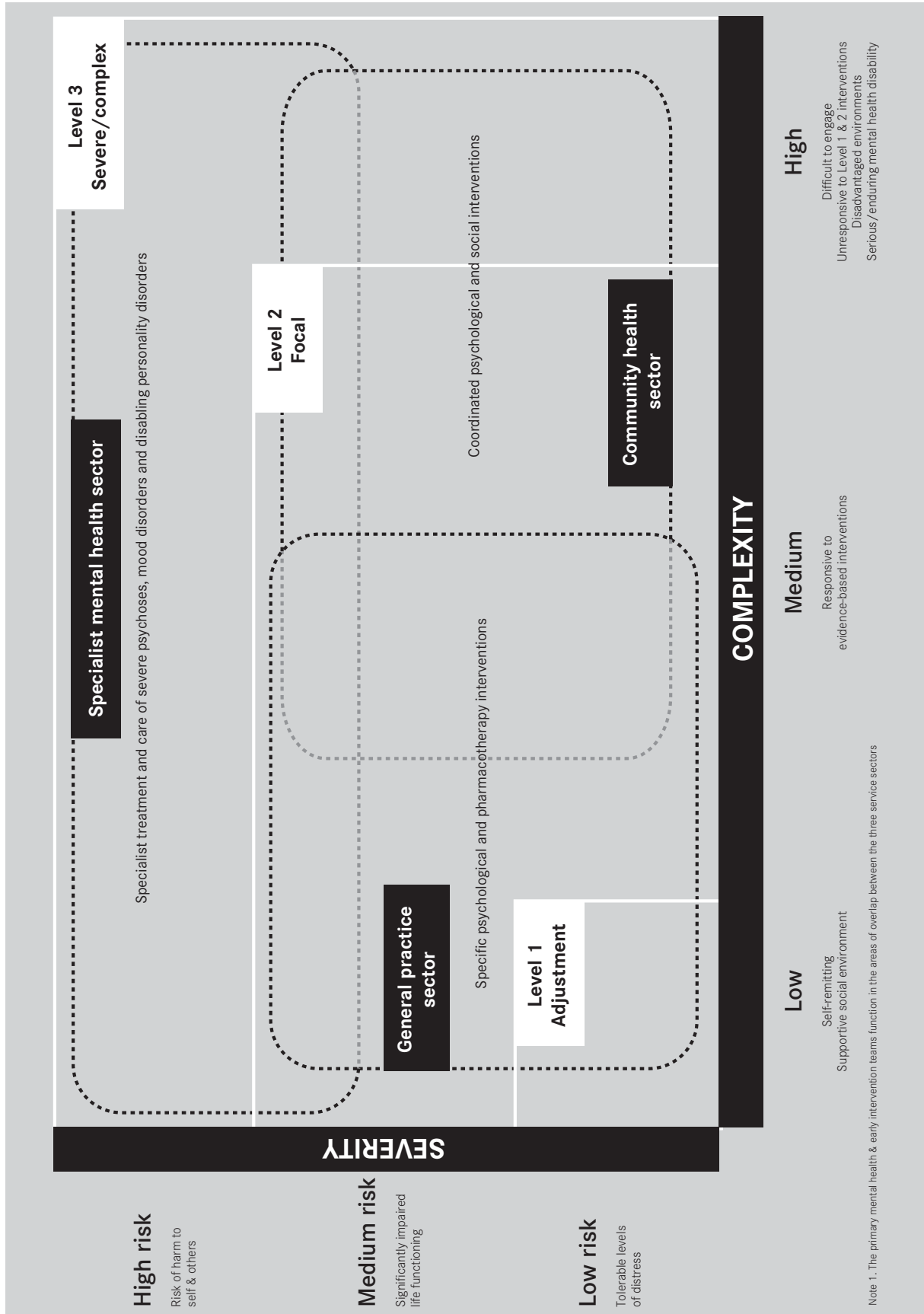
Because mental health problems are fairly common, other practitioners will come into contact with people with mental health problems. For example, physiotherapists, podiatrists, nurses providing medical care, an in-home support worker, or a recreation officer or youth worker whose primary job role is conducting an activities program, can be ideally placed to provide helpful responses and appropriate referral in the course of providing their own particular service. Community health counsellors are able to provide secondary consultation and support to practitioners from other disciplines.

Figure 2 illustrates three levels of mental health need (adjustment, focal and severe/complex) and the related effective interventions (generalist, specific and specialist interventions).

Table 3: Four level schema for primary care mental health treatment

Needs	Interventions	Typical settings	Outcomes
<p><b>Level 1. Adjustment problems</b></p> <p>Adjustment to specific problems of living that cause tolerable distress and that will remit over time – grief, divorce, loss, changed life circumstances.</p>	<p><b>Level 1 Generalist</b></p> <p>Supportive counselling, problem solving, relaxation training.</p>	<p>General practice. Family, friendship networks, volunteer organisations – churches, citizens advice bureaus, telephone counselling</p>	<p>Reduced severity and duration of distress.</p> <p>Screening, assessment and referral to Levels 2 and 3.</p>
<p><b>Level 2. Focal problems</b></p> <p>Specific mental health needs responsive to evidence-based interventions – panic attacks, PTSD, episodic depression, problem drinking, relationship problems, parenting issues.</p>	<p><b>Level 2 Specific</b></p> <p>Specific psychological, social and pharmacotherapy interventions according to evidenced-based protocols.</p>	<p>General practice, Community Health Services and some telephone counselling.</p>	<p>Focal and sustained improvement in specific problems. Identification and referral to Level 3.</p>
<p><b>Level 3. Severe/complex/disabling</b></p> <p>At high risk of harm to self or others (severe) and/or</p> <p>difficult to engage or unresponsive to Levels 1 and 2 interventions (complex) and/or</p> <p>with enduring and serious mental health disability – family violence, child abuse.</p>	<p><b>Level 3 Specialist</b></p> <p>Formulate and implement individual psychological, pharmacotherapy and social interventions for complex and unique problems.</p>	<p>General practitioners with specialist mental health skills, community health counselling and specialist mental health services.</p>	<p>Focal or generalised improvement in severe/complex/disabling problems.</p>
<p><b>Level 4. Optimal practitioner and service effectiveness</b></p> <p>Practitioners and services require consultation, training and support.</p>	<p><b>Level 4 Knowledge, skills transfer and service development</b></p> <p>Generation, transfer and maintenance of knowledge, skills and protocols to ensure the effectiveness of Levels 1–3.</p>	<p>Primary mental health and early intervention teams, lead Community Health Services, GP Division support units.</p>	<p>Assuring cost-effective interventions and promoting a system of primary care mental health services.</p>
<p><b>Other significant contributing factors</b></p> <p><b>Disadvantaged environments</b></p> <p>Many people undertaking mental health interventions will be living in disadvantaged social environments along with other family members also at risk.</p> <p><b>Impaired physical health</b></p> <p>People (including families) struggling with acute illness/accidents, those people and their families coping with chronic ill health.</p>	<p><b>Casework, advocacy and case finding</b></p> <p><b>Casework coordination</b> of a range of other social supports including vocational, social security, child care, family and parenting support.</p> <p><b>Advocacy</b> for the person in their relationships with other services and for classes of people with government and organisations.</p> <p><b>Case finding</b> and referral for other people in the environment with identified problems or at risk.</p> <p>Health promotion Including dietary, nursing and medical care.</p>	<p>All settings.</p> <p>All settings.</p>	<p>Effecting changes in the social environment with consequent reduced impact on mental health.</p> <p>Identifying others in need, such as partners, carers and children.</p> <p>Improved physical health with consequent reduced impact on mental health.</p>

Figure 2: Mental health needs and services



## A profile of community health counselling services

In 2002–2003, counselling services funded through the Community Health Program provided 241,205 occasions of service to 38,000 people.<sup>1</sup> Activities associated with the provision of a counselling service included consulting, preparation, training and quality assurance.

- Just on two thirds of those seen for counselling were females and one third were males, the dominant age group being 25–45 years. Children, young people and the elderly were under-represented in proportion to their numbers in the population and the known prevalence of mental health problems in these age groups.
- The Review of counselling services in community health – discussion paper (Department of Human Services, 2002a) found that in 1999–2000 counselling durations varied, with the largest group being seen for a one-off session. Most clients were seen for 1–3 consultations, and only very few for more than 5–7 consultations.
- In 2002–2003, 40 per cent of clients attended counselling once, 20 per cent attended two or three times and 30 per cent attended four or more times.
- Approximately 80 per cent of those seen for counselling in CHSs were reported as having health care cards, most receiving a government pension or allowance.
- Many counsellors participated on a roster basis in a general intake system for their CHS. The counselling service is, therefore, central to the quality of access generally to the CHS.
- There was evidence to indicate the considerable potential for creating new demand through public campaigns raising awareness about mental health problems and services that provide effective interventions.
- Counselling services have different and often informal approaches to the management of waiting lists and the priorities given to clients on them; as a result, the available data on waiting lists is difficult to interpret.
- Demand for counselling in community health increased by 77 per cent from 1999–2000 to 2002–2003.
- Relationships between counselling services and other relevant mental health service providers, including GPs, specialist mental health services and school-based welfare services, vary greatly.

## Primary mental health service in general practice

Victorian data from the *Mental health and wellbeing profile of adults* (ABS 1998b) showed that 39.8 per cent of adult Victorians with a mental health problem sought assistance. Of those, GPs were sought by 29.6 per cent while 24 per cent sought help from ‘other health professionals’. Counsellors in CHSs overlap significantly in their mental health functions with general practice. Within the general practice profession in Australia, it is usually agreed that GPs have a key role in the management of people with mental disorders. GPs are accessible in a physical and economic sense and perceptions of stigma may be less when attending the local doctor’s surgery for health care.

The 2001 Commonwealth Budget initiative, Better outcomes in mental health care (BOMHC), identified access to mental health services in the primary care setting as an area requiring special attention. The initiative provided \$120.4 million over four years to assist GPs to offer structured mental health care. The care is based around assessment and referral for patients with a range of disorders recognised under the WHO ICD-10 PHC Version (World Health Organisation International Classification of Diseases Primary Health Care) with provision for treatment in the general practice setting. The BOMHC initiative comprised five components:

- Enhanced education and training for GPs to offer assessment.
- Service incentive payments (SIP) for a completed, three-step assessment process requiring an assessment, treatment plan and review consultation with referral for appropriate treatment.

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<sup>1</sup> Data source: Department of Human Services, Primary Health Datamart & Primary Health Registered Clients database, Department of Human Services, February 2004

- The introduction of Focussed Psychological Strategies (FPS) items under the Medicare Benefits Schedule to allow GPs to offer six time-limited treatment consultations to patients within the general practice setting, following assessment. GPs were required to undertake 20 hours of approved clinical skills training (or receive Recognition of Prior Learning from the Royal College of General Practitioners) after successful completion of the requirements to register with the BOMHC initiative and with the Health Insurance Commission.
- Funding to Divisions of General Practice to support linkage of GPs with approved local private and public mental health providers to assist referral of patients for a minimum of six sessions of approved treatment, at no or reduced cost to the patient. A further six sessions can be offered if the GP reviews the patient.
- Access to the Advice from Psychiatrist in an Urgent Situation Service. Three trials are being conducted nationally to offer GPs access via phone, fax and web to psychiatrists to provide advice in an urgent situation.

Previously, those patients unable to access services through CHSs or non-government organisations have had to pay for private psychologists. The Access to Allied Health Services program has provided a substantial opportunity to address the need for patients without the means to pay to access these services. The program recognises the role of the GP as having responsibility for the overall care of the patient for both their physical and mental health issues.

### Complying with privacy laws

The NSHMW (ABS 1998a) indicated that many clients undertaking mental health interventions will have impaired physical health (such as musculoskeletal, poor nutrition, respiratory and gastrointestinal problems) and inadequate health care that interact with their mental state. They may require access to dietary, nursing and medical care as part of an assessment and intervention for their mental health problems. Referral between CHSs, GPs and other private sector providers needs to comply with the *Health Records Act 2001*, Health Privacy Principle 2 (Use and Disclosure). This places limits on when and how an organisation can share information. The term ‘use’ means using and sharing information within the organisation; while the term ‘disclosure’ means sharing outside the organisation. The essential principle is that a consumer’s health information may only be used or disclosed for the purpose for which it is collected, that is, its **primary purpose**. If the information is to be used for a different (**secondary**) purpose, then consent should usually be obtained.

