

Advancing national wellbeing **through** **the psychology** **workforce**

**Australian Psychological Society (APS)
Pre-Budget Submission 2026-27**

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Executive summary

Psychologists are trusted professionals who promote mental health and wellbeing across diverse settings and sectors. As Australians continue to experience cost of living pressures, the ongoing effects of climate-change and related disasters, and other life stressors, strategic and sustainable investment is essential to reverse chronic psychology workforce shortages and meet increased service demand.

The APS Pre-Budget Submission 2026-27 presents a set of costed and practical initiatives aimed at strengthening the psychology workforce, improving access to care, supporting our youth, and improving wellbeing for Australians now and into the future.

This submission complements key Government priorities, including *The Thriving Kids initiative*, developing sustainable *models of care for youth mental health*, the *National Mental Health Workforce Strategy 2022-2032*, and the forthcoming update to the national *Mental Health and Suicide Prevention Agreement*. Psychologists are essential to achieving these reforms as trusted experts in human behaviour, mental health, and wellbeing, and as providers of evidence-based early intervention and support for young people and their families. Independent Cost Benefit Analyses conducted by ACIL Allen show that investment in psychologists through the Better Access program and other initiatives presented here represents strong economic value.

This Pre-Budget Submission provides reform solutions to future proof the psychology workforce, support our workforces in disaster and collective-trauma contexts, improve equity of mental health care, and enhance the mental health and wellbeing of children and young people. Our initiatives are organised into three overarching objectives: (1) Prepare for the future by strengthening and future-proofing the psychology workforce to meet Australia's growing mental health and wellbeing needs, (2) Ensure access and equity to make psychological care more accessible, affordable, and responsive to community need, and (3) Support our youth by ensuring that young Australians receive timely, evidence-based care that promotes learning, development, and long-term wellbeing.

Together, these objectives reinforce a single national priority: strengthening the mental health and wellbeing of all Australians through an accessible, capable, and forward-looking psychology workforce. We call for Government support to fund the following 10 initiatives designed to maximise the benefits psychologists deliver to all Australians:

1. [Develop a National Psychology Workforce Strategy](#)
2. [Extend Commonwealth Prac Payments to postgraduate psychology students](#)
3. [Collaborative benchmarking of AI and Digital Mental Health Services](#)
4. [Sustain and scale the APS Disaster Response Network \(DRN\)](#)
5. [Increase and index Medicare rebates for psychology services](#)
6. [Enable psychologists to determine treatment length](#)
7. [Streamline GP mental health appointments](#)
8. [Improve youth access to psychology services](#)
9. [Extend the flexibility of family and carer participation sessions under Better Access](#), and
10. [Restructure MBS items related to the Assessment of Complex Neurodevelopmental Disorders](#)

Representing one of the most trusted professions delivering mental health services, promoting wellbeing, and advancing evidence-based research and practice, the APS looks forward to working collaboratively with the Government to deliver these cost-effective initiatives.

About the APS



The Australian Psychological Society (APS) is Australia's longest standing peak professional body for psychology, representing the largest community of psychologists and psychological scientists nationally. Since its founding in 1966, the APS has played a pivotal role in advancing the profession across all areas of psychological practice and strengthening the contribution of psychology to the Australian community.

We bring national attention to emerging issues, provide expert, evidence-based advice, and advocate for system improvements that enhance psychological practice and access to care. Our most recent [Annual Report](#) outlines a number of significant achievements in 2024-25, including:

Advocacy

- Providing more than 30 practical policy submissions addressing a range of current social issues.
- Representing the psychology profession and the needs of our communities on working groups, committees, inquiries and expert advisory bodies.
- Launching the second APS [Thinking Futures report](#) to advocate for Government to invest in strategies to transform women and girls' psychological health, including more support for victim-survivors of domestic and family violence.

Media and public impact

- Delivering close to 1,200 media contributions across television, radio, online, and print reaching an audience of 45 million people across Australia to provide an expert psychological perspective on important community issues.

Partnerships and collaborations

- Continuing our social impact partnerships, programs and initiatives with governments and many organisations, implementing six high impact projects, including the 5th edition of the [Evidence-based Psychological Interventions in the Treatment of Mental Disorders](#) and the launch of a new website for the [Trauma Support Directory](#), part of the Australian Government's [National Redress Scheme for people who have experienced institutional child sexual abuse](#).

Workforce and professional practice

- Securing funding to offer 1,000 free supervisor training sessions, supporting the Australian Government's workforce strategy.
- Responding to almost 5,000 professional practice enquiries to our Professional Advisory Service.

Continuing Professional Development (CPD) and Knowledge

- Issuing more than 100,000 CPD hours in our 4.8 star rated CPD approved library and developing 40 bespoke CPD programs with partners including Movember, the Australian Sleep Association, and multiple universities.
- Developing and delivering new or updated free resources for the community and psychologists, including 18 member-led resources.

Community access

- Facilitating timely and tailored access to psychological support for 1.1 million Australians in need via our online [*Find a Psychologist service*](#), with over 7.9 million page views.
- Supporting frontline and emergency workers, through the APS Disaster Response Network, which provided more than 780 services and collaborated with over 30 organisations including the Australian Red Cross and the Salvation Army.

For more information about the APS, see psychology.org.au

The 2026-27 Budget

The APS has a strong record of constructive engagement with the Federal Government on mental health policy and workforce issues. As Australians continue to experience cost of living pressures, increased service demand, and chronic psychology workforce shortages, strategic and sustainable investment is needed.

This submission presents a set of practical initiatives aimed at strengthening the psychology workforce, improving access to care, supporting our youth, and improving wellbeing for all Australians now and into the future.

The APS Pre-Budget Submission 2026-27 complements key priorities for the Government, including [The Thriving Kids initiative](#), developing sustainable [models of care for youth mental health](#), the [National Mental Health Workforce Strategy 2022-2032](#), and the eventual updating of the national [Mental Health and Suicide Prevention Agreement](#).

Psychologists and psychological scientists are critical to the realisation of these ambitions for the following reasons:

- We have expertise in the early intervention and support of young people and their families, kin, and carers including screening, planning, diagnosis, family coaching and support, evidence-based intervention and therapy, capacity building, environmental and systems adaptation, and research¹.
- As experts in human behaviour, mental health and wellbeing², we can help prepare and cope with the increasing impacts related to recent world events, climate change and related disasters and other collective trauma events³.
- As Ahpra regulated professionals bound by a Code of Conduct, psychologists have a duty to act in patients' best interests and remain competent in their area of practice, drawing upon the well-established psychology evidence-base.
- We are trusted by the Australian public as providers of safe, effective, and person-centred care^{2,4,5}.

Psychology services are incredibly cost effective. Recent analysis conducted by ACIL Allen concludes that:

...for every \$1 spent on psychological services under Better Access, \$3.93 in benefits are generated for the Australian economy⁶.

The APS Pre-Budget Submission 2026-27 identifies three broad objectives that will help Government achieve the aims of priority national plans and strategies to:

1. **Prepare for the future**
2. **Ensure access and equity**
3. **Support our youth**

The following section of this Pre-Budget Submission presents a high-level summary of the issues that underlie each objective and the rationale for APS' reform solutions. For many initiatives where data is available, the APS has commissioned Cost Benefit Analyses (CBA) by ACIL Allenⁱ to determine the economic value of:

- a) Psychology services provided under Better Access as a whole, and
- b) Many of the individual initiatives proposed in this Pre-Budget Submission¹.

These CBAs demonstrate the strong value for money that investment in psychology brings to the broader Australian community and economy with each returning benefit-cost ratios (BCR) well above one and positive net present values (NPV), even using conservative models.

Overall, analyses by ACIL Allen:

...demonstrate[s] that psychologists are not only essential to improving individual wellbeing but are also a key driver of national productivity and social cohesion. This aligns with a growing body of evidence that investment in mental health yields substantial economic and societal returns through improved participation, resilience, and reduced service demand⁶.

Given the significant burden of mental health conditions⁷⁻¹⁰, the full contribution that the psychology workforce makes to the mental health and wellbeing of Australian communities through prevention, early intervention, and treatment programs should not be underestimated². Unfortunately, cost is now the biggest barrier Australians face when trying to access psychology services^{11,12}. We know that our initiatives will have marked mental health and social benefits for the many thousands of Australians who seek psychology services. Critically, the ACIL Allen analyses confirm that investing in the psychology workforce and the services we provide produces many positive returns.

The APS is committed to working constructively with the Government to progress initiatives that support the mental health and wellbeing of Australians. This submission builds on previous areas of collaboration, including the APS Disaster Response Network and a range of training and workforce-support activities funded in earlier Budgets. We welcome the opportunity to work together on the further development and implementation of measures that strengthen the psychology workforce and enhance access to care for all Australians.

ⁱ ACIL Allen. (2024). *Cost Benefit Analysis of Pre-Budget Submission 2025-26*. We note that this analysis was originally conducted for last year's submission; however, it remains sufficiently accurate for the current scope, and the estimated cost of the initiative has not changed.

Three objectives to prepare Australia for the future

In this Pre-Budget Submission, the APS outlines three key objectives designed to strengthen the nation’s mental health, wellbeing, and psychology workforce capability.

Together, these objectives provide a strategic framework to prepare Australia for emerging mental health challenges, reduce current inequities in access to care, and invest in the wellbeing of future generations. (See Figure 1)



Figure 1: Three interrelated objectives guiding APS Pre-Budget Submission priorities

Each initiative in this Pre-Budget Submission aligns to one of these objectives, ensuring a clear and coordinated focus on areas of greatest impact. Collectively, the objectives represent targeted investment priorities that will deliver sustainable social, economic, and wellbeing benefits for all Australians. In other words, the BCRs provided in this Pre-Budget Submission are projected to generate economic returns far greater than the costs to implement them.

The three objectives are:

1. Prepare for the future

Strengthen and future-proof the psychology workforce to meet Australia’s growing mental health needs. This includes developing a National Psychology Workforce Strategy, supporting the financial sustainability of student placements, and supporting the APS Disaster Recovery Network (DRN) to ensure a skilled, agile and resilient workforce capable of responding to emerging community and technology needs.

2. Ensure access and equity

Enhance funding and service delivery mechanisms to make psychology services more accessible, affordable, and responsive to community need. Initiatives under this objective focus on designing more viable rebates, introducing bulk billing incentives, enabling psychologists to determine treatment length, and streamlining GP reviews, ensuring equitable, evidence-based care across all communities.

3. Support our youth

Invest early in the mental health and wellbeing of children and young people through targeted supports under Better Access. This includes removing financial barriers to access, expanding family and carer participation sessions, and strengthening pathways for neurodevelopmental assessment and intervention, ensuring that young Australians receive timely, evidence-based care to support their learning, development, and long-term wellbeing.

Together, these objectives reinforce a single national priority: strengthening the mental health and wellbeing of all Australians through an accessible, capable, and forward-looking psychology workforce.

