NATIONAL RURAL HEALTH ALLIANCE LTD

7 February 2020

Dear Productivity Commission

Please accept this submission from the National Rural Health Alliance in response to the *Productivity Commission Mental Health Draft Report*.

We will gladly answer any questions you have regarding this submission.

Best regards

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Chief Executive Officer
National Rural Health Alliance

NATIONAL RURAL HEALTH ALLIANCE

Response to the Productivity Commission Mental Health Draft Report

FEBRUARY 2020

NATIONAL RURAL HEALTH ALLIANCE LTD

… healthy and
sustainable rural,
regional and remote
communities

NATIONAL RURAL HEALTH ALLIANCE LTD

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Introduction

The National Rural Health Alliance commends the Productivity Commission on providing a comprehensive Mental Health Draft Report (the Draft Report) and welcomes the opportunity to provide a response.

The National Rural Health Alliance (the Alliance) is comprised of 44 member organisations. The Alliance is committed to improving the health and wellbeing of the almost 7 million people living in rural, regional and remote Australia.[1] Our membership is diverse and geographically dispersed and this reflects the complex nature of rural health. Members include consumer groups, Aboriginal and Torres Strait Islander peak body organisations in the health sector, health professional organisations and service providers. For a full list of our members see Appendix A.

In this response to the Draft Report, the Alliance provides some general comments about the proposed reform areas, as well as further suggestions intended to strengthen the recommendations, to improve health and wellbeing outcomes and access to mental health care for people living in rural regional and remote Australia.

There are two key points that the Alliance would like to draw the Productivity Commission's attention to:

1. the proposed rebuild model
2. the need for a holistic approach to mental health wellness as well as mental health care in rural communities.

The rebuild model

The Alliance supports the concept that, for rural communities, a pooled funding model is appropriate and this is something for which the Alliance has been advocating in recent times. However, the Alliance believes that, if the volume of Medicare Benefits Schedule (MBS) rebates for allied mental health care in the regions is going to be used as the benchmark for funding arrangements for the proposed rebuild model methodology, this is inequitable. Rural communities do not have equitable access to allied health services, particularly in mental health care and, as a result, MBS rebates are low. Conversely, presentations to emergency departments and hospital admissions are higher, to address the need to access mental health care. To use MBS rebates for allied mental health care as a basis for a new funding model is a fundamentally flawed approach and will leave rural communities with a disproportionately small funding pool with which to provide services. The Regional Commissioning Authorities (RCAs) sound, in theory, like they will be a useful interface between state and territory governments and the Australian Government. However, the Alliance would like to see more detail on how the RCAs would work in practice and is concerned that there remains many grey areas and blurred boundaries, particularly around the National Disability Insurance Scheme [the Draft Report: Table 2, p44].

Holistic approach to mental health wellness as well as mental health care in rural communities

The Alliance notes that, in the Productivity Commission's issues paper *The Social and Economic Benefits of Improving Mental Health*, published in January 2019, it proposed to take a broad view to

[1] Throughout this submission references to remoteness areas are based on ASGC-RA, in which categories are 1 Major cities, 2 Inner regional, 3 Outer regional, 4 Remote and 5 Very remote. Because of small numbers, Remote and Very remote are often reported jointly. In the submission, references to 'regional areas' mean Inner plus Outer regional; and references to 'remote areas' mean Remote plus Very remote.

address mental health issues, that takes into account a population health view ranging from well population to severe mental illness. The Alliance also notes that the issues paper outlined the importance of the promotion of good mental health as an effective strategy to prevent illness and maintain wellness. However, there is very little reference in the Draft Report to a population health approach to promoting better mental health. In rural communities, it is preferable to have a focus on wellbeing—wellness not illness—and this approach needs to be implemented as part of a holistic approach to mental health wellbeing in conjunction with the medical mental health model proposed in the Draft Report. A good example of interventions that work in rural and remote communities are the *Community Wellbeing Collaboratives* researched and implemented by the Centre for Rural and Remote Mental Health.[2]

