

Review of Counselling Services in Community Health

Discussion Paper

Review of Counselling
Services in Community Health
Discussion Paper

February 2002

Published by the Victorian Government Department of Human Services
Melbourne Victoria

February 2002

Also published on www.dhs.vic.gov.au/phkb

© Copyright State of Victoria, Department of Human Services, 2002

This publication is copyright. No part may be reproduced by any process except in accordance with the provisions of the Copyright Act 1968.

(0071201)

Disclaimer

The views expressed in this report are solely those of the responsible consultants and do not necessarily reflect the views of the Department of Human Services, State Government of Victoria.

The Review of Counselling Services in Community Health is being carried out during 2001-2002. For further information about this discussion paper please contact:

Cathy Henenberg, Project Manager
Community Health Policy
Department of Human Services, Victoria
555 Collins Street
Melbourne 3000
Phone: (03) 9616 6136
Email: Cathy.Henenberg@dhs.vic.gov.au

Contents

Tables and Figures	v
Executive Summary	1
1. Rationale for the Review	5
1.1 A Framework for Counselling Casework, 1999	5
1.2 Counselling Related Initiatives for 2000–2001	5
1.3 Review of Community Health Counselling	6
1.4 Reference Group	6
1.5 Scope of the Report and Feedback	6
1.6 An Important Note about Terminology and Policy Development	7
2. Mental Health Problems and Counselling	9
2.1 Overview	9
2.2 Emerging Knowledge about Mental Health Needs	9
2.3 The Mental Health and Wellbeing of Australians	10
2.4 The Burden of Mental Disorders in Victoria, 1996	12
2.5 Emerging Knowledge about Effective Counselling Interventions	13
2.6 Investment in Health Services for Mental Disorders in Australia	14
3 Mental Health Policy and Developments	15
3.1 Overview	15
3.2 Commonwealth Policy and Service Developments	15
3.3 Victorian Department of Human Services—Mental Health Branch	17
3.4 Victorian Department of Human Services—Community Care Division	19
3.5 Victorian Department of Human Services—Primary and Community Health Branch ..	19
3.6 Victorian Health Promotion Foundation—Mental Health Strategy	21
4. Needs Met through Counselling in Community Health	23
4.1 Overview	23
4.2 Client Profile of Community Health Counselling Services	23
4.3 Profile of Needs in the Community	24
5. Counselling Casework Interventions in Community Health	27
5.1 The Nature of Counselling Casework	27
5.2 What Counselling is Already Being Provided?	28
6. Resource Allocation for Assessment and Counselling in Community Health	31
6.1 Introduction to Expanding Counselling Funding in Community Health	31
6.2 A Burden of Disease Approach to Community Health Counselling	31
6.3 Redressing Historical Inequities	31
6.4 Burden of Non-Psychotic Mental Health Problems	33
6.5 Regional Funding Allocations for Counselling Casework	33
6.6 Distribution of New Counselling Funds within Regions	34

7. Socioeconomic Factors and Non-Psychotic Mental Health Problems . . .	37
7.1 Mental Health Problems are Associated with Socioeconomic Status	37
7.2 Areas with Low Socioeconomic Status Have High Mental Health Burden.	38
7.3 Socioeconomic Status and Mental Health of Children and Adolescents	39
8 A Social Health Approach to Counselling in Community Health.	41
8.1 Overview	41
8.2 National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, 2000	41
8.3 Strategic Analysis of Counselling in Community Health	42
8.4 Proposed Refocusing of Community Health Counselling Casework	44
8.5 Proposed New Policy Directions.	45
9. References	47
10. Reference Group	49
11. Glossary	51

Tables and Figures

Table

1. Leading Causes of Years Lived with Disability in Developed Regions, 1990	9
2. Prevalence of Children’s Mental Health Problems in Specific Areas	11
3. Mental Health: Health System Costs by Health Sector, Australia 1993–94	14
4. Differentials in the Burden of Disease and Injury between Top and Bottom Quintiles of Socioeconomic Disadvantage, by Selected Main Disease Categories and Sex, Australia 1996	37
5. Prevalence of Mental Health Problems by Family Type and Prevalence by Weekly Household Income	39
6. Strategic Analysis of Community Health Counselling, 2001	43
7. A Social Model of Non-Psychotic Mental Health Problems in Community Health Services..	45

Figure

1. Prevalence of Single and Comorbid Anxiety, Affective and Substance Use Disorders amongst Australian Adults in the Past Year	10
2. Percentage of Children and Adolescents Scoring in the Clinical Range of the Child Behaviour Checklist Attending Each Service	12
3. The Burden of Illness by Major Category of Mental Disorder, 1996	13
4. Victorian Health Promotion Foundation, Mental Health Promotion Framework	22
5. Community Health Counselling Clients per 100,000 Population, 1999–2000	23
6. Age Distribution of Community Health Counselling Casework Clients, 1999–2000	24
7. Female Disability Adjusted Life Years for Non-Psychotic Mental Health Problems by Region	25
8. Male Disability Adjusted Life Years for Non-Psychotic Mental Health Problems by Region	25
9. Components of a Unit of Counselling Casework	27
10. Mean Consultations per Counselling Client, 1999–2000	28
11. Counselling Funding as a Proportion of Community Health Program Funding across Regions	32
12. Burden of Non-Psychotic Mental Health Problems by Region	33
13. Regional Mental Health Weightings for Burden of Non-Psychotic Mental Health Problems	34
14. Differentials in YLD Rates between Top and Bottom Quintiles of Socioeconomic Disadvantage, Selected Mental Health Disorders, Australians Aged 18 Years and Over, Australia 1996	38
15. Burden of Non-Psychotic Mental Health Problems and Socioeconomic Status for Metropolitan Melbourne Local Government Areas	38
16. Barriers to Obtaining Help for Children and Adolescents with Mental Health Problems	40

Executive Summary

Review of Counselling Services in Community Health

1. The Review of Community Health Counselling is being undertaken to improve the Department of Human Services' capacity to plan for and fund accessible and high quality counselling services in community health services across Victoria. This report on Stage One of the Review contains information and recommendations that will assist the Department in making decisions on resource allocation for counselling services in community health.

Stage Two of the Review will primarily be concerned with specifying issues related to the role of Community Health Program funded counselling in community health services within the broader primary care system, as well as the type and quality of such services.

Mental Health Problems and Counselling

2. The projected social and economic consequences of growing levels of non-psychotic mental health problems—such as anxiety and depression—are prompting governments to tackle these problems more systematically than in the past. Mental disorders were the third largest group of conditions contributing to the burden of disease in Victoria, ranking behind cancers and cardiovascular diseases. Depression was the greatest cause of disability in both men and women. Eighteen per cent of the Australian adult population meets the WHO diagnostic criteria for non-psychotic mental health problems, including anxiety disorders (10 per cent), affective disorders (6 per cent) and substance use problems (8 per cent). In children and adolescents, a similar proportion were reported as having mental health problems.
3. There is good evidence from outcome studies conducted elsewhere in the world that there are effective counselling interventions for depression, anxiety disorders, problem drinking and smoking and that provision of short term counselling may reduce general health care service utilisation and costs. There is also evidence that for people with more serious non-psychotic mental health problems, the integration of drug therapies and counselling gives superior outcomes to either used alone.

Mental Health Policy Responses

4. In Australia, there is increasing community, political and economic interest in policy development and service planning to better address anxiety and depression. There is evidence, however, of a lack of coordinated policy to effectively integrate these disparate developments.
5. The Second National Mental Health Plan seeks to place anxiety and depression on the agenda of state and federal governments and to develop a coherent service system to address these problems. In contrast, government mental health services have to date focused exclusively upon the much less prevalent, but individually more disabling, mental illnesses of psychosis, such as schizophrenia and bipolar affective disorder. Interventions for anxiety and depression are presently available through general practitioners, community health services, mental health services and private practitioners.

Needs Met through Counselling in Community Health

6. In 1999–2000 generalist counselling services funded through the Community Health Program in Victoria provided 112,000 occasions of service to 21,500 people, averaging 5 occasions for each person (1999/2000). Just on two thirds of those seen for counselling were female. Age distribution, compared to that seen in the populations they serve, is distinctly biased to those between 25 and 45 years of age.

7. According to the Australian Survey of Mental Health and Well Being, 18 per cent of the population has significant non-psychotic mental health problems, one third of whom will express a need for assistance with mental health problems each year. This represents 282,000 people in Victoria. About half of those seeking help will do so through a general practitioner. The balance of those with non-psychotic mental health problems, (3 per cent or 141,000 people), seek assistance from a range of other services, presumably including community health services.
8. This analysis suggests that at present, community health counselling serves up to 7.5 per cent of those people seeking help for these non-psychotic mental health problems. Counselling in community health represents the most systematic effort to provide intervention for this population. The data also indicate that there is very considerable unmet need that could lead to new demand, through public campaigns to raise awareness about these mental health problems and relevant services. It is likely therefore that the forthcoming public awareness campaign to be conducted by Beyond Blue will significantly impact upon counselling services in community health services.
9. Statewide, there is a clear trend that problems of depression and anxiety are predominant amongst females. Among males, depression and alcohol problems are predominant. It is clear that problems of depression, anxiety and alcohol use are the main features of people who are likely to benefit from counselling in primary care settings. In children and young people depression, anxiety and behavioural problems are the most common problems reported.
10. While the pattern of relative problems is the same across Victoria, the overall magnitude of problems differs significantly between regions. Specifically, the regions with greatest social disadvantage—Western, Northern and Barwon South-Western—also have the greatest burden of illness from these non-psychotic mental health problems. Eastern Metropolitan Region, with the least social disadvantage, has the least burden of non-psychotic illness.

Counselling Casework Interventions in Community Health

11. Community health counselling has long been a significant and established part of community health services, providing diverse services for people of all ages with social, emotional and psychological problems. These counselling services are delivered to individuals, groups and families in community, home and other settings.
12. Examining the distribution of the number of consultations by clients shows a trend towards most clients being seen for 1 to 3 consultations and only very few for a number of consultations greater than 5 to 7 consultations. The evidence from research outcome trials for counselling for anxiety and depression indicates that a minimum of 6 to 12 consultations are required to effect significant positive change. The message here is that few clients seem to be receiving enough counselling to make a difference in their wellbeing and social functioning.
13. Most counsellors participate on a roster basis in a general intake system for their community health service. The counselling service is therefore central to the quality of access generally to the community health service. Most counsellors are aware of the Better Access to Services (BATS) initiatives connected to the Primary Care Partnership Strategy. Current work on the Initial Needs Identification (INI) Tool has meant that these staff are becoming more directly engaged in this key initiative.
14. Because counselling services have differing approaches to the management of waiting lists and the priorities given to clients on them, the available data on waiting lists is inconsistent.
15. In the absence of complete statewide data sets, defining clients by their presenting problems, data for individual counselling services in community health indicate that problems of anxiety, depression and family and relationship conflict are the most common problems seen.

Resource Allocation for Counselling Casework in Community Health

16. As part of this Review, alternative policy and funding approaches for community health counselling were examined. Support was received for recognising the significance of burden of non-psychotic mental health problems in the funding formula for allocating new funds. The present community health funding formula was adjusted to include a 15 per cent weighting for the burden of non-psychotic illness. In general, the introduction of the weighting for non-psychotic mental health is in the same direction as the previous weighting for socioeconomic disadvantage.
17. As an outcome of the Review, to plan for the use of the new and reallocated funds for generalist counselling in community health services, regional offices were requested to consider guidelines related to the following priorities for 2001–2002:
 - Improving the credibility and profile of community health counselling services.
 - Equity between community health services.
 - Primary Care Partnerships—support for the Better Access to Services initiatives.
 - Priority for local government areas with highest burden of non-psychotic mental health problems.

A Social Health Approach to Counselling in Community Health

18. There is considerable evidence underpinning the model used by the Victorian Health Promotion Foundation—that non-psychotic mental health problems are primarily related to social disadvantage, alienation and low social status. This mental health promotion model is generally consistent with the counselling approach taken in community health services and provides a useful foundation for future policy development.
19. The policy context in the Community Health Program should give a central role to the social and economic causation and remediation of non-psychotic mental health problems. Specifically, the program should adopt a social model of these problems and advocate for and support approaches that integrate across government and communities, counselling, health promotion, and community, social and economic policy initiatives.
20. Counselling in community health should refocus its efforts to give priority to the greatest burdens of non-psychotic mental health problems, including anxiety and depression.
21. An increased emphasis should be given to adopting, refining, developing and widely disseminating evidence-based approaches for counselling delivered in community health.
22. Counselling in community health should continue to provide a mix of counselling, practical assistance, service coordination, case advocacy and social support. It should emphasise the delivery of a broad range of professional counselling services by competent practitioners with tertiary qualifications in counselling.
23. The Community Health Program should support improved service planning, quality improvement, competency development, research and evaluation activities designed to improve the quality of community health counselling casework services.
24. ‘Upstream’ interventions, including health promotion and the School Nursing Program, should be linked with counselling casework services, to better address non-psychotic mental health problems in community health settings.
25. Because of the cost-benefits, early intervention for children and adolescents with non-psychotic mental health problems—specifically those with a parent or siblings with these problems—should be given a greater priority in community health counselling.

26. Community health counselling services should address behaviours that are associated with anxiety and depression, giving a priority to smoking, alcohol and pharmaceutical drug use.
27. Community health services should widely advocate with communities, industry and governments for improved responses to the most common mental health problems, including anxiety and depression.
28. In partnership with the Victorian government's mental health program, the community health program should be a leader in representing the needs of people with non-psychotic mental health problems. In addition, the program should actively contribute to ensuring that the social and economic origins of these problems are acknowledged and addressed in policy development and service planning.
29. In partnership with the Divisions of General Practice, the new Primary Mental Health and Early Intervention Teams, schools, non-government organisations and local communities, Victoria's community health services should contribute to the development and effective delivery of a system of services for people with non-psychotic mental health problems.

1. Rationale for the Review

Historically, affordable generalist counselling has been available from community health services, some local governments and non-government organisations. The last few years have seen an expansion of some specialist counselling services provided in community health settings for problems of gambling, drugs and alcohol and family support.

The Government has responded to the increasing demand for generalist counselling and the need to expand access to high quality, accessible and affordable counselling in community based settings, by providing an additional \$10.6 million over three years (from 2000–01) for the expansion of counselling services. This additional funding will augment the \$11.9 budget that existed in 1999. In 2001–02 the Community Health Program allocation to counselling related activities in community health services across Victoria has increased to \$15 million.

In addition to expanding services, the Department has a commitment to addressing a range of issues relating to the quality and consistency of generalist counselling that it funds through this program. More generally, over time the Community Health Unit will develop a comprehensive policy framework, which will aim to improve its responses, including counselling, to the range of psychosocial needs of local communities.

1.1 A Framework for Counselling Casework, 1999

In January 1996 the Department of Human Services (DHS) tendered for a project to develop a trial framework for counselling services in the then Primary Care Division of the Department. The central aim of the project was to develop a taxonomy of counselling service types provided in the community sector, in order to improve the way in which the Department funded and planned for community-based counselling.