### Counselling and the other primary care services – service coordination

Guidelines for service coordination were introduced as part of the Primary Care Partnerships (PCPs) Strategy in 2002 (Department of Human Services, 2002c). Service coordination is a consistent statewide approach for collecting and sharing client information between practitioners and agencies. A common set of forms (tool templates) has been developed to record client registration information, undertake initial needs screening, make referrals and collect client consent to share information between providers. The introduction of the common tool templates into software systems used across the health and community sector allows for improved communication between multiple care providers because, with client consent, common information can be collected and shared. Of even greater significance is that, with the increasing use of electronic referral, information collected and stored electronically forms the basis of a common health record. The *Statewide Services Directory* [www.humanservicesdirectory.vic.gov.au](http://www.humanservicesdirectory.vic.gov.au) is the other component of service coordination that is improving service delivery as it means that clients can be referred quickly, easily and accurately.

Counsellors in CHSs are expected to comply with both the service coordination guidelines and the privacy laws when managing client information. The specific applications of these protocols are referred to throughout the guidelines (Chapter 7).



## 4. Community health and the National Mental Health Plan 2003–2008

Chapters 4, 5 and 6 outline the three principles on which counselling in CHSs should be founded.

**Principle 1. Counselling services in Community Health Services should be well positioned to contribute to the *National Mental Health Plan 2003–2008*.**

### Context

The *Second National Mental Health Plan* (1998) provided a five-year framework for activity at the national, state and territory levels. It built on achievements and focused on three key themes:

- promotion/prevention
- the development of partnerships in service reform
- the quality and effectiveness of service delivery.

The *Second National Mental Health Plan* emphasised common mental health problems such as depression and anxiety, this focus being consistent with the evidence from the Burden of Disease study (Department of Human Services, 1999a).

The *National Mental Health Plan 2003–2008* continues the work begun under the Second National Mental Health Plan (progressed through the National Action Plan for promotion, prevention and early intervention for mental health) in the areas of mental health promotion, and mental illness and suicide prevention. The *National Mental Health Plan 2003–2008* is guided by the four priority themes:

- promoting mental health and preventing mental health problems and mental illness
- increasing service responsiveness
- strengthening quality
- fostering research, innovation and sustainability.

### Mental health promotion

Mental health promotion (in the context of the *National Mental Health Plan 2003–2008*) involves any action to improve the mental wellbeing of individuals, families, organisations or communities. Mental health promotion is essentially concerned with:

- how individuals, families, organisations and communities think and feel
- the factors that influence how they think and feel, individually and collectively
- the impact this has on overall health and wellbeing.

Primary prevention refers to interventions designed to prevent a disorder or problem occurring.

Prevention may be:

- universal – targeted to the whole population, such as preschool day care
- selective – targeted to individuals or groups at increased risk, such as home visits for low income mothers
- indicated – targeted to individuals with early symptoms, for example, cognitive therapy for children with behavioural problems.

Secondary prevention is concerned with reducing prevalence, through early intervention and tertiary prevention, of disability that is likely to arise. Early interventions target individuals developing or experiencing a first episode of a mental health problem, while tertiary prevention is aimed at preventing re-occurrence of mental health problems.

As with health in general, the distinction between prevention and promotion in mental health is not always clear – for example:

- some promotion programs, such as to promote employee participation, may reduce stress related illness and result in a range of broader outcomes such as increased job satisfaction and higher productivity
- interventions designed to prevent specific problems, such as postnatal depression, may also have a wide range of socioeconomic benefits extending well beyond the impact of the intervention on the mother

- World Mental Health Day initiatives to reduce negative media coverage of mental health issues have the same goals as tertiary prevention: to reduce the problems experienced by people with a diagnosis (Commonwealth Department of Health and Aged Care 2000).

Mental health promotion has an important role in preventing mental health problems, notably anxiety, depression, drug and alcohol dependence and suicide. But it also has a wider range of health and social benefits. These include improved physical health, increased emotional resilience, greater social inclusion and participation, and higher productivity. Mental health promotion can also contribute significantly to the health and wellbeing of people with mental health problems and has a key role to play in challenging discrimination and increasing understanding of mental health issues.

Wilkinson and Marmot, in *The solid facts* (1998) reviewed the literature and recommended the following targets and actions for mental and physical health promotion (Box 1). They argue that interventions delivered at the individual level, such as counselling alone, are unlikely to achieve improvements in a community's health status without also addressing these factors.

**Box 1: Targets for evidence-based health promotion** (Wilkinson and Marmot, 1998)

**1. Social gradient**

People's social and economic circumstances strongly affect their health throughout life, so health policy must be linked to the social and economic determinants of health. Good health involves reducing levels of educational failure, job insecurity and income differences in society.

**2. Stress**

Stress harms health. Communities and workplaces that can give people a sense of belonging and of being valued are likely to be healthier places than those in which people feel excluded, disregarded and used.

**3. Early life**

The effects of early development last a lifetime; a good start in life means supporting mothers and young children. New action is needed to foster health and development early in life, particularly among people in poor social and economic circumstances.

**4. Social exclusion**

Social exclusion creates misery and costs lives. A variety of actions at a number of different levels are needed to tackle the health effects of social exclusion.

**5. Work**

Stress in the workplace increases the risk of disease. A virtuous circle can be established: improved conditions of work will lead to a healthier workforce; this will lead to improved productivity, and hence to the opportunity to create a still healthier more productive workplace.

**6. Unemployment**

Job security increases health, wellbeing and job satisfaction. Policy should have three goals: preventing unemployment and job insecurity; reducing the hardship suffered by the unemployed; and restoring people to secure jobs.

**7. Social support**

Friendship, good social relations and strong supportive networks improve health at home, at work and in the community. In the community, reducing income inequalities and social exclusion can lead to greater social cohesiveness and better health in the population.

**8. Addiction**

Individuals turn to alcohol, drugs and tobacco and suffer from their use, but the wider social setting influences use. Work to deal with drug problems needs not only to support and treat individuals but also to address the patterns of social deprivation in which the problems are rooted.

## Increasing service responsiveness

The *National Mental Health Plan 2003–2008* advocates that consumers and their families should be able to access care appropriate to their mental health needs. Access problems can arise across the continuum of care and in association with demographic and geographic variations across the state. The Department of Human Services is currently examining ways of achieving best practice in managing demand in CHSs. The work being planned on demand management will aim to introduce consistency in waiting list management and measurement, and develop agreed benchmarks for acceptable waiting times. This will enable, for the first time, an accurate picture of where demand is, ensuring that measures to manage demand are properly targeted.

The Department of Human Services has put significant effort and resources into service coordination and developing a more planned and evidence-based approach to the delivery of health promotion services in primary health care, including mental health. It is anticipated that in the long term both strategies will contribute to improved health outcomes and help moderate demand for services.

Primary Mental Health Teams have been established by the department with the objectives of:

- improving access to, and the quality of, mental health services provided by specialist and primary health care providers to people across their life span
- supporting and enhancing the capacity of a range of primary care providers, in the first instance CHSs and GPs, to recognise and treat mental health problems and disorders more effectively, via the provision of education, training and secondary consultation
- promoting shared-care arrangements between specialist mental health services and primary care providers
- providing an improved service delivery approach, including treatment to people with high prevalence disorders, in particular but not limited to, depression and anxiety disorders. Other disorders (for example, eating disorders) that are identified through the community mental health plan process as being a specific problem for that area would also, in time, become a focus for the teams.

The focus of the initiative is the primary health care sector. It is expected that the majority of the clinical, liaison, consultative and educative work will be carried out in primary health care settings. The work of the teams occurs through community-based public facilities or on an outreach basis.

## Strengthening quality

Quality is the third theme of the *National Mental Health Plan 2003–2008*. New quality guidelines for counselling aimed at strengthening quality in CHSs were developed in consultation with the sector and are outlined in Chapter 7.

## Fostering research, innovation and sustainability

Fostering research is the fourth priority theme of the *National Mental Health Plan 2003–2008*. The department encourages research partnerships between service providers, universities and policy makers, focusing on the development of long-term, economically sustainable interventions. Consumers and carer perspectives should inform research and the main focus should be on achieving better outcomes for clients and their families. Participation in research by counsellors in CHSs will lead to improved service planning to meet growing demand and inform decision making about future resource allocation.

## **Mental health literacy and awareness**

Jorm, Korten and Jacomb (1997) coined the term 'mental health literacy' to refer to knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowing risk factors and causes, self-treatments and the professional help available; and attitudes that promote recognition and appropriate help-seeking.

*Beyondblue*, a national initiative to address issues associated with depression, anxiety and related substance misuse disorders, focuses on prevention of depression and early intervention campaigns. This initiative undertakes school-based and workplace-based programs. One aim of *beyondblue* is to promote community awareness and understanding of depression as a general 'health' issue rather than more isolated 'mental health' problem. Community awareness and understanding of depression underpins successful implementation of prevention, early intervention and treatment programs (Parslow and Jorm, 2002).

## 5. Social model of health and community health counselling

**Principle 2. The social model of health, which underpins counselling services in Community Health Services, should substantially contribute to the development of primary care mental health policy, planning and services**

### Context

Social disadvantage, alienation and low social status are often associated with common mental health and other problems for which people seek out counselling. Counsellors in CHSs understand that problems of mental health and wellbeing can arise from a person's social, family and economic circumstances, individual vulnerabilities, adverse life events and their responses, including emotional distress and attempts to cope.

Social capital has been defined as 'the norms and networks that enable collective action' (World Bank 2003). It is an attribute of society or a group, and is distinguished from social support, which is something that works between individuals (McKenzie 2003). Acknowledging the dimension of social capital allows for the integration of the bio-psychosocial determinants of mental disorders (such as genetics, neurobiology, psychological factors and social environment) in a way that brings an understanding of population mental health beyond the aggregation of individual health characteristics or risk factors (Cullen & Whiteford 2001).

### Mental health and wellbeing

Mental health is more than an absence of mental illness. A person's state of mental health influences how they think, feel and interpret events. It affects the capacity to learn, to communicate, and to form and sustain relationships. It also influences the ability to cope with change, transition and life events – for example, having a baby, going to prison, experiencing bereavement.

Mental wellbeing is influenced by many factors, including genetic inheritance, childhood experiences, life events, individual ability to cope and levels of social support, as well as factors like adequate housing, employment, financial security and access to appropriate health care. Gender has a significant impact on mental health and vulnerability to mental health problems. Racism, homophobia and other forms of discrimination also affect mental health and can be an underlying cause of mental health problems.

The social model of health is a conceptual framework for thinking about all of these factors. Within this framework, improvements in mental health and wellbeing are achieved by directing efforts towards addressing the social and environmental determinants of health, in tandem with biological and medical factors (Department of Human Services 2001).

Mental health problems are often defined in relation to specific diagnoses, for example, depression or schizophrenia. However, a mental health problem can refer to any problem that disrupts the way we think and feel, either temporarily, such as following bereavement, or on a more severe and enduring basis.

Everyone has mental health needs, whether or not they have a diagnosis of mental illness. These needs are met, or not met, at home, at work, on the streets, in prisons and hospitals, in schools and neighbourhoods – where people feel respected, included and safe, or on the margins, in fear and excluded. Because everyone has mental health needs, the need for mental health promotion is universal and relevant to everyone.

### Mental health impacts on physical health

There is a substantial body of research that demonstrates the relationship between poor mental health status and physical ill health. Much of the research in this area is concerned with how the social environment acts on biology to cause disease (Marmot & Wilkinson 1998). What has been called 'stress biology' looks at the relationship between chronic stress and the nervous system, the cardiovascular and the immune systems, cholesterol levels, blood pressure, blood clotting, immunity and growth in childhood.

There is increasing recognition that people's social and psychological circumstances can seriously damage their health in the long term. Chronic anxiety, insecurity, low self-esteem, social isolation and lack of control over work appear to undermine mental and physical health.

