The Australian College of Specialist Psychologists Inc.
PO Box 447, South Fremantle WA 6162
Telephone: 08 9487 1859
www.acsp.net.au

Problems with and new concepts for community based mental health services: A discussion paper. *May 2012*

Written by: Dr. Jillian Horton
President of the Australian College of Specialist Psychologists

Contact details:
Mail: *PO Box 447,*
South Fremantle WA 6162
Website: *www.acsp.net.au*
Email: *jhorton@iprimus.com.au*

The Australian College of Specialist Psychologists Inc.
PO Box 447, South Fremantle WA 6162
Telephone: 08 9487 1859
www.acsp.net.au

Summary and Recommendations

1. *The term "mental illness" should only be used as a summary label for psychiatric disorders such as schizophrenia and bi-polar disorder. The term "psychological disorders" should be used all other depression, anxiety and relationship based disorders.*
2. *The terminologies of "mild, moderate and severe" need to be removed from Government concepts and thinking with regards to mental health disorders as it confuses and diminishes the real experiences and care required for people with mental health issues.*
3. *Custom built "Education and Prevention centres" need to be built in all States.*
4. *Community Life Centres need to be established and developed in all States.*
5. *Medicare funding to support proper therapy time frames (at least 20-25 sessions per year) with private specialist psychologists need to be started immediately.*
6. *The ATAPs program needs to be dismantled immediately. Or at the very least, needs to be monitored to ensure it only provides for those it is meant to target and does not have a negative impact on other private psychological services.*
7. *Tele-psychotherapy for people in rural and remote areas who have psychological disorders need to be supported via Medicare and the full range of specialist psychology services need to be included in this scheme.*
8. *Clear guidelines for the involvement of NGOs in the support of people with psychiatric disorders need to be written. Case management should not cover clinical care, only non-clinical services such as housing, education, work and welfare support.*
9. *Better co-ordination and assistance for people with psychiatric disorders need to be planned and implemented to assist them and their families to move through the tertiary hospital based services to primary care services.*

Introduction

This discussion paper aims to raise several important issues regarding the current parameters used to define mental health, and the impact these definitions have on service delivery models and funding in Australia. The paper also suggests a different conceptual model of mental health service delivery, which hopefully will stimulate further discussion and broader thinking.

Section 1: The Effects of Terminology

(a) "Mental illness" as a term to describe all mental health problems – help or hindrance?

The language used to define and describe mental or psychological ill-health has considerable impact on the shared understanding of what people are experiencing and why people are suffering. This understanding in turn significantly impacts the choices Government make about what service delivery models to support and what the funding priorities need to be.

The term "mental illness" is currently used to embrace and describe all psychiatric and psychological disorders, regardless of the type of disorder or level of disability. When this term is used in such an all embracing way is becomes, at the very least unhelpful, but more importantly is highly detrimental to people with psychological problems because it generates a very circumscribed understanding of what psychological ill-health is, what factors may cause the malaise and how people should be treated.

Understanding of the emotional and psychological mind has emerged after many decades of research in the social sciences which have explored the normal development of emotional, neurological, social and learning of humans across the life span, from infancy to old age. The resulting perspective then allows for a greater understanding of how family, social and environmental circumstances, as well as a persons personal attributes and neurobiology can negatively affect the well-being and emotional adjustment of an individual. This research has lead to treatment models and interventions being developed, which have been tailored towards assisting people with a large range of psychological disorders. Psychotherapy or the "talking therapies" now have significant evidence showing their effectiveness and cost-effectiveness in treating psychological disorders.

The psychotherapy process is a very empowering process as it aims to help a person towards independence and self care, so that they can establish and maintain good psychological health and functioning. This treatment approach is most powerful and effective when it is nestled within a strong "therapeutic relationship", requiring a partnership in the treatment process between the specialist and the patient (or *client*, which is often the preferred term in psychology, as it moves the relationship into a more collaborative concept). It takes some time for a therapeutic relationship to be formed and to build the essential ingredient of trust. This relational ingredient however is essential because a client has to feel free and comfortable to disclose very personal and often very disturbing experiences to someone they

don't know, without fear of judgement or shame. Building the bond of the therapeutic relationship and skilfully using the treatment processes require significant skill and proper training in the therapist, in order to be effective and to increase the chances of a positive outcome. When insufficient time is allowed for this whole process, then it is impossible to understand and treat the person holistically.

