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AUSTRALIAN ASSOCIATION *of* PSYCHOLOGISTS INC

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# Feedback to the Mental Health and Suicide Prevention Agreement Review

11 March 2025

To the committee,

We are writing to provide our thoughts on the Productivity Commission final review of the National Mental Health and Suicide Prevention Agreement. The Australian Association of Psychologists Incorporated (AAPi) is the leading not-for-profit peak body representing all psychologists Australia-wide. We represent over 14,000 psychologists and are committed to supporting the health and well-being of psychologists in Australia, and all Australians who need access to psychological support

Suicide remains one of the leading causes of death for Australians, with more than 3,000 people dying by suicide every year. Suicide prevention is complex given the range of factors that can contribute to suicidal distress. In addition to efforts to strengthen the mental health system, effective suicide prevention requires targeted approaches to ensure a range of supports are available to individuals in need.

Please see our responses below.

Consultation scope

a) The impact of mental health and suicide prevention programs and services delivered under the National Agreement to Australia's wellbeing and productivity

In 2023, 1.8% of all deaths registered were by suicide (3,214 suicide deaths of 183,131 total). There are still on average nine suicides per day across Australia, which means there is still significant work to be done to reduce this figure to zero (AIHW, 2025). There is a limited effectiveness of the mental health and suicide prevention programs and services because of a lack of funded services and large unmet needs in the community, due to an incidence of psychological distress that is currently experienced by the community

b) the effectiveness of reforms to achieve the objectives and outcomes of the National Agreement including across different communities and populations

Monitoring the number, trends and rates of suicide in Australia is key to understanding who is at risk and for the planning and targeting of suicide prevention activities, and this is a key objective in the national agreement.

Early reviews indicate that the reforms have positively impacted overall wellbeing and productivity by enhancing access to mental health services and integrating support systems across jurisdictions. However, challenges remain in ensuring equitable access for all communities, particularly in rural and remote areas. Without a significant investment into the mental health sector, the level of psychological distress that is

often a precursor to suicidality will remain high and unmet, particularly in at-risk groups.

The National Agreement on Closing the Gap includes provisions for improving social and emotional wellbeing among Aboriginal and Torres Strait Islander communities. The SEWB Policy Partnership focuses on a holistic approach, addressing mental health, cultural connections, and social determinants of health. Initial outcomes suggest that these reforms are fostering better mental health and community cohesion, though continuous efforts are needed to address systemic barriers and ensure sustainable progress. The effectiveness of reforms varies across different communities and populations. For instance, culturally and linguistically diverse (CALD) communities, LGBTIQA+ individuals, and people with disabilities have unique needs that require tailored approaches. The National Agreement emphasises inclusive policies and programs to cater to these diverse groups, but ongoing monitoring and adaptation are crucial to address emerging challenges and disparities.

Regular reviews and stakeholder consultations help identify gaps and areas for improvement, ensuring that reforms remain aligned with the objectives of enhancing wellbeing and productivity. Overall, while the reforms under the National Agreement have made significant strides in improving Australia's wellbeing and productivity, continuous evaluation and adaptation are necessary to address the diverse needs of different communities and populations.

c) the opportunities under the National Agreement to adopt best practice approaches across Australia, particularly where productivity improvements could be achieved

Productivity improvements could be achieved in many ways, firstly by increasing in the number of Medicare Better Access sessions available to clients. This is restricted to a maximum of 10 sessions per calendar year, drastically reducing the available treatment options for clients and reducing treatment effectiveness. Cognitive Behavioural Therapy (CBT) literature indicates an average of 12 sessions for clients to gain benefit from treatment, and Schema Therapy recommends 40+ sessions for complex presentations such as trauma and personality disorders. Dialectical Behaviour Therapy recommends 1-2 years of treatment for personality disorders and co-morbid trauma, including a multidisciplinary approach involving in-patient stays, outpatient groups, and individual therapy and phone coaching. By these standards, 10 Medicare rebated psychology sessions per calendar year are vastly deficient. For more complex clients, it forces them to either space out the frequency of their sessions or wait until the following year to access more rebated treatment, which by that point could mean a significant regression in their wellbeing.