The power of psychosocial factors to affect health makes biological sense. The human body has evolved to respond automatically to emergencies. This stress response activates a cascade of stress hormones that affect the cardio-vascular and immune systems. The rapid reaction of our hormones and nervous system prepares the individual to deal with a brief physical threat. But if the biological stress response is activated too often and for too long, there may be multiple health costs. These include depression, increased susceptibility to infection, diabetes, high blood pressure and accumulation of cholesterol in blood vessel walls, with the attendant risks of heart attack and stroke' (Brunner and Marmot 1999, p.41)

These findings have had an important impact on debates about health because they address the way in which a wide difference in income distribution – the gap between rich and poor – results in chronic stress for whole communities (Wilkinson, 1996)

## Mental health problems and socioeconomic status

There is considerable evidence across many countries that health problems generally can be related to socioeconomic factors, including absolute income and relative socioeconomic disparities (Wilkinson & Marmot, 1998). This is certainly true for the most common mental health problems of anxiety, depression and substance use. In Australia, those in the bottom quintile of socioeconomic status experience up to 50 per cent additional disability-adjusted life years (DALYS)<sup>2</sup> associated with mental disorders than those in the top quintile (Mathers, Vos & Stevenson, 1999).

Socioeconomic status appears to be more associated with the burden for certain mental health problems, such as borderline personality disorder, anxiety and depression.

Mental health problems in children and adolescents are almost three times as likely to be found in low income families than in high income families. This may be because low income families have lower functioning family members, including parents who are less skilled at parenting. However, a more likely explanation is that low income and social disadvantage are potent stressors on individuals and families, manifesting in the emotional and behavioural adjustment of parents, children and adolescents.

## Counselling within a social model of health framework

While counsellors principally deliver their services to individuals, small groups and families, they do so acknowledging the influence of social and economic factors by:

- educating their clients about the impact of these factors
- recognising that social disadvantage and problems of mental and physical health tend to cluster together and, therefore, require coordinated approaches for effective intervention
- discouraging the attribution of responsibility for problems of emotional health and wellbeing solely to individuals, families or mental illness
- actively contributing the social health perspective as a complementary view to the biological and psychological perspectives of other practitioners
- linking their counselling services to the wider range of health promotion and prevention interventions being undertaken in their local area.

Community health counsellors assess and intervene with people:

- in significant emotional distress
- coping with adverse individual, family, social and economic circumstances, vulnerabilities, stressors and life events
- including children, carers and partners affected by the distress and behaviour of a family member.

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<sup>2</sup> Over the past decade there has been a change in the way population health has been quantified in order to strengthen and broaden the evidence base for health care policy. In 1993, the disability-adjusted life year (DALY) was introduced as measure that combines healthy life years lost because of premature mortality with those lost as a result of disability (World Bank 1993).

By delivering **effective** face-to-face counselling interventions in centre, home and offsite settings, community health interventions are designed to:

- provide relief from emotional distress
- enable longer term coping with adverse circumstances
- reduce vulnerability in the future
- reduce the adverse circumstances faced.

The notion of targeting counselling interventions upstream and downstream will be expanded using cases with reference to Figure 3.

### Generalist counselling

Generalist counselling is the application of knowledge and a range of skills, such as reflection, constructive confrontation and problem solving, with the goal of reducing distress or harmful behaviour and improving quality of life, social functioning and health, within the context of an interpersonal relationship that is designed to facilitate these changes.

### Advanced therapeutic interventions

Suitably qualified counsellors are able to use therapeutic knowledge and skills from a range of approaches, such as cognitive-behavioural therapy, family therapy and psychodynamic psychotherapy, with the goal of helping people change thoughts, emotions and behaviour, when required.

**Figure 3: Model of common mental health problems and associated interventions in community health counselling**

Problems				
Upstream		Dowstream		
Vulnerabilities	Present stressors	Distress	Behaviours	Impact on others
Inter-generational poverty. Family history of anxiety/depression. Poor parental models for coping. Childhood disadvantage. Refugees. Chronic illness. Childhood sexual abuse.	Financial hardship. Family violence. Poor social position. Physical disability. Social isolation. Poor return for work efforts.	Unhappiness Anxiety Depression Anger Over-concern about physical health.	Social isolation/avoidance. Suicidal behaviour. Poor health care. Erratic relationships. Aggression, family violence and abuse. Interpersonal conflict. Overweight. Smoking Problem drinking. Psychotropic drugs.	Childhood anxiety/depression. Child behaviour problems. Sibling contagion. Conflict with partners/carers. Friends. Shop keepers. Social networks. Health care providers.
Interventions				
Upstream		Dowstream		
Promoting self-managed care. Advocacy for preventive interventions. Linkage and referral to mental health promotion services. Initiate local social support networks.	Case plan. Practical assistance. Referral and support in obtaining legal, financial and vocational advice. Case advocacy Close and ongoing coordination with general medical practitioner and other providers. Monitoring and progress review.	Intake assessment. Referral. Counselling assessment. Case plan. Supportive individual, group, relationship and family counselling. Facilitated self-help. Single session work. Arrange for symptomatic medication.	Suicide prevention. Health screening and risk factor assessment. Problem drinking programs. Social support groups. Anger management. Activity programs. medication.	Case finding and identification. Early intervention with children of parents with mental health problems. Carer support groups.



## 6. Assuring effective counselling

### **Principle 3. Effective counselling.**

The effectiveness and ongoing development of counselling services in Community Health Services should be assured through improved recruitment, competency development and quality processes.

### **Context**

Assuring the quality of counselling, along with the quality of the work of the wide range of other practitioners in CHSs, is increasingly viewed as a responsibility of effective corporate governance of CHSs.

CHSs are required, as a condition of funding, to participate in an external quality accreditation program, such as Quality Improvement and Community Services Accreditation (QICSA) or Evaluation and Quality Improvement Program (EqUIP).

### **Evidence-based practice**

Once described by Sackett and colleagues (1996) as ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual clients’, evidence-based practice has come to be regarded as the cornerstone of contemporary quality health care. Evidence-based practice promotes the use of scientific evidence on the efficacy and effectiveness of interventions in combination with the clinical experience/expertise (‘judgement’) of health professions. The definition of evidence-based practice leaves space for the adjustment of care to the patients’ choice because ‘judgement’ is not restricted to the decision of the health profession (Perleth, Jakubowski & Busse 2001).

### **Levels of evidence**

There is a convention of ranking evidence from systematic research according to the rigour of the methodology and controls used and the consequent confidence that outcomes arise from a true treatment effect rather than from the many possible sources of error.

- Level I evidence – obtained from a systematic review of all relevant randomised controlled trials.
- Level II evidence – obtained from at least one properly designed randomised controlled trial.
- Level III-1 evidence – obtained from well-designed, pseudo-randomised controlled trials (alternate allocation or some other method).
- Level III-2 evidence – obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case-control studies, or interrupted time series with a control group.
- Level III-3 evidence – obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group.
- Level IV evidence – obtained from case series, either post-test or pre-test and post-test.

Source: National Health and Medical Research Council 1999, p.56

### **Quality assurance: efficacy and effectiveness**

A key principle of quality assurance is that the delivery of counselling, along with other human services, should be informed by evidence of the efficacy and effectiveness of interventions, where such evidence is available. The term ‘efficacy’ refers to evidence of positive effects found in research settings and the term ‘effectiveness’ refers to positive effects found in actual service settings.

The scientific community and governments generally accept the randomised control group trial (RCT) as the best test of an intervention’s efficacy (Level I evidence). The randomised research design assigns participants prospectively and randomly to one of at least three groups: treatment, no treatment, and a credible intervention matched in time and contact hours. Interventions with the most convincing evidence of effectiveness have been subject to multiple RCTs showing the generality of positive effects across a range of settings and client groups in real services as well as in research settings.

The consensus of expert practitioners is used as the standard against which quality practices are judged in the many areas of health intervention where there is an absence of evidence from systematic research. The challenge for quality assurance is to translate the proven efficacy of treatments demonstrated in research trials to effective practice in routine service delivery. This requires that services are clear about the treatment outcomes sought and the threats to effectiveness.

## **Effectiveness of counselling**

While significant and sustained positive changes in emotions, behaviours and life-functioning are the commonly stated outcomes sought in counselling, the following factors are critical in achieving effective counselling.

### **Access**

A counselling service should be as accessible as possible to people with the defined need. For example, services conducted only during work hours, that are costly in fees or time commitment, that require long periods on a waiting list or that emphasise a high level of intellectual functioning, may be accessible to only a small proportion of the people who may find them useful.

### **Acceptance**

This refers to whether people perceive counselling as relevant and likely to meet their needs. Poor acceptability will be evident in failures to commence counselling following an initial problem assessment, dropping out of counselling after commencing, and attending but not participating adequately in counselling. Dropping out of counselling is sometimes the result of incompatibility or weak therapeutic alliance between the client and the practitioner. There needs to be a means for providing access to another counsellor.

### **Fidelity**

This refers to the amount and kind of treatment provided (including the duration, sequencing and consistency of interventions) with those of proven efficacy and effectiveness for the target population.

### **Response**

This refers to improvements in measured aspects of wellbeing and life functioning occurring while counselling is being undertaken. A response profile may be narrow, for example, a person with depression may simply cry less; or it may be broad, for example, simultaneously reducing levels of depression while improving relationship functioning and parenting.

### **Maintenance**

Whether changes following the completion of counselling are maintained is the most important test of effectiveness. It is in this period that counselling's cost-effectiveness becomes most tangible through the reduced use of other human services.

### **Iatrogenic effects**

Iatrogenic effects are unintended effects of counselling and those of most concern are the negative outcomes. In counselling there may be negative effects, such as anxiety sensitisation or even psychosis precipitated by inappropriate confrontation, or hopelessness and a sense of failure from being promised rapid progress when this is unrealistic. Too great a dependency on counselling may also be a negative effect. The positive effects of counselling need to be weighed against possible negative effects for each person.

### **Generalisation**

This refers to whether effects found in the therapeutic setting are also found in real life settings at home, work and public venues. Interventions found to be effective in a therapeutic setting may have reduced or different outcomes in applied settings.

## Threats to counselling effectiveness

Apart from the severity of a person's needs, the maintenance of treatment fidelity is the single most significant factor in accounting for differences in effectiveness of therapeutic interventions. This is the most common explanation for therapeutic interventions with efficacy in research outcome trials failing to achieve comparable effectiveness in routine service settings. Threats to program integrity may arise from organisational, practitioner or consumer factors, and may include:

- **Program drift** – where, in spite of committed staff, the original focus, quality and consistency of the services change as each practitioner, drifts towards activities that interest them and fit with their own talents. A consequence is that, over time, the interventions delivered bear little resemblance to those originally specified, instead comprising a smorgasbord of well-intentioned but discordant practitioner activities.
- **Program reversal** – where staff and/or clients disagree with the goals or methods of the original evidence-based interventions and, over time, completely reconfigure them to meet their own goals.
- **Program non-compliance** – where staff or clients are insufficiently motivated to participate properly in programs because of the demoralised or conflict-ridden culture of the program, inadequate physical infrastructure or staffing, or lack of confidence and competence.

Provided there is adequate and competent staffing and physical infrastructure, several means for maintaining therapeutic integrity are commonly used:

- **Bringing together** the staff in multidisciplinary working groups to agree on and to regularly refine and recommit to a common approach in counselling. This may require a review of traditional roles and responsibilities but, if achieved, addresses practice differences between disciplines, which can be a barrier to implementing a common vision for counselling services.
- **Specification of interventions** in the form of detailed session-by-session manuals and associated support materials.
- **Practitioner and client self-monitoring** of the delivery of interventions, their satisfaction and compliance with them and the consequent outcomes.
- **Observer monitoring**, rating and feedback by independent practitioners, peers, supervisors or auditors of the fidelity of interventions and the nature of the therapeutic culture.

These measures are integral to all outcome trials of effective treatments and should ideally also form part of the routine delivery of counselling.

## Emerging knowledge about effective counselling interventions

There is good evidence from outcome studies conducted in several countries that there are effective counselling interventions for many problems occurring with high prevalence in the community, including depression, anxiety disorders, problem drinking and smoking. Provision of short-term counselling may reduce general health care service use and costs (Department of Human Services, 'Opening the door on counselling', 1997, unpublished report).

Psychosocial interventions for anxiety and depression, such as those delivered by counsellors in CHSs, have been compared to medications in several scientific trials, including cost-effectiveness studies.

In general, medications are of equal effectiveness in the short term and are less expensive than psychosocial interventions (Craighead and Craighead, 2001) Psychosocial interventions are more acceptable and achieve greater compliance. Furthermore, psychosocial interventions continue to have preventive effects for one to two years after counselling ceases. In contrast, medications need to be continued on a maintenance basis to achieve this effect.