In our 2020–21 pre-budget submission, the Alliance proposed the creation of six place-based health and wellbeing networks (PBHNs) in rural and remote communities in a four-year trial designed to test the efficacy of alternative funding and service delivery approaches to address under-servicing of health, aged care and disability services in those communities. The Orange Declaration suggests that place-based interventions for those with mental health problems—that are holistic, integrated and co-designed by local communities—show promise and could be evaluated through this initiative.[3]

The aim of the networks is to improve access to patient-centred, primary health care that is integrated with community and social services, where possible, as well as with acute care facilities. Networks would be situated in a defined geographic region, where people can receive team-based health care, either through mainstream services or Aboriginal Community Controlled Health Services (ACCHS). The project takes a collaborative, strengths-based approach[4], bringing together the health, social care, disability, justice, aged care, education and regional planning sectors within local communities, to deliver multipurpose primary health PBHNs.

General Comments

Reform area 1: prevention and early intervention for mental illness and suicide attempts

The Draft Report identifies that 'early intervention—either early in life or after the detection of risk factors that may lead to mental illness—is important to prevent the onset of illness or curtail a deterioration in mental health' and further identifies that 'young people are particularly unlikely to seek help' [the Draft Report: p11] however the recommendations and proposed activities in this reform area do not capture critical risk groups, including disengaged young people aged 17–25 years, or those at other times of high risk (post-natal, or following adverse life events) and we consider that these should be reconsidered for inclusion in reform area 1.

One example of a community-based youth social development program is the Communities that Care Alpine initiative being run in the Alpine Shire of Victoria.[5] The program is directed at children and young people of school age, but the implementation strategies reach beyond the child by also engaging the adolescents and adults (families) surrounding them. Thus this model engages people across the spectrum of mental illness, at a critical developmental phase, as well as reaching at-risk

[2] Centre for Rural and Remote Mental Health. Community health and wellbeing collaboratives: resources [Internet]. Centre for Rural and Remote Mental Health n.d. [cited 2020 Feb 7]. Available from: https://www.crrmh.com.au/programs-and-projects/community-wellbeing-collaboratives/community-wellbeing-collaboratives-resources/

[3] Perkins D, Farmer J, Salvador-Carulla L, Dalton H, Luscombe, G. The Orange Declaration on rural and remote mental health. Aust J Rural Health. 2019. DOI: 10.1111/ajr.12560.

[4] Bourke L, Humphreys JS, Wakerman J, Taylor J. From 'problem-describing' to 'problem-solving': Challenging the 'deficit' view of remote and rural health. Aust J. Rural Health. 2010;18.

[5] Alpine Health. Communities that Care Alpine (CTCA) [Internet]. Alpine Health 2020 [cited 2020 Feb 5]. Available from: https://www.alpinehealth.org.au/services/youth-services/communities-that-care-alpine

and well people in the community with tailored programs and strategies that address locally identified issues and risk factors.

The Alliance agrees with the statement that much is already expected of schools in supporting children's social and emotional wellbeing. It is for this reason that the Alliance has concerns about adding additional tasks to an already busy teacher workload, and requiring considerable upskilling and ongoing supervision and support. The Alliance recommends providing schools with accredited mental health professionals, such as mental health nurses, to fulfill the proposed role of mental health leader. However, the Alliance does support teachers being trained to screen for emotional and social developmental, communication or learning difficulties, and this should be a mandatory part of a teacher training curriculum. What also needs to be in place are the referral and support pathways to respond to the child's needs, when identified by the early childhood educators or school teachers. An example of such a program that has been successfully implemented by Royal Far West, however, is restricted in its geographical spread due to funding limitations. Royal Far West has also implemented successful projects within school environments for many years and is able to provide the Productivity Commission with a range of reports and data to demonstrate their effectiveness.

