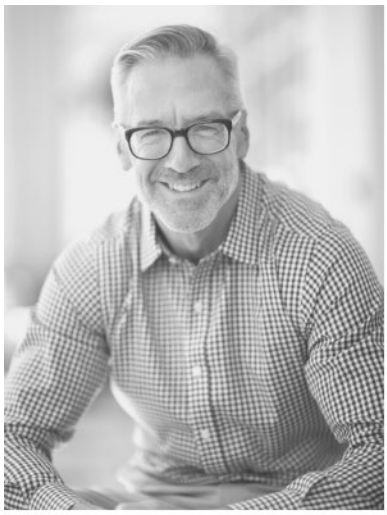
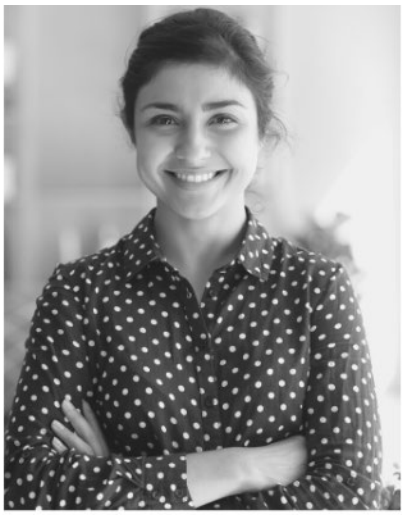
Australian Association of Psychologists incorporated (AAPi)

AAPi
AUSTRALIAN ASSOCIATION of PSYCHOLOGISTS INC
a true voice for psychology

Submission to the Select Committee on Mental Health and Suicide Prevention

AUSTRALIAN ASSOCIATION of PSYCHOLOGISTS INC
a true voice for psychology

Introduction

The Australian Association of Psychologists incorporated (AAPi) thanks the House of Representatives Select Committee on Mental Health and Suicide Prevention for the opportunity to provide information and recommendations.

We thank the AAPi Aboriginal and Torres Strait Islander Expert Reference Group for their valuable contribution. We would like to specifically acknowledge the contribution of David Ball, Tracey Cairns, Peter Smith, and Roslyn Snyder. The voice of Aboriginal and Torres Strait Islander People - herein also referred to respectfully as Indigenous or Indigenous Australians, is unique to Australia and needs to be heard, with changes to service provision immediately put in place to enable cultural safety and healing.

We are starting to see what we expect will be a huge spike in mental health challenges ranging from presenteeism through to self-harm. Priority must be given to making highly skilled mental health professionals accessible to Australians.

We have already seen a growing trend in anxiety and indicators of PTSD and depression. Australia needs to start flattening the mental health curve urgently to avert another national crisis and the long-term, far-reaching effects on our health, economy, society, and education.

AAPi represents psychologists traversing a wide range of areas of practice around the country. Our members are on the front line dealing with the increasingly fragile mental health of Australians.

Using these insights, we urge the Federal Government to strongly consider our recommendations to address a developing national mental health crisis.

Sincerely,

[redacted]

Tegan Carrison
Executive Director
Australian Association of Psychologists Inc

Phone 0488770044
Email admin@aapi.org.au
Website www.aapi.org.au
Postal Address PO Box 107 North Melbourne, Vic 3015

AUSTRALIAN ASSOCIATION of PSYCHOLOGISTS INC
a true voice for psychology

About AAPi

The AAPi is the leading not-for-profit peak body representing all psychologists Australia-wide. Our members include psychologists from all areas of endorsement and those who have chosen not to pursue endorsement, from graduates through to university lecturers and leaders in their field.

A group of passionate psychologists formed our organisation in 2010 to:

- Represent a united voice for psychologists to government and funding bodies
- Promote the recognition, professionalism, skills, and expertise of psychologists
- Improve access and equity to psychological services in Australia by removing barriers to effective treatment
- Advocate for the removal of the inaccurate and publicly damaging two-tier funding system and reinstate one Medicare rebate for the clients of all psychologists
- Uphold the value of all psychological expertise and pathways to registration
- Serve the professional needs of all psychologists by providing members with quality professional development opportunities, expert support, and guidance

By advocating for equality for psychologists, the AAPi is also fighting for equitable access to mental health services for all Australians.

AAPi represents the interests and integrity of all psychologists regardless of endorsement status, with members in all States and Territories of Australia.

AUSTRALIAN ASSOCIATION of PSYCHOLOGISTS INC
a true voice for psychology

Summary of Recommendations

The skills needed to support Australians in their mental health already exist. They simply need to be made more accessible and for the already available help to be accessed more readily. Qualified professionals are ready to assist clients but are not being used to their fullest extent.

There are two main issues for people needing services – access and flexibility of service delivery. Access issues include barriers such as entry requirements for treatment services excluding a large majority of consumers, red tape required to gain access to private services, difficulties navigating the system, lack of culturally appropriate services, particularly for youth and Aboriginal and Torres Strait Islander people. The restricted way that services are provided also reduces the cultural appropriateness of services as well as reducing the ability to engage in multidisciplinary treatment. Utilising Aboriginal Mental Health Workers and Youth Workers would assist with these groups' cultural safety needs, social and spiritual requirements.

We recommend fifteen initiatives that will quickly address this cost-effectively and powerfully:

1. One-tier Medicare rebate for the clients of all registered psychologists in Australia.
2. Raise the Medicare rebate to $150 per session to allow for greater access, facilitate more bulk billing, and enable appropriate treatment rather than an inadequate psychological health care response.
3. Telehealth to be a permanent option for Medicare consumers.
4. Implementing the Productivity Commission recommendation for up to 40 rebated sessions per annum.
5. Simplify the process of access to a psychologist. This includes simplifying referrals to registered psychologists and that of review letters back to referrers and upgrading the MBS to reduce the burden on psychologists. Psychologists should also not be held financially accountable for referral errors by medical practitioners.
6. Broaden MBS rebateable sessions to psychologists to incorporate:
    - Vital prevention and early intervention strategies in addition to responding to mental illness.
    - Psychological interventions for couples counselling and family therapy;
    - Re-instatement of self-referral processes integral for client's sense of autonomy, important for psychological recovery, and to increase access to psychological services.
    - Include Medicare rebated assessments funded at a sufficient level to minimise out-of-pocket consumer expenses.
7. Culturally appropriate treatment options.
8. Fund a dedicated preventative/early intervention psychology workforce.
9. Establish a 'Provisional Psychologist' Medicare rebate.