Taking into account the costs of non-compliance with medications and relapse requiring further intervention, including inpatient treatment, the cost-effectiveness of medications and psychosocial interventions for depression delivered in primary care settings seem to be equivalent (Rowland et al., 2001). There is evidence that for many people with more serious mental health problems the integration of biomedical and psychosocial approaches gives superior outcomes to either alone.

Effective approaches to intervention for depression and anxiety disorder problems have been documented by the US Agency for Health Care Policy and Research and the World Health Organisation for dissemination to primary care practitioners. These interventions are typically conducted over five to 20 consultations over 12 to 20 weeks by counsellors adhering to therapy manuals. However, the therapeutic alliance, engagement and personal relationship are critical to effective psychosocial interventions.

The following features of effective counselling were agreed by consensus across counsellors from six programs funded by the Victorian Department of Human Services.

## Box 2: Consensus-based features of effective counselling

- Generic counselling skills including empathy, active listening, probing, paraphrasing, reflecting feelings, summarising, clarifying, interpreting, self-disclosing and confronting are a precondition for effective counselling.
- Structured assessment is carried out and a documented plan for intervention is developed in collaboration with the client.
- Screening is undertaken for serious physical and mental health problems that may require interventions additional to counselling.
- Specific therapeutic interventions are used, as described in the social work, psychology and mental health practice literature, and preferably having been proven in scientific outcome studies for problems like those of the client.
- The principles and interventions documented in manuals associated with proven approaches to counselling are adhered to or, where these do not exist, expert consensus informs practice.
- Counsellors have demonstrated competence in these recognised interventions through training, expert supervision and appraisal of their observed performance.
- Clients generally take as much responsibility as possible for their own lives, choices between treatment options and participation in counselling; but advocacy, coordination of service provision and practical assistance are available where a client would be disadvantaged in obtaining access to appropriate services or resources unaided.
- Prior to the client's agreement to commence counselling, an opinion is given about the most effective counselling interventions, the likely duration and other complementary or alternative interventions available.
- Referral is made or supervision is sought if the counsellor has insufficient competence to deliver effective counselling for a client.
- Realistic objectives are set, in collaboration with the client, and an agreed plan is made for a time limited episode of counselling to achieve these objectives.
- Careful monitoring of progress occurs in counselling, specifically attending to the client's perceptions.
- Alertness for emerging issues that may lead the counsellor to change their opinion about the nature and duration of counselling is maintained and, if necessary, the plan is renegotiated with the client.
- Systematic measurement of client progress using self-report, counsellor ratings or ratings of significant others occurs.
- At the completion of an episode of counselling, arrangements are made, where necessary, for further counselling or other support.

## Types of quality assurance

More broadly, drawing on the quality assurance literature, four general approaches to quality issues can be identified, each with separate histories and seeking distinct and important outcomes. These four approaches, whose foci can be loosely termed respectively 'bad, benign, better, best', are illustrated in Figure 4 with reference to a hypothetical normal curve representing the frequency distribution of the performance of all counselling services.

**The deviance approach** seeks to identify and remediate deviant practices in a timely way. This approach commonly requires service providers to collect and submit reports of specified incidents, such as deaths, waiting lists and service closure, to the funder or delegated authority in real time. This approach has long been a feature of human services and is part of risk management.

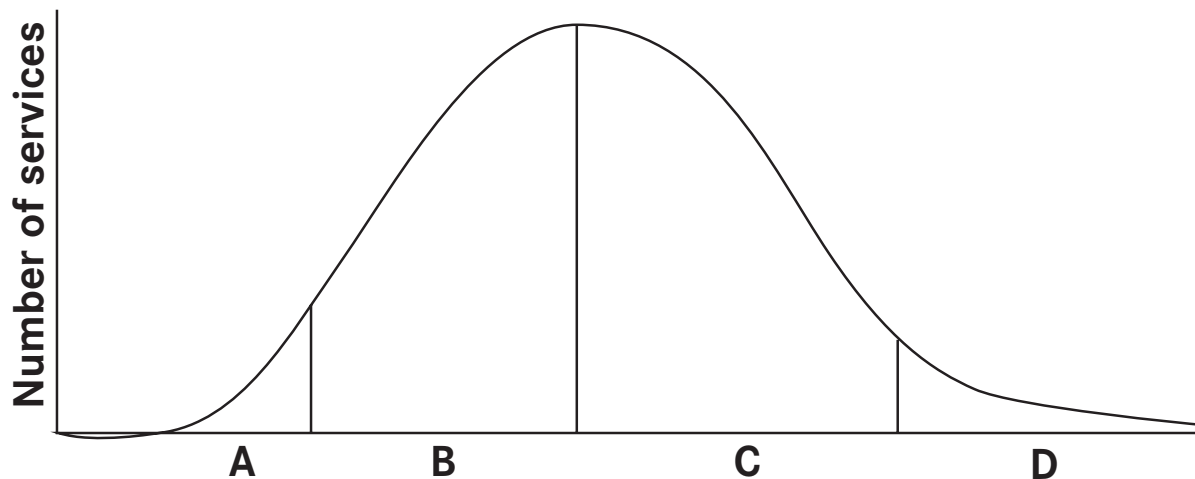
**The minimum requirement approach** seeks to ensure that services are operating above a minimum threshold required to prevent adverse events and that provides the necessary foundation for practices to be effective. This approach contractually requires providers to deliver services that meet mandatory basic standards, such as staffing and physical infrastructure, and to report non-compliance. The providers may determine assessment of compliance themselves, by random audit or by some accreditation process. This approach is essentially preventive and is associated with the doctrine of 'first, do no harm' in health care, and with the legal requirement under common law negligence of providers and funders to do what is reasonable to prevent harm to others affected by their actions.

These quality assurance approaches are features of most health care services and their funders in Western countries. However, they are limited in only assuring the minimum preconditions for effective services. Alone, these quality assurance measures do not specify and assure that the type, amount and duration of interventions delivered are sufficient to lead to positive outcomes for consumers.

**The good practice approach** seeks to ensure that services are delivered at a performance level that is at least consistent with the mean level of performance of similar services in the industry. This can be achieved by defining standards and guidelines that represent good practice and evaluating services against these through accreditation or audit. Benchmarking services' intervention practices and processes against each other is another means of identifying the mean level of performance across similar services and the services that fall above or below this mean.

This approach assumes that services aspire to achieve good practice relative to industry standards and that through regularly comparing their performance against these standards they identify opportunities for better meeting them. In the quality assurance literature these have been termed 'learning organisations'.

Figure 4. The total quality spectrum



Service Performance			
A. Deviance	B. Minimum requirements	C. Good practice	D. Best practice
Objectives Timely identification and remediation of deviant practices Historical origins Code of Hammurabi's (2100 BC) Risk management	Ensures that services operate above a minimum performance threshold Hippocrates – Do no harm Duty of care	Ensures that services operate at least an industry mean performance Learning organizations Scientific approach	Promotes world's best practice maximizing treatment fidelity and the introduction of new innovations Management science/TQM Technical efficiency Best value for money

Source: Merry in Burton (2000)

**The best practice approach** actively promotes world's best practice through constantly seeking to optimise the cost-effectiveness of interventions through improvements to treatment fidelity, reduced costs and the introduction of new innovations in therapeutic interventions. Routine monitoring of outcomes is a common feature of this approach, together with benchmarking effectiveness and costs against other similar services both nationally and internationally. Funders of services may provide direct financial incentives or make the awarding of new services conditional upon achieving performances at the upper end of those in the industry.

Historically, this approach has been associated with the translation of modern management practices from the manufacturing industries to human services and with the interest in technical and allocative efficiency by health economists seeking improved productivity from publicly funded human services that are funded from a fixed taxation base.

New recruitment, competency development and quality processes are required to support this position for community health counselling.

### Community health counsellors

Community health counsellors should be tertiary trained and professionally qualified to provide effective psychosocial interventions for the most common emotional and social problems of children, young people and adults.

**Advanced counsellors**

More experienced counsellors in community health, usually with postgraduate qualifications, have advanced knowledge and skills in counselling adults and children with more complex psychological and social problems.

**Specialist competency development**

Counsellors in community health may pursue training to gain competencies in specialist areas that are complementary to community health counselling practice.

**Professional development**

Community health counsellors are committed to reflecting on and striving to continuously improve their practice through participation in the professional development activities of their organisation and professional bodies.

**Casework, practical assistance and advocacy**

Counselling and therapy may be closely integrated with other activities, such as advocacy, casework and practical assistance.

The role of counselling in CHSs will always include significant counselling and therapeutic interventions and may also include varying amounts of practical assistance and support, advocacy, service coordination, health promotion and management activities. The balance of counselling, advocacy, practical assistance and casework is determined in an individualised way by each counsellor according to a client's needs.



## 7. Quality counselling guidelines

### Overview

These guidelines are to be used by CHSs delivering counselling services, funded by the Community Health Program under the activity termed 'counselling'. It should be noted that a range of other counselling services funded by the Victorian and Commonwealth governments are delivered through CHSs for which other service requirements and standards exist.

These guidelines were informed by the requirements and standards defined in:

- *Primary Care Partnership service coordination initiatives*
- *Department of Human Services Quality framework, 2002*
- *National standards for mental health services, 1997*
- *National practice standards for the mental health workforce, 2002.*

The *Quality counselling guidelines* emphasise:

- improved operational processes to ensure that priority is given to people who are most in need and who will most benefit from counselling
- improved access for children and young people
- more effective practices based on evidence and an outcome orientation
- upgraded entry qualifications and ongoing competency development
- improved integration of counselling with mental health promotion and wellbeing efforts both within and external to the CHS
- promotion of research and development.

Successful implementation of the guidelines over the next two years for counsellors in Victoria's CHSs, supported by a range of quality counselling initiatives, will further raise the profile and credibility of these established and valued services with consumers, other service providers and the community.

### Limitations of the guidelines

These guidelines and strategies are not an exhaustive account of the necessary requirements for an effective counselling service in a CHS. They should be read in the context of the service agreement for the CHS, the standards required for accreditation by the relevant quality authorities and the protocols agreed by members of PCPs.

The guidelines emphasise priority issues, identified in the *Review of counselling services in community health* (Department of Human Services, 2002a) as requiring improvement. The quality counselling guidelines are not a substitute for good corporate management or for the application of accepted professional standards by counsellors. The guidelines are general statements with relevance for counselling services in CHSs.

Their implementation will require local adaptation through local protocols and initiatives relevant to different settings, target groups, number of counsellors and business and quality operations already in existence. Individual CHSs will determine the sequence of actions for implementing the guidelines.

**Guideline 1. Counselling services will be underpinned by the principles of the social model of health through their practices and in their relationships with other providers and the community.**

### Rationale

The bio-psycho-social approach to understanding and addressing problems of mental health and wellbeing underpins Australia's mental health policy. CHSs have a long history of advocating for people living in socially disadvantaged circumstances and for understanding and tackling these problems from the perspective of the social model of health.

There is evidence to indicate strong correlations between material and social disadvantage and mental health and wellbeing (see Chapter 5). There are, therefore, opportunities for CHSs to have a greater input to the current dialogue in the community and among service providers about the contributions of the social model of health for understanding and effectively dealing with problems of mental health and wellbeing.

While counsellors principally deliver their services face-to-face to individuals, small groups, couples and families, they do so acknowledging the potent influence of social and economic factors by:

- educating their clients about the impact of these factors
- recognising that social disadvantage and problems of mental and physical health tend to cluster together and therefore require coordinated approaches for effective intervention
- discouraging the attribution of responsibility for problems of emotional health and wellbeing solely to individuals, families or mental illness
- actively contributing the social health perspective as a complementary view to the biological and psychological perspectives of other practitioners
- linking their counselling to the wider range of health promotion and prevention interventions.

### **Strategy 1.1 CHSs and the Department of Human Services will promote the social model of health approach**

CHSs and the department will communicate the approach underpinned by the social model of health so that it positively influences counselling practice, policy development, mental health promotion, other service providers and community opinion.

#### **Anticipated outcomes**

- The social model of health will be an integral part of the training, supervision and practice of counsellors.
- Counsellors will effectively apply a social model of health approach to their counselling practice.
- Counsellors will contribute to understanding of mental health by using a social model of health approach when preparing presentation materials for health promotion activities.

