Chapter 2

Funding and mental health service models

2.1   Throughout the inquiry, the committee heard that the way mental health services in Australia are funded and commissioned can be complicated, confusing and frustrating for many service providers and consumers in rural and remote Australia.

2.2   This chapter will outline mental health services funding and provision in Australia and the stepped care model of practice on which these services are based. This chapter also explores concerns about how services are commissioned and some of the ways in which technology is being used to deliver and inform mental health service provision.

2.3   According to the Australian Institute of Health and Welfare, the total amount of national spending on mental health was almost $9 billion in 2015–16. Of that, about 60 per cent of spending ($5.4 billion) was by state and territory governments, 35 per cent ($3.1 billion) by the Commonwealth Government, and the remaining 5 per cent ($466 million) by private health insurance funds (see Figure 2.1).[1]
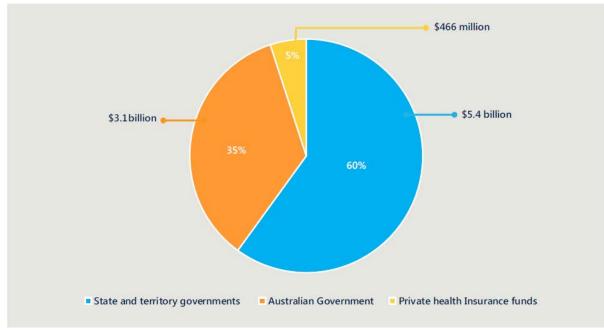
Figure 2.1—National spending on mental health services 2015–16

Source: Department of Health.[2]

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1   Australian Institute of Health and Welfare (AIHW), *Mental health services in Australia: Expenditure on mental health services*, 11 October 2018, https://www.aihw.gov.au/reports/ mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on- mental-health-related-services (accessed 25 October 2018). See also: Department of Health, *Submission 30*, p. 3.

2   Department of Health, *Submission 30*, p. 3.

State and territory funding for mental health

2.4   As discussed in Chapter 1, state governments play a significant role in the provision of mental health services in rural and remote Australia. State and territory governments account for the largest proportion of all mental health spending in Australia. State and territory governments fund and deliver mental health services though:

- public psychiatric hospitals;

- psychiatric units or wards in public hospitals;

- community mental health services;

- residential mental health services; and

- commissioning of non-government organisations to deliver services.[3]

2.5   In addition, several states have an independent mental health commission, each with different operating and reporting structures and responsibilities, but with a common goal of mental health reform.[4]

2.6   State and territory governments also provide school psychologists, counsellors, guidance officers and nurses through their departments of education. These professionals can have a significant role in identifying young people with psychosocial, mental health or substance use issues and providing follow-up care, particularly in remote communities.[5]

Federal funding for mental health

2.7   The Commonwealth Government is not a direct provider of mental health services but provides a significant amount of funding to the sector through:

- Medicare Benefits Schedule (MBS) services for mental health;

- Pharmaceutical Benefits Scheme (PBS) prescriptions for illness related to mental health;

- the federal share of public hospital funding for mental health services;

- the proportion of private health insurance rebates used for mental health services;

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3   AIHW, *Mental health services in Australia: Expenditure on mental health services*, 11 October 2018, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/expenditure-on-mental-health-related-services (accessed 25 October 2018).

4   Australian Mental Health Commissions, *Submission 52*, p. 5.

5   Ms Nicole Cockayne, Director of Discovery and Innovation, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11; Ms Elizabeth Foley, Federal Professional Officer, Australian Nursing and Midwifery Federation, *Committee Hansard*, Canberra, 19 July 2018, p. 18; Alannah and Madeline Foundation, *Submission 73*, p. 8; Mr Nicholas William Newman, Mental Health Coordinator, Ngaanyatjarra Health Service, *Committee Hansard*, Alice Springs, 10 July 2018, p. 20.

- mental health research through the National Health and Medical Research Council;

- the National Mental Health Commission; and

- mental health program funding.[6]

2.8   In 2017–18, the Commonwealth Health Portfolio's estimated total mental health expenditure was $4.3 billion, of which $778 million, or around 18 per cent, was for mental health programs.[7] The Commonwealth operates a number of grants-based mental health programs through five program areas: national leadership; primary mental health care; promotion, prevention and early intervention in mental health; psychosocial support; and suicide prevention.

2.9   Funding for mental health programs is generally provided either directly to service providers for specific programs (for example, to beyondblue for the Way Back Support Service and to Lifeline Australia for telephone crisis services) or to Primary Health Networks (PHNs) as a flexible primary mental health care funding pool for commissioning of mental services.[8]

Primary Health Networks

2.10   PHNs play a significant role in commissioning and coordinating federally-funded mental health and suicide prevention programs at a local level in regional, rural and remote Australia.

2.11   PHNs were established in 2015 with the objectives of increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.[9] The Department of Health described that PHNs are about 'thinking nationally and acting locally'.[10]

2.12   PHNs receive and distribute both quarantined funding for specific mental health services and a flexible funding pool for planning, integrating and commissioning other mental health services in each PHN's local community in accordance with the needs of that community. In 2018–19, the flexible funding pool represents around 59 per cent of mental health funding to PHNs, while 32 per cent of

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6   Department of Health, *Submission 30*, p. 3; Department of Health, answer to question on notice No. 312, 2018–19 Budget estimates, 30 May 2018.

7   Department of Health, answer to question on notice No. 312, 2018–19 Budget estimates, 30 May 2018.

8   Department of Health, *Submission 30*, p. 5; Commonwealth of Australia, *Budget Measures: Budget Paper No. 2 2018–19*, p. 122–124.

9   Department of Health, *Submission 30*, pp. 4–5. See also Department of Health, *PHN Background*, 19 July 2018, http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background (accessed 2 November 2018).

10   Dr Alison Morehead, First Assistant Secretary, Primary Care and Mental Health Division, Department of Health, *Committee Hansard*, Canberra, 18 September 2018, p. 1.

funding has been quarantined for youth psychosis and headspace initiatives and 9 per cent has been quarantined for Aboriginal and Torres Strait Islander mental health.[11]

2.13   Fifteen out of the 31 PHN regions are predominantly non-metropolitan and represent around 33 per cent of the Australian population (see Table 2.1).[12] Mental health and suicide prevention funding to these regions is weighted by the Commonwealth Government to account for rurality, Indigenous status and socioeconomic status, as these factors are associated with higher levels of need and lower rates of access in rural and remote regions; this means that the funding per capita in these non-metropolitan PHN regions is around double that of metropolitan regions.[13]

Table 2.1—Mental health flexible funding to PHNs (2018–2019 estimate)

PHN region type	Number of regions	% of Australian population	% of PHN funding	Per capita funding
Non-metropolitan*	15	33%	50%	$24.70
Metropolitan**	16	67%	50%	$11.95
Total	31	100%	100%	$16.14

* predominantly (>50%) non-major city populations

** predominantly (>50%) major cities populations

Adapted from: Department of Health.[14]

2.14   Three PHNs in rural and remote areas – Murrumbidgee, North Coast New South Wales (NSW) and Tasmania – have also been established as mental health lead sites. The Department of Health explained that:

> Those PHNs were provided with additional funding to enable them to accelerate implementation, trial innovative approaches and share their learnings with the other PHNs. The sorts of things they are doing range from piloting innovative clinical supports for young people to a formal evaluation of clinical care coordination for people with severe and complex mental illness.[15]

2.15   PHNs are also responsible for leading the implementation of the National Suicide Prevention Trial. The National Suicide Prevention Trial was launched in 2016, providing $36 million over three years to fund suicide prevention programs in

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11   Department of Health, *Submission 30*, pp. 4–5.

12   A map of the Primary Health Networks (PHNs) in Australia is included in Appendix 4.

13   Department of Health, *Submission 30*, pp. 5–6.

14   Department of Health, *Submission 30*, p. 7.

15   Dr Alison Morehead, Department of Health, *Committee Hansard*, Canberra, 18 September 2018, p. 2.

12 sites across Australia in identified priority areas, including a number of rural and remote locations. In May 2018, a further $1 million was allocated to each trial site to extend the trial through until 30 June 2020. These trial sites are led by the local PHN, in consultation with local community members and service providers, to design and deliver services that are tailored to the needs of each community.[16]

2.16   Evidence received by the committee suggests that the efficacy of the PHN-based approach to commissioning mental health services in rural and remote areas varies widely from network to network and is a major contributing factor to service access and delivery. These concerns, relating particularly to flexibility, contract length, and commissioning of services which understand local communities' needs, are detailed later in this chapter.

Aboriginal Community Controlled Health Services

2.17   Aboriginal Community Controlled Health Services (ACCHSs) also play a significant role in providing federally-funded mental health services in rural and remote Australia. ACCHSs are primary health care services initiated and operated by local Aboriginal and Torres Strait Islander communities to deliver comprehensive and culturally-appropriate health care to their communities, and are controlled through a locally-elected board of management.

2.18   ACCHSs receive federal funding via the Department of Health and Department of Prime Minister and Cabinet, such as grants for the operation of the service, specific grants for targeted programs (such as child and maternal health), Medicare rebates, and other program funding through PHNs.[17] ACCHSs also receive some grant funding through state and territory programs, for example NSW Health funds 16 ACCHSs for mental health projects in 17 locations.[18]

2.19   The committee heard about the frustration faced by ACCHSs in seeking funding directly from governments to provide mental health services. The Central Australian Aboriginal Congress explained that accessing grants and other funding for mental health services as an ACCHS has 'taken a long time' due to confusion about whether funding should be provided from the state/territory or federal government:

> For many, many years we just kept getting told, 'The states fund mental health and the Commonwealth don't. Go to the state.' The state never funded mental health through Aboriginal health services; they funded through their own system.[19]

2.20   The National Aboriginal Community Controlled Health Organisation (NACCHO), the peak body representing ACCHSs, explained in its submission that it

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16   Department of Health, *Submission 30*, p. 24.