APS Pre-Budget Submission 2026-27 initiatives

Objective 1. Prepare for the future	
1. <u>Develop a National Psychology Workforce Strategy</u>	Fund the APS to develop an evidence-based national psychology workforce strategy to address structural barriers limiting psychologists' participation, distribution, and service delivery, and to align workforce planning with population need.
2. <u>Extend Commonwealth Prac Payments to postgraduate psychology students</u>	Extend the Commonwealth Prac Payment to postgraduate psychology students, including a loading for students on placements in rural and remote areas to prevent placement poverty.
3. <u>Collaborative benchmarking of AI and Digital Mental Health Services</u>	Undertake collaborative benchmarking and evaluation of artificial intelligence (AI) large language models (LLM) and other digital mental health services (DMHS) to ensure they are reliable, safe, effective and appropriately integrated into existing mental-health service delivery.
4. <u>Sustain and scale the APS Disaster Response Network (DRN)</u>	Sustain and expand investment in the highly successful APS DRN to sustain and scale access to a coordinated network of volunteer psychologists providing wellbeing preparedness, response, and recovery support to community-facing workforces nationwide.

Objective 2. Ensure access and equity	
5. <u>Increase and index Medicare rebates for psychology services</u>	Increase Medicare rebates for psychology services to make them more viable, and introduce annual indexation consistent with CPI, ensuring rebate values keep pace with delivery costs and support affordable, sustainable access to psychology services.
6. <u>Enable psychologists to determine treatment length</u>	Enable psychologists to set treatment length under Better Access (up to 20 sessions for complex conditions and up to 40 sessions for high-impact, lower prevalence conditions), ensuring care more closely aligns with clinical need and evidence-based practice.
7. <u>Streamline GP Mental Health Appointments</u>	Shift GP Mental Health appointments from after 6 sessions to the end of treatment or when Better Access session limits are reached, reducing unnecessary costs and administrative burden while maintaining coordinated care.

Objective 3. Support our youth	
8. <u>Improve youth access to psychology services</u>	Introduce a \$0 youth mental health 'safety net' threshold for Better Access sessions to ensure young Australians aged 14 to 25 can access psychological care without financial hardship for themselves or their families.
9. <u>Extend the flexibility of family and carer participation sessions under Better Access</u>	Extend the number and flexibility of family and carer participation sessions under Better Access to support family-inclusive, evidence-based interventions for children and young people.
10. <u>Restructure MBS items related to the assessment of Complex Neurodevelopmental Disorders</u>	Redesign MBS items related to the assessment of Complex Neurodevelopmental Disorders and eligible disabilities to improve diagnostic validity and access and align with Foundational Supports reforms.

Objective 1:
Prepare for the future

**Align psychology
workforce capacity
with population need**



1. Evidence-based psychology workforce strategy



Australia continues to experience significant and persistent unmet demand for psychology services¹³. Despite growth in the psychology workforce, many Australians experience long wait times, high costs, and limited access to care, particularly in public services and in regional, rural, and remote communities.

This pattern suggests that workforce challenges extend beyond the number of registered psychologists and reflect broader system and funding settings that constrain psychologists' participation, distribution, and service delivery.

Psychologists play a central role in Australia's mental health system; however, the current system does not consistently enable psychologists to operate to their full capacity or in the settings where need is greatest. Without targeted workforce planning, these constraints are likely to continue limiting access to appropriate psychological care, even as demand increases.

Limitations of existing reform activity and structural barriers

The current Psychology Board of Australia (PsyBA) review of psychology training pathways¹⁴ is an important reform initiative and is expected to address aspects of entry to the profession, including the structure, sequencing, and supervision requirements of psychology training pathways. These reforms represent an important step in improving the accessibility and clarity of pathways into the psychology workforce.

However, training pathway reform alone is insufficient to address the broader factors that shape psychology workforce participation and service capacity once psychologists are qualified and registered. These factors sit largely outside the scope of entry-to-practice reform and require coordinated, whole of career workforce planning.

The psychology workforce is predominantly female and characterised by high levels of part-time work across career stages¹⁵. These patterns interact with system and funding arrangements, including supervision requirements, service models, and limited flexibility in some public and community roles, to constrain sustained workforce participation and reduce effective service capacity.

In addition, the nature of psychological work and current service models create ongoing pressures on workforce participation and career sustainability, particularly in high-demand and publicly funded settings^{16,17}.

Together, these structural factors limit the system's ability to translate workforce supply into accessible psychological care. Without complementary workforce planning to address participation, retention, and sustainability across the career lifecycle, training reforms are unlikely to deliver the intended improvements in access and service availability.

Missing profession-specific workforce planning

Broader national initiatives, such as the [Scope of Practice Review](#) and the [National Mental Health Workforce Strategy 2022-32](#), have provided valuable high-level insights into workforce pressures and system design across the mental health sector. However, these initiatives are necessarily broad in scope and primarily top-down in focus. As a result, they provide limited visibility of profession-specific workforce dynamics, including psychology's distinct training pathways, supervision requirements, regulatory settings, and patterns of participation across sectors.

In the absence of profession-specific workforce planning, psychologists are often grouped within broad 'allied health' or mental health workforce categories. This limits the system's ability to identify and respond to challenges that are specific to the psychology workforce, including supervision bottlenecks, training capacity constraints, and uneven service distribution.

Psychology is a diverse discipline, with psychologists working across health, education, organisational, forensic, community, and other settings⁶. Current workforce data and modelling largely focus on health settings, limiting understanding of workforce supply, demand, and service capacity across the full range of contexts in which psychologists practice. In work we have conducted with ACIL Allen⁶, it is clear that the current data limitations present a limited view of the profession. In turn, this precludes a holistic understanding, and beneficial utilisation of the full contribution of psychologists and psychological scientists to the Australian economy and social outcomes. Specifically:

"The psychology workforce already makes a demonstrably high-value contribution to Australia's social and economic wellbeing. Yet this contribution is not fully realised due to fragmented data, uneven access, and limited integration with other parts of the health and social system. Importantly, there remains limited visibility of the scale, distribution, and measurable value of this workforce, which constrains effective policy and planning."^{6(p. 30)}

A comprehensive, psychology-specific workforce strategy is, therefore, required to develop a clearer evidence-base on workforce participation, career trajectories, and service delivery across sectors. This is necessary to inform targeted policy responses to attract, sustainably train, and retain psychologists across the full continuum of practice, including prevention and wellbeing promotion, early intervention, and treatment.

Initiative 1: Develop a National Psychology Workforce Strategy

Fund the APS to develop and deliver a National Psychology Workforce Strategy that provides actionable, evidence-based advice to governments on how to equip, sustain, and extend the psychology workforce across Australia.

As the largest and longest standing peak body for psychology, the APS is uniquely positioned to lead this initiative, drawing on the expertise of its members, data capability, and national networks across sectors.

Specifically, this initiative:

- **Includes a co-production process with psychologists**, people with lived experience, employers, peak bodies, education providers, and Government representatives.
- **Utilises mixed-method research and human-centred design** to identify the drivers and barriers to workforce participation.
- **Enables a national roundtable** to discuss discovery findings and initiate the development of solutions.
- **Provides a final report to Government** with clear, evidence-based recommendations for implementation.

Expected outcomes:

Assuming implementation of recommendations by governments, the expected direct benefits would include:

- **Improved effective service capacity within the psychology workforce** through better alignment of workforce participation, retention, and deployment with population need.
- **Stronger attraction and retention of psychologists to and within the public sector** informed by improved understanding of workforce flows, incentives, and constraints across sectors.
- **Better utilisation of psychologists' skills across sectors** recognising psychology's contribution to prevention, early intervention, and complex care in health, education, justice, community, and organisational settings.
- **Improved efficiency and return on Government investment** in psychology training and supervision, by addressing system settings that limit workforce participation over the career lifecycle.
- **Enhanced workforce data and insight** addressing current information gaps and supporting Government priorities, including implementation of Recommendation 17 from the *Final Report of the Independent Review of Overseas Health Practitioner Regulatory Settings (the Kruk Review)*.

Beyond direct workforce impacts, the initiative would deliver **broader system benefits**, including:

- **Cross-sector value** through the development of a profession-led, evidence-informed workforce planning approach that could be adapted for other disciplines.
- **Alignment with national gender-equality priorities**, such as the *Working for Women: A Strategy for Gender Equality* and *Including Gender: An APS Guide to Gender Analysis and Gender Impact Assessment*, recognising the predominantly female psychology workforce and the role of system design in supporting workforce participation and economic contribution.

Benefit-Cost Ratio (BCR): 3.25

Anticipated return of \$3.25 per \$1 invested

2. Commonwealth Prac Payment

The [*introduction of a Commonwealth Prac Payment*](#) was announced in advance of the 2024-25 Budget, based on Recommendation 14 of the Australian Universities Accord Final Report¹⁸. Specifically, nursing, midwifery, teaching and social work students undertaking mandatory placements would be eligible for a weekly payment from July 2025¹⁹. While the APS has supported the introduction of the payment²⁰, we are deeply disappointed that this payment currently excludes psychology students.

Many psychologists work in critical mental health services, education, defence, forensics, and other public service positions. Given that it is estimated that the psychology workforce in Australia is meeting just 35% of projected national demand¹³, with more current modelling by the Department of Health, Disability and Aging underway²¹, we urgently need to support initiatives to bolster the number of qualified psychologists to ensure the health and mental health of future Australians.

Placements are required by PsyBA to become a registered psychologist²². Becoming a registered psychologist is a long road which requires hard work and dedication and is financially burdensome. Master of Professional Psychology (MPP) students are required to undertake 300 hours of placement over one year, while students completing a higher degree in an Area of Practice Endorsement (AoPE) undertake 1,000 hours of placements over two years.

While we acknowledge the recent Government grants to increase the number of psychology postgraduate places and to fund 1,500 internships for provisional psychologists²³, students need direct financial support across the board. In addition to often not earning income during this time (e.g., not being able to continue other employment due to the demands of the placement), students sometimes have to pay the supervising psychologists' hourly rate to complete the supervision requirements required for their placement. This places extra financial burden on students trying to complete their studies on the pathway to becoming a registered psychologist.

Currently, the scope of the Commonwealth Prac Payment scheme conflicts with the [*National Mental Health Workforce Strategy*](#) and the [*Universities Accord*](#) which singled out psychology students (in the interim report)²⁴ as needing more support. Given that more than 80% of psychologists in Australia are women¹⁵, this decision also contrasts with the findings from the [*Women's Economic Equality Taskforce*](#).

Studying psychology should be based on merit, not a student's ability to afford to live as they complete compulsory, unpaid placements hours. Currently, socioeconomically disadvantaged students are dissuaded from pursuing psychology qualifications. For these reasons, we urgently call on the Government to include psychology students on mandatory placements as future recipients of the Commonwealth Prac Payment.

Initiative 2: Extend Commonwealth Prac Payments to postgraduate psychology students

Extend the Commonwealth Prac Payment (\$319.50 at time of calculation[†]) to postgraduate psychology students completing mandatory placements and include a loading for students while on placements in rural and remote areas.

Specifically, this initiative:

- Reduces the financial burden on postgraduate psychology students associated with undertaking unpaid placements while completing their studies.
- Achieves greater alignment with the policy intention underpinning the initial scope of the Commonwealth Prac Payment, as psychology students experience similar placement-related financial pressures as students studying to be a nurse, midwife, social worker, or teacher while also sometimes incurring an additional cost of paying the hourly rate of their supervisor²⁶.
- Supports approximately 2,000 students commencing a professional program of study in psychology across Australia each year.
- Provides an additional loading of \$150 per week to postgraduate psychology students who are based in rural and remote locations for their placements to assist with travel and associated costs, consistent with APS advocacy for incentives to increase the number of psychologists available to support rural and remote-based communities^{26,27}.