**Guideline 2. Counselling services will ensure a continuity of quality care, adapted to the particular needs of the client, from first contact, through assessment, counselling and review to completion.**

#### **Rationale**

The *Review of counselling services in community health* (Department of Human Services, 2002a) found no consistent approach across counselling services to the process by which a person seeking a service proceeds through screening, assessment, planning, evidence-based intervention, review, further counselling if necessary and, finally, completion and/or referral (Department of Human Services, 2002a, p.29).

The counselling client services model (Figure 5) shows the **process** by which a person progresses from general intake to counselling screening, assessment, planning, an episode of counselling, further episodes if required and, finally, completion and referral where necessary. It should be noted that this process would vary considerably in duration and intensity depending on the urgency and complexity of each person's needs. Completion of a course of counselling for a defined problem may lead to case closure, referral for another service either in or outside of the CHS, or a further course of counselling.

The form and sophistication of the client services model may vary according to the number of counsellors in the CHS; the nature of client needs, including children, young people, adults and families; and related services both within and external to the CHS.

Documented guidelines, protocols and forms are a feature of quality service delivery and already exist in many counselling services. Those shown in Figure 5 are simply for the purpose of illustration. Some of these may be already in use by other practitioners in the CHS. Their specific content for counselling may be adapted from those already in use to ensure consistency with the CHS's general protocols and procedures.

The benefits of a formalised client services model will include enhanced consumer understanding and satisfaction with counselling, improved effectiveness of counselling arising from greater consumer responsiveness and an outcome orientation. This model will include liaison and shared care with GPs and specialist mental health services when a joint approach to client care is required.

### **Strategy 2.1 Counselling services will develop, document and implement a counselling client service model consistent with service coordination and appropriate for their particular CHS**

Building on the existing service coordination strategies introduced through PCPs, counselling services in CHSs will develop, document and implement a counselling client services model consistent with service coordination. This model will formalise client pathways from initial needs identification and screening, counselling-specific screening, associated case planning and review protocols, from first referral through the general intake system to counselling-specific screening, assessment, interventions, review and completion.

Development of the counselling client services model, should include:

- initial needs identification
- counselling-specific screening
- assessment, including clarifying the client's presenting problem
- prioritising, considering waiting list
- feedback to referrer
- case allocation
- determining intervention approach
- care planning
- review and outcome measures
- referral practices
- case closure.

Counselling services may choose to base their counselling client services model on particular approaches, for example, the single session approach.

Initially, the counselling client services model should include the following components:

- **Initial needs identification**

The initial response to an enquiry will be from a skilled intake worker and will include an initial assessment of urgency and risk. When an immediate crisis intervention is required, this may be provided within the CHS or by supported referral and linkage to another service.

- **Counselling-specific screening and assessment**

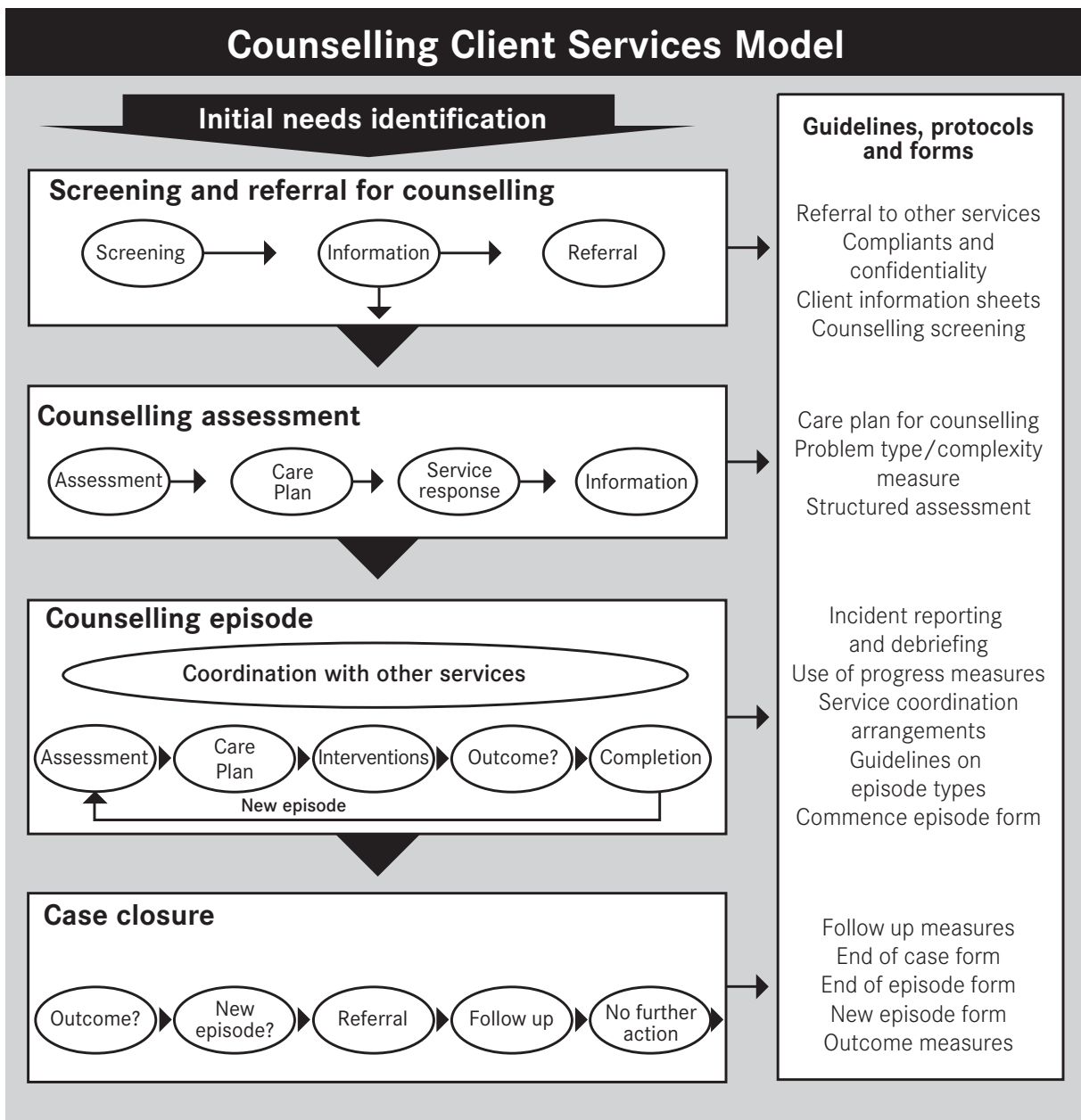
As soon as possible after initial intake, people requesting counselling should be attended to, either by phone or in person, by a counsellor, to determine their reason for requesting counselling and to further assess their psychosocial state and the severity of their problems. This forms the basis for deciding if the counselling service or some other service provider is best able to meet their needs. The counsellor and the client would together identify the best options for the client. Another appointment may be offered or referral or information provided about another service.

Further components of the client services model are also outlined as part of guideline 3 (prioritising, case allocation) and guideline 4 (care planning and review).

**Anticipated outcomes**

- Documentation and operational use of a counselling and client services model that guides the day-to-day work of counsellors with their clients.
- Improved continuity of care and planned care for counselling clients.
- Improved process for communication and referral between counsellors and other service providers.

**Figure 5: Counselling client services model [Adapted from Department of Human Services, Framework for counselling casework (1999b)]**



**Guideline 3. Demand for counselling services will be managed by a needs-based case allocation and by targeting people who are most likely to benefit, waiting list management, and by identifying related client supports.**

### Rationale

Effective counselling is quite widely available on a fee-for-service basis in the private sector. However, there are few publicly funded counselling services for assistance with common mental health and social problems.

The findings of the *Review of counselling services in community health* (Department of Human Services, 2002a) indicate that most of the clients seen for counselling have mental health and social problems of considerable severity and complexity. Counselling services in CHSs will continue to deliver counselling to these people but with progressively improved service models and standards of practice. In establishing priorities, each CHS should document policies that ensure a balance between people with problems of marked severity and complexity and those earlier in the course of mental health and social problems.

Analysis of client data in the review also indicates that counselling services see a proportionately lesser number of children, young people and adult males than are in their local communities. Evidence suggests that intervention with children and young people may be more effective than that delivered to adults with more longstanding problems.

The review (Department of Human Services, 2002a) found that there were no consistent mechanisms for managing client demand and waiting lists. It also found that services have differing, often informal, approaches to the management of waiting lists and the priorities given to clients, so that the data available on waiting lists is inconsistent and does not provide an accurate prediction of demand.

Counselling services in CHSs will commence the development of formalised and transparent waiting list management and case allocation guidelines. Counselling-specific screening and assessment tools, consistent with the PCP service coordination initiatives, will be developed to identify the nature and severity of mental health and social problems as a basis for making effective intervention allocation decisions. This work will assist the broader demand management strategy to be introduced by the Community Health Unit.

### Strategy 3.1 Counselling services will target priority needs groups

Counselling services will give priority to people with social and economic disadvantage and balance the priority given to early intervention and to people with more established mental health needs.

Counselling services assess and intervene with people:

- in significant emotional distress
- who are coping with adverse individual, family, social and economic circumstances, vulnerabilities, stressors or life events
- including children, carers and partners affected by the distress and behaviour of a family member.

Through improved client targeting, counselling services will progress over the following year to a balance between early intervention (including that with children and young people) and management of people with more established problems of mental and social health.

### Anticipated outcomes

Counselling services will:

- maximise the number of people in the priority needs groups who can access counselling and therapy from the resources available
- progressively achieve a balance in their caseload between early intervention, including work with children and young people, and work with people with more established mental health and social problems
- establish collaborative arrangements with private practitioners in counselling in the local area to ensure improved access to services.

### **Strategy 3.2 Counselling services will contribute to the development of effective counselling service models to increase access for priority target populations**

Counselling services will participate in the development and trial of effective counselling intervention models for the following priority target populations:

- children and young people
- Indigenous people
- culturally and linguistically diverse populations.

#### **Anticipated outcomes**

- Increased access to counselling for target populations.
- Service models will be identified that overcome perceived barriers and are welcoming to target populations.

### **Strategy 3.3 Counselling services will improve waiting list management and case allocation as part of a counselling client services model**

#### **Waiting list management – reflecting prioritisation of needs**

After counselling-specific screening and assessment in situations where a counsellor cannot be immediately allocated to a client, the client should be placed on a waiting list common to the CHS counselling waiting list. CHSs should develop a system to indicate priority of those people on the waiting list that indicates:

- the severity and complexity of a person's needs
- the risks associated with waiting for, receiving or not receiving counselling
- their ability to benefit from the counselling available at the CHS
- their special needs, including cultural and linguistic diversity and physical and psychiatric co-morbidity.

#### **Case allocation**

The counselling service should regularly review the waiting list and, as soon as possible, offer counselling according to priority or provide information and referral to another counselling service, considering:

- the client's need, and ability to benefit
- the size and problem mix of counsellors' caseloads
- the competence of the available counsellors to deliver effective counselling for that person's problem.

#### **Waiting list communication and support**

People on a waiting list for counselling should be regularly advised of the likely period of time to receive a service and alternative services available. There should be a systematic approach to delivering information, self-help support and brief interventions for every person on a counselling waiting list.

#### **Anticipated outcomes**

- Improved system of prioritisation of clients attempting to access counselling.
- Increased consistency with PCP service coordination initiative.
- Improved planning of individual interventions.
- Improved monitoring of client's progress.

### **Strategy 3.4 Department of Human Services supports the introduction of a ‘single session work’ approach**

During 2004–2005, training in single session work was offered to encourage the development of approaches to reduce client waiting times and substantially assist some people with only one to two sessions.

#### **Anticipated outcomes**

- Increased consumer access to counselling through more efficient waiting list practices.
- Increased support for people on waiting lists.
- Improved accountability for decisions about prioritising needs for counselling.
- More accurate estimation of the true demand for counselling services to inform service planning and future funding.

### **Strategy 3.5 Counselling services and the Department of Human Services will work together to improve data collection**

#### **High quality client data and reporting**

Counselling services will participate in the development of improved data systems to support future service planning, including:

- standardised reporting of client problem types (such as depression) to be nationally consistent
- standardised intervention data, such as nature, duration, intensity, cost
- providing incentives for data collection compliance
- integrating routine outcome measures with data systems
- progress towards a desktop counselling practice management and reporting system.