17   Department of Health, *Submission 30*, p. 8.

18   NSW Government, *Submission 106*, p. 13.

19   Associate Professor John Dominic Boffa, Chief Medical Officer Public Health, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 1.

is in the interest of government to invest in the ACCHS sector to reduce the economic burden of mental illness:

> There is a strong argument for optimising government investment in areas where populations are most at risk and most vulnerable to mental illness, and for directing investment to facilitate effective mental health, and consequent fiscal gains.[20]

2.21   For the three financial years 2016–17 through 2018–19, PHNs have received $85.7 million from the Commonwealth Government through the Indigenous Australian's Health Programme to provide Aboriginal and Torres Strait Islander people with access to effective, high quality mental health care services across Australia. The Department of Health explained in its submission that this funding is provided to ACCHSs 'wherever possible and appropriate', as well as to mainstream services.[21]

2.22   NACCHO described that the redirection of mental health funding away from direct grants and into PHN administration 'is having a deleterious and inequitable impact on Indigenous Australians accessing appropriate and effective services', emphasising in its submission that:

> …if Government is serious about closing the gaps in health and mental health services, positively directing funding for Aboriginal service delivery to the ACCHS sector is imperative.[22]

2.23   The Aboriginal Medical Services Alliance Northern Territory (AMSANT), an organisation which is also one of three company members of the Northern Territory PHN, told the committee at its Darwin hearing that PHNs in the territory had prioritised the Aboriginal primary healthcare sector, however:

> …in other jurisdictions funding was provided to mainstream organisations—rather than to Aboriginal providers in many cases. We believe this is flawed and will result in suboptimal outcomes.[23]

2.24   The Western Queensland PHN has also taken an active step in ensuring that PHN funding is meeting the service requirements of local Aboriginal and Torres Strait Islander peoples through the Nukal Murra Alliance which comprises four ACCHSs in the region. At the committee's hearing in Mount Isa, Western Queensland PHN's Executive Manager of Service Provider Commissioning described that:

> Western Queensland PHN does not make decisions on behalf of Aboriginal and Torres Strait Islander people. We draw on the cultural authority and intelligence from the members of the Nukal Murra Alliance.[24]

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20   National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 128*, p. 6.

21   Department of Health, *Submission 30*, p. 8.

22   NACCHO, *Submission 128*, pp. 3–4.

23   Mrs Danielle Dyall, Team Leader Trauma Informed Care and Social Emotional Wellbeing, Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Committee Hansard*, Darwin, 9 July 2018, p. 7.

2.25   Western Queensland PHN is further supporting primary care service integration between mainstream and ACCHS services through its tripartite agreement with Gidgee Healing and the North West Hospital and Health Service and the introduction of an integrity framework to guide cultural competency of commissioned providers.[25]

2.26   However, Ms Vanessa Harris, Executive Officer of the Northern Territory Mental Health Coalition and board member of Danila Dilba Health Service, contended that even with a commitment to community controlled services, it is important for Aboriginal and Torres Strait Islander peoples to have choice in mental health services from a variety of providers:

> …if you're living in this sort of situation in the Northern Territory, in Darwin or Katherine or wherever, and there are health boards and Aboriginal health services throughout the NT, people still have the opportunity for a choice of service. If they feel that Danila Dilba gives them the choice of a certain type of service, they can go there, absolutely—or to TeamHEALTH or to MIFANT, if they give them another type of service. I think it's their right to have a choice in where they go for what supports them in their life and where they are at that point in time, and I think that's really important.[26]

2.27   The issues around culturally competent services for Aboriginal and Torres Strait Islander peoples are explored in detail in Chapter 4 of this report.

National Disability Insurance Scheme

2.28   The National Disability Insurance Scheme (NDIS) plays a significant role in facilitating access to mental health services funded by the Commonwealth Government for some people with mental health and psychosocial disability.

2.29   There has been ongoing criticism of the provision of services for people with psychosocial disabilities related to a mental health condition under the NDIS. In 2017, the Joint Standing Committee on the NDIS conducted an inquiry which examined these issues in detail.[27] That committee made 24 recommendations to strengthen the effectiveness of the NDIS and ensure that people with psychosocial disabilities are appropriately supported.[28]

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24   Ms Sandy Gillies, Executive Manager, Service Provider Commissioning, Western Queensland PHN, *Committee Hansard*, Mount Isa, 29 August 2018, p. 5. See also Western Queensland PHN, *Submission 125*, p. 3.

25   Western Queensland PHN, *Submission 125*, pp. 3–4.

26   Ms Vanessa Harris, Executive Officer, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 19.

27   Joint Standing Committee on the National Disability Insurance Scheme, *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, August 2017.

28   Joint Standing Committee on the National Disability Insurance Scheme, *Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition*, August 2017, pp. xi–xvi.

2.30   A new NDIS stream for psychosocial disability was announced on 10 October 2018.[29] This stream is designed to improve the process of accessing the NDIS and to provide dedicated support for people with severe and persistent mental health issues. The stream will include the employment of specialised planners and Local Area Coordinators; better linkages between services, National Disability Insurance Agency (NDIA) staff and NDIA partners; focus on recovery-based planning and episodic needs; connecting people, including those found to be ineligible for the NDIS, with appropriate supports; employing and/or funding mental health peer workers; and psychosocial disability awareness training for staff and coordinators.[30]

2.31   As part of the roll-out of the NDIS around Australia, a number of federally-funded mental health and support programs are now part of or in the process of transitioning to the NDIS. Some of these programs include Personal Helpers and Mentors (PHaMs),[31] Mental Health Respite: Carer Support,[32] Partners in Recovery (PIR)[33] and Day to Day Living.[34] For each of these programs, the Commonwealth Government has outlined a timeline for transition to the NDIS ahead of the full roll-out on 1 July 2019. After this date, funding under a 'continuity of support' measure has been allocated to support people who are assessed as ineligible and those who are eligible but have not yet finalised their package:

> …PHNs will have funding through [the continuity of support] measure and through the National Psychosocial Support Measure to be able to continue to support people through PIR and Day to Day Living while they are waiting on their packages.[35]

2.32   During the course of this inquiry a number of concerns were raised about this process.

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29   Dr Gerry Naughtin, Strategic Advisor, Mental Health and Psychosocial Disability, National Disability Insurance Agency, *Committee Hansard*, Canberra, 16 October 2018, p. 3; The Hon Paul Fletcher MP, Minister for Families and Social Services, and the Hon Sarah Henderson MP, Assistant Minister for Social Services, Housing and Disability Services, 'Government announces improved NDIS mental health support', *Media release*, 10 October 2018.

30   National Disability Insurance Agency, answers to questions on notice, 16 October 2018 (received 7 November 2018).

31   Department of Social Services, *Personal Helpers and Mentors (PHaMs)*, https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/personal-helpers-and-mentors-phams (accessed 5 November 2018). Note: a person does not need to have a formal clinical diagnosis of a severe mental illness in order to participate in PHaMs.

32   Department of Social Services, *Mental Health Respite: Carer Support,* https://www.dss.gov.au/our-responsibilities/mental-health/programs-services/mental-health-respite-carer-support (accessed 5 November 2018).

33   Department of Health, *About Partners in Recovery*, http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pir-about (accessed 5 November 2018).

34   Department of Health, *Support for Day to Day Living in the Community*, http://www.health.gov.au/internet/main/publishing.nsf/content/mental-d2dl (accessed 5 November 2018).

35   Ms Emma Wood, Assistant Secretary, Mental Health Services Branch, Primary Care and Mental Health Division, Department of Health, *Committee Hansard*, Canberra, 16 October 2018, p. 4.

Eligibility to transition

2.33   Evidence received by the committee indicates that a high percentage of the people who accessed services such as PIR, PHaMs, Day to Day Living and Mental Health Respite: Carer Support in the past will not be eligible under the NDIS and that continuity of support funding is not addressing these gaps in the communities where the NDIS has already rolled out. The Mental Health Council of Tasmania described its concern with the NDIS transition during the hearing in Devonport:

> What the federal government decided was that everybody who was accessing those services would be transitioning to the NDIS. Therefore it seemed logical to roll that funding for those programs into the NDIS. What they hadn't realised at the time was that not everybody who was in those programs would be deemed eligible for NDIS.[36]

2.34   Witnesses told the committee that their experience has shown that a significant number of people in regional areas are not, or will not be, transitioning to the NDIS. The Mental Health Council of Tasmania estimated that at least 30 per cent of people in Tasmania who have been a part of the aforementioned federally-funded programs will not be eligible for the NDIS, with up to 90 per cent of PHaMs participants ineligible.[37] The Northern Queensland PHN told the committee that only 10–25 per cent of PIR and 15 per cent of PHaMs participants in their area have been identified as eligible, while service provider Neami National estimated that only 30 per cent of their PIR and PHaMs participants would be transitioning.[38]

Continuity of support and other funding concerns

2.35   The National Psychosocial Support measure was announced in 2017 to maintain community-based, non-clinical support services outside of the NDIS; the Commonwealth Government has committed $80 million over four years to be matched by state and territory governments.[39] While the Department of Health explained that the intention of the National Psychosocial Support measure is to provide psychosocial support to people who are not currently participating in PIR, Day to Day Living and PHaMs, the committee heard that some service providers are unsure if this funding will adequately support new clients.[40]

2.36   The committee heard how the shift of funding for mental health programs from states to the NDIA ahead of the NDIS roll-out is contributing to gaps in service

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36   Mrs Connie Digolis, Chief Executive Officer, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 39.

37   Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, pp. 40 and 41.

38   Ms Karen Thomas, Queensland State Manager, Neami National, *Committee Hansard*, Townsville, 30 August 2018, p. 14.

39   Department of Health, answer to question on notice no. 7, 16 October 2018 (received 12 November 2018).

40   Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 40.

which are not being adequately met by continuity of support funding.[41] Consumers of Mental Health WA explained that:

> The NDIS is an example where the Commonwealth has invested in servicing people who have severe mental health issues, and there are still issues with what the state has been doing. In the complexity of the NDIS there are people who have significant mental health issues who aren't eligible, but the funds for state based programs have been shifted across into the NDIS. So, you have a group that the NDIS is servicing who now have got access to programs that have been taken away from people who, for whatever reason, aren't eligible or choose not to be in the NDIS.[42]

2.37   A broad range of witnesses told the committee that one of the most significant concerns about continuity of support for this cohort was impact of the loss of 'block funding' for the service providers which had previously delivered those programs being transitioned to the NDIS, which would impact on those organisations' ability to meet overhead costs.[43] Selectability told the committee that some estimates suggest that the number of NDIS provider organisations in Australia is estimated to drop from 2600 to 400 over the next five years due to loss in block funding to cover overhead costs.[44] The issue of lost block funding in the broader mental health sector is discussed later in this chapter.

2.38   The committee also heard that the inability to meet overhead costs, even when taking into account loadings for rural and remote areas,[45] is deterring some providers from entering into or continuing NDIS service provision. Neami National, a service provider in Queensland, reported that the cost to deliver NDIS services in some remote communities was 180 per cent higher than in an urban location.[46] In mid-western NSW, the Benevolent Society has decided not to continue to provide psychosocial disability supports under the NDIS because it is not financially viable and resulted in a significant financial loss to the organisation. However, there are no

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41   For example: Ms Amanda Bresnan, Chief Executive Officer, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 24; Mr Jeremy Audas, Member, Queensland Alliance for Mental Health, *Committee Hansard*, Townsville, 30 August 2018, p. 49.

42   Ms Shauna Gaebler, Chief Executive Officer, Consumers of Mental Health WA, *Committee Hansard*, Albany, 5 June 2018, pp. 47–48.

43   Mr Ivan Frkovic, Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Mount Isa, 29 August 2018, p. 52; Ms Helen Egan, Chief Executive Officer, TeamHEALTH, *Committee Hansard*, Darwin, 9 July 2018, p. 20.

44   Mrs Debra Burden, Chief Executive Officer, selectability, *Committee Hansard*, Townsville, 30 August 2018, p. 51.

45   For further detail about loadings, see: National Disability Insurance Agency, answers to questions on notice, 16 October 2018 (received 7 November 2018).