Expected outcomes:

- **Removal of financial barriers** to psychology students completing their studies, contributing to filling critical workforce gaps and ensuring an adequate pipeline of future psychologists.
- **Improved attraction and retention of psychologists working in rural and remote locations**, through increased numbers of students choosing to undertake placements and then continue to work in these locations^{27,28}.
- **Improved equity of access to support training** for psychology students, contributing to the development and sustainability of the psychology workforce.
- **Greater policy alignment** with recommendations from the National Mental Health Workforce Strategy, Universities Accord, and Women's Economic Equality Taskforce.
- **Improved economic security** for a female-majority profession.

[†] increasing to \$338.60 per week as of 1 January 2026 ²⁵

3. Collaborative benchmarking of AI

In preparing for the future, we must engage with technological advances as well as the human experience of, and interactions with, technology. Digital mental health services (DMHS) and artificial intelligence (AI) continue to evolve rapidly with direct effects on the mental health and wellbeing of Australians, the provision of mental health services, as well as the psychology workforce. Australian psychologists and the APS are committed to harnessing technological innovations which improve equity, access, and patient experience^{29,30}. The APS recognises the substantial benefits and potential risks associated with Artificial Intelligence (AI) applications in healthcare and wants to maximise the opportunities they can afford both safely and ethically.

In this period of profound change, psychologists with strong foundations in science, ethics, and critical research skills, are already considering the design, implementation, and other implications of AI and technology for the wellbeing of the Australian community. While we are aware of the powerful possibilities that AI and other DMHS afford, the APS is concerned about the potential for technology to solidify existing inequities, create new problems, and result in other unintended consequences.

We note the rapidly growing body of research literature^{31–39} and the current initiatives undertaken by Government such as the regulation work led by the Therapeutic Goods Administration (TGA)^{40,41}, the Australian Commission on Safety and Quality in Health Care⁴², and the Department of Health, Disability and Ageing⁴³. We also commend the Government's commitment to increasing the awareness and the knowledge of health practitioners about DMHS in the recent Mid-Year Economic and Fiscal Outlook (MYEFO) 2025-26⁴⁴.

The APS has also previously emphasised that notwithstanding this research, there are significant gaps in our collective understanding about the use, experiences, and consequences of AI by Australians^{45–47}. Australian research published in an APS journal found that mental health professionals have a critical role in facilitating a person's informed decision to use a DMHS. That is, DMHS cannot be considered as standalone services but must be embedded within the mental health system⁴⁸. Digital and AI-based mental health solutions that are not integrated with models of care based in human relationships and experience create serious risks of further fragmentation of services and knowledge.

Working collaboratively with other leaders in the sector, the APS is uniquely equipped to engage with government to increase understanding of the psychological impacts of technological advances in mental health and to develop psychology-informed solutions which benefit patients, health professionals, policy makers, and the Australian community. Building on our strong existing partnerships in this field, and growing track record ^{see also}⁴⁶, we propose to undertake a collaborative benchmarking and evaluation project to clearly identify considerations regarding the reliability, safety, and efficacy of AI large language models (LLM) and other DMHS.

Secondly, we propose to utilise this knowledge to ensure that DMHS are appropriately embedded within the mental health system to ensure that the potential benefits are maximised.

Initiative 3: Collaborative benchmarking of AI and Digital Mental Health Services

Undertake a collaborative benchmarking and evaluation of artificial intelligence (AI) large language (LLM) models and other digital mental health services (DMHS) to ensure they are reliable, safe, effective, and appropriately integrated into existing mental-health service delivery.

Specifically, this initiative:

- **Complements and extends** work already been undertaken by the TGA and others to ensure that DMHS are reliable, effective, and safe to use in mental health care in Australia.
- **Utilises the APS' current collaborations and growing track record** in DMHS to understand the technological readiness of psychologists to work effectively with DMHS, and to identify opportunities for reform and support to minimise barriers.
- **Benchmarks and evaluates** AI LLM in terms of reliability, safety, and efficacy.
- **Distils the evidence about the intersection between DMHS and professional-led services**, to ultimately develop locally-applicable clinical wisdom and evidence, to inform the design of transition processes between clinical practice and DMHS.

Expected outcomes:

- Positions Australia as a leader in the ethical and effective use of DMHS and AI in ways that safely supplements the provision of mental health care.
- Addresses the looming gaps at the critical intersection between DMHS and clinical service delivery by mental health professionals.
- Builds connections between the development of innovative technological solutions, as well as understands, appraises and evaluates the human and psychology impacts of technology, to ensure DMHS are reliable, safe, and effective.
- Positions Australia as central to the discussion on an ethical and psychology-informed human-AI interface in conjunction with world experts.

4. APS Disaster Response Network

Australian communities face a rising volume, frequency, and complexity of disasters, emergencies, and collective trauma events^{49,50}. These include natural disasters, critical incidents, pandemics, mass-casualty events, and other large-scale disruptions, many of which are increasingly driven or intensified by climate-related factors⁵⁰.

The psychological impacts of these events are often widespread, with the [*National Disaster Mental Health and Wellbeing Framework*](#)⁵¹ noting that after a major event “a large proportion of the population will require some emotional or psychosocial support to cope with potentially traumatic events” (p. 14). Evidence shows that psychological effects can emerge immediately or develop over months and years, and can become more severe with successive disasters, placing prolonged pressure on communities^{52–55}.

These events affect not only directly impacted community members, but also the paid and volunteer workforces who sustain Australia’s planning, response, and recovery efforts. This includes those in first responder and emergency services roles; crisis helplines and recovery support; council and neighbourhood centres as well as other community-facing workforces across health, education, welfare, and related sectors, and including administrative and ancillary

staff. These workforces often experience exposure to trauma, cumulative stress, fatigue, and moral distress, which can undermine their wellbeing and their sustained capacity to support others^{56,57}.

This reinforces the need for scalable, coordinated psychological support for a diverse range of paid and volunteer workforces and roles that support communities across the disaster cycle. However, supports often focus on the more visible disaster response roles and are predominantly reactive, concentrated during and immediately after an event.

As a result, substantial gaps remain in reach, proactive preparedness, and sustained support throughout extended recovery periods for our community-facing workforces⁵⁰.

These gaps present two significant opportunities to strengthen Australia's disaster readiness:

1. Building a trained, scalable, and readily deployable mental health workforce capable of providing timely psychological support to the broad range of community-facing workforces that sustain communities during periods of heightened demand associated with disasters, emergencies, and other significant events.
2. Enhancing the preparedness, response, and recovery capacity of community-facing workforces, enabling them to anticipate, withstand, and recover from the psychological impacts associated with their roles and responsibilities across the disaster cycle.

The APS Disaster Response Network (DRN)⁵⁸ is already helping to realise these opportunities and has demonstrated strong potential for ongoing and expanded national impact with sustained investment.

Success and impact of the APS Disaster Response Network

As Australia continues to face increasingly complex disaster, emergency, and other events, the DRN⁵⁹ provides a coordinated, evidence-informed mechanism for strengthening the psychological preparedness, response, and recovery capacity of community-facing workforces.

Since its establishment in 2009, the DRN has demonstrated sustained national impact, scale, and effectiveness. Initially formed to support the Australian Red Cross, the DRN has expanded into a trusted, whole-of-workforce wellbeing initiative now comprising more than 1,000 volunteer psychologists across all Australian jurisdictions, reflecting its strong reputation and engagement within the profession.

With Commonwealth Government support, the DRN has grown rapidly—from a single organisational partnership to 36 not-for-profit, healthcare, emergency, recovery, and community organisations—all of which have opted in due to the demonstrated value of the DRN's evidence-informed services and the coordination and support provided by a dedicated APS team. Commonwealth funding has allowed the APS to increase the provision of wellbeing services by 1,274% between 2021 and 2025.

The DRN model delivers evidence-informed wellbeing services across the full disaster lifecycle, including proactive wellbeing checks, group psychoeducation, and in-person deployments to workplaces and event-affected sites (see Figure 2). Its ability to scale, attract, and retain a large national cohort of trained volunteer psychologists, and to consistently provide structured, trauma-informed support across diverse settings underscores the initiative's effectiveness and credibility.

During the current period of Commonwealth investment, the DRN has been mobilised across a wide range of disaster, emergency, and collective trauma contexts nationally, reflecting both its flexibility and its relevance beyond natural hazards alone. This has included sustained recovery support for health and community workforces affected by major flooding events in Victoria, Queensland, and New South Wales; rapid response and recovery support following multiple bushfire events in Victoria and Western Australia; deployments in response to cyclones and severe storms in Western Australia and Queensland; and psychologically informed support for frontline and community-facing workers following collective trauma events, including mass-casualty and community violence incidents, such as the December 2025 mass shooting at a Jewish community event at Bondi Beach, Sydney.

Demand for DRN supports continues to increase as organisations recognise the importance of psychological preparedness, response, and recovery and the tangible benefit the DRN provides in strengthening workforce wellbeing, capability, and readiness for disasters, emergencies, and collective trauma events.

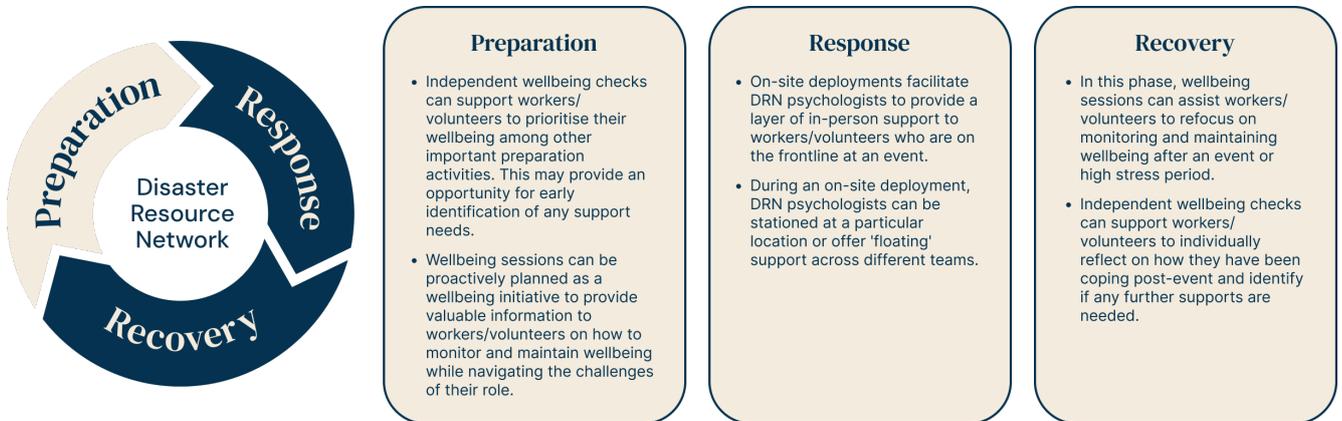


Figure 2: The different elements of the DRN in the disaster lifecycle

Strengthening national preparedness and wellbeing through a sustained and scaled APS Disaster Response Network

Australia’s climate-related disaster risk is escalating, and both the APS and governments recognise the need to strengthen national preparedness. In our Position Statement on *Psychology and Climate Change*⁵⁵, we emphasise the importance of preventative action to minimise disaster-related risks and the need for psychological preparedness and early intervention alongside response and recovery efforts. This aligns with the Government’s commitment, articulated in the *National Health and Climate Change Strategy*⁶⁰, to reducing disaster risk and building resilience across the full disaster continuum, including psychological preparedness, response, recovery, and long-term risk reduction.