A Framework for Counselling Casework (DHS, 1999) was developed and was underpinned by the following assumptions:

- That interventions need to be informed by scientific evidence (evidence-based practice) and expert consensus about interventions where available.
- Features of effective counselling casework should underpin a service delivery framework.
- Guidelines and protocols are needed to support a service delivery framework.
- Practitioners whose main job role is counselling need to have minimum qualifications.

In December 1997 there was in principle support and positive feedback on the framework from the field. The paper was published and widely distributed as an information resource for primary care and community support services. The Community Health Unit now wishes to build upon Framework for Counselling Casework (DHS, 1999) with a specific focus on counselling services in community health.

1.2 Counselling Related Initiatives in the Community Health Program for 2000–2002

The Community Health Program has embarked on a number of initiatives during the 2000–2002 financial years, of which a two-stage review of counselling services in Community Health is one element.

Other key initiatives comprise:

- Additional funding of \$2.3 million in 2000–2001 and \$1.4 million in 2001–2002 has been allocated to increase the availability of counselling in local community health services and relevant statewide services.
- Support for community health services that will assist their involvement in the Better Access to Services (BATS) policy framework of the Primary Care Partnership Strategy.

- Additional recurrent funding of \$150,000 has been allocated to statewide language service providers, to increase access to language services for clients of community health services.
- During 2001 funds of up to \$300,000 have been allocated on a submission basis to service development projects designed to address issues relating to recruitment and retention for counselling practitioners in community health services in rural and remote Victoria.

1.3 Review of Community Health Counselling

The Review of Community Health Counselling has been undertaken to improve the Department of Human Services' capacity to plan for and fund accessible and high quality counselling services through the Community Health Program, in community health services across Victoria. This objective will be achieved in two stages.

Stage One

The purpose of Stage One is to provide information and recommendations that will assist the Department to make decisions on resource allocation of Community Health Program funded counselling services in community health across Victoria.

To begin addressing this issue, a primary focus of Stage One will be to describe and analyse the range of counselling activities undertaken in community health services and funded by the Community Health Program of the Rural and Regional Health and Aged Care Services Division, Department of Human Services. In broad terms, this profile will include an analysis of counselling services provided in community health: nature and type of services, client profiles, issues of demand and referral processes.

Stage Two

Stage Two of the Review will primarily concern itself with issues related to the role of Community Health Program funded counselling in community health services within the broader primary care system, as well as the type and quality of such services.

This Stage will include an analysis of relevant data and the provision of recommendations to assist the Department to address the following questions and issues:

- The role of community health counselling services in the primary care service system.
- The type of counselling provided by community health services (for example long/short, generalist/specialist).
- People's entitlements to counselling including targeting and fees policy.
- The quality of counselling services offered in community health.

1.4 Reference Group

The Review was supported by a Reference Group that met monthly throughout the course of the project. The composition of the Reference Group reflects a cross section of stakeholders, both within and outside of the Department. The Reference Group have been very active participants in refining the methodology for the Review and contributing to a consideration of the findings. The membership and meeting schedule for the Reference Group are described in Section 10 of this report.

1.5 Scope of the Report and Feedback

This report has been prepared by the consultants, People Care Australia, to meet the requirements for Stage One of the project brief. The report provides information and aspects of policy pertaining to counselling that will be considered in Stage Two to inform the development of a framework and guidelines for counselling in community health services. The report describes an improved method for resource allocation to achieve needs-based funding of counselling services. Finally, the

relationships between social disadvantage and non-psychotic mental health problems are described and possible new directions outlined for counselling in community health. In Stage Two, the role and functions of counselling in community health services will be fully developed and described and a plan for implementation proposed.

1.6 An Important Note About Terminology and Policy Development

It should be noted that this report follows the convention used in a number of recent surveys of mental health and wellbeing and mental health policy documents by distinguishing between psychotic (serious mental illness) and non-psychotic mental health problems. While this may be a convenient distinction, the use of these terms in this report is not meant to imply that counselling services in community health do not see people with psychoses or that specialist mental health services only see people with psychoses. A more sophisticated analysis of the needs of people with mental health problems is required as a basis for future service planning across primary care services in Victoria.

The development of new mental health services in primary care settings like community health services challenges policy development to better define the respective roles and responsibilities of general practitioners, community health counsellors and specialist mental health services. As a consequence of the work described in this report, the Department of Human Services is now developing a framework to provide guidance for agencies about the respective functions and target populations of these three service sectors. This work will be presented in detail in the Stage Two Report.

2. Mental Health Problems and Counselling

2.1 Overview

The burden of non-psychotic mental health problems among adults and children is growing, especially anxiety and depression. These have now become the main mental health problems in Western countries.

The projected social and economic consequences of increasing prevalence of non-psychotic mental health problems, such as anxiety and depression, are prompting governments to take these problems more seriously than in the past.

There are two main drivers for the recent attention being given to drug therapies and counselling services by Western governments. First, evidence that several mental health problems not previously considered as serious are major contributors to ill health and have substantial economic costs. Second, evidence that there are effective drug and counselling interventions for addressing these problems.

2.2 Emerging Knowledge about Mental Health Needs

The *Global Burden of Diseases Study* (Murray, 1996) considered both the number of years lived with various disorders and the burden of associated disability.

In developed countries unipolar major depression, alcohol use, and self-inflicted injury were all amongst the ten leading causes of years lived with a disability, and all three were associated with a higher burden of disease than either schizophrenia or bipolar disorder. In both developing and developed regions, depression is the leading cause of disease burden for women.

Table 1. Leading Causes of Years Lived with Disability in Developed Regions, 1990

Illness	Percent of total
Ischaemic heart disease	9.9
Unipolar major depression	6.1
Cerebrovascular disease	5.9
Road traffic accidents	4.4
Alcohol use	4.0
Osteoarthritis	2.9
Trachea, bronchus and lung cancers	2.9
Dementia/degenerative CNS disorders	2.4
Self-inflicted injuries	2.3
Congenital abnormalities	2.3

Source: Murray 1996

The above findings on adults are also reinforced by a major international survey conducted in 1994, which found that the community prevalence of depression, suicide, suicidal behaviours, and other psychosocial disorders were all increasing rapidly among young people throughout Europe and North America (Rutter & Smith, 1995). Similar patterns are emerging and being recognised by community leaders in Australia. Interestingly, in Australia counselling services for children and adolescents are well established in specialist settings, but tend not to be part of the routine work of general counselling services.

The *WHO Collaborative Project on Psychological Problems in General Health Care* (Ustün & Sartorius, 1995) was carried out in 14 countries with 25,916 persons aged 18 to 65 consulting health care services. The results of this study show that psychological problems constitute a major public health problem worldwide because:

- They are frequently expressed needs of people seen in primary health care settings.
- Can have severe consequences for individuals and societies.
- Existing effective treatments are not currently being applied to a sufficient degree.

Disability levels among primary care patients with a psychological disorder were greater, on average, than disability levels among patients with common chronic physical diseases such as hypertension, diabetes, arthritis and back pain. Many of the patients with psychological problems were neither recognised, nor treated sufficiently, despite their high levels of disability.

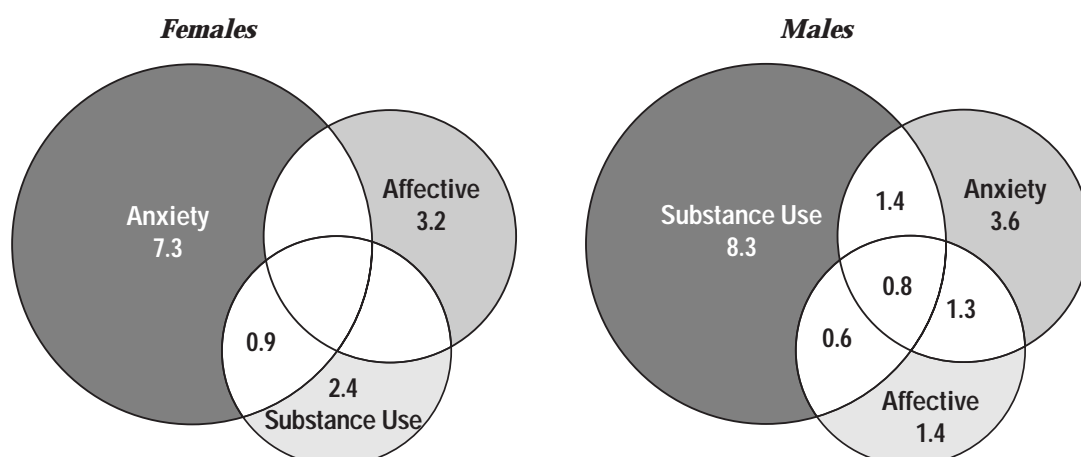
These findings reinforce the significance of levels of disability and service utilisation for mental health problems that are not classed as serious mental illness.

2.3 The Mental Health and Wellbeing of Australians

For the first time in Australia’s history the community prevalence of mental health problems has been determined. In 1997-98 the Australian Bureau of Statistics (ABS) conducted several large-scale community surveys designed to describe the community prevalence of mental health problems. The first report described the nature and frequency of non-psychotic mental health problems and service utilisation in Australian adults aged 18+ years (ABS, 1998). A report on the mental health problems of Australian adolescents and children has more recently been released (ABS, 1999).

In the Australian community, eighteen per cent of the adult population meets the WHO diagnostic criteria for non-psychotic mental health problems including anxiety disorders (10 per cent), affective disorders (6 per cent) and substance use problems (8 per cent). An additional 3 per cent of people have serious mental disorders such as schizophrenia, bipolar affective disorder, dementia and personality disorders. As shown in the following figure, there are distinct gender trends, with substance use problems and anxiety and depression being more common in men and women respectively. Around 40 per cent of these men and women also have chronic physical health problems, including cardiac, respiratory disorders and arthritis.

Figure 1 Prevalence of Single and Comorbid Anxiety, Affective and Substance Use Disorders amongst Australian Adults in the Past Year



Source: Andrews et al 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 below. Broadly, these problems can be divided into internalising problems—bodily (somatic) complaints, being withdrawn, anxious and depressed—and externalising problems through aggressive and delinquent behaviour.

Table 2 Prevalence (%) of Children’s Mental Health Problems in Specific Areas

CBCL Scale	All Children	4–12 years		13–17 years	
		Males	Females	Males	Females
Somatic Complaints	7.3	7.2	5.6	10.6	6.8
Delinquent Behaviour	7.1	7.4	7.8	6.4	5.9
Attention Problems	6.1	7.4	6.2	4.8	4.6
Aggressive Behaviour	5.2	5.9	5.2	5.0	4.0
Social Problems	4.6	6.5	3.9	3.8	3.0
Withdrawn	4.3	5.4	2.9	4.8	4.2
Anxious/Depressed	3.5	4.1	2.9	3.6	3.6
Thought Problems	3.1	3.2	2.7	3.4	3.1

Note: CBCL = Child Behaviour Checklist

Source: Sawyer et al 2000, p.10.

While not all these adults and children with mental health problems will express their need by requesting counselling services, these prevalence estimates provide a basis for 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. Data is also available on the physical comorbidities that coexist with each of the mental health problems, including back pain, headache, and chronic illness.

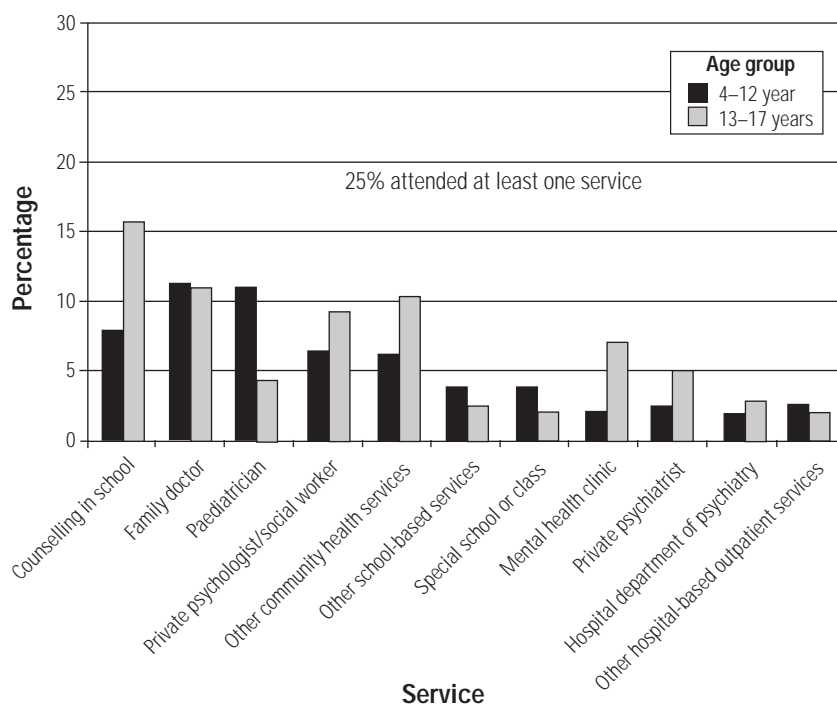
A second important feature of the report is that it describes what services people with mental health problems use (expressed need) and whether these services have met their needs in the last 12 months. These data set a baseline for how people with mental health problems use services to address their needs.

Of adults with non-psychotic mental health problems, over 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 and with good effect.

About half of adults with non-psychotic mental health problems consult with their general practitioner for assistance with these problems each year. 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 service providers in a year.

Among children and adolescents with mental health problems, 25 per cent attended at least one service for help in the past year. As shown in Figure 2 below, most saw a school counsellor, family doctor or paediatrician.

Figure 2 Percentage of Children and Adolescents Scoring in the Clinical Range of the Child Behaviour Checklist Attending Each service



Source: Sawyer et al 2000, p.28.

Questions arise from this analysis for Australian adults and children with mental health problems:

- Where is the capacity to deliver counselling to these adults and children each year in Victoria?
- To what extent does this capacity already exist?

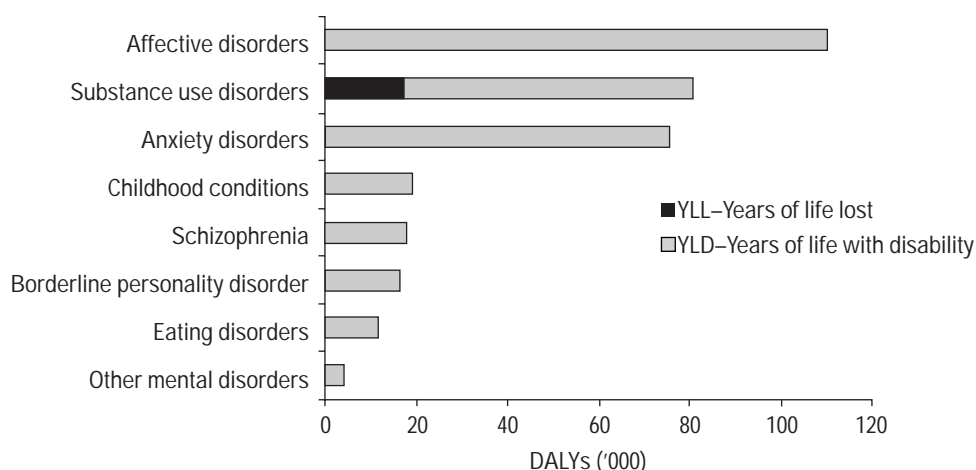
Using these recent findings on the prevalence of mental health problems, the Review of counselling services will contribute to the improved planning of generalist counselling by community health services for their local areas.

