



Australian Counselling Association Inc - ABN 12 242 711 378

## **ACA Submission**

**to the Inquiry by  
The Senate Community Affairs Committee  
into  
Commonwealth funding and administration  
of mental health services**

Dated:  
4<sup>th</sup> of August 2011

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## INTRODUCTION AND EXECUTIVE SUMMARY

The Australian Counselling Association (ACA) is a national and well-regarded professional association that sets appropriate standards for the training, registration and ongoing professional counselling of several thousand counsellors and psychotherapists.

We believe that it is important to participate in the current debate about a National Mental Health Agenda positively and constructively, drawing on the experience and expertise of our members as committed mental health professionals wanting only the best for their clients. We are aware that there has been some robust debate about policy, programme and funding mechanisms in the mental health community, but we are approaching this Inquiry, and the Commonwealth's consultation processes for a long-term National Mental Health Roadmap, in the spirit that what unites the mental health community – the best welfare of our patients and clients – is far greater than what divides us in our individual professional disciplines.

Indeed, the time has come to move past discipline “silos” and jealousies to seek a new way of looking at the mental health professional workforce as a continuum of disciplines (often overlapping) serving a continuum, by severity and complexity, of client need.

This is why our principal message to the Committee is that Commonwealth, State and Territory governments, mental health professionals and, above all, people affected by mental health problems and illnesses, families and carers, should work together to ensure that people living with mental health challenges have easy access to professionals with the training and expertise most relevant to their needs.

The ACA is also advocating that if this path is pursued that provider eligibility for public and private sector subsidy programmes, especially the highly successful Better Access to Mental Health Services programme funded under Medicare, is linked to a provider's registration under a proposed National Register of Mental Health Professionals. This proposal is contained in a private submission to this Inquiry by Dr Clive Jones and Mr Philip Armstrong, and the ACA fully endorses it as a positive step. We want to pursue a round table discussion of the plan with potentially interested parties and hope that the proposal can be explored in the context of the National Mental Health Roadmap.

We believe that thinking laterally in this way will transform the public policy and funding approach to primary mental health services, especially with both sides of politics finally recognising the need to foster and operate primary mental health services of the best possible quality, as directly relevant to clients as possible, and as cost-effective to payers. Basically, client need should determine the best mode and disciplines(s) of care, not funding sources.

This submission covers the Inquiry's terms of reference but does not follow them slavishly. The ACA prefers to offer comments on what we see as key matters and issues, where we have the capacity and experience to offer insights of genuine use to parliamentarians and policy-makers.

The ACA is client-focused, and this Inquiry and the emerging national mental health landscape need to be as well.

## ABOUT THE AUSTRALIAN COUNSELLING ASSOCIATION

The ACA is Australia's largest single registration body for counsellors and psychotherapists with over 3,000 members. The ACA was established over ten years ago and has since that time provided the counselling profession with a voice and political representation. Our primary goal is to register counsellors and psychotherapists in Australia through a vigorous process of credentialing, and to give them a professional standing based on competence and skill and to provide a mechanism of accountability to the mental health consumer.

ACA's other primary role is provide representation and advocacy on behalf of its members and the profession, in the interests of our clients.

Membership criteria to ACA are governed by three principles:

1. Qualifications gained from an appropriate training provider accredited by the ACA and meeting ACA training standards. Graduate qualifications in Counselling must be underpinned by a relevant undergraduate qualification.
2. Experience must be relevant to counselling in a therapeutic setting, positions such as case management do not meet this criterion.
3. All practising members must maintain an annual log book reflecting Professional/Clinical supervision hours and Ongoing Professional Development hours.

Membership levels within the ACA are ascertained through a combination of these three principles which ensure practising members are well-qualified to work anywhere along the spectrum of mental health service delivery appropriate to their registration level.

ACA counsellors work with mental health consumers along the complete spectrum of mental health service delivery from social support and mental health problems to mental illness/disorders. According to a recent internal audit of member files, our practising members work within Non-Government Organisations (NGO), Government agencies and in private practice. ACA- registered private practitioners are evenly spread throughout Australia, with many working in regional and country areas.

