AAPi
AUSTRALIAN ASSOCIATION
of PSYCHOLOGISTS INC
a true voice for psychology

Feedback on the Mental Health and Suicide Prevention Agreement Review Interim Report

17 July, 2025

Dear Productivity Commission,

The Australian Association for Psychologists Incorporated thanks the Productivity Commission for seeking further submissions on the Mental Health and Suicide Prevention Agreement Review Interim Report. We hope the information we provide below is of assistance. We have restricted our feedback to matters that are particularly pertinent to the practice of psychology in Australia.

Throughout the report, it is clear that the drivers of mental ill-health are increasing, as is demand for services, but unless something is done to lower costs and increase the professional health services workforce, the gap between demand for mental health services and supply of those services will continue to grow. The AAPi have been in discussions with the Federal government for several years about our concerns, and we partnered with industry researchers in the development of the McKell report 'Under Pressure, 2022', which we have attached as an additional document for your perusal. This has also been handed in to multiple Federal ministers, including Mark Butler.

The AAPi was not surprised by many of the responses from consumers. We have long been advocating for significant changes to the Medicare system, and increasing access and affordability to mental health support services such as psychology. Currently in Australia, 7,845 provisional psychologists are unable to provide their clients with Medicare rebates. Allowing provisional psychologists to offer their clients Medicare rebates would increase the total number of individuals able to provide psychological services by 22.5 per cent, substantially addressing the demand for mental health services and the availability of professionals to address it. There are also significant external social and environmental factors that contribute to the decline in mental health, including an increase in the frequency and severity of extreme weather events, the COVID-19 pandemic, and the cost-of-living crisis.

Climate change is impacting extreme weather events, which are increasing in both severity and frequency worldwide (Palinkas & Wong, 2020). There is a strong link between mental health disorders and extreme weather events, with impacts that include increased rates and occurrences of people who suffer from anxiety and mood disorders, sleep disruption and deprivation, acute stress reactions and post-traumatic stress disorders, and suicide and suicidal ideation (McKell 2022).

The cost of services and high out-of-pocket expenses are one of the top concerns when it comes to people accessing mental health care, and this is echoed throughout the interim report. Second to that is accessibility in terms of the timeliness of that service, where waiting lists act as a barrier to entry into the mental health system. AAPi firmly believes that as part of the overhaul required, it includes modernising Medicare and expanding the Medicare Better Access scheme. The Federal Government's own evaluation of Better Access in 2022 demonstrated improved access to mental health support for some sections of the population, noting that the predominant reason people in lower socioeconomic brackets were unable to access psychologists was that the Medicare rebates were too low. Those people still had to pay out-of-pocket expenses, which were too high. In terms of the timeliness of care, and due to a workforce shortage, waiting lists also pose a significant barrier to access. Again, as a solution to this, expanding eligibility requirements to include provisional psychologists would greatly increase the number of professionals who could address the shortage.

The Medicare rebate for mental health patients should be increased to $150 for all psychologists. This would decrease out-of-pocket expenses, ensuring that mental health services are more accessible for those in lower socioeconomic areas and increasing bulk billing.

The Productivity commissions own report in 2020 on the Mental Health Inquiry found that Australia's current mental health system does not sufficiently cater to those in need, and that reform of the system would engender significant benefits to the quality of life for those suffering from mental illness valued at up to $18 billion per annum, with the added yearly benefit of $1.3 billion due to increased economic participation.

While not surprising, it was still heartbreaking to read the below commentary from those struggling to access or afford sufficient mental health supports;

"…When asked about any changes in services they've noticed over the past three years, many respondents said they felt waiting times had become longer and costs had also increased, making services less accessible and less affordable for them.

> In regional areas the availability, access and affordability has dramatically reduced (and it was poor to begin with). (sr. 126)
>
> Getting worse, less services available, longer wait times or all have closed books. (sr. 213)
>
> When we had COVID was allowed 20 sessions covered. This was great. Now back down to 10 that may cover 10 months going once a month. Does not help the long-term patients at all. (sr. 248)".

We were also saddened to hear again the same messaging about the need for higher subsidies so people can access the support they need "…Similarly, many respondents told us about difficulties accessing psychologists, with several highlighting the limited access to publicly subsidised consultations.

I can only get 12 visits to a psychologist - how is that going to fix years of trauma and clinical major depressive disorder and PTSD? (sr. 25)

10 psychologist sessions a year is not enough. (sr. 116)

There are no bulk-billing psychologists available within reach. (sr. 137)

No psychologist will treat me as I can only get 10 govt funded mental health sessions per 12 months, I have been told again and again that unless I can afford 40 sessions over a year they cannot help. (sr. 173)”

And a statement that has become far too common over the last 5 years “I stopped seeing my psychologist because I couldn’t afford it. (sr. 37)”.

