Community health counselling
Policy framework and program standards

February 2009

This policy framework contributes to *Because mental health matters: Victorian Mental Health Reform Strategy 2009-2019*.

A Victorian
Government
initiative

Victoria
The Place To Be

Published by Primary Health Branch, Victorian Government Department of Human Services, Melbourne Victoria.

February 2009

Authorised by the State Government of Victoria

Also at www.dhs.vic.gov.au

Ministers' foreword

In February 2009, the Victorian Government released *Because mental health matters: Victorian Mental Health Reform Strategy 2009–2019*, following an extensive consultation process involving around 1200 people across a wide range of sectors.

There is an increasing awareness that prevention and early intervention approaches to mental health problems lead to better outcomes for individuals, families and the community as a whole. The strategy identifies the need for a greater emphasis on building capacity in the broader service system to respond to and prevent mental health problems.

This policy, *Community health counselling: Policy framework and program standards*, guides an important part of the contribution Community Health Services (CHSs) will make to mental health reform in Victoria.

CHSs provide counselling services that focus on people with chronic ill health, young people and their families, and people with complex and multiple problems, including mild to moderate mental health problems.

Since being elected in 1999, the State Labor Government has supported a range of initiatives designed to improve the availability and effectiveness of counselling in CHSs. Between 2001 and 2003 a review of CH counselling was undertaken to support decision-making regarding future expansion and service development. Funding to CH counselling has been increased in areas with the highest need.

From 2004 and continuing until 2009, the Department of Human Services has sponsored a series of workforce and service development initiatives to improve the quality of, and access to, counselling. CHSs have embraced these initiatives, and the combined effort of all involved has resulted in more responsive and effective counselling services being offered in CHSs.

We look forward to hearing about the progress of CH counselling as a significant contributor to the psychosocial aspects of primary care in Victoria and the mental health and wellbeing of all Victorians.

Daniel Andrews.

Hon Daniel Andrews MP
Minister for Health

Hon Lisa Neville MP
Minister for Mental Health

Acknowledgements

Community health management and counsellors, representatives from related programs and professional associations gave their time and support in the formulation of this policy.

The past and present members of the Counselling Review Reference Group are gratefully acknowledged for their contributions to the review and the development of this policy. Only the current members of the reference group are listed below.

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Other contributions

The Department of Human Services thanks all the stakeholders who supported the development of these standards through participation in regional consultations, focus groups and providing feedback on the public consultation draft.

Judy Poll, Community Psychologist from Eastern Access Community Health Counselling Service, was seconded to the Primary Health Branch of the Department of Human Services, and in conjunction with other members of Primary Health Branch, revised this policy document.

Jeff Young and Shane Weir, from the Bouverie Family Therapy Centre, La Trobe University, reviewed several sections and made significant contributions to Standards 4 and 5.

This paper is divided into two parts and five chapters:

Part I: Policy framework (Chapters 1–4) comprises an introduction, the focus, the principles and the interventions for community health counselling.

Part II: Program standards (Chapter 5) comprises the standards for community health counselling.

There is also an Appendix comprising supplementary notes to Chapters 1–3 and Chapter 5.

Contents

Executive summary

This paper is the culmination of several years of developmental activities undertaken to improve the specification, quality and future directions of counselling in Community Health Services (CHSs). The Department of Human Services' expectations about the future directions for Community Health (CH) counselling are explained in the paper.

Chapter 1 provides the purpose and policy context of the paper and profiles service providers and consumers.

Chapter 2 outlines three areas on which CHSs are expected to focus CH counselling:

1. Chronic conditions
The research literature indicates a strong relationship between psychological and physical wellbeing. For example, having diabetes more than doubles the risk of developing depression. The immune and cardiovascular systems are affected by prolonged exposure to stress, and research has found a link between depression and anxiety and cardiovascular and cerebrovascular disease.

2. Young people and their families
The years of adolescence and young adulthood are a critical developmental period in terms of social and emotional wellbeing as young people decrease their dependence on families and school and move towards independence and autonomy. Twenty-seven per cent of young people aged 18–24 years report having mental health problems, compared with 19 per cent of adults aged over 24 years. Family-based approaches can be helpful to the whole family as well as the young person, strengthening protective factors within the family environment.

3. Mild to moderate mental health problems
Some people with mental health problems are now being assisted by private providers and claiming a rebate either though Medicare or a private health fund. CH counselling provides services to people with mild to moderate mental health problems for whom private services are not an option. People with complex and multiple problems are often better assisted by a flexible mix of problem solving, supportive counselling and therapy.

Chapter 3 outlines six overarching principles that will guide CHSs' provision of high-quality, consumer-centred counselling:

Principle 1: Consumer-centred counselling approaches
Services are designed and provided based on the needs of consumers.

Principle 2: Fairness and equity
Fair and equitable service provision is integral to the provision of CH counselling

Principle 3: Service planning
CHSs participate with other services in local area planning to ensure that through collaborative agreement between services, the catchment population's needs are met.

Principle 4: Quality improvement
CHSs' quality planning processes include a structured plan for auditing CH counselling processes and guidelines, and for implementing needed changes.

Principle 5: Determinants of mental health
CHSs embrace models of care that reflect the diverse underlying determinants of health.

Principle 6: Cost not a barrier
Cost is not a barrier to accessing community health counselling.

Chapter 4 outlines the three main types of counselling interventions used by CH counselling: supportive counselling, casework and advanced therapeutic interventions.

1. Supportive counselling
Supportive counselling is the foundation for other interventions. Counsellors providing supportive counselling aim to work collaboratively with the consumer to identify their strengths and resources, leading to greater self-reliance.

2. Casework
Casework describes supportive actions undertaken by counsellors to help the consumer manage issues that are impacting on their wellbeing. CH counselling aims to help consumers develop their own supportive local environment.

3. Specific therapeutic interventions
Specific therapeutic interventions are evidence-based practices that propose how change can occur within a theoretical framework.

Chapter 5 contains the seven minimum standards which CHSs are expected to implement over time, with consideration of population need at a local level and using the PCP platform for protocol development and planning. Each standard incorporates a number of 'anticipated outcomes' that agencies can use to assess their progress towards meeting the standards.

The seven standards are:

Standard 1: Mental health promotion
CH counselling maintains a balance between individual- and population-focused work by contributing to organisational mental health promotion plans.

Standard 2: Consumer, carer and community participation
CH counselling promotes consumer, carer and community participation in all aspects of service provision.

Standard 3: CH counsellors: qualifications, learning and development
CHSs have mechanisms to ensure the competence of counsellors, including minimum qualification requirements for employment, and requirements for ongoing clinical supervision and continuing professional development.

Standard 4: Evidence-based practice
CH counselling implements systems to promote evidence-based counselling practice.

Standard 5: Demand management
CHSs manage demand for CH counselling by focusing on vulnerable population groups and prioritising access based on need.

Standard 6: Partnering to provide better services
CH counselling partners and complements the local area network of associated services.

Standard 7: Continuity of care
CH counselling has in place a documented model of service delivery that complies with service coordination practices.

The Appendix comprises supplementary notes to Chapters 1–3 and Chapter 5.

Part I: Policy framework

Chapter 1: Introduction

1.1 Context and purpose of this paper

This paper is the culmination of several years of reform that has occurred in the Community Health (CH) counselling sector. It positions the CH counselling sector to work collaboratively with providers of psychotherapeutic interventions available through Medicare, supporting complementarity and avoiding duplication between available services.

1.1.1 The review of counselling in Community Health Services

From 2001 to 2003, an independent consultancy was engaged to review the features, strengths and weaknesses of CH counselling. The review produced the report *Review of counselling services in community health: Discussion paper* (DHS, 2002b), which can be downloaded at the Department of Human Services (the Department) website.[1] Since the review was conducted, a range of projects have been implemented during the period 2002–2008 to address the findings of the review.

For more information, see the supplementary notes to section 1.1.1, in the Appendix.

1.1.2 Medicare

In 2006 Medicare was expanded to include services to assist people with mental illness. These services include psychotherapeutic interventions provided by Medicare-registered private practitioners. Details can be viewed at the Department's MBS website[2] or the COAG Mental Health website.[3]

The availability of psychotherapeutic interventions through Medicare has eased some demand on CH counselling, enabling CH counselling services to focus resources more on people with chronic conditions, young people and their families. Consumers struggling with complex combinations of common mental health problems, practical and psychosocial needs will continue to be a strong focus for CH counselling.

Collaborative effort between CHSs and Medicare mental health practitioners will increase access to services for consumers. Some CHSs have taken steps to host private Medicare-rebateable sessions in CHSs. These types of arrangements have the potential to increase the availability of services in areas where there are shortages of services and in situations where consumers cannot afford the gap payment.

1.1.3 The purpose of this paper

Community health counselling: Policy framework and program standards provides future directions for CH counselling in Victoria:

- by outlining how CH counselling complements rather than duplicates Medicare-rebateable services
- by conveying a clearer understanding to CHSs of the Department's expectations in relation to targeting CH counselling services
- by increasing other service providers' understanding about the type of assistance that can be offered by CH counselling
- by setting minimum standards that provide a baseline for mental health promotion, consumer participation, counsellor qualifications and development, evidence-based practice, demand management, partnering and coordinated care.

1.2 Process for developing this paper

Preparation for this current paper included releasing a public consultation draft in 2005 titled *Counselling in community health services: Future direction and guidelines for quality counselling* (DHS, 2005b). Feedback was received from regional consultations and written submissions and focus groups were then held to further explore the main issues from the consultations and written submissions.

1.3 A snapshot of community health counselling

1.3.1 Program profile

The Department of Human Services, as a primary health initiative, provides funding to Community Health Services (CHSs) to provide counselling services. CHSs employ qualified counsellors to provide supportive counselling, casework and specific therapeutic interventions.

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[1] www.health.vic.gov.au/communityhealth/downloads/rev_cnsllng_discpaper_mar02.pdf

[2] www.health.vic.gov.au/communityhealth/gps/mbs/mental_health.htm

[3] www.health.gov.au/internet/main/publishing.nsf/Content/mental-coag-prog

Individual CHSs determine the mix of services offered, based on local area demographics and the availability of other services in the local area. This includes decisions about the composition of counselling teams. A small CHS might employ a single counsellor who can provide supportive counselling and casework functions, but if the counsellor is not sufficiently qualified to provide therapeutic interventions, the CHS is expected to partner with a service or provider with the capacity to provide therapeutic services. A larger CHS, on the other hand, might have the capacity to employ a range of qualified counsellors that allows for specialisation in particular areas, for example family therapy or health psychology.

CH counselling focuses on people with significant multiple and complex problems, requiring a flexible and responsive consumer-centric service. CH counselling, being part of CHSs, has an overall focus on reducing health inequalities.

1.3.2 Consumer profile

Of people who attend CH counselling, 62 per cent indicated they held Centrelink Concession Cards and received a government pension or allowance. Just over two-thirds of CH counselling consumers are females, and the most commonly seen age group is 25–45 years. Children, adolescents and young adults aged 18–24 years are under-represented. Approximately 70 per cent of CH counselling consumers attend three or fewer sessions (42.4% attend once, 27.5% attend two or three times).

1.4 Policy context for community health counselling

The following National and State policies and frameworks have informed the planning, development and future directions for CH counselling in Victoria.

1.4.1 National policies

Since 1992, States and Territories have agreed on a national approach to improving mental health in Australia. After the adoption of a National Mental Health Strategy in 1992, all state and territory Health Ministers have endorsed four National Mental Health Plans covering the period 1992–2011.

The *First national mental health plan 1993 to 1998* (DOHA, 2005) focused on serious mental illness and on a move toward deinstitutionalisation. It signalled a move towards community-based care, including care provided by generic health services, with the aim of improving access for people with serious mental illness and reducing stigma associated with mental illness.

The *Second national mental health plan 1998–2003* (DOHA, 2005) built on these principles and called for greater attention to population-based approaches to address high-prevalence disorders such as depression and anxiety, focusing on three key themes:

- Health promotion and illness prevention
- Development of partnerships in service reform
- Quality and effectiveness of service delivery.

The second plan emphasised mental health promotion, early intervention and relapse prevention. It highlighted the benefits of linkages between specialist mental health services that focus on the three per cent of the population with serious mental illness, and other services in the broader health system responding to high-prevalence disorders.

The *Third national mental health plan 2003–2008* (Australian Health Ministers, 2003) prioritises:

- Promoting mental health and preventing mental health problems and mental illness
- Increasing service responsiveness
- Strengthening quality
- Fostering research, innovation and sustainability.

The third plan also focuses on a population health approach to mental illness, arguing for prevention, early intervention, rehabilitation and recovery, whilst recognising that social and economic factors have a major influence on mental health and wellbeing. It argues that the determinants of health translate into either risk or preventative factors, either increasing the likelihood of mental illness developing or bolstering people's resilience by moderating life's stressors, thereby reducing the likelihood of developing mental illness.

National Action Plan on Mental Health 2006–2011

The Health Ministers met in 2006 during the Council of Australian Governments (COAG) meeting, and committed to reform the mental health system in Australia. The National Action Plan highlights the need for greater coordination and collaboration between State and Commonwealth Government–funded services, private and non-government providers to develop a better-connected system of care for people with mental health problems (DOHA, 2006b).

Better access to psychiatrists, psychologists and general practitioners through the MBS

In October 2006, the Australian Government, in *Better access to mental health care* (Council of Australian Governments, DOHA, 2006a), announced funding of $538 million over five years through the Medicare Benefits Schedule (MBS) to provide a structured framework for medical practitioners and clinical psychologists to undertake assessment, care planning and management of people presenting with mental disorders on referral from a GP or a consultant physician or specialist in the practice of his or her field of psychiatry or paediatrics.

The initiative provides Medicare rebates for sessions of psychological therapy provided by private therapists (psychologists, clinical psychologists, social workers and occupational therapists) for individual or group therapy, and for individual therapy sessions provided by GPs with additional training.

Co-payments (the difference between the Medicare rebate and the care provider's fees) can be a financial barrier to accessing services (DHS, 2007c). Many GPs and some mental health providers will bulk-bill concession card holders and children under 16 years of age or regular patients known to be unable to afford gap payments (Australian Psychological Society, 2007). Increasingly, CHSs are developing partnering relationships with Medicare providers, for example providing consulting rooms within a CHS to reduce the co-payment charge to the consumer.

Information about Medicare rebates can be found at the Department's MBS website[4] and the Commonwealth Government's website about Medicare rebates for mental health.[5]

1.4.2 Victorian policies and key strategies

Because mental health matters: Victorian Mental Health Reform Strategy 2009–2019 was released in February 2009.

The strategy is built on the core concepts of prevention, early intervention (early in life, illness and episode), recovery and social inclusion.

It recognises that better individual and community outcomes in mental health depend on an integrated cross-government approach. To this end, the strategy involves partnerships between mental health services and a range of other service sectors, including primary health, early childhood, education, community services, acute health, employment, youth, justice, police and corrections, housing and aged care. This approach will promote shared responsibility for prevention and early intervention, more connected care for consumers, and more effective support for their families and carers.

Drawing on an extensive public consultation, the strategy sets out a reform agenda to be pursued over a 10-year period. Primary health services play an important role across a number of reform areas, incorporating prevention, early intervention, treatment and recovery support.

Because mental health matters: Victorian Mental Health Reform Strategy 2009–2019 is available on the Mental Health Reform Strategy website.[6]

A fairer Victoria: Creating opportunity and addressing disadvantage (Department of Victorian Communities, 2005), Victoria's overarching social policy, directs action towards improving the lives of disadvantaged Victorians.

A fairer Victoria establishes a framework to address disadvantage by developing and implementing innovative approaches to service delivery. The guiding elements are:

- ensuring that universal services provide equal opportunity for all
- reducing barriers to opportunity
- strengthening assistance to disadvantaged groups
- providing targeted support to the highest-risk areas
- involving communities in decisions affecting their lives and making it easier to work with Government.

A range of key policy documents guide the development of State-funded primary health care services. They are briefly outlined below.

Community health services – creating a healthier Victoria (DHS, 2004a) identifies CHSs as substantial providers of primary health care in Victoria. CHSs provide the major platform for the delivery of population- and community-based health services in Victoria, including a range of allied health and counselling services, support and self-help groups and mental health promotion. The policy identifies mental health promotion as a population-based approach shown to be effective in reducing depression, suicidal behaviour and behavioural problems in the longer term.

Care in your community (DHS, 2006b) sets out a framework for a consistent approach to the development of a health care system that is integrated and coordinated around the needs of people rather than service types, professional boundaries, organisational structure, funding and reporting requirements.

This strategy refocuses planning and investment to ensure the best mix of inpatient and community-based integrated care services, and to be responsive to the need

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[4] www.health.vic.gov.au/communityhealth/gps/mbs/mental_health.htm

[5] www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-amhpm

[6] www.health.vic.gov.au/mentalhealth/reformstrategy

for prevention, early intervention, self-management and health promotion.

Planning and investment for the delivery of integrated, community-based health care should be:

- based on a single set of area-based planning catchments
- informed by a single set of planning principles
- supported by area-based planning networks
- focused on three high-level areas of need
- conducted on the basis of defined modes, settings and levels of care.

More information can also be found at the Victorian Government Health Information website.[7]

The Primary Care Partnerships Strategy (DHS, 2005c) has its origins in the primary health care sector, although Primary Care Partnerships (PCPs) have broadened their scope over time. PCPs are made up of a diverse range of member agencies. All PCPs include hospitals, CHSs, local government and divisions of general practice as core members of the partnerships. Other types of agencies such as mental health, drug treatment and disability services are also members of PCPs. The partners can also be specific to local issues and needs. For example, some PCPs have engaged with the police, schools and community groups.

Foundations for primary care mental health treatment services in Victoria (DHS, 2004b) was developed under a bilateral agreement between the Victorian Department of Human Services and the Commonwealth Department of Health and Ageing. 'Foundations' supports local area partnerships between three key service sectors: specialist mental health services, CH counselling and GPs in the provision of mental health treatment services for children, adolescents and adults in primary care settings in Victoria.

Tackling mental health strategy (DHS, 2006f) was released in October 2006 by the Victorian Government. As part of this strategy, the Government allocated $3.75 million across drought-declared areas of rural Victoria, in recognition of the personal impact of drought on rural communities. This funding boosted counselling hours of service through the Family Services Program and through the Community Health Program. As part of this response to support rural communities affected by drought, PCPs were also allocated funding to enhance service coordination, service and community planning, and facilitate training and skills development across health and community service practitioners, general practice, early years service sectors and rural communities.

In the 2007–08 Victorian State budget, $3.1 million was allocated to further assist communities affected by the drought under the *Sustaining community wellbeing in drought* initiative (DHS, 2007c). This initiative was further boosted in October 2007 when the Victorian Government committed an additional $1.9 million to counselling and support services to assist rural people affected by drought.

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[7] www.health.vic.gov.au/ambulatorycare/careinyourcommunity

Chapter 2: The focus

The Victorian Government's Social Policy, *A fairer Victoria* (Department of Premier and Cabinet, 2005) outlines a commitment to strengthening assistance to disadvantaged groups; ensuring services are accessible for those with the highest risk of poor social and economic outcomes and further disadvantage. People with low education levels, low-status occupations and low incomes have poorer mental health than their higher status and more affluent counterparts (Astbury, 2001).

Focus areas

A fairer Victoria, together with a review of the literature and service usage data, has led the Department to ask that CHSs focus the proactive, preventative and early intervention components of CH counselling on the following areas:

1. **Chronic disease and chronic conditions**
2. **Young people and their families**
3. **Mild to moderate mental health problems in people unable to access a Medicare-rebateable private provider.**

CHSs should consider these three focus areas when planning and reviewing contributions to health promotion and shaping service delivery approaches. This would include consideration of:

- the mix of particular counselling services offered (individual, groups, outreach etc.)
- professional development and clinical directions of counselling team members
- service promotional and marketing initiatives and products.