ACA has successfully engaged with other industry stake holders and is the co-founder of the Australian Register of Counsellors and Psychotherapists (ARCAP). ARCAP brings 40 counselling and psychotherapy stake holders together under one register. ARCAP reflects ACA's ability to work successfully with multiple stake holders within the counselling profession and clearly demonstrates the cohesion within the counselling and psychotherapy profession.

ACA has also successfully engaged with other international key stake holders within our region and holds a senior representative position with the Asian Pacific Rim Confederation of Counsellors which has members from over 15 countries from within Asia. The 2<sup>nd</sup> Asia Pacific Rim conference was held in Hong Kong in March this year and ACA along with its Asian counter part accepted a bid by the Malaysian Psychotherapy Association to host the 3<sup>rd</sup> conference in Sarawak in 2013. This reflects ACA's ability to work constructively with other significant counselling bodies outside of Australia to build upon the reputation of Australia as a regional leader in this industry.

The ACA has also built solid partnerships with other peak bodies in the UK, USA, Canada and New Zealand.

## **THE MENTAL HEALTH SPECTRUM & COUNSELLORS**

There is a common misconception that counsellors only work within a narrow field primarily in social support with a few senior counsellors working with client groups with a mental health problem.

Counsellors are qualified and trained to work within disciplinary areas of mental health problems and mental illness. Degree-qualified counsellors are required, under the ACA's training standards, to undertake significant field placements in years two and three under clinical supervision. A high proportion of post graduate and Masters qualified counsellors currently work with mental illness and disorders in clinical settings. ACA level 3 and 4 members would have equivalent or in most cases a higher level of training and experience than many of those who already have access to Medicare rebates.

Counsellors are trained at the same level as other mental health workers, within the Australian Qualifications Framework (AQF) system, who deliver mental health services within the Medicare system.

AQF Level 1-4: Social support

AQF Level 5-7: Psychotherapeutic aid for mental health problems.

AQF Level 7-9: Psychotherapeutic treatment for the mentally ill.

As with other mental health workers, ACA counsellors are required to have completed a certain amount of client contact time and years of supervised practice after completing a degree program before being eligible for level 3 or 4 membership. This is consistent with current Medicare providers in tier 1 and 2 of the Better Access initiative and other Medicare rebateable programs for mental health services.

In short, ACA counsellors and psychotherapists are trained professionals practising in their discipline.

## **THE MENTAL HEALTH REFORM AGENDA**

The ACA welcomes the commitments of both the Government and the Opposition to improving mental health services and support in general and primary mental health services in particular.

We welcome especially the focus on primary and early intervention for younger Australians as integral to the national mental health reform agenda, and are delighted that the both sides of politics have listened to the experience and commitment of key mental health advocates in Professors Patrick McGorry, John Mendoza and Ian Hickie.

Like other mental health professional groups, the ACA is disappointed that the Government has decided to contain the cost of its expansion into early intervention by cutting back severely ongoing funding for the Better Access to Mental Health Services (Better Access) programme, and this will be discussed below. But the ACA also has decided that any genuine policy commitments and any major expansion in funding for mental health in Australia are to be welcomed and not condemned, and

that it is important for us, as well as for other mental health professionals, to rise above sectional self-interests and attempt to take a broader view.

After all, we in the mental health community, and that includes the Government and Opposition, have a common commitment to making real progress in helping the millions of Australians who have a chronic mental illness or who at various times in their lives are confronted with serious mental health issues.

With this in mind, the ACA therefore has decided to approach what the Government has put on the table in the May 2011 Budget with the starting position that more investment is definitely a matter for the good. What we can do, from our vantage point in our section of the mental health continuum as described by Clive Jones and Philip Armstrong in their private submission to the Committee, is to make constructive and hopefully adopted suggestions about how that investment can be maximised and made more relevant to the everyday need of Australians with mental health issues, their families and carers.