2.4 The Burden of Mental Disorders in Victoria, 1996

Between 1998 and 1999, a burden of disease assessment was carried out in Victoria, applying and improving on the methods of the Global Burden of Disease Study (Vos et al, 2001). The National Survey of Mental Health and Wellbeing provided data on the occurrence of the major adult mental disorders in Australia. Data from international studies and expert advice further contributed to the construction of disease models, describing each mental health condition in terms of incidence, average duration and level of severity, with adjustments for comorbidity with other mental disorders.

Mental disorders were the third largest group of conditions contributing to the burden of disease in Victoria, ranking behind cancers and cardiovascular diseases. As shown in Figure 3 below, depression and affective disorders were the greatest cause of disability in both men and women. Eight other mental disorders in men and seven in women ranked among the top twenty causes of disability.

Figure 3 The Burden of Mental Illness by Major Category of Mental Disorder, 1996



Source: Mathers et al 1999, p.38.

2.5 Emerging Knowledge about Effective Counselling Interventions

There is good evidence from outcome studies conducted in several parts of the world that there are effective counselling interventions for depression, anxiety disorders, problem drinking and smoking and that provision of short term counselling may reduce general health care service utilisation and costs (Department of Human Services, 1997 *Opening the Door on Counselling*).

Psychosocial interventions for anxiety and depression, such as those delivered in counselling services in community health, have been compared to medications, in several scientific trials, including cost-effectiveness studies, for these problems with the following findings.

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

Taking into account the costs of noncompliance with medications and relapse requiring further treatment, 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 non-psychotic mental health problems the integration of biomedical and psychosocial approaches gives superior outcomes to either used alone.

Effective approaches to intervention for depression and anxiety disorders 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 twenty consultations over twelve to twenty weeks, by counsellors adhering to therapy manuals.

The Review of counselling services will make recommendations concerning the best means for achieving an evidence-based approach to the provision of counselling in community health services.

2.6 Investment in Health Services for Mental Disorders in Australia

As shown in Table 3 below, investment in health services for mental health problems in Australia has principally been directed to dementia, severe depression, schizophrenia and substance use problems. This has been driven by the high level of disability for each person with these problems and the impact on their families. In contrast, the high prevalence mental health problems identified in the National Survey of Mental Health described earlier, while affecting many more people, have a lower level of individual disability. These non-psychotic mental health problems have existed as a quiet epidemic without significant community awareness until recently.

Less than 2 per cent of the mental health budget is spent on the mental health problems of children and adolescence. This probably reflects their problems being early in their course of development and their not being recognised or appreciated as likely precursors to more severe mental health problems in ensuing years.

Table 3 Mental Health: Health System Costs by Health Sector, Australia 1993–94 (\$million)

	Hospital ^(a)	Medical ^(b)	Pharma- ceuticals	Other Health Services ^(c)	Other ^(d)	All sectors	Percent of total
Dementia	110	11	2	9	582	714	23.6
Substance abuse disorders	136	46	12	18	136	348	11.5
Schizophrenia	275	26	8	106	40	454	15.0
Other non-drug psychosis	63	5	1	6	53	128	4.2
Affective disorders	217	141	68	70	148	644	21.3
Anxiety disorders	24	102	51	25	37	239	7.9
Personality disorders	24	7	1	12	9	53	1.8
Stress and adjustment disorders	28	27	7	31	19	112	3.7
Mental retardation	16	1	0	3	5	26	0.9
Disorders of psychological development	2	2	0	3	10	16	0.5
Eating disorders	14	3	0	1	4	22	0.7
Disorders of childhood adolescence	10	9	1	19	16	55	1.8
Behavioural syndromes and other mental disorders	17	53	45	9	50	174	5.8
Unspecified mental disorders prevention and screening	5	6	2	23	1	37	1.2
Total	941	438	199	334	1,110	3,022	100.0

Notes:

(a) Public and private acute hospitals, repatriation hospitals and psychiatric hospitals. Excludes public hospital non-admitted services.

(b) Medical services for private patients in hospitals are included under Hospitals.

(c) Includes hospital non-inpatient services, specialised community mental health services, residential and non-residential treatment services run by non-government organisations, and allied health services.

(d) Includes National Drug Strategy funding for prevention, research expenditure and other institutional, non-institutional and administration expenditure. Does not include expenditure for other public health services, non-specialised community health services, ambulances, or medical aids and appliances.

Source: AIHW analysis of health expenditure data, Mathers et al 1999, p.90.

3. Mental Health Policy Developments

3.1 Overview

In Australia, there is increasing community, political and economic interest in policy development and service planning to better address anxiety and depression. There is evidence, however, of inadequate policies unable to effectively integrate these disparate developments.

The Second National Mental Health Plan seeks to place anxiety and depression on the agenda of state and federal governments and to develop a coherent service system to address these problems.

In contrast, government mental health services worldwide have to date focused exclusively upon the much less prevalent, but individually more disabling, mental illnesses of psychosis, such as schizophrenia and bipolar affective disorder.

Interventions for anxiety and depression are presently available informally through general practitioners, community health services, mental health services and private practitioners, but have not been specifically planned for by governments.

Counselling services and mental health promotion in community health services should progress to form distinctive and significant components of a system of services for problems leading to anxiety and depression.

3.2 Commonwealth Policy and Service Developments

Since 1998 the Commonwealth government has given increasing attention to non-psychotic mental health problems—specifically anxiety and depression—both in the National Mental Health Strategy and several other programs described in this section.

3.2.1 Second National Mental Health Plan 1998–2003

One of the key principles of the *First National Mental Health Policy* was that priority should be given to people with severe mental health problems and mental disorders. An unforeseen consequence of this has been that public mental health services have excluded people seen as having less serious conditions and have erroneously equated severity with diagnosis, rather than level of need and disability.

The Second National Mental Health Plan focuses on ways to promote mental health, reduce the incidence and prevalence of mental disorders and address associated disability. To encourage the provision of a mix of education, health and welfare, employment and income support services, this plan places major emphasis on the need to forge linkages and partnerships, in collaboration with stakeholders and agencies providing primary care health services and community support.

3.2.2 National Health Priority Areas Initiative

The National Health Priority Areas initiative, which is a collaborative effort between Commonwealth, State and Territory governments, has targeted depression as a primary focus. Mental health activity under the National Public Health Partnerships also includes a focus on depression.

3.2.3 National Youth Suicide Prevention Strategy

A total of \$31 million was allocated over 1995–99 for the National Youth Suicide Prevention Strategy (NYSPPS). The four goals of the NYSPPS were:

- Prevent premature death from suicide among young people.
- Reduce rates of injury and self-harm.
- Reduce the incidence and prevalence of suicidal ideation and behaviour.
- Enhance resilience, resourcefulness, respect and interconnectedness for young people, their families and communities.

Major achievements under the National Youth Suicide Prevention Strategy included:

- Parenting skills programs implemented nationally, using proven primary prevention and early intervention approaches. Included development and distribution of brochures promoting skills for parenting children and adolescents.
- Training programs delivered to over 2,500 general practitioners and community health workers, rural, Aboriginal and Torres Strait Islander communities and other community members and tertiary students in medicine, nursing, teaching, journalism, youth work, and juvenile justice.
- LIFE—a national framework for suicide prevention has been developed, which can be used by the whole community.
- Appointment of a National Advisory Council on Youth Suicide Prevention that brings together Commonwealth, State and Territory governments, community representatives and technical expertise to ensure a national and coordinated approach to suicide prevention.
- Initiation of suicide prevention strategies in each state and territory of Australia. (Only Western Australia had a youth suicide prevention policy prior to the development of the National Strategy).
- Identification of effective models for intervention and prevention of suicide in emergency, mental health, youth and community services.
- Publication of a national stocktake of over 1,000 suicide prevention programs.
- Suicide prevention Internet sites (such as 'ReachOut!') and extensive research and information publications for a range of audiences.
- Grants to States and Territories for boosting rural and regional youth counselling services. Funding for telecounselling services such as Kids Helpline and Lifeline.

3.2.4 Commonwealth Regional Health Strategy

The Regional Health Services Program is being substantially expanded, with a budget allocation of \$68.9 million providing 85 additional services to be established nationally over the next four years (from 2000–01). The aim of the program is to work with rural communities to identify local priorities and develop and support integrated services to address these priorities. A wide range of services is being supported under the program, including counselling and mental health services.

3.2.5 Commonwealth More Allied Health Services Program

The *More Allied Health Services Program* aims to improve the health of people living in rural communities by providing additional allied health services, in both quantity and range, to rural areas. The Federal Government has committed \$49.5 million over four years (from 2001–02) to this Program for the employment of more allied health professionals. These allied health professionals will include mental health workers, psychologists and counsellors. More Allied Health Services program will encourage stronger links between local General Practitioners and allied health professionals.

3.2.6 Medicare arrangements

In the 2001–2 Commonwealth budget, several adjustments have been announced to the Medicare arrangements affecting the capacity for general practitioners to provide and access mental health counselling services. These include provision for longer consultations and subsidies for allied mental health services.

The Review of counselling services will consider the relationship of expanded counselling services in community health services to the mental health initiatives forming part of the Regional Health Strategy, More Allied Health Services Program and the new Medicare arrangements.

3.2.7 SPHERE: A National Depression Project

The SPHERE Project was launched in February 1998 as a Commonwealth funded support and education system designed to assist general practitioners to identify and treat the common forms of depression and anxiety. Specifically, the Project stresses the critical role general practitioners can play in providing a comprehensive 'Disease Management Program' for patients suffering from common psychological disorders. The SPHERE Project is currently in contact with just under 3,000 general practitioners nationwide, with over 1,200 enrolled in the 'Case-Identification System' and over 1,000 participating in the SPHERE continuing medical education programs. Overall, more than 46,000 primary care patients were screened for psychological and somatic distress in 1998 and 1999.

3.2.8 Beyond Blue—National Depression Initiative

Beyond Blue was established in 2000 as a \$35 million five year initiative by the Federal and Victorian Governments to reduce the prevalence of depression in Australia. Further financial contributions have been committed from other state and territory governments. Initial work will focus on lifting community awareness, improving the management of depression in general practice and developing a national schools-based education program.

3.2.9 Mind Matters—National Mental Health Promotion for Secondary Schools

Almost 20 per cent of all children and adolescents in Australia may have experienced mental health problems, with half of these showing impaired schooling and social development. Depression is the most common of these problems, with up to 24 per cent of young people having experienced some form of depression by age 18 years. Related manifestations may include self-harm, suicidal ideation and behaviour, eating disorders and the abuse of alcohol and drugs.

MindMatters is a national mental health promotion program for secondary schools being conducted with funding from the Commonwealth Department of Health and Aged Care. MindMatters emphasises a whole school approach to mental health promotion and suicide prevention and aims to enhance the development of school environments where young people feel safe, valued, engaged and purposeful.

3.3 Victorian Department of Human Services—Mental Health Branch

In Victoria, a number of new and expanded service programs outlined in the following sections have been funded by Government to address non-psychotic mental health problems. Several of these initiatives have been developed independently and there are opportunities for stronger coordination across local communities to enhance the development of a coherent system of services. Community health services, because of their local knowledge, networks and service histories, are well placed to contribute to this coordination.

3.3.1 Mental Health Policy

The Victorian Government's recent mental health policies highlight several priority areas. These include support for the Second National Mental Health Plan, improving access to mental health services and developing a more inclusive mental health service system

Victoria is undertaking three initiatives associated with the Second National Mental Health Plan:

- Development of Community Mental Health Plans.
- Planning, development and implementation of primary mental health and early intervention teams (PMH and EIT).
- Planning for development and implementation of a specialist early intervention service initiative targeted to adolescents and young adults at risk of psychosis.

3.3.2 Community Mental Health Plans

These will form part of the Primary Care Partnership Strategy Community Health Plans and will involve the following:

- Review of local community populations' mental health needs (population will be based on Adult Clinical Area Mental Health Service catchments).
- Identification of priority target areas.
- Identification of gaps and barriers to effective service provision.
- Identification of the range of strategies required to meet the current and future mental health needs of the population, across the continuum of care.
- Priorities for service development.

The Review of counselling services will recommend what contribution counselling in community health services will make to the development of Community Mental Health Plans.

3.3.3 Primary Mental Health and Early Intervention Teams (PMH and EIT)

The objectives of the Primary Mental Health and Early Intervention Teams are to:

- Improve access to, and the quality of, mental health services provided by specialist and primary health care providers to people across their life span.
- Support and enhance the capacity of a range of primary care providers, in the first instance community health services and general practitioners, to recognise and treat mental health problems and disorders more effectively, via the provision of education, training and secondary consultation.
- Promote shared-care arrangements between specialist mental health services and primary care providers.
- Provide a more timely response to people experiencing, or at risk of experiencing, crisis as a result of a mental disorder.
- Provide 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 will occur through community-based public facilities or on an outreach basis.

Challenges exist in bringing together the traditionally separate services, ideologies and practices of mental health and community health. The Review of counselling services will inform the development of the relationships between the Primary Mental Health Teams and counselling services in community health.

3.4 Department of Human Services—Community Care Division

3.4.1 Enhancing Family Support Services

Enhanced services will be developed to help families who require a level of assistance to provide a safe, nurturing and stable environment for their children. The target group includes families that may require one-off or short term assistance for a single issue. This may be in the form of individual information and advice, or participation in group education or skills building activities. The target group also includes families with multiple and complex needs who require direct intervention as well as coordination (case management) of a range of specialist services, such as drug and alcohol or mental health services.

3.4.2 Victorian Parenting Services

These services have been set up to assist parents and families with children aged 0 to 18 years and include:

- The Victorian Parenting Centre (VPC), a statewide service which has core functions of research and evaluation in the parenting area, training of professionals who work with parents, development of resources for use by parents and professionals and coordination of the Regional Parenting Resource Services (RPRS).
- Nine Regional Parenting Resource Services (RPRS) that provide information, advice and education to parents and professionals.
- The Positive Parenting Program (PPP), a statewide empirically-based parenting and family support system, coordinated through the VPC that aims to promote positive parenting practices.
- Three pilot Family Intervention Services, funded for three years to deliver the more intensive levels of the PPP to families experiencing higher levels of difficulty.
- Parentline. A statewide 24-hour telephone advice and referral service for parents. This service is co-located with the Maternal & Child Health Line.
- Early Parenting Centres provide assistance to families with children 0–3 years of age who are experiencing difficulty in the early years of parenting. Families may be admitted to centres for a residential stay, or attend the centre for a day stay program. Some centres offer home visiting and telephone advice.

The Review of counselling services will consider the relationship between community health services and the Family Support Services and Victorian Parenting Services and how better to support the delivery of counselling to families seen in community health services.

3.5 Department of Human Services—Primary and Community Health Branch

3.5.1 Primary Care Partnerships (PCPs)

Community Health Services, Psychiatric Disability Support Services, Community Care, Divisions of General Practice, local government and a range of other community services are currently participating in the formation of 32 Primary Care Partnerships (PCPs) across Victoria. The Primary Care Partnership Strategy aims to create a primary care service system by helping the Department of Human Services, local governments, providers and professionals to coordinate their work for clients they may have in common. The Primary Care Partnerships are formulating community health plans, which will address, in part, the needs for counselling and mental health promotion.