These focus areas are concerned with how services are promoted to encourage particular population groups to access assistance and should not be taken to mean that people who do not fit within one of these groups should be denied a service. Standard 5 in Chapter 5 sets out a framework for prioritising access to CHSs, including CH counselling.

2.1 Chronic disease and chronic conditions

In Victoria, approximately 70 per cent of the total burden of disease is attributable to six groups: cardiovascular disease, cancers, injuries, mental health conditions, diabetes and asthma. Risk factors include lifestyle factors: tobacco smoking, physical inactivity, alcohol consumption, diet, unsafe sex and intimate partner violence; and physiological states: obesity, high blood pressure and high cholesterol. These factors are responsible for a sizeable proportion of the burden of disease in Victoria (DHS, 2001d).

The *National survey of mental health and wellbeing* (ABS, 1997) identified that approximately 40 per cent of the people who experienced anxiety, depression or alcohol disorders also had chronic medical conditions, including cardiac and respiratory disorders and arthritis, suggesting a strong association between mental and physical health problems.

2.1.1 Chronic disease and mental health problems

> 'Depression… and lack of social support place people at greater risk of coronary heart disease and are as important as other well-known risk factors such as smoking, high cholesterol and hypertension.'
>
> (Bunker et al., 2003)

The immune and cardiovascular systems are affected by prolonged exposure to stress, making people more vulnerable to a range of conditions including infections, diabetes, high blood pressure, heart attack and stroke (Wilkinson & Marmot, 2003) as well as complications in pregnancy (Syme, 1996).

Research has also found a particular link between depression and anxiety and cardiovascular and cerebrovascular disease (Herrman, Saxena & Moodie, 2005).

Depression, social isolation and lack of social support place people at greater risk of coronary heart disease and are as important as other well-known risk factors such as smoking, high cholesterol and hypertension (Bunker et al., 2003), and people with a chronic disease, such as hypertension, cancer or stroke, suffer noticeably higher rates of depression than the general population.

The number of Australians diagnosed with diabetes is growing at 9 per cent per annum and the prevalence of diabetes, including undiagnosed cases, is estimated to be twice that number, with a further 1.5 million persons pre-diabetic (Access Economics, 2006).

Having diabetes more than doubles the risk of developing depression, and the rate of depression for people with diabetes is nearly three times higher than for people with HIV/AIDS and nearly four and half times higher than for people who do not have chronic ill health. Depression can also increase the likelihood of developing diabetes complications (WHO, 2003).

2.1.2 The role of CH counselling in a multidisciplinary care plan to assist people with chronic conditions

Counselling can contribute to reducing the impact of chronic disease and of conditions such as depression, and also assists people who have physical chronic conditions such as cardiovascular disease, cancers, injuries, diabetes and asthma to manage their condition.

There is evidence to show that specific therapeutic interventions can be effective in changing behaviours which contribute to the development of chronic disease. For example, cognitive behavioural therapy can lead to effective and sustained weight loss by also addressing the psychological factors that contributed to the weight gain (Cooper & Fairburn, 2001).

Mental health problems can exacerbate the impact of chronic illness by being a barrier to successful treatment and they can also hinder people's adherence to chronic disease management plans. For example, physical activity may be an important management technique for coronary heart disease, but social anxiety may inhibit a person from leaving the home to engage in planned physical activity. When care planning coordinates multiple service providers for people with chronic conditions, it can include counsellors from the CH counselling program providing interventions to assist people to manage chronic mental and/or physical health conditions.

2.1.3 The Early Intervention in Chronic Disease initiative (EliCDI)

The Early Intervention in Chronic Disease initiative (EliCDI) commenced in 2005–06 to increase service system capacity to focus on chronic disease.

Early evidence from evaluation of EliCDI suggests that the consumers accessing the program also have indicators of high levels of psychosocial distress. Given the common co-occurrence of common mental health problems such as depression with chronic disease, there will be a role to play for CH counselling in responding to chronic disease. The EliCDI initiative is implementing a variety of approaches to support consumers to better manage their conditions, including:

- training and implementation of self-management support approaches such as Stanford Better Health Self-Management, Flinders Care Planning, Health Coaching and Motivational Interviewing
- assisting CHSs to develop models based on the Wagner Chronic Care Model[8]. The department has developed a set of guidelines[9] to assist PCPs and agencies implement the Chronic Care Model in their local context. The model identifies the essential elements required by an agency, together with a service system that encourages high-quality chronic disease care.

Examples of team care that are likely to be relevant to CH counselling include:

- case conferencing, which could include a counselling provider along with other health professionals, for example CH counselling or a Medicare-registered mental health provider
- links established with Mental Health Services (particularly Primary Mental Health Teams) and/or counselling services
- uptake of mental health MBS items to augment services provided by CHSs
- use of peer support groups to discuss aspects of consumer care and approaches used with consumers
- secondary consultation provided by CH counsellors and/or psychologists

2.2 Young people and their families

The years of adolescence and young adulthood are a critical developmental period, particularly in terms of social and emotional wellbeing, as young people decrease their dependence on families and school and move towards independence and autonomy (DOHA, 2000a). Adolescence is also a time when many mental disorders have their first onset and most of the major disorders of adult life begin to escalate during this period (DOHA, 1999)

There can be significant negative and long-term effects of even mild mental health issues in adolescence as they can cause social, emotional and cognitive changes into later adult life. Mental health problems in late adolescence can impede a young person's growth, erode quality of life, affect levels of confidence and self-esteem, create unwanted dependence on families, strain social and family relationships, disrupt education and career prospects and hinder social development (DOHA, 2000a).

Children and adolescents who live in low-income families are at an increased risk of developing mental health problems

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[8] www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/ (viewed 7 November 2007)

[9] www.health.vic.gov.au/communityhealth/downloads/cdm_program_guidelines.pdf (viewed 7 November 2007)

compared to those in higher-income families (ABS, 1998). As a universal service provider, CHSs can play a very important preventative role by shaping services and health-promoting activities to encourage young people and their families to seek out assistance before concerns turn into crises.

2.2.1 The risks faced by young people

Young people with a high level of mental health problems are more likely to engage in risky behaviours (DOHA, 2000a). In the 12 months before the DOHA survey:

- 54% had smoked
- 48% had used alcohol and over 30% had engaged in binge drinking
- 23% had used painkillers not for medicinal purposes.

Some of the most concerning evidence of correlated risks focuses on suicidal/self-harming behaviours. Of surveyed young people with very high level of mental health problems:

- 42% had seriously considered suicide
- 25% reported attempting suicide in the previous 12 months.

Other evidence suggests that young people's rates of self-harming behaviours are substantially higher than those of adults (DOHA, 2004).

Of young people aged 12–17 years, 14 per cent will experience a mental health problem in any 12-month period (DOHA, 2000b). This rises to 19 per cent when using self-report measures.

2.2.2 Service usage by young people

CH counselling data collected between 2004 and 2007 indicate that only 8 per cent of CH counselling consumers were aged 18–24 years even though 27 per cent of people in this age group report having mental health problems. Similarly, only 5.4 per cent of CH counselling consumers were aged 12–17 years[10] even though 14 per cent of people in this age group report having mental health problems.

Although there is clear evidence that many young Australians experience mental health problems that will have significant long-term negative impacts if not addressed, the majority receive no professional help. Only 25 per cent of adolescents with mental health problems received professional help, increasing to 38 per cent of adults (DOHA, 2000a).

Barriers to accessing services for young people

Barriers for young people accessing services include:

- high cost
- inaccessibility
- lack of knowledge of available services
- lack of recognition of mental health problems
- long waiting lists
- concerns about confidentiality
- perception that professional services will not help
- general lack of engagement with services. (DOHA 2000a)

Strategies that may overcome some of these barriers include:

- offering counselling services to families
- flexible outreach services to actively engage young people
- timely interventions and a reduction in waiting times
- using suitable written material and media to orient young people to counselling
- better promotion of services to combat lack of knowledge of services
- partnerships with youth centres, community houses, shopping complexes, schools and sport and recreation agencies to provide counselling and groups offsite.

2.2.3 Family-based approaches

The families of young people may be aware that their son or daughter, brother or sister is struggling with emotional or mental health difficulties (Rickwood, Deane & Wilson, 2007) but might feel helpless and not know where to turn. Family-based approaches can be helpful to the whole family as well as the young person, strengthening protective factors within the family environment. Family work often begins with one or both parents seeking assistance, then inviting the young person and other family members to a family session.

The Department-sponsored training in family therapy skills offered to CH counsellors in 2006–07 was aimed at increasing access to counselling by children, young people and their families. This was in response to one the findings of the review of CH counselling conducted between 2001 and 2003: that counselling was offered mainly to adults, with too few CHSs offering substantial interventions to families, adolescents and children (DHS, 2002b).

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[10] Source: Primary health datamart, Department of Human Services, 2007

The training project (*Focus on Families*, The Bouverie Centre, 2006) focused on increasing the scope of CH counselling by increasing counsellors' confidence and capability to work with:

- families
- multiple people in the room together
- people across the age-group spectrum – children, adolescents and adults.

The broad aim for CHSs in relation to young people should be to ensure that suitable counselling services are accessible for young people, either provided by the CH counselling service or provided by other services. CH counselling, as part of a universal service system, is well placed and unique in its capacity to provide free or low-cost family-centred or 'whole-of-family' and flexible approaches. Increased efforts in this area would provide significant early intervention and prevention initiatives for young people's emotional and mental health problems.

2.3 Mild to moderate mental health problems

> 'Mental illness is the largest single cause of disability, accounting for 27 per cent of all years lived with disability and 45 per cent for those in the prime working age group of 25–44 years.' (DPC, 2006)

Each year nearly one in five of Victorians (19 per cent) will experience some degree of mental illness (DPC, 2006). The prevalence of mental illness varies by age. In young people aged 12–17 years, it is estimated at 14 per cent, increasing to 27 per cent among 18–24-year-olds and declining to 6 per cent for those over 65 years of age (excluding dementia).

Some people with mental health problems are now being assisted by private practitioners providing Medicare-rebateable therapeutic services on referral from a medical practitioner or by paid private services that may be rebateable through a private health fund (DOHA, 2007a).

CH counselling provides services to people who are unable to pay for a private service or are unable to access a Medicare-rebateable service. Common reasons for not being able to access a Medicare-rebateable service include living in an area where there is a lack of private practitioners; not being able to afford gap payments; and having complex health issues requiring a flexible mix of casework and counselling rather than a psychotherapeutic intervention only.

For the purpose of determining an appropriate service response, mental illness has been categorised into three tiers according to severity (DPC, 2006):

Tier 1	comprises the approximately 12 per cent of the population who experience mild disability including mild depression and anxiety disorders.
Tier 2	comprises the 4 per cent of the population who suffer illnesses including moderate depression and anxiety, personality disorders, eating disorders, adjustment disorders and substance-related disorders.
Tier 3	comprises the 3 per cent of the population with a severe disability including psychotic and bipolar disorders, severe anxiety and depression and severe eating disorders.

Decisions about which service or mix of services can best assist a person with mental health problems are largely influenced by the complexity and severity of the presenting symptoms.

Many people who experience mental health problems can be assisted by a GP and a private mental health practitioner providing Medicare-rebateable services, or by a CH counsellor. People with multiple problems – for example a mental health problem together with one or more other problems such as risk of homelessness, lack of support from friends and family, and/or low income – can find CH counselling's practical and flexible approach very helpful. CH counselling can play an important part in preventing the sometimes escalating and cumulative effect of multiple and complex problems by using a combination of practical problem-solving techniques and supportive counselling.

In a smaller percentage of more serious cases, referrals to the Area Mental Health Service (AMHS) will be required for specialist care. Involvement of an AMHS may be required for problems that:

- cause moderate to severe distress and impairment
- are associated with a greater risk of enduring disability
- are associated with a moderate to high risk of harm
- may involve the presence of a complicating co-morbidity
- require specialist psychiatric treatments or psychosocial interventions (DHS, 2006a).

For more information, see the supplementary notes to section 2.3, in the Appendix.

Chapter 3: The principles

CH counselling is guided by seven overarching principles that support the provision of high-quality, consumer-centred counselling services that aim to help people achieve and maintain wellbeing.

3.1 Consumer-centred counselling approaches

Principle 1: Consumer-centred counselling approaches

Services are designed and provided based on the needs of consumers.

CH counselling adopts a flexible approach to providing counselling services, offering supportive counselling, therapeutic interventions and casework (described in detail in Chapter 4). CH counselling is aimed at assisting consumers to overcome a wide range of social, emotional and mental health problems that, without effective intervention, could lead to more serious mental health problems.

Clinical decision-making is informed by processes that include monitoring the consumer's progress and counselling outcomes (see Chapter 5, Standard 4).

CH counselling provides a coordinated service response to consumers' needs, supporting referral pathways to a range of allied health, medical, dental and other specialist counselling services if needed. These services are often located within the CHS or provided by other neighbouring services that have established links with the CHS through PCPs.

3.2 Fairness and equity

Principle 2: Fairness and equity

Fair and equitable service provision is integral to CH counselling.

The State Government's social strategy, *A fairer Victoria* (Department of Planning and Community Development, 2008), emphasises the need for prioritising people from disadvantaged groups in order to reduce the inequality in health status that is associated with disadvantage. The strategy emphasises the need for:

- early intervention and prevention
- matching services to local needs
- assisting communities to support individuals
- making services easier to access, more responsive and more successful.

CHSs have an overall focus on people with the poorest health and the greatest economic and social need (DHS, 2008c). They prioritise consumers, including those wishing to access CH counselling, according to need. Decision-making about the provision of CH counselling is informed by evidence-based practice, leading to efficient and effective provision of counselling services.

3.3 Service planning

Principle 3: Service planning

CHSs participate with other services in local area planning to ensure that through collaborative agreement between services, the catchment population's needs are met.

CHSs adopt and/or participate in a local area planning approach when planning services, based on the catchment population's need and identification of other services being provided in the local area. PCPs provide the ideal platform for this collaborative approach to service planning. For counselling this will include identification of catchment population characteristics – for example higher-than-average ageing population, or growth area with a higher-than-average proportion of young families – as well as identification of other counselling services in the local area and service gaps.

The needs and preferences of the population being serviced will inform the mix and type of services offered, such as the amounts and types of group work, health promotion and outreach, or centre-based counselling sessions. For example, people from other cultures, particularly people who have recently arrived in Australia, might prefer to meet up with a counsellor at a culturally sensitive agency of their choice.

Planning of CH counselling will include analysis of data collected about consumer needs and usage patterns within the CHS. CHSs can collect service-specific data to reflect particular local area needs.

Future planning for data collection will include the provision to collect *problem type* and *presenting issues.* This will assist:

- individual services to accurately plan services to best reflect the needs in the local community
- the planning of integrated mental health promotion plans with other services in the region
- the capture of important information that can guide research, with the anticipated outcome of building an appropriate evidence base for interventions used in CHS counselling services (see Standard 4, Chapter 5).

For more information, see the supplementary notes to section 3.3, in the Appendix.

3.4 Quality improvement

Principle 4: Quality improvement

CHSs' quality planning processes include a structured plan for auditing CH counselling processes and guidelines, and for implementing needed changes.

The provision of high-quality counselling requires regular and ongoing review of service structures, systems and processes. CHSs' quality planning processes include a structured plan for auditing CH counselling processes and guidelines and for implementing needed changes.

Clinical supervision is an essential quality improvement strategy that contributes toward the health and safety of consumers, communities, and counsellors. All counsellors, from students and new graduates to those who are highly experienced, will participate in regular clinical supervision of their work.

All CHSs are required to be accredited by an independent safety and quality program, such as the Quality Improvement and Community Services Accreditation (QISCA) or the Evaluation and Quality Improvement Program (EQuIP).

The quality framework *Better quality, better healthcare* (DHS, 2005a) underpins the policy and funding guidelines for primary health services in Victoria.

For more information, see the supplementary notes to section 3.4, in the Appendix.

3.5 Determinants of mental health

Principle 5: Determinants of mental health

CHSs embrace models of care that reflect the diverse underlying determinants of health.

Risk and protective factors

Environmental and individual risk factors can increase the likelihood of mental health problems, while protective factors can moderate the effect of risk factors by building resilience.

While the presence of risk factors increases the likelihood of onset of mental health problems and their severity and duration, protective factors can moderate the effect of risk factors.

For example, risk of homelessness and being unemployed can be moderated to some extent by having strong social support through a network of friends. Psycho-education and support groups around topics such as stress management and problem-solving skills can help to moderate individual risk factors.

> 'Mental health problems are mostly a cumulative effect of:
>
> - the presence of multiple risk factors
> - the lack of protective factors
> - the interplay between risk and protective situations.' (Meijer, 2007)

Individual determinants include biological, genetic, family-related factors, personality traits (Meijer, 2007) and behavioural and psychosocial factors (Talbot & Verrinder, 2005).

Environmental determinants include poverty, loneliness, social isolation and child abuse. Protective factors improve a person's resilience to risk factors, modifying a person's capacity to overcome environmental hazards (Meijer, 2007).

Evidence for links between disadvantage and mental health

There is evidence that people who are socially excluded or isolated have between two and five times the risk of dying from all causes compared to those who maintain strong ties with family, friends and community (Berkman & Glass, 2000).

For more information, see the supplementary notes to section 3.5, in the Appendix.

Community health focus on disadvantage

Consistent with Victoria's social policy, *A fairer Victoria* (Department of Victorian Communities, 2005), which guides efforts to improve the lives of disadvantaged Victorians, CHSs prioritise disadvantaged people to reduce inequality in health status (DHS, 2004a). See Standard 5 in Chapter 5 for more information.

A model of care that bolsters protective factors

CHSs embrace models of care that are responsive to their consumers and reflect the diverse underlying determinants of health. In this way, CHSs combine the social model of health with clinical care to maximise outcomes for their consumers (DHS, 2004a).

The social model of health has been defined as:

> 'a conceptual framework within which improvements in health and wellbeing are achieved by directing effort towards addressing the social and environmental determinants of health, in tandem with biological and medical factors.' (DHS, 2002d)

Important concepts reflected within this model include: strengthening community action and creating supportive local environments for health; balancing prevention with early intervention; and encouraging and supporting self-help (Owen & Lennie, 1992).

For more information, see the supplementary notes to section 3.5, in the Appendix.

3.6 Cost not a barrier

Principle 6: Cost not a barrier
Cost is not a barrier to accessing community health counselling.

Many people seeking access to counselling may already be experiencing significant stressors. Cost or the fear of costs will not be a barrier to accessing CH counselling. In recognition of this, the fees policy for CHSs states that there is no charge for low- and medium-income earners. Higher-income earners will be charged 'full cost recovery'. The Department's *Community health, home and community care programs fees policy* (DHS, 2008b) provides detailed information about fees and income levels. CHSs establish links with providers of Medicare-rebateable services to assist the disadvantaged to access needed services.

Chapter 4: The interventions

CH counselling is one of the main State Government publicly funded services offering low-cost or free accessible generalist counselling. For the majority of people accessing CH counselling, the service will be free, however the Department expects CHSs to charge higher-income earners *full cost recovery.*[11] CHSs target disadvantaged and vulnerable groups; people from these groups are also more likely to have chronic and complex conditions. Many CH counselling consumers have multiple and complex conditions that require a combination of counselling interventions, such as counselling and casework, as well as a range of 'other' health services.