However, prevention and early intervention for psychological resilience and mental health remain significantly underfunded. The Productivity Commission found that only three per cent of taxpayer investment is directed to these activities⁶¹, which adds to the constraints in building national capacity to psychologically prepare communities and workforces. These limitations are especially pronounced in rural and regional communities, where shortages of qualified mental health professionals coincide with lower levels of disaster resilience⁶².

While the DRN does not provide direct clinical services to disaster-affected community members, it plays a vital complementary role alongside other services that do, by sustaining the wellbeing of the diverse workforces who support the community and who are an essential pillar for effective preparedness, response, and recovery. In this way, the DRN model also recognises the importance of local knowledge, including the cultural and environmental knowledge of First Nations peoples, as a core component of effective community-based psychosocial preparedness, response and recovery, consistent with the guiding principles of the *National Disaster Mental Health and Wellbeing Framework*⁵¹.

Demand for DRN services continues to grow as organisations increasingly recognise the importance of psychological preparedness and wellbeing of their workforces. Yet, the current funding model constrains the DRN’s future capacity to meet rising demand; expand to additional sectors and regions; and maintain the coordination, training, and surge-readiness required of a nationally deployable volunteer mental health workforce.

Continued and expanded Commonwealth Government investment in psychological preparedness, delivered through a strengthened, scaled, and future-proofed DRN, would support nationally significant outcomes, including:

- (1) strengthened disaster resilience, and (2) better-supported community-facing workforces, and (3) more effective

responses across the disaster continuum, contributing to improved mental health for Australians. This aligns with national priorities articulated in the National Mental Health and Suicide Prevention Agreement⁶³ and the *National Mental Health Workforce Strategy 2022-32*⁶⁴, both of which emphasise prevention, early intervention, and a capable, scalable mental health workforce.

Initiative 4: Sustain and scale the APS Disaster Response Network (DRN)

This initiative seeks continued Commonwealth Government investment to sustain, scale, and future-proof the APS DRN, ensuring ongoing, evidence-informed psychological support continues to be provided to diverse community-facing workforces who, in turn, provide local support across the disaster lifecycle.

Further investment would enable the DRN to maintain support for its current 36 partner organisations and provide them with reassurance of the continuation of vital DRN services over the longer term. It would also enable the DRN to extend its model for psychological preparedness, response, and recovery to additional workforces in community-facing organisations and sectors.

Specifically, this initiative:

- Sustains and expands the DRN's national cohort beyond the current 1,000 volunteer psychologists.
- Scales the DRN to deliver a psychologist-led training program to foster psychologically safe work environments in the emergency response sector; understand, build, and coordinate community psychosocial wellbeing; and strengthen organisational supports and leadership for psychological preparedness, response, and recovery in community-facing workforces.
- Enables targeted expansion into additional sectors with high exposure to cumulative stress during the disaster lifecycle, such as education, community services, and local government.
- Supports strengthened coordination, data systems, and governance so the DRN can meet rising national demand and deliver consistent, evidence-informed psychological support across the disaster lifecycle.

Expected outcomes:

- **Greater continuity of support across the disaster lifecycle**, enabling earlier intervention, reducing psychological distress, and strengthening resilience among community-facing workforces.
- **Strengthened national surge capacity**, ensuring trained volunteer psychologists can be rapidly mobilised when disaster, emergency, and/or collective trauma events occur.
- **Expanded reach**, enabling the DRN to support a wider range of community-critical organisations to embed evidence-based psychological readiness into their planning for preparedness, response, and recovery.
- **A more prevention-focused national mental health system**, supported by scalable, coordinated psychological expertise integrated throughout the disaster lifecycle.

Objective 2:

Ensure access and equity

**Affordability is the
leading barrier to
psychology services
in Australia**



Despite widespread community support for the contribution of psychology to mental wellbeing, there is concern that the Government is not doing enough to make their services genuinely affordable or accessible¹². National evidence shows that financial barriers remain the most significant obstacle to accessing psychology services in Australia^{4,11}. A 2024 APS member survey¹¹ found that affordability is now the leading barrier to treatment, with cost-of-living pressures limiting access despite strong community demand ^{see also 65,66}.

Cost of living pressures, financial stress, inadequate Medicare rebates, and limited system reform have left many Australians unable to access the mental health treatment they need⁶⁷. One respondent from research conducted by Lived Experience Australia in collaboration with the APS simply said “The cost is prohibitive”^{5(p. 14)}. The most recent [National Mental Health Report Card](#), shows that the number of people delaying or avoiding treatment due to cost is increasing. Delays in accessing psychology treatment can mean that issues become chronic and lead to even greater social and economic costs. Addressing these barriers is essential to ensuring equitable, sustainable psychology services that meet community demand both now and in the future.

The following initiatives set out targeted reforms to reduce cost pressures, improve affordability, and remove access barriers for people across regional and remote communities.

5. Deliver accessible and equitable psychology services to all Australians

The Better Access initiative, introduced in 2006, has delivered measurable benefits to the Australian community but remains constrained by structural and financial gaps. Medicare rebates have not kept pace with inflation and the costs of providing services, leaving many patients unable to afford care^{4,5,11,65,67}. Research from Monash University’s Centre for Health Economics demonstrates that higher Medicare rebates improve access and workforce distribution, including in non-metropolitan areas⁶⁸.

A RedBridge Group survey conducted for the APS reinforced these findings, showing that 93% of Australians believe the Government should increase investment in psychology services for people with mental health concerns¹². When individuals cannot access timely psychology services, they are more likely to present to GPs, emergency departments and crisis care, further increasing the cost burden on the health system^{66,69}.

Initiative 5: Increase and index Medicare rebates for psychology services

Higher Medicare rebates are essential to make psychology services affordable, to sustain adequate availability, and to ensure equitable access for all Australians^{11,66}. Introducing higher rebates for Better Access services, indexed annually in line with the consumer price index (CPI), would ensure that rebate values reflect true service-delivery costs, including the unbillable administrative time involved in Better Access work, and correct the below-CPI indexation of schedule fees since 2018–19⁷⁰.

Economic modelling indicates that increased Medicare rebates are associated with increased clinical FTE among psychologists providing services under Better Access, as well as a greater proportion of psychologists practicing in non-metropolitan areas⁶⁸. The cumulative effect of lower than CPI increases to Better Access rebates means that the gap between running costs and relevant rebates has steadily grown over time. Without appropriate indexation, psychologists are put in the position of needing to either absorb cost increases or raise their fees, which in turn reduces service availability and affordability, particularly for disadvantaged groups.

Specifically, this initiative:

- Increases the Medicare rebate for all Better Access psychology sessions.
- Introduces annual indexation of relevant MBS items consistent with CPI.

Expected outcomes:

- **Improved affordability and access** to psychological services for low-income, rural, and remote Australians by reducing out-of-pocket costs.
- **Greater workforce participation**, with more psychologists remaining engaged in Better Access service delivery.
- **Stronger service sustainability**, ensuring rebate values keep pace with actual delivery costs
- **Reduced pressure on GPs, emergency departments and crisis services** through earlier access to psychology services.

Benefit-Cost Ratio (BCR): 2.14

Anticipated return of \$2.14 per \$1 invested

6. Provide services according to clinical need

Effective psychological treatment depends on matching care to individual need. Evidence consistently shows that while brief interventions of 10 sessions are sufficient for some people, those with more complex or severe presentations often require longer-term support^{71,72}. A 2021 study found that psychological outcomes improve with longer treatment duration, particularly for people with more severe presentations, and that flexible, appropriately dosed therapy yields the greatest clinical gains⁷², a fact acknowledged by an independent evaluation of the Better Access scheme (p. 17)⁷³.

Rigid session limits reduce clinical effectiveness and create inefficiencies in the mental health system. Providing only partial treatment, which is contrary to evidence-based practice, leaves patients at risk of stagnation or deterioration, leading to greater service inefficiency and resource wastage. The risk is these under-treated patients do not fully recover and are at greater risk of relapse and returning to the system in the future^{48,54–56}.

Community sentiment strongly supports greater flexibility. The RedBridge Group survey conducted for the APS found that over 70% of Australians believe the number of Medicare-funded psychology sessions should be determined collaboratively between a psychologist and their patient, not fixed by the Government^{4,12}. This sentiment was also supported by research conducted by Lived Experience Australia in collaboration with the APS⁵. Out of 224 respondents, the average number of sessions patients reported having with a psychologist was 18. Almost half of respondents said that the number they planned/received was less than they wanted. The second evaluation of the Better Access initiative reached a similar conclusion, recommending that additional sessions be retained, particularly for patients with complex mental health disorders⁷³.

Providing treatment length based on clinical expertise would ensure care is delivered according to evidence, improve patient outcomes, and reduce preventable system demand.

Initiative 6: Enable psychologists to determine treatment length

Amend requirements for Better Access items to enable psychologists to determine the clinically necessary number of sessions for each patient. This initiative would allow psychologists to deliver evidence-based treatment aligned with best practice and patient need, rather than arbitrary limits. Patients would receive the right amount of care for effective outcomes, reducing relapse risk and the potential for unnecessary re-entry into acute services⁶⁹.

Patients would receive the treatment they require and would not have to artificially delay or forego psychology sessions due to financial factors and in contradiction to best clinical practice.

Specifically, under this initiative psychologists could:

- Determine up to 20 sessions per calendar year for patients with complex mental health conditions.
- Determine up to 40 sessions per calendar year for chronic, high-impact, lower prevalence conditions (to be specified in the MBS and reviewed periodically with input from the APS).

Expected outcomes:

- **Improved treatment effectiveness** by aligning treatment planning with clinical evidence and individual patient need, leading to better outcomes and reduced symptom persistence.
- **Reduced relapse and recurrence** by ensuring adequate treatment length to prevent recurrence or deterioration⁷⁴⁻⁷⁶.
- **Improved system efficiency** through higher recovery rates that reduce reliance on GPs and acute and emergency services⁶⁹.
- **Promotes more equitable outcomes** by removing arbitrary session caps that disadvantage individuals with complex, comorbid, or severe presentations.
- **Enhances workforce sustainability** by enabling psychologists to practice in accordance with evidence-based standards and remain engaged in Medicare-funded service delivery.

Benefit-Cost Ratio (BCR): 2.71

Anticipated return of \$2.71 per \$1 invested

7. Streamline GP mental health appointments

The Better Access initiative currently requires patients to return to their referring practitioner after an initial course of treatment (six at maximum) to continue to receive subsidised treatment. While intended to support coordinated care, these reviews create avoidable costs for patients and add an avoidable administrative workload for both GPs and psychologists. The APS advocates to align the review processes with Recommendation 12 of the Better Access Evaluation which supports flexible review cadences based on a patient's level of need⁷³.

The *Seventh Australian Healthcare Index* (September 2025) found that cost of living pressures were affecting 74% of respondents' healthcare decisions, and 55% had delayed GP visits as a result. These findings highlight the growing financial strain disrupting access to routine and preventative healthcare across Australia.