AUSTRALIAN ASSOCIATION of PSYCHOLOGISTS INC
a true voice for psychology

10. Expand the evidence-based approaches able to be used by psychologists to allow the clinician to use any technique that has adequate Level I, Level II or in some specific conditions Level III evidence.
11. Review the evidence and Government spending on mental health "hubs".
12. Cease discrimination of psychologists without clinical endorsement in areas including but not limited to employment opportunities, scope of practice and funding.
13. Prioritise key prevention and early intervention settings such as schools and workplaces.
14. Address and minimise the current over reliance on psychiatric medication.
15. Introduce incentives for rural and remote psychologists - similar to GP's.

AUSTRALIAN ASSOCIATION of PSYCHOLOGISTS INC
a true voice for psychology

1. One-tier Medicare rebate for the clients of all registered psychologists in Australia

The Medicare system currently places psychologists into two different categories with vastly different rebate amounts for clients.

The current two-tier Medicare system is fundamentally flawed and needs to be immediately discontinued. Predicated on false assumptions and lack of supporting evidence, AAPi seeks this Select Committee to recommend the implementation of a one-tier system for registered psychologists to improve access to vital mental health services.

AAPi is concerned that the inequity of the two-tier system has led to misinformation about the skills of all psychologists and restrictive access for the public to psychological services. Examples of where this occurs include Centrelink, the Department of Veteran Affairs, the public sector, including hospitals and health services, and private health funds.

Australians need access to skilled psychologists now more than ever, improving access is critical.

<u>One profession yet two rebate levels</u>

In 2006 the Australian Government implemented health reforms that saw psychological services included in Australia's Medicare system under the Better Access Scheme. The Medicare items for psychologists under Better Access were drafted into two categories: clinical psychology services and general psychology services. This became the two-tiered model that provides higher rebates for clinical psychologist's clients (currently $128.40 for a 50-minute session) and a lower rebate for the clients of all other registered psychologists (currently $87.45 for a 50-minute session).

This division has created significant inequitable access to mental health treatment for the Australian public and discord within the psychology profession. Medicare items are generally linked to the service provided rather than the professional's qualifications, so psychology has become an anomaly. This anomaly has had serious financial consequences for consumers and the Government.

The system suggests that the 30% of psychologists deemed 'clinical psychologists' should attract a higher level of Medicare funding than the remaining 70% who are 'registered psychologists' or have endorsement in areas of than clinical psychology and provide the same service to the same client population, client condition type and severity. The scientific literature supports the position of AAPi, and clearly demonstrates that there is no difference, and rather that all registered psychologists are capable of providing the same level of psychological services.

The two-tier rebate pushes the Australian population toward 30% of psychologists, exacerbating waiting times and limiting accessibility. Those Australians who see the 70% of psychologists on the lower rebate, have a greater out of pocket expenses which creates further

stress and disproportionately disincentivises those with limited resources from seeking mental health care.

All psychologists share core competencies and equivalent treatment outcomes

Research demonstrates that both registered psychologists and clinical psychologists achieved beneficial outcomes. At the same time, there is no evidence to support that clinical psychologists are better skilled at providing services than other psychologists. There is simply no evidence to warrant a difference in funding or endorsement. A notable research project commissioned by the Australian Government itself (Pirkis et al., 2011) clearly indicates that psychologists treating mental illness across all training pathways (operationalised through both tiers of Medicare Better Access), produce strong treatment outcomes for mild, moderate, and severe cases of mental illness (Jorm, 2011).

All psychologists provide the same service, to the same standards (as governed by their registration with AHPRA), and to the same population group. The dual Medicare rebate system has caused divisiveness in the profession, financial disadvantage to the Australian public, misleading information to the Australian public, and restriction of psychological service provision to the Australian public.

Ultimately, it is the community members in need who are missing out. This erroneous notion of superior skills based on area of interest versus actual competency has additionally contributed severe negative impacts at an economic/financial level, on career viability and to the wellbeing of the psychology profession. Clinical psychologists and all other psychologists have the same operating costs including insurance, registration fees, administration support, rent and continuing professional development requirements. In view of the accelerating need for mental health support for Australians, all psychologists need to be supported to continue delivering these vital services.

The current Medicare Benefits Schedule overlooks the real costs associated with accessing and delivering vital mental health support, shutting out many clients from psychologists' care when Australians need them most. Clients still need to pay more out of pocket due to the lower rebates eligible to most practitioners in the country. On average, clients are paying $175 each session to see a registered psychologist, yet are only able to claim back $87.45 from Medicare. If the same client was seeing a clinical psychologist, they can claim back $128.40. Many clients cannot afford these out-of-pocket expenses, so do not seek the help they need when they need it, nor for the appropriate duration required for adequate treatment and recovery. This keeps clients untreated and perpetually unwell, so they return for services but are unable to receive adequate intervention because of the financial disparity. The costs (both monetarily and to society) associated with mental ill health are clearly outlined in the recent Productive Commission Report on Mental Health.

Ultimately, this prevents Australians from accessing mental health support as we continue to deal with heightened levels of anxiety, depression, and stress. The federal Government has tabled a major pandemic mental crisis plan following research that forecasts suicides directly related to the economic shutdown. The associated distress could outstrip direct deaths from the coronavirus by 10 times.

If all psychologists had access to the one higher tier, then more clients could be bulk billed or out of pocket expenses minimised, without risking the financial viability of services.

Now is the time to make these important changes before it is too late, and we see a needless loss of life as predicted in recent suicide modelling. We are on the cusp of another urgent crisis, as people not receiving help in a timely manner will lead to greater pressure on hospitals and other treatment facilities, not to mention the long-term, far-reaching effects on our national health, economy, society, and education. We need to start now to urgently flatten the mental health curve.

Psychologists need to be made more accessible to all Australians while ensuring psychologists can function with financial viability whilst they are providing these vital services.

It is critical to urgently arrive at a solution that benefits both the Australian community and the psychology profession delivering these services. We need to remove barriers to the access and provision of mental health services and enable individuals to get the help they need from ALL psychologists. Failing to do so will cause an even greater decline in the nation's mental health, as Australians must pay more out of pocket due to the lower rates eligible to 70% of practitioners in the country and thereby to each of their clients.

We have also written a petition that includes some of these advocacy items. At the time of writing, we have over 8000 signatures, primarily from psychologists. The petition can be accessed below:

https://www.change.org/p/department-of-health-minister-greg-hunt-one-telehealth-medicare-rebate-for-all-psychologists

2. Raise the Medicare rebate to allow for greater access and facilitate more bulk billing

Raising the Medicare rebate will enable more psychologists to bulk bill; it will enable more clients to stay in treatment so their condition is adequately treated; it will also retain more psychologists in the profession that has increasingly become financially unviable and professionally restrictive due to the Medicare two-tier rebate complications.