The consumer-centred philosophy of community health encourages and supports CH counsellors to be truly responsive to the consumer's needs. CH counselling offers flexible counselling approaches, assisting people to overcome a wide range of emotional or mental health problems that could lead to more serious mental health problems without effective intervention. In addition to direct counselling interventions, CH counselling also contributes to wellbeing at a population level by involvement in mental health promotion.

CH counselling uses three main types of 'counselling' interventions: supportive counselling, casework and advanced therapeutic interventions.

4.1 Supportive counselling

Supportive counselling is the foundation for other interventions. The counsellor offers warmth and empathy in a genuine, respectful and non-judgmental space in which consumers can reflect on aspects of their lives they would like to change (Rogers, 1951). Counsellors providing supportive counselling aim to work collaboratively with the consumer to identify the consumer's strengths and resources, leading to greater self-reliance.

4.2 Casework

Casework describes supportive actions undertaken by counsellors to help the consumer manage issues that are impacting on their wellbeing. CH counselling aims to help consumers develop their own supportive local environment. Casework can enhance the effectiveness of supportive counselling and advanced therapeutic interventions. Casework, undertaken in collaboration with the consumer, can include strategies such as:

- resourcing a consumer with information
- coordinating a range of other services assisting the consumer
- referral
- establishing partnerships
- advocacy
- facilitating and attending case conferences.

The amount of time providing casework will vary, depending on the complexity of the needs of the consumer. Casework is not a substitute for specialist mental health case management where this is necessary, but counsellors may be working in partnership with specialist mental health services, GPs or private therapists. Casework is undertaken with reflection on what other services may be available to assist a consumer in their local area. An important part of CH counselling is building a body of knowledge about, and relationships with, other services and resources in the local community.

Consumers with multiple and complex conditions may require a higher level of casework (for example referral or coordination). A high level of clinical knowledge and expertise is needed to accurately assess the situation and to sensitively respond to the consumer's needs by supporting them to enlist the help of agencies or follow through on other actions as needed.

During casework, opportunities can arise when the consumer discovers new approaches to what might have seemed an intractable problem in the past – these key breakthrough moments may occur during the course of practical problem solving activity.

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[11] See DHS, 2008b

4.3 Advanced therapeutic interventions

Advanced therapeutic interventions are evidence-based practices that propose how change can occur within a theoretical framework. Examples of advanced therapeutic interventions include but are not restricted to:

- interpersonal therapy
- narrative therapy
- psycho-education
- cognitive behavioural therapy
- systems approaches
- family therapy
- solution-focused therapy
- psychodynamic therapy.

Therapy helps consumers to understand their thoughts and feelings and to identify strategies to manage or resolve them. Counsellors usually find one or more therapeutic approaches fit with their own interpersonal style. Standard 4 discusses evidence-based practice in relation to therapeutic approaches in community health settings.

CH counsellors will only practise advanced therapeutic interventions for which they hold appropriate postgraduate qualifications. When a CH consumer requires a particular therapeutic intervention, the CH counsellor may suggest a referral to another therapist (see Standard 4 in Chapter 5).

Group work

Advanced therapeutic interventions can be used not only in individual work but also in group work, an important aspect of CH counselling. In both settings, advanced therapeutic interventions can be used in tandem with supportive counselling. The nature of group work can also assist in creating supportive settings for consumers by enhancing social support.

4.4 Mental health promotion

In addition to the provision of counselling, CH counselling also operates at a community level, providing prevention responses to emerging problems. CH counselling can contribute to mental and social wellbeing at a community level through involvement with mental health promotion. Standard 1 (Chapter 5) outlines mental health promotion roles and activities that CH counsellors can undertake.

Part II: Program standards

Chapter 5: The standards

Overview

The standards presented in this chapter apply to CH counselling. They have been developed to guide safe and effective counselling service provision. Other counselling services funded by the Victorian and Australian Governments that may be located in CHSs will have separate specific program guidelines, for example those for Alcohol and Other Drug Services.

The standards were informed by the requirements defined in:

- Primary Care Partnerships' Service Coordination initiative, as outlined in Better access to services: A policy and operational framework (DHS, 2001a)
- Service quality framework (DHS, 2002c)
- National standards for mental health services (DOHA, 1997)
- National practice standards for the mental health workforce (DOHA, 2002).
- Victorian service coordination practice manual (DHS, 2007d)
- Service access models: a way forward. Resource guide for community health services (DHS, 2006e).

Emphasis of the standards

The *Review of counselling services in community health* (DHS, 2002b) identified the need for CH counselling to adopt a quality improvement focus and to plan for future demand.

Limitations of the standards

These standards should be read in conjunction with agencies' Funding and Service Agreements, the standards required for accreditation by the relevant quality authorities and the protocols agreed by members of PCPs.

Implementation of the standards

The standards should be implemented with consideration of local-level planning such as integrated area-based planning described in *Care in your community* (DHS, 2006b) and PCP protocol development and planning. PCPs provide the forum for local-area service providers, identifying local community needs and planning solutions. Participation in PCPs informs CHS planning about focusing counselling resources; for example, a CHS might work in partnership with other providers in the area to ensure that community needs are being met with minimal duplication of services.

Meeting the standards

Each standard incorporates a number of 'anticipated outcomes' that agencies can use to assess their progress towards meeting the standards. These standards will be incorporated within broader-level 'whole-of-service' work being undertaken to develop a clinical governance framework.

Individual CHSs should determine the sequence of actions for implementing the standards.

5.1 Mental health promotion

Standard 1: Mental health promotion

CH counselling maintains a balance between individual- and population-focused work by contributing to organisational mental health promotion plans.

Anticipated outcomes

- CH counselling undertakes roles in planning, supporting, conducting and evaluating mental health promotion plans.
- CH counselling increases its participation in planning and consultative processes for mental health promotion plans at a service and PCP level.

5.1.1 Determinants of mental health

The VicHealth (2006) *Framework for the promotion of mental health and wellbeing* outlined three overarching social and economic determinants of mental health: social inclusion; freedom from violence and discrimination; and access to economic resources and participation (based on the work of Keleher & Armstrong, 2005). This framework[12] guides CHSs' work in the area of strengthening protective factors by adopting a mental health promotion approach at a community or population group level.

The VicHealth definition of 'mental health' highlights that social and economic factors influence mental wellbeing:

> '[Mental health is] the embodiment of social, emotional and spiritual wellbeing. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just.' (VicHealth, 1999)

There is evidence of the impact of particular factors on mental wellbeing. For example, people who are socially excluded or isolated from others have between two and five times the

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[12] www.health.vic.gov.au/healthpromotion/evidence_res/mhp.htm

risk of dying from all causes compared to those who maintain strong ties with family, friends and community (Berkman & Glass, 2000). Experiencing violence and discrimination has also been linked to a poorer sense of wellbeing and increased depression, anxiety and other mental health issues (Brown et al., 2000).

5.1.2 Planning mental health promotion

Contributing to CHS and PCP health promotion plans is an effective way that CH counselling can contribute to prevention of mental health problems.

One of the seven Statewide health promotion priorities approved by the Minister for Health for 2007–12 is *Promoting mental health and wellbeing*. This presents the opportunity for CH counselling to inform population-based mental health promotion activities – informing, resourcing and reinforcing PCP health promotion priority setting.

CH counselling

Mental health promotion plans contribute to general health promotion by taking action to ensure that social conditions and factors create positive environments for the mental health and wellbeing of populations, communities and individuals.

‘Mental health promotion requires action to influence determinants of mental health and address inequities through the implementation of effective multi-level interventions across a wide number of sectors, policies, programs, settings and environments.’ (VicHealth, 2006)

Within a service, mental health promotion plans should be sub-plans of the service’s overall health promotion plan. Mental health promotion plans should focus on the three determinants of:

1. Social inclusion
2. Freedom from violence and discrimination
3. Access to economic resources and participation (work, education, housing, money).

Mental health plans should aim to:

- improve the social, physical and economic environment that determines mental health
- enhance protective factors of coping, resilience and connectedness
- identify both whole populations as targets and subgroups
- apply the full range of health promotion actions.

5.1.3 Health-promoting activities for use by CH counsellors

The kinds of activities that can be undertaken within a mental health promotion program form a continuum that ranges from those that have an individual focus to those that target whole populations (see Figure 1 and the text below). A mix of activities should be chosen to achieve the best outcome. CH counsellors participating in the organisational health promotion plan might be involved in activities on any part of this continuum.

Screening, individual risk assessment, immunisation: These interventions involve the systematic use of tools to detect individuals at risk of developing a specific disease that is amenable to prevention or treatment (e.g. K10 depression tool). This type of intervention falls within the intersection between treatment services and mental health promotion programs, and therefore is useful as an engagement strategy rather than a direct health promotion activity.

Health education and skill development: These interventions provide education to individuals or groups with the aim of improving knowledge, attitudes, self-efficacy and individual capacity to change (e.g. a ‘managing anxiety’ course). This type of intervention is an early intervention strategy.

Social marketing and health information: These interventions are programs designed to advocate for change by influencing the voluntary behaviour of the target audience. They shift attitudes and raise public awareness through mass media (e.g. a poster campaign at maternal child health centres to raise awareness of postnatal depression).

Figure 1: Continuum of health promotion interventions

Health promotion interventions and capacity building strategies

Individual focus ↔ *Population focus*

Screening, individual risk assessment, immunisation	Health education and skill development	Social marketing and health information	Community action	Settings and supportive environments

Community action: These interventions are programs that aim to encourage and empower communities to build their capacity to develop and sustain improvements in social and physical environments (e.g. supporting local community members to approach a local council about setting up a community vegetable patch).

Settings and supportive environments: These interventions involve organisational development, economic and regulatory activities and advocacy (e.g. ensuring that bullying, discrimination and violence are not acceptable in agency policy and practice).

Drawing on their particular area of knowledge and skill, counsellors can undertake particular actions to support the planning and implementation of mental health promotion programs by:

- Being alert to local priority issues: Counsellors can take note of the presenting issues and particular determinants that are affecting the local population's mental health, as evidenced through their direct counselling work, and disseminate this information to the relevant health promotion groups within their service and local PCP.
- Being a mental health researcher: Based on their specialist knowledge of elements of mental wellbeing and appropriate resources, counsellors can conduct literature reviews to inform mental health promotion planning.
- Being a mental health advocate in planning: Counsellors can use their experience and knowledge in mental health to review general health promotion plans and activities with a 'mental health lens', and outline opportunities to address mental health and wellbeing.
- Being a group skills trainer: Based on their particular experience facilitating therapeutic groups and their training in group dynamic theory, counsellors can provide facilitation skills training for other staff to use in health promotion meetings, forums and focus groups.

5.1.4 Partnerships for mental health promotion

Some of the partnerships that will help CH counselling to contribute to mental health promotion plans will be partnerships within their own service, while others will be with other services: other neighbouring CHSs, Area Mental Health Services, PCP member agencies, local government, and other non–health service sectors, e.g. housing, recreation and education. Partnerships occur across the continuum. Although a partnership on any level is useful, the most effective partnerships are 'collaborative' partnerships, and though these relationships require the most amounts of time and trust, they yield the most benefit for the local community.

The *Integrated health promotion resource kit* provides a basis for the priority setting within the context of the broader cycle of planning, implementation, evaluation and dissemination of health promotion. The *Integrated health promotion resource kit* contains checklists for each step of the planning framework. For more detail, see the section *Health promotion practice* on the Health Promotion website.[13]

The *Evidence-based mental health promotion resource* provides a detailed section on applying the planning framework to mental health promotion programs. The resource can be downloaded from the Health Promotion website.[14]

5.2 Consumer, carer and community participation

Standard 2: Consumer, carer and community participation

CH counselling promotes consumer, carer and community participation in all aspects of service provision.

Anticipated outcomes

- Consumers become aware that the service values the active participation of consumers and carers in shaping how services are provided and which services are provided.
- Consumers will be actively involved in the planning, developing and evaluation of services.
- CH counselling has in place procedures to support consumer participation.
- Consumers are informed about the avenues to provide feedback, suggestions and opinions about their experience of being a consumer of the service.

> 'The rights of consumers and their families and carers must shape reforms.'
>
> A key principle of the *National mental health plan 2003–2008* (DOHA, 2007b)

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[13] www.health.vic.gov.au/healthpromotion/downloads/integrated_health_promo.pdf

[14] www.health.vic.gov.au/healthpromotion/downloads/mental_health_resource.pdf

5.2.1 Definitions

'Consumers – people who are current or potential users of health services. This includes children, women and men, people living with a disability, people from diverse cultural and religious experiences, socioeconomic status and social circumstances, sexual orientations, health and illness conditions.

Carers – families and friends providing unpaid care to consumers. Carers may often be receiving a government benefit or allowance.

Communities – defined as groups of people who have interests in the development of an accessible, effective and efficient health and aged care service that best meets their needs.' (DHS, 2006d)

5.2.2 Meaning of participation

'Participation occurs when consumers, carers and community members are meaningfully involved in decision-making about health policy and planning, care and treatment and the wellbeing of themselves and the community. It is about having your say, thinking about why you believe in your view, and listening to the views and ideas of others. In working together decisions may include a range of perspectives.'

The term 'participation' usually implies a sharing, not only of information and opinion but also of decision-making power. Real participation means joint problem-solving, joint decision-making, and joint responsibility. (Banyule Nillumbik Primary Care Alliance, 2003)

5.2.3 Consumer, carer and community participation in counselling

Consumer participation in CH counselling can occur across many organisational levels, from individual counselling processes to service-wide processes, as follows:

i. Participation in counselling process

Counsellors elicit individual consumer participation when utilising an outcome-informed perspective to guide planning for counselling services. This evidence-informed practice relies on consumer feedback to inform the efficacy of the techniques used and the 'experience' of the counsellor–consumer relationship.

ii. Participation using existing counselling groups

Groups that are either facilitated by member/s of the counselling team or self-help groups that operate within the CHS can provide a ready-made accessible option for inviting participants to provide consumer feedback.

iii Participation in providing service-wide feedback

Consumers of CH counselling can participate in shaping services by providing feedback about their experience as a consumer through formal activities, such as:

- questionnaires and surveys
- individual and group interviews
- responding to or commenting on papers, facts sheets, websites or education packs
- public meetings.

iv. Consumers engaged as service-wide consumer consultants and advocates

Consumers of CH counselling can hold ongoing formal positions in CHSs as:

- board members
- advisory group members.

v. Participation in service-wide delivery and evaluation

There are a variety of service evaluation processes in which consumers of CH counselling may participate, such as:

- evaluation and monitoring (developing guidelines for incident reporting and responding to complaints)
- service and facilities planning
- developing clinical processes
- accreditation.

vi. Participation in service-wide policy and planning

Consumers of CH counselling may also be engaged by the CHS to participate in 'whole-of-service' planning and policy development, for example:

- strategic planning
- policy development
- developing visions and mission statements.

What can consumer participation do?

'Consumer participation in health is about change. It is a reallocation of power between experts and users. It is making individuals and communities take responsibility for the protection of their wellbeing, and the promotion of healthier communities. It will change how organisations are structured, and their culture…' (East Gippsland and Wellington PCPs, 2004)

5.2.4 Useful websites

www.participationinhealth.org.au
www.chf.org.au
www.mhca.org.au
www.latrobe.edu.au/nrcconsumerparticipation
www.healthissuescentre.org.au (free training for both consumers and staff)

For more information, see the supplementary notes to section 5.2, in the Appendix.

5.3 CH counsellors – qualifications, learning and development

Standard 3: CH counsellors – qualifications, learning and development

CHSs have mechanisms to ensure the competence of counsellors, including minimum qualification requirements for employment, and requirements for ongoing clinical supervision and continuing professional development.

Anticipated outcomes

- As a minimum requirement, all counsellors hold membership or registration with a professional body that has a code of professional conduct, continuing professional development requirements, and procedures for managing complaints against members.
- All counsellors participate in regular clinical supervision that meets the guidelines for clinical supervision.
- All counsellors develop a professional development plan that is reviewed annually and is appropriate to their experience, competencies and work requirements.

5.3.1 Minimum mandatory qualifications[15]

CH counsellors should hold relevant tertiary qualifications – i.e. relevant to the provision of counselling – that enable membership of an organisation that requires full members to hold or be subject to the following:

- a professional code of ethics
- requirements for regular clinical supervision
- requirements for continuing professional development
- effective complaints handling and disciplinary mechanisms
- professional indemnity insurance
- a rigorous code of professional conduct
- successful completion of academic study that has significant components of professional ethics, theoretical frameworks, and supervised practice in counselling or therapy.
  For example, the Australian Psychological Society (APS), the Australian Association of Social Workers (AASW)

It is highly desirable for CH counsellors to have:

- training and experience in working with young people and families
- studies and experience in casework
- studies and/or knowledge of health promotion
- postgraduate counselling qualifications

CHSs should work with underqualified CH counsellors to develop an agreed timetable to gain minimum qualifications.

5.3.2 Clinical supervision

Clinical supervision is a collaborative and creative process of professional support. Clinical supervision provides counsellors with the opportunity to develop skills, clarify issues that may affect their practice, and gain new insights and perspectives. Clinical supervision is based on an evolving contractual relationship between an appropriately trained and experienced supervisor and the CH counsellor that is characterised by regular meetings to discuss the counsellor's professional practice. Clinical supervision encompasses discussion about specific cases, professional development needs, and translating theory into practice, with the ultimate aim of ensuring consumer welfare and improving consumer outcomes.

Both corporate supervision and clinical supervision are essential quality improvement strategies to ensure the health and safety of consumers, communities and counsellors. It is expected that all counsellors, from students and new graduates to those who are highly experienced, will participate in regular clinical supervision of their work.

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[15] From 2009, compliance with this document 'Community health counselling: Policy framework and program standards' will be a requirement under Schedule 3 of the Department of Human Services Funding and Service Agreement, thereby mandating these minimum qualifications.

The essence of clinical supervision

'Clinical supervision is a working alliance between counsellors in which they aim to enhance clinical practice, fulfil goals of the… organisation and meet ethical, professional and best-practice standards… while providing personal support in relation to the professional practice.' (Kavanagh et al., 2002)

5.3.3 Guidelines for clinical supervision

Clinical supervision of CH counsellors should:

- provide a safe environment where trust can develop, and be private, regular, supportive and uninterrupted
- be a collaborative and respectful process, based on adult learning principles that encourage a mutual learning environment for both counsellor and supervisor
- allow the counsellor to grow from their experience and increase their self-awareness
- provide in-depth reflection on practice that is useful and relevant to the counsellor
- have a strengths focus and validate the counsellor's work whilst addressing developmental areas
- include challenging counsellors' thinking and practice in a supportive way,
- be in place for all counsellors, not just counsellors new to the sector,
- assist counsellors to identify times when referral to a specialist service is appropriate
- encompass evidence-based approaches and processes
- have the flexibility to be delivered through a combination of group, peer and individual clinical supervision format, depending on the counsellor's need or preference and the resources of the service
- be provided in a format or combination of formats that is negotiated between the counsellor, the clinical supervisor and the organisation
- in regard to the amount of supervision provided to each counsellor, be determined by caseload and the number of hours worked each week or fortnight
- be based upon a formal, written supervision agreement.

5.3.4 Responsibility for the provision of clinical supervision

The employing agency is obliged to ensure that counselling staff are receiving adequate clinical supervision (see Chapter 3, Principle 2). All health services, including CHSs, will increasingly find it necessary to ensure all clinical staff are receiving adequate clinical supervision (appropriate to their discipline) to comply with clinical governance obligations.

The provision of high-quality clinical supervision supports the provision of high-quality effective counselling.