46   Ms Karen Thomas, Neami National, *Committee Hansard*, Townsville, 30 August 2018, p. 9.

other service providers in the region and it is unclear who will be able to take over these supports.[47]

2.39   Other organisations expressed concerns that funding received for staff under the NDIS has been significantly reduced from what was provided for programs previously. The Mental Health Council of Tasmania observed that the anticipated reduction in funding by nearly half has also meant a 'shift in the level of qualifications of staff' providing supports such as PIR since their transition to NDIS.[48] Other witnesses across the country agreed that this will have a major impact on the quality and appropriateness of service provided.[49]

2.40   Consumers of Mental Health WA explained that as it becomes difficult for local non-government organisations to afford to maintain services under the NDIS 'there's a tendency…for the larger NGOs to move into the region' and that this can cause distress for members of the community and the smaller service providers.[50]

2.41   The Victorian Council of Social Service recommended in its submission that NDIS pricing should be amended to 'reflect the components of quality service delivery' to ensure access to essential mental health services for people in rural and remote areas:

> Depending on the circumstances, different approaches may be required, such as block funding core services, retaining a 'provider of last resort', and leveraging or building the capacity of established community organisations, such as community health services.[51]

2.42   Barriers to people accessing mental health services in rural and remote Australia, including mental health services provided through NDIS, are addressed in Chapter 3 of this report.

The stepped care model for service planning and delivery

2.43   Mental health services in Australia, particularly those funded through Commonwealth grants or PHN flexible funding, are predominantly commissioned based on the stepped care model of mental health service delivery. The Department of Health submitted that the inclusion of the stepped care model 'at the core of PHN

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47   Benevolent Society, *Submission 71*, p. 11.

48   Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 41.

49   Mrs Debra Burden, selectability, *Committee Hansard*, Townsville, 30 August 2018, p. 47; Mr Colin Penter, Projects Lead and Policy Officer, Western Australian Association for Mental Health, *Committee Hansard*, Albany, 5 June 2018, p. 49; Ms Helen Egan, TeamHEALTH, *Committee Hansard*, Darwin, 9 July 2018, p. 25.

50   Ms Shauna Gaebler, Consumers of Mental Health WA, *Committee Hansard*, Albany, 5 June 2018, p. 49.

51   Victorian Council of Social Service, *Submission* 107, p. 12.

regional planning, funding and commissioning' is an important measure in improving quality service delivery.[52]

2.44   The stepped care model, as set out in the Department of Health's *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care* (PHN Stepped Care Guidance), is defined as 'an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs'. The PHN Stepped Care Guidance is designed for all PHNs across Australia and describes how:

> In a stepped care approach, a person presenting to the mental health system is matched to the intervention level that most suits their current need. An individual does not generally have to start at the lowest, least intensive level of intervention in order to progress to the next 'step'. Rather, they enter the system and have their service level aligned to their requirements.[53]

2.45   The stepped care model, as set out in the *Fifth National Mental Health and Suicide Prevention Plan*, is summarised in Figure 2.2 below. According to the PHN Stepped Care Guidance, the multiple levels within a stepped care approach do not operate in silos or as one directional steps, but rather 'offer a spectrum of service interventions' for mental health consumers.[54]

2.46   While witnesses and submitters to the inquiry were broadly supportive of the stepped care model for planning, commissioning and delivering mental health services, evidence received by the committee has shown that the availability and appropriateness of stepped services can vary widely when the model is implemented in regional, rural or remote locations.

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52   Department of Health, *Submission 30*, p. 16.

53   Department of Health, *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care* (PHN Stepped Care Guidance), p. 2.

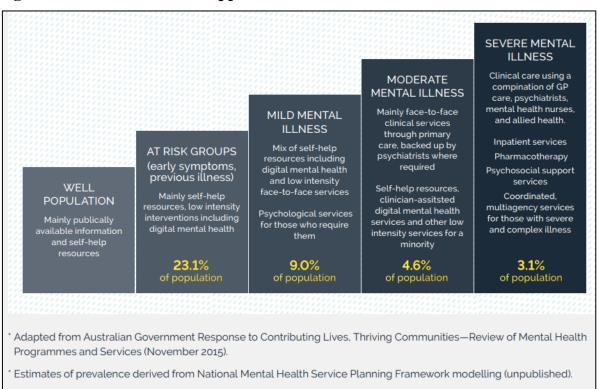54   PHN Stepped Care Guidance, p. 2.

Figure 2.2—Mental health stepped care levels of need and services

WELL POPULATION

Mainly publically available information and self-help resources

AT RISK GROUPS (early symptoms, previous illness)

Mainly self-help resources, low intensity interventions including digital mental health

23.1% of population

MILD MENTAL ILLNESS

Mix of self-help resources including digital mental health and low intensity face-to-face services

Psychological services for those who require them

9.0% of population

MODERATE MENTAL ILLNESS

Mainly face-to-face clinical services through primary care, backed up by psychiatrists where required

Self-help resources, clinician-assisted digital mental health services and other low intensity services for a minority

4.6% of population

SEVERE MENTAL ILLNESS

Clinical care using a compination of GP care, psychiatrists, mental health nurses, and allied health.

Inpatient services

Pharmacotherapy

Psychosocial support services

Coordinated, multiagency services for those with severe and complex illness

3.1% of population

* Adapted from Australian Government Response to Contributing Lives, Thriving Communities—Review of Mental Health Programmes and Services (November 2015).

* Estimates of prevalence derived from National Mental Health Service Planning Framework modelling (unpublished).

Source: Council of Australian Governments.[55]

Stepped care not designed for rural and remote areas

2.47   Professor Luis Salvador-Carulla, Centre Head of the Australian National University (ANU) Centre for Mental Health Research, explained to the committee that rural mental health is different from urban mental health and the problem with the stepped care model is how it was developed for urban areas:

> This model was developed in a highly urbanised area in the Netherlands. It has been tested in the southern part of Norway. It has been tested in urban areas in the UK. My feeling is that it does not work for rural areas. This is just one example of many of how just translating and adapting what has been developed in cities in urban mental health does not work in rural health. We have to develop a new understanding of these services, if we want to change the problems we have in this area.[56]

2.48   Professor Salvador-Carulla proposed that mental health care in rural Australia should not be compared with Sydney but rather global locations with similar population densities and needs, such as the northern part of Scandinavia, Greenland, the Labrador Peninsula in Canada, and some areas in Latin America. The ANU Centre for Mental Health Research is currently conducting a comparison of healthcare in the

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55   Council of Australian Governments, *Fifth National Mental Health and Suicide Prevention Plan*, p. 20.

56   Professor Luis Salvador-Carulla, Centre Head, ANU Centre for Mental Health Research, *Committee Hansard*, Canberra, 18 September 2018, pp. 18–19.

Pilbara and Kimberly with the Lapland region of northern Finland and developing partnerships with Canada and Denmark to help understand 'what is happening with our rural system'.[57]

2.49   The WA Primary Health Alliance also commented that the National Mental Health Service Planning Framework (which is used to guide stepped care service commissioning by PHNs[58]) is not suited to respond to the mental health needs of 'sparse and disparate populations' in rural and remote Australia and that refinement of that framework for rural and remote settings is 'several years away'.[59]

2.50   Dr Sharon Varela, a mental health academic from the James Cook University Centre for Rural and Remote Health and chair of the North West Queensland Mental Health Network, told the committee that the stepped care model has an 'urban-centric bias' and that:

> The stepped care model itself is actually a really good model. The limitations are on how it's funded in rural and remote regions, and the stipulations on that funding.[60]

2.51   The Mental Health Academic Network, a staff network of the Australian Rural Health Education Network, observed that while the stepped care model can fund community-based services for consumers at the mild–moderate level with an 'open door policy', moderate–high level services in rural and remote areas may be more restricted due to strict access rules, such as requiring a consumer to have a mental health treatment plan, being a condition of the service funding:

> These decisions seem to have been made on metropolitan funding equations where more expensive services are restricted and less expensive services are easier to access. In metropolitan regions this can work quite well as there are numerous options across the stepped care model; however, in rural and remote where there are fewer service options this can create a barrier to accessing services, with consumers assuming they do not have enough services to meet their needs.[61]

General Practitioners in the stepped care model

2.52   The PHN Stepped Care Guidance states that the role of General Practitioners (GPs) is critical to the stepped care approach as GPs are 'typically the first point of clinical contact for people seeking help for mental health problems and mental illness

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57   Professor Luis Salvador-Carulla, ANU Centre for Mental Health Research, *Committee Hansard*, Canberra, 18 September 2018, p. 19.

58   PHN Stepped Care Guidance, p. 11.

59   Dr Daniel Rock, Principal Adviser and Research Director, WA Primary Health Alliance, *Committee Hansard*, Albany, 5 June 2018, p. 14; WA Primary Health Alliance, *Submission 33*, [p. 2].

60   Dr Sharon Varela, Mental Health Academic, Centre for Rural and Remote Health, James Cook University, *Committee Hansard*, Mount Isa, 29 August 2018, p. 31.

61   Australian Rural Health Education Network (ARHEN) Mental Health Academic Network, *Submission 76*, pp. 3–4.

and are gatekeepers to other service providers'. The PHN Stepped Care Guidance anticipates that access to primary mental health services commissioned by PHNs will require referral from GPs or other health professionals.[62] However, the committee found that during the inquiry that access to GPs can be difficult and further that views differed about what the role of GPs should be in providing stepped care mental health services in rural and remote Australia.

2.53   General Practice Mental Health Standards Collaboration (GPMHSC), a multi-disciplinary body managed by the Royal Australian College of General Practitioners, observed that limited availability of specialist services in rural and remote regions means that patients are more likely to seek help for mental distress from their GPs. However, GPMHSC explained that the PHN Stepped Care Guidance does not recognise GPs as having a role in the health promotion or early intervention steps and, as GP referral is not required for low intensity care in some PHNs, this may run the risk of fragmenting care.[63]

2.54   The Rural Doctors Association of Australia submission called for 'team-based models of care and telehealth' in rural and remote areas, wherein aspects of stepped care are undertaken by practice staff, community support staff or mental health professionals, but coordinated by GPs to ensure continuity of care.[64]

2.55   In contrast, the Queensland Alliance for Mental Health described that in its experience many PHNs have remained too 'doctor-focused' in their approach, stating that while GPs 'do a fantastic job in community… sometimes the care the person needs might be a therapy assistant or a community arrangement, not a GP' and that one of the challenges of accessing PHN funding is that it is sometimes controlled by people who want to keep a medical focus on services.[65]

Between the steps

2.56   The committee also heard that one of the concerns about the stepped care model in rural and remote areas is the lack of accessible 'steps'. The Australian Psychological Society submitted that despite development of the stepped care model, many Australians in rural and remote areas:

> …have limited access to fully stepped mental health care, leaving many with little to no intervention until the severity of their mental illness requires tertiary level mental health care.[66]

2.57   The committee heard that while some areas lack these early intervention services, meaning that people cannot access care until they are at crisis point, others instead lack acute care services.