The current Medicare rebate for psychology is insufficient to cover the actual cost of care and this directly affects the access of psychological services. This leaves the option of passing this on to the consumer, who often must choose between vital mental health care or other essentials of daily life or leaves psychologists with a financially unviable service. The financial challenge of providing care and covering costs results in the psychologist being under undue financial distress or leaving the profession - often earning more in employment areas not requiring their expert skill level or tertiary education.

Indigenous psychologists working from an Aboriginal Medical Service, where all services are bulk billed, have to choose between taking on excessive client numbers or leaving altogether because their practice is unviable. Many stay because of cultural connections, but this trend sets up a perpetual problem for psychologists working in these communities and the community, who then have a high turnover of providers as psychologists leave due to burnout or financial insecurity. This is also seen in Rural and Remote areas of Australia as there is few incentives for psychologists to stay long-term.

The current system is hindering career progression, income (due to the two-tier Medicare rebate system), and employment opportunities. Many registered psychologists are getting so frustrated with the current structure that they are leaving the workforce. Considering that over 80% of registered psychologists are women, this is having a massive impact once again on female workers.

The Australian Government purports to value mental health yet is placing at serious risk the occupational health and safety of psychologists, the service delivery professionals, and is sacrificing the mental health care of the Australian public.

The current Medicare rebate is set at $87.45 for the majority of psychologists. This is insufficient for expert mental health care. The Medicare rebate for Psychology has only increased by $12.45 since the inception of Better Access in 2006. This is far below inflation rates and does not reflect the significant and exorbitant costs of maintaining professional educational or registration requirements, let alone running a professional private practice. Private practice is the most accessible means of service provision for Australians and needs to be funded adequately. High numbers of consumers who fail to present for their initial psychology session after a Mental Health Care Plan is created and who cease treatment after one session would indicate that psychological treatment remains too expensive for many people, including the most disadvantaged, including Aboriginal and Torres Strait Islander people.

We call on the Select Committee to urgently endorse the increase of the Medicare rebate to $150 for a standard 50-minute session. This long-awaited higher rebate will assist those most vulnerable in making mental health services more accessible and encouraging more psychologists into private practice, which will help alleviate those areas with waiting lists, which is significant problem in a large number of areas across the country.

AAPi conducted a Private Practice Survey in Oct 2020. Of the 789 respondents, 86% said they would bulk bill more if the rebate were raised to $150.

Affordable and accessible mental health care has been discussed in some detail in the media of late. As noted above, the other clear factor in the problem with bulk billing and the Medicare rebate is the erroneous, misleading, and destructive two-tier system that needs to be immediately terminated and replaced by one set of item numbers for all psychologists. The burden of the national mental health crisis is being propped up by a broken system. We need to move beyond a list of numbers on the Medicare Benefits Scheme, and look at the individuals who are suffering across Australia and the impact this is having on our economy and to our society.

Increasing the rebate to $150 for all psychologists will allow psychologists to bulk bill more clients while also attracting more psychologists into private practice thus reducing many of the barriers to accessing the expert mental health care that registered psychologists provide.

We call on the Select Committee to run through the modelling of the cost of this increase and compare it to the cost of what we will face with inaction and short-term band-aid solutions. The looming cost of a major mental health care crisis would far outstrip a sensible measure, such as what we are proposing.

3. Permanent universal access to telehealth

Universal access to telehealth has been one of the successes of the Federal Government's response to the COVID-19 pandemic. However, at present, telehealth remains temporary.

We are calling on the Government to make this a permanent and universal addition to MBS.

Telehealth has the following benefits:

- Increases access to those with mental health conditions that make attendance at a clinic difficult (i.e., agoraphobia).
- Increases access to those that have physical disabilities that impact on their mobility.
- Allows those that have carer responsibilities to attend psychological treatment without being absent from the home for long periods of time.
- Reduces risk of transfer of illness to vulnerable populations.
- Increases access for those in rural and remote regions of Australia to have access to psychological care.
- Allows for clients to access psychological treatment outside of their local geographical area that may have long wait times, allowing immediate access.
- Allows clients to have access to more providers that are experienced in treating their mental health conditions, particularly those with rare disorders.

- Allows for culturally appropriate treatment. Eighty percent of Indigenous Australians live in urban locations, and they would be disadvantaged without the benefit of telehealth where they can access an Indigenous psychologist or a culturally responsive therapist.

At the time of writing, telehealth has only been approved until June 2021, and we urgently need this extended to give certainty to both psychologists and clients.

Clients need to know with certainty that they will be able to plan to access psychological treatment beyond June 2021. At the time of writing this submission, that is only three months away. People under stress need certainty when it comes to getting help.

4. Implementing the Productivity Commission recommendation for up to 40 sessions

Much commentary has been written about the current increase to session numbers in the media. According to the Better Access finding, in 2016/17, only 4.64 sessions of the 10 allowable were accessed by Australians. Some sectors of the medical community point to this figure as a reason why session numbers should not be increased more widely. However, this fails to consider the myriad of reasons people have less than 10 sessions and completely ignores those who use well over this number.

For some clients that access a small number of sessions, it is because their reason for presenting can be managed relatively easily. Some find that by the time they commence mental health assistance, the calendar year rolls over, and they have not reached their limit. Yet for many, it is the financial burden due to the low rebate applied to mental health

providers – in particular, the 70% of registered psychologists in Australia only able to provide client with the lower Medicare rebates due to a legislative mistake that we have shown above needs to be urgently rectified.

We advocate for self-referral to psychologists for rebatable sessions to remove the barriers for people seeking help. There are barriers that typically stop people from seeking support such as a GP referral or Mental Health Plan to access support.

There is also a substantial drop in people utilising their first 10 sessions once their Mental Health Plan requires them to return to their GP after their 6th session for an additional referral.

Through consultation with our membership base, we have identified that many members provide pro-bono services each year when clients' 10 rebated sessions run out. This is not reflected in the Medicare usage data.

Even though a small number of clients access over 10 sessions in a calendar year, these clients return year after year because they do not reach optimum treatment levels to resolve their illness because of the annual cap of rebated sessions, representing only 10 hours of mental health care for treating serious/severe/complex and chronic psychological conditions. This is simply not sensible nor sustainable, and in fact is irresponsible and re-traumatising. For some illnesses, this will require up to 40 sessions. If sufficient treatment is provided, clients will likely exit treatment and be more able to engage fully and productively in the community, reducing disease burden. Providing adequate and consistent treatment will also reduce the pressure on emergency departments and mental health wards of hospitals.

The Australian Government should not be expecting individual psychology providers to be propping up an underfunded system. This will result in financial distress for providers as well as increased risk of burnout. This is a serious occupational health and safety risk for psychologists and becoming more evident with each passing year and particularly during the COVID-19 pandemic.