#### **Anticipated outcome**

- System developed to create accurate quantifiable profile of demand for counsellors in CHSs.

### **Guideline 4. Counselling services will promote effective practices through care planning and review, and the delivery of evidence-based interventions.**

#### **Rationale**

Care planning, undertaken in collaboration with the client, is a fundamental process for supporting engagement with the counsellor and communicating an agreed understanding about expectations, including the goals and anticipated duration, intensity and outcomes of counselling.

In preparing care plans, it was noted in the *Review of counselling services in community health* (Department of Human Services, 2002a), that counselling services have found a range of types of counselling to be valuable for the purposes of communication, for relating counselling interventions to a person’s needs or for describing caseloads (Table 4). These were derived as an agreed outcome of a wide-ranging consultation process with counsellors across the Department of Human Services (*Framework for counselling casework*, 1999b). Most of these types of counselling may be conducted with an individual adult, adolescent or child, with a couple or family, or with a group of adults, children, and couples or families.

The review of counselling services found that there was inadequate awareness amongst counsellors of evidence-based approaches for the most common mental health problems (Department of Human Services, 2002a, pp. 28 & 43).

The delivery of counselling in CHSs should be informed by evidence and expert consensus about the effectiveness of counselling interventions. All counsellors should be progressively oriented and educated in the nature and critical appraisal of evidence-based approaches to intervention.

**Table 4: Counselling types**

<b>Types of individual, couple, family and group counselling</b>	
<b>Type</b>	<b>Definition</b>
Counselling screening	Brief assessment by a counsellor generally by phone or face to face. The urgency and nature of the problem is clarified and a decision about the appropriate action is made. May include brief information, advice and/or referral elsewhere. (1–30 minutes)
Counselling assessment	A relatively comprehensive assessment, generally at a scheduled appointment and involving a detailed exploration of the presenting problem. May include information, support and/or referral elsewhere. (30 minutes–2 hours)
Crisis care	Flexible and immediate emergency counselling casework response addressing the needs of a person faced with an immediate crisis or traumatic event. While this activity may from necessity occur in Community Health Services, it should be noted that this activity is not routinely provided or funded on a 24-hour, seven-day basis. (30 minutes–12 hours)
Single session	An approach based on a philosophy that allows clients to collaborate on decisions about how much contact is needed, in recognition that many people only want to see a counsellor one or twice. The counsellor helps the client to define presenting problem and identify strategies to manage or relieve problem. Involves a longer-than-normal face-to-face contact and a follow up phone call with another session if client wishes.
Brief	Individual, family or group counselling, and other casework over a period of up to three months, generally with relatively frequent consultations at least initially, usually focused on achieving resolution of the presenting problems or support through a crisis, usually involving a total of up to 12 consultations. (1–12 consultations)
Medium term, low intensity	Individual, family or group counselling, and other casework over a period of up to six months with consultations that are relatively infrequent, except perhaps at times of crisis, generally intended primarily to provide support and/or harm reduction, and to 25 consultations. (1–25 consultations)
Long term, low intensity	Individual, family or group counselling, and other casework over a period of more than six months and up to a year with consultations that are usually relatively infrequent, except perhaps at times of crisis, generally intended primarily to provide support and/or harm reduction, and usually involving a total of up to 25 consultations in a year. (1–25 consultations)
Long term, high intensity	Individual, family or group counselling, and other casework over a period of more than six months and up to a year with relatively frequent consultations at least initially, generally focussed on achieving resolution of the presenting problems, usually involving a total of up to 50 and rarely up to 100 consultations in a year. (1–100 consultations)

Source: Adapted from: *A framework for counselling casework* (Department of Human Services 1999b, p. 25)

### **Strategy 4.1 Counselling services will improve care planning and review**

Counselling services deliver effective face-to-face interventions in centre, home and offsite settings, designed to:

- provide relief from emotional distress and its social consequences
- promote longer term coping with adverse circumstances
- reduce vulnerability to mental health and social problems in the future.

The documentation of care planning, goal setting, outcome monitoring, and review and adjustment of the care plan should be core processes to support effective counselling and communication between counsellors and other primary care or specialist providers where warranted. The care plan may vary in its standard and individualised forms, depending on the counselling service and the nature of people's problems.

**Anticipated outcome**

- Proportion of clients with an agreed and documented case plan that has been reviewed in the previous three months will increase.

**Strategy 4.2 Counselling services will develop a process for care planning, ensuring outcomes are considered by counsellors and clients when identifying the client's counselling progress**

Counselling services will participate in the development and implementation of a process of care planning that can be routinely used. To demonstrate improvements resulting from counselling, it is necessary that life functioning prior to and following the completion of counselling should be routinely assessed. An outcome orientation is a feature of effective counselling and of contemporary health service delivery.

**Anticipated outcomes**

- Community health counsellors will be able to identify and record client progress and gauge effectiveness of interventions.

**Strategy 4.3 The Department of Human Services will develop an evidence-based practice resource monograph**

The department has engaged a consultancy to research and develop a resource monograph about evidence-based practices in community health counselling. The monograph will be published and provided to community health counsellors to inform their approaches to common client problems. Community health counsellors will contribute to the development of the resource monograph.

**Anticipated outcomes**

- Counsellors will understand the nature of evidence-based practice, have greater access to the literature on evidence-based practice and have increased confidence and competence in participating in discussions and debates with other mental health practitioners.
- Consumers will be confident that the counselling interventions they receive will increasingly be linked to those of proven effectiveness or about which there is expert consensus.
- Improved relationships between community health counsellors, GPs and specialist mental health practitioners are also likely to follow from the use of a common commitment to evidence-based practices.

**Strategy 4.4 Counselling services and the Department of Human Services will work together to develop a research and development agenda and seek external research funds**

Counselling services will participate in the development of a research, evaluation and development agenda for counselling that:

- ensures that counselling services are optimised through a research, evaluation and development agenda that identifies trends in client needs and new knowledge about effective interventions and regularly evaluates services against contemporary knowledge and practices
- creates mechanisms to enable external grant funds to be accessed for research and development in community health counselling and ensures that findings are published and disseminated.

**Anticipated outcomes**

- Improved evidence base for effective psychosocial interventions as a result of counsellors in CHSs participating in or conducting research.

#### **Strategy 4.5 The Department of Human Services will support increased effective counselling practice with children, young people and their families by providing training**

Counselling for children, young people and their families should be informed by evidence of the effectiveness of interventions, where such evidence is available, to reduce error and inform decision making about resources. Evidence-based family therapy training will be offered to increase community health counsellors' skills and knowledge in working with children, young people and families.

##### **Anticipated outcome**

- Counsellors will be better equipped to work effectively with children, young people and families.

#### **Guideline 5. Quality improvement processes will be an ongoing feature of counselling services.**

##### **Rationale**

Quality improvement is a fundamental requirement of good governance of CHSs and of ethical professional behaviour. Standards relevant to the quality of counselling are documented by the established quality authorities and have been agreed by the peak professional bodies of social work and psychology in the *National practice standards for the mental health workforce* (Commonwealth Department of Health and Ageing 2002).

Currently, there is no consistent approach to ongoing quality improvement for counselling services in CHSs. While there is evidence of the effectiveness of counselling, this depends on the vigilant maintenance of the fidelity of effective interventions.

#### **Strategy 5.1 The Department of Human Services will support implementation of the quality improvement initiatives outlined in this paper through the provision of the Regional Counselling Leadership Initiatives**

Counsellors will participate in local, regional and statewide networks or mechanisms for supporting the improved quality of community health counselling. Wherever possible, they will ensure that quality improvements for counselling services in CHSs are informed by and consistent with those already in place or being undertaken for other counselling services in community health, including alcohol and drug, problem gambling and family counselling.

##### **Anticipated outcomes**

- Counselling services in CHSs will set goals for quality improvement; strategies, activities and supports for achieving the goals will be agreed within regions.
- Counselling quality improvement will become an ongoing feature of counselling services in CHSs.
- Local leadership will encourage and sustain improvements in counselling practice.
- Information will be shared locally, regionally and statewide to inform service planning.

#### **Strategy 5.2 Counselling services will develop protocols for referrals between mental health and community health services**

The development of protocols between counselling services in CHSs and specialist mental health services would improve the quality of care for clients by encouraging improved communication between specialist mental health and community health services, resulting in more appropriate referral practices.

### Anticipated outcomes

- Community health counsellors will be better able to plan effective counselling interventions for clients with mental health problems.
- Community health counsellors will be better able to determine when referral to specialist mental health services is required.
- Mental health services will have increased understanding of the role of community health counselling services.

**Guideline 6. Consumer participation will be a feature of planning and ongoing monitoring of the quality of counselling services and mental health promotion.**

#### Rationale

Consumer input to counselling services tends to be minimal when compared to services for physical illnesses or disabilities. Consumer participation should be a core feature of a service built on a social model of health. It signals a shift in the power balance between consumers and health professionals, ensures that consumer attitudes and expectations are factored into service planning and operations, and provides a rich source of ideas for improving service access, acceptability, quality and effectiveness.

#### What consumer participation means

Consumer participation begins with activities involving the presence of consumers. However, consumer involvement can only be judged 'participation' if it has a tangible impact and leads to changes in the ways in which services are delivered and experienced. Effective consumer participation creates a view of the consumer as a partner in service delivery, offering feedback leading to adjustments to service design and delivery. The outcome is mental health services that respect the individual and more closely meet the needs of consumers [*Evaluation of consumer participation in Victoria's public mental health services* (Department of Human Services 1999c, p. 16)].

Table 5 illustrates the continuum of consumer participation from no or minimal involvement, to participation in individual case planning and to becoming an integral, ongoing and valued part of the service. Improved consumer participation can be progressively achieved in counselling services by a wide range of means tailored to the size and nature of the service and the community served (*Guidelines for consumer participation in mental health services*, Department of Human Services, 1996).

**Table 5: Consumer, carer and community participation in service planning**

Level of participation	Role of consumers, carers and communities	Example of participatory activities <sup>2</sup>
Community control Delegated power	Communities control and run health services. Services ask consumers, carers and communities to make decisions about particular aspects of service planning	Consumers, carers and communities are provided with resources to develop strategies and programs to address specific issues. <sup>3</sup>
Partnership	Consumers, carers and communities are asked to participate as partners in service planning decision making. For this activity to occur consumers, carers and communities should be provided with all the information provided to other stakeholders required to participate in decision making.	<ul style="list-style-type: none"> <li>• Consumers, carers and communities are involved in all activities from the beginning</li> <li>• Consumers, carers and community members participate in decision making service planning committees and advisory groups.</li> <li>• Consumers, carers and community members participate in workshops where all stakeholders come together to work through issues and participate in decision making.</li> </ul>
Consultation	Consumers, carers and community members are involved in a consultation process where they provide information and comment on documents and strategies. Consumers, carers and community members may participate in decision making processes.	Combinations of information seeking/sharing activities (see below), plus consumer, carer and communities asked to comment on documents and strategies.
Information seeking/ sharing	Consumers, carers and communities are asked to provide services with information and/or services provide consumers, carers and communities with information. Services decide what to do with the information.	<ul style="list-style-type: none"> <li>• Focus groups</li> <li>• Consumer advisory groups</li> <li>• Consumer representatives on committees</li> <li>• Development of links with consumer groups to share information.</li> <li>• Community forums</li> </ul>
No input	Consumers are not engaged in service planning.	

Source: Information resource, *Consumer participation in service planning*, Primary Care Partnerships 2001

The key elements of effective consumer participation are summarised as:

**Immediate/individual** – this includes respect for consumers, information and rights, complaints mechanisms and specific service feedback and surveys.

**Long term/systems** – this includes staff training and selection, service development and policy (Department of Human Services, 1999c).

### **Strategy 6.1 Counselling services in Community Health Services will improve community participation in planning**

Counselling services in CHSs will ensure consumer participation in individual case planning and in local counselling and mental health promotion service planning, operations and review.

Mental health professionals encourage and support the participation of consumers and carers in determining (or influencing) their individual care plan. They also actively promote, encourage and support the participation of consumers, family members and/or carers in the planning, implementation and evaluation of mental health service delivery

(*National practice standards for mental health professionals, Standard 2, p. 11*).

