Australian Counselling Association Response to the (DRAFT) National Stigma and Discrimination Reduction Strategy

1 February 2023

Priority Actions Summary

Thank you for the opportunity to provide feedback to strengthen the Draft Strategy and its proposed actions. Our feedback is provided in the following 2 sections:

- Part 1: Responses to your 5 questions on the actions
- Part 2: Individual feedback to the actions in each section

The Australian Counselling Association

The ACA is a peak professional body incorporated as a not-for-profit association. ACA is the largest single registration body for counsellors and psychotherapists in Australia with currently approximately 12,000 members. ACA is committed to advancing the profession of counselling and work under a Scope of Practice for Registered Counsellors which acknowledges the needs of the mental health system and responds to the needs of the consumer, their loved ones and the community.

ACA currently is involved in many curriculum development boards for Bachelor and Masters programs with the following Universities and higher education providers: UQ, QUT, USQ, Monash University, Notre Dame, ACAP, AIPC, Cairnmillar Institute, Darwin, Torrens University, University of Canberra, University of Melbourne, Edith Cowan and Victoria University. ACA has a strong background and history in curriculum development. The ACA CEO is also on the national Industry Reference Committee for the Vocational Training which is part of the Department of Education. ACA was instrumental in having the Bachelor of Counselling award accepted by the Department of Education as the foundation qualification as a government approved pathway into the counselling profession.

Feedback

The ACA are supportive of the initiative to address stigma and discrimination associated with Mental Health in Australia and agree with the 4 priorities around which the actions are developed. The ACA supports the vision that the National Mental Health Commission are working to achieve. The Lived Experience workforce does have an important role in providing support, however more needs to be done to ensure relevant and appropriate mechanisms are in place to protect those working in that field and those who are receiving support.

We (the ACA) have provided feedback on the actions (noted later in Part 2) that are relevant to our Scope of Practice and experience and predominantly relate to organisational supports and strategies needed to support the Lived Experience Workforce:

- Establishment of a National Peak Body Association
- Lived Experience workforce who provide support (including education)

Lastly, The ACA welcomes the opportunity to become an active contributor on any engagement/focus groups in helping to develop this area.

Part 1: Responses to key areas of focus

1. **Feasibility:** Are the actions achievable in the recommended timeframe and allocated to the correct responsible party/parties? Is there a readiness for change?

Please refer to individual feedback provided on the actions where timeframes and responsible parties have been identified.

2. **Enablers:** What might support the actions and/or assist the work needed to implement the change?

The establishment of a National Peak Body to support the Lived Experience workforce, does not need to be set up under the Australian Government. This can be achieved under private enterprise to meet a shorter timeframe (possibly within 12 months) and consult to the Government. Bringing the Lived Experience workforce under an existing relevant national association such as the ACA could provide the training, support, supervision, accreditation and advocacy services as well as introduce employment opportunities.
The key principles of Lived Experience work as defined in the Summary of Consultations "*Lived Experience (Peer) Workforce Development Guidelines"* is that of the role of a Counsellor with the exception that a counsellor does not disclose a personal lived experience as the focus remains on the person receiving support. Most counsellors enter this industry from their own personal lived experience.

In terms of scaling up the workforce, the ACA recommends complementing existing structures within organisations to provide an on-site counsellor. This trained workforce will assist in closing the gap in accessibility that currently exists today. On-site counsellors can provide qualified support and arrange specialist support to the Lived Experience workforce when required and applicable.

Providing onsite access to a counsellor can provide the emotional wellbeing and support required to support an organisation whilst continuing care under a Code of Conduct. Counselling also serves as a preventative measure in delivering healthcare. Counsellors can assist in navigating structures to get the support required and can further work within the organisation to change stigma's and discrimination as it occurs.
Counsellors can be embedded in the organisation's HR team acting independently in line with their professional code of conduct. Counsellors can serve purpose to both employees and consumers as required and provide immediate support in the emotional wellbeing of its workforce.

The ACA proposes a trial within the Mental Health and Healthcare environments with further aim to expand the trial to employ within government, government owned corporations and large organisations as a means of providing appropriate levels of care.

3. **Barriers:** What might slow down or prevent the gaining of support for the actions, or their implementation?

- Implementing a new national peak organisation: There is a risk that this may take longer than expected if not joining an existing national peak body resulting in the inability to provide a safe environment for the workforce to be operating in.

- Creating a new workforce instead of leveraging off: There is an opportunity to recruit appropriate lived experience resources who are qualified to provide mental health support.
- Advocacy: gaining support and momentum of the new workforce and promoting the role to organisations.
- Lived Experience workers without appropriate qualifications supporting people in vulnerable situations
- Costs associated with establishing a national peak body organisation: staff, office space, IT etc.