5. Simplify the process of accessing a psychologist

It is imperative that we reduce the 'red tape' when it comes to accessing a psychologist. This includes simplifying referrals to registered psychologists, and that of review letters back to referrers, and upgrading the MBS to reduce the burden on psychologists by implementing standardised MHCP forms and referral letters. AAPi is suggesting funding to work with the GP Associations to develop standardised referral letters and forms.

Currently, one of the greatest stressors for psychologists is the regulatory burden of working within the MBS. Psychologists are held responsible for all aspects of referrals and processes being completed incorrectly and face the consequence of repaying their client's rebate when audited. Psychologists are responsible for following up with referrers to ensure that referrals are valid and contain the necessary information and then ensuring that they are reporting back to referrers at the appropriate time in treatment, as well as ensuring their clients return to their referrer for a re-referral for treatment and keeping up to date with changing legislation around the MBS. Psychologists are performing many hours of unpaid administrative work each week

and requiring their clients to reschedule their important treatment appointments in order to be compliant with an onerous, inefficient, and ineffectual system.

Clients are likely to drop out of treatment when they are required to present back to the referrer for review. Additionally, clients are anxious about presenting for a 'review' and confused about whether this means 'do we need to see a different psychologist'. It does not make sense to the Australian public and it is does work for them.

Additionally, making a living wage under the current system is increasingly difficult for the psychologist, considering the many hours of unpaid work coupled with the low rebates and the inequitable lower rebate for registered psychologists.

We would like to see the Medicare administrative burden reduced through upgrading the MBS to include standardised referral forms/letters and reducing reporting requirements and re-referral requirements. The Mental Health Care Plan also requires modifications as its current form provides little value to treatment planning or intervention. A mental health professional is best placed to complete this if it is still required so that psychological risks can be appropriately managed and communicated to other health care providers. AAPi is suggesting funding to work with the GP associations to develop standardised forms and letters to be used, reducing the administrative burden required by both GPs and psychologists.

The online assessment tool as described in the Productivity Commission Report should be investigated and adjusted so that it can be used to facilitate referrals and communication between psychologists and referrers:

> "A new assessment tool, that is consistent with the Australian Government Department of Health Guidance on Initial Assessment and Referral, should be developed and implemented across the mental health system, to ensure a robust and person-centred approach to assessment and referrals."

The model proposed to allow people entry into the mental health system will not hit the mark for all Australians and needs to be modified significantly. Any barriers that are put into place reduce access for the community.

6. Broaden MBS rebatable sessions to psychologists to include prevention and early intervention- not just mental illness

With regards to our call for a prevention focussed approach to mental health care, it is vital that an overarching policy framework or funding strategy be put in place to guide action in the promotion of mental health and prevention of mental health conditions in Australia, like there is in relation to physical ailments.

Australia actively takes a prevention approach with many public health programs including for example women's health regarding breast and ovarian cancer to identify issues early. The same applies to skin cancer by encouraging people to have regular skincare check-ups to avoid dangerous cancer complications by intervening early. We similarly need these

screening and early intervention models to address the escalating mental health crisis in Australia.

We know that nearly half of all Australians (45% according to the Black Dog Institute) will experience a mental illness in their lifetime. It is imperative, particularly with these alarming statistics, that a preventative approach should be the Government's priority for all Australians' mental/psychological well-being, like it is for physical issues.

An area that is significantly underfunded is the treatment of families and couples. This is extremely important to address, as attachment-based issues (those found in couples and families) cause significant lifelong distress for children and other family members. When these issues are addressed earlier through the provision of family-focused therapies or couple therapy, it reduces the severe trauma and distress experienced and felt by children and family members across their lifespan. Many issues seen in children are also best dealt with by implementing family-based therapies as are some disorder types such as eating disorders. Similarly, when families are supported through distressing events such as separation and divorce, then the mental health of children is best protected. We are calling on the Select Committee to fund couple counselling and family work and screenings for early intervention.

Australian and international guidelines recommend children wait no longer than three months for a developmental assessment. There is inconsistency around the provision of these within the school system and many families are required to seek assessments outside of the school system. With families waiting between 12 and 24 months in many cases to seek publicly funded assessments they are going to private psychologists for assessment, without access to any Medicare rebates unless their child is suspected of having Autism Spectrum Disorder.

These assessments are used to identify the underlying cause of developmental delays, assist in education planning and intervention and assist with access to other services such as NDIS.

Families are missing out on the opportunity for early intervention because of these delays. Delaying treatment for a condition such as dyslexia, means that the child falls further and further behind before adequate assessment is completed and treatment recommendations are made. There is increased risk and detrimental effects on the child's confidence and future learning when these important psychological assessments and interventions are delayed.

7. Culturally appropriate services

Psychologists play an important role in contributing to closing the health gap for Aboriginal and Torres Strait Islander people. Services are currently limited and not directed in a way that will have a broad impact for Indigenous Australians. To facilitate more extensive support, the Government needs to fund more psychology positions in Community Controlled Services, not just Aboriginal Health Services. These should extend to include Land Councils, Housing Services and other services that address the social and health gaps for Indigenous Australians. This inclusion of psychology positions could involve more creative partnerships or co-locations that, for instance, provide rooms, incentive payments and/or funding so private psychologists could outreach to communities. Medicare support is required for psychologists to support Youth, Men's and Women's groups using a more flexible model

than one-hour sessions. Trust and cultural safety can be increased when services are provided using culturally relevant approaches and in more appropriate settings.

Another initiative that will improve mental health outcomes for Indigenous Australians is the funding provision for partnerships with Aboriginal Health Workers so that joint sessions with psychologists are able to be provided to promote cultural safety. Medicare rebates for joint family sessions needs to be provided, to assist with establishing strong support relationships and culturally appropriate therapy and care plans.

The range of psychological strategies able to be utilised through Medicare also needs to be expanded to include culturally safe options. The current allowable therapies are inadequate to provide appropriate intervention for Indigenous Australians. We refer to the work completed by the Aboriginal and Torres Strait Islander Healing Foundation (2011) for these appropriate and culturally safe psychological strategies. These strategies are brought forward by the Indigenous Australian Community to promote healing from intergenerational trauma experienced by these communities. Such strategies, in order to implement on a large scale, would also require the training of non-Aboriginal or Torres Strait Islander Psychologists and the co-facilitation of Aboriginal Health Workers to work in these models. Culturally Responsive therapeutic practice with Aboriginal and Torres Strait Islander people is now a core competency for all APAC accredited courses and is a part of the national psychology examination. It requires of the practitioner to work within a holistic framework that should also incorporate a social and emotional wellbeing therapy paradigm and understanding the determinants of mental health. This is an important skill area and should not be overlooked. We would ask for more funding to be provided to allow more education to the current field of practitioners so that there are more culturally safe treatment options available for Indigenous Australians. We would ask that the Select Committee recommend Government funding of such large scale training initiatives as a priority.

