Australian Association of Psychologists incorporated (AAPi)

Submission to the Mental Health Select Committee QLD

Introduction

The Australian Association of Psychologists incorporated (AAPi) thanks the Mental Health Select Committee Queensland for the opportunity to provide information and recommendations to their inquiry.

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

We are seeing a huge spike in mental health challenges ranging from presenteeism through to self-harm currently, with many stressors contributing as well as the impact of the COVID-19 pandemic. Priority must be given to making highly skilled mental health professionals accessible to Australians.

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

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

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

Sincerely,

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Summary of Recommendations

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

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

Terms of Reference

We offer the following information regarding the Mental Health Select Committee's Terms of Reference:

c. opportunities to improve economic and social participation of people with mental illness through comprehensive, coordinated, and integrated mental health services (including alcohol and other drugs and suicide prevention):

a) across the care continuum from prevention, crisis response, harm reduction, treatment and recovery;

Currently there is very little integration between different levels of the care continuum with significant barriers in place in order to access services. Step-up care is largely unavailable and step-down care requires admission to a hospital setting which is generally very hard to access in Queensland. This is true more so for those with diagnoses that are difficult to manage such as personality disorders and those who are perceived as 'frequent flyers' within these settings. Often individuals have the incorrect diagnosis recorded on their file, meaning that access to services is largely impossible. The most common misdiagnosis is neurodivergence namely Autism and Intellectual Disabilities. Getting a diagnosis changed on the system is very difficult, something that the disabled are not able to do themselves and often takes many attempts from mental health clinicians in order to change. The lack of appropriate assessment and consideration of differential diagnosis within these acute settings due to high pressures on staff is an area that needs to be addressed. A study performed by Nyrenius, et.al has shown that of those individuals attending adult psychiatric outpatient services in Sweden, 26 out of the 48 who participated in autism screening

met criteria for autism, with an additional 8 having subthreshold autism symptoms. Out of this number, very few had an existing diagnosis of autism. It would be realistic to consider that this would also be the case for Australian consumers of mental health services and that these individuals would benefit from assessment and assistance to access appropriate supports through disability specific services so that their health and well-being could be improved over the long term, and they could be supported to engage with the community without such high levels of distress. To obtain an assessment outside of the public health system would generally cost between $1,000 and $2,000 and involve being on a waitlist for services for some months. This would be outside of the capacity of many Queenslanders to be able to afford through the private sector and would be close to impossible to find within the public sector.

With regard to harm minimisation, there seems to be an over reliance on medical treatment models within hospital and community settings. This focus on medication to treat immediate symptoms with no long term, therapeutic plan. There are programs which do excellent long-term work such as the Borderline Personality Disorder and drug and alcohol programs through Princess Alexandra hospital, but they have restricted access, likely due to resourcing.

There is an endemic lack of follow up due to lack of resources and programs often exit patients from programs if they do not respond after very limited follow up attempts. Outpatient programs often have quite stringent rules for engagement which don't allow for individual life circumstances - parenting or work. Patients often fall out of these services as a result. There are very few programs that are publicly funded that would allow operation outside of work hours to accommodate for this.

Within the public system there are also limited staffing and/resources to provide effective long term treatment plans to patients - hospital and community health are often unaware of treatment resources for patients outside of their settings, and do not understanding private practice capabilities, or provide adequate communication with private practices they are referring on to. These are often done quickly, with limited time available to spend on clients who are exiting a service and are often made to practices that do not have capacity or do not provide bulk billing services which those exiting hospital often need. For patients in immediate need, this is incredibly harmful and often results in them not seeking any support at all, re-presenting to hospital again during subsequent mental health deterioration, creating a revolving door of hospital presentations with little to no follow up treatment provided.

Ideally, there would be funding or subsidies available to allow for those who have had an acute mental health presentation to be appropriately cared for in the private sector. Current Medicare funding arrangements do not allow many private practice psychologists to provide bulk billing services due to the extremely low rebate available, which if they were to rely on would mean their business would not be financially viable. There is also a funding anomaly within the mental health sector which sees some types of psychologists provided vastly lower rebates than their peers (the two-tier Medicare system mentioned in section h below).

b) across sectors, including Commonwealth funded primary care and private specialist services, state funded specialist mental health services, non-government services and services funded by the NDIS;

It is a common experience that patients who do not fall in the alcohol/drug dependence or suicidal categories but who are in crisis, often get turned away from public health services or on-referred to local private practices. There is little regard for the financial status of the patient or the waitlists within private practice. Obviously, limited funding to the public system has led to hospital and community-based programs needing to be selective as to who they can take on and limited funding outside of Medicare is available to patients to assist with private mental health treatment. This leaves people with chronic mental health diagnoses and those who are deemed a "mild or moderate" risk with limited treatment options, particularly when they require bulk billed or free services due to their financial status. There is also very little integration across public and private sectors, with one often assuming the other will just pick up where the other left off and not communicating with each other when there is a change of client circumstances.