It is contended that the term "mental illness" for psychological problems does not engender this conceptual understanding nor the importance and relevance of the psychotherapies for effective treatment outcomes with psychological disorders. The term "mental illness" if anything, tends to perpetuate the view that a persons' brain is at fault (or unwell) and hence medication is essential or the main ingredient in a positive outcome.

The medical theory of whether a chemical imbalance in the brain is a causal factor, or even a contributing factor in psychological disorders, is receiving a lot of attention even in the medical community. A Harvard research Psychiatrist, recently stated on a US 60 minute TV program (February 2012, see link below) that the theory of a chemical imbalance in the brain as an explanation for depression, for example, needs to be seriously re-examined and "is a gross simplification of the evidence, although it is still taught in medical schools and believed by many". Consequently, the actual impact and value of psychoactive medication for depression is also being debated by researchers, and new findings are indicating that medication effects do not provide much above a placebo effect. (A placebo effect is established in double-blind research trials where subjects believe they have received a psychoactive medication, when they actually haven't, and the belief itself produces an improvement in their symptoms.) For a very interesting summary of these debates see the US 60 minute program "Treating Depression: Is there a placebo effect?" discussed by Dr. Irvine Kirsch on the website link:

http://www.cbsnews.com/video/watch/?id=7399362n&tag=contentBody;storyMediaBox.

Even with research questioning the medical understanding of depression and hence the use of antidepressant medications, these medications are still the second most prescribed group of drugs in the US. Similarly, figures from the NHS Prescription Services in the UK show an increase of 43% in the last 4 years in the prescription of selective serotonin re-uptake inhibitors (SSRIs), the most commonly prescribed group of anti-depressants (April 2011).

Unfortunately the pervasiveness of the medical model (supported by the term "mental illness") to treat psychological disorders is still widely evident. It is also highly funded and promoted, directly by pharmaceutical companies and/or indirectly by Governments - through the structure of services and style of access to services they support. When people cannot get easy, affordable and open access to evidence based non-drug psychological therapies, then the medication option becomes the main one promoted and pushed onto vulnerable people, with all the side-effects and other costs associated. Essentially we end up blaming the person rather than looking deeper into the circumstances surrounding them, both past and present, and assisting them to feel empowered to make positive changes in their life and emotional self. Psychological disorders require psychological treatments, and the concepts and terminology to support these.

In addition, the label "mental illness", not only drives the medical model of thinking and treatment of psychological disorders, it is also highly stigma producing. Historical media reports, and even some fictional movies about psychiatric institutions have often directly or indirectly portrayed people with a diagnosis of "mental illness" to have highly unpredictable or even violent behaviour. It can be argued that this term is still in the minds of many, as meaning people who have bizarre, dangerous or "crazy" behaviour. The fear then of being labelled or possibly viewed by others in this very negative way, is often a major factor in reducing help seeking behaviour of those needing assistance with psychological problems.

Whilst some inroads into reducing stigma and improving help seeking have been made, the ongoing use of this term in education and media campaigns for people with psychological problems is not helpful.

(b) "Mild" and "moderate" levels of disturbance – what does this imply or actually mean?

In recent debates and documents about mental health, the descriptor terms of "mild" or "moderate" have been often used in conjunction with most psychological disorders which are not embraced by the term "*severe* mental illness". Linguistically, it makes sense that if there are "severe mental illnesses" then there must be also mild and moderate levels too. However this is where the terminology does not assist in any meaningful way, and actually denigrates the impact of psychological problems on peoples' lives. In saying this, it is clear that any one individual, including those with psychiatric disorders, may present with symptoms that vary in intensity and disability, and which can also vary over the course of the treatment.

However, if an assessment of a psychological disorder indicates that professional treatment is required, this signifies that the level of intensity has moved beyond the coping mechanisms of the individual, and that normal supportive approaches have not been sufficient to assist with the issue(s). It can be argued that the descriptor terms "mild" and "moderate", produce a disconnect in the public understanding of what it means to need psychological therapy and increases the impression that they should be able to sort it out for themselves. For example, it would be reasonable to think that if a person is "mildly depressed" they wouldn't reach diagnostic levels and they wouldn't seek out or need professional treatment.

