de WEVER, Ms Johanna, Chief Executive Officer, Psychotherapy and Counselling Federation Australia [by video link]

STOW, Dr Dianne, President, Psychotherapy and Counselling Federation Australia [by video link]

[10:40]

CHAIR: I welcome witnesses from the Psychotherapy and Counselling Federation of Australia to give evidence before the committee. I remind you that, although the committee does not require you to give evidence under oath, the hearings are legal proceedings of the parliament and they warrant the same respect as proceedings of the House. The giving of false or misleading evidence is a serious matter and may be regarded as contempt of parliament. Before we move to general discussion and questions, would you like to make a brief opening remark about PACFA?

Dr Stow: Thanks very much for this opportunity to talk this morning. We are very appreciative. I'm thinking that you probably aren't familiar with the Psychotherapy and Counselling Federation of Australia, so what I'd like to do is quickly introduce us and our members.

Our organisation is a peak body for counsellors and psychotherapists. We've got more than 4,000 expert members nationally and we were, in fact, established in the early 2000s through the merger of several smaller counselling and psychotherapy groups. We are run by a board, the board's made up of members and we're registered and not for profit.

Our members work predominantly in private practice in the community; but they also work in schools, with not-for-profit organisations, in government, with first responders, with veterans and, indeed, in academia. Our members have bachelor degrees or postgraduate qualifications in counselling and meet continuing professional development requirements, hold insurance, and follow our code of ethics.

Whilst the interest in mental health policy and treatment may wax and wane in the broader community, our members have been working with clients for decades to increase self-awareness, support behaviour change, address family dysfunction and assist with relationship challenges, all of which are proven protective factors which reduce the risk of mental illness. Our members don't just support the worried well; they provide an essential early intervention for people who are carers, people dealing with substance abuse and those responding to past trauma. In addition to preventing future illness, counsellors and psychotherapists are trained to support people with mild to moderate mental illness. Evidence proves that talking therapies such as cognitive behaviour therapy or solutions therapy are just as effective when delivered by a counsellor as a psychologist.

At this point, I'd like to share a little about myself and my journey, as, in many ways, I'm typical of PACFA members and counsellors more generally. My position as president of PACFA is a volunteer one. I work full-time in private practice, in Hobart, and I talk with people on a daily basis about their lives. Before becoming a counsellor I was a teacher for many years and then worked in educational management and with the state government. I then under took postgraduate studies in counselling.

In my practice I specialise in grief and loss. For my PhD I investigated the connection between grief and loss and philosophy. That means that every day I hold the space to enable people to explore their own feelings related to eating disorders, infertility, death and tragedy. These are not easy conversations but I believe the work I do is crucially important to the people coming to my rooms. Helping people understand what has happened is key to enabling them to move on. Without this progress people can fall into depression, with lifelong implications. During the last 10 months, in particular, demand in my area has increased, notably around the response to Me Too and anxiety about COVID, even in Tasmania. I live in Hobart. More broadly, I can attest to the significant capacity that is still available in the counselling workforce.

At PACFA we recently surveyed our membership about their availability. Whilst our psychologist colleagues are reporting waiting lists of three to six months and, typically, charge more than $200 per session, counsellors with equivalent bachelor degrees and postgraduate certificates have said, and I refer here to my notes, 62 per cent could see a new client within two weeks; 23 per cent could see a new client within 48 hours. Our workforce study recently found that 33 per cent of the counselling and psychotherapy workforce are located outside metropolitan capital areas. This is substantially more accessible than psychologists or, indeed, psychiatrists, according to the most recent Institute of Health and Welfare data, which put them at approximately 16 per cent and 15 per cent respectively.

It's probably obvious to you, the difference this could make in the life of someone grappling with mental health concerns. Getting immediate access to a counsellor can reduce a person's distress and begin the process of supporting the development of coping strategies. It can certainly accelerate the triage of people with suicidal

ideation, as a counsellor is ready and able to refer a person to specialist services as outlined in our scope of practice. Importantly, a counsellor's accessibility and responsiveness empowers a person at a time of key vulnerability and despair. That window of action is crucially important for help seeking. Yet we know that many people don't reach out to counsellors. Most likely, we think, it's because they've been referred to a psychologist by their GP under Better Access that provides the rebate, which is not available to counsellors.