The Alliance notes that Headspace funding should be conditional on centres following the stepped care model. The Alliance recommends further rigorous evaluation of Headspace programs in rural settings to determine if this model is an effective approach to address mental health issues in young people. In addition, the Alliance would like to see flexibility in how the Headspace service model is designed in a rural town, as a metro-centric stepped care approach may not be appropriate. Other models such as the No Wrong Door approach may be a better fit.

In addition, if more Headspace centres are to be rolled out, the Alliance strongly suggests identifying and investing in specific non-health sector services and supports. For example, the availability of (preferably free) transport for those clients who do not have access to private or public transport.

Overall, the Alliance would like to see a stronger emphasis on, and commitment to, mental health promotion as a core part of any prevention and early intervention strategy—in particular, programs and services that focus on wellness rather than illness.

We also note recommendation 24.2 [the Draft Report: p106] which proposes that commissioning agencies have regional autonomy over service provider funding. The Alliance supports this recommendation on the principle that collaborative, locally designed networks of health services, including mental health services, are best placed to identify and address the mental health prevention and early intervention needs of the people in their regions.

Reform area 2: close critical gaps in health care services

Improving the consumer and carer experience of the mental health care system—to ensure the care received is timely, is consistent with treatment needs and does not impose undue burden on either the consumer or their carer—is an outcome that the Alliance would welcome. However, the current disparity in access to mental health care in rural areas needs to be urgently addressed if this goal is to be met. Accessing low intensity care sounds good in theory but, as there is already a paucity of mental health care in rural areas, the Alliance has concerns as to how his will work in a rural setting. In addition, the Alliance would like the services to be connected to referral pathways and service networks, and not standalone services, to ensure no-one falls through the gaps.

In terms of meeting health care service gaps, the Alliance is broadly supportive of further development of a national phone line for assistance, the expansion in online portals that include more information on e-health, telehealth and group therapy services and mental health pathways in local communities. However, the Alliance does not want digital health strategies to be implemented as a means of not adequately addressing the maldistribution of the mental health care workforce in rural communities. There must be a mix of face-to-face and online/digital services available. It is not an either/or scenario.

The Alliance is pleased with recommendation 11.7 [the Draft Report: p65] regarding incentives to attract a rural health workforce, such as greater use of videoconferencing and the expansion of initiatives to encourage locum work and outreach services, as this would support the existing workforce to attend training from whatever sector they work in. Even though the Draft Report outlines workforce capacity building strategies, mental health workforce maldistribution and shortages remain ongoing issues.

The Alliance would like to see a stronger emphasis on strategies to recruit and retain rural mental health practitioners and provide pathways to advance skills development for all members of the mental health care team. The team should also be supported by an equitable commitment to incentives, professional development, supervision, and investment in physical, capital and technological rural health infrastructure, equitably distributed across the workforce. In particular, there is a need to ensure that mental health training and skills development is included in the National Rural Generalist Pathway for general practitioners and allied health professionals. This training needs to include instruction on how to work as a member of a multidisciplinary team and collaborative, team-based models of care.

The Alliance supports the recommendation to increase the number of mental health nurses, but would also like to see a commitment to increasing the workforce in all disciplines in rural areas. The Alliance is encouraged to see that allied health professionals, such as social workers, dietitians and occupational therapists, are included in mental health teams, as part of improving access to other specialist moderate intensity services. However, not all allied health disciplines that can contribute to mental health and wellbeing have been considered. The Alliance would also like to reiterate that there is growing evidence that 'non-traditional' interventions such as diet modification and exercise therapy have a role in treating mental illness, not just physical comorbidities. The Alliance would like to recommend that allied health professionals who assist with physical care issues be considered, for example the allied health professionals who contribute to chronic disease management and team care arrangements could be a starting point.

Access to specialist psychiatric care in rural communities is an issue that must be addressed. The Alliance is broadly supportive of the recommendations made by the Royal Australian and New Zealand College of Psychiatrists in their 2020–21 pre-budget submission[6], specifically the recommendation to provide funding to support programs which upskill psychiatrists and other health professionals in the use of e-health resources as adjuncts to assessment, management and treatment monitoring.

