PACFA Feedback Statement to the National Stigma and Discrimination Reduction Strategy 1st February 2023

Members of the Psychotherapy and Counselling Federation of Australia (PACFA) have reviewed and discussed the Reduction of Stigma and Discrimination Strategy documents and offer the following feedback on the topics of Barriers, Effectiveness, Enablers, and Anything Missed. We broadly endorse the intentions and aims of the Australian National Mental Health Commission Reduction of Stigma and Discrimination Strategy.

Our feedback about some important considerations for reducing stigma and discrimination is informed by the PACFA mission, and the diverse professional and lived experiences of the mental health workforce that is represented within PACFA. We provide our feedback with hope that the strategy will promote beneficial change and developments throughout the sector, with a focus on broader access for mental health care and support that includes counselling, psychotherapy, Aboriginal and Torres Strait Islander healing practices, and creative, somatic, and experiential therapies.

About PACFA

The Psychotherapy and Counselling Federation of Australia (PACFA) is a national peak body for the counselling and psychotherapy allied health profession.

Our members work with a broad range of modalities, and with individuals and groups reflecting the diversity of Australian society. PACFA exists to support its members and the community by regulating the training & practice of Psychotherapy, Counselling and Indigenous Healing Practices to the highest standards of safety, quality and professionalism.

PACFA promotes the development and practice of counselling, psychotherapy, and Indigenous healing practices, and respects and supports the diversity of approaches within the counselling and psychotherapy field. We provide a united forum for practitioners, foster professional identities, support training and research, and ensure

public accountability. PACFA provides support to members through their branches, colleges and interest groups.

PACFA's colleges are groups for members with particular practice specialties or frameworks, in which members can network, share information, and learn. They are:

- College of Counselling
- College of Psychotherapy
- Australian College of Relationship Counsellors
- College of Aboriginal and Torres Strait Islander Healing Practices
- College of Counselling and Psychotherapy Educators
- College of Creative and Experiential Therapies.

PACFA provides self-regulation functions for the counselling and psychotherapy profession, ensuring that our members have met PACFA's Training Standards, which are the highest for our profession in Australia.

PACFA has the highest standards for Counsellors and Psychotherapists nationally and supports the introduction of national minimum standards as recommended by the Senate Inquiry into Mental Health and Suicide Prevention. Our members are required to hold as minimum relevant Bachelor or postgraduate level qualifications as well as meeting professional development and supervision requirements to be eligible for registration with PACFA as either a **Registered Clinical Counsellor**, **Registered Clinical Psychotherapist** or **Certified Practising Counsellor**. PACFA members are the only registered counselling and psychotherapy professionals recognised as Allied Health professionals by the Allied Health Professionals Australia.

PACFA now has more than 6000 tertiary trained members working across Australia with 32% in regional, rural, and remote areas.

Stigma and discrimination in mental health practices and structures

"When laws, policies, practices and organisational structures enable unfair treatment of people with personal lived experience, and their families and support people. This includes the unintended consequences of practices and structures that make it much harder for people with lived experience to access vital services and to participate in society."

PACFA understands that stigma, exclusion, and discrimination are frequently experienced by people with a diverse range of lived experiences including but not limited to these intersecting social determinants of mental health:

- Aboriginal and Torres Strait Islander Peoples, who experience the impacts of intergenerational racism, trauma, colonisation, and lack of cultural awareness and cultural safety in the dominant Eurocentric medical model in the mental health system (Durey, 2010; Kairuz et al, 2021; Kelaher, Ferdinand, & Paradies, 2014; McGough, Wynaden, & Wright, 2018; Priest et al, 2011).
- People from racialised and culturally and linguistically excluded backgrounds and communities and forcibly displaced people, who experience racism, exclusion, and lack of cultural awareness and cultural safety in Australian mental health services (Dune et al., 2022; Gopalkrishnan & Babacan, 2015; Walker & Sonn, 2010).
- Neurodivergent people, who experience a lack of neurodivergent-affirming practices, challenges accessing respectful and safe funding and services, access barriers, and limited choice and autonomy in funding and services. For example, Autistic people– particularly Autistic young people– in Australian mental health care systems are routinely subjected to coercive and non-consensual reparative therapy approaches such as Applied Behaviour Analysis (ABA), which was developed by Ole Ivar Lovaas, based on the same principles of his sexuality and gender conversion therapy (Pyne, 2020). Research shows that ABA causes harm and trauma for many Autistic people and is routinely imposed without the informed consent of Autistic people themselves or against their wishes (Anderson, 2022; Kupferstein, 2018, 2019; Levinstein, 2019; McGill & Robinson, 2020; Sandoval, Shkedy, & Shkedy, 2020; Wilkenfeld & McCarthy, 2020). In addition, both speaking and non-speaking Autistic people are frequently excluded from decisions about their own mental health care and denied access to Augmentative and Alternative Communication (AAC) options for exercising their rights as mental health consumers (Donaldson, Corbin, & McCoy, 2021; Heyworth, Chan, & Lawson, 2022).
- People with disability-related needs, who report experiences of ableism, exclusion, access and communication barriers, and discrimination in mental health services (Newman, Fisher, & Trollor, 2022; Trollor, 2014).
- People with lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQI) lived experiences and other people whose gender, body, kinship, and sexuality (GBKS) lived experiences are not included in Anglocentric “LGBTQI” terminology (e.g. Sa’moan fa’afafine and fa’atama, Aboriginal Sistergirls and