Fundamentally, we encourage the select committee to think strategically about the role of counsellors and psychotherapists at this time of enormous demand for mental health support and to envisage a policy environment where counsellors could assist more people and complement the work of psychologists, social workers and mental health nurses in supporting the Australian community. We'd welcome the opportunity to discuss this further with government and other health workforce agencies and to raise awareness among the community. I'd like to leave it there, Fiona, in terms of my opening remarks. Again, thank you so much for enabling us to talk with you this morning. That is just a really great opportunity. Thank you.

CHAIR: Thank you. Johanna, did you want to provide an opening mark, or are you happy for us to go to questions?

Ms de Wever: I think Di has done an excellent job, but thank you.

CHAIR: Fantastic. I'll start questions. Sorry, I am juggling a lot of tech here to communicate with members, and I'm taking notes and talking, so bear with me. It's a bit like running a therapy session. Your membership is vast. Some counsellors and psychotherapists have undergraduate qualifications in counselling, and others have postgraduate qualifications in counselling. Is there a tier system or are there higher levels of membership at PACFA and lower levels of membership based on qualifications and continuing professional development?

Dr Stow: Yes, Fiona. Thanks for that question. In PACFA we have a clinical register and we also have provisional members. Our clinical register includes people with graduate diplomas and with bachelor degrees and further postgraduate qualifications like masters level and PhD. Our clinical members are fully accredited and registered. They have to provide evidence of ongoing professional development, appliance to the code of ethics and supervision. So we have a very rigorous accreditation program. In answer to your question, the actual requirements to be on either the clinical level or the provisional level—and I would particularly like to highlight the clinical level—are very rigorous and high level.

CHAIR: Is the code of ethics publicly available on your website?

Dr Stow: It is, yes. On our PACFA website the code of ethics is available there for all to see.

CHAIR: You mentioned that members of PACFA don't just treat the worried well; they treat carers, people with substance abuse and past trauma. You said that they're just as effective—I didn't quite get all of the sentence, but I think you said they're just as effective as psychologists, and there is evidence in that respect. Are we able to get the evidence? Are you able to provide that evidence to the committee?

Dr Stow: I can provide evidence. One document that I am referring to is the Converge Australia document which got 60,000 responses indicating that counsellors were indeed as relational as psychologists, if not more. I would be very happy to provide that report to you, including the supporting evidence.

CHAIR: That would be great. Thank you very much. I note the comments you make about how the demand has increased, particularly around anxiety about COVID, and that members of PACFA and counsellors in general have shorter waitlists than clinical psychologists and psychiatrists. You talked about the role of counsellors at this time of need. I'm just wondering: in other OECD countries that are equivalent to Australia, what is the role of counsellors? How are counsellors and psychotherapists, who reflect at least the membership of your association, represented in terms of the general mental health system? Do you have that information?

Dr Stow: Yes, I do have that information. I serve on the board of the International Association for Counselling, so I'm talking and meeting on a regular basis with international colleagues and international counsellors. There's great evidence—in fact, not just evidence; the fact is that in the countries that you've mentioned, counsellors are much more acceptable or go-to, including psychotherapists. In fact, before Better Access in Australia, GPs would refer to counsellors or refer to psychotherapists. Since Better Access for our psychologist colleagues, that suddenly equals mental health, and counsellors and psychotherapists, albeit equivalent parallel training, seem to have been kind of left off the list. But, internationally, counsellors are standing alongside psychologists. Psychotherapists internationally are standing alongside psychologists.

CHAIR: Could we get a copy of the evidence that you referred to in relation to that so that we can compare that?

Dr Stow: Yes, I'd be delighted to give you that evidence.

CHAIR: Thank you. I also have general questions about burnout and wellbeing for people who work in the mental health space, particularly at a time like this. Demand and waitlists have increased, and the pressure is on to help as many people as you can. What can be done from a policy or government perspective to assist with reducing the burnout and improving the wellbeing of one of our most important workforces at the moment?

