

Mental Health inquiry
Productivity Commission
GPO Box 1428
Canberra City ACT 2601



16 April 2019

Re: Productivity Commission - Mental Health Inquiry

Dear Chair,

Thank you for the opportunity to provide a public submission to the Productivity Commission in relation to the Mental Health Inquiry. The following submission is made by AusPsy, a not for profit organisation set up to respectfully support the ongoing needs of psychologists in collaboration with the other mental health professionals who provide psychological services. AusPsy strongly supports the right of all Australians to have collaborative, accessible, equitable and quality care that includes having the choice of their own provider and the participation of stakeholders.

AusPsy embraces the World Health Organisation's definition of mental health wellness as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is from this definition that AusPsy bases the recommendations in this submission. Our responses in this submission draw from the British Psychological Society's Power Threat Meaning Framework (PTMF). The PTMF was developed as an alternative to psychiatric diagnosis which is now widely accepted to have significant conceptual and empirical limitations (Johnstone et al., 2018). In addition, our responses draw on decades of research performed by the European Federation of Psychologists' Associations (EFPA) on behalf of the 34 European countries who sought to identify a more viable mental health workforce solution in Europe.

Sincerely,

On behalf of the members of AusPsy,

Caroline Ooi
Psychologist & Director
AusPsy Ltd

Executive Summary

Psychology Workforce

Australia has a large and capable psychology workforce that is committed to the welfare of the Australian public. It has strong potential for future growth that should be nurtured to meet the demand for skilled professionals working in the mental health care sector. Regardless of their training pathway, all registered psychologists in Australia are trained in providing assessment and treatment to those with/or at risk of developing mental health difficulties and produce equivalent outcomes.

Psychology is the specialisation and differences between training pathways are minimal and vary according to the level of dominance of the medical model. The medical model of mental health care which presently dominates in Australia is widely accepted to have its limitations and to be incompatible with non-western beliefs and practices. Australia is a very multicultural society comprised of people with diverse beliefs and practices. Diversity in Australian psychology should be nurtured to re-balance the dominance of the medical model in the Australian mental health care system.

It is our contention that the EuroPsy approach to accreditation for psychologists capitalises on the development of expertise of psychologists by virtue of their training and experience gained in workplaces. In their communications with stakeholders, the APS, APAC and the PsyBA have acknowledged that they are implementing their own version of the EuroPsy model. A substantial amount of research went into the development of EuroPsy and in failing to implement the EuroPsy model in its entirety they are failing to implement key aspects of the model that ensure public protection and eliminate the workforce issues within the profession.

The EuroPsy approach fairly acknowledges the competencies and scope of practice of all psychologists. Under EuroPsy there are no general psychologists. This term is misleading. All psychologists develop a specific set of competencies within a certain area of psychology practice. The EuroPsy model affords better protection to the public, is less confusing to the public and allows them to make more informed choices about their treating professional. In addition the EuroPsy approach creates greater flexibility for psychologists to change their field of practice which aids in burnout prevention and workforce retention.

Integrated and applied psychological practice can be preserved through revisions to the national law, reforms within the Psychology Board of Australia, and the prevention of restrictions that are being placed upon scope of practice in relation to area of practice

endorsements. We ask that the Minister urgently review these issues within the psychology profession. We recommend that Australia follow the EuroPsy approach to training and accreditation in psychology in its entirety and endorse an area of practice to every psychologist by virtue of their competencies developed through training and experience in practice rather than solely the APAC accredited qualification model they have completed.

Preventative, Integrated and Community-based Care

Mental health care in Australia is dominated by the westernised medicalised diagnostic and treatment services and reactive approaches. There are no quick fixes to enhancing the wellbeing of a population. Better safeguarding policies and more appropriately placed funding to enhance the Australian populations quality of life are needed. This is a valuable opportunity for us to reform our mental health systems and to be an international example of best practice in mental health care that is resilience building, culturally sensitive and provided in the least restrictive manner. We call upon the Health Minister to improve the quality of mental health-related data reporting and to implement Australia-wide projects to monitor the barriers to care and the strategies to address them.

Human functioning is enhanced when the person-environment mismatch is reduced and personal outcomes are improved. Because such functioning is multidimensional, considering supports as a means to improve human functioning provides a structure for thinking about more specific functions of support provision. Comprehensive community health supports are consistent with the definition of health as a state of complete physical, mental and social well-being and relate to accessing high quality and affordable health care, based on self-determination and respect. Understanding how risk factors interact across the lifespan is also essential for the design of effective prevention supports. An effective health supports system provides accessible, affordable and acceptable care that incorporates the principles of holism, normalisation and self-determination and has a functional and support needs basis.

It is important that we establish a clear consensus on operational definitions of any meaningful aspect of mental health indicators, mental health services and patterns of care to be used in routine data collection. This includes having a clear and universal consensus of stepped care. AusPsy advocates for a system which is client centred and which allows for continuity of the therapeutic relationship. AusPsy therefore recommends that stepped care be based on the intensity of need along the continuum of wellbeing rather than the use of clinical labels and qualifications of the treatment provider.

Integrative care is whole of person, collaborative and client driven. AusPsy argue that mental healthcare in Australia has continued to be based upon a unidimensional system of support and that the multidimensional system required for truly integrated care has not yet been introduced in Australia. We ask that the Government commit to promote the participation of all stakeholders in service planning, monitoring and delivery at all levels of care and to promote user-friendly access to mental health care that is in agreement with the service users illness models and expectations.

Creating systems of care that involve layers of administration is expensive and does not directly equate to the provision of quality care. Before the Australian Government considers increasing funding to mental health hubs, that restrict consumer choice and create layers of administrative burden, it should ensure that it has properly attempted to provide integrated care within our currently funded system. Introducing a conceptual framework based on the intensity of support needs as defined under a multidimensional framework of human functioning within our currently funded systems, will not only provide more person-centred and comprehensive care but will go a long way towards bridging the gap between the professionals working within mental health and between the mental health care system and the supports provided for mental health under NDIS.

AusPsy propose an integrated care model that is community-based, makes use of the existing funding streams and workforce and incorporates stepped care by virtue of the intensity of support needs of the individual who is experiencing mental distress. Within this model we make recommendations for team care arrangements, funding and session allowances. We believe that the GP should remain as the principle coordinator for the provision of specialist care. We recommend that available funding for mental health be increased and that session numbers should also be increased for those whose treatment team determine that they have high support needs. To meet with acceptability of care and the service users illness models and expectations

Our intention behind our proposed model is for it to be enacted by a system of enhanced supports for those with mental illness, rather than, as some have proposed, a system of restrictions based on an arbitrary hierarchy of providers. In this manner when a person's support needs are higher they have greater access to providers. They also have the benefit of regular and paid collaboration between their treating practitioners to enhance the care of their complex and severe mental health concerns. We propose an integrated care model that does not need to be co-located, but is always consumer focussed and non-restrictive.