Clinical supervision is an essential strategy within a quality improvement program to ensure the health and safety of consumers, communities and counsellors.

Qualified counsellors are also required to undertake clinical supervision to maintain their professional registration. The quality and accessibility of high-quality clinical supervision being offered by potential employers could be an important consideration for clinicians when considering employment choices.

Whether clinical supervision is provided internally from within the employer's resources or externally is a matter of negotiation between the employee and employer. However the unit price for direct care services under the Primary Health Funding Approach incorporates all the costs associated with delivering services, including clinical supervision.

For more information, including information about peer consultation, see the supplementary notes to section 5.3, in the Appendix.

5.4 Evidence-based practice

Standard 4: Evidence-based practice
CH counselling implements systems to promote evidence-based counselling practice.

Anticipated outcomes

- Counsellors will work from an evidence-based framework, taking into account multiple sources of evidence.
- Clinical supervision provided to counsellors draws on evidence-based practice frameworks to promote effective counselling practice.
- There will be increased individual consumer participation in counselling service delivery, via utilising 'consumer knowledge' evidence.
- There will be an increase in the effectiveness of services for people who attend once or twice.
- CH counselling will use local-area demographic data to inform planning of counselling interventions.
- There are methods employed to gather data on the effectiveness of counselling services delivered by the service.

5.4.1 Defining evidence-based practice

A great and increasing challenge facing all counsellors is how to keep abreast of new research findings.

Evidence-based practice has been defined as the integration of the best research evidence with clinical expertise, together with the consumer's wishes and preferences (Sackett et al., 2000, cited in Levant, 2005).

Evidence-based research about psychological and pharmacological treatments has been driven by the impetus to develop recommendations and guidelines for 'best practice' interventions to treat psychological problems (Levant, 2005).

5.4.2 Ranking of research method to obtain evidence

The convention when analysing research is to rank the method of obtaining the data. There are six *levels of evidence* that range from the systematic review of all relevant randomised controlled trials through to the results of case series obtained from individual case studies, pre- and post-test (NHMRC, 1999).

Table 1 below sets out the levels of evidence which is required to understand Table 2, which follows over two pages. Table 2 was developed by the Australian Psychological Society (2006) and indicates the levels of evidence for psychological interventions for a range of psychological conditions.

Table 1: Designation of levels of evidence

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

Source: NHMRC, 1999

Table 2: Categorisation of levels of evidence for psychological interventions[16]

Condition	Intervention									
	Psycho-education	Cognitive behaviour therapy	Interpersonal therapy	Psycho-dynamic therapy	Dialectical behaviour therapy	Family therapy	Solution-focused therapy	Narrative therapy	Hypnosis	Mindfulness therapy	Bibliotherapy
Depression	Insufficient evidence of efficacy[*]	Level I	Level I	Level I (using short-term psychodynamic psychotherapy)	Level II	Level I (childhood and adolescent depression)	Level II	Level II (effect largely lost at follow-up)	Insufficient evidence of efficacy	Level II (relapse prevention)	Level III-1
Bipolar disorder	Level III-1	Level III-1	Insufficient evidence of efficacy	NS[†]	NS	Level III-2	NS	NS	NS	NS	NS
Obsessive compulsive disorder	NS	Level I (especially exposure with ritual prevention)	NS	NS	NS	NS	NS	NS	NS	NS	NS
Panic disorder	NS	Level I	NS	Insufficient evidence of efficacy	NS	NS	Insufficient evidence of efficacy	NS	Insufficient evidence of efficacy	Level III-2	Level III-1
Generalised anxiety disorder	NS	Level I (inconclusive evidence in older adults)	NS	Level I (effect lost at follow-up)	NS	NS	NS	NS	NS	NS	Level III-1
Phobic disorders	NS	Level I	Level IV	Level III-2	NS	Level II (childhood phobias)	NS	NS	Level II (for dental phobia)	NS	Level I (administered via computer)
Eating disorders[‡]	Level III-1 (AN)	Level I (obesity) Level I (BN) Level I (BED) Insufficient evidence of efficacy (AN)	Level III-1 (BN and BED) Insufficient evidence of efficacy (AN)	Level II (obesity and AN)	Level III-1 (BED and BN)	Level II (AN and obesity)	NS	NS	Level I (when an adjunct to CBT for obesity)	NS	NS
Psychotic disorders	Level I (improved insight and compliance, and lower relapse rates)	Level I (improved symptom management, and lower relapse rates)	NS	Insufficient evidence of efficacy	NS	Level I (improved compliance, and lower relapse rates)	Insufficient evidence of efficacy	NS	Insufficient evidence of efficacy	NS	NS

[*] Studies found no support for the intervention, according to NHMRC guidelines

[†] NS = no studies meeting criteria were identified

[‡] AN = anorexia nervosa; BED = binge eating disorder; BN = bulimia nervosa

continues…

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[16] According to NHMRC designation of levels of evidence, 1999, in Australian Psychological Society, 2006

Table 2: Categorisation of levels of evidence for psychological interventions (cont.)

Condition	Intervention										
	Psycho-education	Cognitive behaviour therapy	Interpersonal therapy	Psycho-dynamic therapy	Dialectical behaviour therapy	Family therapy	Solution-focused therapy	Narrative therapy	Hypnosis	Mindfulness therapy	Bibliotherapy
Dissociative disorders	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS	NS
Adjustment disorders	NS	Level III-2 (in spinal cord injury)	Level III-2	NS	NS	NS	NS	NS	NS	Level IV (in breast cancer)	NS
Drug use disorders	Level I	Level I	Insufficient evidence of efficacy	NS	Level II (dual diagnosis – personality disorder)	Level I (for adolescent drug use)	NS	Level IV (effects largely lost at follow-up)	NS	NS	NS
Alcohol use disorder	Level II (for greater awareness of consequences)	Level I	NS	Level II	Level II (dual diagnosis – personality disorder)	Level I (for adolescent alcohol use)	NS	NS	NS	NS	Level I
Conduct disorder	NS	Level I (especially parent management training)	NS	NS	NS	Level I (multisystemic family therapy)	Level III-2	NS	NS	NS	NS
ADHD	Level II	Level I (as an adjunct to medication)	NS	Level III-1 (multimodal day treatment with psychodynamic focus)	NS	Level III-1	NS	NS	Level IV	NS	NS
Enuresis	NS	Level I (behavioural interventions incorporating urine alarm)	NS	NS	NS	NS	NS	NS	Level III-1	NS	NS
Sexual disorders	Level III-3 (with medication for erectile dysfunction)	Level II (hypoactive sexual desire)	NS	NS	NS	NS	NS	NS	Insufficient evidence of efficacy	NS	Level I
Sleep disorders	NS	Level I (especially behavioural therapy)	NS	NS	NS	NS	NS	NS	NS	Level III-2 (in breast cancer)	Level III-1
Chronic fatigue syndrome	NS	Level I (CBT and graded exercise therapy)	NS	NS	NS	Level IV	NS	NS	NS	Level III-1	NS
Unexplained somatic complaints	NS	Level I	NS	Level IV	NS	NS	NS	NS	Level III-3	NS	NS

An alternative approach posits that factors that are similar across models are important to consider – originally coined 'common factors' by Rosenzweig in 1936 (Rosenzweig, 1936; Frank & Frank, 1991; Assay & Lambert, 1999).

Assay and Lambert's four common factors model

Assay and Lambert (1999) identified and estimated the contribution of four common factors that influence the success of counselling:

1. Extra-therapeutic factors (factors outside of counselling, such as consumer's support system)
2. Therapeutic/relationship factors (factors within the counselling relationship)
3. Hope/placebo (consumer 'self-healing' through hope and belief)
4. Counselling technique or model.

See the supplementary notes for Section 5.4, in the Appendix, for an expanded explanation of Assay and Lambert's (1999) work and a discussion of the possibilities of CH counselling adopting this approach to create an evidence base about CH counselling.

5.5 Demand management

Standard 5: Demand management

CHSs manage demand for CH counselling by targeting vulnerable population groups and prioritising access based on need.

Anticipated outcomes

- Services have a system to prioritise access to counselling, so that those most in need will be most highly prioritised.
- Equity of access is a driving principle in developing a prioritisation system.
- Services have processes that lead intake workers and counsellors to consider whether community health or another service can best meet the consumer's needs.
- People on waiting lists for counselling are informed of (a) the estimated waiting time, (b) opportunities for re-contacting the service whilst waiting, and (c) other service options.
- Services collect service usage data that can inform prediction of future demand.

The need to target services and prioritise access

The Counselling Review (DHS, 2002b) found that CH counselling services had differing, and often informal, approaches to managing demand and determining consumer access to counselling. Consequently waiting list data were inconsistent and did not provide an accurate picture or prediction of demand.

Prioritising access

In 2005–06, the Department's Primary Health Branch initiated a three-year project to develop a demand management framework for CHSs. Part of this work has included the development of the publication *Towards a demand management framework for CHSs* (DHS, 2008c). The purpose of the project is to identify a standardised, Statewide CHS demand management model that addresses waiting list definition, prioritisation of access, and managing demand for services provided in CHSs including CH counselling. This project included the development of a generic tool for prioritising access to CHSs. Discipline-specific tools, including counselling, were also developed.

The generic tool should be used as a first step in determining the priority of access for consumers. CHSs overall give priority access to people from the following disadvantaged groups: people at risk of homelessness, refugees, indigenous people and people with complex care needs that require a priority service to ensure a coordinated team approach. Prioritisation according to clinical risk is established by use of the discipline-specific tool (the counselling-specific priority tool).

The *counselling-specific priority tool* is designed to determine the need for counselling and the consumer's level of priority for service. A series of questions guides the intake worker to collect the necessary information to determine the level of priority. Intake workers without counselling qualifications should clearly advise consumers that they are not counsellors, and in-depth discussion about the consumer's problem should not be initiated. It is important that consumers with a risk of harm to self or others are identified, and those that require immediate assistance and support should receive this from an appropriately skilled and qualified worker.

The priority tool guides the decisions that are required to determine the priority level of a new consumer. The tool identifies three groups:

Priority 1	The person's situation presents imminent risk of harm to consumer and/or others, and immediate response may be required to ensure safety of consumer and/or others.
Priority 2	A significant delay in providing a service will exacerbate the situation.
Priority 3	The person has interim supports available and the situation is stable.

Indications that the consumer is priority 1 include:

- The consumer is at risk of harm to themselves or others.
- A high level of carer or family stress is jeopardising care or safety at home.
- The consumer is feeling unsafe or vulnerable for any reason, e.g. elder abuse or domestic violence situation (physical/financial/psycho-emotional).

Both of the prioritisation tools are located in the publication *Towards a demand management framework for community health services* (DHS, 2008c), available at the Community Health website.[17]

The information collected during the prioritisation process is recorded on the Service Coordination Tool Templates (see Standard 7).

More information about the demand management framework can be found at the Community Health website.[18]

5.5.3 Improving data collection and sharing of information

There has been variation in the type and amount of data collected in CHSs, including for CH counselling. The release of the revised *Primary health funding approach* (DHS, 2007b) is improving the quality, consistency and accuracy of data collected, leading to improvements in the planning of services.

In the longer term Healthsmart, a comprehensive Department-wide consumer record management software system, will be implemented. The aim is for Healthsmart to be fully implemented by 2009. Full implementation of Healthsmart will result in the collection of high-quality comprehensive data to inform the forecasting and planning of future services. Healthsmart will also support the sharing of consumer health and core information, provided the consumer gives consent.

Future planning for data collection will include the provision to collect *problem type* and *presenting issues.* This will assist:

- individual services to accurately plan services to best reflect the needs in the local community
- the planning of integrated mental health promotion plans with other services in the region
- the capture of important information that can guide research, with the anticipated outcome of building an appropriate evidence base for interventions used in CHS counselling services (see Standard 4).

5.6 Partnering to provide better services

Standard 6: Partnering to provide better services

CH counselling partners and complements the local area network of associated services.

Anticipated outcomes

- Consumers experience increased continuity of care across service sectors and tailored services to effectively meet their needs.
- The CHS counselling service has established effective partnerships with other relevant service providers.
- Counsellors have a thorough understanding of the local service system.
- The agency has incorporated processes to identify and reduce or remove duplication in service delivery.
- Development of referral protocols between CH counselling and mental health services leads to more accurate, better-targeted referral practices.

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[17] www.health.vic.gov.au/communityhealth/downloads/demand/demand_management_framework_feb08.pdf

[18] www.health.vic.gov.au/communityhealth/publications/waiting_time

Either at intake or during the counselling process, other consumer needs may be identified which are best addressed by linkages or referral to other services. It is important that community health intake workers and counsellors are familiar with other available services.

5.6.1 Collaborative approaches

There is strong evidence that people with chronic and complex conditions are likely to have better outcomes from coordinated collaborative care compared to single-provider care (Hickie & McGorry, 2007). GPs, Medicare-eligible mental health care providers, CH counsellors and CH allied health professionals can work collaboratively to provide integrated coordinated care for people with chronic and complex conditions. The complexity of the consumer's situation may require multiple services and activities that can be best provided in a community health setting, for example a social support group, drug treatment services, counselling for depression and assistance with diabetes self-management. When a team approach to a consumer's care is considered, the selection of team members should be determined according to the consumer's needs and preferences.

There are emerging models of complementary partnership arrangements developing between (State-funded) CHSs and Medicare-eligible mental health providers. These models encourage (private) Medicare-registered providers to be part of multidisciplinary team approaches within community health settings.

CHSs considering negotiating agreements with Medicare-registered providers to provide private services in community health settings should develop formal agreements. Agreements need to clearly articulate arrangements and processes that pertain to clinical governance. These agreements could, for example, include arrangements to bulk-bill low income consumers in return for the agency providing *in kind support* such as rooms, equipment, administrative staff and other support services. It is also important that arrangements with private health providers do not compete unfairly with existing practices offering similar services to similar communities – in other words, that brokered services are fulfilling genuine gaps for local communities. Counsellors working in both public and private practice need to ensure that there is a clear demarcation between their public and private practice in accordance with their professional registration body's code of ethics.

More information about Medicare rebates can be found at the Department's MBS website[19] and the Commonwealth Government's website about Medicare rebates for mental health.[20]

Initial analysis by the Mental Health Council of Australia (2007) indicates there is now a higher availability of GPs and (Medicare-registered) mental health providers in metropolitan and larger regional population centres.

5.6.2 Rationale for partnerships

CHSs are core members of PCPs, and CH counselling is well positioned to have a presence on the PCP platform and to encourage other counselling programs to participate in PCPs. The PCP platform provides an opportunity for counsellors to increase awareness of social and environmental factors that impact negatively on people's wellbeing, for example the lack of availability of social activities for young people in given geographical areas.

The PCP platform supports collaborative service planning. CH counsellors can provide a link between PCPs and clinical counselling networks, informing better service system development and reinforcing PCP priority setting (see Standard 1).

The counselling and support services that interact and work collaboratively with CH counselling each have their distinct role to play in providing a comprehensive and integrated holistic counselling and support service system.

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[19] www.health.vic.gov.au/communityhealth/gps/mbs/mental_health.htm

[20] www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-amhpm

5.6.3 Effective partnerships

A partnership may be defined as a voluntary arrangement that is developed between parties that agree to work cooperatively towards shared and/or compatible objectives.

A partnership does not compromise the principles of the partners. The term ‘partnership’ carries responsibilities about sharing of resources, risks and decision-making; trust; cooperation towards shared and/or compatible objectives; and negotiation of shared goals towards interests in a shared future (Torjman, 1998).

There is a continuum of the level of integration within a partnership, as shown in Figure 2. Although a partnership on any level is useful, the most effective partnerships are ‘collaborative’ partnerships, and though these relationships require the most amounts of time and trust, they yield the most benefit for the local community.

5.6.4 Benefits of partnering

The report *Improving mental health outcomes in Victoria: The next wave of reform* (DPC, 2006) identified the need for improved collaboration between providers of the extended mental health service system in Victoria. This highlights the need for the broad range of mental health and social services to work together.

Partnerships can increase the power of an agency to best serve community needs by leveraging off the unique skills and strengths of other providers and organisations. There are a number of specific outcomes that can be achieved when CH counselling develops and maintains effective partnerships with other local-area mental health and social services. These include:

- new service delivery pathways, leveraging off the unique skills of other providers
- continuity of care for consumers that access a number of service sectors, through primary care integration
- education of other health service providers about the unique services that community health can offer
- greater likelihood of addressing the social and economic determinants of mental health
- resource maximisation, and avoidance of duplication
- systems development and change through changed relationships between organisations
- social and community development aimed at strengthening communities.

For more information, see the supplementary notes to section 5.6, in the Appendix.

5.7 Continuity of care

Standard 7: Continuity of care

CH counselling has in place a documented model of service delivery that complies with service coordination practices.

Anticipated outcomes

- Services providing CH counselling have a model of service delivery that is consistent with, and combines, assessment and intervention in the first session, to respond to the many consumers who only attend one or two sessions.

Figure 2: Continuum of types of partnerships in integrated health promotion

Level of integration	Process	Purpose
Low ↕	Networking	The exchange of information for mutual benefit. Requires little time and trust between partners.
	Coordination	Exchanging information and altering activities for a common purpose. Match and coordinate needs and activities. Limit duplication of services.
	Cooperation	As above, plus sharing resources. It requires a significant amount of time and high level of trust.
High	Collaboration	In addition to the other activities described, collaboration includes enhancing the capacity of other partners for mutual benefit and common purpose. Building interdependent systems to address issues and opportunities. Sharing resources and making equal commitment.

Source: *Integrated health promotion: A practice guide for service providers*, DHS[21]

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[21] www.health.vic.gov.au/healthpromotion/downloads/ihp_invictoria_1.pdf

- Consistent with the Service Coordination framework, the consumer's first contact with the service includes initial needs identification, in which the consumer's needs are explored, the need for counselling and/or other services is identified and the consumer participates in care planning that might include referral to other counselling or non-counselling services.
- Smooth, routine processes are established for cross-referral and other communication between counsellors and/or other services, resulting in improved access, continuity of care and outcomes for consumers (particularly those involved with multiple services).
- CH counsellors are well placed to initiate inter-agency care planning and support consumer coordinated care arrangements when multiple services are involved. Inter-agency care plans are developed in collaboration with the consumer and other participants involved in their care.
- All consumers have case plans that document the consumer's original goals for counselling as well as changes in goals.
- The counsellor and the consumer regularly monitor progress against the consumer's original goals for counselling.
- Counsellors use service delivery frameworks that combine assessment and intervention in the first session, to respond to the many consumers who only attend one or two sessions.
- The service has implemented clear exit processes that are informed by reviews of counselling progress undertaken by the counsellor and the consumer.
- Systems are in place to assure service quality through audits of service processes and guidelines.

5.7.1 Rationale for continuity of care in CH counselling

Consumers can benefit from CHSs developing active and positive relationships with organisations from other sectors that also provide community services to consumers, for example housing services. Placing the consumer at the centre of service delivery is crucial to ensuring that consumers get the highest-quality care available. A framework for the coordination of services has been developed as part of the Department's Primary Care Partnerships Strategy. The Service Coordination framework provides common tools and processes to support consumer-centred care planning; better referral and coordination of services; and clearer, accurate communication between service providers when more then one service is involved.