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62   PHN Stepped Care Guidance, p. 5.

63   General Practice Mental Health Standards Collaboration (GPMHSC), *Submission 23*, p. 3.

64   Rural Doctors Association of Australia, *Submission 79*, p. 10.

65   Ms Simone Finch, Acting Chief Executive Officer, Queensland Alliance for Mental Health, *Committee Hansard*, Townsville, 30 August 2018, p. 52.

66   Australia Psychological Society, *Submission 103*, p. 11.

2.58   Orygen, the National Centre of Excellence in Youth Mental Health, submitted that a lack of workforce and vast distances in more rural and remote areas can affect the fidelity of the early intervention step, while:

> Parts of Australia may not have the population size or workforce to set up full services, particularly those that cater to moderate to severe mental health needs.[67]

2.59   Country and Outback Health, a service provider in South Australia (SA), described how across its services (including headspace in Whyalla and Port Augusta) the organisation is 'holding onto' high-risk and chronic clients longer than the stepped care model would recommend because of the lack of appropriate severe or acute care services:

> …because there aren't necessarily people with capacity to hand them on to in the state-based system. So, whilst we are working as closely as we can within the parameters, we are still seeing and holding onto clients that, if we were in a metropolitan setting with access to a greater number of services, we would automatically refer on; whereas we tend to hold onto them longer here.[68]

2.60   The committee also heard that lack of prevention and early intervention services can lead to people accessing emergency services as their only option. Mental Health Carers Tasmania argued that:

> …we should not be allowing people to become so unwell that the only option they have is to go to emergency. We need to be having those preventative and prevention opportunities for people to access within communities before they become so unwell that they end up in emergency.[69]

2.61   The availability of appropriate mental health services, including the role of emergency departments in the management of acute mental health, is discussed in further detail in Chapter 3.

PHNs working to make the model fit

2.62   The committee received evidence about how a number of PHNs with rural and remote catchment areas are working to make the stepped care model meet the needs of the local population.

2.63   The Country SA PHN informed the committee of its approach in administering the stepped care model, explaining that it is 'trying to identify the missing gaps within communities to enable [stepped care] within communities and regional areas'. It indicated that stepped care is 'an evolution and a staged approach'

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67   Orygen, *Submission 44*, p. 6.

68   Ms Andrea Triggs, Operations Manager, Country and Outback Health, *Committee Hansard*, Whyalla, 20 July 2018, p. 13.

69   Ms Maxine Griffiths AM, Chief Executive Officer, Mental Health Carers Tasmania, *Committee Hansard*, St Helens, 6 September 2018, p. 53.

and emphasised the importance of keeping services in communities, rather than creating gaps by defunding existing services.[70]

2.64   Primary Health Tasmania, the PHN responsible for the entire state of Tasmania, told the committee that it had taken a different approach to many other PHNs, by first commissioning providers 'to get services on the ground' and then later developing its stepped care plan. It is currently working to develop a regional application of the stepped care model, using Commonwealth Government guidance to identify the steps of care needed but 'putting a Tasmanian spin on it, to ensure that the steps are something that the community will adopt and appreciate'. Public consultation on the regional plan is due in late 2018 in anticipation of the plan being in place by 2020.[71]

2.65   The WA Primary Health Alliance procured a new model of primary mental health delivery in 2017, Integrated Primary Mental Health Care, based on the principles of stepped care and designed to meet the needs of people across the state.[72] The WA Primary Health Alliance told the committee:

> …this approach targets patients with mild to moderate conditions and functionally referred by a GP and includes the use of a virtual clinic, telephone and face-to-face modalities. The virtual clinic has the capacity and capability to reach most of the main populated areas of each region across WA, improving equity of access to those most at risk of poor health outcomes. The approach utilises existing distribution systems technology; however, where this is not available or not appropriate for the population subgroups, increased focus is based on building local capacity.[73]

'No wrong door' to receiving care

2.66   The 'no wrong door' approach within the stepped care model—i.e. assisting consumers to receive the appropriate mental health care for their needs no matter their entry point into the health system—was discussed as a solution to meeting the needs of mental health consumers in rural and remote areas. However, the committee heard that consumers see access rules around the mental health system as confusing[74] and this was supported in evidence from the Katherine hearing, where Mr Dylan Lewis, an individual with lived experience of mental health issues, described the difficulty of navigating the mental health system:

70   Mr Reg Harris, Director Mental Health and Alcohol and Other Drugs, Country SA Primary Health Network, *Committee Hansard*, Whyalla, 20 July 2018, p. 50.

71   Mr Grant Akesson, Health Stream Lead, Mental Health and Alcohol and Other Drugs, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 11.

72   WA Primary Health Alliance, *Submission 33*, [p. 7]; WA Primary Health Alliance, *Integrated Primary Mental Health Care*, https://www.wapha.org.au/primary-health-networks/mental-health/ipmhc/ (accessed 6 November 2018).

73   Ms Lesley Pearson, Regional Manager, WA Primary Health Alliance, *Committee Hansard*, Albany, 5 June 2018, p. 13.

74   ARHEN Mental Health Academic Network, *Submission 76*, pp. 3–4.

> If you're sick, break your arm or anything, you go to the hospital. I can't see why it should be any different for mental health.[75]

2.67   The Central Australian Aboriginal Congress has a highly-praised 'no wrong door' policy in Alice Springs[76] which allows patients to access integrated services for all of their health concerns, rather than requiring separate specialists, diagnoses or services for each concern. This is model has been particularly important when managing complex care needs, including trauma, in the region.[77] The committee heard that the 'no wrong door' approach has also been successful in other ACCHSs, such as Gidgee Healing in Mount Isa[78] and Cyrenian House Milliya Rumurra Outreach Service in the West Kimberley region.[79]

2.68   The Central Australian Rural Practitioners Association made the point that while the 'no wrong door' approach has been successful for self-contained organisations such as Congress, it does not work so well when remote patients are referred from a point of contact which is unable to meet their needs to a specialist with a two-year waiting list, even if that specialist is 'happy to see them'.[80]

2.69   The committee heard that some organisations are trying to meet the needs of patients through a 'no wrong door' approach by pushing the boundaries of the services for which they are funded. For example, Youth, Family and Community Connections Inc, a service provider in the north-west and west coast of Tasmania, explained that their approach to 'no wrong door' is to use a holistic assessment and case management process to support anyone who visits the service, 'even though they might not neatly fit into [the] funding streams'.[81]

2.70   Northern Queensland PHN has funded a 'no wrong door' referral service to improve access to stepped care in the region. Connect to Wellbeing, run by provider Neami National, commenced in June 2018 and provides a single point of entry to allied health and psychological services following referral from GPs, state health funded services and primary health workers. The service provides intake, assessment and triage, contacting the individual to determine their needs and the relevant

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75   Mr Dylan Lewis, Private capacity, *Committee Hansard*, Katherine, 9 July 2018, pp. 21–22.

76   Professor Paul Worley, National Rural Health Commissioner, Department of Health, *Committee Hansard*, Canberra, 19 July 2018, p. 82.

77   Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 2 and 4.

78   Mrs Renee Blackman, Chief Executive Officer, Gidgee Healing, *Committee Hansard*, Mount Isa, 29 August 2018, p. 3.

79   Ms Sally Malone, *Submission 127*, p. 1.

80   Mrs Lynette (Lyn) Byers, Secretary, Central Australian Rural Practitioners Association, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 28–29.

81   Ms Roslyn Atkinson, Chief Executive Officer, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 31.

available services for them.[82] At the hearing in Townsville, Neami National told the committee that Connect to Wellbeing receives approximately 30 referrals per day, of which a number are from remote locations. Although there is a lack of providers in certain regions, Connect to Wellbeing is able to identify alternatives such as phone counselling to ensure that people get support.[83]

2.71   However, the committee also heard that having 'no wrong door' approach is not always enough to meet the needs of the community. Witnesses in Whyalla described that although the 'no wrong door' approach is one of the strengths of the headspace centres in the region, it can be difficult for people to get an initial appointment to get their foot through that door.[84] In Albany, Palmerston Association Inc explained that seeking services in the first place can still be a major barrier for individuals who need help:

> The well-worn concept of 'no wrong door' has not created the ease of access to services that was intended. Services need to move away from the expectation that their clients must come to them. For people experiencing mental health problems, those who feel isolated and alone, those contemplating suicide, the easier it is to think it is too hard to get help, the less likely they are to get it.[85]

2.72   Community Mental Health Australia emphasised the need for 'no wrong door' in accessing all health and disability services in rural and remote Australia, noting the significant intersections between mental health and disability, and recommended that PHNs, the NDIA, state governments and other funding agencies should work more closely with remote communities to meet their specific needs.[86]

2.73   Some of the challenges of understanding and navigating the mental health system are discussed in Chapter 3.

Committee view

2.74   While the committee supports the aims of the stepped care model to provide a spectrum of service interventions for mental health, it holds significant concerns that

82   Neami National, answers to questions on notice, 30 August 2018 (received 20 September 2018), p. 1; Connect to Wellbeing, https://www.connecttowellbeing.org.au/faq (accessed 13 November 2018). See also: Queensland Nurses and Midwives' Union, *Submission 36*, p. 7.

83   Ms Karen Thomas, Neami National, *Committee Hansard*, Townsville, 30 August 2018, pp. 9 and 13–14. See also: Neami National, answers to questions on notice, 30 August 2018 (received 20 September 2018), p. 1.

84   Ms Andrea Triggs, Country and Outback Health, *Committee Hansard*, Whyalla, 20 July 2017, p. 9; Dr Krista Maier, General Practitioner, Nunyara Aboriginal Health Service, *Committee Hansard*, Whyalla, 20 July 2017, p. 37.

85   Mr Benjamin Headlam, Manager, Great Southern Community Alcohol and Drugs Service, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 18.

86   Ms Amanda Bresnan, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, pp. 24–25.

this spectrum is not being made appropriately available to people in rural and remote Australia.

2.75   The committee questions whether the stepped care model can be adequately implemented in areas where the local population is small and cannot support a workforce or service spread of a suitable size to deliver all of the model's steps. The committee also holds concerns that, even where all steps are available, consumers are unsure of how to access these services.

2.76   In light of this, the committee is strongly supportive of the no wrong door approach to service delivery. The committee was particularly impressed by the example set by the Central Australian Aboriginal Congress in meeting the needs of its consumers in this way, but recognises the challenges for smaller service providers which do not have the benefit of being self-contained and still rely on referrals to outside services when supporting consumers to access other levels of care.

2.77   The committee notes that commissioning of services, particularly through PHNs, appears to be vital in filling the gaps between steps in communities in rural and remote Australia and ensuring that all consumers can access the right service at the right time.