With the Committee's terms of reference, we wish to comment specifically on the following points:

- The future of Better Access and the Access to Allied Psychological Services (ATAPs) programme.
- The need to ensure that enhancing effective and adequate early intervention and support services in primary mental health should not be focused overwhelmingly on the young and people with chronic mental illness;
- The proposed governance changes, particularly the possibility of a National Mental Health Commission; and
- The need to ensure that the mental health workforce is recognised as covering a continuum of mental health need, and funding of services under programmes such as Better Access and ATAPS, but also private sector services such as those supported by private health insurers, should be provided by the mental health professional according to the needs of clients, and that who provides a clinically-relevant service shouldn't be restricted by the eligibility criteria for Better Access or any other funding programme.

### **Better Access and ATAPS**

The ACA has always taken the view that Better Access and ATAPs are highly important and much-needed support programmes in the primary mental health sector.

Introduced by the Howard government, and retained by its successors, both programmes have done what mental health professionals have advocated since the advent of Medicare in the 1970s – to not have a medical monopoly of government-subsidised mental health services.

By opening up the ability to fund psychologists' services on Medicare, particularly for those who hitherto have had great difficulty in affording access to them – the most socially and economically disadvantaged members of our community – both ATAPS and Better Access were major advances in both policy and service provision. These were truly giant strides, and the ministers responsible for

them, Kay Patterson and Tony Abbott, deserve great credit. Equally to their credit, current Health minister Nicola Roxon and Mental Health minister Mark Butler clearly have come to accept the value of the Better Access and ATAPS.

The ACA's position on Better Access is that if one programme is demonstrably superior to another then it is not necessarily wise to reduce available funding to it. We believe that on the basis of the programme's evaluation, and anecdotal evidence within the professional community, that Better Access does a good job. The very strong take-up through GPs also highlights that. Additionally, as essentially a fee-for-service programme Better Access doesn't require extensive administrative infrastructure and, indeed, bureaucracy to keep it running.

Given this, the ACA's view is that the Government's decision to reduce the Better Access spend to cross-subsidise other initiatives is potentially counter-productive. But we also accept (however reluctantly) that, in the current Budget climate that not every service can be funded as fully as we would like. Our concern, therefore, is that any significant funding reductions and programme reorganisation do not undermine the range and quality of services available to Australians with mental health needs.

### *GPs as gatekeepers*

The ACA has no difficulty whatsoever with general practitioners being the gatekeepers to better Access and ATAPS, working with their patients and with mental health service providers to develop care plans appropriate to their patients' needs.

We see GPs as the centre of the primary health care network, and we want to work with them to ensure that patients with mental health issues are properly triaged and treated. Better Access and ATAPS have proven to be great tools in this direction, and therefore we want to see them continue in this role. That both programmes underwent significant operational reviews in the last couple of years, with the outcomes of those reviews being factored into the mental health reform agenda, is certainly a good thing.

As a supporter and partner in the National Mental Health Agenda, the ACA intends to continue to build up already good relations with general practice. We will work with the Australian General Practice Network (AGPN) to ensure that GPs are aware if the services can provide for their patients, whether or not they are subsidised. We will also work with existing Divisions of General Practice, and Medicare Locals if and as they are established, in promoting local primary health services that are relevant and responsive to local needs.

Nevertheless, we recognise that GPs will feel constrained in referring their patients to mental health providers whose services are subsidised and therefore more affordable. In both Better Access and ATAPS, this effectively means referring overwhelmingly to psychologists. This has been an ongoing problem for non-psychologist mental health professionals, but the added prioritisation of primary mental health services on the national agenda, and even the Government's decision to rationalise spending on Better Access, could result on a broader and therefore better range of services being offered to eligible patients under both programmes.

Given this, and although very disappointed in the proposed funding cuts to Better Access, the ACA is determined to see the silver lining of the Government's decision which, on the face of it, simply redistributes funding from one significant pool of need to others.

### ***Provider eligibility***

Having so successfully broken the Medicare medical monopoly in this space the previous government made, in the ACA's view, a significant implementation error. It supposed that in the main only one professional group – registered clinical and general psychologists – is capable of providing subsidised primary mental health services, particularly in the part of the mental health need continuum that Jones and Armstrong, drawing on work used to support the first National Mental Health Plan, classify as mental health problems (as opposed to more severe mental illness)<sup>1</sup>. These include short and intermediate-term episodes of need due to personal or family stress or other factors, as well as common lower-level but debilitating chronic conditions such as depression and anxiety.