The terms "mild" or "moderate", or "the worried well" when used by policy makers and others in the public arena, also tend to carry a strong implication that the treatment which is associated with this cohort is somehow simplistic and the number of sessions can be limited or restricted, without interfering with the integrity of the treatment process or the likely outcomes. On the contrary, peoples' lives are complex as highlighted previously. They bring their emotions, relationships (past and present), stresses, disappointments, hopes and dreams into therapy. The complexity of peoples' lives and of the process of psychotherapy needs to be understood and respected better. Especially by policy makers when they are considering how much psychological therapy they are willing to fund, and what level or amount of training is sufficient to provide psychological therapies, as their decisions can significantly impact on the well-being of the community.

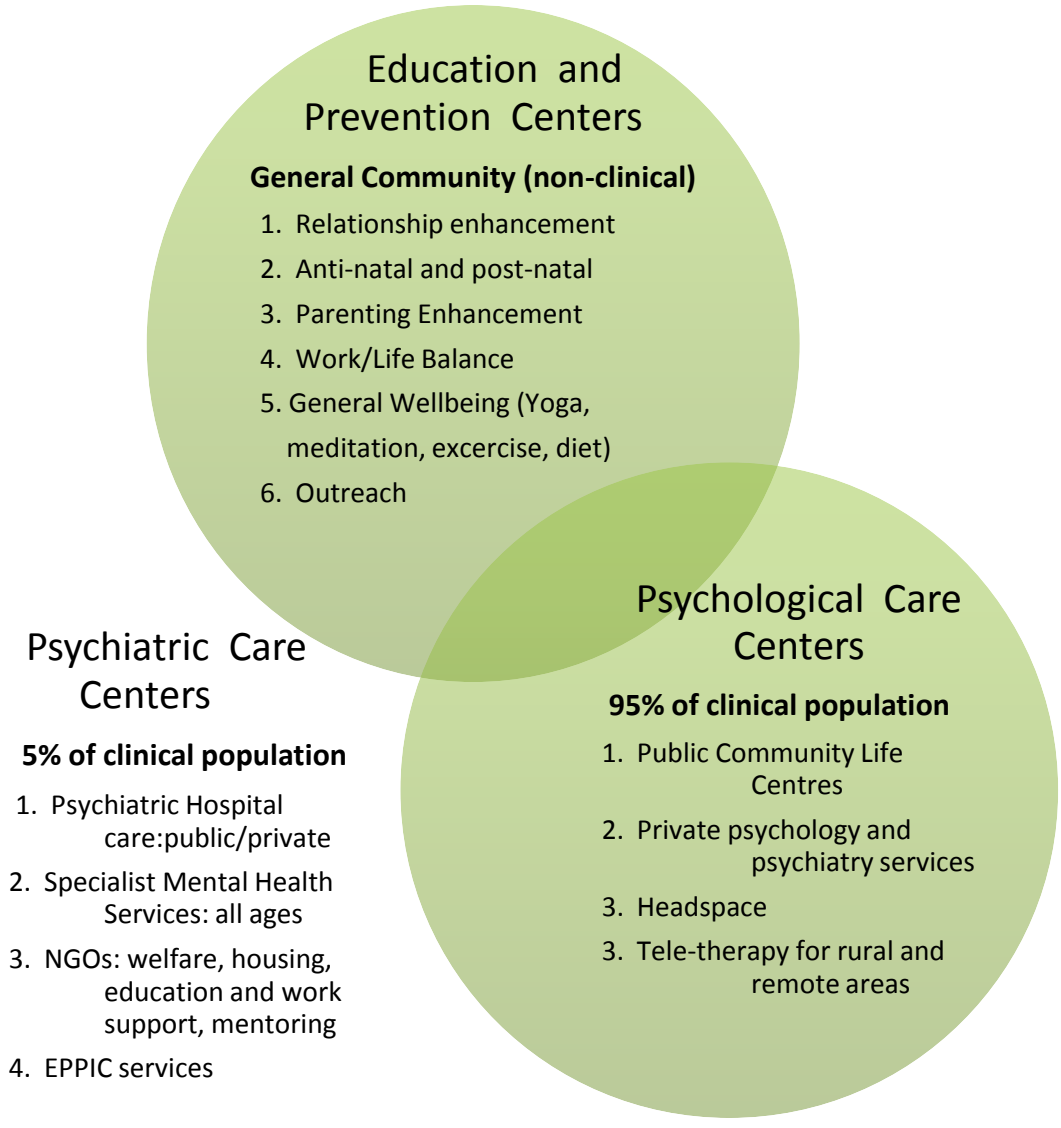
Although people with psychological disorders represent the vast majority of people with mental health problems (approximately 95% as compared with approximately 5% for psychiatric disorders) the Australian Federal Government's response to supporting this cohort has been less than ideal, especially when compared with the comprehensive support offered to those with psychiatric disorders. This is indicated by their decision to cut the already very limited number of Medicare supported psychotherapy sessions in the Better Access scheme from twelve to ten sessions *per year*. Reductions in Medicare support in the private sector means that thousands of Australians will not be able to afford to complete the psychotherapy treatment they need. Government policies which take the decision making power away from the treating specialist, regarding the length or type of treatment required, is dangerous to the mental health of community members and is hence highly unethical. This would not be tolerated in any medical treatment area, and nor should it be in the psychological treatment area.