Commissioning services for community needs

2.78   Evidence throughout this inquiry emphasised the need for funders of mental health services in Australia to work collaboratively with rural and remote communities to commission appropriate services for the specific needs of those communities.[87]

2.79   Identifying and commissioning for the needs of the local community is one of the key functions of PHNs and the Department of Health submitted that this function:

> …is vital for mental health and suicide prevention services in rural and remote communities, where most people do not have access to local mental health specialist services, and local GPs are the first (sometimes only) available service.[88]

2.80   However there have been significant challenges faced by PHNs in realising this role since their establishment in 2015.

2.81   The Australian Psychological Society and Australian College of Rural and Remote Medicine both submitted that PHNs with regional, rural and remote catchments across large geographical areas have been tasked with building regionally-tailored stepped care services for what can be a wide range of community needs with a limited amount of funding.[89]

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87   For example, see: Mental Health Victoria, *Submission 51*; beyondblue, *Submission 85*; COTA Australia, *Submission 64*; Sane Australia, *Submission 130*.

88   Department of Health, *Submission 30*, p. 5.

89   Australian Psychological Society, *Submission 103*, p. 11; Australian College of Rural and Remote Medicine, *Submission 43*, p. 6. See also: Rural Doctors Association of Australia, *Submission 79*, p. 3.

2.82   Beyondblue submitted that PHNs 'must…establish governance arrangements that allow and support them to engage with the community and health professionals, to ensure that the services they commission respond to local needs' but need time to overcome the challenge of working out 'what works best where and for whom'. beyondblue recommended that PHNs require long-term funding to build the infrastructure and workforce required to meet the needs of rural and remote communities.[90]

2.83   The Centre for Rural and Remote Health described PHN and local mental health service commissioning arrangements as 'immature' and reported that:

> Many rural PHNs have found it difficult to recruit the skills needed to lead regional mental health planning and this is not made easier by short term funding which impacts on the duration of contracts with mental health service providers. This, in turn, weakens rural service providers who face particular challenges in building and retaining a skilled workforce. Thus PHNs need time and support to mature, and to work with local services to commission effective mental health services fit for the needs of rural communities.[91]

2.84   The Australian Mental Health Commissions joint submission discussed the importance of PHNs working in partnership with local hospital networks, public health services and other social and welfare support providers to plan, commission and provide services which match population needs. However, the Australian Mental Health Commissions also made the significant point that services need to be made available in rural and remote areas for the PHNs to commission and that this will require federal, state and territory governments to 'invest [in] community-based approaches and retention of mental health professions'.[92]

2.85   PHNs with regional, rural and remote catchment areas also provided evidence to the committee about how they view their roles in leading community coordination.[93] Country SA PHN, responsible for all country regions of SA, described that identifying gaps in communities is 'not an instantaneous process' and that it is committed to sustainability of services and market growth to address those gaps. It told the committee that:

> We also acknowledge that the process isn't just about service procurement, it's actually about the PHN being a leader and trying to better coordinate the sector and, in some cases that we've heard from communities, it's not

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90   beyondblue, *Submission 85*, pp. 13–14.

91   Centre for Rural and Remote Mental Health, *Submission 87*, p. 5.

92   Australian Mental Health Commissions, *Submission 52*, pp. 7–8; see also Rural Doctors Association of Australia, *Submission 79*, p. 11; Consumers Health Forum of Australia, *Submission 10*, p. 6.

93   See, for example, WA Primary Health Alliance, *Submission 33*, [p. 9]; Mr Grant Akesson, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, pp. 10–11.

necessarily always about a service gap: it's about the interaction of the service providers at that level.[94]

2.86   The Western Queensland PHN made a similar point, stating that evidence from its commissioned service providers indicates 'the increased need for collaboration between services to facilitate shared care planning'. However, the PHN also noted that an aversion among service providers in the region to collaboration, as well as perceived market competition, feared loss of intellectual property and branding, and other structural, financial and organisational barriers, are contributing to fragmentation and duplication within that region.[95]

Inadvertent duplication of services

2.87   Many submitters and witnesses reported that lack of coordination from service providers and funding streams from multiple sources are causing inadvertent duplication in commissioned mental health services in rural and remote areas and contributing to consumers' difficulty in accessing the right service at the right time.[96]

2.88   The Mental Health Council of Tasmania told the committee that there 'isn't any coordination at a regional level' in Tasmania to ensure that funding from multiple sources, such as the PHN, state and federal governments, is used effectively and efficiently.[97]

2.89   AMSANT submitted that having multiple sources of Social and Emotional Wellbeing and suicide prevention funding for the Northern Territory (NT) (i.e. PHNs, Department of Health, Department of Prime Minister and Cabinet) is causing duplication and confusion and recommended that it would 'increase efficiency and equity of funding' to direct this through a central body, such as the Commonwealth Department of Health.[98]

2.90   Dr Beryl Buckby, acting coordinator of the Clinical Psychology Program at James Cook University, told the committee at the Townsville hearing that duplication in suicide prevention programs, particularly for veterans, has also occurred in that region.[99]

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94   Mr Reg Harris, Country SA Primary Health Network, *Committee Hansard*, Whyalla, 20 July 2018, p. 50.

95   Western Queensland PHN, *Submission 125*, p. 8. See also Mr Benjamin Headlam, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 17.

96   For example: Wesley Mission, *Submission 38*, p. 9; Royal Far West, *Submission 42, Attachment 1*, p. 5; Australian College of Rural and Remote Medicine, *Submission 43*, p. 6; Central Australian Aboriginal Congress, *Submission 55*, p. 14; ARHEN Mental Health Academic Network, *Submission 76*, p. 6; National Farmers Federation, *Submission 83*, p. 7; Rural Doctors Association of Australia, *Submission 79*, p. 3.

97   Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 38.

98   AMSANT, *Submission 129*, p. 4.

99   Dr Beryl Buckby, Coordinator Clinical Psychology Program (Acting), James Cook University, *Committee Hansard*, Townsville, 30 August 2018, p. 37.

2.91   Similarly, the Western Australian Government submitted that funding from multiple sources is contributing to overlaps in suicide prevention programs in that state and that 'there is scope to consider alternate funding models such as through coordinated commissioning, pooling of resources and expertise'.[100]

2.92   MindSpot, a digital mental health service provider, also recommend that greater national coordination is required to reduce duplication of resources and services in the digital mental health sector to avoid confusing consumers and health professionals.[101]

2.93   Marathon Health, a service provider in western NSW and the ACT, described how there is not necessarily a trusted partner for organisations to approach to confirm whether establishing a service in an area will 'run into somebody else'. Marathon Health explained that for independent organisations, there is a business risk in sharing plans with 'the competition', i.e. other service providers, due to the small amount of funding available.[102]

2.94   However, coordination failure between services is not necessarily deliberate. During the hearing in Katherine, Miss Mary Maloney from Wurli-Wurlinjang Health Service described working five months to establish a perinatal program in a remote community east of Katherine, only to learn by chance that representatives of another agency had been attempting to establish a similar program in the same community. Miss Maloney told the committee:

> [The program] was about to start and, by happenstance, I was talking to some people from another agency. I happened to be sharing a donga with them one night and found out that they were also about to start a new mothers group in the same community. So how onerous, time consuming, confusing for people in the community. We really need to collaborate more efficiently is my opinion. Perhaps one way of doing that is to support increased community control, so community members are actually involved in who comes into their community and delivers what service and how and when.[103]

Competitive tendering for services

2.95   Meeting the needs of the community in rural and remote areas is as much about commissioning the right provider as it is about commissioning the right service. The committee heard a number of examples throughout the inquiry of providers which are ill-suited to the needs of the community being commissioned through competitive tendering processes, in some instances taking the service away from an existing local provider.

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100   Western Australian Government, *Submission 35*, p. 13.

101   MindSpot, *Submission 5*, p. 5.

102   Mr Stephen Jackson, Chief Executive Officer, Marathon Health, *Committee Hansard*, Canberra, 19 July 2018, p. 73.

103   Miss Mary Maloney, Wellbeing Manager and Registered Mental Health Nurse, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 8.

2.96   In the Kimberley, the current funded service to develop the Halls Creek suicide network is based in Queensland, with an outreach worker based in Darwin, and in Kununurra the suicide network is managed on a fly-in, fly-out (FIFO) basis by an organisation in Sydney. The Shire of Halls Creek described that suicide prevention services in that town have little connection to local families.[104]

2.97   AMSANT observed a similar situation in the NT, expressing a view that providing mental health funding to mainstream organisations with weak links to Aboriginal communities operating services on a FIFO basis is not effective.[105] Central Australian Aboriginal Congress shared this view, explaining that 'competitive tender doesn't lead to quality or access' and that large corporations delivering services in small communities 'is not going to work; you need a regional approach'.[106] The Northern Territory PHN explained that:

> …where services target Aboriginal people we tend to prefer Aboriginal community controlled health services, or similar, to be the service providers where that is possible—which of course is not always possible—depending on the particular service.[107]

2.98   The committee also heard of instances where city-based mainstream organisations which were successful in securing contracts in rural and remote areas were unable to deliver services due to a lack of workforce and capacity in the region.[108]

2.99   The Australian College of Mental Health Nurses described a 'noticeable trend' of funding being taken away from small, locally-based and trusted providers, contracts instead being awarded to larger organisations 'with substantially greater capacity to develop a strong tender application'. In some instances, these larger organisations have not had the workforce on the ground which they claimed and have struggled to recruit a new workforce to provide the service for which they are funded.[109]

2.100   The Royal Australian College of General Practitioners echoed concerns about smaller providers in rural areas failing to secure contracts, with Dr Caroline Johnson,

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104   Mr Jake Hay, Regional Program Manager Youth, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12; Mr Simon Dann, *Committee Hansard*, Halls Creek, 5 July 2018, p. 7.

105   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

106   Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 6.

107   Mrs Nicola Herriot, Chief Executive Officer, Northern Territory PHN, *Committee Hansard*, Darwin, 9 July 2018, p. 15.

108   Ms Peta Rutherford, Chief Executive Officer, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 6.

109   Australian College of Mental Health Nurses, answers to questions on notice, 19 July 2018 (received 17 August 2018); Adjunct Associate Professor Kim Ryan, Chief Executive Officer, Australian College of Mental Health Nurses, *Committee Hansard*, Canberra, 19 July 2018, p. 20.

Clinical Lead for Mental Health, observing that many mental health nurses in Victoria have lost positions 'they weren't part of more sophisticated commissioning services'. Dr Johnston told the committee that it was too soon to assume that the commissioning model is a failure, noting that PHNs have to commission services at an affordable rate, but described:

> …what has definitely happened, as a secondary consequence, is some existing relationships that were very well-established, particularly between general practice and mental health nurses, have been severely threatened, and in some cases probably irreparably harmed, and that is a great tragedy of the reform process.[110]

2.101   The Central Australian Aboriginal Congress made a link between duplication of services and competitive tendering, submitting that competitive tendering for short-term funding creates a culture of competition between providers, rather than one of collaboration and that:

> Government funding, policies and processes based on competitive tendering have unfortunately been a major driver of the disconnected, inefficient and hard-to-navigate mental health and social and emotional wellbeing system for Aboriginal communities.[111]

2.102   Service providers also told the committee about how onerous applying and reapplying for tenders can be, particularly for small organisations which are unable to dedicate a staff member to the task.[112] Derby Aboriginal Health Service described that the amount of time it takes for the organisation to tender for funding requires nearly one full-time staff member to be taken off service provision.[113] This is of particular concern due to short funding cycles, as providers need to spend considerable time in applying to maintain their services within the community.