Dr Stow: I'll answer that question, Fiona, in two parts. I know, based on your background, that you will be well and truly familiar with supervision, for example. For me in Hobart, in Tasmania, PACFA actually has a Tasmanian branch and, as a consequence, we've got access to the opportunity for peer supervision and the opportunity for group supervision, which often, for the practitioner, has a smaller cost factor involved. Certainly individual supervision is a cost factor borne by the practitioner. Supervision is critical around burnout, and I think across the country, not just in Tasmania, people are accessing supervision. Also, network meetings and talking with people on LinkedIn, for example, and just getting together with colleagues are real positives in the sense of managing burnout.

It's challenging for the government to look at ways to support counselling and psychotherapy and the allied health professions generally, in terms of funding, because funding is just—everybody wants money for this, everybody wants money for that. But building in an opportunity to provide support for the profession in this time of need is critical. That might be supporting professional organisations. That might be educating the community around seeing professionals and educating themselves about supporting those professionals.

CHAIR: For the benefit of the committee, could you describe what a typical formal supervision session would entail? And also explain how critical it is for the performance or the effectiveness of a clinician?

Dr Stow: Yes, I'm really delighted to do that from two points of view. I work as a supervisor myself—I'm an accredited PACFA supervisor—and, as a consequence, I work with counsellors, psychotherapists and psychologists providing supervision. I also attend supervision myself, one-on-one and in a group supervision situation. The experience of both being a supervisor and being a supervisee is a very rich experience. I also run group supervision.

I'll speak as if I'm sharing with you from a one-on-one perspective. Before I go to my supervisor, I would prepare with some cases that maybe I want to share because I think they've gone really well and I'd just like to talk them out privately and confidentially. I also want to get some feedback about tips, techniques and strategies from the supervisor to enhance my practice. Maybe even more importantly to an extent, I might want to talk about challenges, talk about my scope of practice and where I might refer people to—just get reassurance about how I'm going with managing the lovely clients who come to the room. It's always a safe environment, which helps me to chat in a comfortable way, but also to have really important discussions so that I can be allowed to feel or hear myself speak out loud and hear my own confidence around the way I'm practising.

The supervisor might ask me some challenging questions around ethics and challenging questions around if I might like to do some professional development to enhance my skills in dealing with this particular client or this particular client group. Very often, I come away feeling more energised and more passionate about my work, because I've been able to have a stimulating conversation, I've been able to share some joys and highlights and also wonder about some concerns, and I've come away with some value-add—some tools, some techniques, some tips.

What I would like to be absolutely clear about, and be humble about this, is that, as a supervisor, I would want my supervisees to take away some positive energy and encompass the sorts of things that I myself get from supervision. It really does help to decrease burnout. I might also be wanting to talk about self-care and ideas around what's going to help me to keep my boundaries, dispel the heaviness of some of the stories that my clients are telling me. As a counsellor, I want to be the best I can be for each person who comes into the room so that they can work through their issues, get well, get better if that's the way it's going, and be their best selves. So it's kind of a win-win.

CHAIR: What are the consequences of burnout in clinicians? You mentioned boundaries, so boundary violation for the non-clinician committee members listening in. I guess what I'm getting to is what are the costs of burnout? What could happen if a clinician isn't supported properly, or isn't taking the initiative to meet their needs with supervision and continuous professional development?

Dr Stow: I'm really excited and impressed around the topic that we're now talking about! This is really critical because the mental health of the country is so important. We have limited numbers of people in the mental health workforce to do the work. It is absolutely essential that they stay as well as possible. So the challenges of burnout—I can think of things like the practitioner not being as mentally well or as mentally alert, and maybe even tired. I know with my own supervisees, when I hear them say, 'I squeezed another person in,' that's like a red

flag to me, in the sense of being organised. This comes down to some of the competencies of being a counsellor or being a psychotherapist—that is, we need to be organised; we need to have our boundaries clear around how many people we see a day, a week; our note-taking and our follow-up around records, our administration. That's all part of reducing burnout. I guess burnout could allow for slippage in terms of some of those areas, which totally is not—we can't have that. We have to have everybody working at their capacity in the role that they've signed up to do.

Burnout might actually mean physical sickness and having to take time off work. It could therefore lead to rescheduling clients to further down the track. I mentioned waitlists of a couple of weeks, but if people are burning out and seeing fewer people and have to take time off, even waitlists for counsellors and psychotherapists are going to break out and be longer.

