PRODUCTIVITY COMMISSION EVIDENCE BEFORE THE HOUSE SELECT COMMITTEE ON MENTAL HEALTH & SUICIDE PREVENTION

Peer workers question on notice

In answer to the question from the Chair Dr. Martin, who asked '[k]nowing that the peer workforce is expanding, there is no specific recommendation about the regulation and training of the peer workforce?'

The Productivity Commission's Mental Health Inquiry report does not make specific recommendations about the regulation, training or qualifications for peer workers.

However, our report contains a detailed consideration of the issue at pages 730 to 732 of the Final report. We note that:

> [H]aving a more developed and standardised system of qualifications could give employers and peer workers common expectations for requisite training. However, it would be undesirable to require (through regulation or specifications in provider contracts) minimum standard qualifications. The unique value of peer workers is that they bring to bear their lived experience of mental ill-health and recovery, rather than qualifications through education (2021, p. 731).

Action 16.5 does include recommendations to support the development of the peer workforce, including that:

- The Australian Government should provide once-off seed funding to create a professional association for peer workers.
- The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role and value of peer workers in improving outcomes for consumers.

Additional information on affordability

In addition to our oral evidence and discussion of affordability with Ms Templeton:

Chapter 12 discusses the gaps in mental health care and how they can be addressed. There are two key gaps:

- Low intensity gap — low intensity mental health services are low cost, low risk and easy to access, but they are vastly underutilised, with many people who could benefit from these services instead accessing higher-intensity and higher-cost services.
- Missing middle gap — there is a significant shortfall in clinical, psychosocial and bed-based services, meaning that many people who require significant care and support to manage their conditions do not receive it.

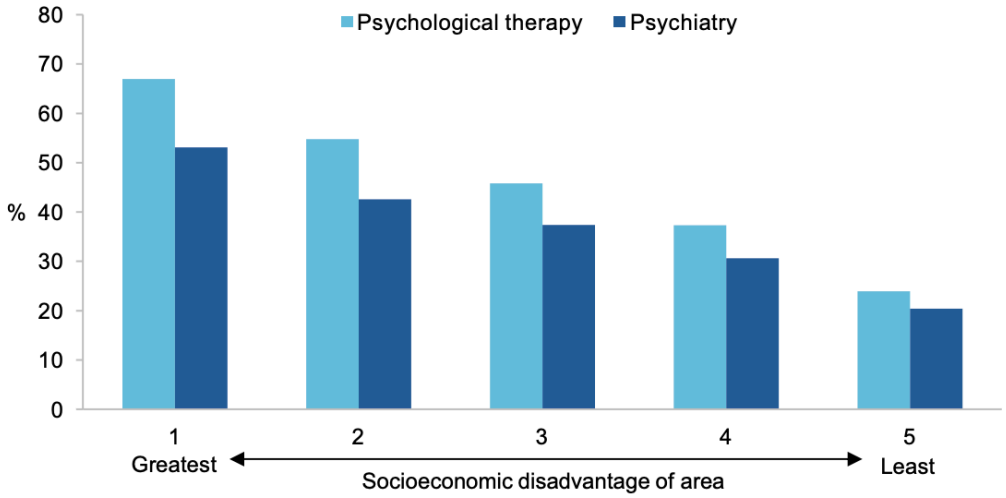
These gaps exist because of four key reasons: service underprovision; inadequate information; locational mismatch; and out-of-pocket costs.

Many inquiry participants argued that the co-payments associated with seeing a psychological therapist or psychiatrist were a barrier to accessing treatment (pages 534-8 discuss inquiry participants' concerns about the affordability of mental health care in detail). Many people were unable to afford the full cost of psychological treatment after the ten sessions of MBS-rebated therapy ran out. Participants also raised concerns about the cost of medications, including the cost of medications that are not on the PBS and the co-payments associated with medications that are on the PBS.

MBS data shows that, while people from more disadvantaged areas are less likely to face out-of-pocket expenses when receiving care, a substantial proportion are faced with fees in excess of the MBS rebate (figure 12.4). In the most disadvantaged areas, more than one in five people paid out-of-pocket costs for psychological therapy, while around 45 per cent paid out-of-pocket costs to access psychiatric care. The report does not include information about the number of people who forego treatment due to out-of-pocket costs, as such data is not systematically collected.

Figure 12.4 **People from more disadvantaged areas are more likely to pay nothing for a consultation**

Percentage of MBS-rebated consultations with no co-payment, by quintile of socioeconomic disadvantage, 2019[a]



[a] Psychological therapy includes both Psychological Therapy Services and Focused Psychological Strategies. Socioeconomic disadvantage of area defined as the ABS Socio-Economic Index of Areas (SEIFA).

Source: Productivity Commission estimates using unpublished MBS data.

The inquiry report included a number of recommendations that would improve the affordability of mental health care. For example:

- Action 10.4 involves the creation of a national digital mental health platform, which aims to give all Australians access to free assessment of their treatment needs, supported online treatments and short-course, structured therapy delivered by videoconference or phone. The platform would also provide an alternative gateway to MBS-rebated therapy, in addition to referral from a GP, removing a barrier that prevents some from accessing therapy.
- Action 12.1 includes actions to encourage more group therapy, which is usually less expensive for the consumer.
- Action 12.2 involves expanding access to psychological therapy and psychiatry via telehealth, which can help people access more affordable clinicians.
- Action 12.3 involves trialling and evaluating an increase in the session limit for MBS-rebated therapy to 20 sessions per person per 12-month period.
- Action 23.5 involves changing funding rules to give PHNs more flexibility in funding and providing mental health care.