It is also on record that the current Federal mental health Minister has stated that if more than this limited number of sessions are required, then a person should be seen by a Psychiatrist, (with 50 sessions per year supported by Medicare) or be treated by a GP, (with unlimited Medicare support). This differentiated and biased support for the medical model of intervention for psychological disorders essentially means that people are being pushed, even if inadvertently, towards a medical model of care. This is even more concerning in the treatment of children and adolescents, where a complex array of family, school and social factors often play a role in the causal components of psychological disturbance, all requiring time for proper assessment, liaison and individualised interventions.

It could be argued that the concepts linked to terms such as "mild" or "moderate" disorders has supported these decisions. It is therefore concluded that it would be more appropriate and accurate to use the general term "mental illness" only for psychiatric disorders (if one really has to use this term at all), and the term "psychological disorders" to be used for depression, anxiety and relationship based disorders. The use of these different general terms better distinguishes between the causal or contributing factors considered as primary, the main treatment models needed, and the types of services required for recovery.

Section 2: A different concept for mental health services and a change in funding targets?

The service types and support requirements for people with psychiatric disorders (or mental illnesses) and those with psychological disorders, may overlap on occasions but are largely different, and hence require different planning and funding responses from Federal and State Governments. Likewise the services for preventative work in the non-clinical or "normal" population needs to be considered in a different way, as does the funding approaches. Below is a diagrammatical representation of possible service delivery concepts which will be outlined in the following section. The three different 'centers" may be either *actual* centres with all services housed within it (such as an Education and Prevention Center), or *conceptual* centers, where different services are provided in different physical localities. Services in the three types of "centers" would require a mix of Federal and/or State funding.



Description of services and functions of each of the "Centres"

Education and Prevention Centers

Early intervention and primary prevention have been highlighted in many Government documents as essential to curbing the growth in psychological health difficulties and enhancing well-being. Prevention programs also have the scope to reduce costs, both financially and emotionally when a persons' progression into psychological and/or psychiatric care centers can be prevented. These centres would service the general **non-clinical** population. That is, those people who do not have a diagnosed mental health problem but are seeking education/prevention services to enhance their general skills and wellbeing.

Education and prevention centers need to be purpose built new buildings, located throughout metropolitan areas, plus some located in rural and remote areas. The infrastructure and equipment would need to be initially funded by the Federal Government with States having responsibilities to fund the staffing and ongoing running/equipment costs. They could be "centres of excellence" for co-ordinated preventative health care in each state and could come under the guidance of the Mental Health Commission in each State.

Guidelines:

i) **Community Access**: Self referrals and referrals from community agencies and all mental health professionals. Any staff within a prevention and education centre could also alert specialist psychologists/psychiatrists who consult into the centre to participants who may need assessment and possible referral to a psychological or psychiatric center. Sessions would either be free to the public or heavily subsidized by the State, so that there are no financial barriers.

ii) **Staffing**: A mix of specialist mental health professionals and staff with other training would facilitate services at the centers. Specialist staff would screen for clinical problems and refer people who are found to have a diagnosed mental health problem to either psychology or psychiatric centers as appropriate.

iii) **Format and limit of services**: Services and educational training programs would use a format of skills based groups. There would need to be clear ongoing guidance and training for staff running groups so they can differentiate the boundaries between an educational program and a therapy intervention, the later not being the role or function of education center services. No individual services would be provided at these centers.