3.5.2 Better Access to Services

To guide the development of improved access to services for people presenting to primary care services Primary Care Partnerships will undertake several common strategies:

- Coordination of the Better Access to Services initiatives.
- Development of a local Initial Needs Identification tool.
- Development of a local Care Planning tool.

In 2001–02, each partnership will build on the Initial Needs Identification template to develop its own Initial Needs Identification tool. Partnerships can also choose to work with ‘neighbouring’ or other regional partnerships to develop shared and consistent Initial Needs Identification tools across partnership catchments. Partnerships can build on the care planning tool template developed by Department of Human Services and develop and implement an agreed care planning tool and associated processes and practices.

The Review of counselling services will develop recommendations for assessment that are consistent with the Better Access to Services concepts and that contribute to achieving the outcomes of improving access to services.

3.5.3 School Nursing Program

A comprehensive Secondary School Nursing Program has recently been introduced aimed at reducing risks to young people and promoting better health in the school community.

The policy commits the Government to an expanded school nursing program that focuses on primary health care and early intervention in the secondary school system. The specific goals of the Victorian Secondary School Nursing Program are to:

- Play a key role in reducing negative health outcomes and risk-taking behaviours among young people, including drug and alcohol abuse, tobacco smoking, eating disorders, obesity, depression, suicide and injuries.
- Focus on prevention of ill-health and problem behaviours by ensuring coordination between the school and community-based health and support services.
- Support the school community in addressing contemporary health and social issues facing young people and their families.
- Place nurses in areas of greatest health need and socioeconomic disadvantage.
- Provide appropriate primary health care through professional clinical nursing, including assessment, care, referral and support.
- Establish collaborative working relationships between primary and secondary school nurses, to assist young people deal with any difficulties in their transition from primary to secondary school.

Traditionally, generalist counselling services in community health have had a limited role in counselling young people and children. The Review will consider an expanded role for these services in community health and their relationship with the Primary and Secondary School Nursing Program.

3.5.4 Improving Counselling in Rural and Remote Victoria

Up to \$300,000 was allocated in 2000–2001 to undertake service development projects, which focus on service quality improvement in rural and remote Victoria consistent with the Government’s rural health policy.

To achieve the overall aim the project objectives are as follows:

- Development of strategies that address recruitment and retention of suitably qualified and experienced staff.
- Development of models that address priority issues for counselling, as identified by the local population.
- Development and implementation of programs, which engender collaboration between agencies, communities and professions.

The Review of counselling services will examine rural initiatives and their preliminary findings and use them to inform recommendations concerning initiatives to enhance services in rural and metropolitan areas.

3.6 Victorian Health Promotion Foundation—Mental Health Strategy

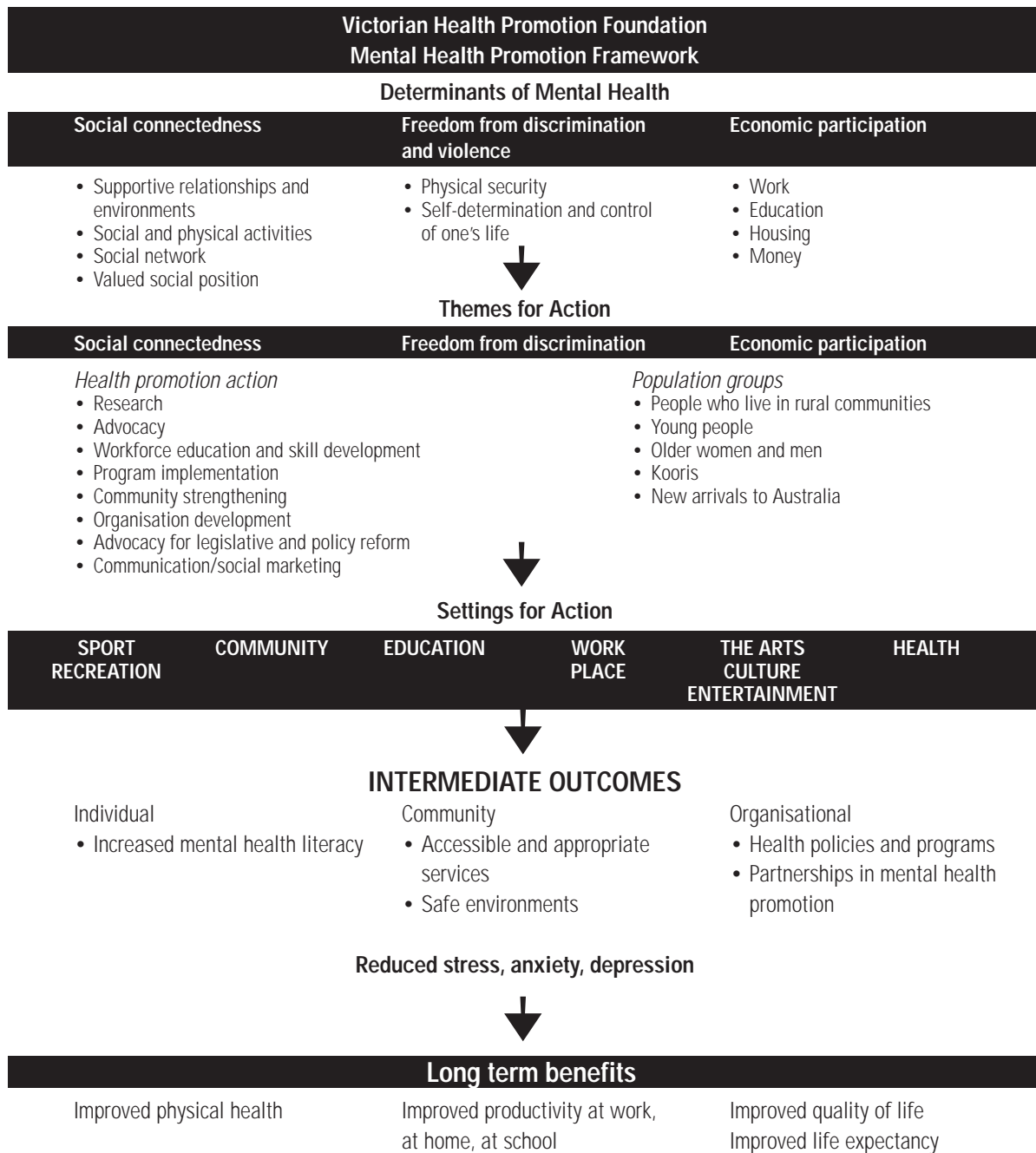
The Victorian Health Promotion Foundation has developed and published a mental health strategy based upon a social model of health to support its grant program for mental health promotion. This strategy is illustrated in the following Figure. Several community health services are grant recipients from the Foundation's mental health strategy. In general, this model of mental health promotion is consistent with the approach taken to counselling in community health services, especially in the emphasis given to the social determinants for non-psychotic mental health problems.

The Review of counselling will look at the activities being undertaken by community health services funded by these grants, and make recommendations concerning their relationship to generalist counselling services.

In Stage Two, the Review will consider the use of the Victorian Health Foundation's mental health promotion model as a possible basis for a more general social model for the delivery of mental health promotion and counselling in community health services.

In a later section in this report, the place of counselling as one component of the available mental health promotion interventions is developed further.

Figure 4. Victorian Health Promotion Foundation, Mental Health Promotion Framework



Source: Victorian Health Promotion Foundation, 1999, p.18

4. Needs Met through Counselling in Community Health

4.1 Overview

In 1999–2000, counselling services funded by the Community Health Program provided 112,000 occasions of service to 21,500 people. There was significant variation between regions regarding client numbers. Statewide, two thirds of those seen were females, and the age distribution, compared to that seen in the populations they serve, was biased to those aged 25–45 years of age. Children, young people and the elderly are under-represented in their use of counselling services in Community Health. Community Health counselling services are predominantly used by people on low incomes.

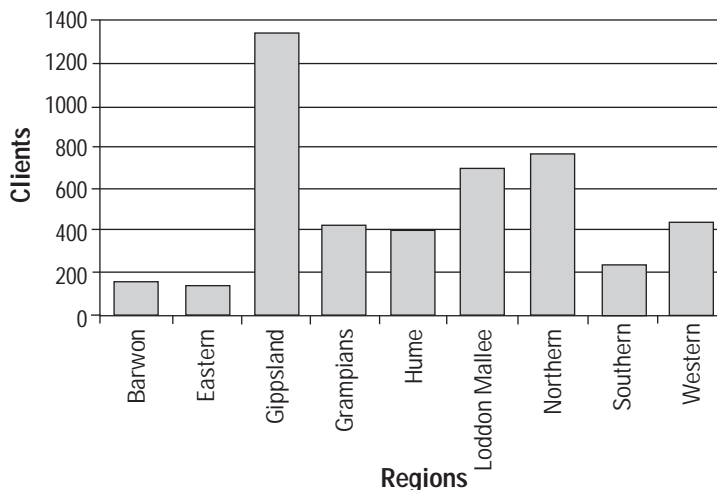
4.2 Client Profile of Community Health Counselling Services

In 1999–2000 generalist counselling services funded through the Community Health Program provided 112,000 occasions of service to 21,500 people each year, averaging 5 occasions for each person (1999–2000). Activities undertaken in running a counselling service, apart from the time seeing the person, included preparation, training, and quality assurance.

Little specification is given in service agreements with the Department of Human Services, apart from output targets in hours of counselling provided. As might be anticipated, there are wide variations in the individual profiles of clients seen for counselling in each of the community health services. The Gippsland Region, for example sees many more clients for counselling than do the other regions (Figure 5). As shown in the next section however, this is because they are not seen as often as clients seen by services in the other regions.

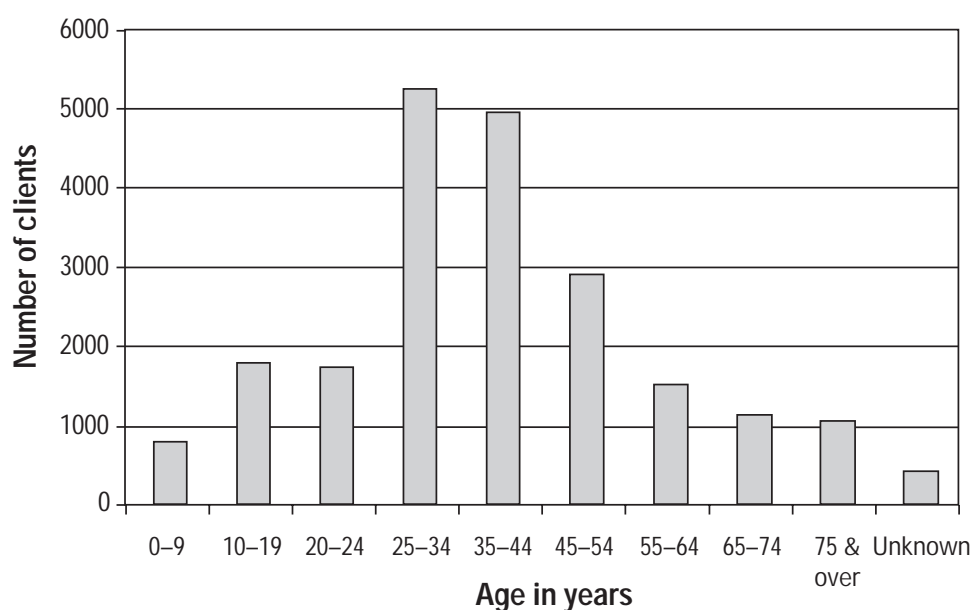
Just on two thirds of those seen for counselling were females, one third males. A notable feature of the clients seen for counselling in the community health services is that their age distribution, compared to that seen in the populations they serve, is biased to those aged 25–45 years of age (Figure 6). Children, young people and the elderly are under-represented in proportion to their numbers in the population and the known prevalence of non-psychotic mental health problems in these age groups.

Figure 5. Community Health Counselling Clients per 100,000 Population, 1999–2000



Source: Department of Human Services, Primary and Community Health quarterly reports, 1999–2000

Figure 6. Age Distribution of Counselling Casework Clients, 1999–2000



Source: Department of Human Services, Primary and Community Health quarterly reports, 1999–2000

4.3 Profile of Needs in the Community

According to the *Australian Survey of Mental Health and Well Being*, the size of the population with significant non-psychotic mental health problems is 18 per cent, a third of whom will express a need for assistance with mental health problems each year. This represents 282,000 people or 6 per cent of the population of Victoria. Many more people of course might express needs if services were more available than they are at present. About half of those seeking help will do so through a general practitioner, with an apparently satisfactory outcome. The balance of those with non-psychotic mental health problems (3 per cent or 141,000 people) seek assistance from a range of other services, including, presumably, community health services. This analysis suggests that at present community health counselling serves up to 7.5 per cent of those people seeking help for these mental health problems. Little is known about the range, nature and effectiveness of other services that people with mental health problems seek.

The Burden of Illness data for regions illustrates the type and magnitude of non-psychotic mental health problems that might be addressed in community health services. From this analysis have been excluded drug and gambling problems which are already planned and funded in community health services through other branches of the Department of Human Services. Among females, there is a clear trend across regions for problems of depression and anxiety to be predominant (Figure 7). Among males, depression and alcohol problems are predominant (Figure 8). It is clear that problems of depression, anxiety and alcohol use are common to most people who benefit from counselling in primary care settings. In children and young people depression, anxiety and behavioural problems are the most common problems reported.

Across regions, while the pattern of relative problems is the same, the overall magnitude of these problems differs significantly. Regions with greatest social disadvantage—Western, Northern and Barwon South-Western—also have the greatest burden of illness from these non-psychotic mental health problems. Eastern Metropolitan Region, with the least social disadvantage, has the least burden of non-psychotic illness.