The ACA's position is that these programmes should have been opened up more widely at the start to give eligibility to accredited counsellors, mental health social workers and occupational therapists. We believe that many clients have missed out both on access to the sort of service that is best for them, or even on access to any services at all. Clearly, this is not good enough, and the opportunity should be taken as part of the National Mental Health Agenda and Roadmap to redress this.

The ACA's position is simple: any registered mental health practitioner with expertise most directly relevant to the client's circumstances should be able to take a GP's referral under Better Access and ATAPS. The only criterion should be that a practitioner is properly registered or otherwise accredited, and therefore that they demonstrate sufficient training, competence and ethical behaviour to undertake the care tasks at hand.

The ACA believes that the Jones and Armstrong proposal for a National Register of Mental Health Professionals, linked to eligibility for Better Access, ATAPS, and private early intervention and chronic care programmes funded by health insurers, would solve the problem of government and private funders "picking winners" along the primary mental health continuum. This workforce-related proposal will be discussed in more detail below.

### ***Better Access tiers***

The ACA is very much aware of the debate within the mental health community, particularly among psychologists, of the effects of the current two-tier rebate structure for Better Access.

The Association's view is that we do not oppose the continuation of the two-tier approach, with the higher-rebate tier being reserved for psychologists, whether clinical or general. What we believe, however, is that the lower rebate tier should be made fully contestable for all registered and/or accredited mental health professionals, including counsellors, mental health social workers and occupational therapists, on the condition that their skill set matches the identified needs of the referring GP's patient.

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<sup>1</sup> See Dr Jones and Mr Armstrong's private submission to the Committee.

The ACA believes that the services of its members are cost-effective as well as clinically effective for those clients whom they support. Indeed, an average cost per counsellor service of around \$80 (based on ACA member data) compares favourably with the second tier Better Access rebate.

Furthermore, if a wider spread of practitioners is eligible for a Better Access rebate, this could be reflected in the range of services being provided under GP care plans, and the care plans themselves could be done either directly by the GP or in consultation with a suitably-qualified psychologist at the point of an initial first tier Better Access visit to a psychologist.

Put simply, funding more services at less average cost means that Government's limited subsidy investment can go that much further. Therefore, while certainly we would prefer that Better Access funding not be reduced, the programme can be reconfigured to maximise the delivery of perhaps more services that the funding currently can sustain. If the ACA's view was adopted as Government policy, arguably there would be a win-win situation all round – more services, much greater depth in the range of services, and a lower cost per service to the Commonwealth Budget.

### ***Rationalisation of the number of sessions accessible under a Better Access care plan***

The Government's package provides for a reduction from 12 to 10 of the maximum number of mental health consultations per calendar year that can be funded under a Better Access care plan for an eligible client.

While the ACA's view is that the change appears to be for budgetary rather than clinical reasons, it also believes that there is no hard and fast number of sessions for all clients – primary mental health is not “one size fits all”.

Assuming that this rationalisation goes ahead, the ACA prefers that it is kept under continuous evaluation by the Government and mental health practitioners and clinical experts. If the evidence shows that the cap should be restored to 12, or indeed raised higher, such expert recommendations should be implemented.

The Government's own information states that 87 per cent of Better Access users receive one and ten sessions, and therefore relatively few reach the current 12 session cap.<sup>2</sup> However, it may not be appropriate for users at the high end of use to progress to other forms of MBS-funded treatment, such as psychiatrist consultations. A bit of common sense in allocating or rationing services can make a big difference to best patient outcomes.

The ACA therefore recommends that there be some built-in discretion for the GP and the treating mental health professional to approve up to three additional Better Access sessions, if the need for them can be clinically demonstrated by the treating practitioner with the concurrence of the GP. If implemented, the use of this discretion can be part of the continuous monitoring and evaluation process that we have suggested.