5.7.2 Primary Care Partnerships' Service Coordination initiative

A framework for improved service coordination was produced as part of the Primary Care Partnerships Strategy in 2001, in *Better access to services: A policy and operational framework* (DHS, 2001a). Service coordination reform aims to place consumers at the centre of service delivery – ensuring that they have access to services needed, opportunities for early intervention and health promotion, and improved health outcomes. Service coordination is facilitated by PCPs, where agencies come together to agree on how they will coordinate their services so that consumers experience a human service system that works together. Service coordination includes the following fundamental components:

- Agencies have clarified and agreed on how they will work together when they have consumers in common, including standards of service coordination practice. This work has resulted in the documentation of practices, protocols, processes and systems that support effective service coordination. For example, agencies led the development of the Victorian service coordination practice manual (DHS, 2007d).
- A common set of forms (Service Coordination Tool Templates, SCTT) has been developed to support a standard approach to collection and sharing of information about the consumer, including consumer registration, screening of needs (initial needs identification), obtaining consumer consent to share information, care planning and referral.
- Current practice is constantly examined and modified. Recent examples include the revision of consumer intake processes, including eligibility and risk assessment criteria; an examination of referral mechanisms; and a systematic approach to the management of waiting lists.
- Consumer information is collected and shared according to agreed protocols. It is essential that consumers can be confident their information will be handled appropriately. PCP privacy resources[22] and a consumer privacy brochure in community languages are available to assist counsellors in their discussions with consumers regarding how their information will be dealt with.
- Technology is used to support good practice, such as electronic referral. Another example is the Human Services Directory[23], which provides immediate access to up-to-date, reliable information about services.

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[22] www.health.vic.gov.au/pcps/coordination/privacy.htm

[23] www.humanservicesdirectory.vic.gov.au

CHS counselling services are expected to practise service coordination as detailed in *Better access to services* and comply with the *Victorian service coordination practice manual*. Service coordination is mandated for all Community and Women's Health funded agencies.

5.7.3 Service coordination for CH counselling

Consumers ideally experience all aspects of any health service as coherent and connected, consistent with their needs and personal context. Three aspects of continuity of care are:

- The sense of connection between consumer and counsellor, sometimes called 'relational continuity' or continuity of the therapeutic relationship.
- Consistency of care by the various people involved in the consumer's care (not working 'at cross purposes'), sometimes called 'management continuity' or a consistent approach[24].
- Continuity of information across service provision, particularly through documentation, and review of notes from previous episodes of counselling/referrals, sometimes called 'informational continuity'.[25]

Relational continuity is addressed in the discussion on Standard 4: Evidence-based practice, particularly around monitoring the quality of the therapeutic relationship. Standard 7 is concerned with management continuity and informational continuity. One strategy to ensure both management and informational continuity of care is to have clearly articulated and documented pathways through the counselling service that are broadly consistent across the community health counselling sector.

5.7.4 Counselling consumer pathways models – the essential elements

A service model that describes and guides how consumers enter and exit CH counselling must consider the data that indicate that up to 50 per cent of consumers only attend CH counselling once or twice. This is consistent with data collected in other counselling services both within Australia and internationally and was the impetus for the Department implementing the training on single session work (see Standard 5 for more information).

To be consistent with the Service Coordination framework, CH counselling must include the following essential elements for quality service delivery. For a full explanation of service coordination please refer to the *Victorian service coordination practice manual* (DHS, 2007b). More information is available at the Department's Service Coordination website.[26]

5.7.5 The counselling consumer pathways model

A counselling consumer pathways framework incorporates the following components:

1. Initial contact

Initial contact is the first point of contact with the system, and includes the provision of service information. The agency that the person has contacted may be the provider of the services required or alternatively the agency may act as a 'gateway' into the service system, linking the person with the services needed. If services are required the initial needs identification (INI) will be completed.

2. Initial needs identification (INI)

INI occurs when a potential consumer or family member requests a service, and a preliminary screening is conducted to determine the person's counselling and non-counselling needs. A decision is made about whether the person would be best assisted by the CHS or another service, and the nature and urgency of the response required, taking into account other available services in the local area. Where it is considered that the person's needs are best met at another service, the intake worker should offer a facilitated referral. Alternatively, the person should be given information about other services and a copy of the SCTT to take with them. Feedback should also be provided to referrers. INI occurs either over the telephone or face to face. INI is an ongoing process that begins with the consumer's first contact; counsellors may identify the consumer's other needs at any time throughout the counselling relationship.

An initial risk assessment, including determination of priority, is part of the INI process.

Staff conducting counselling INI need to be sensitive and receptive to verbal and non-verbal cues, and have high-level communication and engagement skills. They need to be aware that:

- people seeking counselling may find it difficult to articulate their reasons for seeking counselling;

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[24] This type of approach is assisted by inter-agency care planning and the development of a service coordination plan to link individual service-specific plans together.

[25] Adapted from Royal Australian College of General Practitioners, 2005

[26] www.health.vic.gov.au/pcps/coordination

they may be distressed, embarrassed, confused or angry about deeply personal concerns that they find difficult to discuss

- people who are depressed can appear apathetic and may minimise the level of their distress
- when a person is seeking counselling, the objective stressor is not as important as the person's own individual experience of it.

3. Generic prioritising

At a 'whole-of-service' level in CHSs, the INI prioritises people who are homeless, indigenous, refugees or people with complex care needs requiring a coordinated team approach.

3a. Counselling-specific prioritising

See Standard 5 for the triage model of prioritising access to counselling based on the level of distress of the person and the person's other available supports.

4. Feedback to referrers

Feedback is provided to referrers or other care providers at one or more of the following points in accordance with the *Victorian service coordination practice manual* (DHS, 2007b):

- acknowledgement of receipt of referral
- advice about whether consumer is accepted for assessment
- advice about result of assessment and time for provision of service (e.g. waiting period)
- progress of counselling
- exit summary (discharge feedback).

(The individual consumer–referrer relationship should determine the appropriateness and frequency of feedback provided.)

5. Waiting list communication

People who are placed on a waiting list should be contacted either by phone or letter to give an estimate of the length of wait they can expect, and advised to re-contact the service if their circumstances change.

6. Counselling service

This includes:

a. Intake and ongoing review of the consumer's needs
b. Follow-up contact after a single session
c. Individual care plans
d. Intra-agency and inter-agency care plans
e. Interventions
f. Monitoring and collaborative review
g. Planning exit
h. Exit and evaluation
i. Quality assurance mechanisms

a. Intake and ongoing review of the consumer's needs

After the intake session, assessment of the consumer's needs continues throughout consumer contact. Tools that assist the consumer and counsellor to monitor changes and review progress are used regularly to ensure that the focus remains on helping the consumer achieve their goals for counselling.[27]

b. Follow-up contact after a single session

A single session can be offered as part of an intake process. If a single session is conducted, a follow-up contact occurs within a few weeks at a time determined by the consumer and counsellor to identify any further consumer needs.

c. Individual care plans

When the consumer is only seeing one practitioner, in this situation a counsellor, the consumer and counsellor together develop an individual care plan (DHS, 2007a). The counsellor assists the consumer to identify goals for what they hope to achieve from counselling. The consumer and counsellor need to work together to ensure that the wording truly reflects the consumer's needs. It is important that the wording in the plan reflects the consumer's explicitly stated goals rather than the counsellor's interpretation of the consumer's words. These stated goals are referred to as *expressed needs* and should be identified as such in the care plan. The consumer and counsellor can then work together to map out a process for achieving the consumer's goals in relation to their needs. Care plans need to be regularly reviewed as the consumer progresses through the counselling experience and goals are achieved or change.

d. Intra-agency and inter-agency care plans

When a consumer has multiple needs, requiring assistance and intervention from multiple counsellors from the one agency, an *intra-agency care plan* is developed. When multiple agencies are involved, an *inter-agency care plan* should be developed. Both intra-agency and inter-agency care plans are focused tools for communication between the consumer and other 'involved' service counsellors (provided the consumer has consented to information sharing). Intra-agency and inter-agency care planning assists the consumer by guiding consistent approaches between multiple practitioners and

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[27] There is a wide range of tools that have been developed to support various therapeutic approaches, for example *Solution focused therapy* (www.talkingcure.com); and *Single session work: Implementation resource* (The Bouverie Centre, 2006b).

by coordinating care; for example, a person with a chronic medical condition may benefit from the GP, district nurse and counsellor working collaboratively to coordinate care.

e. Interventions

Interventions are drawn from three of the four components of community health counselling – supportive counselling, advanced therapeutic interventions and casework. (The fourth intervention, population-based mental health promotion, is not utilised within the individual service provision phase.) The amount and type of interventions used will be contingent upon the consumer's strengths and needs. Interventions are informed by four sources of relevant evidence (see Standard 4).

f. Monitoring and collaborative review

Counsellors use outcome monitoring tools to monitor the counselling work by eliciting the consumer's perception of the relationship as well as the consumer's evaluation of their progress. A collaborative review of the care plan offers an opportunity to work from an outcome-focused orientation, using consumer feedback to guide the therapeutic process. If a single session framework is used, a follow-up contact will occur to determine the usefulness of the session and collaboratively decide on the next step.

g. Planning exit

Monitoring the consumer's progress and outcomes is fundamental not only to providing effective consumer-directed evidence-based counselling, but also to facilitating timely exit from the counselling service. Counselling service provision includes a clear review process that checks consumer progress against the original goals for counselling and the care plan, identifies any emerging needs, and identifies the consumer's plan of action for the future. This may include referral to another service.

h. Exit and evaluation

A consumer exits the counselling service when the reason for seeking counselling has been resolved, the service is no longer useful in assisting the consumer to achieve their goals, or another service can better meet the consumer's needs. CH counselling should have quality improvement processes in place to continuously evaluate and improve the service. Tools to undertake evaluation may include simple service evaluation surveys or conversations with the consumer upon exit of the service. Evaluation processes need to be documented in order to be utilised in service evaluation processes.

i. Quality assurance mechanisms

Quality assurance mechanisms are based on consumer and outcome reviews. These may include:

- regular reviews between counsellor and clinical supervisor
- regular peer review between counsellor and colleagues
- regular service process and guidelines audits that are presented to a higher organisational committee, for example a quality committee or middle management team.

5.7.6 Compliance with privacy laws

CHS counselling services are part of a Department-funded agency and so are obliged to comply with the *Information Privacy Act 2000*, the Victorian *Health Records Act 2001* (where appropriate), and, where Commonwealth funding is received, the Federal *Privacy Act 1988*. Additionally, service agreements between the Department and funded agencies oblige agencies to ensure compliance with the Victorian Information Privacy Principles.

The Department endorses good privacy practice, and promotes and encourages privacy-compliant information collection and handling practices in CHS counselling services. Consumers will be provided with detailed statements outlining how their personal information will be used, to whom it may be disclosed, how they can access information held on them by the CHS counselling service, and any consequences for the consumer should they choose not to provide some or all of their information to the service.

Where provisions in other legislation override the requirements of the Information Privacy Act, detailed practice instructions will provide practical guidance for counsellors. The Department's privacy policy is available on its Privacy Statement web page.[28]

There is a range of practical privacy tools (some of which form part of the Service Coordination Tool Templates – SCTT suite) developed with the Department's Privacy Unit and with input from the Health Service Commissioner's office available at the Department's Service Coordination website.[29]

For more information, see the supplementary notes to section 5.7, in the Appendix.

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[28] www.dhs.vic.gov.au/privstat.htm

[29] www.health.vic.gov.au/pcps/coordination/privacy.htm

Appendix

Supplementary notes

This appendix comprises supplementary notes to Chapters 1–3 and Chapter 5. The subheadings with a blue background indicate the section or sub-section in those chapters to which the subsequent notes apply.

Notes to Chapter 1: Introduction

1.1.1 Review implementation projects

From 2002, a series of initiatives have been undertaken by the Department in response to the review of CH counselling conducted from 2001 to 2003.

2002–2004

- Developmental projects to increase the accessibility and quality of counselling provided in rural areas
- Increased funding for counselling, allocated according to the burden of common mental health problems in each region
- Improved coordination between specialist mental health services, primary mental health teams and community health counselling
- Development of the policy paper Foundations for primary care mental health treatment services in Victoria (DHS, 2004b), to improve coordination and collaboration between State and Commonwealth departments with responsibility for primary mental health initiatives
- Minor works grants with a focus on improving the physical infrastructure of counselling facilities in CHSs
- Training offered to CH counselling practitioners in single session work (SSW)

2005–2006

- Fifteen demonstration projects trialling implementation of draft standards contained in the final policy
- CH regional counselling forums (recurrently funded), providing a minimum of three professional development forums per year in each DHS region

2006–2007

The Bouverie Family Therapy Centre of La Trobe University was contracted to provide three clinical training programs:

- Clinical Supervision, for senior CH counselling practitioners
- a Family Therapy Skills training program for community health counselling practitioners, to increase counselling offered to families, children and couples
- Single Session Work training and support, continued until 2009.

Notes to Chapter 2: The focus

2.3 Mild to moderate mental health problems

National economic costs of mental health problems

In 2002–03 mental disorders were the primary condition of 25 per cent of the 670,000 Australians who received the disability support pension (DOHA, 2005).

Depression costs the Australian economy $3.3 billion in lost productivity each year. Six million working days are lost, with another 12 million days of reduced productivity. Economic studies indicate that each employee with untreated depression and related conditions will cost their organisation nearly $10,000 a year (The Australian Rotary Health Research Fund, 2006).

Economic costs for Victoria

These national statistics are also mirrored in the Victorian population, where mental illness accounts for 26 per cent of disability for men, and 27 per cent for women. The resulting impact on the hospital system has been significant. In 2003–04, there were:

- 45,664 hospital admissions for males with a mental health-related principle diagnosis
- 73,540 hospital admissions for women with a mental health-related principle diagnosis.

Service usage data in Victoria indicate an under-utilisation of available services. In 2004, of the entire Victorian population:

- only 7 per cent of males sought help for a mental health problem
- only 13 per cent of females sought help for a mental health problem. (DHS, 2005d)

Notes to Chapter 3: The principles

3.3 Service planning

Effective use of data for service planning

After identifying the area of investigation and what data need to be collected, the service then needs to:

- set up systems to collect the relevant data
- develop a plan to review the data (including who is responsible)
- develop processes for feedback of results and implementation of change if indicated.

Local community demographics

Data evidence that should also inform counselling services is the specific gender, cultural, age and household elements of the local community. This evidence can be sourced through local ABS data breakdowns from the local government. Such evidence can also guide the configuration of service programs; for example, if there is a high prevalence of single parent families in the local community, the counselling service may offer particular programs for single parents.

Planning group programs

Services can investigate data about the kinds of problems for which consumers request or attend counselling (e.g. depression, domestic violence, relationship issues), to prioritise what group programs are most needed in the local area. The data should be supplemented with surveying what other group programs targeting this issue or group are available in the area, in order to avoid duplication, or even develop partnerships.[30]

Planning service delivery models

When planning which service delivery models to use (e.g. single session work), services can investigate data about how often consumers attend the service. The data can provide service-specific evidence of consumer attendance that can be compared with overall percentages of attendance in community health counselling services across the state.

Planning professional development

When deciding priorities for professional development for counsellors, services can be informed by data about the kinds of problems for which consumers request or attend counselling as well as who is presenting (e.g. age of consumers and constellation such as families or couples). Again, these decisions should also be informed by what other issue- or group-specific counselling services are available in the local area, to avoid duplication.

3.4 Quality improvement

Quality improvement activities

Services that engage in quality improvement activities review service structures, systems and processes and make changes that will increase quality of services and safety for consumers. Services then develop a plan for undertaking any improvements, which may involve activities such as improving consumer record-keeping, reviewing consumer satisfaction surveys, implementing evidence-based practice, and implementing programs designed to improve the health of the whole local community (e.g. reducing the impact of depression, increasing the social support opportunities for women).

Better quality, better healthcare framework

All CHSs are required to be accredited by an independent safety and quality program, such as the Quality Improvement and Community Services Accreditation (QISCA) or the Evaluation and Quality Improvement Program (EQuIP). The quality framework *Better quality, better healthcare* (DHS, 2005a) underpins the policy and funding guidelines for primary health services in Victoria 2006–09. Quality improvement within the framework is defined as 'the continuous improvement of all processes and the products and services that are the outcomes of those processes'. Safety is defined as 'a state in which risk (measured in terms of consequences and likelihood) has been reduced to an acceptable level' (DHS, 2005a). The framework outlines dimensions of quality and organisational elements through which quality improvement and safety is achieved (see Figure 3).

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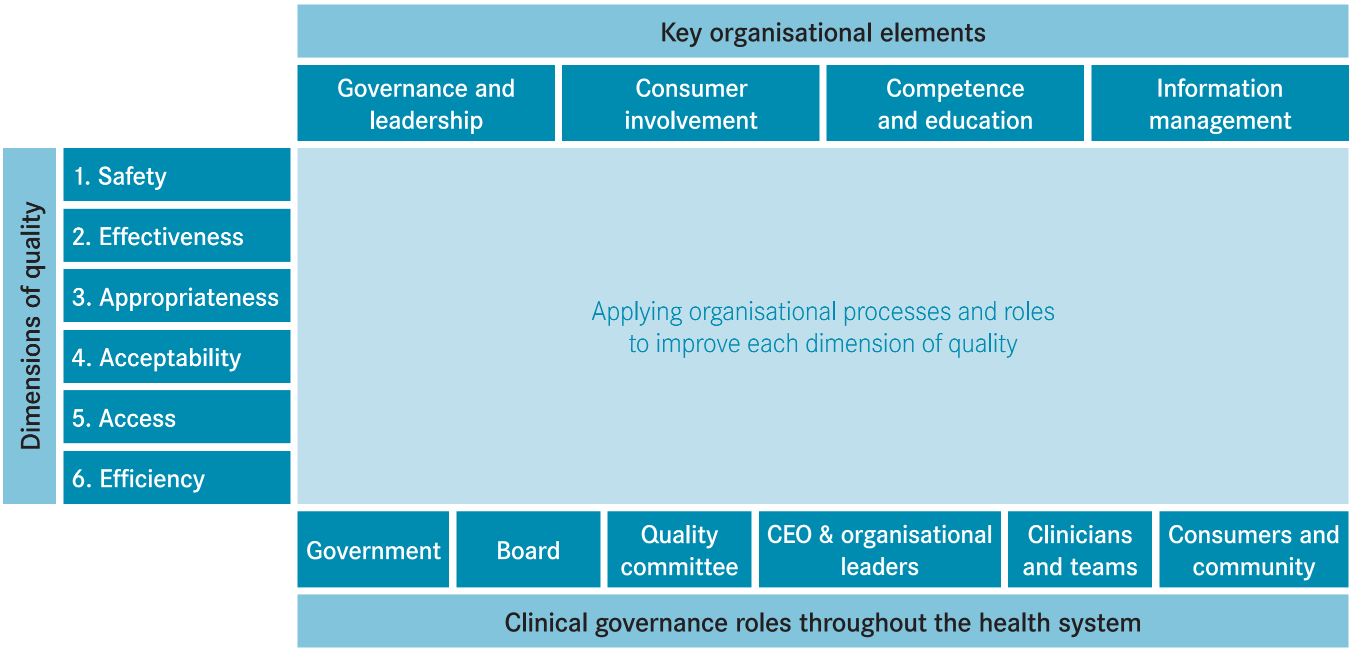
[30] Many CHSs use the health promotion program, Quality Improvement Program Planning System (QIPPS), www.qipps.com, to plan and evaluate health promotion activities. The QIPPS tools and processes can also be adapted and used to guide planning and evaluation of counselling programs.

Figure 3: Better quality, better healthcare quality improvement framework



Dimensions of quality applied to CH counselling

Safety

The safe progress of consumers through all parts of the system is an overarching aim for CHSs. Standard 7 outlines a counselling consumer pathways framework for continuity of care that is adapted to the particular needs of the consumer, from first contact through assessment, service provision, review and completion. Standard 3 addresses qualifications, training and clinical supervision for counselling practitioners. These requirements overlap and complement the clinical governance responsibility to credential and determine the scope of practice of clinical staff.