Brotherboys, polyamorous people and families, etc.). These communities often experience pathologising, discrimination, access barriers, and mistreatment in mental health settings (Carman et al., 2020; McNair & Bush, 2016; Pallotta-Chiarolli, Sheff, & Mountfold, 2020; Riggs, Ansara, & Treharne, 2015; Sandbakken, Skrautvol, & Madsen, 2022; Smith et al., 2014; Strauss et al., 2021)

- Sex workers, who often experience discrimination, stigma, and stereotypes in mental health services (Reynish et al., 2022; Treloar et al., 2021).
- People labelled with mental health diagnoses (e.g., people labelled as having psychosis, schizophrenia, Borderline Personality Disorder, etc.), who can often experience mental health care as stigmatising, discriminatory, and coercive practices (Ball & Picot, 2021; Henderson et al., 2014; Maylea et al., 2021; Watson et al., 2014). This includes plural people and communities, who face pathologising narratives that contain a lack of awareness and understanding of their own insights and lived experiences (Blunden, 2021), and people with past experiences of harm in mental health service settings.
- People experiencing homelessness, who often experience disconnection from mental health services and lived experience of multiple intersecting social disadvantages (Bower, Conroy, & Perz, 2018; Lee et al., 2010).
- Incarcerated people and people returning from incarceration (Cutcher et al., 2014; White & Whiteford, 2006)
- Infants, children and young people: For example, talk therapies that are commonly provided by mental health practitioners on the Medicare *Better Access Scheme* are often inappropriate for children and some young people. These therapies fail to reflect the communication styles of infants, children, and some young people. A range of developmentally appropriate therapies are currently excluded from Medicare rebates. For example, some evidence-based approaches with children and young people include (but are not limited to) dyadic therapy (Slade et al., 2020) and child-centred play therapy (Fullalove, 2019). For infants, children, and young people with mental health needs, providing early support options from a strengths-based, trauma-informed, neurodiversity positive, and non-coercive approach is essential to ensuring their optimal development and quality of life. In contrast, compliance-based ‘early intervention’ practices that deny young people’s autonomy, promote deficit models, and fail to prioritise their rights, comfort, or consent can cause trauma and impede healthy development (see citations above on the widespread harms caused by ABA with Autistic young people).

- Carers; the hidden emotional, physical and mental labours that carers contribute are often unacknowledged and undervalued, leaving carers isolated, without the time or resources to access appropriate care and support to maintain mental, social and emotional wellbeing. Carer-specific mental health support approaches, such as the use of Carer Peer Support Workers, can be beneficial (Visa & Harvey, 2019).
- People living in rural and remote areas, who face a range of mental health challenges and increased suicide risk due to the top-down mental health service models based on urban assumptions, that do not address the needs of rural and remote communities; absence of integrated 'whole of community' approaches; access barriers; limited workforce capacity; funding inequities; and limited research that considers rural and remote communities' insights about their needs (Perkins et al., 2019).
- Older people, who often face stigma and ageism, the absence of human dignity and respect for their basic human rights. These rights include fairness and flexibility, freedom of movement and association, freedom of sexuality and gender expression, and rights recognised in the Australian Charter of Healthcare Rights, such as the right to comment and give feedback (Commonwealth of Australia, 2021)

Some additional intersecting lived experiences include:

- People who access Alcohol and Other Drug (AOD) services; lack of understanding of mental health / trauma and the association between unmet mental health / trauma-related support needs and substance use
- 'The missing middle': people without financial means to access private services frequently experience mental health issues that are not deemed permanent / a disability; hence they remain ineligible for subsidised services (such as NDIS).
- People affected by family violence including sexual abuse and coercive control, including children; these harms are often hidden and undisclosed for long periods of time, and, while the impacts are profound and long lasting, services often provide only short term support. Families that do not conform to a heterosexual, monogamous nuclear family structure are often invisible, underserved, and misunderstood when seeking mental health services related to family and intimate partner violence.

Some essential characteristics in mental health services

As shown above, it is well-established that discrimination and other forms of structural oppression can have devastating mental health impacts and increase the need for mental health care and support (State of Victoria, 2021).

PACFA maintains that this mental health care and support need to be high quality, appropriate services that

- offer choice and agency to the recipient,
- respect autonomy, human rights, and self-determination,
- provide diverse and accessible opportunities for communication and comment, and prioritise the insights of people with lived experience on their own behalf, so that:

1) they can respond effectively to factors and characteristics of these impacts

and

2) the experience of care will neither compound existing harms or trauma nor result in new harms and trauma.