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<sup>2</sup> *Fact Sheet: Rationalisation of mental health services under Better Access: 2011-12 Budget measure*



## **Improving primary mental health care, support for people with severe chronic mental conditions and early intervention services**

The ACA welcomes the emphasis on these areas in the package of measures announced in the Government's Budget. Indeed, the ACA also commends the Coalition for its own proposals in these areas, which the Association understands are still Coalition policy.

In respect of good primary care and early intervention, it is as axiomatic in mental health as in other areas of healthcare that the sooner a problem is detected, the sooner it can be treated, managed or, ideally, cured. For too long there has been too much emphasis on the acute and chronic part of the mental health equation, where the infrastructure needs to be more extensive, the costs are high and, sadly, for many people with mental illness the horse has bolted.

### ***Headspace and EPPIC***

Beyond the attenuated continuation of Better Access and the expanded funding for ATAPS, key measures in the Government's mental health package is almost \$500 million to improve services to children and young children, particularly through *headspace* and Early Psychosis Prevention and Intervention Centres (EPPIC).

This is welcome, and given that the Coalition made similar commitments in its own 2010 policy, the ACA looks forward to this investment becoming a reality. Indeed, ACA members have worked in or with *headspace* and EPPIC organisations, and will work positively and cooperatively to make this extra investment a reality. The ACA and its State and Territory affiliates will also do all they can to persuade State and Territory governments to match the Commonwealth's commitment.

### ***Adult primary mental health and early intervention***

The ACA notes, however, that a big gap in the Government's Budget package, and indeed in the Coalition's alternative policy, is the relative lack of recognition of the value of early intervention and good primary care support for adults. It appears that the resumption of both packages is that this is the target group for Better Access and ATAPS, and that this is sufficient for this large cohort of the population.

Unfortunately, mental health problems don't stop the day you turn 18 or 25. In its most recent burden of disease report, the AIHW estimated that depression and anxiety alone, and their related consequences such as ischaemic heart disease and suicide, account for 8.2 per cent of Australia's overall burden of disease<sup>3</sup>. It accounted for about 60 per cent of Disability Adjusted Life Years attributable to mental illness<sup>4</sup>.

Overall, 93 per cent of the estimated burden of mental illness is due to disability rather than to lives cut short. The vast majority of the lives affected belong to adults. The impact of mental illness, especially depression and anxiety, is primarily due to its insidious chronic blighting of the lives of people affected by it<sup>5</sup>.

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<sup>3</sup> AIHW, 2007, *The burden of disease and Injury in Australia 2003*, chapter 3, page61.

<sup>4</sup> *Ibid.*

<sup>5</sup> *Ibid*, page 60.

The ACA believes that while support for Better Access and ATAPS is very helpful, more could be done to help adults with mental health challenges, whether it be in clinical practice or adult-focused versions of services like *headspace* and EPPIC. How best to deal with known and undiagnosed mental health needs should be an integral part of the National Mental Health Roadmap. Given its members' professional experience and expertise, the ACA would be very keen to be engaged in this process to ensure that all Australians with mental health issues can get reasonable access to support for their situations.

### ***More and better coordinated services for the severely mentally ill***

The ACA welcomes this element of the Government's package, as those affected by more severe mental conditions, their families and carers have a tough challenge to live from day to day. We are particularly concerned to ensure that families and carers get the support and encouragement that they need to undertake roles that involve great stress, sacrifice and often heartbreak.

Counsellors are well-equipped to contribute in terms of respite, support and mentoring services under the *Support for Day to Day Living in the Community* and *Personal Helpers and Mentors* programmes. The ACA is keen to work with governments, service providers and other practitioners to enhance the reach and efficacy of these programmes and the services that they fund.

Particularly, the ACA sees an enhanced role for counsellors not just in providing support for people with severe mental illness, but also in providing outreach and debriefing support for family members and carers. The Association would endorse any recommendation by the Committee to expand possibilities for family and carer support under these programmes.

### **Governance and implementation issues**

There are a number of governance and implementation issues in the Government's package. The ACA has some brief comments on the National Mental Health Roadmap, the proposed National Mental Health commission, and the proposed e-mental health portal.