CHAIR: Can burnout lead to errors in being able to diagnose or provide sufficient therapeutic treatment for somebody who is in front of you?

To get straight to the point, given we treat very-high-risk patients, are there risks for their safety if the mental health workforce is suffering too?

Dr Stow: Fiona, that's an obvious yes. Speaking broadly for the mental health workforce, I think it's really critical that our mental health workforce is kept well. I've referenced self-care already in our conversation. The self-care arena is so critical for mental health professionals, so that they reduce the possibility of burnout—in fact, so that they can continue working in a positive space, so that there aren't errors, so that there aren't misdiagnoses. As a supervisor, I'm watching out for this in my supervisees all the time and advising them and working with them to better their practice, to take a break, to at least have the weekend off, and that kind of thing.

I'm experienced. I've been in this game for decades, and I think my experience value-adds to my capacity to assist people—in fact, my clients, whatever fields they might be working in—with regard to not getting burnout. I'm very well versed in this and would be happy to talk further about this with you and provide different sorts of evidence.

CHAIR: We'd love to hear more, but because of time I probably should leave my questioning there. I might hand over to the deputy chair, Emma McBride, to see if she's got further questions for you.

Ms McBRIDE: Thank you for your submission and your evidence today. I'm interested to pick up on the comments you made about carers and how you support carers. Some of the evidence we've heard has been that sometimes carers feel that they're not central to treatment or support. I just wanted to get your general observations about how you and your colleagues support carers, particularly through the context of COVID.

Dr Stow: Yes, I agree with you in terms of the importance of supporting carers, absolutely, Emma. We've got counsellors and psychotherapists, probably predominantly our counselling members, who are working in carer organisations. Their role is to support the carers as the carers are working for their clients. That's one particular way. That would be the main way. Carers, of course, would and could come as clients to counsellors and psychotherapists and also see my colleagues, who are supervisors, for support. Johanna, can you think of any other examples? You've perhaps got a little bit more info on this one for the moment.

Ms de Wever: I think it's well known that carers often don't feel that their own health is a priority and that it becomes very challenging for them over the course of supporting a family member who might be having difficulties. I certainly see a lot of encouragement for those people to be able to access counselling services, often in private practice, because it is discreet and less stigmatising and because they may not necessarily qualify for a mental healthcare plan through their GP, and because they want to be able to talk about their situation and they want to be able to get feedback and support through it in a confidential and safe space. I think counselling is often underestimated for the value it provides a lot of people who have a variety of needs for talking therapies.

Dr Stow: Thanks, Johanna. That adds value to the answer to that question. How does that sound, Emma? Is that enough information for you?

Ms McBRIDE: Yes, thank you. I appreciate that. I note your general observations about the mental health workforce and increasing demand and capacity. If this has been covered off in your submission, I apologise. You've spoken about some of the training and credentialing of your workforce, but what is the general distribution of counsellors?

I know that often if you live in a big city you typically have much better access to health care in general and mental health care in particular. What does the distribution or pattern of your workforce look like?

Dr Stow: I'm going to swing to Johanna because I know—we've planned this together—she's got those stats right in front of her. I'd rather she be super accurate than me just speaking about it from my memory.

Ms de Wever: We actually conducted a workforce study last year, during COVID, which will be published in our academic journal. We identified that 33 per cent of the respondents were outside metropolitan capital cities. That, to be honest, was actually higher than we thought. That's why we're making a key point of it. Thirty-three per cent is obviously significantly more accessible than the comparable numbers for psychologists and psychiatrists, not that, of course, we're looking at the same areas. But, fundamentally, in terms of talking-therapies support for people in regional areas, at 33 per cent our members are much more available than a psychologist or a psychiatrist at, I think, 18 and 16 per cent respectively.

Ms McBRIDE: Typically, how would someone get an appointment with a counsellor? Is it self-referral or otherwise?

Dr Stow: It's self-referral, which has got significant advantages. In my own practice in Hobart, because I've been working for at least a couple of decades, I've got links with GPs and specialists and they refer their patients to me. Those people just phone up my reception and get an appointment. They don't need an actual referral from the GP. Some of my colleagues across Australia might advertise their services, therefore, the general public, depending on where they are, would see some of those advertisements. PACFA runs a lot of professional development programs and so on, so people would get to know about the availability of counsellors and psychotherapies through there as well as through universities and the colleges. The actual answer to your question is self-referral.