The Better Access review indicated that consumers who had more complex needs would benefit from an increase in Medicare-funded Mental Health Care Plan sessions,

and evidence has shown that particularly complex clients with eating disorders are already benefitting from the additional care plan sessions afforded to them through the Eating Disorders Treatment Plan of up to 40 sessions per calendar year. Psychologists cannot work to their full scope of practice if the public cannot afford to access reasonable treatment amounts, as rebate amounts and the number of rebated sessions available are inadequate for their presenting problem. If this continues, psychologists working within the few allowable therapeutic modalities allowed by Medicare will not be able to provide treatment that completely resolves the symptoms of mental health conditions, meaning that clients will present with a need for treatment for long after they should require this.

There is also the chronic issue of the continued workforce shortage. There is a significant need to utilise provisional psychologists' full scope of practice (The McKell Institute, 2023). Provisional psychologists are, at a minimum, four or five-year educated psychologists embarking on a final period of supervised practice, which is overseen and mentored by a qualified psychologist. They have studied each of the competencies required for registration and are gaining relevant experience under supervision to meet full registration requirements. At present, a significant proportion of provisional psychologists engage in unpaid employment to meet their requirements for full registration. Given the increasing demand for psychology services and increasing waiting lists to access psychologists, we believe that allowing provisional psychologists to provide Medicare services a necessary and effective solutions to swiftly improve the availability of much-needed mental health care support for Australians.

d) the extent to which the National Agreement enables the preparedness and effectiveness of the mental health and suicide prevention services to respond to current and emerging priorities

   Many of the principles in the agreement have not been met. Suicide prevention in Australia requires a holistic approach that integrates social, economic, and health policy reforms. While there have been commendable efforts in mental health and suicide prevention, gaps persist due to systemic fragmentation, workforce shortages, and policy constraints. The following discussion outlines how current policies and initiatives must evolve to meet essential priorities in reducing suicide rates nationwide.

   - Facilitate an effective investment, policy and service mix that reduces gaps and overlaps in mental health and suicide prevention services to best support mental health outcomes;

   Medicare sessions were reduced from 20 to 10 in 2023, with the Federal Government stating they would introduce community programs to support the people who would be impacted by this. These services are still yet to materialise.

Mental health and suicide prevention services remain fragmented across prevention, primary care, and specialist settings. Many individuals fall through the gaps, particularly those with severe and enduring conditions. Addressing this requires integration of mental health services across healthcare and social services, increased funding for community-based mental health care, and targeted workforce initiatives to recruit and retain professionals, particularly in rural and regional areas.

- Reduce system fragmentation, gaps and duplication across prevention, primary and secondary care specialist settings with an increased focus on prevention, early intervention and effective management of severe and enduring conditions in the community and tertiary settings;

Outdated Medicare legislation significantly limits access to evidence-based mental health care. The current cap on subsidised sessions and inadequate rebates place psychological support out of reach for many. Critical reforms should include the expansion of Medicare-subsidised mental health sessions beyond the current limit that leaves too many Australians out of pocket, an increased rebates for psychological and psychiatric services to improve affordability, and the inclusion of more evidence-based treatments under Medicare to cater to diverse needs.

- Support and enhance the capability of the mental health, suicide prevention and broader health and related workforce to meet current and future needs, particularly in rural, regional and remote communities and priority populations;

There is a significant shortage of mental health professionals in rural, regional, and remote areas, making it difficult for residents to access timely and appropriate care. To ensure a sustainable workforce that meets current and future needs, training and education must be rolled out nationally consistently. This includes increasing incentives for healthcare workers to practice in underserved regions and enhancing university and vocational training programs with rural placements. Additionally, policies should support career progression and retention in these areas through financial incentives, professional development opportunities, and improved workplace conditions.

- Ensure the particular needs of Australia's rural, regional and remote communities are equitably addressed;

♦ The increasing frequency of climate-related disasters (e.g., bushfires, floods) exacerbates distress, particularly in rural and regional areas. Climate anxiety is also growing, especially among young Australians. To address this, the government must commit to real zero emissions and drastically reduce the use of fossil fuels before 2035, mental health services should incorporate climate distress interventions, greater investment in community resilience programs and disaster recovery

support, and implement a national climate adaptation strategy that integrates mental health considerations.

- Recognise the role of social determinants of health on people's mental health and wellbeing, and facilitate a whole-of-system approach that draws together mental health and suicide prevention services and other services delivered by government outside of the health system.