An emphasis in our model is on greater choice and control over the services and supports consumers receive that mirror that which is provided by the NDIS. All consumers have the right to choose their mental health support team, whether that contains informal supports such as friends and family or whether it contains Social Workers, Occupational Therapists, Mental Health Nurses, Psychiatrists, Support Workers or Psychologists. Consumers should be the drivers of their mental health treatment and have ease of access to whomever they choose. We emphasise the importance of self-determination as an essential component of Mental Health Care. The restriction of providers and differentiated rebates to consumers does not achieve this goal of self-determination. All mental health provider services should be appropriately funded at the same rate to allow consumers flexibility and the ability to choose the best provider to suit their need.

It is recommended that GP mental health plans are no longer required to have a diagnosis of a mental disorder to enable the individual to access treatment. It is more appropriate that a quality of life and supports intensity measure be utilised to assess the need for referral and to monitor progress and outcomes. It is requested that the Government consider providing AusPsy with funding necessary to undertake joint research with the Australian Association of Social Workers to develop an appropriate measure of individual support needs that can also be used to assess and monitor outcomes at the individual and population health level.

Enhancement of Mental Health Through Workforce Contribution

Psychology as a Profession

Australia has a large and capable psychology workforce with strong potential for future growth. All registered psychologists in Australia have undertaken a rigorous registration program of a minimum of six years of training. All psychologists are also required to complete mandatory professional development and ongoing supervision for annual re-registration. Registration as a psychologist in Australia provides all psychologists with the right to practice psychology within their self assessed scope of competence. As professionals with highly developed critical, analytical and reflective skills, psychologists target their ongoing professional development to meet the needs of the specific population in which they provide psychology services. Compared with other health professionals, there are very few complaints made in relation to the psychology profession.

Structural Weakness in the Psychology Workforce

Psychology is a multifaceted discipline with a shared foundation of scientific knowledge and methods and a shared commitment to the welfare of others. It is comprised of various sub disciplines and fields of practice which service individuals, families, organisations and communities. The diversity within psychology is both its strength and weakness. It has allowed psychologists to integrate well within other discipline areas and fields of practice but it has also facilitated unhelpful divisions within the profession. To the detriment of its workforce and its shared commitment to the welfare of others, the profession has been vulnerable to exploitation.

Due to the politicism and dominance of some within psychology in Australia over the last couple of decades, Australian psychologists without clinical endorsement have increasingly been arbitrarily denigrated and obstructed from exercising their complete capabilities to provide mental health support to the community. These tensions have been compounded by medical lobbyists and the dominance of the biomedical model in the Australian mental health system. In response to similar concerns, many European countries including the United Kingdom, have already sought to enhance and re-diversify their psychology workforce in order to shift the balance of mental health care to more integrated practices. In contrast, the dominance and misrepresentation of psychologists with clinical endorsements as specialized within Australia has created a narrow focus of mental health care that is biomedically driven and lacks diversity. As a

result, the majority of highly skilled and experienced integrative and applied psychologists, who utilise evidence based psychological practices in a manner tailored to individual needs, are on the verge of becoming functionally “decommissioned”. This is an enormous cost to the Australian community as it would lose a highly skilled workforce of registered psychologists with their knowledge and practice experience. It would arbitrarily and unnecessarily increase the costs of psychological care by reducing the number of functional psychologists and work against the Government’s intention to increase access for consumers rurally and regionally as well as embedded within a consumer’s local area.

There are two methods being utilised to decommission Australian psychologists without endorsement in clinical psychology. The first is through what we believe to be a misapplication of the provision made in the National Law for endorsements. There are unnecessary restrictions placed on the obtainment of, or recognition of an Area of Practice Endorsement (AoPE). The current endorsement of divisions within psychology in Australia and the subsequent training and accreditation pathways to these endorsements, discriminate and restrict psychologists from practicing, developing and obtaining recognition for their skills. For a detailed explanation of these issues and how they impact upon the Australian public, please see the AusPsy submission to the PsyBA <https://auspsy.org.au/submissions/>. The second is through the arbitrary restrictions that are being placed upon the scope of practice of psychologists without an area of practice endorsement in clinical psychology. This unethically restrains the majority of psychologists from providing the best therapeutic approaches in which they are trained. A flow on effect is that they are increasingly prevented from providing publicly funded services. This is what we mean by the claim, psychologists are being “functionally deregistered” and unable to practice their profession.

Australian based research has not supported the claims that psychologists who have an AoPE in clinical psychology have superior training and skills in assessing and treating mental health conditions (Pirkis et al, 2011). The equivalence of training content and competency outcomes across clinical, health and counselling psychology training was acknowledged by the European Federation of Psychologists’ Association (EFPA) (Lunt et al., 2015). In addition, after some resistance and a thorough investigation, the EFPA rejected clinical psychology as a proposed area of specialisation and concluded that psychology itself was the specialisation and advanced areas of practice certificates to recognise those with further study, research and supervisory experience, could only be issued for psychotherapy or organisational psychology. This is not the standard to which recognition for advanced level of study is being held to within Australia.

Unfortunately the Australian Health Practitioner Regulation National Law (2009), which makes distinctions between specialisations in Health practices and endorsements, is being used by some members of the Psychology profession in a manner, we submit, that was not the intention of the legislation. It is being used to lead the public and other health professionals to believe that there are specialist titles in psychology. Psychology is the specialisation and it is not available to psychologists under the National Law to claim to be a specialist. There are also now pressing concerns that these members have been making concerted efforts to dominate funding only towards psychologists who have undertaken a clinical psychology, Australian Psychology Accreditation Council (APAC) approved post-graduate course. This has been achieved by populating the Boards of the regulator and the training accreditor with representatives of, or associates of the small group, in a manner and matrix not seen in any other area of AHPRA regulated professions. The claims of separation of powers between key associations, regulators and course accrediting bodies need to appear to be so, rather than them simply making statements to be so. In other words, because of their powers at law, there needs to be a very high standard of separation applied such that there is face validity of the separation. This means there should be a much more diverse board for each of these bodies than is currently the case.