Barriers: Current barriers to mental health services access

Harmful community impact of professional discrimination

Conceptual and structural barriers within the current professional accreditation categories for mental health practitioners undermine equitable access to mental health services. This includes the lack of formal recognition of PACFA registered psychotherapists and counsellors as allied health professionals and as mental health practitioners in existing legislation. This limitation prevents the potential workforce of allied health professionals to be treated as valued, contributing members of the mental health and wellbeing workforce. As Bloch-Atefi et al. (2021) documented, recognising the Australian counselling and psychotherapy workforce in Medicare rebate schemes and professional opportunities could address the existing workforce shortage and lack of access to suitable practitioners among people from a range of marginalised and underserved communities.

Harmful impact of Medicare exclusions

At present, only 'talk-based' models of mental health care, provided by a very limited range of AHPRA regulated professions and some Social Workers, are available for Medicare subsidies. This contributes to the risks to mental health consumers for whom talk-based services are inappropriate, inaccessible, or uncomfortable feeling excluded and unsupported.

For example, non-speaking people and people with situational mutism often find evidence-based expressive arts therapies and somatic and sensorimotor psychotherapy more useful and accessible than talk-based therapies; a person experiencing trauma-related mental health issues may present with complex symptoms such as alexithymia (difficulty finding words and communicating about their feelings and internal experience) that require trauma-sensitive approaches to engagement, such as using somatic experiencing and other evidence-based modalities instead of talk-based therapy.

In addition, there is evidence that psychosomatic and experiential modalities that provide more diverse and flexible processes than talk-based counselling, are necessary for trauma recovery (Levine, 2010), yet, practitioners specialising in these approaches are still not eligible to be approved mental health practitioners.

Experience of stigma and discrimination can be decreased through connection, rapport, and sense of belonging that are enabled through experiential therapeutic approaches, within individual and group or community settings, and through access to practitioners with similar lived experiences, identities, and community memberships. Through such active community and culturally sensitive engagement, the contributions of a broader therapeutic workforce could prove to have both positive and preventative implications for decreasing stigma and discrimination, experienced by people accessing support. Creative and experiential approaches to mental health have highly effective ways of working with individuals and community members to promote well-being, cultural identity and sense of belonging (Dunphy et al 2013, Fancourt & Finn 2019).

Effectiveness: Actions promoting change

The policy outlines significant areas of improvement for human rights. “This new approach also takes into account different experiences of mental ill-health, trauma, distress and suicidality, alongside specific identities, experiences, and cultural and

social contexts. More inclusive approaches, in attitudes and behaviours, and across systems and services have the potential to benefit everyone." (Australian Government 2022, p. 14).

PACFA strives for the provision of mental health services that promote justice, equity, diversity, and inclusion. Our association offers Colleges listed above, and has evolved over the years to reflect the complexity of highly qualified and experienced practitioners.

For the actions of the Strategy to be successful in promoting the changes we have outlined, it will be important that the workforce is suitably diverse to meet the diversity of mental health needs in the community. This includes professional recognition and support for practitioners with a range of excluded and marginalised lived experiences.

Enablers: Expand access to a broader range of services

"PRIORITY 2 Reduce structural stigma and discrimination
2.1 Require the mental health system to provide safe and empowering environments for people seeking services
2.2 Ensure equity of access to quality healthcare"

PACFA supports the expansion of access to a broader range of services and resources that increase choice, agency and self-determination, and provide opportunities for individual and/or collective voice and self-expression, as an important part of reducing structural stigma and discrimination and supporting equity of access to quality healthcare.

Anti-discrimination policies need to include "Broader Access" - not just "Better Access" - to real choices for people in how we seek support for and manage our own mental, social and emotional health and wellbeing.

"Broader Access" would include access, through public health funding and services, to the range of services provided by PACFA members. This would mean community members with diverse life experiences can access timely support from a broad range of skilled practitioners who work in Culturally safe and accessible ways, including Indigenous Healing Practitioners, Counsellors, Psychotherapists and Creative and Experiential Therapists.

The Australian Government is well placed to make significant changes to the mental health care service system by increasing access to a broader range of services. PACFA's regulation of the diverse Counselling and Psychotherapy practitioners represented in our membership offer a distinct opportunity to enable this broader access.

Increasing choice, agency and self-determination, and more opportunities for individual and/or collective communication and self-expression, is an essential step towards reducing structural stigma and discrimination and working more substantively towards equity of access to quality healthcare. We recommend that the Australian Government engage in further consultation with the people and communities with marginalised and excluded lived experiences whom we have discussed above. In particular, providing communication and comment opportunities that these marginalised and excluded people and communities consider accessible and culturally safe will be essential to gaining understanding about their mental health needs.

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