Consumer participation includes:

- collaborative case planning
- regular forums for consumers to meet together and with counsellors to discuss their experience of services and talk about ways to improve services to better meet their needs
- self-help groups well linked to counselling services and consumer representation
- consumer satisfaction surveys, including the means for addressing the consumer issues emerging from the survey
- consumers on working groups for particular projects
- consumer participation in quality improvement activities, including the consideration of incident reports and complaints and the development of practice guidelines
- ongoing consumer representatives appointed, to both gain consumer input and provide avenues for it to be heard and acted on
- consumer representatives supported to participate in area and regional consumer forums and networks and statewide consumer advocacy organisations, with their observations relayed to the sponsoring service
- a consumer participation plan developed to detail how consumer participation in counselling services is to occur.

### Anticipated outcomes

Consumer views and perspectives are understood and influence service provision through:

- consumer satisfaction surveys
- well utilised feedback and complaints processes
- representation of consumers in the activities associated with achieving each of these guidelines
- ongoing representation of consumers in counselling quality improvement processes.

**Guideline 7: The competency of counsellors will be assured through the use of minimum qualifications, continuing professional development, workforce planning and clinical supervision.**

### Rationale

Community health counsellors should be tertiary qualified and competent in the delivery of effective psychosocial interventions for the most common emotional and social problems of children, young people and adults.

Community health counselling includes significant counselling and therapeutic interventions and may also include varying amounts of casework, practical assistance and support, advocacy, service coordination and health promotion activities.

To date, the Department of Human Services has not required minimum qualifications to practice as a counsellor in a CHS. The proposed minimum qualifications are not based on formal analysis of counselling competencies but they are consistent with the minimum required in outcome studies by most organisations for which consultations were undertaken for the *Review of counselling services in community health* (Department of Human Services, 2002a). While a wide range of other qualifications and experience different from these might allow a counsellor to practice effectively, there is no basis or means at present for being assured of this.

There is no legislative basis specifically for the practice of counselling in Victoria. The practice of psychologists, medical practitioners and nurses, who may do counselling, is regulated by professional registration in most countries, including Australia. Anyone else may advertise and practice as a counsellor or psychotherapist without regulation.

The provision of professional development and clinical supervision is the responsibility of CHS management in relation to corporate governance and of each professionally qualified counsellor. The cost of clinical supervision has been included in the unit price build-up. For more detail, see the *Community and Women's Health Program guidelines, 2003-04 to 2005-06* (Department of Human Services, 2003).

Professional development includes training or study that is relevant to the role of the community health counsellor.

Clinical supervision is a creative process that provides counsellors with the opportunity to clarify issues that may affect their counselling practice in a safe, supportive environment. The supervisor offers practical and theoretical knowledge in an explorative manner that assists the counsellor to identify useful strategies to progress particular situations or overall counselling practice development.

A suitably qualified and experienced counsellor, who either is external to the CHS or a senior practitioner within the CHS counselling team, can provide clinical supervision.

When supervision is provided externally, the community health counsellor receiving supervision would be required to comply with privacy laws and with the employer's accountability requirements.

Clinical supervision is distinct from line management supervision that addresses issues of work performance and administrative issues. In many CHSs the counselling team leader/manager may provide both the clinical supervision and the line management supervision. When the same person provides both types of supervision, a clear distinction needs to be made between the function and occurrence of both types of supervision.

### **Strategy 7.1 Department of Human Services will introduce minimum qualifications for counsellors in CHSs**

The minimum requirement for the recruitment of counsellors will be eligibility for:

- registration with the Psychologist Registration Board of Victoria
- membership of the Australian Association of Social Workers (AASW)
- registration with the Psychotherapy and Counselling Federation of Australia (PACFA) (a minimum four-year degree or equivalent)
- Post graduate counselling qualifications are highly desirable.

Note: The minimum requirement will not apply to those counsellors currently employed as community health counsellors.

### **Anticipated outcome**

- An increasing proportion of counsellors will meet the minimum qualifications.

### **Strategy 7.2 Department of Human Services will mandate professional development and clinical supervision**

All counsellors' workplans should include planning for professional development and clinical supervision aligned with the requirements of their professional association.

### Anticipated outcomes

- All counsellors participate in a professional development program appropriate to their experience, competencies and work requirements.
- All counsellors will receive regular clinical supervision of their work, which should be more frequent in the first years of a counsellor's experience.
- External education, training and supervision arrangements meet the requirements of the professional associations or of recognised universities.

### Strategy 7.3 Department of Human Services will support the provision of clinical supervision

During 2005, the department will support CHSs to implement plans to ensure that all counsellors in CHSs receive regular clinical supervision.

#### Anticipated outcome

- All community health counsellors will regularly participate in clinical supervision.

### **Guideline 8. Counselling services will operate as one part of a continuum of mental health promotion.**

#### Rationale

In the past, a distinction has been made between efforts directed at primary, secondary and tertiary prevention for mental health and associated social problems. The *National Action Plan on mental health* (Commonwealth Department of Health and Ageing 2000) argues instead for considering these strategies as integral parts of a single approach to promoting mental health. This means that greater coordination is required between prevention, early intervention and intervention, and between service providers, including GPs, private mental health practitioners, counsellors and specialist mental health services.

### Strategy 8.1 Counsellors in CHSs will increase contribution to mental health promotion

Consistent with the social model of health, counsellors will assess and intervene with consideration for the range of domains in a person's life, including emotional distress, interpersonal relations, physical health, leisure, social support and work. While a counsellor's principal competencies may be with mental health and social needs, they will work with other service providers as necessary to ensure that a person's needs are addressed in an integrated manner.

In addition to their case related work, counsellors should take the opportunity to engage in informing policy and planning for mental health promotion across local communities and to priority groups identified to be at risk. CHSs should develop a strategic approach to mental health promotion that integrates the planning and operation of counselling, prevention and other mental health promotion initiatives already funded through the Community Health Program. This approach will ensure that mental health and wellbeing promotion initiatives across the organisation, local area, PCP and region are coordinated with the provision of counselling in CHSs. Community health should be recognised as a significant stakeholder and active contributor to primary care mental health.

### **Anticipated outcomes**

- Inclusion of counselling services in planning and development of the CHS's mental health promotion strategies.
- Joint planning of mental health promotion between services within CHSs.
- Improved mental health care coordination across services within CHSs.
- Participation of counselling services in the planning and consultative processes for mental health promotion for the local area, PCP and region.
- Improved care coordination between counselling services, GPs, private practitioners and specialist mental health services.

## Summary of guidelines and strategies

Guideline	Strategies
1. Counselling services will be underpinned by the principles of the social model of health through their practices and in their relationships with other providers and the community.	1.1 Counselling services and the Department of Human Services will promote the social model of health approach.
2. Counselling services will ensure continuity of quality care, adapted to the particular needs of the client, from first contact, through assessment, counselling and review to completion.	2.1 Counselling services will develop, document and implement a counselling client services model consistent with service coordination and appropriate for their particular CHS.
3. Demand for counselling services will be managed by a needs-based case allocation and by targeting people who are most likely to benefit, waiting list management, and by identifying related client supports.	3.1 Counselling services will target priority needs groups. 3.2 Counselling services will contribute to the development of effective counselling service models to increase access for priority target populations. 3.3 Counselling services will improve waiting list management and case allocation as part of a counselling client services model. 3.4 The Department of Human Services supports the introduction of a single session work approach. 3.5 Counselling services and the Department of Human Services will work together to improve data collection.
4. Counselling services will promote effective practices through care planning and review, and the delivery of evidence-based interventions.	4.1 Counselling services will improve care planning and review. 4.2 Counselling services will develop processes for care planning, ensuring outcomes are considered by counsellors and clients when identifying the client's counselling progress. 4.3 The Department of Human Services will develop an evidence-based practice resource monograph. 4.4 Counselling services and the Department of Human Services will work together to develop a research and development agenda and seek external research funds. 4.5 The Department of Human Services will support increased effective counselling practice with children, young people and families by providing training.
5. Quality improvement processes will be an ongoing feature of counselling services.	5.1 The Department of Human Services will support implementation of quality improvement initiatives outlined in this paper through the provision of the Regional Counselling Leadership Initiatives. 5.2 Counselling services will develop protocols for referrals between mental health and CHSs.
6. Consumer participation will be a feature of planning and ongoing monitoring of the quality of counselling services and mental health promotion.	6.1 Counselling services in CHSs will improve community participation in planning.
7. The competency of counsellors will be assured through the use of minimum qualifications, continuing professional development, workforce planning and clinical supervision.	7.1 The Department of Human Services will introduce minimum qualifications for counsellors in CHSs. 7.2 The Department of Human Services will mandate professional development and clinical supervision. 7.3 The Department of Human Services will support the provision of clinical supervision.
8. Counselling services will operate as one part of a continuum of mental health promotion.	8.1 Counsellors in CHSs will increase contribution to mental health promotion.



## 8. Meeting the challenges of the three guiding principles

This implementation plan outlines actions for the department (8.1) and for counselling services in CHSs (8.2) to support implementation, based on the three guiding principles referred to in Chapter 1.

### 8.1 Department of Human Services objectives and challenges

Strategic objectives/Challenges	Actions
<b>1. Community health and the National Mental Health Plan 2003–2008</b>  <b>Counselling in Community Health Services will be well positioned to contribute to the implementation of the National Mental Health Plan</b>	
To define the role of community health counselling and relationships to general medical practitioners and specialist mental health services.	1.1 Develop an agreed framework for primary care mental health with the Mental Health Branch and general medical practitioners: <i>Foundations for primary care mental health treatment services in Victoria</i> , August 2004.
<i>Research, development and evaluation</i> Ensure that counselling services are optimised through a research and development agenda that identifies trends in client needs and new knowledge about effective interventions. (See Guideline 4, Strategies 4.3, 4.4)	1.2 Develop a research, evaluation and development agenda. 1.3 Publish findings for wide distribution. 1.4 Develop strategy to seek research funds externally.
<b>2. The social model of health</b>  <b>The social model of health, which underpins counselling services in Community Health Services, should substantially contribute to the development of primary care mental health policy, planning and services.</b>	
<i>Positive influence</i> Support the use of approaches that reflect the social model of health, in policy development, mental health promotion, counselling practice, other service providers and community opinion. (See Guideline 1)	2.1 Encourage approaches that incorporate an awareness of the social model of health in training and supervision of counsellors. 2.2 Generate and take up opportunities to promote discussion and debate concerning the contributions of the social model of health approach.
<b>3. Effective counselling</b>  <b>The effectiveness and ongoing development of counselling services in Community Health Services should be assured through improved recruitment, competency development and quality processes.</b>	
<i>Competency development</i> Develop the range and depth of community health counsellors' competencies in assessment and individual, group and family interventions with children, adolescents, adults and older people. (See Guideline 7, Strategy 7.1)	3.1 Introduce the following minimum qualifications for counsellors – eligibility for membership to the AASW, APS or PACFA. 3.2 Introduce the requirement that continuing professional education and supervision is required for all counsellors.
<i>Quality assurance</i> Ensure quality counselling practices. (See Guideline 4, Strategies 4.2, 4.3, and Guideline 5)	3.8 Develop and publish a resource guide about evidence-based practice for common client problems. 3.9 Introduce routine monitoring of client outcomes. 3.10 Improve data collection methods and reports back to CHSs.
<i>Client centred data reporting</i> Improved client monitoring, reporting and performance systems. (See Guideline 3, Strategy 3.5, and Guideline 4, Strategy 4.2)	3.11 Progress to client-related rather than time-related data reporting 3.12 Standardise reporting of client problem types to be nationally consistent. 3.13 Integrate routine outcome measures with data system. 3.14 Progress toward to desktop counselling reporting system.