There are 24,000 psychologists registered to practice psychology in Australia who have not participated in an APAC approved postgraduate qualification leading to an AoPE and until recently have not been asked to do so in order to continue to practice their profession. Many of these psychologists have participated in masters and doctorate level studies in psychology based subjects and their associated fields of practice that have not been APAC accredited. Many psychologists have chosen to do this as a result of the limited availability of APAC approved courses and/or the lack of relevant and industry specific content provided by the APAC approved courses, particularly for practicing psychologists who are already working within the field.

A Personal Account of a School Psychologist

I have worked as a school psychologist for 5 years. Before this I worked and trained as a psychologist with children and adults in the disability sector. I live in NSW where there are no APAC approved courses in Educational and Developmental psychology so pursuing this qualification and AoPE endorsement has never been an option for me. I also have a young family and my husband is a small business owner so relocating or fly in fly out was not a choice either.

A few years ago I noticed some legislative and funding changes within the education and disability sectors that favoured endorsed Educational and Developmental Psychologists and even Clinical psychologists. I suddenly felt increased pressure to obtain an endorsement. I tried to look at alternate pathways to achieve endorsement as an Educational and Developmental Psychologist and couldn't find any. Instead I came across an online Masters in Education specialising in student wellbeing and mental health through Flinders University. Whilst this wasn't an APAC approved course to enable me to use the title of Educational or Clinical Psychologist, the course content had real-time industry currency and I

knew it would be of relevance to me in my role and therefore to the school in which I work.

Aside from the fact that APAC courses in Educational and Developmental Psychology don't exist in NSW, the qualifications framework for these courses are actually developed for psychologists with no training or experience working as a school psychologist. If I was starting out in my training then the APAC approved course content would be beneficial but the competencies they measure I had been assessed in when I undertook the flexible training pathway to registration through the PsyBA under an approved supervisor. Participating in the current APAC training would simply be a costly and time consuming exercise to obtain a certificate that provides me with a title. At this point in my career, the training I require is much more than this qualification can offer.

My MEd is delivering the most current research in the field of educational psychology and is in alignment with the National Association of School Psychologists USA (NASP) competency framework. With the education policy changes in Australia moving towards that which are in place in the USA I find the NASP training model much more up to date with the Australian education system than the 2019 update to the APAC qualification framework. APACs qualifications framework for already practicing school psychologists and AHPRAs inflexibility to acknowledge alternate pathways to AoPE and advanced study in psychology are failing us as professionals and the specific industry areas of psychology in which we work.

The issues highlighted within the personal account of a school psychologist do not appear to be unique to psychologists working in schools. Other fields of practice in psychology report similar concerns. For example, to meet industry specific need, Organisational Psychology courses are being replaced with unrecognised Business Psychology courses. Universities are claiming that there is industry demand for the courses but they are simply not prepared to provide the postgraduate psychology courses prescribed by APAC leading to AoPE. As a result, post-graduate courses leading to registration and AoPE other than clinical psychology are continuing to close. Online APAC post-graduate courses are not being made available. Experienced registered psychologists applying for APAC post-graduate courses are being advised that they must redo their undergraduate degree if it is more than ten years old and the cost to currently undertake a postgraduate course is \$60,000. With a professional workforce comprised mostly of women in their 30s to 40s, who exceed the undergraduate threshold, the pathway to area of practice endorsement is not viable. Proposed changes made in 2018 to the area of practice endorsements and qualification criteria do nothing to address these issues. The reasons for this are unknown but AusPsy has noted a lack of advocacy for change from influential groups.

A Personal Account of an Psychologist who post-registration and years of practice undertook an APAC accredited post-graduate course in clinical psychology:

I'm a psychologist registered without endorsement. Last year given the push for clinical endorsement I enrolled in the clinical masters at Sydney university. I observed lecturers repeatedly tell us that we are the elite, studying at the best university in Australia and that we are studying masters level clinical training so will be the most experienced and best qualified to practice psychology. After 6 months, I had learnt nothing and had students asking me questions about the 'real world' that the lecturers were unable to answer. That includes placement. In the end, I felt I was wasting my time and I withdrew from

the program. The lesson I have learned from this and in providing placements to clinical psychology registrants within my practice is that psychologists without an AoPE do not have inferior skills and training to a clinical psychologists.

Psychology Registration & CPD

Psychology has a well regulated registration program that requires continued professional development (CPD). Whilst other industries recognise CPD as a form of upskilling and advancing professional practice, psychology within Australia fails to do so. In addition, psychology in Australia applies an annual CPD and re-registration cycle. AusPsy believe that years of practice and professional development in psychology should be recognised and that the annual CPD cycle should be evolved towards the three or five year re-registration and CPD cycle employed across Europe and other leading industries here within Australia. There are merits to psychology taking this more lengthy re-registration and CPD approach which values a deep learning rather than surface learning process and is less onerous on the regulator administratively.

Recognition of Prior Learning (RPL) in Psychology

Unfortunately many psychologists who have graduated and been working in the field of psychology and even those who have undertaken doctoral level studies in psychology are ongoingly refused an AoPE. EuroPsy distinguishes between two ways of assessing competency in a field of practice. The PsyBA only undertake one of their methods of assessing competency which they refer to as prospective. Prospective assessment of competency refers to activities that commence at the start of practical work. EuroPsy's retrospective processing that the PsyBA fails to implement includes work history such as a resume, portfolio and references.

Stress & Burnout in Psychologists

Stress, burnout, compassion fatigue and vicarious trauma are significant wellbeing concerns for all professionals who work in mental health. The wellbeing of mental health workers is often strained by excessive workloads, long working hours, low pay, overnight shifts and personal safety risks on top of the emotionally demanding nature of the work. In addition, there are challenges contributing to stress such as, the lack of positive feedback within the profession, stigma towards the profession and demanding and difficult relationships with clients and other professionals who may themselves be suffering from job related stress. Client suicide is another specific stressor that has major implications on the mental health of the treating professional.

Mitigating factors in preventing stress and burnout in mental health workers are identified to be job autonomy and social support (Kim & Stoner, 2008). The majority of community-based mental health professionals are self-employed and working in a private practices alongside other health professionals. It is vital that Government continues to fund rebates for these professionals services. The flexible working conditions that private practice provides within a female dominated profession, together with the collegial support of other health professionals, is a popular and mentally healthy work structure.

Currently much of the Australian psychology workforce are reporting significant amounts of distress caused by influential mental health lobbyists and lack of action from some representative bodies to preserve them within their profession. Many of these psychologists are already reporting a reduction in the means by which they secure an income. For others the continual denigration, and lack of recognition of their skills, without due cause, is having a very negative impact on their wellbeing. Many experienced professionals who have already been blocked from areas in psychology which they previously provided services, have commenced pathways to new employment in other fields of work. Others who advise that they are feeling a sense of helplessness and hopelessness report that they are currently identifying alternate career pathways. When asked whether they will try to secure a place on a course leading to an Area of Practice Endorsement many state that even if they were able to secure one of the few course positions that are available, there are other factors that would prevent them for undertaking it such as the need for an income.