Effectiveness

Effectiveness is the extent to which the intervention achieves the desired outcome. Standard 4 on evidence-based practice supports increased effort on improving effectiveness.

Appropriateness

Appropriate interventions are selected based on relevant evidence that they will produce the desired outcome. Standard 4 describes particular strategies to undertake evidence-informed practices.

Acceptability

Opportunities must be provided for consumers to participate collaboratively with CHSs in planning, delivery, monitoring and evaluation of CH counselling at all levels. Consumer and community participation should enhance the acceptability of services (the degree to which the service meets or exceeds the expectations of informed consumers). Standard 2 explains ways that consumers can be more involved in shaping CH counselling.

Access

Services should offer equitable access for local populations on the basis of need. This includes availability of service, physical access and access to information. Standard 5 outlines the rationale and process for prioritising population groups known to have fewer options for accessing services and the greatest needs.

Efficiency

Services must ensure resources are utilised to achieve efficiency and value for money. This can be achieved by the allocation of resources to those services that provide the greatest benefit to consumers. Standard 4 describes strategies to improve data collection, to assist in future service planning and to ensure services offered match the needs of the local community. Standard 6 highlights the importance of partnerships with other relevant service sectors, in order to avoid duplication of services and achieve the best allocation of resources.

Organisational elements relevant to quality

The *Better quality, better healthcare* framework also outlines four organisational elements through which a planned approach to safety and quality can be achieved:

1. Governance, leadership, and culture
2. Consumer and community involvement
3. Competence and education
4. Information management and reporting.

1. Governance, leadership and culture

A *culture* of quality improvement is best achieved when strategies are based on shared values. The standards for CH counselling outline a framework for maintaining a minimum standard of high-quality work, with Statewide consistency. The regional CH counselling forums outlined in Standard 3 support the implementation of the quality standards through information sharing, partnerships and local leadership in counselling practices.

2. Consumer and community involvement

Consumer involvement is critical to effective service planning, evaluation and the achievement of optimal care outcomes. Standard 2 outlines how consumer participation will be a feature of the planning and ongoing monitoring of the quality of counselling services and mental health promotion.

3. Competence and education

The *competence* of, and *education* provided to, support teams and individual workers is an overarching focus and priority for review and action. Standard 3 mandates that the competency of counselling practitioners will be assured through the use of minimum qualifications, clinical supervision and annual professional development plans.

4. Information management and reporting

The collection of *information* and how data are *reported* and converted into information used in practice has significant implications for CH counselling in the future. This element is outlined in Standard 4, directing counselling services to participate in the development of improved data systems to support future service planning and evaluation.

3.5 Determinants of mental health

Evidence for links between disadvantage and mental health

The study of the 'burden of disease' in Australia conducted by Mathers, Vos and Stevenson (1999) found that children and adolescents with mental health problems are almost three times as likely to be found in low-income families than in high-income families.

The study also found that people in the bottom quintile of socioeconomic status had up to 50 per cent additional disability-adjusted life years (DALYS[31]) associated with mental disorders compared to people in the top quintile.

Experiencing violence and discrimination has also been linked to a poorer sense of wellbeing and increased depression, anxiety and other mental health issues (Brown et al., 2000; Kessler et al., cited in VicHealth, 1999).

Gender as a determinant of mental health

The Victorian Population Survey (DHS, 2004, cited in DHS, 2006g) indicated that on average women experience higher levels of distress than men. Martin (DHS, 2006e, p. 30) identifies gendered sources of stress related to 'economic dependence, family caring responsibilities, physical, sexual abuse and social isolation'.

In Victoria, women's income averages 64 per cent of men's income, when including both full- and part-time work (Women's Health Victoria, 2004).

Roades (cited in Biaggio & Hersen, 2000) reported on a study conducted by Hughes and Galinsky in 1994 that examined differences in reported psychological distress between men and women who are married and are in full-time employment. They found that women reported higher levels of distress and more specific stressors at work and home and less job enrichment compared to men, more inequity in relation to housework and child care and higher levels of home and family interference in their jobs.

The Victorian Population Survey (DHS, 2004, cited in DHS, 2006g) also indicated that women's level of psychological distress varies over the life course, and is highest in the age

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

groups from 15–24 years to 55–64 years. A Canadian survey found that from the 45–54 age group onward, a widening *gender gap* emerges, with women increasingly reporting more distress than men of the same age (DHS, 2006g).

Mirowsky (1996, cited in DHS, 2006g) argues that there is a relationship between *feelings of distress* and *social status*, referring to this phenomenon as the *cumulative disadvantages thesis*. The frequency of women's reports of distress increase with age, whereas men's reports of distress do not. According to the *cumulative disadvantages thesis*, this difference is related to the cumulative effects over time of the differing gender roles (women being subjected to higher demands from work and family roles) and the lower status of women.

Intimate partner violence is a main issue that impacts on women's physical and mental wellbeing. Over 20 per cent of women are victims of intimate partner violence (DHS, 2006g). 'Intimate partner violence is responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking,' (VicHealth, 2004). Over 57 per cent of deaths in women resulting from homicide or violence were perpetrated by an intimate partner, with women being over five times more likely to be killed by an intimate partner than are men (VicHealth, 2004).

Notes to Chapter 5: The standards

5.2 Consumer, carer and community participation

Purpose of consumer, carer and community participation

Consumer participation in service planning ensures that consumer attitudes and expectations are integrated into overall service planning and operations, and provide a rich source of ideas for improving service access, acceptability, quality and effectiveness.

Consumers, carers and other community members may participate as individuals or they may undertake a specific role in participation. Roles can include being a representative of a consumer organisation in the role of *consumer, carer* or *community member*.

Figure 4 is an adaptation of how Draper (1995) conceives the range of community voices within consumer participation. Moving down the list, the focus spreads outward from the individual until it includes the whole community. Therefore consumer participation at these broader levels is also referred to as community participation. As such, within this standard, the phrase 'consumer participation' is assumed to include carer and community participation.

Figure 4: Draper's list of community voices

Individual ↑	Individuals who are receiving or have received health care services
	Carers and/or family members who support individuals who receive health care
	Groups of consumers (who may share a common experience)
	Consumer organisations including advocacy, self-help and consumer network organisations
	Potential consumers such as those with unmet needs or from population groups with particular needs or access issues
	Members of the community including future users and the wider community that benefits from health care services
↓ Community	Taxpayers and citizens who ultimately pay for services

Source: Draper, 2005

The benefits of consumer, carer and community involvement

Research and experience has found many reasons why consumer participation is beneficial for all stakeholders involved:

1. Participation improves health outcomes: when staff share decision-making with consumers, consumers experience an increase in perceived control, which in turn improves their overall health outcomes (Breemhar & van den Borne, 1991; Renhard, 1998).

2. Participation improves the quality of health care: if a service is designed and delivered with an understanding of the views and needs of those who use it, the service is more likely to effectively target these needs, and therefore offer a higher-quality service.

3. Participation is an ethical and democratic right: effective participation in primary health services is a right of health consumers, and is reinforced by government legislation (e.g. consumer rights, local government legislation).

4. Participation is a mechanism to ensure accountability: participation is one way to facilitate community accountability, which also improves community trust and confidence in the service.

5. Participation can improve social wellbeing: by treating consumers as citizens with legitimate rights, participation promotes societal wellbeing and assists community capacity building.

Principles of consumer carer and community participation

The following principles are based on a philosophy of inclusion and open communication and offer a guiding ideological framework through which participation can occur. The principles were developed to guide agencies and consumers work effectively together. They are taken from *Doing it with us, not for us* (DHS, 2005d).

Trust

Participation works best where there is mutual agreement of the processes and assessment of the issues under consideration as developed through productive working relationships.

Respect

All participants need to show consideration and value each other as equal contributors to the participation process.

Openness

Participation must be built from the ground up and this can only be ensured if all participants are open to considering the ideas of consumers, carers and the community, and are willing to accept change.

Equal opportunity

At the earliest possible time, involve all those that will be affected by the decisions, inform them of the decision-making processes and ensure they have access to the information and the means to participate.

Advocacy and support

Participation must be supported from the top and resourced so that participation is meaningful for the consumer, carer and community member.

Responsiveness

The capacity to undertake participation requires skilled organisations and benefits from multiple strategies and resources.

Shared ownership and accountability

All involved share ownership of the process and decision and are responsible for monitoring and evaluating the impact and outcomes. How the responsibility is distributed should be defined as part of the participation arrangement.

Dissemination

Decisions made and how consumers', carers' and community members' participation influenced those decisions should be communicated to all those involved and affected by the decisions.

Evaluation

Lessons learnt form the participation process should be identified and communicated as widely as possible.

The continuum of consumer carer and community participation

The concept of a ladder of participation (Brager & Specht, 1969) is often used to illustrate consumer participation activities and the desired degree of participation. Table 3 illustrates the ladder or continuum of consumer participation from no or minimal involvement, to participation in individual case planning, to becoming an integral, ongoing and valued part of the service. Improved consumer participation can be progressively achieved in CHSs by a wide range of means tailored to the size and nature of the service and the community served (DHS, 1996).

5.3 CH counsellors – qualifications, learning and development

Clinical supervision agreements

Formal written clinical supervision agreements should clearly state mutual obligations of the employer and employee. Clinical supervision agreements:

- should be negotiated between all parties before commencement, and clearly set parameters of the supervisory relationship, and responsibilities of all relevant parties
- outline what the supervisor's responsibility is, including when to breach confidentiality if duty of care issues arise, and what actions should be taken
- outline the process of review that provides opportunities for the counselling practitioner to give feedback (about their supervisor) safely, as well as negotiate a change in supervisor when needed (e.g. as professional development needs of the counselling practitioner change).

Recruiting community health counsellors

The qualifications outlined in section 5.3 are a minimum standard or baseline to guide CHSs' recruitment of counselling practitioners. Many psychologists, social

Table 3: Consumer, carer and community participation in service planning

Level of participation	Role of consumers	Example of participatory activities
Community control Delegated power	Communities control and run health services. Services ask consumers to make decisions about particular aspects of service planning.	Consumers are provided with resources to develop strategies and programs to address specific issues.
Partnership	Consumers are involved in all activities from the beginning. Consumers are asked to participate as partners in service planning and decision-making. For this activity to occur consumers should be provided with all the information provided to other stakeholders required to participate in decision-making.	Consumers participate in decision-making service planning committees and advisory groups. Consumers participate in workshops where all stakeholders come together to work through issues and participate in decision-making.
Consultation	Consumers are involved in a consultation process where they provide information and comment on documents and strategies. Consumers may participate in decision-making processes.	Combinations of information seeking and information sharing activities (see below), plus consumers are asked to comment on documents and strategies.
Information seeking and information sharing	Consumers are asked to provide services with information and/or services provide consumers with information. Services decide what to do with the information.	• Focus groups • Consumer advisory groups • Consumer representative on committees • Development of links with consumer groups to share information • Community forums
No input: Consumers are not engaged in service planning.		

Source: *Primary care partnerships information resource: Consumer participation in service planning* (DHS, 2001c)

workers and family therapists employed as CH counselling practitioners hold postgraduate counselling qualifications.

CHSs should recruit counselling staff whose qualifications, experience and interests will best serve the particular role to be filled.

There are benefits from having CH counselling teams that are comprised of counselling practitioners with a diverse range of different qualifications, training and experiences:

- Diversity in team members' backgrounds can assist in providing varied interventions for consumers, increasing the likelihood that the service can match interventions to a consumer's personal theory of change (one important predictor of successful therapeutic outcome; see Standard 4 for more details).
- A breadth of therapeutic philosophies can increase innovation and creativity in service responses.
- A team of counselling practitioners with different academic backgrounds can provide more diversity in team clinical knowledge and expertise. This can increase the potential internal professional development opportunities for staff.
- Increased opportunities for professional development is a strategy shown to increase retention rates of experienced counselling practitioners, as well as improve the overall quality of the service.

CHSs with just one counselling practitioner will require the counselling practitioner to maintain a broad, generalist approach, whereas larger CHSs may have the capacity to allow counselling practitioners to specialise in particular areas as part of a complementary team approach. This latter approach is well-established in some CHSs and further complemented by the development of multidisciplinary counselling teams comprising counselling practitioners funded through other programs, for example problem gambling, alcohol and other drug, and family violence.

Clinical supervisors

Clinical supervision can be provided by suitably qualified and experienced senior counselling practitioners who have undertaken training in the provision of clinical supervision and who are either internal or external to the employing service.

There are different models of clinical supervision that reflect the differing professional training and expectations and needs of counselling practitioners. The supervisor therefore should have appropriate skill and training to provide the type of supervision needed and have an understanding of the environment in which the counselling practitioner works (e.g. rurality).

The supervisor should also receive supervision about their supervisory practice to support the quality of clinical supervision provided. Clinical supervision networks provide peer supervision to senior practitioners to support their supervisory practice and, where available, are a valuable resource to support the provision of high-quality counselling.

The choice of supervisor needs to be informed by the level of the counselling practitioner's experience and knowledge and their needs. When supervision is provided externally, the CH counselling practitioner receiving supervision would be required to comply with privacy laws and with the employer's accountability requirements.

Peer consultation

> '"Peer consultation" is a term used to refer to a process of peers consulting with peers in a non-hierarchical fashion.' (Australian Psychological Society, 2004, p. 2).

Peer consultation has developed as a means for highly experienced senior practitioners to work collaboratively to share clinical information and opinions and to receive support and rigorous evaluation of clinical practice. Peer consultation supports the development of best practice.

Line management (corporate supervision) and clinical supervision

Clinical supervision is distinct from line management (corporate) supervision, as the former emphasises professional development and support and the latter monitors work performance and administrative issues. In some services the counselling team manager may provide both the clinical and line management supervision. Whether a line manager or someone else should provide clinical supervision has at times been a dilemma for both counselling practitioners and service management. There are benefits and risks in both models. Therefore each service should give careful consideration to which model best suits their service's counselling practitioners, resources and work context. If a service chooses the model in which the same person provides both line management and clinical supervision, a number of points should be considered to effectively balance the roles:

- Clear distinction needs to be made between the function and occurrence of both types of supervision so processes involved are transparent to all parties.
- Supervisors need to have an unequivocal acceptance of the varied functions of their role.
- Clarity about what information is shared between supervisors and management is essential.
- Clearly articulated policies and procedures should provide a clear message about the value of supervision in an organisation.
- Training, development and supervision of supervisors acknowledges the need for ongoing support and development required to supervise.
- Supervisees must be aware of how their work will be recognised and rewarded, what support is available, and the limits of certain behaviour (and consequences).
- Any processes must work equally well for supervisees and supervisors in terms of dealing with unsatisfactory supervisory performance. (Shaw, 2004)

Continuing professional development plans

A continuing professional development plan is a document outlining the individual CH counselling practitioner's professional development needs and the ways to address these, taking into account the counselling practitioner's prior training, experience, interests and current skills. All CH counselling practitioners should have current professional development plans that are negotiated annually with their line manager and in consultation with their clinical supervisor. Professional development plans should be directed by both the counselling practitioner's individual development needs as well as the needs of the employing service. The provision of continuing professional development is both the responsibility of management in the context of clinical governance and of the counselling practitioners in the context of professional registration or membership requirements. The provision of professional development opportunities is a powerful strategy to both improve the quality of the service as well as retain experienced counselling practitioners in CHSs. One opportunity for ongoing professional development is the regional community health counselling forums.

Regional community health counselling forums

The 'Review of counselling in community health' conducted between 2001 and 2003 led to a range of quality improvements, including the regional counselling leadership initiative (RCLI). Between 2003 and 2005 each Department region received non-recurrent grants to develop a RCLI to support sustainable implementation of service improvements. A review of these initiatives indicated that counselling practitioners would benefit from regular, structured opportunities to share best practice and to network.

The Department has provided funding for a CHS in each of the eight DHS regions to organise three regional community health counselling forums each year that:

- are theme based, for example depression or working with families
- include a guest speaker who is knowledgeable on the theme of the day
- allow time for workshopping the theme of the day, or other discussion time
- provide an opportunity for services to showcase research and innovative approaches to service delivery.

The forums enable networking between counselling practitioners and also support the implementation and sustainability of service improvements throughout the region, encouraging enthusiastic, innovative approaches to counselling. The forums aim to:

- contribute to the professional development of counselling practitioners
- counteract the professional isolation experienced by sole practitioners and those from rural areas
- contribute to the development of community health counselling practitioners' sense of professional identity, leading to increased job satisfaction and retention of experienced counselling practitioners in the sector.

The main target group of the forums is community health program–funded counselling practitioners. However CHSs may, collectively within in a region, decide to broaden the invitation to all counselling practitioners located in CHSs or, broader again (perhaps in rural areas), to all counselling practitioners in the region.

5.4 Evidence-based practice

Outcome-informed practice

Outcome-informed practice is an alternative view of evidence-based practice for counselling and therapy which draws evidence primarily from the consumer. Whilst it adds an important perspective – a consumer-directed focus – it still has limitations. The overall research in counselling and therapy practice suggests that best practice requires a broader understanding of what is the most useful evidence-based practice framework for counselling and therapy (DHS, 1999).

There is a large variety of counselling models in existence, estimated as numbering anywhere from 250 to 1,000 (Miller, 2004). A counselling model usually comprises a particular theory of how positive change can occur in a person's life, and the consequential tasks, questions or exercises that a counselling practitioner uses to put that theory into practice. One approach to gaining the maximum benefit from this multitude of models posits that factors that are similar across models are important to consider, originally coined 'common factors' by Rosenzweig in 1936 (Rosenzweig, 1936; Frank, 1991; Assay & Lambert, 1999).

Assay and Lambert's four common factors model

Assay and Lambert (1999) identified and estimated the contribution of four common factors that influence the success of counselling:

1. Extra-therapeutic factors (factors outside of counselling, such as the consumer's support system)
2. Therapeutic/relationship factors (factors within the counselling relationship)
3. Hope/placebo (consumer 'self-healing' through hope and belief)
4. Counselling technique or model.

Following is a brief summary of the four common factors identified by Assay and Lambert (1999).

1. Extra-therapeutic factors

Forty per cent of the outcome in counselling is influenced by extra-therapeutic factors, aspects of the consumer's life that are independent of counselling, such as internal strengths, persistence, faith, optimism, motivation, membership of a community, ability to identify focal problems, spiritual faith, or a supportive friend. These factors also include serendipitous interactions between such inner strengths and current events, such as a new job or successfully resolving a crisis.

2. Therapeutic/relationship factors

These factors have been shown to constitute approximately 30 per cent of consumer change and include the consumer's experience of the counselling practitioner as caring, empathic, warm, accepting, and encouraging of appropriate risk-taking. A good working relationship requires all parties to be working on the same issues in an agreed-upon way.

3. Hope/placebo

Research shows that 15 per cent of the outcome in counselling is explained by hope/placebo; when a consumer is engaged in an activity such as counselling, it mobilises their hope, energy and self-healing.

Hope – strengths-based and change-focused

Counselling practitioners can influence the hope/placebo factor by focusing on consumer strengths and highlighting consumer-directed change throughout the counselling process.

4. Counselling technique or model

Fifteen per cent of consumer change can be attributed to the counselling technique or model. Evidence indicates that particular therapies are more effective than others for particular conditions, for example exposure techniques for anxiety.[32]

Translating common factors research into practice

Based on Assay and Lambert's (1999) work, an expanded evidence-based framework is suggested for use by CH counselling. It acknowledges that 45 per cent of changes (hope 15% and relationship 30%) in consumer outcomes are related to the therapeutic experience in some way, independent of the particular therapeutic techniques (Duncan et al., 2004).