Stable housing is a fundamental determinant of mental health. The current crisis in housing affordability and soaring rental prices place individuals and families at increased risk of homelessness, financial distress, and mental health deterioration. Addressing this requires increased investment in social and affordable housing initiatives, stronger rental protections, including rental caps and longer-term lease and expansion of crisis housing options for those experiencing acute distress or domestic violence.

- Financial insecurity is a significant contributor to stress, anxiety, and suicidality. The rising cost of living, including food, utilities, and healthcare, exacerbates distress for many Australians. Policy responses should include increased social welfare support, including a liveable JobSeeker payment, targeted financial assistance programs for individuals experiencing economic hardship and economic policies that prioritise job security and fair wages.

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- Work together to close the gap, improve mental health and wellbeing outcomes and reduce suicide for vulnerable cohorts, including Aboriginal and Torres Strait Islander peoples, CALD communities, LGBTQIA+SB communities, people impacted by problematic substance use and people with a co-occurring disability, and deliver services to these cohorts in a culturally and locally appropriate manner.

Aboriginal and Torres Strait Islander peoples are overrepresented in suicide statistics, with suicide rates among First Nations people being twice as high as the general Australian population. This crisis is particularly alarming among First Nations children and young people. The impact of intergenerational trauma, systemic disadvantage, and inadequate access to culturally appropriate mental health services contribute to these distressing figures. Suicide prevention efforts must prioritise community-led, culturally safe interventions that empower First Nations communities. Increased investment in Aboriginal Community Controlled Health Organisations (ACCHOs), expansion of culturally competent mental health services, and recognition of Indigenous healing frameworks are essential. Addressing social determinants such as housing, employment, and education is also crucial to reducing suicide rates and improving long-term mental health outcomes.

e) whether any unintended consequences have occurred such as cost shifting, inefficiencies or adverse consumer outcomes

The rise of AI-driven mental health services presents both opportunities and risks. While AI can improve accessibility, it cannot replace human connection, particularly for those in crisis. Necessary safeguards include immediate regulatory oversight of AI-driven mental health services to ensure ethical standards, investment in hybrid models that combine AI efficiency with human-led care, and policies that prevent cost-cutting measures leading to a reduction in professional mental health support.

There are also broad inefficiencies across Medicare legislation.

Currently, there are legislative and funding barriers that prevent psychologists from working to their full scope of practice. This relates to Area of Practice Endorsement (AoPE) being misused across the sector. Scope of practice and endorsement are frequently confused.
Scope of practice refers to the professional role and services that an individual registered practitioner is educated, trained and competent to perform. The scope of practice for psychologists is defined by the general registration competencies. These competencies distinguish a psychologist from other professions. The competencies describe the knowledge, skills, abilities, behaviours, values, and other attributes that enable a person to engage in safe and effective practice as a psychologist in Australia. An individual's scope of practice evolves over time and can change depending on their career path, experience, further training, and interests.

The general registration competencies are relevant to all psychologists who hold general registration, including those with an AoPE and those without. The psychology profession only has three registration categories: provisional, general, and non-practicing. AoPE is not a separate registration category but a notation on general registration. Endorsement should not be conflated with scope of practice and should not be used to decide on remuneration or limit employment. An individual's experience is more appropriate. Endorsement also does not equate to higher levels of education. Many psychologists with general registration have more education and training than those with an endorsement. There are nine endorsement categories in Australia, as well as general registration. The vast majority of psychologists (70%) do not have an endorsement. Limiting employment eligibility, restricting career progression or remunerating psychologists differently based on endorsement status alone is harmful to all concerned. It is harmful to the employer as it restricts whom they can employ in certain positions to a much smaller group of potential applicants. It is reducing the ability to employ or retain experienced psychologists who do not fit this arbitrary criterion. This is particularly problematic due to extreme workforce shortages in the sector.

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

All psychologists provide the same service to the same standards and to the same population. The endorsement system has caused divisiveness in the profession, financial disadvantage, misleading information, and restriction of psychological service provision to the Australian public. Ultimately, it is the community members in need who are missing out. This erroneous notion of superior skills based on area of practice endorsement versus actual competency has additionally contributed to severe negative impacts on an economic/financial level, career viability and the wellbeing of the psychology profession. The Medicare system is a cause of significant confusion and misunderstanding of the scope of practice of psychologists. Rebates for psychological services are arbitrarily divided into clinical psychology services and all other psychologist services (8 other endorsement types and those without endorsement, which represents the majority, 70%, of the profession). Clinical psychologist services receive a 40% higher rebate for clients. The same services provided by psychologists without clinical endorsement receive a significantly lower and largely insufficient rebate. This restricts the availability and affordability of psychological care for many Australians. This creates a two-tiered system that discriminates against psychologists and their clients. There is no evidence to support a two-tier system for psychologists and no evidence that endorsement leads to improved patient outcomes. The two-tier system is a historical error that must be corrected.

f) effectiveness of the administration of the National Agreement, including the integration and implementation of Schedule A and the bilateral schedules that support its broader goals.