At a time when mental health problems are on the increase and there is a workforce shortage the ongoing restrictions on competent and skilled psychologists are counter productive and non sensical. The EFPA suggested that psychologists often tire from their area of practice after ten years due to boredom or burnout and that losing them from the field altogether was unnecessary and a loss of valuable skills. They rectified these issues for practicing psychologists within the EuroPsy training and accreditation model which emphasises supervision and competency demonstrated within the workforce rather than requalifying through university based training.

Email to the PsyBA chair from a Psychologist with 13 years professional practice:

Dear Ms Phillips,

Thank you for your input into the difficulties that the psychology profession is currently facing. It is very unnerving for many people. It also feels highly orchestrated, secretive and blatantly unfair that rules seem to be changing without due consideration for a large portion of the workforce to which you refer. Proposed changes are negatively impacting a highly committed and dedicated workforce of the past 15 years plus.

You are no doubt aware of the fractures that are being experienced and the considerable exodus of members from the APS. This may be the reason for your sudden and unexpected email. I am replying because I would like my view and feelings to be known.

I have no issue with altering the structure of qualifications to practice as a psychologist to reflect current times and needs. What I am absolutely opposed to is for these changes to go ahead without recognition that a large portion of the current psychology workforce completed a registration path that ALL relevant bodies determined to be of the highest standard and satisfactory to work with any client group. To all of a sudden decide that this decision was incorrect means that many psychologists have pursued their training requirements based on incorrect information and guidance from those who are meant to be informing us.

Whilst there are many issues in the industry that I am currently concerned about, I will restrict this email to just this point: I was told by all regulatory bodies that the pathway I chose (i.e 4 + 2) in order to work in the field of psychology was sufficient and to the highest standard. I was accepted by AHPRA as a Registered Psychologist. For anyone or any organisation to now suggest that their advice was incorrect, to me, requires further investigation.

Whilst I acknowledge that the political and financial needs in such a large industry are complex, as an offering of a possible solution, may I suggest the following. At the very least, might there be consideration for any changes to the required qualifications to work as a registered psychologist capable and accepted to treat any area of psychology in which they maintain required professional development (as has always been advised) be put into effect from a given future date. This seems only fair and reasonable. To discriminate against those who took the past advice of governing bodies is only going to cause more damage to an already significantly fractured psychology workforce. The ramifications of which are being felt among colleagues more than you might imagine. Just to highlight, there are clinics and workplaces who currently have a range of psychologists and the tension and 'lunchroom' communication has actually at best become needing to be 'managed' and at worst is becoming unpleasant.

Please consider this input. An industry that I love is hurting badly.

Rural, Remote and Regional (RRR) Psychologists

The restrictions being imposed upon scope of practice and the PsyBA and APAC's narrow and inflexible post-registration offerings for psychology training have an even more specific concern for psychologists practicing in Rural, Remote and Regional (RRR) areas. RRR psychologists are predominantly non-endorsed. To complete higher degree courses RRR Psychologists are required to leave their communities and even states to complete APAC approved qualifications as a very limited number of APAC accredited courses are available through distance education and still require supervised practicums and the attendance in person at residential schools a number of times a year.

The divisions in psychology are reported to have already had a significant impact on the ability of RRR psychologists to deliver services to their communities. For example, psychologists had provided Centrelink reports for decades but with the Social Security (Tables for the Assessment of Work-related Impairment for Disability Support Pension) Determination in 2011 these same Psychologists were overnight deemed incapable to write Centrelink reports regarding mental health. No logical explanation or research

evidence showing that psychologists with a clinical psychology background were more capable, was given. Ongoing lobbying against psychologists who are not clinically endorsed, negatively impacts upon rural communities because the majority of their psychologists are thereby restricted in providing funded services that they are perfectly well trained to deliver. The monopolising of public health funds by block funded services are also limiting rural access to treatment. These services are not being delivered within RRR areas. With accessibility to mental health services being an identified key issue in preventing and providing early intervention for mental distress it is important that these issues be addressed.

A personal account of an RRR Psychologist:

I am a non-endorsed female psychologist who has been practicing for 12 years. For the last 8 years I have enjoyed running my own private practice. My training pathway leading to registration as a psychologist and the flexible working conditions of private practice has allowed me to support and be responsive to the needs of my family.

I am located in a low socio-economic area. My referral base is a mixture of Better Access (referrals initiated by consumers, GPs and schools), Open Arms/Defence referrals, Workers Compensation (referrals initiated by GPs, insurance companies and rehabilitation providers) and Private referrals. The demand for services continues to grow and I regularly have to close my books.

I have experience working with victims of crime and providing trauma counselling but unfortunately, due to the two-tier system that is in place, without a clinical endorsement I have to turn these clients away. Despite my experience, I am also prevented from using psychological treatment with Better Access referrals and must instead only work within focussed psychological strategies. This is incredibly frustrating considering I am recognised by Defence and Workers Compensation as having the skill to do so.

I have no shortage of referrals so over the years it has been tempting to refuse to work within the Better Access Model and instead just work with those organisations (or private referrals) that recognise my abilities. I am, however, dedicated to servicing my community and continue to take on Better Access referrals, bulk-billing the majority of them. I was once advised by a clinical psychologist that I could solve my issue of having to close my books all the time by only private-billing and at a much higher rate. I was also discretely advised by another clinical psychologist that if I didn't bulk bill like they did I could guarantee that I get to work with a 'different kind of client' without all the associated issues that come with being on centrelink and drug addiction. Whilst this may be an easy alternative to the complex clients I see, I did not get into this profession to treat the walking wounded and I believe this leaves incredibly vulnerable people within my community without the services they desperately need.

My community has been deeply impacted by Centrelink's investment in the belief that only psychologists with clinical endorsement can assess clients for the disability support pension (DSP). Whilst I used to provide this service I now have to advise clients to see a clinical psychologist or a psychiatrist. In my experience, local clinical psychologists are unwilling to take on a new client for the purpose of assessing for DSP. I had a particularly negative experience with a Workers Compensation client who, after losing his entitlement and needing to apply for DSP became angry that I could not do

this assessment for him and angrily questioned whether I was actually a 'real, legitimate psychologist' and threatened to sue me. He was not in a position to be able to process the politics behind the divisions in psychology.