We also wish to emphasise the importance to prevention (work in schools, work places and communities), to increase understanding of intergenerational trauma (addressing lateral violence and promoting reconciliation) and to promote healing (in line with Statement from the Heart, particularly supporting a truth telling process).

With 80% of Indigenous Australians living outside the MMM 4-7 areas that allow for permanent telehealth service, universal telehealth access needs to be enabled permanently to allow access to Indigenous Psychologists or culturally responsive psychological services. Indigenous Australians would be disadvantaged without the benefit of telehealth. We also make recommendations regarding service provision to remote communities in recommendation 15.

8. Fund a dedicated preventative/early intervention psychology workforce

Globally, we have a wealth of evidence showcasing that promotion and prevention initiatives play a crucial role in achieving optimum mental health and reducing the impact of mental health issues in society.

Less than 1% of the Commonwealth mental health budget is spent on promoting good mental health and preventing mental health issues among the Australian population. AAPi believes this needs to change. We would like to work together with the Government for greater investment and action in promotion and prevention and the creation of a mental health promotion workforce to undertake this work.

Amid the current Coronavirus pandemic, where we see a rise in stress and distress, the important role preventative interventions can play in promoting and protecting community mental wellbeing have never been more apparent, or more necessary.

To achieve the maximum community benefit, we need to incorporate preventive strategies with mental health care. Psychologists are paramount in this process. Psychologists have a deep understanding of mental well-being and mental ill-health and are equipped to contribute to community wellbeing initiatives. However, what is presently lacking is adequate and dedicated funding to support preventive mental health.

We see considerably more scope for psychologists to become far more active in promotion and prevention across a wide range of areas. A focus on mental well-being continues to grow in importance, both during the COVID-19 crisis and beyond.

Psychologists are already working in these sectors and are very well-placed to advance promotion and prevention efforts in schools, workplaces, universities, and even local Government, in parallel to providing personal supports and services in these settings. More and more sectors will require psychologists as people become aware of the benefits of including a focus on mental well-being. Our emphasis is to unlock the potential of psychologists to reach and benefit people through a broader range of mental health initiatives.

AAPi would like to work with the Government and other stakeholders to raise awareness about the importance of promotion and prevention in the mental health field and work with psychologists to build a strong mental health promotion workforce for all Australians' benefit.

9. Establish a 'Provisional Psychologist' Medicare rebate

As of March 2020, there are over 5,500 provisional psychologists available in Australia. Provisional psychologists are at a minimum, four or five-year trained psychologists, embarking on a final period of 'supervised practice', overseen and mentored by a qualified psychologist. They have studied across each of the competencies required for registration and are gaining relevant experience and supervision to meet full registration requirements.

Provisional psychologists have completed more formal study than the vast majority of other allied health disciplines who can provide services under Medicare after their four years of study.

At present, a significant proportion of provisional psychologists engage in supervised employment in an unpaid capacity to meet their requirements for full registration. Given the increasing demand for psychology services and increasing waiting lists to access psychologists, we believe the deployment of provisional psychologists is an ideal solution. This will not only address the provision of an adequate service from a trained psychologist

with the benefit of a supervisor, but to also increase the value of the psychologist in the payment for their valuable services, for which they have invested significant funding to complete their tertiary qualifications and supervision process. Having a 'provisional psychology' Medicare rebate will enable this strategy and its benefits.

In essence, the Australian Government has over 5,500 university trained mental health professionals available at it's fingertips, and this will address the growing need for adequate mental health support that goes beyond the experience of an urgent phone call to a helpline.

We are calling on the Select Committee to support these future mental health experts in their training and development whilst also providing the community with an affordable option for Medicare rebated services. Tapping into our future mental health professionals to support the current crisis is the ideal solution.

AAPi recommends funding for a 'Provisional Psychology Better Access' pilot project before rolling out a wider scheme.

10.Expand the evidence-based approaches able to be used by psychologists.

The current restrictions of psychologists working within the Better Access Scheme to a prescribed and limited list of availability therapies for psychologists is limiting the use of effective interventions to achieve therapeutic outcomes for clients. The current list is limited to the following;

1. **Psycho-education**

(including motivational interviewing)

2. **Cognitive-behavioural therapy including:**

· **Behavioural interventions**

- Behaviour modification
- Exposure techniques
- Activity scheduling

· **Cognitive interventions**

- Cognitive therapy

3. **Relaxation strategies**

- Progressive muscle relaxation
- Controlled breathing

4. **Skills training**

- Problem solving skills and training
- Anger management
- Social skills training
- Communication training
- Stress management
- Parent management training

5. **Interpersonal therapy** (especially for depression)
6. **Narrative therapy** (for Aboriginal and Torres Strait Islander people).
7. **Eye-Movement Desensitisation Reprocessing (EMDR)**

We propose that the list of available therapies be expanded to allow the clinician to use any technique that has adequate Level I, Level II or in some specific conditions Level III evidence.

Psychologists are trained in evaluating the evidence base for the use of therapeutic techniques and need to have the professional freedom to select the best approach for each client independently rather than have restrictions on their treatment.

11.Review the evidence and Government spending on mental health "hubs"

Mental health hubs while attractive to Government, utilise a significant amount of funding, in the order of 400% greater than the cost of attending a private psychologist. The financial investment to establish and maintain these hubs is significant. Generally, there is reported high staff turnover due to low financial renumeration for providers due to their reliance on bulk billed Medicare rebates for practitioners. There is also concerns regarding access to mental health services to those with disabilities, transport issues, or who live a distance away from the facility. Adequately funding the Medicare system to allow clients to choose a mental health clinician in their local area, or via telehealth as required, is the most cost effective and easily implemented strategy.

What is a 'mental health hub'?

It is a health service primarily for people suffering mental distress or disability in which people receive integrated medical and other services in one location. The model of these services has been immensely popular, rolled out across the country (e.g. $14 million for an adult community mental health centre in Townsville) and has attracted very large amounts of funding –the Morrison government will provide a total of $114.5 million for 8 community mental health centres.

The Royal Commission into Victoria's Mental Health System (2018-2021) has recommended that integrated services be provided for the full range of mental health disorders, including those requiring emergency response from (preferably) ambulance personnel and in-patient treatment, however there is scant evidence of either cost effectiveness or beneficial client outcomes.