This framework for developing evidence-based practice in a community health setting takes four sources of evidence into account:

1. consumer knowledge (consumer's beliefs, attitudes, the effect of the experience of counselling, and consumer's other events/experiences)
2. counsellor knowledge (interpersonal skills, personal characteristics, relationship development)
3. research evidence (methods of keeping abreast of current research)
4. statistical data (utilisation of relevant data).

Action research – creating an evidence base for CH counselling

The proposed CH counselling four-feature model (see below) is an action research approach, designed to contribute to the development of an evidence base for CH counselling. Evidence-based practice draws upon a range of appropriate sources of evidence to inform practice. One of the best sources of evidence to specifically tailor programs within a service is data from the service itself. CHSs can create their *own* evidence base to direct practice – an evidence base that reflects the unique elements of their local community and consumer group. CH counselling can undertake such research[33] on a local level, through implementing simple data collection systems.

The data can assist services in two areas:

1. service development
2. evaluating effectiveness.

Research and service delivery planning for CH counselling

Creating an evidence base for service planning can assist services in a range of ways and is achieved through reviewing data already collected, as well as collecting other relevant data.

Some CH counselling services already have mechanisms in place to collect data about the consumer's presenting problems. The data can be used to plan services. Other services may not currently have such mechanisms in place. When beginning to develop mechanisms to collect data to inform planning, CH counselling services should begin with deciding which issue they want to research, and then have a clear rationale about what sort of data could help to investigate the issue. Some examples are given below.

After identifying the area of investigation and what data need to be collected, the service then needs to:

- set up systems to collect the relevant data
- develop a plan to review the data (including who is responsible)
- develop processes for feedback of results and implementation of change if indicated.

Proposed four-feature model for CH counselling

The four-feature model is depicted in Figure 5 opposite, showing the four sources of evidence that contribute to evidence-based practice in CH counselling. Explanations of the four sources of evidence follow, with recommendations on how to access each evidence source as well as some strategies to translate the evidence into practice. The first feature or source of evidence, 'client knowledge', will be outlined in more detail than the other three features, as client

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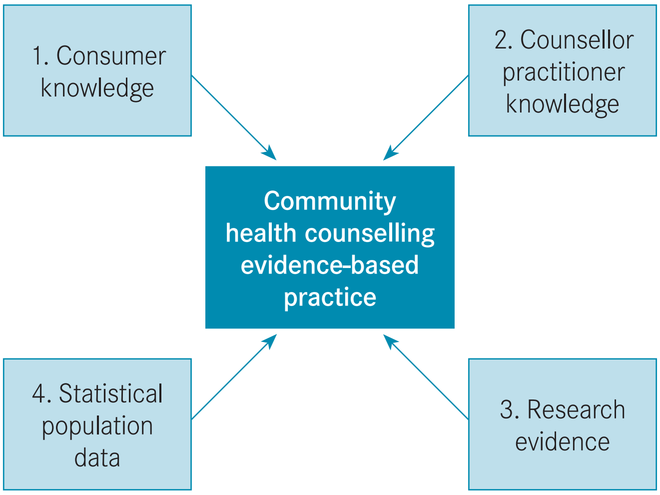
[32] Although counselling technique or model makes a lesser contribution to change than the other factors, in terms of measuring psychological change, 15 per cent is substantial. See Table 2, pages 21–22, for more information about particular therapies that have been found to be effective for particular conditions.

[33] Action research is research that pursues action (or change) and research (or understanding) at the same time. In most of its forms it does this by using a cyclic or spiral process that alternates between action and critical reflection. People affected by the change are usually involved in the action research. This allows the understanding to be widely shared and the change to be pursued with commitment. (Wadsworth, 1984; Dick, 2002)

knowledge may be a newer and less familiar evidence source than the other features within the model.

Figure 5: Proposed four-feature model for CH counselling evidence-based practice



1. Consumer knowledge

The inclusion of 'consumer knowledge' as an evidence source is underpinned by the common factors research described above that found around 55 per cent of outcome (i.e. the 'extra-therapeutic' and 'hope/placebo' factors) is attributed to consumer skills and perceptions.

One framework that can be used to access this source of evidence is termed 'outcome-informed counselling'. Using this framework, counsellors use clear, simple and effective methods to access the consumer's knowledge by collaboratively and regularly reviewing with the consumer the effectiveness and outcome of the counselling. In this way, outcome-informed counselling places the consumer firmly in the driver's seat of the process. Five major issues are addressed when practising from an outcome-informed framework:

a) Matching interventions chosen with the individual consumer's theory of change
b) Monitoring the counselling relationship
c) Monitoring the outcome of counselling
d) Ways of monitoring counselling outcome
e) Barriers and strategies in implementing outcome-informed counselling practices

a) The consumer's theory of change

The consumer's (knowledge about their) theory of change is their evolving 'view of the presenting problems, potential solutions, and ideas about the change process' (Gold, 1994; Kelly, 1955; Erickson, 1980).

To elicit the consumer's theory of change, ask:

- how change usually happens in the consumer's life
- what role the consumer and other people play in beginning and maintaining change
- how previous attempts to change current problems have occurred.

The consumer's change theory can be used to determine which solutions, ideas and techniques would be the most effective for the consumer. Not only is the change process for each consumer unique, but it is also usually an emerging set of ideas, uncovered through the counsellor's conversations with the consumer. To learn about a consumer's theory of change, a counsellor listens for and amplifies the stories, experiences and interpretations the consumer offers about their problems as well as their thoughts, feelings and ideas about how their problems might be addressed.

The counsellor can seek to find out about the consumer's change theory through asking about:

- how change usually happens in the consumer's life
- what role the consumer and other people play in beginning and maintaining change
- how previous attempts to change current problems have occurred.

It is also very important for the counsellor to find out what role the consumer would like the counsellors to play in his/her change process. Different consumers require counsellors to be different things: a sounding board, confidant, brainstorming partner, or expert. The degree of input by the counsellor is therefore directed by the consumer's expectations of the role.

Once the consumer's theory of change has been uncovered, counsellors should select models, strategies and approaches that are congruent with this theory. Matching technique with the consumer's theory of change 'facilitates a favourable relationship, increases the consumer participation and therefore enhances positive outcome' (Duncan & Moynihan, 1994). For example, Hester et al. (1990) compared the effectiveness of traditional alcohol disorder treatment with a learning-based approach. Their study found that consumers who believed that their alcohol disorder was caused by a disease were 'much more likely to be sober at six months if they had received the traditional alcohol treatment'. In contrast, consumers who believed that their alcohol disorder was a bad habit were more likely to be successful if they had participated in the learning-based therapy.

Re-aligning relationship?

Strategies may include:

- modifying the counselling practitioner's communication style to better match the consumer's needs
- reviewing the counselling work and re-negotiating the goals or techniques used
- referral
- seeking clinical supervision.

b) Monitoring the counselling relationship

Monitoring and modifying the counselling relationship can support outcome-informed counselling. The 'relationship factors' found to contribute to 30 per cent of outcome is evidence that not only is the therapeutic relationship significant, but that it is the consumer's perception of the relationship that is most important. If a consumer does not perceive the therapeutic relationship as positive, they eventually stop attending, and therefore will not be able to gain much therapeutic benefit. So counsellors should monitor the relationship by finding ways to regularly 'check in' with the consumer to see whether the relationship is working for them or if it's getting 'off track' and, if so, having strategies to re-align the relationship.

c) Monitoring the outcome of counselling

Outcome-informed counselling has been shown to significantly increase the effectiveness and success of counselling in a number of studies (Miller, Mee-Lee, Plum & Hubble, 2005). One way this increased effectiveness has been achieved is when monitoring outcome provides an opportunity to modify counselling that is not helpful – before the consumer stops attending. Gains that occur earlier on in the counselling work are a strong predictor of success. When outcome monitoring finds no or little progress (particularly in the first few sessions), it can provide a warning that continuing the same form of treatment may not prove effective. This warning should signal the need for the counsellors to do something different by checking in with the consumer, changing technique or model, or referring to another counsellor if available. Monitoring outcome is therefore most useful in alerting the counsellor to when things are 'stuck' or not going as well as hoped, as opposed to counselling that is working well.

Methods to monitor counselling relationship and outcome

Methods can range from the less formal, for example simply asking the consumer, using brief pre- and post-session verbal or visual scales, or using 'take ways'; to the more formal methods such as surveys, symptom checklists and structured reviews.

The more formal tools have been shown to be more effective than informal methods, in order to prompt regular reviews, create opportunities for honest feedback from the consumer, and direct changes in approaches or techniques.

Any tools or methods should be tailored to take into account particular characteristics of the consumer, such as their literacy levels, intellectual functioning, culture, gender and age.

Another benefit of monitoring outcome is that it can assist in the scheduling and frequency of sessions. As noted above, research indicates that most change occurs early on in the counselling. To capitalise on this high early rate of change, sessions should be scheduled more frequently in the beginning of the counselling process. When outcome monitoring indicates the rate of change is lessening, sessions can then be scheduled less frequently.

d) Ways of monitoring counselling outcome

Monitoring outcome of counselling can be achieved through monitoring aspects that have been found to be strong predictors of successful therapeutic work, such as the consumer's:

- changes in levels of distress
- functioning in close personal relationships
- performance at work, school or other settings outside the home.

e) Barriers and strategies in implementing outcome-informed counselling practices

There are a number of potential barriers for counselling services to overcome in order to successfully develop an outcome-informed counselling framework. To manage these barriers, services will need to develop strategies to address them. Barriers can include:

- counsellors not being familiar with the outcome-informed philosophy
- counsellors being confronted by the process of asking for feedback from consumers

- counsellors collecting outcome data, but not actually using the data to change their approach when no progress is occurring
- lack of management understanding and support for outcome-informed processes
- a waning of counsellors' motivation and interest in outcome-informed work after initial implementation.

Some strategies to address these barriers are:

- reading and practice for counsellors in outcome-informed processes
- using clinical supervisors who are familiar with outcome-informed processes and are committed to this way of working
- counsellors committing to doing something different if outcome monitoring results in little or no change early on in counselling
- management support
- providing regular opportunities to debrief and review clinical processes, such as within peer support meetings or through standing agenda items at team meetings
- partnering with tertiary institutions to support practice-based research.

However, there are limitations to only relying on consumer knowledge to inform practice. In fact, critical steps in conducting outcome-informed work cannot occur without the counsellor utilising another source of evidence – their own skills and knowledge. For example, the outcome-informed directive for counsellors to modify their communication style and techniques when needed cannot be done if the counsellor does not possess a range of models and styles from which to choose alternatives. Therefore this body of knowledge of different styles and approaches is outlined in the second evidence source termed 'counsellor knowledge'.

2. Counsellor knowledge

Interpersonal skills/personal characteristics

The 'relationship factors' clearly rely on and are enhanced by the counsellor's interpersonal skills and ability to relate (Hillard et al., 2000; Luborsky, Barber & Crits-Christoph, 1999). Counsellor interpersonal characteristics that are necessary to create an effective therapeutic relationship include a caring style, empathy, warmth, an accepting stance, and encouragement of appropriate risk-taking. Yet research has found that the mere presence of these traits is not enough, but that different consumers experience these counsellor traits differently. For example, Bachelor (1988) studied consumer's perception of counsellor empathy, and found that 44 per cent of consumers valued a cognitive-type empathic response, requiring the counsellor to accurately recognise their current innermost experience or state. Thirty per cent of consumers preferred an affective-toned communication, when the counsellor participated in the consumer's current feeling state (i.e. feeling that the counsellor actually felt what the consumer was describing). The remaining consumers either valued a sharing of personal information as empathy, or a 'nurturant-type' response (i.e. where the counsellor is experienced as supportive, fully attentive or a caring presence).

> 'Models and specific approaches are lenses to try on that may or may not fit the frame and prescription requirements of the consumer. Models are useful adjuncts that offer metaphorical accounts of how people can change.' (Duncan, 2002)

Besides this need for counsellors to have a range of ways of expressing empathy, research has also found a need for counsellors to be able to offer a range of therapeutic relationships. Bachelor (1995) studied consumers' perceptions of the relationship and found that nearly 50 per cent of consumers defined a good therapeutic relationship with a counsellor as one that is characterised by respect, empathic understanding, attentive listening, and is a 'friendly' relationship. Another 40 per cent of consumers defined a good therapeutic relationship as one where they acquired improved understanding through the counsellor's ability to give opinions and clarify consumer material. Finally, a small number of consumers viewed a good therapeutic relationship as collaborative, in that both the consumer and the counsellor were responsible for the work. These findings highlight the differing relationships consumers require with their counsellor: some want a friendship, some expert advice, and some a collaborative relationship. Counsellors therefore need to have a high level of flexible interpersonal skills to be able to offer the kind of relationship that matches what an individual consumer requires (Drury-Hudson, 1997; Rycroft, 2004).

> **Importance of a diversity of models and matching consumer's theory of change**
>
> Counselling practitioners should have a diversity of models from which to choose, in order to find a best fit with a particular consumer's theory of change.
>
> Ideally, models chosen should be one which counselling practitioners believe in and are confident of using.

Repertoire of theoretical models

In addition to flexible interpersonal skills, the common factors research shows that in order to match approaches to the consumer's unique theories of change, counsellors need to possess knowledge and practice experience of a variety of theoretical models and frameworks, as well as the ability to modify the choice of approach when needed (Simons & Aigner, 1979, in Drury-Hudson, 1997). As Rycroft paraphrases Yalom: 'A solid knowledge of a range of approaches… provides a repertoire that enables us to offer a "new therapy for every consumer"' (Rycroft, 2004; Yalom, 2002). One way counsellors can develop and maintain flexible interpersonal skills and knowledge of a range of approaches is through clinical supervision.

Clinical supervision – a process through which the counsellor's knowledge is developed

Clinical supervision is not only a critical mechanism to ensure quality within clinical governance, it is also a powerful medium through which counsellors can critically examine and enhance their engagement skills and processes. Clinical supervision can also be a vehicle through which continuous professional development is planned and partly undertaken, to assist counsellors to update skills in using new models and techniques.

Nevertheless, counsellor knowledge, when used in isolation, is in danger of being coloured with individual biases and fixed responses that can result in out-of-date or ineffective models and techniques continuing to be used unchallenged. Therefore, one method to guide the planning of updating professional training is by keeping abreast of new research in models and ways of working – the third evidence source in the model.

3. Research evidence

Techniques and models in therapy are constantly evolving, and newer, possibly more helpful, approaches are being found. Research can provide one point of guidance in choosing which models to learn.

There are a number of ways counsellors can keep up to date with current research evidence, for example:

- ongoing professional development, both within clinical supervision as well as undertaking study or training
- accessing current clinical guidelines around a variety of mental health problems
- accessing online journals and databases (such as Cochrane Collaboration), many of which can be easily accessed through email newsletters or updates.

Keeping abreast of data is also the focus of the fourth and final evidence source within the proposed model.

4. Statistical population data

Although less commonly seen as a source of evidence for evidence-based practice, statistical data are logically an important foundation of evidence that should direct service planning. Planning services in order to tailor programs to meet the unique needs and preferences of the local community is an important tenet in community health values, and is one major rationale for establishing locally based health services in the first place. Both population-based data as well as individual, service-specific data should be used to plan services.

Population-based data: frequency of attendance in counselling

One crucial population-based (Statewide) data finding is that 70 per cent of CHS counselling consumers attend three or fewer sessions: 42.4 per cent attend once and 27.5 per cent attend two to three times.[34] Services need to consider this evidence when planning service delivery frameworks.

Single session work (SSW)

As a response to CH counselling Statewide data, the Department funded The Bouverie Centre at La Trobe University to provide CHSs with extensive training and service system support in SSW between 2003–04 and 2008–09.

SSW is one service delivery framework that can assist counselling services to capitalise on research findings such as the common factors research (Assay & Lambert, 1999), which has shown that:

- improvement early on in counselling is a strong predictor of a positive outcome
- the consumer's opinion on how the counselling is going is one of the best predictors of success.

Population-based data: high-prevalence disorders

Other population-based data evidence is prevalence data of common mental health issues. The National Mental Health and Wellbeing Survey (ABS, 1998) outlined that more Australians experience anxiety, depression and alcohol disorders than any other mental health problems, and that 18 per cent of all Australians experience one or more of these in any 12-month period. The age group with the highest prevalence is 18–24-year-olds.

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[34] See Table 2, pages 21–22

Using service data to increase effectiveness of CH counselling

A first step is to find out whether or not the counselling actually assisted consumers to achieve the changes they wanted to make in their lives (i.e. the desired 'outcome'). Data about whether change has/is occurring are very useful in determining whether a service is effective. As described previously under the 'consumer knowledge' section, 'outcome-informed counselling' is one innovative process to assess what, if any, change is occurring. Some CH counselling services already have good systems in place to evaluate the effectiveness of counselling. For those services that are beginning to develop processes to monitor effectiveness, collecting outcome data is a critical step, and can be done in a number of ways and in different stages of service delivery.

Data collection upon exit of service

Services can collect data within the exit phase of the counselling consumer pathway, to provide the consumer with an opportunity to reflect on how much (if any) change has occurred for them since attending counselling. This could be done through, for example:

- a written qualitative questionnaire (that might ask some general questions around what has changed for the consumer since beginning counselling, and is completed either at the last session or completed at home and posted back to the service)
- The consumer being interviewed, either by the counsellor or an external person (manager/another counsellor), asking similar questions as would be asked in a written survey
- The consumer being phoned by a counsellor at a specified time after the final session, again, asking similar questions as would be asked in a written survey or a face-to-face interview.

These data can give a broad understanding of whether the service is assisting consumers to change over a period of time. This process would exclude those consumers who do not undertake a planned exit from the service.

Comparison data collection – pre and post

Services can undertake slightly more formal effectiveness data collection through collecting 'pre' and 'post' information from the consumer at the beginning (i.e. during INI phase or first session of service provision phase within the counselling pathway) and at the end of counselling (i.e. within the exit phase), for comparison to determine level of change. For example, counsellors can collect pre and post information about:

- a consumer's frequency and amount of symptoms (e.g. through a symptom checklist such as Beck depression inventory)
- a consumer's level of distress (through simple scaling questions where 0 = no distress and 10 = complete distress, administered in either written or verbal format)
- a consumer's level of functioning within different life spheres – social, family, interpersonal, or job (through similar scaling questions for each life area, administered in either written or verbal format).

These data can give more quantifiable evidence of service effectiveness by documenting whether consumers feel that things are different at the end of counselling compared with when they began counselling.

Data collection throughout counselling

The third, and possibly most labour-intensive, method of creating an evidence base to inform practice is to collect data *during* the counselling work with each consumer, to inform the work while it is still taking place ('outcome-informed counselling', as described in the 'consumer knowledge' section). The data would be collected within the service provision phase of the counselling consumer pathways framework by:

- simply asking the consumer at the conclusion of each session whether or not the session had been useful and why
- asking the consumer (towards the end of each session) to complete simple scales assessing aspects of the session – for example the Session Rating Scale (SRS) (Duncan et al., 2004) – which should prompt further discussion of helpful and unhelpful aspects of the counselling process.

Whilst this process can initially be confronting for some counsellors, it can ultimately empower counsellors to change things 'in the moment', and is the most powerful way to use consumer-specific evidence to increase the effectiveness of counselling.