For many patients under Better Access, the additional GP visit required to obtain a referral for additional sessions imposes unnecessary cost and effort, particularly when treatment is ongoing and progress is being made. In most cases, this review is not clinically necessary and can create a barrier to completing treatment or maintaining continuity of care. Research from Lived Experience Australia in collaboration with the APS⁵ also shows that over half of respondents did not agree with the requirement of GP reviewing the number of sessions during care under a Mental Health Care Plan with one suggesting "Once the relationship is established, I think it should be between the person and the psychologist to decide" (p. 36) and another "My psych is the best person to do that [determine the number of sessions required]. It's just another hurdle to jump through, especially when it's not easy to get into a GP here" (p. 22).

Initiative 7: Streamline GP mental health appointments

Amend MBS requirements for the Better Access initiative to streamline referral processes for psychologists, ensuring new referrals are only required when clinically meaningful, at the end of treatment, or when session limits are reached. This would reduce unnecessary GP appointments, while maintaining opportunities for GP involvement and coordinated care as needed.

Specifically, this initiative:

- Replaces the current requirement for returning to the GP mid-treatment with a review at the end of treatment or when session limits are reached.
- Allow patients to continue consulting their GP at any point if clinically required.
- Preserves collaboration between psychologists and GPs through shared care when clinically appropriate.

Expected outcomes:

- **Removes practical barriers for patients** by eliminating unnecessary GP appointments and referral requirements that interrupt treatment continuity and increase costs.
- **Lessens the financial burden** associated with GP consultations, including out-of-pocket expenses.
- **Alleviates pressure on GP practices** by streamlining appointments to occur only when treatment is completed, session-limits are reached, or clinically relevant.
- **Reduces administrative burden** for psychologists and GPs by removing non-billable preparation time associated with mandatory written reports.
- **Reduces Medicare expenditure** by eliminating clinically unnecessary consultations for referral renewal.
- **Aligns review processes** with Recommendation 12 of the Better Access Evaluation which supports flexible review cadences based on consumers' levels of need⁷³.

Benefit-Cost Ratio (BCR): 2.19

Anticipated return of \$2.19 per \$1 invested

Objective 3:
Support our youth

**By investing
in the youth of
today, we secure
a healthy and
productive future
for tomorrow**



8. Improving youth access to psychology services



The prevalence of youth mental ill-health across Australia has reached critical levels, as evidenced by multiple Government and non-government reports and research. For example, the Productivity Commission's recent [Review of the National Mental Health and Suicide Prevention Agreement](#) reported that one in seven children and young people aged 4-17 years experienced a mental illness in the past 12 months⁷⁷. Further, the [National Study of Mental Health and Wellbeing \(2020-2022\)](#) found that mental disorders were most prevalent among young people aged 16-24 years, with a substantial increase in prevalence for this cohort between 2007 and 2020-2022⁶⁷. The National Mental Health Commission's [2024 National Report Card](#)⁶⁷ reported a similar pattern when considering rates of psychological stress measured by the *ANUPoll* survey. For the period between 2020 and 2024, the proportion of people with high and very high psychological distress generally decreased as age increased.

Younger Australians experienced higher rates of educational disruption, job loss, housing stress and loneliness during the COVID-19 pandemic, with associated increases in psychological stress, than older age groups⁷⁸. While the immediate distress related to pandemic disruptions has reduced, ongoing prevalence of elevated youth distress likely reflects continued inequalities in these structural drivers of mental health⁷⁸. Many factors may contribute to the rising number of young people experiencing mental disorders, with the links between financial stress, housing insecurity and poor mental health well established. In addition, increasing concerns about climate change and experiences of social isolation and loneliness are likely contributing to elevated youth distress^{67,78}.

Cost is often reported as a significant barrier to accessing mental health services⁷⁷, with younger people most likely to delay or forego mental health services due to cost^{78,79}. Recent analysis of Out-Of-Pocket (OOP) costs for Medicare subsidised mental health services, for example, demonstrates that young people are incurring higher costs than Australians from other age cohorts and are paying more than in the past few years⁸⁰. In the financial year 2022-23, young people aged 15-24 paid an average OOP cost of \$57.69 to access a Medicare subsidised non-inpatient mental health service, representing a 52% increase since 2020-21. Further, in the financial year 2022-23, young people aged 15-24 paid over 35% more for a Medicare subsidised non-inpatient mental health service than those aged 45-64⁸⁰.

We need bold, multi-pronged solutions to reverse this alarming trend and rising out-of-pocket costs. The APS is a long-term advocate for the provision of affordable and accessible youth mental health services. We commend the Federal Government for its 2025 Election Commitments to improve young people's access to mental healthcare⁸¹ including the recent [Orygen Institute-led Consortium](#) review of youth mental health service models.

However, we strongly advocate that these initiatives are only part of the solution. We need to improve accessibility across *every part* of the mental health care system, including psychology services under Better Access, to ensure that our young people receive the right care when and where they need it most.

Initiative 8: Improve youth access to psychology services

Introduce a \$0 youth mental health Medicare safety net threshold for Better Access psychology sessions. Equivalent to the Extended Medicare Safety Net (EMSN) but with no threshold amount, this initiative would mean that young Australians aged 14 to 25 would receive 80% of the out-of-pocket costs for a Better Access psychology service as a Medicare benefit. In doing so, it would mitigate the significant risk of not ensuring access to appropriate psychology resources and support for our young people. This initiative would mean that young people would be able to receive the care they need, regardless of their personal or their family's financial situation.

Specifically, this initiative:

- Ensures that young people can access psychology services without financial hardship for themselves or their families which is consistent with Recommendation 11 of the Better Access Evaluation Final Report⁷³ and our ongoing advocacy.
- Comes immediately into effect for any person aged 14-25 accessing Medicare psychology services. Specifically, a new Medicare Safety Net threshold of \$0 would apply to these services, drastically reducing the cost of essential treatment without expecting psychologists to bear the full burden of improving access.

Expected outcomes

- **Improved mental health** in childhood and potential productivity and higher income as an adult^{82,83}.
- **Avoids higher future health costs** and burden of disease⁸⁴.
- **Increases equity** in accessing essential psychology services⁸⁵.

Benefit-Cost Ratio (BCR): 1.67

Anticipated return of \$1.67 per \$1 invested

9. Strengthening family and carer involvement in children's mental health care

Families and carers play a critical role in supporting children's mental health and wellbeing. They may provide emotional connection, social belonging, and practical assistance⁸⁶⁻⁸⁸. The *Productivity Commission's Mental Health Inquiry Report*⁸⁹ recognised that families and carers provide a substantial proportion of unpaid mental health care, often filling gaps in monitoring, crisis management, and relapse prevention that would otherwise need to be delivered by formal services. This contribution represents significant economic value to Government by reducing demand for acute and community services and enabling earlier intervention.

Family involvement is recognised as an important component of psychological treatment for children across a range of mental health conditions, developmental disorders and challenging behaviours⁹⁰⁻⁹². Accordingly, the APS has long-called for greater support for evidence-based interventions that actively involve parents and carers⁹³.

Despite this, current Better Access arrangements significantly constrain family or carer participation. Family or carer participation sessions are limited to just two per calendar year and are deducted from the child's individual session allocation, effectively discouraging family-inclusive care. While families may attend some or all sessions with the child

present, it is often clinically important for parents and carers to be able to consult with a psychologist without the child present.

In addition, some psychology interventions are 'parent-directed', meaning they focus on providing parents and carers with strategies and skills to support improvement in their child's mental health i.e. they are centred on what the parent or carer does or can do.

Importantly, as is currently the case, the concept of 'family' in youth mental health should be interpreted broadly to reflect the diversity of supportive relationships in a young person's life. 'Family' may include biological relatives, intimate partners, friends, kinship figures, or others who play a significant personal role in the young person's wellbeing⁸⁸. Similarly, a carer may not be a formal or familial caregiver but anyone providing consistent unpaid emotional or practical support. Using these terms flexibly ensures participation sessions can include the individuals who most influence a young person's recovery and engagement, rather than being limited to traditional parent-carer models. This aligns with contemporary mental health frameworks that emphasise person-centred, family-inclusive practice and recognise the varied social networks that support youth mental health recovery^{86,88,94}. Strengthening the capacity of Better Access to include families and carers as indicated by their psychologist recognises their critical role in improving treatment engagement, recovery outcomes, and system efficiency.

Initiative 9: Extend the flexibility of family and carer participation sessions under Better Access

Amend the flexibility of family and carer participation under Better Access to enable greater involvement of families and carers, as suggested by evidence-based best practice, in supporting children's mental health treatment and recovery.

Specifically, this initiative:

- Provides an increased annual allocation of family or carer participation sessions (up to the session limit; currently 10) under Better Access, available when clinically indicated, to strengthen family-inclusive practice and engagement and be aligned with best clinical practice.
- Enables flexible use of these sessions to include parents, carers, siblings or other key supports who play a significant role in the child's mental health and recovery without the child having to be present.
- Provides greater opportunities for 'parent-directed' interventions to best prepare parents to support their children.
- Is a 'cost-neutral' initiative that reinforces the Government's commitment to promoting the wellbeing of children and young people by strengthening the whole support network, rather than viewing the young person in isolation.

Expected outcomes:

- **Improved treatment outcomes** through strengthened communication and shared understanding between the child and their support network⁸⁷.
- **Greater engagement, adherence, and continuity of care**, supporting earlier intervention and more efficient use of existing sessions^{87,88}.
- **Encourage clinicians to integrate family-inclusive practice** within existing treatment frameworks, promoting early intervention and shared understanding between the child, their supports, and the treating practitioner^{86,95}.

10. MBS items related to the assessment of Complex Neurodevelopmental Disorders and eligible disabilities

Appropriate assessment is essential for identifying developmental delay, intellectual disability, autism, and certain disabilities where early diagnosis and support leads to significantly improved long-term outcomes^{96,97}.

Yet comprehensive neurodevelopmental assessments often remain unaffordable and inaccessible for many families.

The introduction of the MBS Complex Neurodevelopmental Disorder and eligible disabilities assessment items⁹⁸ was intended to address this inequity; however, structural design flaws have created new barriers to access and are misaligned with clinical best practice. As we have noted in our submission¹ and public hearing appearance⁹⁹ at the [Inquiry into the Thriving Kids Initiative](#), now is the ideal time to address the current issues associated with these Medicare items to enable appropriate assessments that best determine what supports our young people with developmental delay and other neurodevelopmental conditions require.

Current MBS framework

Medicare items for Complex Neurodevelopmental Disorders and eligible disabilities were established to enable multidisciplinary diagnostic assessment for children and young people (now up to 25 years of age) with complex neurodevelopmental disabilities including autism spectrum disorder, intellectual disability, and chromosomal or pervasive developmental disorders. These items are:

- Available once per lifetime per patient,
- Limited to eight sessions in total, with a mandatory medical review after four sessions, and
- Subject to referral and oversight by a specialist or consultant physician (typically a paediatrician or psychiatrist).

While these items were intended to support early identification and coordinated multidisciplinary care, the mandatory mid-assessment review requirement and capped service structure have led to substantial clinical, financial, and system challenges. In addition, the low rebate available for these items also adds additional barriers regarding their use in practice.

Mid-point review is impractical

The current requirement for mandatory medical review after four sessions (see Figure 3) is administrative rather than clinical in nature. It can interrupt the assessment process, delays completion, and undermines the validity of neurodevelopmental testing.