Development of mental health hubs

The popularity of mental health hubs can be seen as a continuation of the increased funding provision for mental health. Beginning with the Better Access scheme of 2006, which provided a greatly expanded range of mental health treatment services for adults under Medicare, government funding for mental health in Australia has increased considerably.

The perceived importance of early identification and treatment of mental health disorders among young people led to advocacy for increased availability of mental health services for

this group (McGorry et al., 2007). Youth friendly 'Headspace' services first appeared in 2007, rising from 10 centres to 110 in 2019. By June 2018 over 446,000 young people had used headspace services with 2.5 million occasions of treatment delivered (McGorry, Trethowan & Rickwood, 2019). Centres are commissioned through a lead agency and local consortia and have strong support from both sides of politics and in the community. Funding of these centres is either by direct government grant or via Medicare.

Has youth mental health improved as a result?

Despite the large investment of funds and numbers of clients seen, information about the impact of the services on the mental health of young people is surprisingly and unfortunately for evaluator purposes, disappointingly sparse. Certainly, early intervention and expanded provision of services do not invariably have the desired effect on health. Both in Australia and worldwide, increased availability of treatment services has not always reduced the prevalence of mental health disorders in adults (Jorm & Kitchener, 2020).

Hilferty et al.'s (2015) independent evaluation of the effect size of treatments delivered by Headspace services found that it was relatively weak compared to the outcomes for a matched control group. The results were only marginally better than people receiving no treatment. In their study, less than a quarter of Headspace clients showed significant improvement. Even Headspace services' ardent supporters concede that the effect size for improvement in the total sample of patients remains small to modest (McGorry, Trethowan & Rickwood, 2019). One reason offered is that there is only limited funding for alcohol, drug and vocational interventions. This means that the original vision of a fully integrated mental health intervention is not being achieved.

In the wider community, there is evidence that, despite the large scale of the treatments provided, the prevalence of some forms of youth mental disturbance is increasing. Between 1998 and 2014, Sawyer et al. (2018a) found a substantial increase in major depressive disorder, without any marked increase in ADHD or conduct disorder among young people aged 12 – 17. Burns et al (2020) found a small decrease in the mental health of people aged 18 – 24 years beginning in 2013.

Apart from these articles, no other independent evaluations of the impact of a large number of treatment sessions supplied at enormous cost. It is questionable why the Federal and State governments are prepared to spend so much money without establishing whether their preferred intervention model is working. Possibly the idea that early intervention for health issues is always a good idea has become so accepted that funding bodies see no need to question it. Whilst early intervention can be agreed as being important, it does not also equal that any intervention by any model is effective. This is where the evaluation of hubs and service provision on mental health outcomes for affected populations is vital, not just for protecting the public expenditure of tax payer money, but for the importance of wellbeing for our community – hubs need to be able to answer the question of 'are we helping?'

Why might youth mental health decline?

Why might there have been an average decline in the mental health of these age groups despite large scale service provision? There are several possibilities:

- People in this age range are more exposed to specific stressors (e.g., social media) than older groups.
- They may be more affected by socioeconomic factors (limited employment opportunities, high cost of housing) than established adults.
- Services may not be integrated and effective for them.
- Access to alcohol and drug interventions is not adequate.
- They may not attend sufficient numbers of sessions to see any treatment effect.
- The treatment model may not be appropriate for them.

There are a number of criticisms of the quality of the Headspace services (Cavazzini, 2015, Jorm & Kitchener, 2020). Despite the large number of young people attending these services, only a few attended enough visits for a therapeutic impact; 45% attended less than two sessions. Early dropout among young patients may be due to the heavy reliance on CBT intervention with very little interdisciplinary input from psychiatrists, general practitioners or psychologists using other interventions.

The quality or experience of the clinicians delivering services may be inadequate to deal with some of the complex presentations. Indeed, Professor Elizabeth Scott (quoted in Cavazzini, 2015) identified that ".. there were very few experienced staff.." and her comments about the lack of clinicians with expertise in complex syndromes such as borderline, eating, mood and psychotic disorders were supported by McGorry, Trethowan and Rickwood, (2019).

There is anecdotal evidence that the turnover amongst Headspace clinicians is very high, partly due to relatively low pay, but this could not be substantiated with information from the Headspace reviews, that are lacking and therefore unavailable for proper analysis. In a high turnover situation it is very difficult for clients to form a therapeutic bond with their treating practitioner and of all treatment effects this is the one that has repeatedly been demonstrated to be the most significant across all populations in the psychological research studies and literature.

Are mental health hubs cost effective?

Given that the clinical impact of the services delivered by hubs is small, they are unlikely to be cost effective. Hilferty et al. (2015) found that the average cost per treatment session nationwide was $339 in the 2013/14 financial year. Cost of treatment varied widely around this average, reaching $500 at some locations. This variation in costs across locations suggests opportunity to control costs by better management of taxpayer funding. The relatively high cost of the service delivery compared with the low Medicare rebate (currently $87.45) for psychologists in private practice it is hard to justify this expense if the clinical improvement is so small.

Information about the relative performance of Headspace centres per location is lacking. People cannot know whether their local Headspace is one of the more effective ones or not.

Conclusion

Excessive amounts of money are being spent by hubs in pursuit of the worthy goal of addressing the improvement of mental wellbeing for Australians, but it is far from clear that it is effective, justified or should be continued. Further funding to the area should be paused until this is adequately assessed and evaluated.

In addition, detailed and transparent information about employment conditions and qualifications of the clinicians is needed to evaluate the excessively high turnover by any industry standard. Any future evaluation should be both independent and thorough so that readers can assess the performance of individual Headspace locations.

12.Cease discrimination of psychologists without clinical endorsement in areas including but not limited to employment opportunities, scope of practice and funding

Psychologists practice within their scope of experience as per their Code of Ethics and registration requirements. All psychologists must complete APAC accredited degrees to qualify for national registration. These courses must teach the same set of core competencies. Psychologists may then diversify their practice into different areas of psychology such as forensic or educational/developmental by attending specific training, engaging in further study, or gaining employment and experience in certain areas. For example, typically forensic psychologists were drawn to working in the justice system; clinical psychologists were drawn to working in hospital and psychiatric settings; educational and developmental psychologists were drawn to working in schools or working with people along the lifespan. The current two-tier system has erroneously confused area of interest with area of competency.

All psychologists complete a minimum six-year sequence of education and training. To become registered and be able to use the title 'psychologist' they must complete one of the following programs:

- An approved postgraduate degree (such as a two-year Masters in one of the 9 areas of endorsement) or higher (such as a three or four-year Doctorate); or
- A 5+1 internship program (a fifth year of study and one year of on-the-job supervised practice); or
- A 4+2 internship program (two years of on-the-job supervised practice). This pathway will cease in 2027.