5.6 Partnering to provide better services

Mental health service system

Area mental health services

These services target people with serious mental illness, suffering significant disturbance or impairment. Area mental health services (AMHS) are part of larger health services that deliver a range of hospital and community-based services.

Three main program areas deliver clinical mental health services:

- Child and adolescent
- Adult
- Aged person.

Child and adolescent services

Child and adolescent mental health services deliver services to people up to the age of 18 years who have serious emotional disturbance. The target group includes young people with a diagnosable psychiatric disorder whose condition is seriously detrimental to their growth or development or who have serious difficulties in their social group or family.

Adult services

Adult mental health services focus on people who have significant levels of disturbance and psychosocial disability due to their illness or disorder. Commonly, these people have a diagnosed major mental illness (such as schizophrenia or bipolar disorder), but the target group also includes some people with severe personality disorder or other conditions (such as severe anxiety disorder) and those who present in a situational crisis that may lead to self-harm or inappropriate behaviour towards others. The distinguishing factor is the level of severity of the disturbance, impairment and risk (acute or chronic).

Aged person services

Aged services target people with a long-standing mental illness who have grown older with the illness, and those who have developed illnesses such as depression and psychoses in later life. They also provide treatment and care for people with psychiatric or severe behavioural difficulties associated with organic disorders such as dementia.

Each of the above specialist mental health programs has components that cover a continuum of services from inpatient to community-based options.

Primary Mental Health Teams

Primary Mental Health Teams (PMHTs) are also part of AMHSs and provide assessment and secondary consultation to primary health providers, with the following objectives:

- improving access to, and the quality of, mental health services provided by specialist and primary health care providers to people across their life span
- supporting and enhancing the capacity of a range of primary care providers, in the first instance CHSs and GPs, to recognise and treat mental health problems and disorders more effectively, via the provision of education, training and secondary consultation
- promoting shared-care arrangements between specialist mental health services and primary care providers
- providing brief, time-limited clinical service responses to people with moderate to severe disorders where the primary health provider maintains primary responsibility (including dual diagnosis) across the age range, first presentations and people experiencing a relapse, specifically focusing PMHTs' direct clinical services on:
  - postnatal depression (PND)
  - eating disorders
  - families where the parent has a mental illness (FaPMI)
  - new treatments, for example Clozepine management.

The majority of the clinical, liaison, consultative and educative work is carried out in primary health care (general practice and community health) settings. PMHTs operate in community-based public facilities or on an outreach basis.

Statewide and regionalised clinical services

Statewide and regionalised specialist services support and complement area-based clinical mental health programs. Specialist statewide services have been established to focus on particular problems and disorders (e.g. personality disorder service, early psychosis services). These services are funded to develop and disseminate best practice and service models for working with consumers who have particular needs. They typically engage in direct care, consultation, education and training and research.

Psychiatric disability and rehabilitation and support services (PDRSS)

These services are a non-government mental health sector and provide support to consumers and carers throughout the recovery process, and offer a number of different programs, for example psychosocial day programs and residential rehabilitation.

General practice

General practice[35] is at the front line of Victoria's health care system and GPs are the first point of contact for many Victorians into the health system. Approximately 80 per cent of Victorians see their GP at least once a year, and GPs, practice nurses and other health professionals working within

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[35] General practice refers to the total service/entity including GPs, practice managers, practice nurses, receptionists and, in some cases, other health professionals.

general practice regularly help to link people into State-funded health services.

With specific regard to mental health, general practice is often the first point of contact for people with psychological or emotional problems (Tisher & Jackson, 2001). Since November 2006, GPs can refer patients to Medicare-registered private mental health practitioners, including psychologists, social workers and occupational therapists, for Medicare-rebateable counselling or other treatments for mental disorders, though GPs often also refer patients to CHSs for counselling, particularly those unable to afford a gap payment for private allied health services.

In order to better understand the role of GPs in CHSs, the Department commissioned a study that utilised the BEACH[36] (Bettering the Evaluation of Care and Health) methodology. The research found that patients of GPs located in CHSs were likely to have more than double the rate of psychosocial problems compared to patients of Victorian GPs generally, and were likely to present with two to three problems per visit. CHS GPs were found to manage significantly more depression and schizophrenia, and there was a trend toward increased management of drug abuse and psychological checkups (Bayram et al., 2006).

Private mental health practitioners

Medical practitioners (GPs, psychiatrists, paediatricians) can refer people with a mental disorder to Medicare-registered private providers for psychological treatment under the *Better Access* Medicare program. Under this scheme, rebates will be provided for psychological assessments; therapy is provided by clinical psychologists, and focused psychological strategies are provided by eligible psychologists, social workers, occupational therapists and GPs with additional mental health training.

To access psychological services through the MBS a person needs to first visit their GP. If the GP recommends counselling as a treatment they will prepare a Mental Health Care Plan and refer the person to a private provider of mental health services registered with Medicare (usually a psychologist, social worker or occupational therapist). Up to 12 individual and 12 group allied mental health services can be received by that person per calendar year,[37] and an additional six sessions where warranted in exceptional circumstances. Unless the private provider bulk-bills the person may need to pay a gap fee.

Alcohol and drug services

Alcohol and drug services provide counselling, consultancy and continuing care services and a range of services and supports to assist people who have alcohol and drug use problems.

Services are provided in a range of settings including CHSs, stand-alone alcohol and drug services, hospital-based alcohol and drug services, and other generalist health and welfare services. Services are delivered by a range of professionals including social welfare workers, health professionals, psychologists, GPs, consultant physicians and psychiatrists.

Target groups for these services are people who have alcohol and drug problems and who require treatment and support services to effect and maintain therapeutic change or who require assistance in controlling their drug use. Support can also be provided to families of consumers. Key service requirements can include assessment, counselling, case management and secondary consultation.

The co-occurrence of alcohol and/or drug abuse with common mental health problems requires CHS counselling practitioners to maintain an understanding of alcohol and drug abuse issues. CHS counselling practitioners can provide very effective interventions to people with alcohol and other drug use issues. Specialist alcohol and drug services are available to provide secondary consultation.

The Gambler's Help service system

The Gambler's Help service system provides professional, free-of-charge services from over 100 locations throughout Victoria.

The Gambler's Help service system includes:

- problem gambling casework services, including support and counselling, with the objective of reducing and minimising the harm caused by problem gambling for problem gamblers and their families by providing evidence-based interventions across a range of practice modalities and practice settings.

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[36] BEACH (Bettering the Evaluation and Care of Health) is a continuous national study of general practice activity that began in April 1998 and continuously collects information about the patients seen; reasons people seek medical care; and problems managed and treatments provided in general practice in Australia.

[37] www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-gp-mental-health-care-medicare

- specialist problem gambling financial counselling, with the objective of stabilising and improving the financial situation of problem gamblers and their families by providing information, advice and practical support.
- a community education program which delivers a range of planned activities that increase awareness of problem gambling, teach responsible gambling strategies, promote help services and build community resilience through awareness raising, information and education provision, health promotion and provider education programs.
- the Recovery Assistance Program (RAP), which provides material and financial assistance to individuals and their families when gambling has resulted in financial crisis. The aim is to provide this assistance in a way that does not facilitate or subsidise gambling behaviour, but ensures that essential living needs are met.
- Gambler's Help Line, a 24-hour, seven-days-per-week 1800 telephone and web-based service providing information, referral, counselling and support to problem gamblers and their family members. This service also supports linkages and referral to face-to-face Gambler's Help problem gambling counselling and financial counselling services. A therapeutic telephone counselling program is also offered for people who are experiencing difficulty with a gambling-related problem, but for whom face-to-face therapeutic counselling services may present difficulties.

Gambler's Help services are developing strong service delivery links through a specialist portfolio services program with mental health services, alcohol and other drug services and family services to support integration and care coordination for individuals and families experiencing gambling-related harm and comorbid conditions.

Family services

Family Services provides a range of activities that may include the provision of outreach, assessment, case management, counselling, casework, in-home support, group work, brokerage, as well as other support and information activities. In most cases an initial assessment will be conducted with the family to determine the level, priority and type of service required. Where there are risk factors, early intervention services will be provided. Where there are complex needs, longer-term and episodic individual support for families will be provided. Family Services uses a child/youth-centred, family-focused approach.

Family services are targeted to families with children aged 0 to 18 years who require assistance to provide a safe, nurturing and stable environment for their children. Priority access will be given to families where risk indicators are present. Risk indicators may include the presence of mental illness, disability, substance abuse, family violence, social and economic disadvantage, involvement with Child Protection or the justice system, risk of family breakdown or teenage parents.

Family violence services

Family Violence Support Services for Women & Children

A range of direct services is provided to women and children or young people who may be affected by family violence. Service provision includes individual counselling, specialised support groups, and referral services. These services aim to promote early intervention strategies to prevent the occurrence or escalation of family violence, and prevent future occurrences of family violence by offering post-crisis support. Further assistance is available for women seeking intervention orders through the provision of court support, advocacy and referral. These services also provide support to children to improve their coping skills and self-esteem, and to foster the development of non-violent problem-solving strategies.

Men's behaviour change programs

These services play a key role in promoting the safety of women and children with a primary focus on making men accountable and responsible for their use of violence toward family members. The purpose of these programs is to encourage the change process in men's behaviour, and they provide a forum for exploring and challenging beliefs. All approved programs are required to be members of the peak organisation for male family violence, No To Violence[38] (NTV), and adhere to NTV's prescribed practice standards for running men's behaviour change programs.

Sexual assault support services

Sexual assault support services provide direct services for children, young people and adults who are either recent or past victim/survivors of sexual assault. Services include crisis care responses, counselling, casework, group work, advocacy and a Statewide after-hours telephone service. Agencies also provide community awareness, education and professional consultation services that work towards the prevention and early identification of sexual assault. Some agencies also provide services for children and young people displaying concerning sexual behaviour. A range of support services can

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[38] www.ntv.org.au

respond to the needs of recent and past victim/survivors of sexual assault.

Youth services

Youth Services provides a number of targeted programs to vulnerable young people between the ages of 10 and 18 years to assist them with the challenges they may encounter during this significant period of personal growth and development. Programs aim to improve both the wellbeing and opportunities available to vulnerable young people through the delivery of services that are flexible, responsive and supportive of young people's needs and that also connect them to their local communities.

The individual programs provided to young people through Youth Services include:

- Adolescent support
- Finding Solutions
- Refugee Minor Program
- Innovative Health Services For Homeless Youth (IHSHY)
- School Focused Youth Services (SFYS)
- Secondary School Nursing Program (SSNP)

Adolescent support

The Adolescent Support Services Program provides a range of services to assist and support young people aged 12–17 years, who are living at home or independently, and who are consumers of Child Protection. Adolescent Support aims to provide a responsive and flexible service that addresses the needs of young people who are in immediate crisis or 'at risk' of harm, and to provide ongoing support and supervision where necessary. A range of strategies may be used by Adolescent Support to achieve the identified outcomes, including provision of information to consumers and families, case management, referral, community development and group work.

Finding Solutions

Finding Solutions is an early intervention program targeting young people of secondary school age and their families who are at immediate risk of being placed in out of home care. Finding Solutions provides mediation and support to young people and their families to assist them in identifying, addressing, and resolving issues, behaviours and/or needs that place the relationship 'at risk' of breakdown. The program aims to ease tension in the family without severing links or decreasing the parent's capacity to care for the young person. Finding Solutions aims to divert the family and young person from involvement in the child protection and placement system and to find the best possible solution for the young person and their family.

Refugee Minor Program

The Refugee Minor Program aims to assist 'unaccompanied' young people and children, up to the age of 18 years, with their settlement and establishment into life in their new community through a casework-based approach. The Refugee Minor Program provides the provision of direct services to consumers to assist them (and their relatives or carers) to develop key settlement competencies whilst also establishing and maintaining partnerships with other key agencies in the community. Consumers can be given assistance on a wide range of issues ranging from accommodation and financial support, to physical and emotional health needs, cultural and religious continuity, education, provision of support (re the Refugee Application Process), social and recreational needs, and developing or maintaining family connections.

Innovative Health Services For Homeless Youth (IHSHY)

IHSHY is a Commonwealth/State program to promote health care for homeless and at-risk young people. IHSHY provides a means of engaging young people who are homeless or marginalised and who may not otherwise access health services.

Eighteen community and mental health services, Aboriginal health services and youth-specific health services deliver IHSHY programs in Victoria. IHSHY services provide a range of clinical, health promotion and counselling services to homeless and at-risk consumers, including:

- medical, mental health and maternal health and nursing services
- referral, brokerage and advocacy work to facilitate access to mainstream health services
- health promotion activities including sexual health information sessions and cooking and nutrition classes
- supply of pharmaceuticals, food packs, personal hygiene items and clothing items
- drug and alcohol treatment
- STI and BBV testing.

School focused youth services

School Focused Youth Service (SFYS) is the coordination of preventative and early intervention strategies for 'at-risk' young people aged 10–18 years (with a particular emphasis on those aged 10–14 years), delivered by and through schools and local community agencies. SFYS assists in the development of linkages and coordination between youth services (both in schools and the community), so that the service system can more effectively address and meet the needs of vulnerable young people at an earlier stage. Some brokerage funding is available to purchase services where there is a current service gap and there is an identified need to provide a particular service to young people that would otherwise be unavailable to them.

Secondary school nursing program

The Secondary School Nursing Program (SSNP) aims to improve the health and wellbeing of young people aged 12–18 years and reduce negative outcomes and risk-taking behaviour. Nurses are located in targeted schools throughout rural and metropolitan Victoria. Secondary School Nurses adopt a health promotion and primary prevention framework to address contemporary health and social issues that face their local school community and families. The role of the Secondary School Nurse may encompass individual health counselling, school community development activities, health promotion and planning, small group work focusing on health-related discussion and information; and they may also act as a resource and referral service to assist young people in making healthy lifestyle choices.

Case example – 'Michelle'

Michelle is referred to CH counselling at a CHS because she is experiencing a lowered mood that contributes to difficulties parenting her four-year-old son, who has been diagnosed with autism. Michelle also has a six-year-old daughter who has yet to be enrolled into primary school. Michelle's ex-partner lives in Queensland. Michelle is also experiencing chronic pain from a back injury sustained in a car accident several years ago.

The CH counsellor works with Michelle in developing a care plan, and agrees that whilst counselling can assist Michelle to better understand and manage her thoughts and feelings, other services may also be useful in assisting Michelle to make the changes she wants to make in her life.

The counsellor and Michelle make a referral to a family service, whose support worker can assist Michelle in her home with developing effective parenting techniques, as well as support her to enrol her daughter in school. The family support worker, Michelle and the counsellor work together to determine what goals Michelle works on with each professional, making sure techniques are complementary.

Michelle contacts a local GP, who liaises with the counsellor about developing a pain management program with Michelle and plans to trial Michelle on some tri-cyclic antidepressants that have been helpful for her in the past.

This process of referral and ongoing interdisciplinary work between CH counselling, family services and the GP was greatly facilitated by previous partnerships the CHS had developed with those services through PCP involvement. These partnerships resulted in clear referral protocols, and trusting and respectful relationships between service providers.

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Common terms and abbreviations

Affective disorders (mood disorders)

This term can be used to describe all those disorders characterised by mood disturbance.

Disturbances can be in the direction of elevated expansive emotional state or in the opposite direction, a depressed emotional state.

Anxiety

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

Assessment

Ongoing process beginning with first consumer contact and continuing throughout the service provision phases to exit. The major goals of assessment are:

a) identification of vulnerable or likely cases
b) identification of risk issues
c) choice of optimal interventions based on counsellors' skills and consumer preference
d) evaluation of the effectiveness of the intervention with regards to consumer feedback and outcome of counselling.

Best practice

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

Care

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

Care plan – inter-agency care plan (multiple-agency)

Supports coordinated care for consumers with multiple and complex needs when more than one agency is involved. The range of services required by the consumer are coordinated so that they are provided in the most efficient and effective way to meet the consumer's needs. Care coordination enables continuity of care, avoids duplication of services and ensures that meeting the consumer's needs is paramount over the needs of individual service providers and is not hampered by program boundaries. Care planning can include coordination of care, case management, referral, feedback, review, re-assessment and monitoring.

Care plan – service-specific care plan (individual)

Usually developed using the agency's or program's specific, adapted or preferred tools to capture the consumer's specific goals and the approach determined by the counsellor and consumer together.

Casework

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

COAG

Council of Australian Governments

Community participation

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

Community health service (CHS)

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

Consumers

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

Counselling

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

DALY – disability-adjusted life year

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

DOHA

(Commonwealth) Department of Health and Ageing

DHS

(Victorian) Department of Human Services

Effectiveness

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

Efficacy

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

EQuIP

Evaluation and Quality Improvement Program

Evidence-based practice

A process through which professionals use the best available evidence, integrated with professional expertise, to make decisions regarding the care of an individual. It is a concept that is now widely promoted in the medical and allied health fields and requires counsellors 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 consumer is implicit in the process.

Initial needs identification (INI)

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

MBS

Medicare Benefits Schedule. The schedule lists all Medicare-rebateable services, including items under the Australian Government's *Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule* initiative. See: www.medicareaustralia.gov.au/public/claims/what-cover.jsp

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 and optimal development and use of mental abilities (cognitive, affective and relational). The achievement of individual and collective goals consistent with respect for others is central to a positive 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 is met.

Mental health professionals

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

Mental health promotion

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

Outcome

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

Prevalence

The proportion of the population with the disease or disorder.

Preventive interventions

Programs designed to decrease the incidence, prevalence and negative outcomes of depression, for example:

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

Primary care

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

Primary care partnership (PCP)

A group of primary care providers that have formed voluntary alliances to work together to improve health and wellbeing in their local communities. There are 31 PCPs in Victoria.

Primary health care

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

Primary Mental Health Teams

Primary Mental Health Early Intervention Teams

Primary Mental Health Teams are a component of the public specialist mental health system. Their focus is to support the interface between the primary and tertiary mental health service systems.

Primary Mental Health Early Intervention Teams provide short-term treatment and assessment services to people with high-prevalence disorders who have been referred to them from primary providers. They also provide early intervention to young people with emerging psychosis and significant psychological disorders, and provide consultation and liaison, education and training (including crisis prevention training) to primary care providers.

Psychiatrist

Medical practitioner with specialist training and qualifications in psychiatry.

Psychologist

A psychologist is formally defined as a person who is on the register maintained by a state or territory psychologists board or council to practise psychology in that state or territory. Requirements for registration differ slightly between jurisdictions. The minimum Australian educational requirement to be a registered psychologist is either:

- A four-year degree in a course approved by the appropriate state or territory registration board plus two years of supervised training; or
- A four-year degree plus a two-year full-time masters degree accredited by the Australian Psychology Accreditation Council (APAC).

QIC – Quality Improvement Council

QIC is a national primary health industry body that produces standards for primary health care and associated services. The QIC Review and Accreditation Program is based on the QIC standards, but has the capacity to use service delivery standards developed by other industries provided they meet particular criteria.

QICSA – Quality Improvement and Community Services Accreditation

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

Randomised controlled trial

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

Risk factors

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

Single session work (SSW)

SSW is a service framework to structure both initial individual sessions as well as general intake procedures. It is underpinned by the philosophy of treating each contact as if it may be the last, whilst laying a foundation for ongoing work for those consumers who need it and want it.

Social model of health

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

Socioeconomic status

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

Specialist mental health services

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

STIs/BBVs

Sexually Transmissible Infections and Blood Borne Viruses

Stressor

An event or situation that occasions a stress response in a person.

Substance use disorders

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

Suicide/Suicidal behaviour

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 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 (that endanger life) as suicidal behaviours.

WHO

World Health Organization

State Government Victoria

Department of
Human Services