Types of services offered: The mix of the various packages offered at a centre could depend on the age and social demographic of the catchment area i.e., more young families in the demographic - then more parenting classes etc. Hence funding and programs need to be flexible over time. Some of the services could encompass for example:

1. **Relationship enhancement** – Groups run for couples thinking of living together, getting married, or who have been in a relationship for less than 2 years, who would like to learn general skills of communication, problem solving, emotional support, etc.
2. **Anti-natal/post natal classes** – Groups run for parents who have just started a pregnancy and then also post-pregnancy. Information about baby development up to two years (social, physical, emotional) and how to provide the good physical and psychological nurturing during these early developmental years, woman's health, couple support etc.
3. **Parenting enhancement** – For couples/singles with children from 2 years on who wish to learn about parenting skills e.g. Triple P parenting classes, teaching social/emotional/developmental skills.
4. **Work/Life Balance** – Offering assistance to establish good work/life balance practices for both men and women, importance of leisure time, family time, providing information about legislation eg parental leave, maternity leave, carers etc. This may also require some links into the business community with seminars to organisations about work/life balance and mediation on healthy and family friendly work practices.
5. **General wellbeing classes** – these could be general classes in for example yoga, meditation, diet, exercise, self-defence etc for all ages.
6. **Outreach** – This may also be the co-ordination and/or provision of any of the above services in other settings such as school or community centers. It could also include the provision of any of the above services via teleconference or Skype to people in rural and remote areas, as practicable.

Psychological Care Centers

Psychological Care Centres could be the broad term used for centers/services catering for the large section of the clinical population (approx 95%) who have psychological disorders. Because this is a clinical population, staffing in these centers/services need to highly trained specialists who can competently and ethically provide psychological interventions and support such as specialist psychologists – Clinical, Counselling, Health psychologists and clinical social workers. It would be anticipated that the majority of consumers would have depression, anxiety and/or relationship based problems, but would not be exclusively these disorders. For example, many people with psychiatric disorders also greatly benefit from psychological therapies, along with people with very complex disorders such as personality and eating disorders.

Types of services offered:

1. **Public Community Life Centres -** (currently called Community Health Centers in some states) are a real and viable addition to the primary psychological health care landscape. They already function within a number of States (especially NSW and

Victoria), however in other States they are virtually non-existent. These centers have not received any focus or funding in the current Federal Governments planning, which represents a significant loss for the community. Existing centres function from a non-medical, social inclusion model and represent more closely the concepts found in life span developmental psychology training, as described earlier. Along with mental health services, other non-psychology health services are and could be provided in these centers such as speech therapy, audiology, community nursing, dietician services, physiotherapy. An advantage of placing psychological services in a multi-service center is that community members may feel less stigma, as they would be less readily identified as attending for mental health reasons. These centers could also house research teams which could investigate and track the needs of their local community to facilitate the continuation of appropriate services within the centers as demographics change over time. The provision of primary care psychological services within Community Life Centers needs greater consideration in the present health reform discussions.

Guidelines:

i) **Community Access**: Self referrals and referrals from community agencies and all mental health professionals. There should be no medical gate-keeping of referrals. Sessions would either be free to the public, or heavily subsidized by the State, so that there are no financial barriers. Some services may provide niche or targeted therapy for certain populations, as deemed necessary to facilitate access.

ii) **Staffing**: Good service delivery can only occur if adequate funding is available to ensure appropriate staffing levels and that staff with high levels of training and expertise are employed. Unfortunately this is currently often not the case. The standards of training, particularly of psychological health care providers, are very variable across current services and across different States. There also appears to be a significant blurring of professional (and non-professional) roles and boundaries, especially into the field of psychological diagnosis and therapy. This is clearly evident in situations where "up-skilling" of a range of health professionals and/or others, who do not have the training background in psychology is encouraged. Services significantly reduce their cost-effectiveness when expertise is diluted and shifted from one area to another and in turn, the focus of services moves away from **quality** of services to **quantity** of services**.** Mental health specialist staff would need to be able to clinically work with children, adolescents, adults (of all ages), couples and families. Specialists from Clinical Psychology, Clinical Neuropsychology, Counselling Psychology, Educational and Developmental Psychology, Forensic Psychology and Heath Psychology, who would fit well into this model and type of service provision.

iii) **Format of services**: Funding would cover wages of specialist staff to provide mental health therapy and intervention services for individuals, couples, families and/or group work, along with wages for the other health providers at the center.

iv) **Types of services and service centers supported**: a mixture of services provided under one roof would be required to cater for the range of needs and choices people may wish to make about their care. The mix of the various mental

health (and other) clinical services offered in a Community Life Centre for example could depend on the age and social demographic of the catchment area, as for the education and prevention centers. Hence funding and programs need to be flexible over time for these centers too.