Ms de Wever: Could I add quickly to that, Di?

Dr Stow: Yes, please.

Ms de Wever: I think what's really interesting is that we are very big supporters of better access. There's no doubt that increasing support for people to see mental health practitioners is a wonderful thing, but I think there's been an unintended consequence, perhaps, which is that community understanding of the wide range of services that are available to them has decreased. Now people don't necessarily realise that counsellors are a workforce that they can self-refer to; previously that used to be much more common. So potentially there's a lot of work for us to do and I'm not denying that. But in this conversation you're talking about people having a high need for services, not knowing where to go and being stuck in their situation without the opportunity for support that they really do need. That's why we're really putting our hand up to try and push this idea of the awareness of the workforce.

Ms McBRIDE: If someone typically self-refers and it's not covered through Better Access, what about affordability for the person themselves? Is this covered if someone has private health insurance? What would the out-of-pocket or upfront cost be for somebody?

Dr Stow: You go, Johanna. You've got that information in front of you.

Ms de Wever: Many private health insurers do offer support for counselling. It's often a different item to psychology, so just because you have psychology in a policy doesn't mean that you have counselling, but the more innovative agencies are stepping forward. The reality is that the price of a session is considerably more cost effective for counselling. Our members would typically charge between $100 and $130 for a session. If you've got private health insurance you get a rebate back on top of that. In contrast, psychology sessions are generally $200 and above, but you do get a Better Access rebate if you've come through that program, so that's beneficial. You can get access to much cheaper counselling if you go through one of the many support agencies, the not-for-profit agencies, which often refer people.

In relation to Di's comment earlier, we are seeing issues with the workforce where really senior, experienced practitioners have great practices, but the newer practitioners coming through, who don't have those connections, are finding it quite hard to set up a business and make it sustainable when they don't have much of a pipeline of clients coming through and when community awareness is a little confused.

Ms McBRIDE: I have one last question. I might not have this right, but you spoke about NGOs and counsellors. I know that there's a lot of demand for financial counselling. I don't know if that sits within the scope of the counsellors that are your members.

Ms de Wever: No. Our members are mental health counsellors and we are predominantly talking about organisations like Relationships Australia.

Dr Stow: If somebody were to come to me as a client with those kinds of concerns, which I wouldn't necessarily know about until I had met with them for the first time, it would give me an opportunity to refer them to a more appropriate path for those matters. But it also might be, nonetheless, very useful to have a couple of counselling sessions to just support them in trying to get their finances worked out, actually, yes. But financial counselling is not our remit; we are mental health.

One of the things I've been reflecting on as I have been in this conversation and listening is that we, counsellors and psychotherapists, want to be in the arena with psychologists and psychiatrists. Well, we are, but we are just not in the Better Access arena. If we were able to acquire Medicare item numbers for counselling and psychotherapy, we would be able to be greater help to the mental health of the Australian community. In these COVID times, that's just a critical thing. It might be in telehealth. Maybe we could jump on board in some aspect there. So we want to continue to work alongside, as we actually do, and with Better Access so that, whatever the referral path might be, the referrals can be a little easier or a little more straightforward, perhaps.

CHAIR: We have two more questions, but I might ask you to take them on notice and present the answers in writing, if that's okay. One is in relation to the difference between PACFA and the Australian Counselling Association. What are the membership bases and the similarities and differences between memberships and standards of registration? The other was on PACFA's view of counsellors and psychotherapists working collaboratively in a multidisciplinary team with other mental health professionals who may or may not be registered on the MBS and ways governments can help with incentivising multidisciplinary approaches and case consultation to get better outcomes for people with complex care needs.

Dr Stow: Yes, can we take those two questions on notice.

CHAIR: Thank you. That would be great. I'm just mindful of the time. Thank you so much for your evidence today. We really appreciate your time and your submission as well. You will be sent a copy of the transcript of your evidence when it becomes available and you will have the opportunity to request corrections to any transcription errors. If you have been asked to provide any additional information, please forward it to the secretary within seven working days and please contact the committee secretariat in relation to any other matters arising out of today's hearing. Thank you so much for your time.

Proceedings suspended from 11:18 to 11:40