I am confident in my competencies as a psychologist. My local reputation as indicated by my referrals from GPs and client word of mouth, speak to my skills in practice but if these divisions and denigrations are allowed to continue I will have to consider alternate sources of income.

Telehealth & eHealth Services

Whilst telehealth and eHealth services have potential, the relational nature of psychology means that these services should not be expected to replace the face to face appointments that people may require with a psychologist. AusPsy asserts that online psycho-education can however be complementary and beneficial to some individuals under certain circumstances. AusPsy also asserts that for some individuals telehealth programs could be used to provide mental health triaging services, direct people to beneficial tools and resources, and to provide ongoing monitoring of progress. These services should be delivered in conjunction with a psychologist or other mental health professional in the same way that the Government's Get Healthy program is utilised in conjunction with health professionals such as dieticians.

Enhancement of Mental Health Through Preventative, Integrated and Community-based Care

Preventative Care

Mental health care in Australia is dominated by the westernised medicalised diagnostic and treatment services and reactive approaches. As evidenced by the mental health crisis in this country, our westernised medicalised diagnostic and treatment services and reactive approaches are failing us. Australia needs to proactively develop closer training and research connections with our neighbouring countries and a greater sensitivity to the needs of the Australian population, particularly our Aboriginal and Torres Strait Islander people and communities. This is a valuable opportunity for us to reform our mental health systems and to be an international example of best practice in mental health care.

Whilst many of our well funded evidence-based programmes profess to being preventative care they are more often reactive approaches to assist people who are experiencing early signs of mental distress. Truly preventative mental health care occurs prior to any signs of mental distress. With a push for evidence-based treatment approaches, preventative measures are often overlooked in Government budgets. Their impacts are difficult to empirically quantify but can be measured, albeit more loosely, through population health statistics and quality of life measures.

Many of the proactive and embedded societal structures that are well recognised to increase resilience and reduce mental illness have slowly been stripped away. The lack of funding and out of pocket costs for youth services and arts on top of increased income pressures are just some of the societal changes that are contributing to Australia's poor rates of mental health. Within the diagnostic and treatment context, rather than provide a holistic and integrative healthcare approach, individuals are more often than not, being offered a "quickfix" through the use of pharmaceuticals without being offered the social and emotional support that they need.

Internationally there is a broad consensus on the need to de-medicalise mental health care and replace with community-based models of care that are holistic, de-pathologising and de-stigmatising (Caldas De Almeida & Killapsy, 2011). New models of service delivery and contemporary practice require a workforce that is responsive to changes in how services are delivered, where they are needed, and who can best respond. The workforce must be able to work with families, provide trauma-informed care and work with people from a wide range of culturally and linguistically diverse backgrounds. This also includes further development of a well-integrated peer

workforce across mental health, AOD and suicide prevention (Queensland Mental Health Commission, 2018). With the imminent introduction of Human Rights Legislation into many States and Territories of Australia we need to be mindful that services are provided in the least restrictive manner. Community-based services are associated with greater user satisfaction, better participation in social life, increased met needs and adherence to treatment. Moreover, they promote better continuity of care and more flexibility of services, make possible to identify and treat more often early relapses and allow to fight stigma (Thorncroft & Tansella, 2003).

The most critical Key Performance Indicators (KPI's) for the administration of any mental health service are ease of access, timing of access, type of access and length of access. Whether through Medicare, Headspace, PHN's, other NGO or privately run practices, the system set up of any mental health service must ensure the consumer can easily access, without any delay, the right treatment, with the right clinician(s), for the right length of time. An important aspect of improved accessibility is the implementation of a network of community-based facilities, where the vast majority of patients with mental disorders have access and can be treated. Service accessibility is influenced by three factors: physical accessibility; financial affordability; and acceptability (Boerma et al, 2014; De Silva et al, 2014; Fradgley et al, 2015). Acceptability refers to the psychological, social and cultural factors that may foster or hinder people's willingness to seek services, e.g. personal characteristics of providers, illness models, service organisational rules, provider perceptions of patients' needs and stigma (Barbato et al., 2014). An additional KPI of administrative process is to optimise clinician teamwork and case management. The engagement of social and family network, psychological continuity of care and the responsibility of the entire treatment process by the multi-professional team are important aspects of this process (Seikkula et al., 2006). The Mental Health Reference Group Report of the MBS Taskforce Review aims to have these KPI's met through that system.

Unfortunately, a major impediment in any mental health service is the burden of excessive top-heavy layers of administrative process. Such things impede the KPI's of the system and reduce funds available for services for the consumer. One advantage of Medicare Better Access over PHN's and Headspace is that Medicare does not create its own layered tiers of CEO's, directors and section managers resulting in top-heavy administrative costs. It is in clinicians treating, not administrators administrating, where the real work of effective mental health service provision begins and where the outcomes of service provision are produced. Research on the effectiveness or otherwise of the very expensive Headspace services indicated that only 13.3 percent of their clients experienced a clinically significant decrease in psychological distress. Almost a quarter experienced a worsening of psychological distress and one third

experienced no change. Most significantly, and indicative of the lack of flexibility and cultural sensitivity of the model is that Aboriginal and Torres Strait Islander young people were overrepresented in the group whose distress increased (Hilferty et al., 2015).

Stepped Care

Based on an online search and literature review of available information on how stepped care is conceptualised across Government departments, and across disciplines both within Australia and internationally, there appears to be no clear consensus of definitions of levels of severity within stepped care. This not only raises questions about the models of care that are in operation but also the mental health-related data that is being reported. A scientific paper commissioned by the European Union interestingly reported similar findings (Barbato et al., 2014).

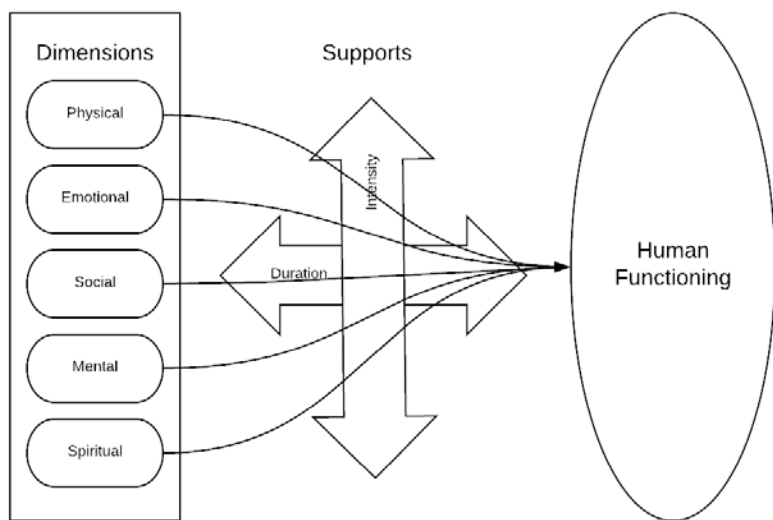
Mental health assessments in psychiatry and clinical psychology are typically based on clinical labels of diagnosis and diagnostic severity. Professionals who adhere to a medicalised concept of mental health appear to also be defining stepped care within the context of their diagnostic labels. This approach to mental health care is problematic and counterproductive to collaborative and culturally appropriate service delivery. Not all members of the Australian public and not all mental health professionals subscribe to a diagnostic conceptualisation of mental health. They are also now widely accepted to be an overly westernised and empirically flawed approach that is stigmatising and has had a disturbing history of human rights violations (Human Rights and Equal Opportunity Commission, 1995).