4. **Effectiveness:** Will the actions lead to the changes we want to see? Are there any potential unintended consequences?

There is a risk that without a formal governance structure and professional supervision in place, Lived Experience workers may be triggered by a situation that results in a relapse resulting in harm which could increase demands on the health system for their recovery.

There is a risk that without formal training and qualifications, Lived Experience workers may cause further harm to someone in a vulnerable state of which they are providing support. The development of an accredited national course will assist in introducing national standards and guidelines for consistency across industries is relevant.

Lived Experience workers who provide support must adhere to professional boundaries of which to operate. These boundaries should fall under a Scope of Practice developed by the national peak body.

With regards to considerations for employment opportunities and increasing employment opportunities (Action 2.3j), Stress can be a trigger especially in leadership roles. Making sure that organisations have the appropriate structure in place to support and take accountability. Specifically, the outcome proposed for this action states, *"Engaged in employment which does not exacerbate their distress"* It will be interesting to see how this can be measured and monitored and assessed when everyone's experience is different. Who ultimately will be liable for care if this happens?

Role clarification needs to be further articulated. Within these actions there has been suggestion that the lived experiences roles will:

- Improve policy reform and processes
- Provide emotional support to persons in similar situations
- Provide support in navigating the system
- Peer support and education

Consideration needs to be given to how persons of lived experience are engaged for these roles. If their experience was years ago, their experience in the structural processes, may have changed. If their experience is too soon, what measures will be in place to assess the risk that they will be safe and not experience a relapse.

5. **Anything missing:** Are there any critical issues or actions to address stigma and discrimination that are not referenced or sufficiently prioritised in the Draft Strategy?

In terms of removing structural stigma, has consideration been given as to liability in the event of a relapse if the worker was employed with a known trauma/experience to which they are providing assistance. Who will be responsible and accountable for this?

Part 2: Individual responses

Priority 1: Implement foundational actions to address stigma and discrimination

Priority Foundational Actions

Ref	Action	Timeframe	Who's responsible	Expected changes
1d	Establish peak body arrangements that recognise, support and amplify the separate and distinct advocacy needs of people with personal lived experience and of families, carers and support people	Medium 1-3 years	~~Australian Government~~	Establishment of national representative bodies
1g	Develop guidelines for Lived Experience workforce roles in sectors outside the mental health system, leveraging guidelines in development in some sectors	Medium 1-3 years	National Mental Health Commission	Guidelines developed. Increase number of lived experience workforce roles and leadership roles available
1h	Commence scoping and socialisation for a program to scale up the Lived Experience workforce through national capacity building and workforce promotion	Medium 1-3 years	National Mental Health Commission	Recommendations made and action taken toward developing a program to increase number of Lived Experience workforce roles and leadership roles available

ACA response:
This would form part of the responsibility under the Establishment of a Peak Body Association and working with the support of the National Mental Health Commission.
As part of scoping and socialisation of a program to scale up the workforce, explore those who are qualified and can provide immediate work in the role. Counsellors more commonly enter the profession based on personal experience. It is this motivation that they undertake the necessary training to ensure safety for their clients and themselves and operating under a Professional Code of Conduct

Priority 2: Reduce structural stigma and discrimination

Priority actions for the mental health system

Ref	Action	Timeframe	Who's responsible	Expected changes
2.1f	Take steps to increase and better support the Lived Experience workforce across all mental health services in line with the *Lived Experience (Peer) Workforce Development Guidelines.* This should include employment of people with personal lived experience and carers and support people in peer support roles and in positions of leadership as well as practical guidance for employers	Medium term 1-3 years	Mental Health Services	Increase in number of mental health services with Lived Experience workers employed in both service delivery and governance roles

ACA response:
Duplicate of 2.2g. Recommendation to delete one.