Throughout the interim report, consumers are echoing the message that 10 subsidised Medicare sessions for psychology do not go far enough, and they need the additional 10 that were provided throughout the COVID-19 pandemic to be reinstated.

We were also not surprised to see the feedback about how the gaps in the National Disability Insurance Scheme (NDIS) discussed in chapter 2 have let consumers and their carers down. Governments have not fully met their commitments in the Agreement regarding psychosocial supports outside the NDIS.

As review participants noted, and as many clients of our members working within the scheme often observe, this approach further delays progress on reform.

> Critically, the National Agreement has (perhaps inadvertently) stalled action in addressing the growing gap in the provision of psychosocial support (“unmet need”). In part this is because it prioritised the re-visiting of the Productivity Commission analysis of need in this area over action, while simultaneously failing to provide a pathway or framework for addressing the gap or addressing the interface issues between the NDIS and the mental health service system. (Australian Psychosocial Alliance, sub. 55, p. 3)

We firmly agree that a whole-of-government approach remains vital and should be integrated throughout the main body of the agreement, with commitments and funding attached. Schedules should be used to focus on issues requiring a distinct approach, including suicide prevention and Aboriginal and Torres Strait Islander social and emotional wellbeing. Strengthening the links between the agreement and other mental health and suicide prevention policies can aid accountability and transparency, while links with other non-health policy documents (such as other national agreements) and systems (such as the National Disability Insurance Scheme (NDIS) can enable a more integrated system of supports for consumers.

Government responsibilities for psychosocial supports and carer and family supports must be clarified in the next agreement. Additional funding and planning are required to address the unmet needs for psychosocial support outside of the NDIS. Governments should immediately address the unmet need for psychosocial supports for the 500,000 Australians outside the National Disability Insurance Scheme

Ensuring the agreement results in best practice approaches to service delivery will be a matter of creating the right incentives, lowering barriers and better supporting enablers of sustainable and high-quality services, which includes working closely with psychologists who are working every day in suicide prevention. We recognise that this reform will take time, and in the interim, several simple and quick changes to federal funding could be implemented to support access and affordability while a new agreement is being designed. A whole-of-government reform that is required must not exclude the social determinants of health and the social drivers of suicidal ideation and behaviours.

We have known for decades that the risk factors for suicide exist at multiple levels; individual (e.g., physical and mental health disorder diagnoses, legal/financial problems, history of violence or trauma), relationship (e.g., social isolation, high conflict or violence), community (e.g., discrimination, limited healthcare access), and societal (e.g., stigma related to asking for help or seeking treatment for mental health disorders). Efforts to identify individuals at high risk for suicide must consider the interconnection of these diverse, multi-level factors. Although physical and mental health-related risk factors are readily identifiable in a healthcare setting, these risk factors may not be enough to effectively identify all people at high suicide risk (Llamocca et al., 2023). Most evidence pertains to unemployment, job insecurity, income, social protection, and childhood adversity (Gallagher, 2025).

Research also tells us that major risk factors for suicide mortality were justice system–involved individuals in the community, exposure to others and parental suicide, firearm accessibility, divorce, experience in foster care, release from incarceration, and unemployment in midlife. Experiences of childhood maltreatment, sexual assault, and gender and sexual minority status are also strong risk factors for suicide attempt and suicidal ideation (Na et al., 2025).

Please also refer to our responses to the interim report information requests below.

4.1 The PC is seeking views on whether there should be an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug use and mental ill health and suicide.

The AAPi agrees that there should be an additional schedule in the next agreement to address the co-occurrence of problematic alcohol and other drug use, mental ill health, and suicide. Research tells us that alcohol use is a risk factor for suicide, and prevention and control of alcohol use can be effective in promoting mental health (Amiri & Behnezhad, 2020). Furthermore, two dimensions of alcohol use, including acute use of alcohol (AUA) shortly prior to a behaviour/event and chronic alcohol use disorders (AUD), are associated with suicide fatalities and nonlethal suicide attempts (Borges et al., 2017).

There are indications of a dose-response relationship between blood alcohol concentration (intoxication level) and acute effects on aggressiveness and impulsivity; on feelings of sadness; and on cognitive functions (Borges et al., 2017). High alcohol doses, as compared to lower doses, seem to produce stronger effects on mood and cognitive states that play a causal role in suicidal behaviour.

4.2 The PC is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. How could successful inclusion and engagement of people with lived and living experience in governance be measured?

Successful inclusion and engagement of people with lived and living experience in governance forums can be measured through both qualitative and quantitative indicators that reflect genuine power-sharing and influence. Key measures might include the proportion of governance roles held by people with lived experience, the presence of co-designed agendas and decision-making processes, and the ability of these individuals to set priorities and contribute meaningfully to policy outcomes. Qualitative feedback should capture whether participants feel heard, respected, and empowered to shape discussions, rather than being tokenised. Additionally, measurable changes in policy, service delivery, or funding allocations that align with insights from lived experience can serve as concrete evidence of their influence. Ongoing evaluation mechanisms, co-led with representatives of lived experience, should be embedded to ensure accountability, learning, and continuous improvement.