Figure 7. Female Disability Adjusted Life Years for Non-Psychotic Mental Health Problems by Region

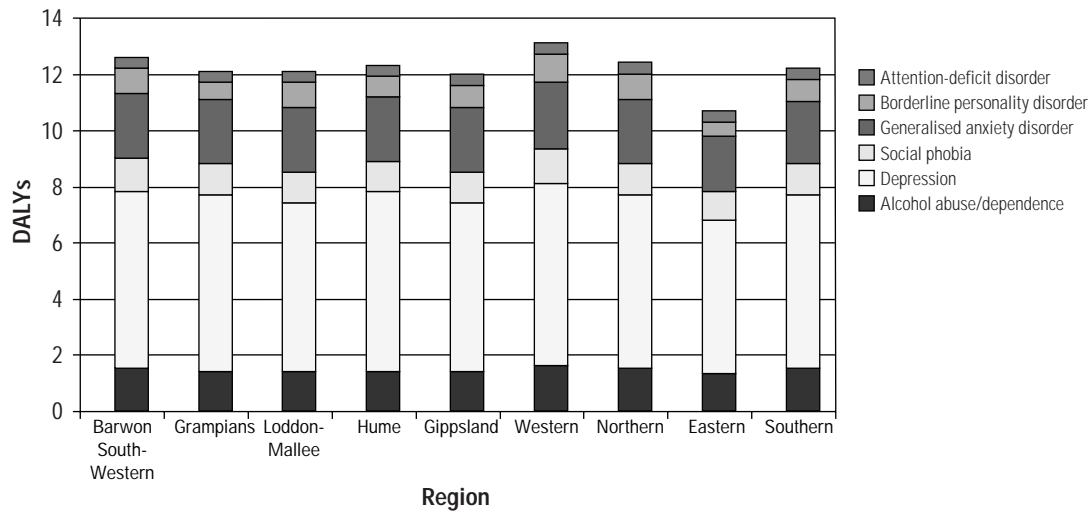
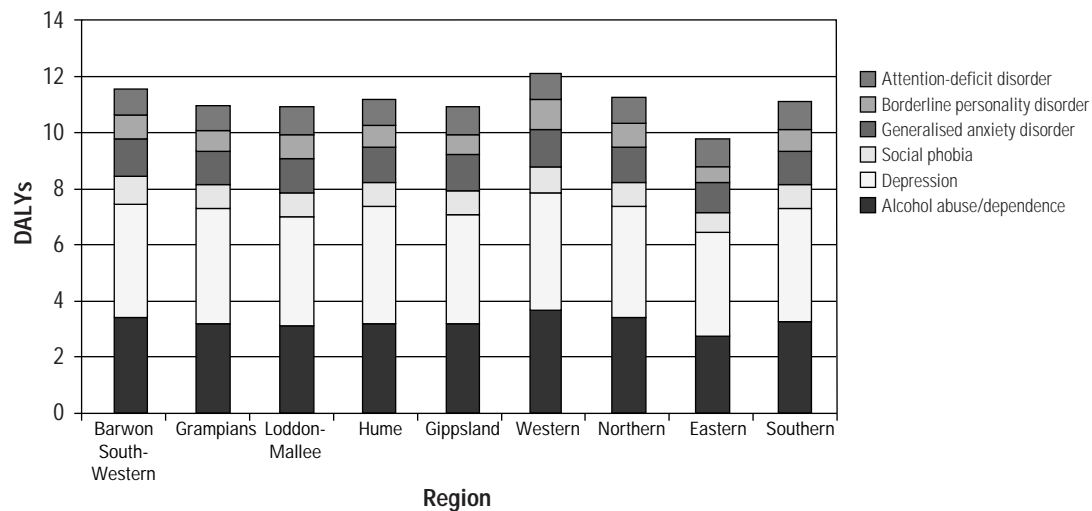


Figure 8. Male Disability Adjusted Life Years for Non-Psychotic Mental Health Problems by Region



Source: Department of Human Services, 2000a Burden of Disease 1996

Burden data is also available at the level of local government areas. This data is increasingly being used to inform regional planning and delivery of counselling services and was a feature of the presentations at the regional forums that were conducted in 2001 with counselling service providers as part of this Review.

In planning counselling services, the distinction should be clearly made between the rate of burden of mental health problems, expressed as the per capita measure of Disability Adjusted Life Years per 1000 people (DALYs), and the absolute burden in a given area which is the product of the DALY and the total population of the area.

It should also be noted that even areas with low average burden may have 'hot spots' of high burden which should be identified by analysis at the level of Australian Bureau of Statistics collection districts of 200 households or through other available measures reflecting local knowledge.

Unfortunately, because few counselling services in community health services record problem type as part of their data recording, it is not possible to contrast the utilisation of counselling services against estimates of the burden of these problems in the general community.

In Stage Two, a proposal for recording client problem type in a routine way that is consistent with national data sets will be developed.

The gender and age data for service utilisation do indicate, however, that males and young people are significantly under-represented in clients receiving counselling in community health services. The needs data also indicate that there is very considerable potential for increased demand, as a result of public campaigns raising awareness about these mental health problems and services that provide effective interventions.

It is likely that the forthcoming public awareness campaign to be conducted by Beyond Blue will significantly impact upon counselling services in community health services.

Almost half of those seen for counselling in community health services are reported as having Health Care Cards, most receiving a government pension or allowance. Unfortunately, there is no data recorded on socioeconomic status for almost 40 per cent of clients. This is an important inadequacy in data collection, because Community Health Program services should be demonstrably targeted to people who are socially disadvantaged.

The Stage Two report will make recommendations to improve the social disadvantage data collected for clients receiving counselling.

5. Counselling Casework Interventions in Community Health

5.1 The Nature of Counselling Casework

In discussions with members of the project Reference Group and community health counsellors, there was general agreement with the generic definitions of counselling casework recommended in the *Framework for Counselling Casework* (DHS, 1999). However, the definitions developed in Stage Two of this project, will be specific to community health services, and need to:

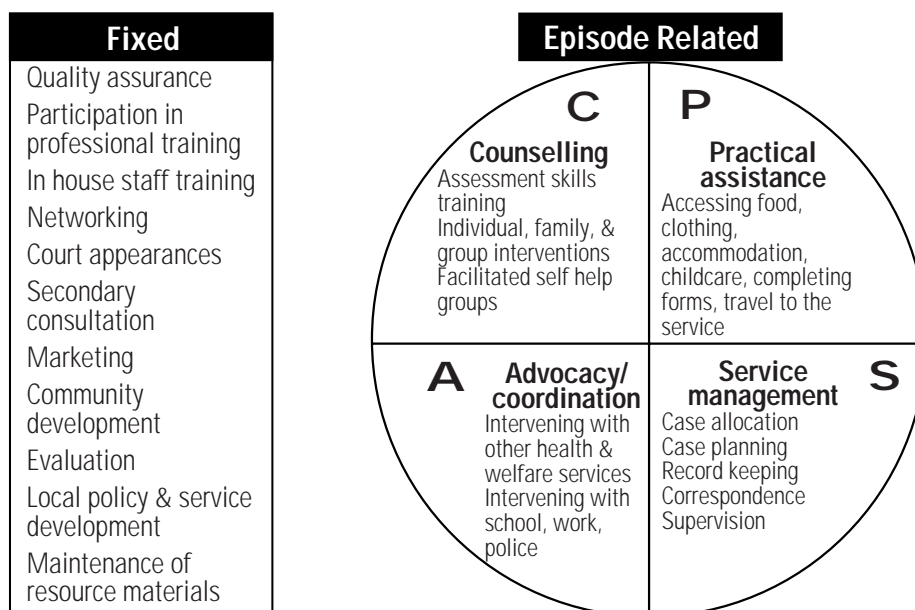
- Be consistent with the social model of health that is a foundation of Victoria’s community health services.
- Specify a continuum of sophistication in counselling, ranging from generalist to specialist and establish where community health counselling lies on this continuum.
- Consider the relationship between counselling and the broader range of activities required to mount an effective mental health promotion strategy in local communities. The role of counsellors as advocates for broader social and economic interventions should also be considered.

In line with the emphasis given in the definition below, from the *Framework for Counselling Casework* (DHS, 1999), the integration of counselling with other important aspects of casework was emphasised by counsellors (Figure 9).

Definition

Counselling or therapy may be closely integrated with other activities such as advocacy, service coordination and practical assistance. Counselling casework will always include significant counselling and or therapeutic interventions and may also include varying amounts of practical assistance and support, advocacy, service coordination and management activities. It is distinguished from other forms of casework by having a major, rather than minor or adjunctive, counselling component.

Figure 9. Components of a Unit of Counselling Casework



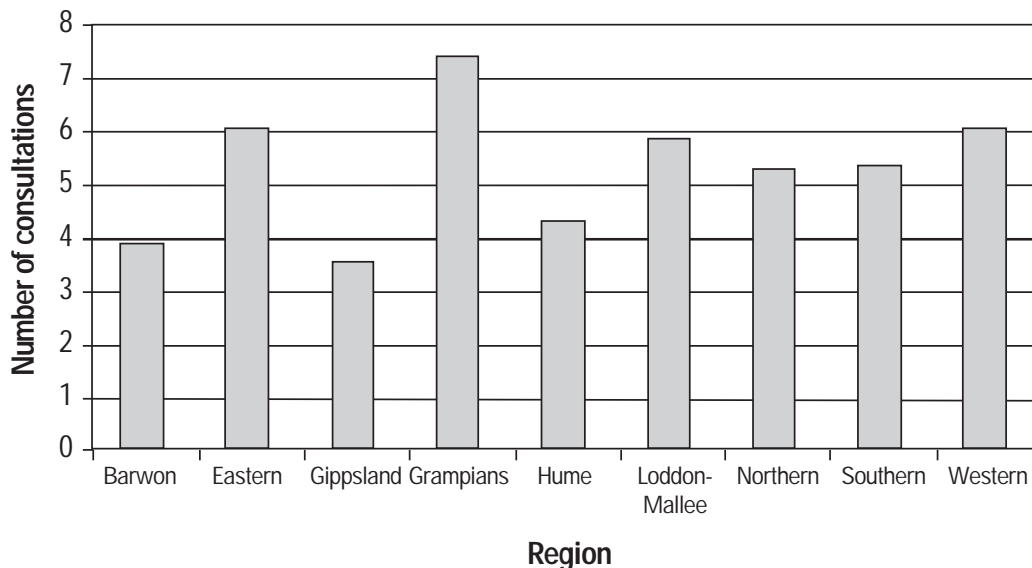
5.2 What Counselling is Already Being Provided?

5.2.1 Variable Durations of Counselling

In Section 4.1 wide variations in the throughput of the counselling services was noted. This can be accounted for largely by corresponding variations in the number of consultations, comprising a course or episode of counselling. Agencies with high throughput generally see clients for fewer consultations (Figure 7).

Examining distribution of the number of consultations by client shows a trend towards most clients being seen for 1 to 3 consultations and only very few for a number of consultations greater than 5 to 7 consultations. This finding is of concern because it indicates that some clients may be using counselling services simply as source of assessment, information and referral, rather than for substantial counselling intervention. The evidence from research outcome trials for counselling for anxiety and depression indicates that a minimum of 6 to 12 consultations are required to effect significant positive change.

Figure 10. Mean Consultations per Counselling Client, 1999–2000



Source: Department of Human Services, Primary and Community Health quarterly reports, 1999–2000.

5.2.2 Underdeveloped Evidence-Based Approach

In the regional forums and site visits that were conducted, reasons for these distributions were explored at an agency level. In general, there appears to be limited evidence overall of counselling approaches in community health that reflect an evidence-based typology of service types, such as that defined in the *Framework for Counselling Casework* (DHS, 1999). The message here is that few clients seem to be receiving enough counselling to make a difference in their wellbeing and social functioning.

In Stage Two, an approach to supporting evidence-based counselling in community health services will be recommended.

5.2.3 Intake Assessment

Most counsellors participate on a roster basis in a general intake and duty system for their community health service. The counselling service is therefore central to the quality of access generally to the community health service. Most counsellors are aware of the *Better Access to Services* (BATS) initiatives connected to the Primary Care Partnership Strategy. Current work on the Initial Needs Identification (INI) Tool has meant that these staff are becoming more directly engaged in this key initiative.

The Review of counselling will consider processes to ensure that counsellors in community health services continue to engage in the Better Access to Services initiatives.

5.2.4 Waiting Lists

Counselling services vary widely in their waiting lists, both between services and over time. In general counselling services report not being able to provide crisis counselling at short notice, most being able to initially assess a client within three days. Waiting periods of up to three weeks are reported by many services. Some counselling services report waiting lists up to three months. Because counselling services have differing and often informal approaches to the management of waiting lists and the priorities given to clients on them, the available data on waiting lists is inconsistent.

A common approach to the management of waiting lists for counselling in community health services will be developed in Stage Two.

5.2.5 Client Problem Types

In the absence of complete data sets defining clients by their presenting problems, counselling services anecdotally report that problems of anxiety, depression and family and relationship conflict are the most common problems seen.

These accounts will be examined in more detail in Stage Two of the Review and recommendations made for the minimum number of problem types that could be used to validly and reliably record this data. Consideration will be given to aligning these problem types with data sets for which there are national standards.

5.2.6 Fee Collection

Consistent with the fee collection policy for Victoria's community health services, counselling services collect fees on a means-tested basis from their clients.

Services report that fees collected by counselling services fall well below that of other community health services. The reasons for this will be examined further in Stage Two of the Review and recommendations developed for a consistent approach to fees for community health counselling.

5.2.7 Service Linkages

Counselling services vary in their relationships with other relevant mental health service providers including the general practitioners, specialist mental health services and school-based welfare services.

The Review of counselling services will make recommendations for a model of service delivery that more formally links counselling in community health services to these other service providers.

6. Resource Allocation for Assessment and Counselling in Community Health

6.1 Introduction to Expanding Counselling Funding in Community Health

The Review of Counselling in Community Health will provide advice to the Department regarding the allocation of resources for counselling services in both the current financial year and beyond. The Review is identifying principles for resource allocation that will assist the Department in the allocation of additional resources that are likely to flow in this area, as a consequence of the growing burden of illness associated with depression and anxiety. The Review will also link with the Department's work on developing an improved funding system for Primary Health.

Over the three-year period 2000–2003, the Victorian Government has committed new funds for the expansion of information, assessment and counselling services. In 2000–01, \$3 million in new funds were allocated to community health services (using the community health weighted population formula) to expand assessment and counselling services. Sixty percent of that amount was allocated recurrently and the remaining 40 per cent was allocated on a one-off basis only for that financial year. In 2001–02, these one-off funds were re-allocated in a recurrent way and a further \$440,000 was also made available. The allocation of these funds has been informed by the Review.

6.2 A Burden of Disease Approach to Community Health Counselling

Following an examination of alternative policy and funding approaches for community health counselling undertaken as part of this Review, and consideration by the project Reference Group representing a wide range of stakeholders, it has been decided to more closely relate community health counselling to a burden of illness approach to non-psychotic mental health problems and the associated evidence-based interventions. Counselling delivered in community health settings will give an increased focus to the mental health problems of depression and anxiety in adults, young people and children. Other mental health problems that are non-psychotic will also continue to be addressed by counselling services, especially where they can be demonstrated to contribute to addressing the burden of illness in the local areas served.

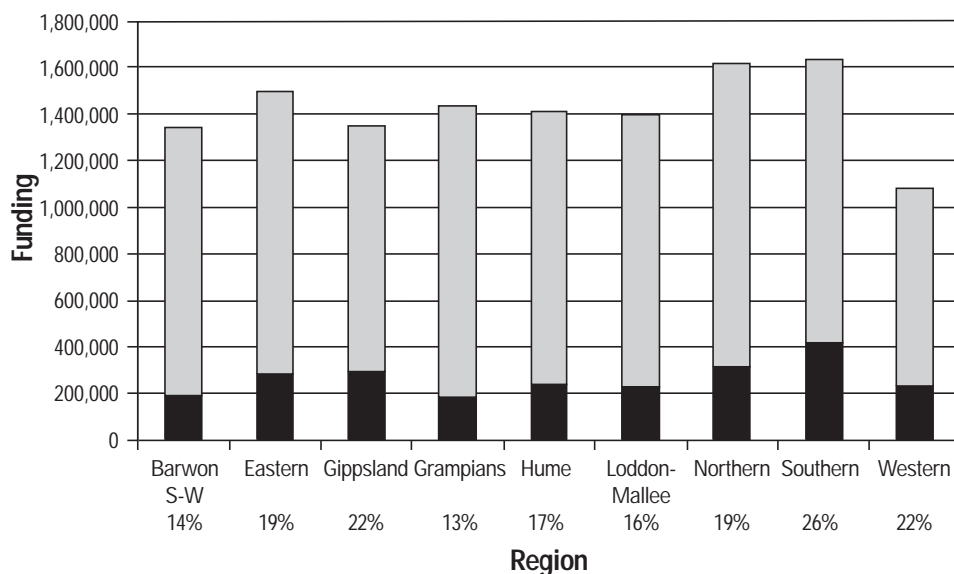
Important implications of this new approach to counselling services are that the burden of illness for non-psychotic mental health problems should influence the funding, planning and delivery of these services.