Ref	Action	Timeframe	Who's responsible	Expected changes
2.1g	Establish a national professional association for lived experience workers, which could provide training, accreditation, support and advocacy services	Medium term 1-3 years	~~Australian Government~~	Establishment of national body with sufficient resources to support lived experience workers
ACA response: Duplicate of 1D. Recommendation to delete as previously identified as a "Priority 1 Foundational Action".				
2.1i	Work with mental health professional bodies to review professional standards and other relevant structures to provide guidance around mental health professionals disclosing their personal lived experience	Medium 1-3 years	Aust Gov and Professional peak bodies	Shifts in revised standards and structures
ACA response: ACA supports this recommendation				
2.1b	Review existing cultural competence/safety frameworks relating to Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse (CALD) backgrounds. Resources should explore barriers to implementation and provide support for adoption	Short term		Increased cultural competence of mental health services, including mental health professional understanding of and attitudes towards Aboriginal and Torres Strait Island people and people from CALD backgrounds
ACA response: ACA would welcome the opportunity to be involved as a consultative stakeholder.				
2.1d	Work with communities and sector organisations to co-design and co-produce a new national strategy for culturally and linguistically diverse community mental health and wellbeing which includes a specific stigma-reduction focus	Medium 1-3 years		Development of national strategy for culturally and linguistically diverse community mental health and wellbeing
ACA response: ACA welcomes the opportunity to be involved as a consultative stakeholder.				

Priority Actions for the healthcare system

Ref	Action	Timeframe	Who's responsible	Expected changes
2.2d	Ensure guidelines for healthcare providers that set out approaches to delivering person-centred care including approaches for empowering people receiving care are in place and disseminated to health services	Short	National Mental Health Commission	Guidelines promulgated to health services with evidence they have been embedded in services
ACA response:				

ACA supports this within the wider healthcare services. Person-centred care is paramount within the counselling environment. It will be interesting to understand reporting expectations around "evidence they have been embedded in services".				
Ref	**Action**	**Timeframe**	**Who's responsible**	**Expected changes**
2.2e	Promote the *Lived Experience (Peer) Workforce Development Guidelines* among health services to encourage the employment of people with personal lived experience or as a support person: • At all levels of the hierarchy including in leadership positions • In lived experience roles that support people accessing the service to feel supported, advocate for their needs and navigate their care (particularly in emergency departments)	Short	National Mental Health Commission	Increased proportion of mental health services with Lived Experience workers employed in both service delivery and governance roles
ACA response: The risk with this action is that you are promoting and encouraging employment of people with personal lived experience before having the appropriate mechanisms in place to ensure their personal safety. In order to address this within a short timeframe, it is recommended to discuss further with the ACA on opportunities of employing counsellors as they are qualified professionals who can assist in the examples provided.				
2.2g	Employ people with personal lived experience or support people in designated lived experience roles within government health departments, including in position of leadership	Medium 1-3 years	Australian state and territory governments	Increased number of people with lived experience in health departments including at executive levels
ACA response: Duplicate of 2.1f. Recommendation to delete one. Noting that you are looking to employ within Mental Health system and Healthcare system.				
2.2i	Review Medicare arrangements to ensure that GPs are incentivised to provide high quality healthcare to people with personal lived experience	Long term	Australian Government	Enhanced experience of people with personal lived experience accessing healthcare from a GP
ACA response: Are you inferring that GPs do not deliver high quality healthcare to people with personal lived experience? Medicare needs to be expanded to include additional rebates to a wider network of health professionals such as Counsellors who provide therapeutic services to clients to increase accessibility of counselling to all people.				

Ref	Action	Timeframe	Who's responsible	Expected changes
2.2k	Develop and deliver in collaboration with the Lived Experience workforce, ongoing professional development training for healthcare professionals that covers the following: • Mental health and suicide prevention fundamentals • Conceptions of mental health across different cultures • The interplay between mental health and physical health • Person-centred care including trust building and shared decision making • Trauma informed care • The impacts of diagnostic over shadowing • The therapeutic benefits of healthcare professionals who appropriately disclose their own personal lived experiences • human rights Workforces to be targeted include primary care, acute care and emergency care professionals	Long term	Relevant health regulatory bodies and professional associations	Increase in health professionals understanding of mental health and attitudes towards people with personal lived experience
ACA response: ACA recommends rewording of this action to: Undertake a review of existing mental health course materials to ensure inclusion of relevant lived experience (or update/expand on existing case studies). If it does not exist, modules to be updated accordingly. We recommend that this course be accredited as either formal ongoing professional training or module within an existing university course.				

Priority actions for social services

Ref	Action	Timeframe	Who's responsible	Expected changes
2.3d	Develop and deliver tailored training (consistent with principles and standards – see above 2.3c) for people working in social services, led by people with personal lived experience that builds trainees' understanding of the social determinants of health, the impact of co-occurring conditions and includes narratives of hope and recovery	Medium 1-3 years	~~Australian, state and territory governments~~	Decreased prevalence of stigmatising attitudes amongst social services employees. Decrease in number of people with personal lived experience reporting stigma and discrimination in their interactions

				with social services staff
ACA response: National course content to be developed and rolled out through Services Australia.				