There are many cases where mentally ill or mentally ill and disabled clients have been transported to hospital on involuntary orders for assessment by police who were then discharged back home after their wounds were stitched up and dressed. One AAPi member disclosed that one client who had been removed by force from their home and then discharged after less than an hour at hospital, sat at home without disability supports for days as none of their support staff was notified that they were at home. All had assumed they were admitted due to the circumstances that led to emergency services being contact by the treatment team. This is not an isolated event unfortunately. The hospital system is grossly under-resourced to deal with these complex mental health presentations. It is hoped that the new services being proposed across the region will go some way towards improving the response to those presenting with acute presentations across the state.

Currently there are significant issues in acquiring adequate mental health supports through the NDIS system due to what seems to be an organisation-wide policy to deny funding for psychologists and tell participants that they need to seek "free psychology sessions through Medicare". This sees disabled Australians being misled into believing that these services exist and can be accessed easily and finding out, to their distress, that there are very few psychologists who are experienced in disability and can afford to bulk bill as most of these experienced clinicians do not have clinical psychology endorsement and can only offer the lower, insufficient Medicare rebate. Many of the participants no longer funded for psychology have had long term established relationships with their psychologist and were working well towards functional improvements. Some have gone to administrative appeals tribunal and been able to see a reinstatement of their funding but many have not had the capacity to do this and have ceased psychology support, reducing the improvements they could have

made and putting them at risk of becoming involved in the acute mental health system again.

e. the mental health needs of people at greater risk of poor mental health;

Currently, the two-tiered Medicare system that acts to limit or reduce the public's ability to see the psychologist of their choice in both practical and financial terms and this affects clients in rural and remote regions of Queensland disproportionally. Firstly, given that most psychologists operating in regional and rural areas are registered psychologists, their clients cannot receive affordable treatment as their urban counterparts, because a registered psychologist currently is only eligible to apply a lower rebate for their clients.

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

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

Indigenous psychologists working from an Aboriginal Medical Service, where all services are bulk billed, must choose between taking on excessive client numbers or leaving altogether because their practice is not viable. Many stay because of community connections, but this trend sets up a perpetual problem for psychologists working in these communities and the community who then have a high turnover of providers as psychologists leave due to burnout or financial insecurity. This is also seen in rural and remote areas of Australia as there is no incentive for psychologists to stay long-term.

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

f. how investment by the Queensland government and other levels of government can enhance outcomes for Queenslanders requiring mental health treatment and support;

We propose investment initiatives that will make a significant difference to the outcomes for Queenslanders- the introduction of a Medicare rebate for provisional psychologists, funding for psychologists in schools, making it easier to access a psychologist, broaden MBS rebateable services, providing culturally appropriate services, and increasing the Medicare rebate to $150 for the clients of all psychologists, removing the two-tier system and allowing for more bulk billing of psychology services.

Establish a 'Provisional Psychologist' Medicare rebate

As of December 2021, there are approximately 6,400 provisional psychologists available in Australia. Provisional psychologists are at a minimum, four or five-year educated psychologists, embarking on a final period of 'supervised practice', overseen and mentored by a qualified psychologist. They have studied across each of the competencies required for registration and are gaining relevant experience and supervision to meet full registration requirements.

At present, a significant proportion of provisional psychologists engage in supervised employment in an unpaid capacity to meet their requirements for full registration. Given the increasing demand for psychology services and increasing waiting lists to access psychologists, we believe the deployment of provisional psychologists is an ideal solution. This will not only address the provision of an adequate service from a trained psychologist with the benefit of a supervisor, but to also increase the value of the psychologist in the payment for their valuable services, for which they have invested significant funding to complete their tertiary qualifications and supervision process. Having a 'provisional psychology' Medicare rebate will enable this strategy and its benefits.

In essence, the Australian Government has over 6,400 university trained mental health professionals available at its fingertips, and this will address the growing need for adequate mental health support that goes beyond the experience of an urgent phone call to a helpline.

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

Funding for more Psychologists in Schools

AAPi proposes the provision of psychologists into schools at appropriate levels and proportionate to the number of students present. Teachers are currently reporting high levels of stress and lack of support in the classroom. The arrival of COVID-19 into Queensland for really the first time since the start of the pandemic due to borders opening has also resulted in increased levels of anxiety for parents and children who are school aged. Intervening with an appropriate level of care for children with high support needs at this early stage will reduce the need for treatment throughout the lifespan.