The National Agreement emphasises a collaborative approach between the Commonwealth, state, and territory governments. The integration of Schedule A, which outlines funding and resource allocation, ensures that all parties are aligned in their efforts.

The bilateral schedules, although tailored to the specific needs of each state and territory, allowing for more targeted and effective interventions, are still underfunded from a state level. While there may have been some increases in investment and new

services established more needs to be done to ensure that the needs of the community are met.

Overall, while the administration of the National Agreement has made significant strides, continuous evaluation and adaptation are necessary to address emerging challenges and ensure that the reforms are effectively integrated and implemented across different jurisdictions.

g) effectiveness of reporting and governance arrangements for the National Agreement

As the National Agreement is not enforceable, unfortunately many of the key priority areas have not been met. The Commonwealth and state governments have failed to adequately fund and integrate mental health and suicide prevention services across critical sectors such as justice, education, disability services, and housing. Mental health does not exist in isolation; it is deeply intertwined with broader social determinants of health. However, gaps remain in cross-sector collaboration, resulting in individuals being passed between services without effective coordination. Governments must prioritise sustainable funding for school-based mental health programs to support early intervention which includes adequate allocation of school psychologists to support assessments and treatment, integrated mental health support within justice and corrections systems to address high rates of suicide among incarcerated individuals and strengthened partnerships between mental health services and homelessness support providers to prevent housing instability from exacerbating psychological distress.

Many Australians living with severe mental illness do not qualify for the National Disability Insurance Scheme (NDIS) yet still require ongoing psychosocial support. The lack of a coordinated, sustainable funding model has left many individuals without essential services, leading to poor mental health outcomes and increased suicide risk. The Commonwealth and states have not effectively worked together to develop future psychosocial support arrangements, resulting in service gaps and inconsistent access. To address this, governments must immediately develop and implement a long-term funding model for non-NDIS psychosocial support services, clearly define roles and responsibilities across federal and state levels to ensure service continuity, and expand community-based psychosocial support programs to reduce reliance on acute mental health services.

h) applicability of the roles and responsibilities established in the National Agreement, and

The applicability of roles and responsibilities in the National Agreement is appropriate, but again, as these are not bound by law, the roles and responsibilities are not uniformly met, and this is an issue. This results in uneven service delivery, funding shortfalls, and gaps in support for vulnerable populations. Without enforceable accountability measures, governments can shift responsibility without ensuring services are delivered effectively. A legally binding framework, increased transparency, and stronger intergovernmental collaboration are necessary to make the agreement more effective in reducing suicide rates nationwide.

i) without limiting the matters on which the PC may report, in making recommendations the PC should consider the complexity of integrating services across jurisdictions and ensuring that the voices of First Nations people and those with lived and/or living experience of mental ill-health and suicide, including families, carers and kin are heard and acted upon.

The Productivity Commission must acknowledge the ongoing challenge of integrating mental health services across jurisdictions while ensuring that the voices of First Nations people and those with lived and/or living experience of mental ill-health and suicide, including families, carers, and kin, are meaningfully heard and acted upon. Many consultations and inquiries to date have failed to integrate all evidence-based recommendations consistently, or at times, at all. This fragmented approach has resulted in a patchwork of service provision that does not adequately meet community needs, further entrenching distrust and frustration. The repeated failure to implement comprehensive, culturally responsive, and person-cantered reforms is damaging community sentiment, as those most affected by mental ill-health continue to feel unheard and disregarded in decision-making processes that directly impact their lives. A truly effective mental health system requires a commitment to translating consultation findings into concrete, accountable action that prioritises lived experience and systemic equity.

The AAPi appreciates the opportunity to contribute to this inquiry and urges the Committee to consider the above recommendations. We remain committed to collaborating with stakeholders to eliminate suicide in Australia.

Sincerely,

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