The Psychology Board of Australia (PsyBA) currently recognises 9 areas of practice endorsement within the psychology profession. These include;

1. Clinical neuropsychology
2. Clinical psychology
3. Community psychology
4. Counselling psychology
5. Educational and developmental
6. Forensic psychology
7. Health psychology

8. Organisational psychology
9. Sport and exercise psychology

According to recent statistics provided by the PsyBA (March 2020) there are 31,633 registered psychologists in Australia.

- Out of this number, only a third, 9520 clinical psychologists, are currently eligible to provide a higher two-tier Medicare rebate.
- The remaining 22,113 psychologists are eligible to provide a lower Medicare rebate.
- Of those on the lower rebate, 4,101 psychologists are endorsed in areas other than clinical psychology. These endorsements represent their area of interest rather than the confusing misinterpretation that endorsement equates to guarantee of specific competency.
- Additionally, most registered psychologists (56.94%) do not hold an area of practice endorsement as it was not professionally relevant or required and was not scientifically demonstrated to bear any relevance to professional practice, client outcomes, or client satisfaction.

Additionally, the current flawed endorsement system was further perverted by a loophole of grandfathering members of various interest groups into endorsement when no such additional education was ever undertaken. Previous research found 30-40% clinical psychologists did not have the further education and were grandfathered just by being part of the APS Clinical College.

This means that a significant number of psychologists who are endorsed as clinical psychologists do not hold the academic qualifications required for clinical endorsement (as per current requirements). Many of these grandfathered clinical psychologists have less academic qualifications than many registered psychologists. This presents a scenario where the Australian Government currently enables psychologists with less experience and less qualifications to receive/provide a higher rebate than the vast majority of psychologists who have more experience and more qualifications.

We believe it is unjust and unreasonable that psychologists who have completed a prodigious amount of education, training, and supervised practice cannot provide an equal rebate to their clients simply because they are not clinically endorsed. In most professions, experience is valued and respected. For instance, Judges are concerned with what an expert witness such as a psychologist can demonstrate about their experience with a client group, rather than simply what tertiary other qualifications they have. In other words, the number of clients they may have treated and their outcomes may carry more weight than tertiary qualifications with less or almost no practical experience.

Many psychologists have completed the same Australian Qualifications Framework (AQF) level of training (or higher) as clinical psychologists and use the same psychological assessments, therapeutic approaches, and work with the same client populations in the assessment, diagnosis, and treatment of all mental health conditions, complexities and severities.

Active Continuing Professional Development (CPD) and recent work experience are the best predictors of a psychologist's recent skill set. This does not limit, and neither should it, the

ability of the psychologist to work in other workplace settings. The skills of a psychologist are generalisable across workplace settings as the fundamental core competencies are met via tertiary studies approved by the Australian Psychology Accreditation Council (APAC), an independent quality and standards organisation appointed by Australian Governments under the Health Practitioner Regulation National Law Act 2009 as the accrediting authority for the education and training of psychologists in Australia.

The endorsement system unfairly impacts consumers in rural areas of Australia disproportionately. As you move further away from urban areas, the number of clinical psychologists decreases. With applications for disability pension requiring diagnostic reports from clinical psychologists or psychiatrists (who are even rarer in rural areas) this means that consumers either wait significant amounts of time for access, do not have the opportunity to apply for disability pension or face fees that are unaffordable to obtain this documentation. These discriminatory systems are replicated in many Government (such as Centrelink) and non-government areas and cause significant distress to the consumer of mental health services. That their existing provider, who they may have worked with for a number of years to try to improve their functioning, is now restricted from being able to provide diagnostic reports and a stranger to the client to be their expert simply because they hold the particular endorsement title. For the client, this is harmful and needs to be reversed immediately.

The AAPi would like to strongly advocate that one Medicare rebate system be implemented for clients accessing psychological services. The AAPi simultaneously strongly cautions against the use of area of practice endorsement as a means of restricting client access to services as has recently occurred.

AAPi strongly opposes the endorsement process as an indicator of specialist skills and any additional Medicare rebate as the endorsement process solely measures area of interest and NOT area of competence nor area of practice. This is in fact in contradiction to the Health Practitioner Regulation National Law Act 2009, as there is no specialisation recognised in Psychology. AAPi firmly believes the Australian public deserves accessible, affordable, and equitable mental health care.

All registered psychologists can treat the full range of mental health conditions from mild to severe and complex. ***The treatment provided should be the only reason for applying a Medicare rebate, not the endorsement of the practitioner, and government funding should reflect this reality.***

13.Prioritise key prevention and early intervention settings such as schools and workplaces

AAPi proposes the provision of psychologists into schools at appropriate levels and proportionate to the number of students present. Teachers are currently reporting high levels of stress and lack of support in the classroom. Intervening with an appropriate level of care for children with high support needs at this early stage will reduce the need for treatment throughout the lifespan.

We need to have this treatment available and accessible at schools so that parents are not having to deal with the barriers to treatment such

as time off work, additional costs, and school absences. Currently where there are funded school psychologist positions, their roles often focus on educational assessments rather than prevention, therapy or wellbeing. We would like to see this changed so there are dedicated psychologists at each school that can service the mental health needs of the children and adolescents.

Another area for key prevention and early intervention is into the workplace. As suggested in the 2020 Productivity Commission Report, Australian, State and Territory Governments should amend Workplace Health and Safety arrangements in their jurisdiction to make psychological health and safety as important in the workplace as physical health and safety. This may be accomplished by adopting the new International Standard for Psychological Health and Safety in the Workplace (ISO 45003).

Workers compensation schemes should be amended to provide and fund clinical treatment and rehabilitation for all mental health related workers compensation claims for up to a period of 6 months, irrespective of liability.
The introduction of no liability treatment for mental health related workers compensation claims will allow more people with workplace injuries to receive early intervention services. A focus on mentally healthy workplaces to help engage people in the workplace and protect their mental health, including mental health in workplace health and safety and reducing psychological hazard for those deemed at risk.

14.Over reliance on medication

There has been a very large increase in prescribing of psychiatric drugs within primary care. We are concerned this has occurred due to the more frequent consultations that clients are required to have with medical practitioners. The red tape involved in the Better Access system, requires the client to return to their medical practitioner every few months. 86% of the prescription of mental health drugs in Australia is done by General Practitioners. Requiring consumers return for repeat reviews with their GP may be playing a part in the high incidence of mental health prescription and worsening mental health of Australians. We acknowledge the use of medications in some cases is helpful but there is strong evidence that psychological treatments provide better recovery options with less side effects.