6.3 Redressing Historical Inequities

Before considering the use of burden of illness data for the purposes of funding new services, distribution of existing funds for generalist counselling in community health services was examined. Figure 11 shows the proportions of Community Health Program funds per capita expended in each region on generalist counselling services. The underlying population base has been weighted using the existing community health weighting method. The proportions spent on counselling range from 13 per cent (Grampians Region) to 26 per cent (Southern Metropolitan Region).

In consultation with the Reference Group, the Department has determined a desire to redress these inequities in funds allocated to counselling across regions, by having community health services gradually progress to spending around 20 per cent of their Community Health Program budget on generalist counselling. This can best be achieved over time, by reallocations from within community health services' existing budgets, rather than through the provision of special grants. This latter approach would contribute to inequities in overall program funding between regions and services.

Figure 11. Counselling Funding (%) as a Proportion of Community Health Program Funding across Regions

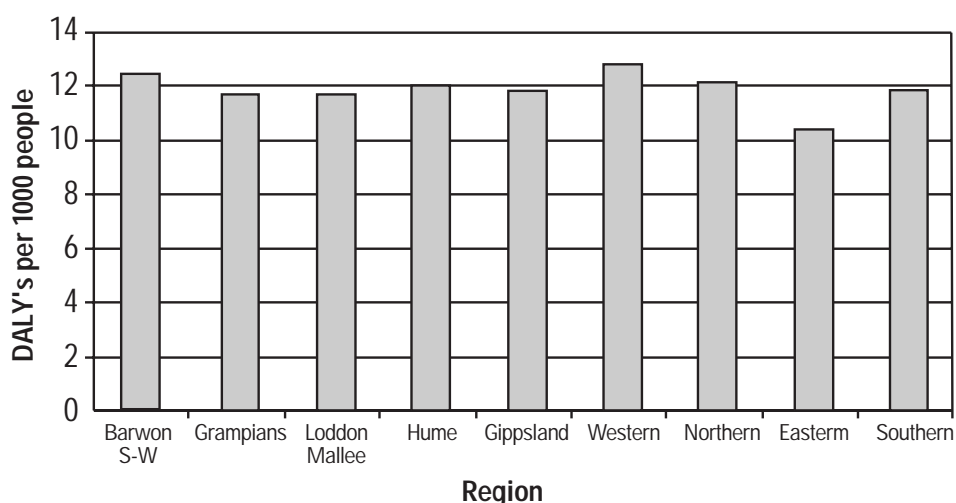


Source: Department of Human Services, Service Agreement Management System

However, an additional funding allocation may be needed in a region where limited counselling services are provided by community health services as a consequence of a lower than average per capita Community Health Program budget. This is so for community health services in Western Metropolitan Region, where per capita program funding (excluding specialist and statewide counselling services) is well below that of the other regions (Figure 11). For this reason, in 2001–02, a special grant will be made to Western Metropolitan Region from the pool of new funds for counselling prior to its allocation across all regions.

The differences in funding levels between the other regions are much less significant, and therefore no reallocations need occur between regions of the non-current funding allocation of 40 per cent made in 2001–02. Regions may of course reallocate these funds across counselling services within their region, to achieve more equitable access to such services. Section 6.6 provides guidelines for regions allocating new funds or reallocating non-recurrent funds for counselling.

Figure 12. Burden of Non-Psychotic Mental Health Problems by Region



Source: Department of Human Services, 2000a Burden of Disease 1996

6.4 Burden of Non-Psychotic Mental Health Problems

As indicated in Figure 12, there are significant differences between regions in the burden of non-psychotic mental health problems. Specifically, Western and Northern Metropolitan Regions and Barwon South-Western Region have the highest burdens resulting from non-psychotic mental health problems. Eastern Metropolitan Region has the lowest burden. It should be noted that along with most other health problems, the non-psychotic mental health problems are closely associated with social disadvantage at the regional and local government levels.

In the course of the current Review, support was received for recognising the significance of burden of non-psychotic mental health problems in the funding formula for allocating new funds.

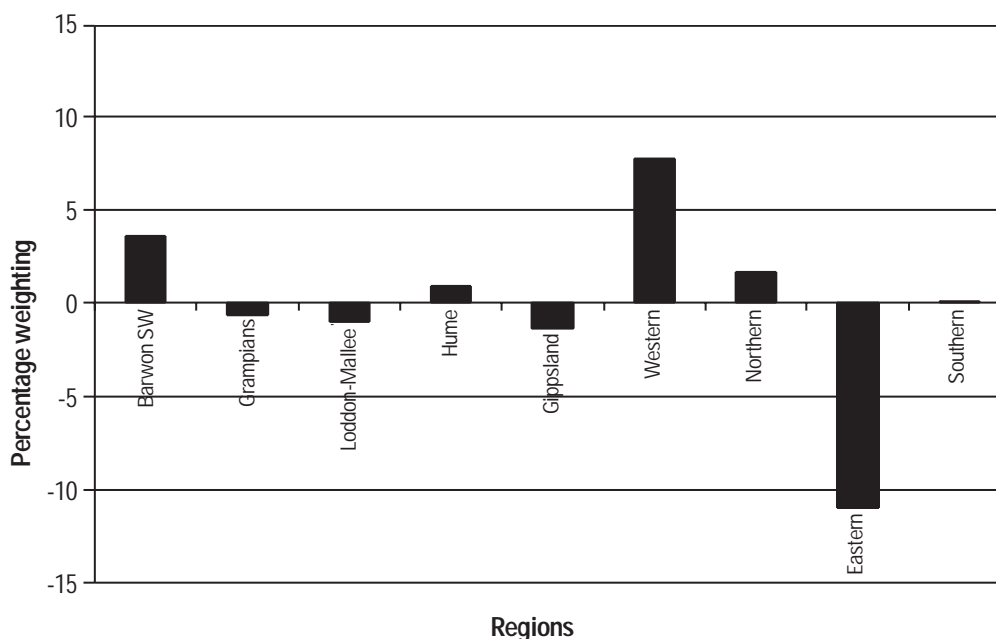
6.5 Regional Funding Allocations for Counselling Casework

The present community health funding formula has been adjusted to include a 15 per cent weighting for the burden of non-psychotic illness. The burden measure includes depression, anxiety, alcohol problems, borderline personality disorder and attention deficit disorder. Drug problems have not been included, because specialist drug services are already funded on a regional basis. Alcohol problems are of much greater prevalence and all counselling services can reasonably be expected to contribute to dealing with them.

The measure of rate of burden of non-psychotic mental health problems shown in Figure 13 was derived for each region from the raw data available for local government areas. Reports of this data by local government area for each region are available from <http://www.dhs.vic.gov.au/phd/lgabod>. The estimates of burden rates for each of the main non-psychotic mental health problems reported were combined to give a single measure for each region.

The regional measures of burden of non-psychotic mental health problems were then scaled from -15 to +15. This maintained the relationships between the relative magnitude of regional burdens giving a mean burden of 0 and a standard deviation of 5. This becomes the burden weighting forming part of the funding formula for counselling services. This weighting approach has face validity and for the first time clearly recognises for the purposes of funding counselling services the respective burdens for regions of non-psychotic mental health problems.

Figure 13. Regional Mental Health Weightings for Burden of Non-Psychotic Mental Health Problems (Scaled weighting +/- 15%)



In general, the effect of the introduction of the weighting for non-psychotic mental health is in the same direction as the previous weighting for socioeconomic disadvantage. This is most notable for Eastern and Western Metropolitan Regions. However, for Barwon South-Western Region the burden weighting contributes somewhat more than the previous socioeconomic weighting.

In contrast, for Grampians and Hume Regions, the burden weightings contribute somewhat less than the socioeconomic weighting. Overall, while the introduction of the burden weighting contributes to the integrity and validity of the funding formula for counselling services, the proportions of new funding to be allocated for counselling across regions in 2001–2002 differ little from those that would have resulted from using the existing community health funding formula.

6.6 Distribution of New Counselling Funds within Regions

As an outcome of the Review, in planning for the use of the new and reallocated funds for generalist counselling in community health services, regional offices were requested to consider guidelines related to several priorities for 2001–2002. Regional offices are responsible for the allocation of their share of the new funds, and the reallocation of this financial year’s non-recurrent funds, according to the advice below.

In general these new funds are for expanding the capacity of counselling services for people living in the region. Where existing counselling services already substantially exceed the agreed targets—so that the targets associated with the new funds can be readily met—the new funds may be used for initiatives to improve access to high quality and evidence-based counselling for the range of non-psychotic mental health problems identified as substantial burdens of illness.

In planning for the use of the new and reallocated funds for generalist counselling in community health services Regional offices were asked to consider the following guidelines.

1. Improving the credibility and profile of community health counselling services

While recognising the requirement to expand the availability of counselling, regions should allocate the new counselling funds so as to contribute to the development of a future infrastructure for counselling in community health—one that has recognised credibility with consumers and other human services and practitioners. Counselling services should be actively supported to becoming

leading contributors to a service system for people and families with non-psychotic mental health problems. Examples of appropriate strategies might include:

- Support of formalised university practice teaching and quality assurance relationships.
- Arrangements for recruiting and retaining experienced and skilled counsellors from other service sectors.
- Joint services with Divisions of General Practice, Primary Mental Health and Early Intervention Teams, mental health promotion and school-based nursing services.
- Services trialing evidence-based practices as part of research and evaluation activities.

2. Equity between community health services

In general, the new and reallocated funds for counselling should be employed to ensure that all community health services are progressing to having a sustainable counselling service (including intake and assessment—see below). It will be important for regions to carefully examine the existing commitments of a community health service's core grant funds to counselling and assessment activities. Where a community health service already has per capita core grant funds equal or greater than an equitable share in a region, but has not allocated a reasonable proportion to intake assessment and counselling services, a plan for progressive reallocation of resources within the agency to these activities should be developed, rather than making new funds available for these purposes.

3. Support for the Better Access to Services initiatives – (Primary Care Partnerships)

It is recognised that counselling services make significant contributions to intake assessment in community health settings. A proportion of the new and reallocated counselling funds may be allocated to contribute to ensuring that all community health services are positioned to deliver on the Better Access to Services initiatives including development of the Initial Needs Identification tool and appropriate referral protocols and service coordination mechanisms.

4. Priority for local government areas with highest burden of non-psychotic mental health problems

In service planning and allocating funds for counselling services, consideration should be given to the rates and nature of the burden of non-psychotic mental health problems in local government areas. Detailed reports of the range of non-psychotic mental health problems at an LGA level and by region are available at the following Web site: <http://www.dhs.vic.gov.au/phd/lgabod> .

7. Socioeconomic Factors and Non-Psychotic Mental Health Problems

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 and Marmot, 1998). This is certainly true for non-psychotic mental health problems. Considered in these terms, non-psychotic mental health problems could just as well be considered as problems of serious unhappiness as problems of mental health disorder and illness.

7.1 Mental health problems are Associated with Socioeconomic Status

The Table below shows the differences in burden for each of the main diseases in Australia for the top 20 per cent and bottom 20 per cent of people grouped by socioeconomic status (Australian Bureau of Statistics, 1998). For mental disorders, it shows that up to 50 per cent of the burden of mental disorders is associated with socioeconomic status.

Table 4. Differentials in the Burden of Disease and Injury between Top and Bottom Quintiles of Socioeconomic Disadvantage, by Selected Main Disease Categories and Sex, Australia 1996

Disease category	DALY ratio ^(a)	
	(bottom quintile/top quintile)	
	Male	Female
A. Infectious and parasitic diseases and acute respiratory infections	1.30*	1.43*
D. Neonatal causes	1.34*	1.32*
F. Malignant neoplasms	1.19*	1.11*
H. Diabetes mellitus	1.64*	2.26*
I. Endocrine and metabolic disorders	1.21*	1.37*
J. Mental disorders	1.43*	1.53*
K. Nervous system disorders	1.32	0.84
L. Cardiovascular disease	1.30*	1.22
M. Chronic respiratory diseases	1.48*	1.34*
N. Diseases of the digestive system	2.11*	1.54*
O. Genitourinary diseases	1.16*	1.23*
Q. Musculoskeletal diseases	1.44*	1.44*
T. Unintentional injuries	1.79*	1.39*
U. Intentional injuries	1.76*	1.54*
Other causes	1.17	1.20*
All causes	1.37*	1.27*

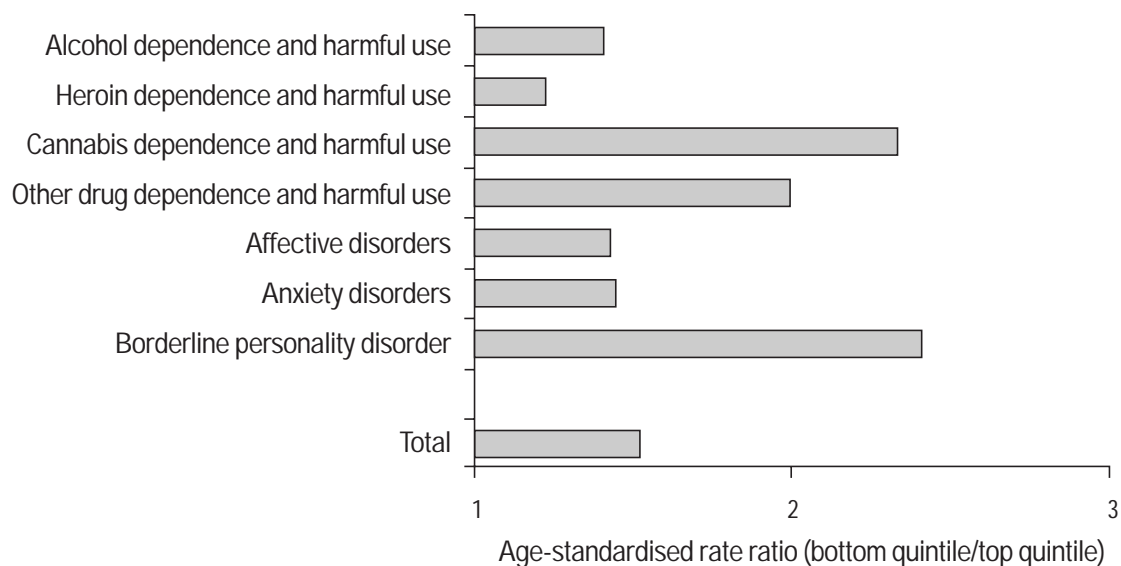
(a) Ratio of age-standardised DALYs per 1,000 population for most disadvantaged (5th) quintile of area index of socioeconomic disadvantage to age-standardised DALYs per 1,000 population for least disadvantaged (1st) quintile.

* Asterisk indicates that ratio differs significantly ($p < 0.05$) from 1.0 (no differential between top and bottom quintiles).