### ***National Mental Health Roadmap***

The ACA supports the concept of the Roadmap, and sees developing it as a way of engaging the whole mental health community – clients, families, carers and practitioners as well as governments. The Association has been ready since Budget night to participate in the Roadmap consultation and development process, but as of now has not been drawn into it.

If it is truly to be effective, the Roadmap needs to draw on more than those who are, for want of a better description, already inside the Better Access tent. This is not a demarcation issue, but simply a desire to ensure that the full range of experience, expertise and commitment is engaged as part of the process. Without this, a final Roadmap product would be devalued and could not be held up by Government as being definitive.

The ACA also notes the government's intention to release the Roadmap by the end of 2011. While commending the Government for its commitment, we are concerned that the lead-time is therefore very short. If it is a choice between meeting a self-appointed deadline and finalising a

comprehensive Roadmap plan that is a practical and workable, long-term vision, the ACA urges the Government to take more time as necessary to consult, consider and respond.

### ***A National Mental Health Commission***

The ACA is neutral on a National Mental Health Commission. It is one of those commitments that promise much, but risk achieving very little and dashing built-up expectations. Simply creating a Commission in the Prime Minister's portfolio and giving it a brief does not guarantee miraculous transformation of the landscape. If it is simply more bureaucrats dealing with the challenges of mental health, each dollar spent on more bureaucracy is merely one less dollar available to be spent on direct care and services.

If a Commission is broadly representative of the diverse experience of the mental health community, and has genuine clout in policy and programme development, then it may well succeed in breaking down barriers to change, such as lines of professional and Commonwealth-State demarcation. If the proposal proceeds, the Government can be assured that the ACA will contribute constructively in any way that it is invited to.

But, on balance, the ACA warns against creating such a body just for the sake of "looking like we're doing something", and also sees the risk of giving it being unrepresentative in terms of experience and opinion across the entire mental health sector. Furthermore, existing organisations like the Mental Health Council and *beyondblue*, already play a big role in providing leadership and engagement within the sector.

### ***e-Mental health portal***

The ACA is delighted at the announcement that an e-mental health portal is to be established.

Access to mental health services that appropriately can be delivered online, rather than face-to-face, will help to overcome physical barriers of isolation and remoteness, particularly in rural and regional Australia, and remote Indigenous communities. It will also give those potential clients who self-identify, or those who are intimidated by face-to-face contact with mental health professionals, another point of access to online and downloadable resource materials to draw upon.

This could be of particular value to those with relatively low-intensity conditions, such as mild depression and anxiety, who can manage on a self-guided basis or with minimal assistance from a psychologist or counsellor – either their own or who is part of the e-mental health service. Indeed, working in support of a portal would be an ideal role for appropriately-trained counsellors.

### **Mental health workforce issues**

The ACA is concerned that the workforce component of the Committee's terms of reference, relating to the mental health workforce, are defined too narrowly because of their exclusive focus on psychologists. Contrary to the assumptions in the terms of reference, psychologists are an undeniably important part of the wider mental health workforce, but they are not the sum total of that workforce.

This misperception has operated in public policy for many years now. Psychologists' near monopoly of policy innovations such as Better Access not only perpetuate the problem, but has a deterministic effect on the wider mental health workforce who are not in the tent. Before Better Access, many GPs referred patients to counsellors not only as an appropriate care option, but also as an affordable option for their patients in the absence of Medicare subsidy<sup>6</sup>. Now GPs prefer patients to Better Access-eligible psychologists, and potential client often approach counsellors but then go to GPs when they learn that counselling services are not covered by Medicare. Worse still, some potential clients may not further pursue access to help at all, leaving them at risk of more serious mental health consequences if potential mental illness or the root causes of anxiety and depression are not identified and tackled.<sup>7</sup>

Attrition of the counselling workforce since the introduction of Better Access is also of very great concern to the ACA. An unintended consequence of Medicare funding being predominantly directed towards psychologists is that at least one thousand counsellors have left the profession since 2006. Our member survey evidence also indicates that ACA members who do not renew their registration are leaving in many cases because they no longer believe that their professional practice as counsellors is financially viable.<sup>8</sup>

The ACA believes that such artificial demarcation barriers are weaknesses in the current system are not going to be alleviated by what both the Government and Opposition so far have announced. We strongly urge the Government to make a commitment to developing and sustaining the whole mental health workforce – psychiatrists, psychologists, counsellors, Indigenous mental health workers, mental health social workers and occupational therapists – so that in the longer term there are not only the range of services available to clients, their families and their carers, but that there are sufficient trained people in the mental health disciplines capable of meeting existing and emerging demand for mental health services.