Whilst clinical labels have historically been helpful in communicating a language between mental health professionals and directing people to specific services they have also not been helpful for making decisions about distributions of service funding. A consumer focused and de-stigmatising conceptualisation of stepped care is required so that a common language across all disciplines that aids in collaboration between all stakeholders can be successfully implemented. AusPsy proposes that classification decisions and funding distribution should be based on meaningful assessment information and planning procedures related to the purpose of developing support systems. These systems should be allocated to the intensity of support needs along the multidimensional construct of wellbeing.

Whilst some organisations are presenting stepped care models that are conceptually based upon clinical labelling and are using this to restrict consumer access to their chosen provider, we propose that it was not the Government's intention for stepped care

to be used in this manner. Rather we propose that it was the Government's intention to present stepped care as a system of enhanced supports for those with varying degrees of mental distress; to improve the mental health care system so that when support needs increase consumers have greater access to providers and collaboration is a regular, paid process to enhance the care of those with complex mental health needs.

The construct of mental illness belongs within the general construct of wellbeing that has evolved to emphasise an ecological perspective that focuses on the interaction of the person with his or her environment and the recognition that the systemic application of individualised supports can enhance human functioning and wellbeing. This changing understanding of mental health from mentally ill to a state of functioning represents a paradigm shift from a view of mental illness as an absolute trait expressed solely by an individual - a disorder, to an expression of the interaction between the person and the environment. With this change in understanding we must move beyond a unidimensional classification system to a multidimensional classification system within a conceptual framework of human functioning and reformulate what ought to be classified from that of mild, moderate or severe mental disorders to that which describes the systems of support that people with mental health problems require.



Supports are the resources and strategies that aim to promote wellbeing and enhance individual functioning. Rather than focusing on inherent traits, deficits and “fixing the person”, individualised supports focus on understanding people by their types and intensities of support needs and enhancing their human functioning and personal outcomes. Because support needs and intensity scales and functional capacity assessments are both concerned with typical performance in everyday activities, the two can be confused. Assessing a person’s support needs and intensity is not the same

as assessing aspects of functioning. Support needs and intensity assessments measure an individual's extraordinary supports. Because mental health problems are fluid, continuous, and changing, the pattern and intensity of a person's support needs should be used as a basis for agency and systems planning and resource allocation.

Integrated Care

Integrative care is whole of person, collaborative and client driven. Advocates of community based mental health hubs and the re-institutionalisation of care through the use of hospital wards for patients not deemed to be in crisis, argue that integrated care has been tried, tested and found to be unsuccessful in community-based private practice. We argue that mental healthcare in Australia has continued to be based upon a unidimensional system of support and that the multidimensional system required for truly integrated care has not yet been introduced in Australia.

Whilst it is the norm for privately practicing service providers to work collectively, and without funding for integrated service provision, healthcare providers are limited by the time and financial resources that they have to engage in collaborative care. Before the Australian Government considers a more costly alternative such as mental health hubs, that restrict consumer choice and create layers of administrative burden, it should ensure that it has properly attempted to provide integrated care within our currently funded system.

A conceptual framework based on the intensity of support needs as defined under a multidimensional framework of human functioning will not only provide more person-centred and comprehensive care but would go a long way towards bridging the gap between the professional fields of mental health and between the mental health care system and the supports provided for mental health under NDIS.

Our Stepped / Integrated Model of Care

AusPsy strongly supports a better integrated mental health care system in Australia. We maintain, that this can be facilitated by adopting a model of stepped care conceptually based on the intensity of support needs and by funding measures to strengthen collaboration within the existing community-based private practice networks.

Mental Health Hubs result in a casualised and underpaid workforce of practitioners whereby there are reportedly significant staff turnovers. The infrastructure costs are high, because of high bricks and mortar and other associated overheads, and accessibility remains poor because they are in hubs and not dispersed within the

community. In contrast mental health care professionals are currently dispersed within the communities and often nearby to general medical practices. Infrastructure costs are met by these small businesses. Indicators that psychological services are, relatively speaking, not provided in low socio-economic areas are not founded. The arbitrarily higher funded rebated services, such as psychiatry and those with clinical endorsements are not found there. What is factual is that the rebates customers receive in those areas are too low for providers to sustain viable practices. It is our contention that boosting rebates would be a much more cost effective solution than funding expensive hubs which cannot deliver the same reach or arguably the same level of care.

The magnitude of mental disorders that are classified as a disability is due to many factors, however a contributing factor is the failure to receive treatment because of the lack of services, barriers or delays in access to treatment. Service accessibility is a significant issue and may be broken down into three dimensions (Boerma et al, 2014; De Silva et al., 2014; Fradgley et al 2015):

Physical accessibility: geographical proximity, opening hours, waiting times, referral systems. Territorial accessibility is considered as an important element that defines equity in health care.

Financial affordability: people's ability to access services without financial hardship; indirect and opportunity costs (e.g., the costs of transport and time away from work) and it is influenced by health financing and by level of household incomes.

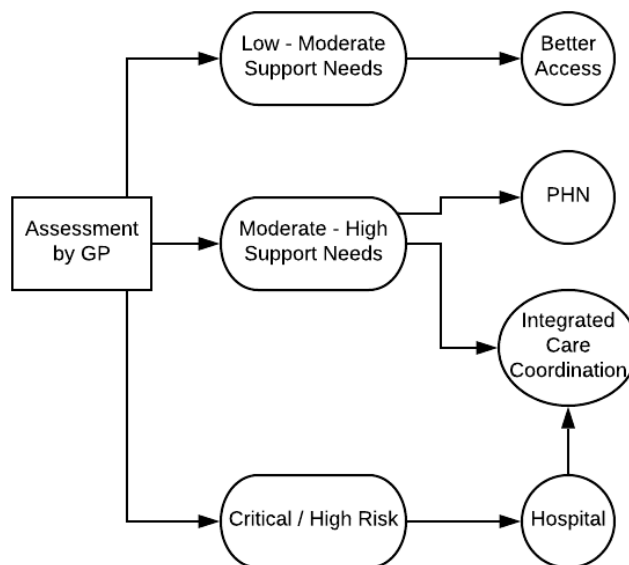
Acceptability: psychological, social and cultural factors that influence people's willingness to seek services, e.g. personal characteristics of providers, illness models, service organisational rules, provider perceptions of patients' needs, stigma.