Ref	Action	Timeframe	Who's responsible	Expected changes
2.3j	Increase employment opportunities available to people with personal lived experience, and support people who can and wish to work	Long	Department of Employment and Workplace relations	Increase in number of people with personal lived experience engaged in employment which does not exacerbate their distress
ACA response: Duplicate of 2.1f and 2.2e. It is noted that the timeframe is "Long" whereas for 2.2e (healthcare was given a "Short" timeframe and 2.1f (Mental health system) was given a "Medium" timeframe.				
2.3e	Embed peer-support workers in social and welfare services to support people with lived experience and families and support people to navigate the services system and link them to other services where appropriate	Medium	Social service providers	Decrease in people with personal lived experience reporting barriers to accessing social services and navigational support
ACA Response: The guidelines *Lived Experience (Peer) Workforce Development Guidelines* define a descriptor of the role as being a navigator to work through the existing structures due to its complexity. Instead of bringing them into the system, consult on the end user experience to define what changes are required to streamline the journey and look to ways to improve people, process and technology. There is an opportunity for onsite counsellors to support.				

Priority Actions for financial services and insurance

Ref	Action	Timeframe	Who's responsible	Expected changes
2.4e	Review rules and protections around how information in Mental Health Treatment Plans (or equivalent care plans) and other medical records can be requested, shared and interpreted for the purposes of finance and insurance matters	Medium	Aust Gov industry peaks and mental health professional peaks	Alignment of rules and protections for the use of Mental Health Treatment Plans and other medical records with best practice principles
ACA Response: Apart from the confidentiality aspect of a Mental Health Treatment Plan – unless a person from the finance and insurance has experience in reading these, it is unclear what benefit or purpose this would be done for.				

Priority Actions for legal systems

Ref	Action	Timeframe	Who's responsible	Expected changes
2.5a	Improve knowledge and awareness of mental health through training co-delivered with people with personal lived experience: • provide a manual and deliver a program of education for judges to inform court procedures and decisions involving people with personal lived experience, including when self-represented • Develop and implement continuing legal education for lawyers and legal support roles to provide extended support for clients with personal lived experience • Build mental health literacy of workers in child protection and family law	Medium 1-3 years	Legal	Increased understanding of mental health among legal and justice professionals
ACA response: National course content/module to be developed and rolled out as part on mandatory Ongoing Professional Development				

Priority actions for education and training settings:

Ref	Action	Timeframe	Who's responsible	Expected changes
2.7c	Review and where necessary update institutional policies, procedures and practice to embed…. Consider trialling or implementing a specific role for mental health engagement person to support and advocate for students with personal lived experience			
ACA response: How does this role vary from that already provided by the qualified Guidance Counsellors that form part of the Wellness Teams in schools? Perhaps that action is to: a) National course content/module to be developed and rolled out as part on mandatory Ongoing Professional Development b) Review and confirm that every Primary/Secondary School has a qualified Guidance counsellor on staff				
2.7g	Initiate steps to incorporate mental health literacy with an explicit anti-stigma focus into pre-career standards, qualifications and ongoing professional development	Long term		Increase in proportion of educators and graduates who have completed mental health training
ACA response: Duplicate as noted on actions 2.5a, 2.3d - National course content/module to be developed and rolled out as part on mandatory Ongoing Professional Development.				

Priority 3: Reduce public stigma

Ref	Action	Timeframe	Who's responsible	Expected changes
3.1b	Design and implement appropriately tailored and culturally-safe hybrid educational and contact-based training initiatives (with a rights based framing) for people in frequent contact with people with personal lived experience including: • Mental health workers (including NDIS administrators, service providers and other employees) • Health workers • Social services workers • Child protection workers • Teachers and early childhood educators • Police • People working in legal and financial systems • Managers, supervisors and people in HR roles As part of this embed informal and formal Lived Experience roles in leadership and support roles throughout organisations	Short term	Peak bodies, professional organisations	Decrease in prevalence of stigma and discrimination in settings with frequent contact with people with personal lived experience.
ACA response: National course content/module to be developed and rolled out as part on mandatory Ongoing Professional Development.				

Priority actions to reduce self-stigma

Ref	Action	Timeframe	Who's responsible	Expected changes
4b	Establish national and/or regional communities of practice for Lived Experience workers	Short	Lived Experience peak/advocacy organisations	Increased access to formal and informal supports for the Lived Experience workforce Decrease in prevalence of self-stigma among Lived Experience workforce
ACA response: This would form part of the responsibility under the Establishment of a Peak Body Association.				