Source: Mathers et al 1999, p.60.

Socioeconomic status appears to be more associated with the burden for some mental health problems. Specifically, as shown in Figure 14 below, substance use problems and borderline personality disorder seem to be associated with up to three times the burden for populations with low socioeconomic status. Findings are similar for smoking related illnesses which is probably related to non-psychotic mental health problems. Up to 50 per cent of the burden associated with anxiety and depression appears to be associated with socioeconomic status.

Figure 14. Differentials in YLD Rates between Top and Bottom Quintiles of Socioeconomic Disadvantage, Selected Mental Disorders, Australians Aged 18 Years and Over, Australia 1996

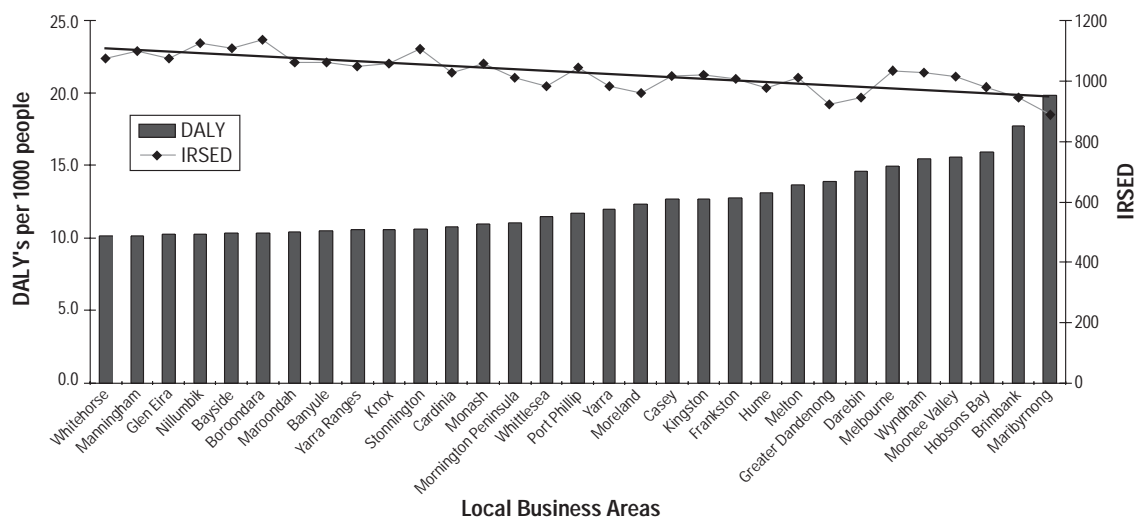


Source: Mathers et al 1999, p.60.

7.2 Areas with Low Socioeconomic Status Have High Mental Health Burden

In Metropolitan Melbourne the relationship between socioeconomic status and burden of non-psychotic mental health problems can be illustrated by plotting socioeconomic status and burden for each of the local government areas. This shows in Figure 15 below that areas low in socioeconomic status, as measured by the Index for Socioeconomic Status (IRSED), have a higher burden for non-psychotic mental health problems for adults.

Figure 15. Burden of Non-Psychotic Mental Health Problems and Socioeconomic Status for Metropolitan Melbourne Local Government Areas



7.3 Socioeconomic Status and Mental Health of Children and Adolescents

The relationship between socioeconomic status and non-psychotic mental health also exists for Australian children and adolescents (Australian Bureau of Statistics, 1999). As shown in Table 5 below, 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.

There are several possible explanations for this relationship. One is that low income families have lower functioning family members, including parents who are less skilled at parenting and children who are more prone to mental health problems. However, a much more likely explanation is that low income and social disadvantage are potent stressors on individuals and families, the consequent distress of which is manifested in the emotional and behavioral adjustment of parents, children and adolescents.

Family type appears to have a significant association with the prevalence of child and adolescent mental health problems with step/blended families and sole parents having almost twice the likelihood of children with mental health problems. Family type is probably closely related to socioeconomic disadvantage and may provide a useful marker for targeting counselling services to families in need.

Table 5. Prevalence of Mental Health Problems by Family Type and Prevalence by Weekly Household Income

Prevalence (%) of Mental Health Problems by Family Type						
CBCL scale	Original parents		Step/blended parents		Sole parent	
	Males	Females	Males	Females	Males	Females
Total Problems	11.3	10.7	25.0	19.7	22.2	26.7
Internalising problems	12.1	9.0	23.0	13.5	20.4	19.5
Externalising problems	9.5	9.8	23.9	19.9	21.4	24.7

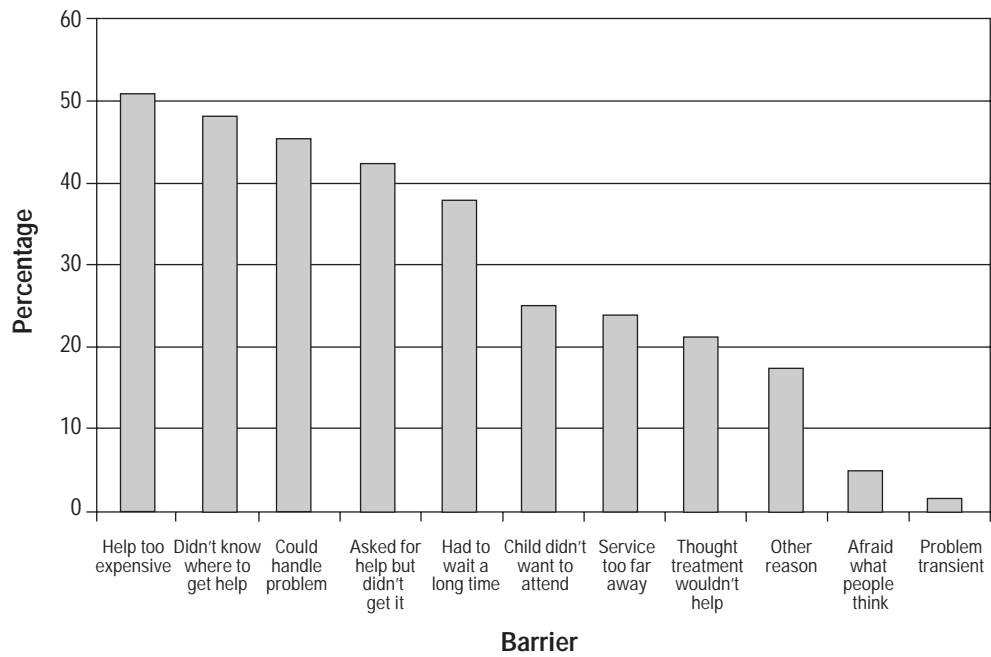
Prevalence (%) of Mental Health Problems by Weekly Household Income			
CBCL scale	Weekly household income		
	less than \$580	\$581–\$1030	Greater than \$1030
Males			
Total problems	21.1	14.8	8.9
Internalising problems	17.5	15.6	11.8
Externalising problems	20.4	13.0	7.2
Females			
Total problems	22.1	13.8	9.1
Internalising problems	16.4	10.5	8.8
Externalising problems	20.4	11.7	9.6

Note: CBCL = Child Behaviour Checklist

Source: Sawyer et al 2000, p.11.

Figure 16 below shows the reasons reported as barriers to parents with children and adolescents with mental health problems seeking professional assistance. Cost, lack of knowledge about services and waiting times were perceived to be the main barriers to accessing services. These are important factors to be considered in designing improved counselling services in community health services.

Figure 16. Barriers to Obtaining Help for Children and Adolescents with Mental Health Problems



Source: Sawyer et al 2000, p.33.

8. A Social Health Approach to Counselling in Community Health

8.1 Overview

The dominant models of causation and treatment for anxiety and depression come from medicine and psychology and have a focus upon individual vulnerability, individual medication and personal interventions, rather than upon broader social and economic factors.

There is considerable evidence (described in the model used by the Victorian Health Promotion Foundation) that non-psychotic mental health problems are primarily related to social disadvantage, alienation and status.

A strategic analysis of counselling services in community health indicates that they are well positioned to be a significant partner with general practitioners and specialist mental health services in delivering the outcomes described in the Second National Mental Health Plan.

For this reason a new policy context, based on a social model of mental health, should be the explicit foundation for counselling services provided through community health services.

This Section outlines key features of a new policy context for counselling in community health, as discussed and agreed upon by the project Reference Group members. These have been tested and refined through a series of regional forums with counselling service providers. In Stage Two of the Review, recommendations will be made concerning detailed models for a social health approach to counselling and the practice and service developments required to support them.

8.2 National Action Plan for Promotion, Prevention and Early Intervention for Mental Health, 2000

The National Action Plan was developed as a resource document to support one of the three priority areas of the Second National Mental Health Plan. The National Action Plan is already gaining acceptance in Victoria. While it has not been formally ratified by the Australian states, it provides a policy reference point which has been lacking since the publication of the Second National Mental Health Plan four years ago.

A strength of the National Action Plan is that it considers the full range of mental health interventions, including counselling, as being integrated under the mental health promotion umbrella. Health promotion is usually defined more narrowly as aligned with prevention interventions only.

However, the National Action Plan does not address several important definitional and conceptual issues, including whether mental disorders are best defined as mental illnesses (p5). It would have been preferable that it was a 'National Action Plan for the Promotion of Emotional and Social Well Being'. This would have been normalising and would not have aligned this important plan around mental illness, but instead aligned it around happiness and wellbeing.

This is not just a problem of words, but reflects the fundamentally different categorical vs dimensional views of mental health. Unlike cancer and cardiovascular disease, mental health problems are everyday human products of temperament and interactions with the environmental context and life events. Anxiety, depression, anger, overconcern about physical health and even 'odd thinking' exist along a continuum of severity in the population, much of which sits within what is culturally acceptable.

Psychiatric diagnostic criteria are a socially constructed set of values about when these problems cause so much harm that they require intervention. It is disturbing that 20 per cent of the population meet these criteria and hence are considered in the National Plan as having a mental illness that requires medically defined intervention. It is preferable to think of this arbitrarily defined 20 per cent of the population as being sufficiently troubled in a way that concerns society that it wishes to actively assist them. There is no naturally occurring cut-off point, such as a blood test, that can be used as basis for categorising people with these problems. Problems of emotional health are better construed as important and potentially disabling social problems like child misbehaviour, delinquency, alcohol and drug use, aggression and crime.

Stressors, vulnerabilities and distress are the key elements required to explain and intervene in problems of emotional health. These words have a currency and validity in everyday living for people, unlike mental illness, which assigns a person to a separate problem category which is the domain of deviance, physical lesions, biochemical abnormalities and expert authorities.

It may be reasonable to assign people with severe mental illness whose behaviour and thinking sits so far outside everyday experience to such a category, because they make no sense to the average person. However, it is unlikely to be productive for 20 per cent of the population to be conceived of in these terms.

A framework for community health counselling and mental health promotion should be aligned with the National Action Plan 2000, but should identify the advantages of a social health approach, rather than disease management approach, to what are essentially very prevalent problems of everyday living.

8.3 Strategic Analysis of Counselling in Community Health

Consultation with a broad range of stakeholders on the project Reference Group, regional offices and 270 counsellors working in community health services who participated in regional forums, generated a very large number of issues for consideration by the Review. Table 6 below summarises these issues in the form of a strategic analysis of generalist counselling delivered in community health services. Each of these issues will be addressed in Stage Two of the project.

Five important themes emerge from this analysis:

- Counselling in community health services is well placed to contribute to the implementation of the *Second National Mental Health Plan*. However, these existing and possible future contributions of community health counselling are not widely recognised or acknowledged in mental health policy.
- Counselling in community health services already services the needs of people with non-psychotic mental health problems and will almost certainly experience increased demand as a consequence of increased community awareness about mental health problems.
- The social health model, which is a foundation of community health services, and acknowledges the substantial evidence linking mental health to social exclusion, will substantially strengthen the effectiveness and acceptability of the present approaches to mental health policy and service planning.
- A formalised framework for quality counselling in community health services is required, together with the associated structures and processes to support quality assurance, ongoing competency development, evidence-based practice and evaluation
- The development of an integrated primary care mental health system comprising a formalised partnership of specialist mental health, community health and the divisions of general practice is required.

Table 6. Strategic Analysis of Community Health Counselling, 2001

Opportunities	Threats
<ul style="list-style-type: none"> • The present focus on non-psychotic mental health by governments will be a long term policy and funding issue for the remainder of this century. • Community health has an existing platform, practitioners, client and resource base (\$15m) to participate in addressing these problems. • Vic Health has an approach to mental health promotion that is consistent with that of community health counselling. • Specialist mental services have clinical credibility but have limited experience in the provision of primary care services and health promotion. • Availability of burden of disease data to support planning and resource allocation. • Increased recognition of a social health model would substantially strengthen the sophistication, effectiveness and community acceptance of the dominant biopsychological approach, which is presently limited by its conception of anxiety and depression as individual disease states. 	<ul style="list-style-type: none"> • National public awareness campaign by Beyond Blue will generate considerable new demand on community health counselling. • Analysis of unmet need suggests that demand for community health counselling could readily treble with increased public awareness. • Community health counselling is not being considered by key policy makers as a means for addressing non-psychotic mental health problems. • Specialist mental health and Divisions of General Practice could become the main service venues for primary mental health with community health counselling having only a secondary role. • If community health counselling becomes limited to social support and casework these functions are likely to be progressively undermined by low cost counsellors in NGOs and the private sector.
Strengths	Weaknesses
<ul style="list-style-type: none"> • Psychosocial interventions with cost-effectiveness comparable to pharmacotherapies are available for anxiety and depression when delivered by well-trained and supervised primary care practitioners. • Community health provides an existing platform of non-stigmatising primary care service venues and community networks. • Contrary to the beliefs of some other service providers community health counselling already manages complex clients with significant comorbidity. • Community health counselling is unique in having a capacity for effectively integrating counselling with mental health promotion across local communities. • Community health services are unique in being able to address in an integrated way the comorbidity between the 'big three' burdens of illness - cardiovascular, cancer and mental health problems especially in disadvantaged populations. 	<ul style="list-style-type: none"> • Minimum practitioner qualifications, standards, agreed competencies and approaches to service delivery need to be more consistent. • Quality assurance processes, supervision arrangements, professional networks, seniority and salary arrangements need to be made more consistent. • Inadequate awareness of evidence-based interventions. • Insufficient breadth in bands of competent practice across target groups—child, adolescent, adult, aged—and interventions for individual, couple, family and group. • Counselling is mainly delivered to adults, with only a few services offering substantial counselling services to children and adolescents. • Mechanisms for managing client demand and waiting lists require development. • Credibility with specialist mental health services and general practitioners requires enhancement. • Lack of explicit targeting of services results in them being defined by inadequate service capacity in other services, such as specialist mental health and child protection. • Definition and record keeping of client problem types requires improvement. • Record keeping for indices of social disadvantage requires improvement. • Fees policy across services ranges from no fees to mandatory fees albeit at minimal levels.

8.4 Proposed Refocusing of Community Health Counselling Casework

Community health counselling has long been a significant and established part of community health services, providing diverse services for people of all ages with social, emotional and psychological problems. These counselling services are delivered to individuals, groups and families in community, home and other settings.