Genuine accessibility ensures that all people with lived and living experience can participate fully and equitably in governance forums, regardless of disability, neurodivergence, cultural background, or socio-economic status. It extends beyond physical access to encompass communication supports, psychological safety, culturally safe practices, and flexible engagement formats that accommodate diverse needs. Without genuine accessibility, participation remains superficial and risks reinforcing the very exclusions these forums aim to dismantle.

4.3 The PC is seeking views on the value and feasibility of having a public dashboard to track and report on progress under the next agreement's objectives and outcomes and any other measurable targets set throughout. Which bodies should be responsible for the collation and publication of dashboard data? What metrics should be included in the dashboard?

The collation and publication of dashboard data should be led by an independent and transparent body such as the Australian Institute of Health and Welfare (AIHW), in partnership with the National Mental Health Commission and the Australian Bureau of Statistics (ABS). This collaboration would ensure data integrity, alignment with existing national data frameworks, and public trust. The dashboard should include metrics such as service access and wait times, levels of unmet need, rates of seclusion and restraint, consumer and carer satisfaction, outcomes from psychosocial supports, housing stability, employment participation, and culturally safe service engagement for Aboriginal and Torres Strait Islander peoples and other priority groups. Importantly, data must be disaggregated by demographics, including age, gender, cultural background, disability, and lived experience status, with space for qualitative insights and feedback mechanisms to capture the real-world impact of reforms.

4.4 The PC is looking for case studies to highlight best practice in integrating peer workers in clinical mental health settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?

There are different types of suicide prevention services delivered by peers, including being a gatekeeper, on-demand crisis support, crisis support in acute care settings, and crisis or relapse prevention. Peer relationships employed in suicide prevention services included fellow laypersons; members of the same sociodemographic subgroup (e.g., racial minority), workplace, or institution (e.g., university, correctional facility); and the shared experience of having a mental condition (Bowersox et al., 2021).

Systematic reviews and meta-analyses have yielded mixed evidence regarding the effectiveness of peer support in improving mental health outcomes. A review of mutual support groups found benefits (e.g., treatment adherence, symptom burden) across a range of outcomes in seven of 12 studies focusing on conditions such as depression/anxiety, bereavement, and serious mental illness. Two meta-analyses focusing on depression care found that peer support was effective for improving depression symptoms compared with no additional treatment and was similarly effective as therapist-delivered treatments. In contrast, a meta-analysis of peer support for individuals with serious mental illness found insufficient evidence for symptom reduction or reducing hospitalisations, although some evidence was found for improving hope. A review of the relevant literature reveals that there have been no systematic evaluations of peer support on suicide outcomes, and there are insufficient high-quality randomised controlled trials on this topic to conduct a meta-analysis (Bowersox et al., 2021).

Due to insufficient controlled trial evidence demonstrating the effectiveness of peer-based programs for reducing suicide attempts or deaths, strong recommendations cannot be made for their implementation. However, the diversity of peer support functions and relationships utilised in suicide prevention services raises important considerations for implementation, including the training, supervision, and prevention of burnout among peer providers. There are too wide a range of variations in the training peers receive to deliver suicide prevention services. Training times range from four hours for gatekeeper training to over 70 hours for some crisis line responders and include in-person and web-based instruction (Bowersox et al., 2021). Training programs should consider the function of the peer support provider, acuity of the clients they serve, and the feasibility of providing the training to the intended population. Supervision of peer providers is also dependent on the functional role and setting. Gatekeepers who are members of the lay public or similar sociodemographic subgroups are unlikely to receive supervision, whereas crisis line workers or peer specialists working within a health system may benefit from regular meetings with a clinician supervisor who has developed experience supervising peers.

Burnout among mental health clinicians is prevalent and negatively impacts workplace satisfaction and client care. It is likely that peer providers may also face similar challenges. Approaches to burnout are also likely to vary by setting and provider type. It may be more feasible to limit work hours or provide greater flexibility for volunteers compared with employed peer specialists. Peer specialists working in mental healthcare settings have reported negative interactions with work colleagues, difficulties with understanding their role, and challenges with maintaining professional boundaries (Bowersox et al., 2021).

Research does show that youth welcome peer support as a mental health intervention, and it may be an effective suicide prevention model for this cohort. The barriers for young people require the collective power of policymakers, health care and other service providers, media, and community leaders to bring about improvements in service delivery, public awareness, and attitudes toward mental illness and suicide (Libon et al., 2023).

Thank you for providing us the opportunity to work with the Productivity Commission on this matter. We look forward to working closely with you in the future to support lowering the suicide rate in Australia.

Sincerely,

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