We need to have this treatment available and accessible at schools so that parents are not having to deal with the barriers to treatment such as time off work, additional costs, and

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

Simplify the process of accessing a psychologist

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

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

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

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

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

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

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

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

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

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

Australian and international guidelines recommend children wait no longer than three months for a developmental assessment. There is inconsistency around the provision of these within the school system and many families are required to seek assessments outside of the school system. With families waiting between 12 and 24 months in many cases to seek publicly funded assessments they are going to private psychologists for assessment, without access to any Medicare rebates unless their child is suspected of having autism spectrum disorder. These assessments are used to identify the underlying cause of developmental delays, assist in education planning and intervention and assist with access to other services such as NDIS. Families are missing out on the opportunity for early intervention because of these delays. Delaying treatment for a condition such as dyslexia, means that the child falls further and further behind before adequate assessment is completed and treatment recommendations are made. There is increased risk and detrimental effects on the child's confidence and future learning when these important psychological assessments and interventions are delayed.

Providing Culturally Appropriate Services

Psychologists play an important role in contributing to closing the health gap for Aboriginal and Torres Strait Islander people. Services are currently limited and not directed in a way that will have a broad impact for Indigenous Australians. To facilitate more extensive support, the Government needs to fund more psychology positions in Community Controlled Services, not just Aboriginal Health Services. These should extend to include Land Councils, Housing Services and other services that address the social and health gaps for Indigenous Australians. This inclusion of psychology positions could involve more

creative partnerships or co-locations that, for instance, provide rooms, incentive payments and/or funding so private psychologists could outreach to communities. Medicare support is required for psychologists to support Youth, Men's and Women's groups using a more flexible model than one-hour sessions. Trust and cultural safety can be increased when services are provided using culturally relevant approaches and in more appropriate settings.

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

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

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

<u>Raise the Medicare rebate to allow for greater access and facilitate more bulk billing</u>

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

The current Medicare rebate for psychology is insufficient to cover the actual cost of care and this directly affects the access of psychological services. This leaves the option of passing this on to the consumer, who often must choose between vital mental health care

or other essentials of daily life or leaves psychologists with a financially unviable service. The financial challenge of providing care and covering costs results in the psychologist being under undue financial distress or leaving the profession - often earning more in employment areas not requiring their expert skill level or tertiary education.

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

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

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

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

Affordable and accessible mental health care has been discussed in some detail in the media of late. As noted above, the other clear factor in the problem with bulk billing and the Medicare rebate is the erroneous, misleading, and destructive two-tier system that needs to be immediately terminated and replaced by one set of item numbers for all psychologists. Increasing the rebate to $150 for all psychologists will allow psychologists to bulk bill more clients while also attracting more psychologists into private practice thus reducing many of the barriers to accessing the expert mental health care that registered psychologists provide.

g. service safety and quality, workforce improvement and digital capability;

Following the trend of Medicare segregating psychologists into two-tiers, the public health system has an overreliance on psychologists with clinical endorsement, meaning that the skills and special abilities of other psychologists is under-utilised in the public and

community health services. This discounts highly experienced and skilled clinicians who do not hold endorsement or hold one of the other 8 areas of endorsement (70% of the profession). Often the workforce is derived from other allied health areas rather than psychologists who do not hold clinical endorsement, or if psychologists without clinical endorsement are employed they are not able to progress through the higher levels of promotion where they may be of great value. Psychology is the only allied health profession whose training is solely on mental health, making them ideal workers for acute and subacute mental health services. We recommend a review of the hiring and promotion practices and policies within Government funded services to remedy this error.

h. mental health funding models in Australia

The Medicare system funding for mental health services is extremely problematic and there are many barriers for consumers. In 2006 the Australian Government implemented health reforms that saw psychological services included in Australia's Medicare system under the Better Access Scheme. The Medicare items for psychologists under Better Access were drafted into two categories: clinical psychology services (for psychologists with clinical endorsement) and general psychology services (for psychologists who do not have an endorsement or who have endorsement in health, community, counselling, educational and developmental, organisational, sport and exercise, clinical neuropsychology, or forensic psychology). This became the two-tiered model that provides higher rebates for clinical psychologist's clients (currently $128.40 for a 50-minute session) and a lower rebate for the clients of all other registered psychologists (currently $87.45 for a 50-minute session). This lower funding level affects approximately 70% of the workforce and means that this 70% is much more vulnerable with regard to the financial sustainability of their practice than their peers who receive a significantly higher Medicare rebate if they bulk bill.

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

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

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

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

7. Health psychology
8. Organisational psychology
9. Sport and exercise psychology

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

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

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

<u>All psychologists share core competencies and equivalent treatment outcomes</u>

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

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

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

The current Medicare Benefits Schedule overlooks the real costs associated with accessing and delivering vital mental health support, shutting out many clients from psychologists' care when Australians need them most. Clients still need to pay more out of pocket due to

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

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