

Productivity Commission Mental Health Submission

We forward this submission to the Productivity Commission as university qualified counsellors, registered with peak professional organisations, and therefore regulated and accountable. We work in private practice and for other private organisations and government funded organisations in as mental health service providers. As qualified, experienced and registered mental health counsellors who are not recognised as allied health professional by the government, we have felt invisible and discriminated against over many years now. We are submitting this document not only for ourselves but mostly for the many Australians who have slipped through the gaping chasms in the Australian Mental Health System over the past decade. We had hoped our voices would be heard but from reading the draft report and recommendations, it appears that counsellors have yet again been completely ignored.

As identified in the productivity draft report, mental health consumers with low intensity needs are being placed on mental health care plans unnecessarily. In our practice we have identified numerous cases where clients had been referred under mental health care plans to see a psychologist outside of the guidelines, when they are clearly not exhibiting a diagnosable mental health condition. We have become aware over the past 10 years that consumers are being inappropriately serviced by allied health professionals under mental health care plans. Our practice has been contacted on numerous occasions by GP's wanting to refer patients to our practice on a mental health care plan for therapies such as relationship counselling or sex therapy, none of which are covered under Medicare. When we have attempted to correct this assumption the response has been, "relationship counselling is covered under Medicare because psychologists are taking on clients for relationship counselling on mental health care plans" and "It is up to the psychologist to determine whether they will provide relationship counselling on a mental health care plan". We have also had feedback from practice clients that they received relationship counselling from psychologists on a mental health care plan.

The primary concern we see with the misuse of the Medicare system in this way is that too many consumers are being funnelled into the system unnecessarily. They are the "worried well" who are clogging up the system. In the meantime, those who generally require mental health services must wait longer to get in to see a psychologist, often 2-3 months. During this time their mental health is rapidly deteriorating. Hence the increased suicide rates, and increased moderate to high level mental health intervention.

We also propose better education for GP's and allied mental health providers about what is the diagnostic requirement for access to a mental health care plan and tighter monitoring of services provided to ensure they meet the criteria and to hold service providers accountable.

The other issue is that the workforce is too small for the number of consumers. This creates several issues. Firstly, professionals who fit into the category of "allied health" will be charging more because there is a shortage of services. Secondly, even with Medicare rebates consumers are not able to afford to see an allied health professional because the gap payment is too great and the purpose of it existing at all starts to become redundant. The obvious solution is to increase the workforce with suitably qualified and trained mental health professionals. More mental health nurses, as recommended in the report is not the solution for those who would fit into the early intervention category.

It is incomprehensible that a whole section of the workforce has been ignored while suicide rates and mental health issues have been steadily increasing since allied mental health and Medicare rebates was created. University qualified counsellors have been completely overlooked for over 10 years now. The question is why? Why wouldn't university qualified counsellors be considered when there is a clear role for them? The second question is why wouldn't university qualified counsellors be considered for low to medium intensity therapy as an early intervention strategy?

Counsellors at our practice, and many other work places, work alongside social workers and psychologists doing the same work and seeing the same clients and providing the same therapeutic interventions but aren't recognised as allied mental health and can't provide mental health services under Medicare.

Our counsellors are all university qualified, one with a 3-year psychology degree and a 2-year master's in counselling. The other has a 2-year diploma in counselling and a 2-year masters of sexual health counselling. Both have worked 16 years full time as counsellors both in private practice and for various organisations including government funded programs. Social workers are not as qualified as many university qualified counsellors and receive far less training in therapy than counsellors, yet they qualify as allied mental health. This doesn't make sense. Many psychologists have little or no therapeutic training when they finish their degrees, yet they are able to step into work that counsellors with 5 years training at university and over 10 years counselling experience cannot.

Despite all these barriers and not being able to qualify for Medicare and private health, our practice thrives because we are good at what we do. Many of our clients have seen psychologists on a mental health care plan and have not improved until they have seen us. On a weekly basis we are turning away client referrals from GP's because we can't offer private rebates or Medicare. Many people pay full price to see us because of our excellent reputation. We would love to be able to assist our clients to better afford our services with at least private health fund rebates.

One of our counsellors works on the Beyond Blue counselling line and often hears from members of the public that it takes too long to get in to see a psychologist and that the sessions are too far apart. They also complain that they cannot afford the out of pocket expense. Some callers have advised that they had been asked to pay for the 6 sessions up front before rebates would be processed

through Medicare to ensure that they attend the full 6 sessions. Other callers advise that they receive better counselling help through Beyond Blue than through their experiences in seeing a psychologist. Many of the beyond blue counsellors are university qualified counsellors who don't qualify as allied mental health professionals, yet they work side by side with allied mental health professionals providing the same interventions and quality of work.

The recommendation in the draft report that low intensity or early intervention be mostly delivered through on-line courses, video conferencing or group therapy may sound like a good solution and may work for some consumers, but we don't believe it will suit most people. In our experience most people want a human connection and the research shows that the most important factor in recovery is the client counsellor relationship. Many people also do not want to attend groups for therapy as they want to keep their issues private. We predict that by not providing a low intensity early intervention face to face counselling option the same problem that exists now will continue – consumers will delay getting help until their issues escalate to the moderate range and again create a bottle neck in the system. Again, there is a whole workforce of counsellors working in rural and remote communities who are being overlooked.

The draft recommendations focus either on a medicalised model or a peer model - there is no in-between. Counsellors are the middle ground particularly for consumers who fit the low intensity category. These consumers do not want to be pathologized and they also generally wouldn't need peer support. Most often what is required is supportive, solution focused face to face therapy.

We are strongly advocating for university qualified counsellors to be included under the banner of allied mental health. University qualified counsellors could provide 3 sessions under Medicare at a cheaper rate than psychologists with a smaller out of pocket expense to the consumer. This would save the health budget millions of dollars annually. We also propose that University qualified counsellors be included as allied mental health professionals so that their scope for employment can increase. Lastly, we recommend that University qualified counsellors be included as providers under private health benefits. We assert that these measures would assist to take pressure off the workforce, reduce waiting times for therapy and potentially reduce the risk of suicide, and save money. We view university qualified, registered counsellors as an integral part of a solution toward improved mental health services in Australia.