To bridge the gaps of accessibility, affordability and acceptability we propose expanding the funding to include items for case management meetings between professionals who have clients with persistent mental health concerns. We are proposing an integrated stepped care model that does not need to be co-located in expensive Hubs, and that is consumer focussed and non-restrictive. We refer to this as an Integrated Care Model.

Some government departments and certain PHN's have already identified the same type of models with similar rationales. For example, the Queensland Mental Health, Alcohol and Other Drugs Strategic Plan Shifting minds 2018–2023 produced by the Queensland Mental Health Commission discusses this need for localised services in line with the The Fifth National Mental Health and Suicide Prevention Plan 2017–2022.

“To remain well and connected to family, work and community, it is essential that people have access to services that are centred around their needs, as close to home as possible. Effective responses aim to support individuals to live their lives on their own terms, rather than solely managing symptoms. This requires a flexible, holistic and integrated service system that acknowledges the equal importance of effective clinical treatment alongside psychosocial support, access to stable accommodation, participation in education, training or work, and social inclusion. Placing community-based services at the centre of care, supported by strong, collaborative partnerships and transitions across the care continuum, improves individual, family and system outcomes. Collaborative and coordinated care is particularly important for those with multiple or complex needs (Queensland Mental Health Commission, 2018).”

For consumers who present with lower support needs we propose the Better Access Model be retained. These consumers can be adequately supported with a team of a GP and a mental health clinician who is registered under this scheme as a provider. These providers are currently Psychologists, Mental Health Social Workers, Mental Health Occupational Therapists and Psychiatrists.



When consumers present with significant and prolonged mental health concerns we believe that they should be seen under a team care arrangement by practitioners that are embedded into the local community and are easily accessible. We recommend an Integrated Model of Care and propose the following;

1. Services be Medicare funded at a rate that is affordable for the chronically unwell (and likely unemployed) and in a volume that would allow for appropriate treatment. Two new Medicare items required to achieve this are

- face to face group liaison (also via teleconference) of the entire treatment team with payment for each provider to attend and
 - Payments for the writing of reports, at a similar rate as other similar services allow (NDIS, Workcover, DVA)
2. Therapeutic session allowances be increased for those with complex needs and provisions to commence a team care arrangement with other professions to be put into place.
 3. In a team care arrangement for chronic health concerns (Chronic Disease Management - GP services Items 721, 723, 732, 729, 731), Medical Practitioners are able to coordinate care with a multidisciplinary team if a patient has a chronic medical condition and complex care needs for 6 months or longer. The referral options for these arrangements should be expanded for those whose mental health condition (without specifying diagnosis) that has been present for 6 months or longer and who require support from a multidisciplinary team. We refer to this model as an Integrated Model of Care.
 4. Teams in a team care arrangement can currently consist of Aboriginal Health Workers, Aboriginal and Torres Strait Islander Health Practitioners, mental health workers, occupational therapists, psychologists, speech pathologists, nurses and should be expanded to include social workers, counsellors, psychiatrists, paediatricians and support workers in order to meet the multidimensional needs of the consumer.
 5. The session allowances should be increased dramatically (up to 80 sessions a year) and the rebate should be substantially increased in order to make these services affordable for the consumer.
 6. Team care arrangement items already allow for preparation and coordination of the plan and reviews, all paid to the referrer. Case conferencing and report writing should be paid to each provider to ensure appropriate follow up is undertaken and communication becomes an acknowledged paid priority.
 7. The GP should remain as the principle coordinator for the provision of specialist care. Anyone within a treatment team who sees an unmet need for the consumer should communicate that with the GP who can then act upon the recommendation and initiate a referral to another appropriate care provider. Note that a very low percentage of consumers require this amount of case

coordination. Most need communication with their initial referrer who is usually a GP or Psychiatrist and could remain under the Medicare Better Access Scheme.

8. That all providers able to provide services under a Model of Integrated Care and Better Access be able to operate under their full scope of practice and provide whatever evidence based interventions they deem in the consumers best interest.

When a consumer presents with mental health concerns that require high levels of support, is in acute distress or are regarded as high risk for suicide we propose that the Public Mental Health System (inpatient as well as outpatient support inclusive of Acute Care Teams) be adequately funded to provide free, intensive support to assist this individual to move out of the acute phase and into active treatment within an Integrated Model of Care Arrangement.

A personal account of a Psychologist in Private Practice:

As a psychologist in private practice, when I talk about my own professional values I always tell people that I work within an integrative care model. Just this week I have had five case communications with one client's treating team, an hour long meeting with one client's community mental health team, and a telephone conversation with two other client's families (This is always done with the clients informed consent and in a transparent manner, with the client often involved in these conversations). I have written 6 letters to GP's about the progress of the clients they referred. I have written two NDIS service requests (unpaid), and next week I have organised for a provisional psychologist to assist with performing a cognitive assessment on one of my clients so that the client can receive NDIS support without paying for costly assessments.

My clients are often bulk billed as those with severe mental health problems typically cannot afford health care. I need to limit the number of bulk billing clients I see, as they often require more intensive care, which results in financial loss to me and my service being offered effectively pro bono. When the 10 allocated sessions are used, my services are often provided on a limited basis for free. The sad story is that there are thousands of providers like myself, with families, who struggle to make an income despite the long hours we put in. We cannot provide ourselves with Super or sick leave. I love and am successful in my private practice. I have long waitlists because I am committed, ethical and clients get great outcomes. The system needs to change to ensure we receive a reasonable level of income and can continue providing services to our communities.

Monitoring and reporting outcomes

The monitoring and reporting of outcomes is inconsistent across funding streams and in some streams it is also unclear whose responsibility it is to collate this data. Overall it appears that each funding stream branch is using outcomes measures that suit the

evidence they consider most useful. Because of this lack of consistency comparability within Australia and to overseas models is difficult.

There are many ways in which clients improve that cannot be quantified. What might be a more appropriate measure is how well supported the consumer feels, what improvements they have noted, how many hospitalisations have they had within the previous 12 months, what is their adaptive function, what is their quality of life. Consumers desire to be the drivers of their mental health care and many state they should have the freedom of choice to do this and to determine whether they are achieving the desired outcome.