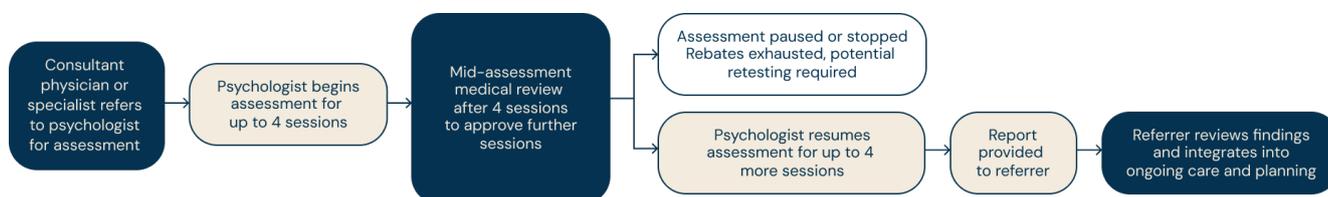


Figure 3: Current process (MBS mandated)¹⁰⁰

Neuropsychological and developmental assessments can differ substantially from standard mental health assessments. They involve caregiver input, clinical observations, and several hours of structured, standardised testing, typically around 3-4 hours of direct assessment time spread over multiple appointments. In addition to direct patient-facing time, assessments also require scoring, interpretation, report writing, and feedback, none of which are currently covered by the MBS.

For validity, standardised testing must be delivered consistently and without interruption so that results can be reliably compared to test norms. Pausing assessment midway for medical review risks compromising validity, delaying diagnosis, and undermining both the clinical and statistical integrity of the process.

The requirement for medical review after four sessions also creates significant access and equity challenges. Securing a paediatrician or psychiatrist appointment mid-assessment often results in lengthy delays; disproportionately affecting families in rural, remote, and First Nations communities, and further compounding existing inequities in access to timely assessment and diagnosis.

In addition, the requirement contributes to system inefficiency by placing unnecessary administrative demands on paediatricians and psychiatrists. Removing the mid-assessment review would allow these specialists to focus on clinical cases where their expertise is essential, rather than routine administrative oversight, improving efficiency across the health system. Moreover, the review provides no additional diagnostic benefit, as the psychologist conducting the assessment is yet to complete gathering and synthesising the relevant clinical information necessary for diagnosis.

As illustrated in Figure 4, a streamlined process would retain specialist oversight at the point of referral and following assessment completion, where results can meaningfully inform ongoing treatment planning. This preserves medical governance considerations while removing unnecessary administrative review, improving access, timeliness, and diagnostic validity, and accuracy.

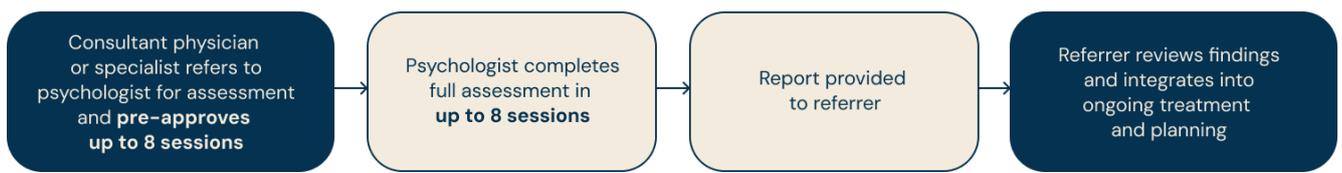


Figure 4: Proposed streamlined process

Impact on access and equity

The current review structure delays both assessment completion and access to intervention, contributing to extended waitlists, fragmented care, and higher out-of-pocket costs. Families in rural, remote, and First Nations communities face particular difficulty obtaining mid-assessment specialist reviews, further exacerbating inequity.

In addition, the lifetime service cap and shared allocation across allied health disciplines force families to choose between essential components of assessment (for example, cognitive versus speech or occupational therapy assessments), undermining the intended multidisciplinary model.

Without targeted reform, families will continue to face significant cost and access barriers when seeking psychological or diagnostic assessments. Many are required to privately fund assessments at considerable expense, particularly in rural and remote settings which can incur additional travel and accommodation costs.

Restructuring the current Complex Neurodevelopmental Disorders and eligible disabilities assessment pathway would streamline diagnostic and referral processes and align rebates with the time and clinical complexity required for multi-disciplinary neurodevelopmental assessment, improving equity and affordability for families across Australia.

These challenges intersect with the broader reform agenda for Foundational Supports, including the Thriving Kids initiative¹⁰¹, which aims to provide early, developmentally appropriate support for children with emerging or mild-to-moderate needs and their families outside the NDIS.

Initiative 10: Restructure MBS items related to the assessment of Complex Neurodevelopmental Disorders

Simplifying referral structures and redesigning neurodevelopmental assessment items would improve access, efficiency, and diagnostic accuracy for children and young people with complex neurodevelopmental conditions and eligible disabilities, while reducing strain on families.

Specifically, this initiative:

- Allows uninterrupted assessment by enabling specialists or consultant physicians to refer to psychologists for up to eight sessions dedicated to diagnostic assessment and intervention, maintaining medical oversight without interrupting testing protocols.
- Establishes separate psychology and allied health allocations to ensure people can access full rebates for psychology-led diagnostic assessments and interventions while preserving access to other necessary allied health assessments (e.g., hearing, speech, or occupational therapy) without exhausting their allocation.
- Creates a dedicated item (or set of items) covering the entire assessment process, including administration, scoring, interpretation, and reporting, to reflect the time and expertise required.
- Adjusts MBS rebate levels to better reflect assessment complexity and duration, reducing out-of-pocket costs and improving access for low-income, regional, and rural families.

Expected outcomes:

- **Improved clinical validity and diagnostic accuracy** by enabling uninterrupted and standardised testing processes consistent with evidence-based assessment protocols.
- **Reduced delays and duplication**, minimising administrative barriers (e.g., mid-assessment medical reviews) and decreasing specialist wait times.
- **Enhanced affordability and access**, particularly for families in rural and low-income areas who currently face high out-of-pocket costs and multiple referral fees.
- **Alignment with Foundational Supports reform under the NDIS**, which aims to provide early, equitable access to supports for people with disability, including neurodevelopmental disorders and developmental delay, outside of the NDIS. Improved neurodevelopmental assessment and treatment pathways available under Medicare would complement these reforms by addressing diagnostic bottlenecks and reducing inequity between NDIS participants and those relying on mainstream supports.

Together, these reforms would create a coherent assessment pathway that complements Thriving Kids and other Foundational Supports initiatives, ensuring children, youth, and families can access early diagnosis and intervention regardless of NDIS eligibility.

References

1. Australian Psychological Society. (2025). *Australian Government Inquiry into the Thriving Kids Initiative*. <https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2025/australian-government-inquiry-into-the-thriving-ki>
2. American Psychological Association. (2020). *What do psychology and psychologists offer humanity?* <https://www.psychology.org.nz/application/files/7415/9772/5216/English-HumanityNeedsPsychology.pdf>
3. Australian Psychological Society. (2024). *Disaster Response Network*. <https://psychology.org.au/disaster-response-network>
4. Australian Psychological Society. (2025). *Thinking Futures: Psychology's role in transforming women and girls' psychological health*. <https://psychology.org.au/getmedia/de877bab-2154-44f6-811d-0fcb4b7eab67/thinking-futures-report-2025.pdf>
5. Lived Experience Australia. (2021). *Consumer and Carer Experiences of Psychology Services in Australia*. https://www.livedexperienceaustralia.com.au/_files/ugd/07109d_2814e70b9ef94966949a7a283f29ed3f.pdf?index=true
6. ACIL Allen. (2025). *The Social and Economic Impact of the Psychology Workforce*.
7. Australian Institute of Health and Welfare. (2022, December 13). *Australian Burden of Disease Study 2022*. Australian Institute of Health and Welfare. <https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2022/contents/about>
8. Australian Bureau of Statistics. (2022). *Health Conditions Prevalence, 2020-21*. <https://www.abs.gov.au/statistics/health/health-conditions-and-risks/health-conditions-prevalence/latest-release>
9. Australian Institute of Health and Welfare. (2024, June 17). *Chronic conditions*. Australian Institute of Health and Welfare. <https://www.aihw.gov.au/reports/australias-health/chronic-conditions-and-multimorbidity>
10. Australian Institute of Health and Welfare. (2024, December 12). *Australian Burden of Disease Study 2024*. Australian Institute of Health and Welfare. <https://www.aihw.gov.au/reports/burden-of-disease/australian-burden-of-disease-study-2024/contents/about>
11. Australian Psychological Society. (2024). *Thinking Futures: Psychology and Climate Change*. <https://psychology.org.au/thinking-futures-report-2024?viewmode=0>
12. The RedBridgE Group. (2024). *Australian Psychological Society Community Survey*.
13. ACIL ALLEN. (2021). *National Mental Health Workforce Strategy—Background Paper*.
14. Psychology Board of Australia. (2025). *Psychology Board of Australia—Redesigning the higher education pathway*. <https://www.psychologyboard.gov.au/About/Education/Redesigning-the-higher-education-pathway.aspx>
15. Psychology Board of Australia. (2024). *Psychology workforce—September 2024*. <https://www.psychologyboard.gov.au/About/Statistics.aspx>

16. Australian Psychological Society. (2023). *Dread, exhaustion and rising helplessness: Inside the burnout among Australia's psychologists*. <https://psychology.org.au/about-us/news-and-media/aps-in-the-media/2023/dread-exhaustion-and-rising-helplessness-inside-t>
17. Macleod, E., Curll, S., Walker, I., Cruwys, T., Greenwood, L.-M., Reynolds, J., Lane, J., Galati, C., Christensen, B., & Calear, A. L. (2025). Mental health, wellbeing, and burnout among practicing psychologists following Australian weather disasters and COVID-19. *International Journal of Disaster Risk Reduction*, 117, 105195. <https://doi.org/10.1016/j.ijdr.2025.105195>
18. Parliament of Australia. (2024). *Australian Universities Accord (Australia)* [Text]. corporateName=Commonwealth Parliament; address=Parliament House, Canberra, ACT, 2600; contact=+61 2 6277 7111. https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/Budget/reviews/2024-25/AustralianUniversitiesAccord
19. Australian Government Department of Education. (2024). *Commonwealth Prac Payment* [Text]. <https://www.education.gov.au/higher-education/commonwealth-prac-payment>
20. Australian Psychological Society. (2024). *APS Response to the Universities Accord (Student Support and Other Measures) Bill 2024 inquiry*. [https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2024/universities-accord-\(student-support-and-other-mea](https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2024/universities-accord-(student-support-and-other-mea)
21. Department of Health, Disability and Ageing. (2026). *Supply and Demand*. <https://hwd.health.gov.au/supply-and-demand/supply-demand-home.html>
22. Psychology Board of Australia. (2024). *Psychology Board of Australia—General registration*. <https://www.psychologyboard.gov.au/Registration/General.aspx>
23. Australian Government Department of Health, Disability and Ageing. (2025, November 13). *Supporting the next generation of psychologists*. <https://www.health.gov.au/ministers/the-hon-emma-mcbride-mp/media/supporting-the-next-generation-of-psychologists>
24. Department of Education. (2023). *Australian Universities Accord Interim Report*. <https://www.education.gov.au/australian-universities-accord/resources/accord-interim-report>
25. Australian Government Department of Education. (2025). *Commonwealth Prac Payment*. <https://www.education.gov.au/commonwealth-prac-payment-cpp>
26. Australian Psychological Society. (2024). *APS Response to Universities Accord (Student Support and Other Measures) Bill 2024 inquiry*. [https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2024/universities-accord-\(student-support-and-other-mea](https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2024/universities-accord-(student-support-and-other-mea)
27. Australian Psychological Society. (2023). *Build, Support, Prepare: Investing in Australia's Future—APS Pre-Budget Submission 2023-24*. <https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2023/aps-pre-budget-submission-2023-24#:~:text=The%20APS%20believes%20that%20the,member%20of%20the%20Australian%20community.>