Counselling in community health should continue to provide a mix of counselling, practical assistance, service coordination, case advocacy and social support. These services will continue to emphasise the delivery of professional counselling services by competent practitioners with tertiary qualifications in counselling.

In general, the principles for effective assessment and counselling described in the Department's *Framework for Counselling Casework (DHS, 1999)* should guide the future delivery of counselling services in community health settings.

Counselling in community health should refocus its efforts in giving a priority to the greatest burdens of non-psychotic mental health problems, including anxiety and depression.

An increased emphasis should be given to adopting, refining, developing and widely disseminating evidence-based approaches for counselling delivered in community health.

In future service planning, including resource allocation, community health should give a priority to improving the quality and effectiveness of its existing responses to mental health problems with the greatest burden of illness and for the expansion of appropriate services.

The policy context in the Community Health Program should give a central role to the social and economic causation and remediation of non-psychotic mental health problems. Specifically, the program should adopt a social model of these problems and advocate for and support approaches that integrate across government and communities, counselling, health promotion, and community, social and economic policy initiatives.

Table 7 illustrates the various points at which intervention can be made in a social health approach to mental health problems. Counselling should be seen as one significant component of such a comprehensive approach to considering mental health problems. This approach is consistent with that of the mental health promotion model used by the Victorian Health Promotion Foundation.

Table 7. A Social Model of Non-Psychotic Mental Health Problems in Community Health Services (priority activities for counselling are shaded)

Stressors X	Vulnerabilities =	Distress +	Maladaptive behaviours =	Impact on others
<i>Low</i> Shopping Leaving the house	<i>Low</i> Transient low mood	<i>Mild</i> Short term sleeplessness Overconcern Reduced concentration	Social isolation/avoidance Suicidal behaviour Poor health care Erratic relationships Aggression Interpersonal conflict Overweight Smoking Problem drinking Psychotropic drugs	Childhood anxiety/depression Child behavior problems Sibling contagion Conflict with partners/carers Friends Shop keepers Social networks Health care providers
<i>Medium</i> Job interview Birth of a child Illness of an aged parent	<i>Medium</i> Shyness Insomnia Family history of anxiety/depression Poor parental models for coping Childhood disadvantage	<i>Moderate</i> Agoraphobia Panic attacks Social phobia Generalized anxiety Unipolar depression Dysthymia	Anorexia Injecting drugs Self-inflicted injury Exhibitionism Violence to others	Crimes against other people Sexual offences
<i>High</i> Major surgery Recent incest Sudden death of spouse Financial hardship Poor social position Social isolation Poor return for work efforts	<i>High</i> New migrants Chronic illness Childhood sexual abuse Severe personality disorder Schizophrenia	<i>Severe</i> Psychosis Homicidal anger		

Interventions				
Upstream				Downstream
Self-managed care Case advocacy Initiate local social support networks Integration with targeted health promotion efforts Community & workplace interventions Environmental engineering Systemic advocacy	Case plan Individual, group, relationship and family therapy Coordination with general practitioner Maintenance medication Progress review Termination	Intake assessment Referral Counselling assessment Case plan Supportive individual, group, relationship and family counselling Facilitated self-help Single session therapy Symptomatic medication Crisis management Acute care	Problem drinking programs Suicide prevention training Anger management Activity programs Personality disorder programs	Case finding and identification Early intervention Primary prevention

8.5 Proposed New Policy Directions

The Community Health Program should support improved service planning, quality improvement, competency development, research and evaluation activities designed to improve the quality of community health counselling casework services.

Upstream interventions, including health promotion and the School Nursing Program, should be linked with counselling casework services to better address non-psychotic mental health problems in community health settings.

Because of the cost-benefits, early intervention for children and adolescents with non-psychotic mental health problems, specifically those with a parent or siblings with these problems, should be given a greater priority in community health counselling.

Community health counselling services should address behaviours that are associated with anxiety and depression giving a priority to smoking, alcohol and pharmaceutical drug use.

Community health services should widely advocate with communities, industry and governments for improved responses to the most common mental health problems including anxiety and depression.

In partnership with the Victorian government's mental health program, the Community Health Program should be a leader in representing the needs of people with non-psychotic mental health problems and actively contribute to ensuring that the social and economic origins of these problems are acknowledged and addressed in policy development and service planning.

In partnership with the Divisions of General Practice, the new Primary Mental Health and Early Intervention Teams, schools, non-government organisations and local communities, Victoria's community health services should contribute to the development and effective delivery of a system of services for people with non-psychotic mental health problems.

9. References

- Andrews, G., Hall, W., Teeson, M. and Henderson, S. 1999, *The Mental Health of Australians*, Commonwealth Department of Health and Aged Care, Canberra.
- Australian Bureau of Statistics 1998, *The Mental Health and Well Being of Australians*, Australian Government Printer, Canberra.
- Australian Bureau of Statistics 1999, *The Mental Health of Australian Children and Adolescents*, Australian Government Printer, Canberra.
- Australian Health Ministers, 1998 *Second National Mental Health Plan*, Commonwealth Department of Health and Family Services, Canberra
- Commonwealth Department of Health and Aged Care and the Australian Institute of Health and Welfare, 1999, *National Priority Areas Report: Mental Health 1998*, Commonwealth Department of Health and Aged Care, Canberra.
- Commonwealth Department of Health and Aged Care 2000, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.
- Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health—A Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.
- Craigehead, W.E., and Craigehead, L.W. 2001, 'The Role of Psychotherapy in Treating Psychiatric Disorders', in *Medical Clinics of North America*, 85 (3), 617-29.
- Department of Human Services (Victoria) 1997, *Opening the Door on Counselling*, unpublished report, Aged Community and Mental Health Division, Melbourne.
- Department of Human Services (Victoria) 1999, *Framework for Counselling Casework*, A Stronger Primary Health and Community Support System (PHACS Information Resource 2), Aged Community and Mental Health Division, Melbourne.
- Department of Human Services (Victoria) 2000a, *Burden of Disease 1996: Local Government Areas and Regions of Victoria*, Public Health Division, Melbourne.
- Department of Human Services (Victoria) 2000b, *Going Forward*, Primary Care Partnerships, Aged Community and Mental Health Division, Melbourne.
- Department of Human Services (Victoria) 2001, *Better Access to Services: A Policy and Operational Framework*, Primary Care Partnership, Aged Community and Mental Health Division, Melbourne.
- Mathers, C., Vos, T., and Stevenson, C. 1990, *The Burden of Disease and Injury in Australia*, Australian Institute of Health and Welfare, Canberra.
- Murray, C.J. 1996, *The Global Burden of Disease*, Harvard University Press, Cambridge.
- Rowland, N., Bower, P., Mellor Clark, J., Heywood, P. and Godfrey, C. 2001, 'Counselling for Depression in Primary Care', *Cochrane Review*, in the Cochrane Library, 2.
- Rutter, M., and Smith, D. (eds) 1995, *Psychosocial Disorders in Young People: Time Trends and their Causes*, Wiley, New York.

- Sawyer, M.G., Arney, F.M., Baghurst, P.A., Clark, J.J., Graetz, B.W., Kosky, R.J., Nurcombe, B., Patton, G.C., Prior, M.R., Raphael, B., Rey, J., Whaites, L.C. and Zubrick, S.R. 2000, *Mental Health of Young People in Australia*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.
- Ustün, T.B., and Sartorius, N. 1995, *Mental Illness in General Health Care*, Wiley, New York.
- Victorian Health Promotion Foundation (VicHealth) 1999, *Mental Health Promotion Plan Foundation Document: 1999–2002*, VicHealth, Melbourne.
- Wilkinson, R. and Marmot, M. (eds) 1998, *Social Determinants of Health: The Solid Facts*, World Health Organisation, Geneva.

10. Reference Group

Terms of Reference

Aim of Reference Group

The aim of the reference group is to provide expert advice and facilitate discussion between the Department of Human Services and relevant practitioners and agencies on key initiatives relating to assessment and counselling in community health.

Roles and Expectations of Members

The reference group will:

- Provide comment on the direction of the assessment and counselling initiatives in Community Health.
- Provide advice on the Review of Counselling in community health.
- Provide comment on draft versions of key documents, as required.
- Raise and discuss pertinent issues relating to the provision of assessment and counselling in community health services.

Membership and schedule of meetings

- The reference group will meet monthly or as required and will have a limited life span of six months, with opportunity for extension
- When appropriate, ad hoc members will be invited to provide additional expertise.
- For current membership, see below.

Reference Group Membership

Tracey Slatter	Manager of Community Health, Rural and Regional Health and Aged Care Services Division, Department of Human Services, Chair of Reference Group
Paul Butler	Manager of Community Health Policy, Community Health Unit, Department of Human Services
Cathy Henenberg	Project Manager for Counselling in Community Health Community Health Policy, Department of Human Services
Graeme Doidge	Manager Adult Mental Health Team, Service Planning and Development, Mental Health Branch, Department of Human Services
Jan Child	Project Manager, Better Access to Services Initiative, Primary Care Partnership Strategy, Community Health Unit, Department of Human Services
Felicity Rorke	Policy Advisor, Family Support Services, Community Care Division, Department of Human Services
Lise Pittman	Regional Representative, Team Leader, Primary Health and Community Service, Department of Human Services, Northern Metropolitan Region
Anne Stanton	Regional Representative, Primary and Community Health Advisor, Department of Human Services, Loddon Mallee Region
Gail Bradley	Manager Continuing Care and Homeless Services, Inner West Area Mental Health Services
Michael McGartland	Senior Lecturer, School of Public Health, Faculty of Health Sciences, Latrobe University, Bundoora
Alison McMichael	Australian Association of Social Workers representative Manager, Child and Family Services, Greater Dandenong Community Health Service
Susan Friedman	Social Workers in Community Health representative, Social Worker, Caulfield Community Health Service
Robert Wilks	Australian Psychological Society representative, Senior Manager, APS National Office
Doug Wright	Victorian Healthcare Association representative, Team Leader Counselling Services, Frankston Community Health Centre
Bala Mudaly	Victorian Healthcare Association representative, Greater Dandenong Community Health Service
Joan Eddy	Victorian Healthcare Association rural representative, Manager, Counselling Team, Djerrivarrh Health Service
Peter Ruzlya	Victorian Healthcare Association representative, Chief Executive Officer, Eastern Access Community Health

11. Glossary

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* 1998 Commonwealth Department of Health and Aged Care.

Affective disorders (mood disorders)

This is a term that 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.

Alcoholism

A behavioural disorder in which, consumption of alcoholic beverages is excessive and impairs health and social and occupational functioning; a physiological dependence on alcohol.

Antidepressant

A drug that alleviates depression, usually by energising the person and thus elevating mood.

Anxiety

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

Antixiolytics

Tranquilisers; drugs that reduce anxiety.

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.

Attempted suicide

The deliberate or ambivalent act of self-destruction, or other life-threatening behaviour, not resulting in death.

Best practice guidelines

Best practice is the benchmark against which programs can be evaluated. 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 both practitioners and consumers, to make the best use of the available evidence.

Bipolar disorder

A mood disorder characterised by the presence of history of manic (or hypomanic) episodes usually alternated with depressive episodes. (A history of depressive episodes is not required for all categories of bipolar disorder.)

Biopsychosocial approach

An holistic approach that considers all the interacting biological, psychological and social factors that contribute to disorder.

Cognitive behaviour therapy

A short term goal-oriented psychological treatment. The two guiding principles are: how we behave (including how we feel) is learned through experience, and therefore may often be changed or unlearned, and that thought processes directly impact on the person. The person is encouraged to examine negative perceptions and interpretations of their experiences. They are also taught problem-solving techniques.

Comorbidity

The co-occurrence of two or more disorders, such as depressive disorder with anxiety disorder or depressive disorder with anorexia.

Community Health Services

In Victoria there are 100 community health services, which operate from approximately two hundred and fifty sites, with forty-two services operating as 'stand-alone' and community managed and fifty eight services operating as part of divisions or units of hospitals, metropolitan health services, or regional health services.

In the last decade, community health services have become major providers of a range of Department of Human Services funded programs which include the following: Community Health Program (community nursing, counselling casework, allied health and health promotion); HACC allied health and day programs to frail older people and younger disabled people; post-acute care services; community dental services; alcohol and other drugs prevention and treatment services; and psychiatric disability and support services. Community health services have also specialised in various areas in response to local demands, for example the provision of disability support services in a number of agencies.

Counsellor

At present, anyone in Australia can call himself or herself a counsellor, therapist or psychotherapist. There are, however, credentialling bodies for counsellors, such as the Australian Body of Certified Counsellors and a range of professional organisations that offer standards, codes of practice, ethical guidelines and continuing education such as the Australian Psychological Society, the Psychotherapy and Counselling Federation of Australia and the Australian National Network of Counsellors.

Cyclothymia

A mood disorder of at least two years' duration (one year in adolescents) characterised by numerous periods of mild depressive symptoms, not sufficient in duration or severity to meet criteria for major depressive episodes, interspersed with periods of hypomania.

Depressed mood

A sad or unhappy mood. May be assessed by self-report questionnaire.

Depressive disorder

A constellation of disturbances in emotional, behavioural, somatic and cognitive functioning defined according to clinically derived standard psychiatric diagnostic criteria.

Dysthymia

A mood disorder characterised by depressed mood and loss of interest or pleasure in customary activities, with some additional signs and symptoms of depression, that is present most of the time for at least two years (one year in adolescents).

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.

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 which 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.

Hypomania

An episode of illness that resembles mania, but is less intense and less disabling. The state is characterised by an euphoric mood, unrealistic optimism, increased speech and activity, and a decreased need for sleep. For some, there is increased creativity, while others evidence poor judgment and impaired function.

Interpersonal psychotherapy

A time-limited psychotherapy approach that aims at clarification and resolution of one or more of the following interpersonal difficulties: role disputes, social isolation, or role transition.

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.

Meta-analysis

A systematic review that employs statistical methods to combine and summarise the results of several studies.

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.

Population-based interventions

Population-based interventions are targeted to populations, rather than high risk individuals or high-risk groups. These interventions include whole population activities as well as those activities deliberately targeted to population subgroups, such as rural or Indigenous peoples.

Prevalence

The proportion of the population with the disease/ disorder.

Preventive interventions

Programs designed to decrease the incidence, prevalence and negative outcomes of depression.

- 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.

Public health framework

Public health describes those activities that aim to benefit a population rather than individuals. Prevention, protection and promotion are emphasised, as distinct from treatment tailored to the needs of individuals with symptoms. A public health approach is structured around the continuum of primary, secondary and tertiary prevention.

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, general practitioners, 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.

Psychologist

While there are various governing laws throughout the States and Territories of Australia, a practitioner is not allowed to call himself or herself a 'psychologist' unless the required training has been undertaken and they are registered with the relevant state registration body.

Psychiatrist

Medical practitioner with specialist training in psychiatry.

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 this individual, rather than someone selected at random from the general population, will develop a disorder.

Socioeconomic status

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

Stressor

An event that occasions a stress response in a person.

Substance misuse

The use of a drug to an extent that the person is often intoxicated throughout the day and fails in important obligations and in attempts to abstain, but where there is not necessarily physical dependence.

Substance dependence

The misuse of a drug accompanied by a physiological dependence on it, made evident by tolerance and withdrawal symptoms.

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.