2.103   Danila Dilba Health Service also described that the limitations on what funding is available means that some smaller organisations are being pushed to design programs which meet the requirements for tender, rather than the requirements of the community.[114]

2.104   Many submitters made the point that there is not necessarily a sufficient market for financial viability in providing mental health services in rural and remote areas, either for general mental health services or for more specialised disability

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110   Dr Caroline Johnson, Clinical Lead, Mental Health, Royal Australian College of General Practitioners, *Committee Hansard*, Canberra, 19 July 2018, p.11.

111   Central Australian Aboriginal Congress, *Submission 55*, p. 14.

112   Ms Joy McLaughlin, Senior Officer, Strategy, Research and Policy, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 25.

113   Dr Prue Plowright, Senior Medical Officer, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 7.

114   Mr Malcolm Darling, Acting Chief Executive Officer, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 24.

mental health under the NDIS, which can also impact on who tenders to deliver a service.[115]

Contracts and funding insecurity

2.105   The committee was concerned by the large number of providers who gave evidence about the impact of short-term funding contracts on their ability to deliver long-term mental health services in rural and remote communities.

2.106   At the committee's first hearing in Albany on 5 June 2018, several local service providers had not yet received confirmation of ongoing PHN funding for the 2018–19 financial year, commencing three weeks later. Providers told the committee that, if they did receive funding from that date, it would likely be granted for another 12 months only and that they would face ongoing uncertainty.[116] The committee heard that this situation was common across the country, with providers in many other locations also facing the uncertainty of receiving only 12 months' worth of funding at a time.[117] The impact of short funding cycles on workforce recruitment and retention in particular was a common theme throughout the inquiry and is explored in Chapter 5.

2.107   The committee heard that short, year-to-year contracts from PHNs to providers have been a run-on effect of similarly short-term funding from the Commonwealth to the PHNs.[118] Primary Health Tasmania explained that:

> Unfortunately, we have to [give 12 month contracts] because that's the length of the funding we receive from the Commonwealth as PHT. Our understanding is that there is work underway to address that and that will

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115   Australian Psychological Society, *Submission 103*, p. 15; Community Mental Health Australia, *Submission 16*, p.10; Flourish Australia, *Submission 50*, [p.1]; Mental Health Victoria, *Submission 51,* p. 7; Benevolent Society, *Submission 71*, p. 3; Australian Services Union, *Submission 94*, pp. 5–6. See also: Mr Stuart Gordon, Chief Executive Officer, Western Queensland PHN, *Committee Hansard,* Mount Isa, 29 August 2018, p. 6; Mr Luke Butcher, Area Manager, Western New South Wales and Special Projects, Mission Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 69; Mr John Mendoza, Director, ConNetica; and Adjunct Associate Professor, Brain and Mind, University of Sydney, *Committee Hansard*, Canberra, 18 September 2018, pp. 21–22.

116   Dr Andrew Wenzel, Manager, Headspace Albany, *Committee Hansard*, Albany, 5 June 2018, p. 20; Ms Alison Woollard, Mental Health Manager, Amity Health, *Committee Hansard*, Albany, 5 June 2018, p. 20; Ms Fiona-Marie Kalaf, Chief Executive Officer, Youth Focus, *Committee Hansard*, Albany, 5 June 2018, p. 21.

117   Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 8; Mr Grant Akesson, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 13.

118   Mr Benjamin Headlam, Palmerston Association Inc, *Committee Hansard*, Albany, 5 June 2018, p. 21; Mr Reg Harris, Country SA Primary Health Network, *Committee Hansard*, Whyalla, 20 July 2018, p. 51; ARHEN Mental Health Academic Network, *Submission 76*, p. 9. See also: Australian Association of Social Workers, *Submission 102*, p. 6.

go into longer-term contracts. Our intent would be that when we get longer-term contracts we'll provide longer-term contracts for our providers.[119]

2.108   For this reason, beyondblue recommended to the committee that PHNs should receive long-term funding in order to commission and develop long-term solutions for mental health in communities.[120]

2.109   A significant number of submitters and witnesses recommended that service providers be commissioned with longer minimum contract lengths, generally three or five years, to ensure that communities and providers alike have long-term security in mental health services.[121] Others suggested that three or five years is still insufficient time in terms of continuity of care for patients, employment security for staff and establishment of infrastructure[122] and recommended that Australia consider adopting even longer contract terms of 10 years or more for mental health service provision.[123]

Finding flexibility in funding

2.110   Another major challenge in commissioning services is allowing sufficient flexibility to meet the needs of the community within the funding granted to service providers.

2.111   A consistent recommendation throughout the inquiry was that service funding, particularly in rural and remote locations, should be provided as part of a 'block funding' model to allow organisations greater flexibility in service delivery to meet the needs of their community. The Royal Flying Doctor Service summarised the benefits and flexibility of block funding:

> The benefit of block funding as opposed to fee for service is that it allows for flexibility for the clinician to spend more time with the individual patient and to tailor the interface with the patient around the patient's needs rather than the service provider's needs. But it also provides the flexibility to us as the service provider to determine which skill best suits the individual or the community that we are serving. Is it a psychiatrist, a psychologist, a mental health nurse, a community worker or an allied health

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119   Mr Grant Akesson, Primary Health Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 13.

120   beyondblue, *Submission 85*, p. 3. See also: Ms Georgina Harman, Chief Executive Officer, beyondblue, *Committee Hansard*, Canberra, 19 July 2018, p. 42.

121   For example: Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 33; MindSpot, *Submission 5*, p. 5; Western Australian Association for Mental Health, *Submission 34*, p. 14; Wesley Mission, *Submission 38*, p.12.

122   Western Australian Association for Mental Health, *Submission 34*, p. 22; Australian College of Rural and Remote Medicine, *Submission 43*, p. 4; Central Australian Aboriginal Congress, *Submission 55*, p. 15; Australian Services Union, *Submission 94*, p. 11.

123   Yura Yungi Medical Service Aboriginal Corporation, *Submission 70*, [p. 2]; Dr Andrew Wenzel, Headspace Albany, *Committee Hansard*, Albany, 5 June 2018, p. 21.

worker? That is determined by the circumstances of the individual patient or that community.[124]

2.112   Witnesses have described that a loss of block funding and a movement towards grants-based and fee-for-service funding makes it difficult to provide mental health services, particularly for organisations providing services under the NDIS.[125] Mr Ivan Frkovic, the Queensland Mental Health Commissioner, explained how, without block funding, organisations providing mental health services under the NDIS do not receive adequate funding for the kinds of overhead costs of keeping an organisation running, as the 'funding model is solely designed on the services delivered to the individual'. He told the committee that:

> The margins for organisations to have adequate funds to be able to put back into training into quality, into governance and all those things are minimal, marginal…[The NDIS funding model] doesn't think about the survival of the organisation that actually has to deliver [services]. More and more we're moving into these funding models that are much more focused on the individual, which is important, and individual needs, choice and control— and I'm certainly very supportive of that. At the same time, we've seen these funding models having major impacts on organisations to be able to train these staff, retain their staff, meet quality standards, improve their reporting, improve their IT systems, HR systems et cetera.[126]

2.113   The committee also heard that, for a person-centred or client-driven approach to mental health services to be successful, a level of flexibility will be needed, as mental health is difficult to compartmentalise and people sometimes require treatment across multiple health and social areas.[127] For example, the Australian College of Mental Health Nurses explained that it can be difficult to determine whether people with a mental illness are using drugs and alcohol to self-medicate or whether the drug and alcohol problems are causing the mental health problems.[128] The significant relationship between mental health and substance use and abuse is discussed in Chapter 3 of this report.

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124   Dr Martin Laverty, Chief Executive, Royal Flying Doctor Service of Australia, *Committee Hansard*, Townsville, 30 August 2018, p. 6.

125   See, for example: Ms Heather Alexander, Director, Rural and Remote, Centacare North Queensland, *Committee Hansard*, Mount Isa, 29 August 2018, p. 19; Mr Ivan Frkovic, Commissioner, Queensland Mental Health Commission, *Committee Hansard*, Mount Isa, 29 August 2018, p. 52; Ms Helen Egan, TeamHEALTH, *Committee Hansard*, Darwin, 9 July 2018, p. 20; Mr Phil Ihme, Senior Director Mental Health Services, Northern Australia Primary Health Limited, *Committee Hansard*, Townsville, 30 August 2018, p. 18.

126   Mr Ivan Frkovic, Queensland Mental Health Commission, *Committee Hansard*, Mount Isa, 29 August 2018, p. 52.

127   Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 33.

128   Adjunct Associate Professor Kim Ryan, Australian College of Mental Health Nurses, *Committee Hansard*, Canberra, 19 July 2018, p. 15.

2.114   The Northern Queensland PHN advocated for flexible, consolidated funding for regions, rather than multiple funding streams, with more focus on outcomes. Dr Vladislav Matic, Board Chair of the Northern Queensland PHN, expressed the view that PHNs could get 'better bang for the buck' with 'regional tailoring, client focus, community focus, regional focus, flexibility, lengths of funding terms and less bureaucracy'.[129] Danila Dilba Health Service, based in Darwin, also recommended that funding could be provided to an organisation as a single 'bucket of money' for mental health which could then be distributed as determined by the service provider to deliver a range of services and outcomes.[130]

2.115   This 'bucket of money' approach, allowing flexibility in how money can be spent to meet the needs of communities, has been one of the successes of the National Suicide Prevention Trial in Tasmania. Relationships Australia Tasmania described that the trial site approach:

> …provides a great opportunity for communities to have a direct say in the types of interventions they would like to have delivered on the ground to address the issues they're acutely aware of and grapple with on a day-to-day basis….It turns the funding approach around a little bit. Often we'll see funding that says 'We have X amount of money to deliver these particular programs; tell us how you might do that,' whereas this approach is: 'Tell us about the issues. How do you think you might address those? How much money might need you [sic] to do that work?' and then applying that.[131]

2.116   Finding flexibility to meet community needs within the PHN funding model as it stands, however, appears to be difficult for some service providers. The committee heard of one instance where a very successful Aboriginal mental health literacy program, Uti Kulintjaku administered by the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council in central Australia, was defunded because it did not neatly fit into the PHN's definition of suicide prevention and there was 'a very limited amount of funds available for that particular program area'.[132]

2.117   North and West Remote Health told the committee that service providers also lack the flexibility to use PHN block funding, even when it is available, to run mental health programs which complement MBS mental health services as this would result in non-compliant Medicare billing due to shared overhead costs of these services. Section 19(2) of the *Health Insurance Act 1973* prohibits the payment of Medicare benefits where other Commonwealth, state, territory or local government funding is provided for that service:

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129   Dr Vladislav Matic, Board Chair, Northern Queensland Primary Health Network, *Committee Hansard*, Townsville, 30 August 2018, p. 13.