2. **Private Specialist Psychology and Psychiatry Services for psychological disorders**
Currently there are several Federal Government funded community mental health services which currently fall into this category. The main services to be discussed here are the Better Access program, private Psychiatry and GP services, all funded via Medicare, the Access to Allied Psychological Services (ATAPS) program, supported with block funding distributed via Medicare Locals, and Headspace. While supporting a range of community services to psychological disorders is generally helpful, there are some serious limitations in the current models offered and these will be outlined below.

As mentioned previously, private services provided by specialist psychologists under the Better Access program is currently restricted to a level of funding which supports community access to only 10 sessions per year, and a further 6 sessions in *exceptional circumstances* – only until December 2012. This will effectively halve the previous level of an already very limited support for private psychological services Funding for private psychiatric services covers 50 sessions per year supported by Medicare, plus substantial additional funding in last years Budget for tele-psychiatry services to rural and remote areas. It is unclear what proportion of the Medicare rebated psychiatric sessions are used for people who experience psychiatric disorders ("serious mental illness") versus people with psychological disorders, and it is unclear what proportion of services are for medical (medication) management or other interventions. GPs, who have undertaken short up-skilling courses, are also funded via Medicare to diagnose and treat psychological disorder under Better Access and there is no Medicare limit on the number of mental health treatments a GP can provide to their patients.

What the levels of support for the different treatment and care options mentioned above indicates, is that there is significant funding to medical oriented interventions and for those providers with training in medicine. This has a considerable impact on the types of services that community members receive, and the options of care they can readily access. It is unclear what empirical evidence was used to determine the number of Medicare funded sessions supported for each of the specialist areas and types of therapy offered. However it appears that funding for the medically trained providers and hence medically oriented services is overly generous, and the psychologically trained provided and oriented services overly restrictive.

Many people in the community prefer non-drug treatment approaches which allow them to explore and resolve the life issues and problems they face. When psychotherapy services are restricted by policy, rather than being determined by the progress in therapy, many people may have to seek multiple treatment options to try

to get adequate care, which is not in the best interests of the consumer and represents false economy by Governments. An even worse outcome is the possibility that people who have incomplete or inadequate treatment feel they cannot recover, or at the very least that psychological therapies just dont work. As with all forms of medical interventions, the length and type of treatment required must be determined by the treating specialist, as they are aware of the therapy process and progress of the client. This should not be determined by another non-treating specialist or a case manager or Government fiscal policies.

The current public sector mental health services are overloaded, often only have the staffing levels to support crisis care, leading to long waiting lists for anything else. Therefore the private sector needs to be a viable option for the treatment and care of community members. The current policy of only providing Medicare support for 10 sessions per year, does not meet this criteria. Nor is it adequately utilizing a highly skilled and trained professional workforce. Therefore, along with expanding the numbers of Community Life Centers and the mental health services within them, access to proper amounts of private psychological treatment (20-25 sessions or something commensurate with the support for medical based mental health services) needs to be immediately supported by Medicare.

The Access to Allied Psychological Services (ATAPS) program, is another program currently funded by the Federal Government for use by certain sections of the population who have diagnosed psychological disorders. The ATAPS program was originally viewed by the Government as complementary to the Better Access initiative. It was designed to target people in rural and regional areas, to have a particular focus on low socioeconomic community members and specific sectors of the population such as indigenous people. Whilst increasing funding for targeted services is laudable, they have unfortunately been expanded at the expense of the Better Access initiative, and although Better Access Medicare support was cut, ATAPS Medicare support remained in place at 18 sessions per year. Some ATAPs services are already reporting that even with the increase in funding they are struggling to cope with the demand for services. As a result, people in need of services are being held on waiting lists which will soon look like those found in the public sector. This has occurred, at least to some degree, because the Government has set up an expectation that ATAPS will be able to cope with referrals that would normally have been seen by Better Access private practitioners. There is also a lack of monitoring of ATAPs to ensure it maintains its focus exclusively on the people it is meant to be targeting. Some concerning reports are starting to surface of how this situation is negatively impacting the private sector, with some private practices closing as they cannot maintain a viable livelihood. In addition it has been reported that some GP Divisions/Medicare Locals are requesting private specialist psychologists to accept referrals from them, but are insisting referrals will only be made if the clients are bulk billed. This will mean the ability to maintain a viable living is further eroded, and it is anticipated that further practices will either reduce services or close. There are also some major concerns with the ATAPs program itself, especially what level of training and skill the providers of services will be required to