### ***Proposal for a National Register of Mental Health Professionals***

It is high time for all non-medical mental health professionals to be brought under a single registration and accreditation umbrella – a single profession-wide National Register of Mental Health Professionals (NHMRP). The NRMHP would operate separately to, but in association with, learned colleges and professional associations such as the ACA and the Australian Psychological Society.

A unified mental health workforce, governed in this way, is consistent with conceiving mental health needs as a continuum, ranging from low-intensity social problems at one end to severe and chronic mental illness at the other.

A single mental health workforce registration mechanism could also be linked to practitioner eligibility criteria for programmes such as Better Access, ATAPS and care management services approved by private health insurers. Such an approach should also promote greater consumer-friendliness, transparency and accountability.

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<sup>6</sup> ACA survey 2007 & 2008

<sup>7</sup> These comments are based on responses of ACA members to internal surveys.

<sup>8</sup> Ibid.

The ACA has considered the private submission to the Inquiry by its CEO, Philip Armstrong, and Dr Clive Jones, Head of School of the Australian Institute of Psychology and the Chair (Queensland) of the College of Counselling Psychologists of the Australian Psychological Society. The ACA fully endorses this submission and its recommendations, and it is keen to initiate discussions with other mental health professional groups to explore the proposal and how it can be implemented in a 2-5 year timeframe as part of a National Mental Health Reform Agenda. Indeed, we are planning to organise and host a Mental Health Workforce Round Table later this year as a first step, and we would hope Commonwealth, State and Territory governments can explore the concept with the mental health professional community.

Our view is that what unites mental health professionals is much greater than what divides us. After all, we all share the common interests in doing everything we can to help our clients cope with the mental health issues. The ACA therefore will work together with our wider professional colleagues and encourage them to work with us.

### ***A qualification and an assurance***

In endorsing the NRMHP concept, the ACA wants to make it perfectly clear to the Committee that the Association and its members do not see a unified profession as a means of compromising or debasing existing high professional standards. An NRMHP will only work if:

- Registered mental health professionals practise only within their accredited discipline and competence.
- A professional should not attempt therapies for which they are not best qualified; and
- A unified registration authority has the power to deal with abuses of these conditions, in order to protect client and public confidence in mental health practitioners and the services that they provide.

## **CONCLUSION AND RECOMMENDATIONS**

As a direct consequence of utilising the current counselling workforce across mental health services greater opportunities for regional services in mental health open up, waiting lists are lowered, cost effective opportunities with service provision through Better Access, ATAPS and other programmes increase, a greater number of culturally aware and indigenous mental health practitioners become available and there is increased consumer safety through the utilisation of registered counsellors.

### **Recommendations**

On the basis of our submission the ACA's key recommendations are:

1. Governments recognise that the primary mental health workforce is a wider group than simply psychologists, and that it is a professional team with overlapping niches.
2. Government commit to developing and sustaining the whole mental health workforce – psychiatrists, psychologists, counsellors, Indigenous mental health workers, mental health social workers and occupational therapists – so that in the longer term there are not only

the range of services available to clients, their families and their carers, but that there are sufficient trained people in the mental health disciplines capable of meeting existing and emerging demand for mental health services.

3. Governments and the mental health professional sector move towards a single national registration framework for all mental health professionals.
4. Any registered mental health practitioner with expertise most directly relevant to the client's circumstances should be able to take a GP's referral under Better Access and ATAPS.
5. That mental health funding programmes include appropriately qualified and registered counsellors and other non-psychologist mental health professionals to ensure that skills and expertise most relevant to a client's needs are available at affordable cost to those clients.
6. Incorporate these principles in the 10 year National Mental Health Roadmap.