130   Ms Joy McLaughlin, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 25.

131   Dr Michael Kelly, Chief Operating Officer, Relationships Australia Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 43.

132   Miss Christine Williamson, Director, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council, *Committee Hansard*, Alice Springs, 10 July 2018, p. 16.

> The simple way to put it is, if we see 10 people and three of those have got GP referrals and care plans, we can't see this person who has the GP referral and charge that to MBS and then see the next person who doesn't have that, who are block funded. We can't see them all together because of the whole transparency around the Medicare guideline.[133]

2.118   These issues are also not exclusive to PHN funding, with the committee hearing that other grants or business sponsorship of mental health programs are often very limited in what they can be used for. Depression Support Network Albany told the committee:

> A really hard thing with going for grants is: if you don't fit smack bang in the middle of what they're asking for, you might as well not bother applying. Often, if you do fit smack bang in the middle of what they're asking for, they'll go, 'We'll pay for a telly.' I might not need a telly, but I might need to pay the insurance. Having something that would cover running costs would be a huge difference.[134]

Committee view

2.119   The committee is concerned by the number of service providers facing uncertainty in funding for mental health services in rural and remote Australia. The committee believes that the year-to-year and other short-term funding from the Commonwealth Government to the PHNs is having an adverse run-on effect for service providers who already struggle to provide services in some regions without the added uncertainty of whether they will have ongoing funding.

2.120   The committee also holds serious concerns about the impact of competitive tendering processes on local service providers that are unable to dedicate the resources required to compete for big contracts. These local service providers have an understanding of their communities that cannot be matched by large city-based organisations with little if any connection to the state, let alone the region.

2.121   The committee recognises that there are significant difficulties faced by funding providers to identify and meet the needs of diverse communities in rural and remote Australia and to commission services to meet those needs within their funding allocation. However, it is clear that further dedication to understanding these needs is absolutely necessary to ensure that appropriate mental health services are available to all consumers in Australia.

2.122   The committee considers that block funding of some services for rural, regional and remote areas should be reconsidered.

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133   Mrs Evelyn Edwards, Chief Executive Officer, North and West Remote Health, *Committee Hansard*, Townsville, 30 August 2018, p. 12. See also: Mr Stuart Gordon, Western Queensland PHN, *Committee Hansard,* Mount Isa, 29 August 2018, p. 6.

134   Ms Johnette Brown, President/Coordinator, Depression Support Network Albany, *Committee Hansard*, Albany, 5 June 2018, pp. 31–32.

Technology and service provision

2.123   Throughout this inquiry, the committee received extensive evidence about how technology can deliver, augment and inform mental health service provision in rural and remote Australia.

2.124   Submitters and witnesses told the committee how telehealth can be an important method of service delivery for many people in rural and remote locations,[135] but cannot replace the genuine need for other mental health services, particularly face-to-face services.[136]

Telehealth

2.125   Telehealth is defined as 'use of telecommunication techniques for the purpose of providing telemedicine, medical education, and health education over a distance' and was the term generally used by witnesses and submitters to this inquiry to refer to the provision of mental health services via telephone and video.[137] The committee heard how telehealth is being used to provide services in rural and remote locations where other services are inaccessible because of factors such as distance, travel cost or lack of available health professionals.[138]

2.126   While some telehealth services are funded through state and territory initiatives[139] or accessed on a private patient basis, the most significant telehealth service for mental health is the federally-funded Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS (Better Access) initiative. The Better Access initiative was expanded by the Department of Health in 2017 to

135   Australian Psychological Society, *Submission 103*, p. 16; Consumers Health Forum of Australia, *Submission 10*, p. 6; Western Queensland PHN, *Submission 125*, p. 7; NACCHO, *Submission 128*, p. 7; AMSANT, *Submission 129*, p. 7; National Rural Health Alliance, *Submission 37*, p. 20; Northern Territory PHN, *Submission 54*, [p. 5]; Central Australian Aboriginal Congress, *Submission 55*, pp. 15–16; Royal Australasian College of Physicians, *Submission 78*, p. 5; Rural Doctors Association of Australia, *Submission 79*, p. 13.

136   Mental Illness Fellowship of Australia, *Submission 20*, p. 1; Centre for Mental Health Research, Australian National University, *Submission 1*, [p. 1]; Western Queensland PHN, *Submission 125*, p. 9; AMSANT, *Submission 129*, p. 7; Services for Australian Rural and Remote Allied Health, *Submission 21*, [p. 4]; Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 12; Western Australian Association for Mental Health, *Submission 34*, p. 21; National Rural Health Alliance, *Submission 37*, pp. 20–21; Australian College of Rural and Remote Medicine, *Submission 43*, p. 8; Australian Rural Health Workforce Agencies, *Submission 48*, p. 8; Central Australian Aboriginal Congress, *Submission 55*, pp. 15–16; Occupational Therapy Australia, *Submission 65*, p. 16; Australasian College for Emergency Medicine, *Submission 91*, p. 7; Royal Australasian College of Physicians, *Submission 78*, p. 7.

137   Department of Health, *Telehealth*, http://www.health.gov.au/internet/main/publishing.nsf/content/e-health-telehealth (accessed 13 November 2018).

138   These barriers to access are discussed in detail in Chapter 3.

139   See, for example: Victorian Government, *Submission 100*, p. 7; NSW Government, *Submission 106*, pp. 17–18; Western Australian Government, *Submission 35*, pp. 22–24.

include a measure for telehealth provision of mental health services for people in rural and remote Australia from allied health professionals only.[140]

2.127　At the time of the referral of this inquiry to the committee, the Better Access initiative had a requirement that one of the first four Better Access sessions be delivered 'face-to-face to facilitate a personal connection with the treating allied health professional'.[141] This was widely criticised by witnesses and submitters, who noted that barriers which lead to people accessing telehealth can prevent them from seeking face-to-face services.[142] Others criticised that GPs were unable to access the MBS items for the telehealth measure for people in rural and remote locations.[143]

2.128　However, in acknowledgement of these concerns, the Department of Health removed the requirement for face-to-face sessions from 1 September 2018[144] and the Better Access initiative was expanded from 1 November 2018 to allow GPs to also provide telehealth services to the rural and remote population.[145]

2.129　The committee also heard that while telehealth plays an important role in service provision in rural and remote Australia, access to telecommunications infrastructure is still a major barrier for many people. These barriers to access are addressed in further detail in Chapter 3.

Online platforms and apps

2.130　The committee also heard how websites, online platforms and apps are being used for mental health literacy and to deliver mental health services for people in rural and remote locations, particularly at the 'early intervention' level of the stepped care approach. Many of these products are designed to deliver sub-clinical self-help services, or act as a referral to appropriate care, while others provide clinical services. Some key examples include:

- Head to Health, a federally-funded digital mental health gateway, which links consumers to early intervention and lower-level mental health services. This website has a dedicated page of information for people in rural and remote

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140　Department of Health, *Submission 30*, pp. 39–40.

141　Department of Health, *Submission 30*, pp. 39–40.

142　Mr Michael Tunnecliffe, Clinical Psychologist, Ashcliffe Psychology, *Committee Hansard,* Albany, 5 June 2018, pp. 38–39; Ms Christine Franklin, Member, Services for Australian Rural and Remote Allied Health, *Committee Hansard*, Mount Isa, 29 August 2018, p. 37; Australian Psychological Society, *Submission 103*, p. 3; MindsPlus, *Submission 15*, p. 3; National Rural Health Alliance, *Submission 37*, p. 5; Royal Far West, *Submission 42*, [p. 3]; Orygen, *Submission 44*, p. 10; National Centre for Farmer Health, *Submission 56*, p. 5; Regional Australia Institute, *Submission 53*, p. 7; Northern Territory PHN, *Submission 54*, [p. 5].

143　GPMHSC, *Submission 23*, p. 5; Royal Australian College of General Practitioners Rural, *Submission 24*, [p. 5]; Australian College of Rural and Remote Medicine, *Submission 43*, p. 9.

144　Dr Alison Morehead, Department of Health, *Committee Hansard*, Canberra, 18 September 2018, p. 2.

145　Ms Emma Wood, Department of Health, *Committee Hansard*, Canberra, 16 October 2018, p. 11.

areas, a search function that includes a regional filter, and a decision support 'chatbot' tool.[146]

- The Black Dog Institute's numerous 'e-mental health' programs, such as StepCare, a mobile tablet-based screening tool which detects symptoms of depression, anxiety and suicide risk among patients in the GP waiting room and provides evidence-based stepped care recommendations to the GP to assist in discussing results with the patient; and iBobbly, a suicide prevention app for young indigenous Australians.[147]

- ReachOut's tools and programs, including Next Step, a tool that recommends customised support options based on a young person's symptoms and how significantly the symptoms are affecting them; apps for managing sleep, worry and anxiety; and ReachOut Orb, a digital game designed for use in Year 9 and 10 classrooms which aims to improve understanding of mental fitness and wellbeing.[148]

- beyondblue's Support Service via web chat and telephone, and online forums for people who have an experience of depression, anxiety or suicide, which offer an avenue for peer support and are moderated to maintain a safe space for participants.[149]

- The eheadspace service, which provides the headspace model of mental health services for young people via web chat, email and by telephone. 25.5 per cent of serviced clients accessing eheadspace were in rural and remote locations.[150]

2.131   Some submitters have cautioned that platforms and apps such as these should be used only in certain circumstances, with the Australian Psychological Society commenting that the use of technology should be considered in the context of stepped care and 'not be used to substitute for appropriate monitoring and interventions where the severity of an individual's mental health symptoms are regarded as moderate to severe'.[151]

2.132   NACCHO further submitted that, although mental health apps have great potential, there is an increasing importance that they are inclusive and culturally appropriate for Aboriginal and Torres Strait Islander consumers.[152] Black Dog

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146   Department of Health, *Submission 30*, p. 39; Department of Health, answers to questions on notice, 18 September 2018 (received 11 October 2018).

147   Black Dog Institute, *Submission 47*, pp. 12–13.

148   ReachOut, *Submission 72*, p. 4.

149   beyondblue, *Submission 85*, p. 17.

150   Mr Jason Trethowan, Chief Executive Officer, headspace National Youth Mental Health Foundation Ltd, *Committee Hansard*, Canberra, 19 July 2018, pp. 67–68; Department of Health, *Submission 30*, pp. 41–42.

151   Australian Psychological Society, *Submission 103*, p. 16.

152   NACCHO, *Submission 128*, p. 7. See also: Aboriginal Health and Medical Research Council of NSW, *Submission 99*, p. 8.