28. Australian Psychological Society. (2022). *Prevent, Respond, Adapt: Improving the mental health and wellbeing of all Australians—Pre-budget Submission 2022-23*. https://treasury.gov.au/sites/default/files/2022-03/258735_australian_psychological_society.pdf
29. Scott, S., Knott, V., Finlay-Jones, A. L., & Mancini, V. O. (2023). Australian Psychologists Experiences with Digital Mental Health: A Qualitative Investigation. *Journal of Technology in Behavioral Science*, 8(4), 341–351. <https://doi.org/10.1007/s41347-022-00271-5>
30. Kerr, J., & Van Houten, A. (2020). Utilizing digital tools to support face-to-face care: Examining uptake within the practices of Australian psychologists. *Human Technology*, 16(1), 35–54. <https://doi.org/10.17011/ht/urn.202002242162>
31. Bhatt, S. (2024). Digital Mental Health: Role of Artificial Intelligence in Psychotherapy. *Annals of Neurosciences*, 09727531231221612. <https://doi.org/10.1177/09727531231221612>
32. Stade, E. C., Stirman, S. W., Ungar, L. H., Boland, C. L., Schwartz, H. A., Yaden, D. B., Sedoc, J., DeRubeis, R. J., Willer, R., & Eichstaedt, J. C. (2024). Large language models could change the future of behavioral healthcare: A proposal for responsible development and evaluation. *Npj Mental Health Research*, 3(1), 12. <https://doi.org/10.1038/s44184-024-00056-z>
33. Golden, G., Popescu, C., Israel, S., Perlman, K., Armstrong, C., Fratila, R., Tanguay-Sela, M., & Benrimoh, D. (2024). Applying artificial intelligence to clinical decision support in mental health: What have we learned? *Health Policy and Technology*, 13(2), 100844. <https://doi.org/10.1016/j.hlpt.2024.100844>
34. Higgins, O., Short, B. L., Chalup, S. K., & Wilson, R. L. (2023). Artificial intelligence (AI) and machine learning (ML) based decision support systems in mental health: An integrative review. *International Journal of Mental Health Nursing*, 32(4), 966–978. <https://doi.org/10.1111/inm.13114>
35. Grodniewicz, J. P., & Hohol, M. (2023). Waiting for a digital therapist: Three challenges on the path to psychotherapy delivered by artificial intelligence. *Frontiers in Psychiatry*, 14. <https://doi.org/10.3389/fpsy.2023.1190084>
36. Koutsouleris, N., Hauser, T. U., Skvortsova, V., & De Choudhury, M. (2022). From promise to practice: Towards the realisation of AI-informed mental health care. *The Lancet Digital Health*, 4(11), e829–e840. [https://doi.org/10.1016/S2589-7500\(22\)00153-4](https://doi.org/10.1016/S2589-7500(22)00153-4)
37. Zhou, S., Zhao, J., & Zhang, L. (2022). Application of Artificial Intelligence on Psychological Interventions and Diagnosis: An Overview. *Frontiers in Psychiatry*, 13, 811665. <https://doi.org/10.3389/fpsy.2022.811665>
38. Jurblum, M., & Selzer, R. (2024). Potential promises and perils of artificial intelligence in psychotherapy –The AI Psychotherapist (APT). *Australasian Psychiatry*, 10398562241286312. <https://doi.org/10.1177/10398562241286312>
39. Camacho, E., Cohen, A., & Torous, J. (2022). Assessment of Mental Health Services Available Through Smartphone Apps. *JAMA Network Open*, 5(12), e2248784. <https://doi.org/10.1001/jamanetworkopen.2022.48784>

40. Therapeutic Goods Administration (TGA). (2025, December 17). *Seeking input from users of digital mental health tools* [Text]. Therapeutic Goods Administration (TGA). <https://www.tga.gov.au/news/news-articles/seeking-input-users-digital-mental-health-tools>
41. Therapeutic Goods Administration (TGA). (2025, August 29). *TGA focuses on compliance of AI and software-based medical devices* [Text]. Therapeutic Goods Administration (TGA). <https://www.tga.gov.au/news/news-articles/tga-focuses-compliance-ai-and-software-based-medical-devices>
42. Australian Commission on Safety and Quality in Health Care. (2025). *Artificial Intelligence*. <https://www.safetyandquality.gov.au/our-work/e-health-safety/artificial-intelligence>
43. Department of Health, Disability and Ageing. (2025). *Safe and Responsible Artificial Intelligence in Health Care – Legislation and Regulation Review*. <https://www.health.gov.au/sites/default/files/2025-07/safe-and-responsible-artificial-intelligence-in-health-care-legislation-and-regulation-review-final-report.pdf>
44. The Australian Government. (2025). *Mid-Year Economic and Fiscal Outlook 2025–26*. <https://budget.gov.au/content/myefo/download/myefo-2025-26.pdf>
45. Australian Psychological Society. (2023). *APS Response to the Safe and Responsible AI in Australia Discussion Paper*. <https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2023/aps-response-to-the-safe-and-responsible-ai-in-aus>
46. Australian Psychological Society. (2024). *APS Pre-Budget Submission 2024-25 – Looking to the future: Leveraging psychology to strengthen Australia’s resilience*. <https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2024/aps-pre-budget-submission-2024-25>
47. Australian Psychological Society. (2024). *APS Submission to the Department of Industry, Science and Resources Consultation on Mandatory AI Guardrails in High-Risk Settings*. <https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2024/submission-ai-guardrails-high-risk-settings>
48. Fisher, A., Corrigan, E., Cross, S., Ryan, K., Staples, L., Tan, R., Titov, N., & Dear, B. F. (2023). Decision-making about uptake and engagement with digital mental health services: A qualitative exploration of service user perspectives. *Clinical Psychologist, In press*. <https://doi.org/10.1080/13284207.2023.2279657>
49. Select Committee on the Impact of Climate Risk on Insurance Premiums and Availability. (2024). Chapter 2—Impact of climate change and more frequent and severe natural disasters. In *Report—Inquiry into the Impact of Climate Risk on Insurance Premiums and Availability*. Parliament of Australia. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Impact_of_Climate_Risk_on_Insurance/ClimateRiskonInsurance/Report/Chapter_2_-_Impact_of_climate_change_and_more_frequent_and_severe_natural_disasters
50. Xu, R., Yu, P., Liu, Y., Chen, G., Yang, Z., Zhang, Y., Wu, Y., Beggs, P. J., Zhang, Y., Boocock, J., Ji, F., Hanigan, I., Jay, O., Bi, P., Vargas, N., Leder, K., Green, D., Quail, K., Huxley, R., ... Guo, Y. (2023). Climate change, environmental extremes, and human health in Australia: Challenges, adaptation strategies, and policy gaps. *The Lancet Regional Health - Western Pacific, 40*, 100936. <https://doi.org/10.1016/j.lanwpc.2023.100936>

51. National Emergency Management Agency. (2023). *National Disaster Mental Health and Wellbeing Framework*. <https://nema.gov.au/about-us/budget-2023-24/Mental-Health-Wellbeing-Framework>
52. Cianconi, P., Betrò, S., & Janiri, L. (2020). The Impact of Climate Change on Mental Health: A Systematic Descriptive Review. *Frontiers in Psychiatry, 11*, 490206. <https://doi.org/10.3389/fpsyt.2020.00074>
53. Li, A., & Leppold, C. (2025). Long-term mental health trajectories across multiple exposures to climate disasters in Australia: A population-based cohort study. *The Lancet Public Health, 10*(5), e391–e400. [https://doi.org/10.1016/s2468-2667\(25\)00068-4](https://doi.org/10.1016/s2468-2667(25)00068-4)
54. Hayes, K., Blashki, G., Wiseman, J., Burke, S., & Reifels, L. (2018). Climate change and mental health: Risks, impacts and priority actions. *International Journal of Mental Health Systems, 12*(1), 28. <https://doi.org/10.1186/s13033-018-0210-6>
55. *Psychology and Climate Change: Position statement | APS*. (2020). Retrieved October 19, 2023, from <https://psychology.org.au/about-us/position-statements/psychology-and-climate-change>
56. Brooks, S. K., Dunn, R., Amlôt, R., Greenberg, N., & Rubin, G. J. (2016). Social and occupational factors associated with psychological distress and disorder among disaster responders: A systematic review. *BMC Psychology, 4*(1), 18. <https://doi.org/10.1186/s40359-016-0120-9>
57. Mohtady Ali, H., Ranse, J., Roiko, A., & Desha, C. (2022). Healthcare Workers' Resilience Toolkit for Disaster Management and Climate Change Adaptation. *International Journal of Environmental Research and Public Health, 19*(19), 12440. <https://doi.org/10.3390/ijerph191912440>
58. Brooks, S., Amlôt, R., Rubin, G. J., & Greenberg, N. (2020). Psychological resilience and post-traumatic growth in disaster-exposed organisations: Overview of the literature. *BMJ Mil Health, 166*(1), 52–56. <https://doi.org/10.1136/jramc-2017-000876>
59. *Disaster Response Network | APS*. (n.d.). Retrieved November 26, 2025, from <https://psychology.org.au/disaster-response-network>
60. Australian Government Department of Health and Aged Care. (2023, December 1). *National Health and Climate Strategy* [Text]. Australian Government Department of Health and Aged Care; Australian Government Department of Health and Aged Care. <https://www.health.gov.au/our-work/national-health-and-climate-strategy>
61. Productivity Commission. (2020). *Mental Health, Report no. 95*. <https://www.pc.gov.au/inquiries/completed/mental-health/report>
62. Longman, J., Braddon, M., Verlie, B., Schlosberg, D., Hampshire, L., Hawke, C., Noonan, A., & Saurman, E. (2023). Building resilience to the mental health impacts of climate change in rural Australia. *The Journal of Climate Change and Health, 12*, 100240. <https://doi.org/10.1016/j.joclim.2023.100240>
63. *The National Mental Health and Suicide Prevention Agreement | Federal Financial Relations*. (n.d.). Retrieved November 26, 2025, from <https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement>