The Alliance supports the rigorous evaluation of the Better Access program and GP mental health care plans.

The Alliance is also supportive of the Australian Government creating an MBS item that allows psychiatrists to provide general advice over the phone to a GP, on diagnosis and management issues for an individual who is being managed by the GP.

Reform area 3: investment in services beyond health

The Alliance commends the Draft Report for its strong commitment to strengthen housing and justice interfaces for persons with mental illness, and the acknowledgement that social inclusion and access to psychosocial supports are an essential part of the recovery process. Nevertheless, the Alliance would like further details on how psychosocial issues will be addressed beyond the health system.

[6] Royal Australian and New Zealand College of Psychiatrists. Australian Treasury 2020-2021 pre-budget submission: Improve the mental health of communities December 2019. RANZCP 2020 [Cited 2020 Feb 7] Available from: https://www.ranzcp.org/files/resources/submissions/ranzcp-2020-2021-pre-budget-submission.aspx

The Alliance is encouraged by the call for a new whole-of-government mental health strategy and cross-portfolio commitment to reforms directed at the social determinants of mental health and suicide prevention. The Alliance's proposed PBHN initiative aims to test the efficacy of this approach at a local level.

Reforms to care coordination, and the proposed RCA model, provide an opportunity to tailor services to suit the unique characteristics and needs of local communities. As previously stated, the Alliance considers that holistic, locally developed and resourced programs are key to improving mental health outcomes in rural and remote settings.

Reform area 4: assistance for people with mental illness to get into work and enable early treatment of work-related mental illness

Employment is a central element to the achievement of social inclusion and it offers significant benefits, beyond income, that enrich individual and community wellbeing. The Alliance endorses the Draft Report recommendations (both for the short and long term) to increase participation of people with mental illness in education and work. The Alliance also supports increasing flexibility in the enforcement of the Targeted Compliance Framework, particularly for people with complex mental health needs.

Student mental health and wellbeing is a concern for those teaching in the health professions. However, feedback from Alliance members indicates a concern that tertiary education institutions may not be the most appropriate avenue to address student mental health issues. Rural students who have mental health concerns generally will not disclose these issues to their university or placement organisation, for fear that it will negatively impact on their placement or career. The Alliance supports the creation of student networks as being better placed to provide this type of support for the student, outside of their university (and in addition to what the university will provide) and placement. In particular, organisations such as the National Rural Health Student Network could be provided with the funding and support to provide this independent service to students.

With regard to addressing the needs of young people who are disengaged, as previously mentioned the Communities That Care Alpine model has been successful in engaging youth in rural settings. The Alliance recommends the Productivity Commission considers this model of care in the final report. The Alliance is broadly supportive of the recommendations outlined in this reform area with regard to the Individual Placement and Support (IPS) program and jobactive providers co-located within mental health teams.

The Alliance is pleased that the Productivity Commission expresses the need for mental health to be seen as an occupational health and safety concern, and the requirement for employers to adhere to standards and codes of practice. Rural health practitioners and allied health professionals also need to recognise and manage their own mental health risks of working in challenging environments that may lead to psychological injury.

Reform area 5: fundamental reform to care coordination, governance and funding arrangements

As outlined in the introduction, the Alliance agrees with the concept of a pooled funding model. However, the Alliance has strong reservations about both proposed funding models linking Primary Health Network/RCA funding to either projected, or past, MBS rebated services.