Whitely (2021) writes "the reality for most Australians seeking mental health help is a visit to the GP, a drug prescription – most often an antidepressant-and a bit of a chat about possible side effects if you are lucky." Medicalising mental health has caused a large increase in health-related problems in the community. Health effects range from weight increase, diabetes, metabolic syndrome, heart attacks, falls, birth defects, addiction, sexual dysfunction and sleep disorder to very strong withdrawal effects. Australia has seen increasing rates of antidepressant prescription to young people despite US FDA warnings about a link between antidepressant use and suicidal thinking and behaviour. Australia has then seen a rapidly rising rate of suicide among young Australians.

The Productivity Commission has also noted this as an issue across the lifespan, not just with youth. In their report in 2020 they made recommendation for an online referral portal to be

established to reduce the over-medicating of mental illness in Australia and assist GPs to make informed decisions about treatment that was most appropriate to the consumer. We see the logic in this recommendation but do not think it goes far enough to address this issue.

We wish to support the importance of GPs in the care of their patients, there are many health conditions that mimic a mental health disorder and it is important to continue health assessments to rule out organic causes. Increasing ease of access to psychologists would assist in the reduction of psychiatric medication prescribing. Allowing flexible options (self-referral, referral by other practitioners such as school counsellors, mental health nurses or social workers for example) for referral will also reduce the need for medical intervention into mental health unless absolutely necessary.

There is a trend of medicating mental health issues and more money needs to be put into providing psychological services to the public. Psychological intervention is well established as being as effective or more effective in reducing distress and mental ill health, yet still gains inadequate funding in Australia. Allowable funded treatment is capped at inadequate levels to allow for full benefit. This needs to be immediately rectified.

15.Incentives for rural and remote psychologists- similar to GP's

Currently, the two-tiered system acts to limit or reduce the public's ability to see the psychologist of their choice in both practical and financial terms. Firstly, given that most psychologists operating in regional and rural areas are registered psychologists, their clients cannot receive affordable treatment as their urban counterparts, because a registered psychologist currently is only eligible to apply a lower rebate for their clients. Conversely, the majority of psychologists who hold an endorsement in clinical psychology, are located in urban areas. It was previously shown that this endorsement erroneously entitles clinical psychologists to provide a higher rebate amount to their clients, who are more likely to also reside in urban areas.

The two-tiered system also disadvantages people from culturally and linguistically diverse communities (including Aboriginal and Torres Strait Islanders), that often desire to access psychological services from bilingual/multilingual and culturally competent psychologists (Tan & Denson, 2019), yet if their treating psychologist does not hold an endorsement in clinical psychology, they too are subject to the same lower rebate.

While rural and remote communities in MMM areas 4-7 are able to access telehealth services, clients can struggle with access to internet and phone services. More psychologists would be drawn to work in rural and remote communities if there were financial incentives to provide these services, as there are with GP's.

Indigenous psychologists working from an Aboriginal Medical Service, where all services are bulk billed, have to choose between taking on excessive client numbers or leaving altogether because their practice is unviable. Many stay because of cultural connections, but this trend sets up a perpetual problem for Psychologists working in these communities and the community who then have a high turnover of providers as psychologists leave due to burnout or financial insecurity. This is also seen in Rural and Remote areas of Australia as there is no incentive for psychologists to stay long-term.

AUSTRALIAN ASSOCIATION of PSYCHOLOGISTS INC
a true voice for psychology

In order to attract providers to service Rural and Remote communities there needs to be adequate funding to allow for practitioners to bulk bill sustainably. This will require not only an increase to the rebate for psychological treatment to a minimum of $150 for all psychologists and bulk billing or rural service incentives to not only attract but retain providers in these communities so that continuity of care can be provided. Currently bulk billing and rural service incentives are provided for General Practitioners and rural loading is provided for under NDIS funding. This needs to be expanded to psychologists working within Medicare.

AUSTRALIAN ASSOCIATION of PSYCHOLOGISTS INC
a true voice for psychology

References

Burns, R. A., Butterworth, P., & Crisp, D. A. (2020). Age, sex and period estimates of Australia's mental health over the last 17 years. *Australian & New Zealand Journal of Psychiatry*, *54*(6), 602–608. https://doi.org/10.1177/0004867419888289

Hilferty, F., Cassells, R., Muir, K., Duncan, A., Christensen, D., Mitrou, F., Gao, G., Mavisakalyan, A., Hafekost, K., Tarverdi, Y., Nguyen, H., Wingrove, C. and Katz, I. (2015). Is headspace making a difference to young people's lives? Final Report of the independent evaluation of the headspace program. (SPRC Report 08/2015). *Sydney: Social Policy Research Centre*, UNSW Australia

Jorm, A. F. (2011). Australia's Better Access Initiative: Do the Evaluation Data Support the Critics? *Australian & New Zealand Journal of Psychiatry*, *45*(9), 700–704. https://doi.org/10.3109/00048674.2011.604302

Jorm, A. F., & Kitchener, B. A. (2020). Increases in youth mental health services in Australia: Have they had an impact on youth population mental health? *Australian & New Zealand Journal of Psychiatry*, 000486742097686. https://doi.org/10.1177/0004867420976861

McGorry, P.D., Purcell, R., Hickie, I.B., and Jorm, A.F. (2007) Investing in youth mental health is a best buy. *Medical Journal of Australia* 187: S5–S7. doi: 10.5694/j.1326-5377.2007.tb01326

McGorry, P., Trethowan, J., & Rickwood, D. (2019). Creating headspace for integrated youth mental health care. *World Psychiatry*, *18*(2), 140–141. https://doi.org/10.1002/wps.20619

Pirkis, J., Ftanou, M., Williamson, M., Machlin, A., Spittal, M. J., Bassilios, B., & Harris, M. (2011). Australia's Better Access Initiative: An Evaluation. *Australian & New*

Zealand Journal of Psychiatry, *45*(9), 726–739. https://doi.org/10.3109/00048674.2011.594948

Sawyer, M. G., Reece, C. E., Sawyer, A. C. P., Johnson, S. E., & Lawrence, D. (2018). Has the Prevalence of Child and Adolescent Mental Disorders in Australia Changed Between 1998 and 2013 to 2014? *Journal of the American Academy of Child & Adolescent Psychiatry*, *57*(5), 343–350.e5. https://doi.org/10.1016/j.jaac.2018.02.012

State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Summary and Recommendations, Parl Paper No. 202, Session 2018–21(document 1 of 6).

Twenge, J. M. (2020). Why increases in adolescent depression may be linked to the technological environment. *Current Opinion in Psychology*, *32*, 89–94. https://doi.org/10.1016/j.copsyc.2019.06.036