64. Australian Government Department of Health, D. and A. (2025, November 7). *National Mental Health Workforce Strategy 2022–2032* [Text]. Australian Government Department of Health, Disability and Ageing. <https://www.health.gov.au/our-work/national-mental-health-workforce-strategy-2022-2032>
65. Marchese, D. (Director). (2024). “Do I put food on the table or go to therapy?” [Broadcast]. In *Hack*. <https://www.abc.net.au/triplej/programs/hack/hack/103414072>
66. Australian Psychological Society. (2024). *People losing access to psychology services amid cost-of-living crisis, APS member poll reveals*. <https://psychology.org.au/about-us/news-and-media/media-releases/2024/people-losing-access-to-psychology-services-amid-c>
67. National Mental Health Commission. (2025, July 18). *National Report Card 2024*. National Mental Health Commission. <https://www.mentalhealthcommission.gov.au/publications/national-report-card-2024>
68. Black, N., Harris, A., Johnston, D. W., & Trinh, T.-A. (2024). *Workforce Impacts of Subsidised Mental Healthcare: Evidence on Supply, Earnings, and Geographic Distribution* (SSRN Scholarly Paper No. 5006944). Social Science Research Network. <https://doi.org/10.2139/ssrn.5006944>
69. Duggan, M., Harris, B., Chislett, W.-K., & Calder, R. (2020). *Nowhere else to go: Why Australia’s Health System Results in People with Mental Illness Getting “Stuck” in Emergency Departments*. A commissioned report to the Australasian College for Emergency Medicine.
70. Australian Medical Association. (2022). *Why medicare indexation matters*. <https://www.ama.com.au/sites/default/files/2022-11/AMA%27s-plan-to-Modernise-Medicare-Why-Medicare-indexation-matters.pdf>
71. Klein, T., Breilmann, J., Schneider, C., Giralanda, F., Fiedler, I., Dawson, S., Crippa, A., Priebe, S., Barbui, C., Becker, T., & Kösters, M. (2024). Dose–response relationship in cognitive behavioral therapy for depression: A nonlinear metaregression analysis. *Journal of Consulting and Clinical Psychology*, 92(5), 296–309. <https://doi.org/10.1037/ccp0000879>
72. Nordmo, M., Monsen, J. T., Høglend, P. A., & Solbakken, O. A. (2021). Investigating the dose–response effect in open-ended psychotherapy. *Psychotherapy Research*, 31(7), 859–869. <https://doi.org/10.1080/10503307.2020.1861359>
73. Pirkis, J., Currier, D., Harris, M., Mihalopoulos, C., Arya, V., & Banfield, M. (2022). *Main Report—Evaluation of the Better Access initiative*. Australian Government Department of Health and Aged Care; Australian Government Department of Health and Aged Care. <https://www.health.gov.au/resources/publications/main-report-evaluation-of-the-better-access-initiative?language=en>
74. Gülpen, J., Breedvelt, J. J. F., Dis, E. A. M. van, Geurtsen, G. J., Warren, F. C., Heeringen, C. van, Hitchcock, C., Holländare, F., Huijbers, M. J., Jarrett, R. B., Jermann, F., Jonge, M. de, Klein, D. N., Klein, N. S., Ma, S. H., Moore, M. T., Denys, D. A. J. P., Williams, J. M. G., Kuyken, W., & Bockting, C. L. (2025). Psychological interventions for preventing relapse in individuals with partial remission of depression: A systematic review and individual participant data meta-analysis. *Psychological Medicine*, 55, e50. <https://doi.org/10.1017/S0033291725000157>

75. Krijnen-de Bruin, E., Scholten, W., Muntingh, A., Maarsingh, O., van Meijel, B., van Straten, A., & Batelaan, N. (2022). Psychological interventions to prevent relapse in anxiety and depression: A systematic review and meta-analysis. *PLoS One*, *17*(8), e0272200. <https://doi.org/10.1371/journal.pone.0272200>
76. Wojnarowski, C., Firth, N., Finegan, M., & Delgadillo, J. (2019). Predictors of depression relapse and recurrence after cognitive behavioural therapy: A systematic review and meta-analysis. *Behavioural and Cognitive Psychotherapy*, *47*(5), 514–529. <https://doi.org/10.1017/S1352465819000080>
77. Productivity Commission. (2025). *Inquiry Report—Mental Health and Suicide Prevention Agreement Review*. Retrieved November 14, 2025, from <https://www.pc.gov.au/inquiries-and-research/mental-health-review/report/>
78. Australia's Mental Health Think Tank, Smout, S., Scott, L. M., Donohoe-Bales, A., Sedgwick, C. C., Spallek, S., & Bower, M. (2025). *Building Mentally Healthy Futures: A Call to Action*. https://ses.library.usyd.edu.au/bitstream/handle/2123/33685/Building%20Mentally%20Healthy%20Futures_A%20Call%20to%20Action%202025.pdf?sequence=1&isAllowed=y
79. Healthengine and Patients Australia. (2025). *Australian Healthcare Index September 2025 Report*. <https://australianhealthcareindex.com.au/australian-healthcare-index-september-2025-report/>
80. System 2 Centre for Behavioural and System Change. (2024). *Cost of accessing mental health services for young people*. <https://system2.org.au/wp-content/uploads/2024/12/System-2-Research-Cost-of-accessing-mental-health-services-for-young-people-Dec-2024.pdf>
81. *APS welcomes \$1 billion mental health package as meaningful step toward system-wide reform* | APS. (2025). Retrieved November 14, 2025, from [https://psychology.org.au/about-us/news-and-media/media-releases/2025/aps-welcomes-\\$1-billion-mental-health-package-as-m](https://psychology.org.au/about-us/news-and-media/media-releases/2025/aps-welcomes-$1-billion-mental-health-package-as-m)
82. Centre for Longitudinal Studies. (2015). *Counting the true cost of childhood psychological problems in adult life* [UCL]. <https://cls.ucl.ac.uk/counting-the-true-cost-of-childhood-psychological-problems-in-adult-life/>
83. Smith, J. P., Monica, S., & Smith, G. C. (2010). Long-Term Economic Costs of Psychological Problems During Childhood. *Social Science & Medicine* (1982), *71*(1), 110–115. <https://doi.org/10.1016/j.socscimed.2010.02.046>
84. Le, L. K.-D., Esturas, A. C., Mihalopoulos, C., Chiotelis, O., Bucholc, J., Chatterton, M. L., & Engel, L. (2021). Cost-effectiveness evidence of mental health prevention and promotion interventions: A systematic review of economic evaluations. *PLoS Medicine*, *18*(5), e1003606. <https://doi.org/10.1371/journal.pmed.1003606>
85. Young, E., & Timms, P. (2023, March 13). Chantelle stopped psychologist visits due to cost. She says they've become something only the wealthy can afford. *ABC News*. <https://www.abc.net.au/news/2023-03-14/mental-health-inequities-widening-lower-income-earners/102009884>
86. Strawa, Cat. (2022). *Family-inclusive approaches when working with young people accessing mental health support*. Retrieved November 12, 2025, from <https://aifs.gov.au/resources/short-articles/family-inclusive-approaches-when-working-young-people-accessing-mental>

87. Andrews, B., Krishnamoorthy, G., Dallinger, V. C., & Maybery, D. (2024). The Role of Caregivers in Promoting Connectedness in Youth with Mental Health Concerns. *Children*, 11(12), 1469. <https://doi.org/10.3390/children11121469>
88. Maybery, Darryl, Casey Jaffe, Irene, Cuff, Rose, Duncan, Zoe, Grant, Anne, Kennelly, Melissa, Ruud, Torleif, Skogoy, Bjorg Eva, Weimand, Bente, & Reupert, Andrea. (2021). Mental health service engagement with family and carers: What practices are fundamental? *BMC Health Services Research*, 21(1073). <https://doi.org/10.1186/s12913-021-07104-w>
89. Productivity Commission. (2020, June 30). *Mental health inquiry: Final report Volume 1, no. 95*. Commonwealth of Australia. <https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf>
90. Australasian ADHA Professionals Association. (2022). *ADHD Guideline Recommendations and Decision-Making Flowchart for Clinicians*. <https://adhdguideline.aadpa.com.au/adhd-treatment-overview-for-clinicians/>
91. NICE. (2017). *Antisocial behaviour and conduct disorders in children and young people: Recognition and management*. NICE. <https://www.nice.org.uk/guidance/cg158/chapter/Recommendations>
92. Australian Psychological Society. (2024). *Evidence-based psychological interventions in the treatment of mental disorders: A literature review*. <https://psychology.org.au/for-the-public/psychology-topics/evidence-based-psychological-interventions>
93. Australian Psychological Society. (2019). *The future of psychology in Australia*. <https://psychology.org.au/getmedia/7f21826a-f7bb-416e-8b37-8f51e8fce5a7/aps-white-paper-at-a-glance.pdf>
94. headspace. (2023). *Family inclusive practice handbook*. headspace. https://headspace.org.au/assets/download-cards/FamilyInclusivePracticeHandbook_Revised.pdf
95. Productivity Commission. (2020). *Mental Health, Report no. 95*. <https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf>
96. Okoye, C., Obialo-Ibeawuchi, C. M., Obajeun, O. A., Sarwar, S., Tawfik, C., Waleed, M. S., Wasim, A. U., Mohamoud, I., Afolayan, A. Y., & Mbaezue, R. N. (n.d.). Early Diagnosis of Autism Spectrum Disorder: A Review and Analysis of the Risks and Benefits. *Cureus*, 15(8), e43226. <https://doi.org/10.7759/cureus.43226>
97. Zoppé, H., Trocmet, L., Rambault, A., Abtroun, Y., Defresne, D., Ansoborlo, M., Hazard, M., & Bonnet-Brilhault, F. (2025). Early detection of neurodevelopmental disorders in children with delayed milestones: Navigating between overlapping trajectories and the limits of a single-diagnosis categorical approach (A Preliminary Study for the CONDOR Cohort). *Asian Journal of Psychiatry*, 109, 104561. <https://doi.org/10.1016/j.ajp.2025.104561>
98. Australian Government Department of Health and Aged Care. (2023). *Complex neurodevelopmental disorders and eligible disabilities: Changes to MBS items for medical practitioners*. [https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/content/17981F6D86263E7CCA2589490006D723/\\$File/PDF%20Version%20QRG-1%20March%202023%20changes%20for%20items%20135%20137%20139%20and%20289_%202401.pdf](https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/content/17981F6D86263E7CCA2589490006D723/$File/PDF%20Version%20QRG-1%20March%202023%20changes%20for%20items%20135%20137%20139%20and%20289_%202401.pdf)

99. *Inquiry into the thriving kids initiative: Hearing before the Standing Committee on Health, Aged Care and Disability* (2025).
https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;adv=yes;orderBy=priority,doc_date-rev;page=2;query=Dataset%3AcomRep;rec=9;resCount=Default
100. Australian Government Department of Health and Aged Care. (2023). *Complex neurodevelopmental disorder and eligible disability FAQs*.
[https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/17981F6D86263E7CCA2589490006D723/\\$File/PDF%20Version%20-%20FAQ%20-%20CNDD%20and%20eligible%20disability%20-%201%20March%202023.pdf](https://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/17981F6D86263E7CCA2589490006D723/$File/PDF%20Version%20-%20FAQ%20-%20CNDD%20and%20eligible%20disability%20-%201%20March%202023.pdf)
101. Australian Government Department of Health, Disability and Ageing. (2025, August 25). *Thriving Kids – a new program to support children with developmental delay and autism, and their families* [Text]. Australian Government Department of Health, Disability and Ageing. <https://www.health.gov.au/news/thriving-kids-a-new-program-to-support-children-with-developmental-delay-and-autism-and-their-families>

We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to their Elders, past and present, for they hold the dreams of Australia's First Nations Peoples. We acknowledge people with lived and living experience and those who care for them. Their knowledge and experience serve us all and remind us of what is most important in the work we do.

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