As identified in the Draft Report, utilisation of MBS rebates for mental health services disproportionately benefits people in Major cities [the Draft Report: Box 24.4, p974] and is not a reflection of the actual burden of mental illness in rural and remote Australia, which is only

marginally lower than that in Major cities (23.5 DALY per 1000 population for Remote and Very remote vice 25.1 per 1000 in Major cities).[7]

Recently released Australian Institute of Health and Welfare (AIHW) data on Medicare-subsidised mental health-specific services shows that the rate of people who receive MBS subsidies specifically for mental health services decreases as remoteness increases, for all types of mental health providers.[8] Conversely, data from the Productivity Commission's *Report on Government Services 2020* showed that the proportion of people receiving clinical mental health services in the public health system was higher in Remote and Very remote areas for all states and territories, with the exception of Tasmania.[9] The 'missing middle' is very apparent in the provision of mental health services in rural and remote parts of Australia.

Without significant remodelling to reflect the current unmet need for primary mental health care in rural and remote Australia, the proposal for the rebuild model to use regional distribution of MBS rebates for allied mental health care as the benchmark for funding arrangements is inequitable. The Alliance recommends the Productivity Commission further consider alternate models for determining the distribution of funding which account for both the unmet need and complexities of accessing affordable, culturally-appropriate and timely mental health care for rural and remote Australians.

With regard to the measurement of success, there needs to be a review of indicators of how success in rural settings will be measured. For example, a rural lens needs to be applied when using measurements such as occasions of service or mood changes, as these indicators do not take into account the rural context. The Alliance suggests having measures that evaluate wellness, social capital, self-efficacy and sense of coherence.

[7] Australian Institute of Health and Welfare 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease series no. 19. Cat. no. BOD 22. Canberra: AIHW.

[8] Australian Institute of Health and Welfare. Mental health services in Australia [Internet]. Canberra: Australian Institute of Health and Welfare, 2020 [cited 2020 Feb 5]. Available from: https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia

[9] Productivity Commission. Report on Government Services 2020, Part E Section 13: Mental health management data tables [Internet]. Productivity Commission; 31 Jan 2020 [cited 2020 Feb 5]. Available from: https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/health/mental-health-management

Appendix

National Rural Health Alliance Members (Feb 2020)

44 organisations with an interest in rural and remote health and representing service providers and consumers

- Allied Health Professions Australia Rural and Remote
- Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)
- Australasian College of Health Service Management (rural members)
- Australian and New Zealand College of Anaesthetists
- Australian Chiropractors Association (Aboriginal and Torres Strait Islander Rural Remote Practitioner Network)
- Australian College of Midwives (Rural and Remote Advisory Committee)
- Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
- Australian College of Rural and Remote Medicine
- Australian General Practice Accreditation Limited
- Australian Healthcare and Hospitals Association
- Australian Indigenous Doctors' Association
- Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
- Australian Paediatric Society
- Australian Physiotherapy Association (Rural Advisory Council)
- Australian Psychological Society (Rural and Remote Psychology Interest Group)
- Australian Rural Health Education Network
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
- Council of Ambulance Authorities (Rural and Remote Group)
- Country Women's Association of Australia
- CRANAplus
- Exercise and Sports Science Australia (Rural and Remote Interest Group)
- Federation of Rural Australian Medical Educators
- Isolated Children's Parents' Association
- National Aboriginal and Torres Strait Islander Health Worker Association
- National Aboriginal Community Controlled Health Organisation
- National Rural Health Student Network
- Paramedics Australasia (Rural and Remote Special Interest Group)
- Pharmaceutical Society of Australia (Rural Special Interest Group)
- RACGP Rural: The Royal Australian College of General Practitioners
- Regional Medical Specialists Association
- Royal Australasian College of Medical Administrators
- Royal Australasian College of Surgeons Rural Surgery Section
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal Australian and New Zealand College of Psychiatrists
- Royal Far West
- Royal Flying Doctor Service
- Rural Dentists' Network of the Australian Dental Association
- Rural Doctors Association of Australia
- Rural Health Workforce Australia
- Rural Optometry Group of Optometry Australia
- Rural Pharmacists Australia
- Services for Australian Rural and Remote Allied Health
- Society of Hospital Pharmacists of Australia
- Speech Pathology Australia (Rural and Remote Member Community)