have, especially when funding is limited and there is pressure to reduce costs as much as possible.

Therefore the whole climate and structure surrounding the ATAPs scheme has the potential to degrade community psychological services, and the people in need with be the ones who will suffer. Having lower quality and quantity of primary care mental health services is not a good outcome for people in the community. Indeed, whether the ATAPs program would even be necessary if Community Life Centres were developed and expanded, is debatable.

3. **Headspace**: There has been some new funding injected into other even more specific populations, such as for youth through the development of Headspace services. Whilst there is research to indicate that many mental health problems can become very problematic in the teenage years, it is very unclear whether targeting a particular age group would be the most effective and cost-effective way of reducing psychological (or psychiatric) disorders. What this particular perspective lacks is the broader acknowledgement of the inter-connection of a range of factors which impact on mental health of children, youth and young adults. Heavily targeting just one part of the whole, will do little to alleviate the incidence of mental health problems in the community. This cohort could be better served within the *Community Life Center* settings.

4. **Tele-therapy** - For people in outer metropolitan, rural and remote locations, online face to face psychological services, like those currently funded for tele-psychiatry need to be introduced. Monthly fly-in/fly-out face to face services to link to the internet based services would also be ideal. This would allow for the expansion of psychological services into the outer areas. Governments could consider going into partnership with large corporations, such as mining companies, in order to share the costs and transport requirements. If centers in rural/remote areas were established where people could access these interfaces, then the significant barrier of distance could be reduced.

Psychiatric Care Centers

There are already well established hospital and specialist community mental health services assisting people with psychiatric disorders throughout Australia. However there has been considerable debate about whether these services are sufficient or whether they adequately provide for the psychiatric population. However, perhaps the issue is not the services per se, but the inadequate specialist staffing levels, the lack of co-ordination of services to assist people to navigate through the system, and the lack of community support services needed by this population, (such as supported housing, assistance with work and educational opportunities). This sector of the population however has received a considerable injection of money from the last Federal Budget in 2011. Such an injection of funding for those suffering from intense and debilitating psychiatric difficulties was long overdue and is welcomed. It

appears that for this small section of the mental health population (3% of the total mental health population) the Government and community alike have finally got the understanding and response right. It can only be hoped that the role out of services continues in a positive way and the term mental illness adds a positive weight to the type and intensity of the response needed.

The 2011 May Federal budget further addressed some essential needs of this population by providing funding for case management services and other aspects of care such as housing, educational and welfare support. Non-government organisations (NGOs) have also been promoted in their role in mental health however it is unclear what and how NGOs will contribute to the care of people with psychiatric disorders. Defining their role is a pressing issue and clear guidelines need to be written. For example, promoting NGOs to co-ordinate non-clinical services for the psychiatric population is a central role they could offer. On the other hand, it would not be appropriate for the clinical care of people, with either psychiatric or psychological disorders, to be managed by this sector as this has historically not been their focus or strength and there are other better suited services to undertake this task.

Summary and Conclusion

Whilst this document does not represent a radically new model, it does suggest a different overall concept of how services could look and link to each other. It more clearly separates the definition and type of services needed for the two distinct psychiatric and psychological disturbed populations, and creates a space for the non-clinical population which may benefit from preventative care services. This document suggests that there are major shortcomings in the planning and co-ordination of preventative services. It also suggests that considerable attention and re-direction of funding needs to be moved towards the large sector of the population with psychological disorders so that the quantity and quality of care can be commensurate with community needs. The psychiatric population has received considerable Government notice recently, and it was greatly needed, but this is only a very small section of the mental health population.

It is hoped that in the near future the Federal and State Governments will re-align funding and support to cover all aspects of mental health prevention and care, and by changing some of the terminology used in this field, this outcome becomes more and more in reach.