Where monitoring and reporting of outcomes are measured the tools should be non-pathologising. A suggestion has been made to use measures of wellness or Quality of Life such as the WHOQOL. A further advantage of measures of wellness or Quality of Life is they overcome limitations of traditional pre and post testing treatment measures which can mislead. This occurs because they indicate a lack of improvement in specific dimensions but simultaneously ignore other improvements in some positive indicators of human functioning, such as ability to access their community, and to reconnect with family and friendships. These factors may have improved while their mental distress levels, as indicated by psychometric instruments, may have remained constant. Depending on the instrument being used, the indicators of mental distress may not be meaningful indicators of functionality.

A more suitable and underutilised measure of Quality of life is that developed by The World Health Organisation. It is an international measure of quality of life that promotes a whole of person approach to health and mental health care. Another alternate suggested measure is based upon support intensity scales that have traditionally been used within the disability sector. These multidimensional classification systems allow for the classification of individuals based on the pattern and intensity of their support needs and assess the extraordinary support that a person needs in order to participate and find meaning in their life. They have a focus on enabling home and community life, along with exceptional medical and behaviour support needs.

A service users reflection on this submission:

As someone who personally struggles to maintain their mental health and has a close family member with serious mental health concerns, I really value the recommendations that AusPsy has made in this submission.

A significant issue for me as a service user has been the accessibility, acceptability and continuity of care that I have received. I have a preference for psychology over using medication. While medication can get me through the day, talking through my issues with a therapist allows me to voice my difficulties and

receive the support that I really need. This is more beneficial for me in the long run as it helps me navigate my life circumstances and the strategies that I learn become valuable coping skills to keep me well. But as a single mum my service choice often comes down to affordability. Two months of medication costs me just \$15 but seeing a psychologist is much more expensive. I don't need therapy or medication all the time but there are periods in my life when I do and I just can't afford it. When I am really unwell, the number of rebateable sessions are just not enough. I hate having to make a choice between spending money on my mental health or paying for other things that my family need. It can be a very hard choice.

After my second child I experienced post-natal depression. What was really unhelpful for me during this time was the lack of continuity of care I received. In the end I was passed through three funded services and I remember feeling this overwhelming pressure to be cured in six sessions. I had struggled with anxiety since I was a teenager and I knew this was unrealistic but the coordinator told my partner the program was six sessions and he assumed that this was the magic number it would take to fix me. The stress that this caused hindered my recovery and the unrealistic expectations that my partner developed caused problems in our relationship.

Something else that really concerns me about mental health care in Australia that AusPsy are recommending a solution for is the lack of engagement of family or other support persons. Access is always being left up to me when sometimes I am simply unable to do or recall the things they are asking e.g. call this phone number. I understand the need for patient confidentiality but at times people need their family to be included and a team approach to care so that professionals can talk to each other rather than rely on us to pass on the information.

Lastly, my sister suffers from long-term and serious mental health difficulties. She has a trauma history and alcohol problems and has been diagnosed with Borderline Personality Disorder. She stays in hospital every 6-8 weeks for a week to receive ECT and other group therapy. Whilst I acknowledge that this treatment has been successful in preventing her from self-harming and self-medicating, it also appears to have become an unhelpful coping mechanism. Between sessions her day to day functioning as an adult and as a parent is poor. She hangs on for her next instay like it's a vacation from life that gets her through her real life until the next visit. What she really needs and isn't getting is community-based services so she can learn how to function in day to day life, to make better decisions and to parent her kids. As a family we are trying our best but it's just not sustainable, we never get any information from her specialists about what we should and should not be doing. There are legal proceedings around the custody of her children and she is soon to without a home. I can really see the benefit of having a community-based, support needs based model of integrated care for someone like my sister. As far as I am concerned she is only receiving a medicalised approach to her care through a private hospital service for drug and alcohol addiction and it is keeping her stable but not helping her get her life back on track.

References

Johnstone, L., Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

Pirkis, J., Ftanou, M., Williamson, M., Machlin, A., Spittal, M. J., Bassilios, B., & Harris, M. (2011). Australia's better access initiative: An evaluation. *Australian and New Zealand Journal of Psychiatry*, 45, 726-739.

Lunt, I., Peiro, J.M., Poortinga, Y. & Roe, R.A. (2015). *EuroPsy: Standards and Quality in Education for Psychologists*. Hogrefe
https://play.google.com/store/books/details/Ingrid_Lunt_EuroPsy?id=QN3sAwAAQBAJ

Kim, H. & Stoner, M. (2008). Burnout and Turnover Intention Among Social Workers: Effects of Role Stress, Job Autonomy and Social Support. *Administration in Social Work*, 32 (3).

Barbato, Angelo & Vallarino, Martine & Rapisarda, Filippo & Lora, Antonio & Miguel Caldas De Almeida, José. (2014). *Access to Mental Health Care in Europe*.
https://ec.europa.eu/health/sites/health/files/mental_health/docs/ev_20161006_co02_en.pdf

Caldas de Almeida J, Killaspy H (2011). *Long term mental health care for people with severe mental disorders*, European Union. Available online from:
http://ec.europa.eu/health/mental_health/docs/healthcare_mental_disorders_en.pdf

Thornicroft G, Tansella M. (2003) *What are the arguments for community-based mental health care?* Health Evidence Network report Copenhagen, WHO Regional Office for Europe. Available online from: <http://www.euro.who.int/document/E82976.pdf>.

Seikkula J, Aaltonen J, Alakare B, Haarakangas K, Keränen J, Lehtinen K (2006). Five-year experience of first-episode non affective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research* 16, 214-228.

Boerma T, AbouZahr C, Evans D, Evans T (2014). Monitoring intervention coverage in the context of universal health coverage. PLoS Medicine 11(9), e1001728.

De Silva MJ, Lee L, FuhrDC, Rathod S, Chisholm D, Schellenberg J, Patel V (2014). Estimating the coverage of mental health programmes: a systematic review. International Journal of Epidemiology 43, 341-353.

Fradgley EA, Paul CL, Bryant J (2015). A systematic review of barriers to optimal outpatient specialist services for individuals with prevalent chronic diseases: What are the unique and common barriers experienced by patients in high income countries? International Journal for Equity in Health 14, 52.

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.

Human Rights and Equal Opportunity Commission (1995). Retrieved on 16th March 2019 from https://www.humanrights.gov.au/sites/default/files/document/publication/Reconvened_MII_Vic.pdf.