Institute told the committee that its mobile app iBobbly is the first suicide prevention app specifically designed for young indigenous Australians and was developed in partnership with Aboriginal communities in the Kimberley region.[153]

2.133   The Queensland Nurses and Midwives' Union also noted the importance of clinical guidance in developing these tools and the need for reliable infrastructure.[154] As with telehealth, access to telecommunications infrastructure is a barrier for people in rural and remote locations accessing web- or mobile-based mental health tools and services.

Mapping and data for service design and delivery

2.134   The committee received evidence about projects which are using information and data about mental health services and the prevalence of suicide to inform planning and commissioning of services in rural and remote areas.

2.135   For example, the Primary Mental Health Care Minimum Data Set has been designed to allow PHNs and the Department of Health to monitor the quality and quantity of mental health service delivery by commissioned providers. This data is also intended to inform future improvements in planning and funding of mental health services though the PHNs.[155]

2.136   The Department of Health submitted that:

> While it will take up to a decade to consolidate a robust database to inform national policy and decision-making, this information is already available to PHNs to support them in their planning.[156]

2.137   The Centre for Rural and Remote Mental Health told the committee that the establishment of this data set is a 'positive step' and recommended that the opportunity should be taken to more widely link this data with other health and social data sets.[157]

2.138   Case studies of two major projects using health and social data—the integrated atlases of mental health and the LifeSpan suicide prevention trials—are detailed below.

Case study: Integrated atlases of mental health

2.139   While it is a role of all PHNs to undertake a degree of service mapping to identify gaps in services and the needs of their local communities, the committee heard that several PHNs have taken the step of commissioning integrated atlases of mental health to inform their planning and understanding of the region.

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153   Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 12.

154   Queensland Nurses and Midwives' Union, *Submission 36*, p. 13.

155   Department of Health, *Submission 30*, p. 20.

156   Department of Health, *Submission 30*, p. 20.

157   Centre for Rural and Remote Mental Health, *Submission 87*, p. 5.

2.140   An integrated atlas of mental health is a service assessment and decision support tool which collects information about mental health services in an area. In Australia, these atlases are produced through the University of Sydney, the ANU and ConNetica, a mental health and suicide prevention social enterprise, and have so far been produced for mainly metropolitan regions.[158]

2.141   An integrated atlas of mental health is built using a standardised classification system, known as the Description and Evaluation of Services and Directories in Europe for Long-Term Care (DESDE-LTC), which allows data to be compared between different geo-demographic areas. The DESDE-LTC was originally designed to map health issues which require long term care, but has been applied to mental health in Australia to include services across a wide range of care intensities and durations. Services are classified in the atlas by the main care structure or activity, as well as the level of availability and utilisation.[159] Mr John Mendoza, Director of ConNetica and Adjunct Associate Professor, Brain and Mind at the University of Sydney, who has been involved in the development of many of the atlases, described for the committee that:

> What these give us is a quite unparalleled visual understanding of what are the population needs in each of those regions, but also what is the capacity and, if you like, the spectrum of care that is available and whether they are located where the population needs are.[160]

2.142   Professor Luis Salvador-Carulla, Centre Head of the ANU Centre for Mental Health Research and coordinator of the DESDE-LTC project, told the committee that developing data of this kind means that it is possible to compare what is happening with rural and remote mental health in other countries with similar regions in Australia; this is how the ANU Centre for Mental Health Research is able to compare mental health services in the Pilbara and the Kimberley with those in the Lapland region of Northern Finland.[161]

2.143   The WA Primary Health Alliance and the Mental Health Commission of WA partnered with ConNetica to produce the first atlas of this nature to map an entire state of Australia. The WA atlas is split into four stand-alone atlases: Metropolitan Perth; Country WA; the Kimberley Region; and Perth North PHN. The WA Primary Health Alliance told the committee how this project would help to identify gaps and

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158   ANU Centre for Mental Health Research, *Atlas of Mental Health Care*, https://rsph.anu.edu.au/research/projects/atlas-mental-health-care (accessed 13 November 2018).

159   Luis Salvador-Carulla et al for DESDE-LTC Group (editors), *DESDE-LTC*: *Evaluation and classification of services for long term care in Europe*, Psicost and Catalunya Caixa , Spain, 2011; ConNetica Consulting, *Integrated Atlas of Mental Health and Alcohol and Other Drugs of Western Australia: Volume 2, Country WA 2017*, pp. 3–4.

160   Mr John Mendoza, ConNetica and University of Sydney, *Committee Hansard*, Canberra, 18 September 2018, p. 17.

161   Professor Luis Salvador-Carulla, ANU Centre for Mental Health Research, *Committee Hansard*, Canberra, 18 September 2018, p. 19.

duplication across mental health services in the state and to help make comparisons with other similar locations. Dr Daniel Rock, Principal Adviser and Research Director for the WA Primary Health Alliance, described that:

> Looking at the data at the moment, it's fascinating. We have in the rural areas some rather unusual service distributions compared to other places in the world and notable gaps. The atlas doesn't say whether that's good or bad; it just says that that's different.[162]

2.144   Community Mental Health Australia told the committee that the kind of detail offered by these atlases is needed in many regions to get a comprehensive understanding of service availability.[163]

Case study: The LifeSpan trials and suicide prevention data

2.145   The committee heard how one of the most significant suicide prevention programs in Australia, the Black Dog Institute's LifeSpan, is using scientific modelling to implement evidence-based, integrated suicide prevention trials across the country.
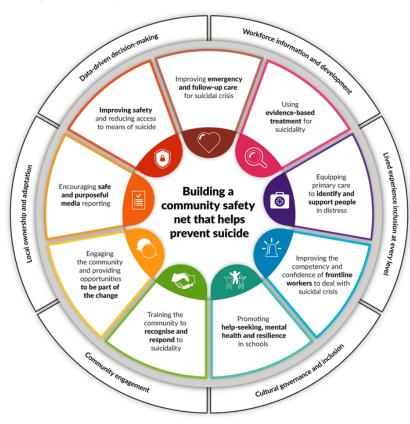
2.146   The LifeSpan program uses nine strategies, ranging from an individual level to the whole population, shown in evidence from international studies to reduce suicide. These strategies, which have a focus on a community-led approach to suicide prevention, are demonstrated in Figure 2.3.[164]

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162   Dr Daniel Rock, WA Primary Health Alliance, *Committee Hansard*, Albany, 5 June 2018, p. 16.

163   Ms Amanda Bresnan, Community Mental Health Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 30.

164   Black Dog Institute, *Submission 47*, p. 1; Black Dog Institute, *LifeSpan strategies and components,* https://www.blackdoginstitute.org.au/research/lifespan/lifespan-strategies-and-components (accessed 13 November 2018).

Figure 2.3—LifeSpan strategies

Source: The Black Dog Institute.[165]

2.147   LifeSpan was initially developed on behalf of the NSW Mental Health Commission by the Black Dog Institute and the National Health and Medical Research Council Centre for Research Excellence in Suicide Prevention. Black Dog received grant funding from the Paul Ramsey Foundation to deliver and evaluate LifeSpan in four regional NSW trial sites.[166]   A fifth trial of LifeSpan, funded by the ACT Government, has recently commenced in Canberra.[167]

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165   Black Dog Institute, *LifeSpan,* https://www.blackdoginstitute.org.au/research/lifespan (accessed 13 November 2018).

166   Black Dog Institute, *Submission 47*, p. 1; Black Dog Institute, *LifeSpan sites,* https://www.blackdoginstitute.org.au/research/lifespan/lifespan-sites (accessed 13 November 2018); Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11.

167   ACT Health Office for Mental Health and Wellbeing, *LifeSpan – Integrated Suicide Prevention*, https://www.health.act.gov.au/about-our-health-system/office-mental-health-and-wellbeing/lifespan-integrated-suicide-prevention (accessed 14 November 2018).

2.148   The Black Dog Institute is also using the LifeSpan approach to support the 12 federally-funded National Suicide Prevention Trial sites and a further 12 place-based trials in Victoria funded by the state government.[168]

2.149   The Black Dog Institute submitted that LifeSpan has been informed by 'Big Data used Intelligently for Suicide Prevention' through a partnership with the ANU and the SAS Institute.[169] Ms Nicole Cockayne, Director of Discovery and Innovation at the Black Dog Institute, told the committee that this means that:

> Black Dog's data team can link previously unrelated datasets from the coroner's office, police, ambulance and hospitals. We can incorporate additional data from health workforce and mental health services, socioeconomic factors, geographical profile and other social risk factors— all of this to build a comprehensive picture to assist a community's early intervention and prevention strategies.[170]

2.150   Ms Cockayne described that this approach to data is a 'powerful tool to enable policymakers, government, planners and health professionals to provide targeted services, supports and means to prevent and reduce suicide' which also allows the Black Dog institute to measure the impacts of the prevention program trials.[171]

2.151   However, the committee heard about the frustrations faced by Black Dog Institute, as well as other organisations, in accessing the necessary data sets to make suicide prevention tools like this a reality. Evidence to the committee demonstrated that there can be a significant lag, sometimes of years, in receiving up-to-date data about suspected suicides.[172] Orygen also noted the need for improved national data sets for the mental health experience of Australians in general.[173]

Concluding committee view

2.152   The committee recognises that the frameworks by which mental health services are funded, commissioned and delivered in rural and remote Australia are incredibly complex, that the concerns of rural and remote communities about the

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168   Black Dog Institute, *Submission 47*, p. 1; Black Dog Institute, *LifeSpan sites,* https://www.blackdoginstitute.org.au/research/lifespan/lifespan-sites (accessed 13 November 2018); Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11.

169   Black Dog Institute, *Submission 47*, p. 3.

170   Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11.

171   Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 11.

172   Ms Paula Chatfield, Executive Director for Mental Health, WA Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 4; Ms Wendy French, Managing Consultant, Talking about Suicide; Member, Break O'Day Suicide Prevention Trial Working Group, *Committee Hansard*, St Helens, 6 September 2018, p. 2; Ms Nicole Cockayne, Black Dog Institute, *Committee Hansard*, Canberra, 18 September 2018, p. 14.

173   Orygen, *Submission 44*, p. 3.

services available to them are great, and that the challenges for local mental health service providers are many.

2.153   It is essential that the mental health services commissioned and delivered in a rural or remote community not only meet the needs of that community, but also are welcomed and trusted. Allowing for longer-term service provision contracts for local providers could be the key to building service capacity, enticing a workforce and developing meaningful, productive relationships with the local community. Greater flexibility in that funding is required for providers to adequately meet the unique and changing needs of each rural and remote community.

2.154   Identifying the needs of a community is a major challenge for all funding providers and the committee is pleased to see that work is being done to use data and mapping to inform this process. However, the committee wishes to emphasise that, in the same way as telehealth cannot replace face-to-face mental health services, data about a community cannot replace the need for face-to-face consultation with members of that community.

2.155   The committee is of the view that the way mental health services are planned and commissioned needs serious review at a national, strategic level. It is not the role of any one PHN, government or organisation to be solely responsible for the planning and coordination of all mental health services in rural and remote Australia. Instead, frequent collaboration is needed between all stakeholders, including representatives of the community, to ensure that the right mental health services are available in the right place at the right time.