## 8.2 Community health service objectives and challenges

Strategic objectives/Challenges	Actions
<b>1. National Mental Health Plan 2003–2008</b> <b>Counselling in Community Health Services will be well positioned to contribute to the implementation of the National Mental Health Plan</b>	
<i>Mental health promotion</i> To plan counselling services as an integral part of an overall mental health promotion strategy in community health. (See Guideline 8)	1.1 Develop a strategic approach to mental health promotion in Community Health Services that integrates counselling and other mental health promotion initiatives.
<i>Service responsiveness</i> To ensure that community health is recognised as a significant stakeholder and actively contributes to the new regional primary care mental health systems. (See Guideline 5, Strategy 5.2)	1.2 Community health counselling will actively contribute to the structures and processes for integrated mental health service planning through the Primary Care Partnerships.
<i>Targeting services</i> To define client target groups for community health counselling and the priority to be given to early intervention and complex problems. (See Guideline 3, Strategies 3.1, 3.2)	1.3 Develop models of assessment to identify and understand the client's presenting problem and to determine the nature and severity of any mental health problems, leading to an understanding between client and counsellor about an appropriate course of action.  1.4 Define the desired proportionate resource split between early intervention and more complex client problems.
<i>Managing increased community demand</i> Manage the increased community demand arising from greater public awareness of anxiety and depression. (See Guideline 3, Strategies 3.3, 3.4)	1.5 Develop standardised waiting list management guidelines and reporting leading to more consistent practice across CHSs.  1.6 Attend single session work training, which can provide satisfactory outcomes for some people from 1–2 sessions.
<b>2. Social model of health approach</b> <b>The social model of health, which underpins counselling services in Community Health Services, should substantially contribute to the development of primary care mental health policy, planning and services.</b>	
<i>Client management</i> Ensure a consistent approach to the management of clients through assessment, intervention, review and termination across counselling services. (See Guideline 2, Strategies 2.1, 2.2)	2.1 Specify an assessment and client services model for counselling specific intake session: <ul style="list-style-type: none"> <li>• Feedback to referrer, for example, GP</li> <li>• Case allocation</li> <li>• Referral practices</li> <li>• Care planning</li> <li>• Guidelines for intervention approaches</li> <li>• Case monitoring and review</li> <li>• Case termination and review</li> <li>• Outcome measures</li> <li>• Fees policy.</li> </ul>

Strategic objectives/Challenges	Actions
<p><b>3. Effective counselling</b></p> <p><b>The effectiveness and ongoing development of counselling services in Community Health Services should be assured through improved recruitment, competency development and quality processes.</b></p>	
<p><i>Coordination of service development</i> Ensure that service development in community health counselling occurs in a planned and coordinated manner.</p>	<p>3.1 Disseminate this paper widely to CHS staff, regional offices, and other service providers and include in the orientation of newly appointed community health counsellors.</p> <p>3.2 Collaborate with the department regional staff to revise service agreement</p>
<p><i>Competency development</i> (See Guideline 7)</p>	<p>3.5 Develop systems and strategies for ensuring all counsellors receive regular supervision and professional development.</p> <p>3.6 Provide incentives to unqualified counsellors currently employed in community health, to gain the necessary qualifications.</p>
<p><i>Quality assurance</i> Ensure quality counselling practices (See Guideline 5)</p>	<p>3.7 Counsellors should actively contribute to the CHS's quality assurance plan.</p> <p>3.8 Counsellors will comply with the department critical incident reporting as a mandatory requirement for all CHSs.</p> <p>3.9 Routine client outcome monitoring to be progressively introduced.</p>



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## Common terms and abbreviations

This glossary has been adapted from several sources, including the Commonwealth Department of Health and Aged Care and the Australian Institute of Health and Welfare, 1999; National health priority areas report: mental health, Commonwealth Department of Health and Aged Care, 1998.

### **Affective disorders (mood disorders)**

This term can be used to describe all those disorders characterised by mood disturbance. Disturbances can be in the direction of elevated expansive emotional state or in the opposite direction, a depressed emotional state.

### **Anxiety**

An unpleasant feeling of fear or apprehension accompanied by increased physiological arousal.

### **Assessment**

Ongoing process beginning with first client contact and continuing throughout the intervention and maintenance phases to termination of contact. The major goals of assessment are:

- (a) identification of vulnerable or likely cases;
- (b) diagnosis;
- (c) choice of optimal treatment; and
- (d) evaluation of the effectiveness of the treatment.

### **Best practice**

A concept of organisational change and improvement that has been adopted from the industrial sector where it is seen as the pursuit of 'world class' performance. Best practice is considered to be a comprehensive, integrated and cooperative approach to continuous improvement of all facets of an organisation's operations. Best practice guidelines are statements based on the careful identification and synthesis of the best available evidence in a particular field. They are intended to assist people in that field, including practitioners and consumers, to make the best use of the available evidence.

### **CALD – culturally and linguistically diverse**

#### **Care**

Assistance or support given to a person to improve their health and wellbeing and to help them achieve maximum quality of life.

#### **Care coordination**

The range of services required by the consumer are coordinated so that they are delivered in the most efficient and effective way to meet individual consumer's needs. Care coordination enables continuity of care, avoids duplication of services and ensures that meeting consumer needs is paramount over the needs of individual service providers and is not hampered by program boundaries (see Care planning).

#### **Care planning**

A process of deliberation that incorporates a range of existing activities, such as care coordination, case management, referral, feedback, review, re-assessment and monitoring. Care planning involves the judgment/determination of relative need as well as competing need, and assists consumers to come to decisions that are appropriate to their needs, wishes, values and circumstances.

#### **Casework**

Practical assistance and support, advocacy, service coordination and management activities.

**Community participation**

Processes that enable individuals and groups in the community to contribute to debate and decision making about a particular activity. This means opportunities for community members to participate in planning, managing and evaluating services, and in identifying issues and ways of addressing them.

**Consumers**

Those members of the community who currently use services, are seeking to use services or who are potential service users.

**CHS – community health service**

Agencies in receipt of Victorian Community Health Program funding that also deliver a wide range of other primary health and support services to meet local community needs. This definition includes community health centres and primary health units or divisions of rural and metropolitan health services.

**Counselling (and psychotherapy)**

Both counselling and psychotherapy utilise the personal relationship to enable clients to develop an understanding about themselves and to make changes in their lives. Counselling and psychotherapy must work within a principled relationship that enables clients to explore and resolve interpersonal issues. Such processes are based on an ethos of respect for clients, their values, beliefs and uniqueness, and right to self-determination. Counselling usually focuses on specific problems or adjusting to life's changes. Psychotherapy is more concerned with the restructuring of the personality or the self. Psychotherapy tends to be more intensive, more frequent and for longer periods of time than counselling. (Psychotherapy and Counselling Federation Association, 2004)

**DALY – disability-adjusted life year**

In 1993, the DALY was introduced as a measure that combines healthy life years lost because of premature mortality with those lost as a result of disability (World Bank 1993).

**Effectiveness**

The extent to which an intervention does more good than harm for the patient when used under 'normal' circumstances.

**Efficacy**

The extent to which an intervention does more good than harm for the patient when applied under 'ideal' conditions.

**EQUIP – Evaluation and Quality Improvement Program****Evidence-based practice**

A process through which professionals use the best available evidence, integrated with professional expertise, to make decisions regarding the care of an individual. It is a concept that is now widely promoted in the medical and allied health fields and requires practitioners to seek the best evidence from a variety of sources; critically appraise that evidence; decide what outcome is to be achieved; apply that evidence in professional practice; and evaluate the outcome. Consultation with the client is implicit in the process.

**Initial needs identification**

An initial assessment process where presenting and underlying issues are uncovered. It is not a diagnostic process but is a determination of the consumer's risk, eligibility and priority for service and a balancing of the service capacity and the consumer's needs.

### **Mental disorder**

A recognised, medically diagnosable disorder, which results in a significant impairment of an individual's cognitive, social or emotional abilities and may require intervention.

### **Mental health**

The capacity of individuals and groups to interact with one another and the environment in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational). The achievement of individual and collective goals consistent with justice is central to a positive state of mental health.

### **Mental health problem**

A disruption in the interactions between the individual, the group and the environment, producing a diminished state of mental health.

### **Mental health literacy**

The ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking.

### **Mental health problems**

Diminished cognitive, emotional or social abilities, but not to the extent that the criteria for a mental disorder are met.

### **Mental health professionals**

Professionally trained people working specifically in mental health, such as social workers, occupational therapists, psychiatrists, psychologists and psychiatric nurses.

### **Mental health promotion**

Action to maximise mental health and wellbeing among populations and individuals.

### **Outcome**

A measurable change in the health of an individual or group of people or population, which is attributable to an intervention or series of interventions.

### **Prevalence**

The proportion of the population with the disease/disorder.

### **Preventive interventions**

These are programs designed to decrease the incidence, prevalence and negative outcomes of depression, such as:

- universal preventive programs applied to the entire population
- selective preventive programs applied to groups or individuals at increased risk of developing the disorder
- indicated preventive programs targeted at high risk individuals on the basis of the individual's minimal, but detectable, behaviours or symptoms that could later develop into a full-blown disorder.

### **Primary care**

In the health sector generally, 'primary care' services are provided in the community by generalist providers who are not specialists in a particular area of health intervention. For example, GPs, Aboriginal health workers, pharmacists and community health workers provide primary health care. Specialist care, or tertiary services, may be provided by accident and emergency services, hospital wards, youth health or mental health services.

**PCP – Primary Care Partnership**

A group of primary care providers that have formed voluntary alliances to work together to improve health and wellbeing in their local communities. There are 32 PCPs in Victoria.

**Primary health care**

Primary health care is essential health care based on practical, scientific and socially acceptable methods and technology. It is made universally accessible to individuals and families in the community through their full participation and at an affordable cost to the community and country. Primary health care is the central function and main focus of the country's health system. It is the first contact of the individual, the family and the community with the national health system, bringing health care as close as possible to where people live and work.

**Primary Mental Health Teams, Primary Mental Health and Early Intervention Teams**

Primary Mental Health Teams are a component of the public specialist mental health system. Their focus is to support the interface between the primary and tertiary mental health service systems. Primary Mental Health Early Intervention Teams provide short-term treatment and assessment services to people with high prevalence disorders, referred to them from primary providers. They also provide early intervention to young people with emerging psychosis and significant psychological disorders. Consultation and liaison, education and training (including crisis prevention training) are also provided to primary care providers.

**PACFA – Psychotherapy and Counselling Federation Association****Psychologist**

While there are various governing laws throughout the states and territories of Australia, a practitioner is not allowed to call themselves a psychologist unless they have undertaken the required training and are registered with the relevant state registration body.

**Psychiatrist**

Medical practitioner with specialist training in psychiatry.

**QIC – Quality Improvement Council**

QIC is a national primary health industry body that produces standards for primary health care and associated services. The QIC Review and Accreditation Program is based on the QIC standards, but has the capacity to use service delivery standards developed by other industries provided they meet particular criteria. These criteria include consistency with QIC's Core Concepts, which are based on the social model of health.

**QICSA – Quality Improvement and Community Services Accreditation**

QICSA provides accreditation services in Victoria under licence from the Quality Improvement Council (QIC).

**Randomised controlled trial**

Research study where participants are allocated at random to receive one of two or more alternative forms of care, with the aim of creating unbiased treatment groups for comparison.

**Risk factors**

Those characteristics, variables or hazards that, if present for a given individual, make it more likely that a particular individual, rather than someone selected at random from the general population, will develop a disorder.

**Single session work**

Counselling intervention that can substantially assist some people with only one to two sessions.

**Social model of health**

A conceptual framework for improving health and wellbeing by addressing the social and environmental determinants of health, in tandem with biological and medical factors.

**Socioeconomic status**

A relative position in the community as determined by occupation, income and education.

**Specialist Mental Health Services**

A comprehensive specialist age-based treatment system that comprises area-based clinical mental health services, mainstreamed with general hospitals, and offers inpatient, community residential and ambulatory services as well as psychiatric disability rehabilitation and support services. Specialist mental health services treat adults with serious mental illness or children and adolescents who have a serious mental disturbance or who are known to be at risk of such disturbance.

**Stressor**

An event that occasions a stress response in a person.

**Substance use disorders**

Disorders in which drugs are used to such an extent that behaviour becomes maladaptive; social and occupational functioning is impaired, and control or abstinence becomes impossible. Reliance on the drug may be psychological, as in substance misuse, or physiological, as in substance dependence.

**Suicide**

Suicide is a conscious act to end one's life. By conscious act, it is meant that the act undertaken was done in order to end the person's life.

**Suicidal behaviour**

Suicidal behaviour includes the spectrum of activities related to suicide and self-harm, including suicidal thinking, self-harming behaviours not aimed at causing death and suicide attempts. Some writers also include deliberate recklessness and risk-taking behaviours as suicidal behaviours.

**WHO – World Health Organisation**

