NATIONAL RURAL HEALTH ALLIANCE INC.

KUMANO CONSULTING

Submission to the Department of Health and Ageing responding to the Government's response to the National Mental Health Commission's Review of Mental Health Programmes and Services

August 2016

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This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

...good health and wellbeing for rural and remote Australia

Foreword

This Submission responds to the Government's Response to the National Mental Health Commission's Review of Mental Health Services and Programmes (will be known as "the Government's Response").

The submission is from the perspective of the Alliance as an organisation committed to improving the health and wellbeing of people living in rural and remote Australia[1]. In Australia some seven million people - one third of the population - live outside major cities. Key issues in rural and remote health care are:

- The health profile of people living in rural and remote Australia is worse compared to the health profile of people living in the major cities.
- Access to health care services in rural and remote Australia is significantly more limited than access to health services in major cities.
- There is a maldistribution of the health workforce in Australia strongly skewed in favour of the major cities.
- Travel distance to services and out of pocket costs are barriers to timely access to health services for people living in rural and remote Australia.

Mental Health in Rural and Remote Australia
The National Rural Health Alliance has a strong and long-standing commitment to better mental health services and improved mental health outcomes for the 30% of the population living outside of major cities in Australia.

Published figures based on ABS health surveys show that the prevalence of mental illness in rural and remote areas is broadly similar to that in Australian's major cities[2][3], or in fact may even be slightly lower[4].

In major cities, people with mental illness can, and do, access a raft of services to assist with the diagnosis, management and treatment of mental illness. They receive primary care from their GP and specialised mental health care from psychiatrists, psychologists, and mental health nurses. On average they receive 40% more Medicare subsidised mental health services than their rural and remote counterparts[5].

In rural and remote Australia access to mental health services is substantially limited with many rural and remote towns having no access to specialised mental health services and relying on limited GP services.

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[1] ABS 2014-15 Publication 3218.0 Regional Population Growth Australia
http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/3218.02014-15?OpenDocument
[2] http://phidu.torrens.edu.au/social-health-atlases/data#TSRtG663r5xqwzOe.97

[3] http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4326.02007?OpenDocument

[4] http://www.aihw.gov.au/publication-detail/?id=60129555173&tab=3
[5] NRHA derived from http://mhsa.aihw.gov.au/home/

Timely diagnosis, treatment and management of mental illness in rural and remote Australia is less likely to occur, if at all. This sometimes leads to the most tragic of outcomes – suicide. Rates of self-harm and suicide increase with remoteness. Those in rural and remote Australia are respectively thirty five percent more likely than and twice as likely to take their own life through suicide as those in major cities[6].

[6] http://www.aihw.gov.au/deaths/mort

Executive Summary

The National Rural Health Alliance previously responded to the Mental Health Commission's Review of Mental Health Services with a submission in April 2014. Many of the key considerations and recommendations remain salient now in August 2016 in this Submission following the Government's Response.

The National Rural Health Alliance welcomes the Government's Response and is very pleased to see the focus on improving access to services for people experiencing mental illness. Further, the Response also recognises the importance of improved health outcomes rather than focussing solely on the numbers of occasion of service.

In terms of areas requiring further effort and action, the Alliance recommends that the Australian Government give further consideration to up-skilling local leaders, particularly in rural and remote Australia. Strong leadership is vital for implementing mental health reform with significant effort required by local communities to ensure that services and programs meet local needs. In many instances, senior clinicians are providing 'leadership' with no formal experience or training. This is exacerbated in rural and remote Australia where limited mentoring, supervision and training opportunities exist. A specific program for providing professional development and up-skilling in mental health is required for GPs, nurses, allied health providers and Aboriginal Health Workers.

Additionally, strong evidence shows that rural and remote Australia does not receive its fair share of mental health funding. This is primarily due to the limited workforce practising in rural and remote Australia, and, as such, the poor access to services means that people experiencing mental illness in rural and remote Australia are not receiving the care they require. The Alliance advocates for rural and remote Australia to receive its fair share of funding for mental health services and that flexible and innovative models of providing services be supported and appropriately funded. There is great potential in the sector for digital health service provision (via telephone, skype and online resources) for assessment and diagnosis as well as ongoing care and management of mental illness.

Further recommendations from the Alliance are documented overleaf and more detail is provided in the body of this Submission.

Key recommendations from the National Rural Health Alliance

1. The Mental Health Service Planning Framework is released in a timely fashion and used to inform service planning and funding allocations to regions and this tool is used to analyse and monitor national mental health investment, disaggregated by rurality.

2. Policy work is undertaken to better define mental health integration, and develop concrete integration reform targets to guide implementation in rural areas.

3. The Commonwealth further develops the model of stepped care, with an emphasis on the principles and processes of stepped care applicable to the 6.52 million Australians living in rural communities of up to 40,000 population.

4. A proportion of mental health funding (5%) is quarantined for promotion, prevention and early intervention initiatives and rural Primary Health Networks are allocated their fair per capita share of the available promotion, prevention and early intervention funding.

5. The Commonwealth carefully consider the importance of 'on the ground' staff needed to support the roll-out of the national mental health digital portal.

6. A national rural mental health leadership development strategy is developed with a particular focus on existing and emerging leaders in rural, consumer/carer and Aboriginal mental health.

Underlying each of these recommendations is the imperative that those living with mental illness in rural settings receive their per capita fair share of Commonwealth and state mental health funding. This includes funding committed to rural mental health research and developing existing rural mental health research infrastructure.

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Introduction

The Australian Government Response to Contributing lives Thriving Communities –Review of Mental Health Programmes and Services (hereafter called the 'Government Response') and associated documents outline **6 platforms for reform**, **9 concrete areas of reform**, and **9 strategic directions** (see Figure 1).
The 6 reform platforms in the Government Response are

1. Person-centred and funded care
2. Regional planning and integration
3. A stepped care approach
4. Early intervention across the lifespan
5. Using digital technology
6. Strengthening leadership

This paper addresses the 6 indicated reform platforms, cross referencing to the concrete areas and strategic directions. Other key reform principles (see Figure 1) prominent in the Government Response will also be addressed.

The Government Response is a document that predicates its reforms on the ability of the Primary Health Networks to drive national (i.e. Commonwealth **plus** states and territories), and system (including GPs, NGOs, private provider, business, local councils and other government agencies) reform. This in itself presents a number of challenges. It is yet to be determined to what extent the states/territories will, in principle, agree with the Commonwealth reform proposals. The same could be said about the NGOs and other mental health stakeholders. Even with good will, effective change relies on organisational capacity and change readiness.

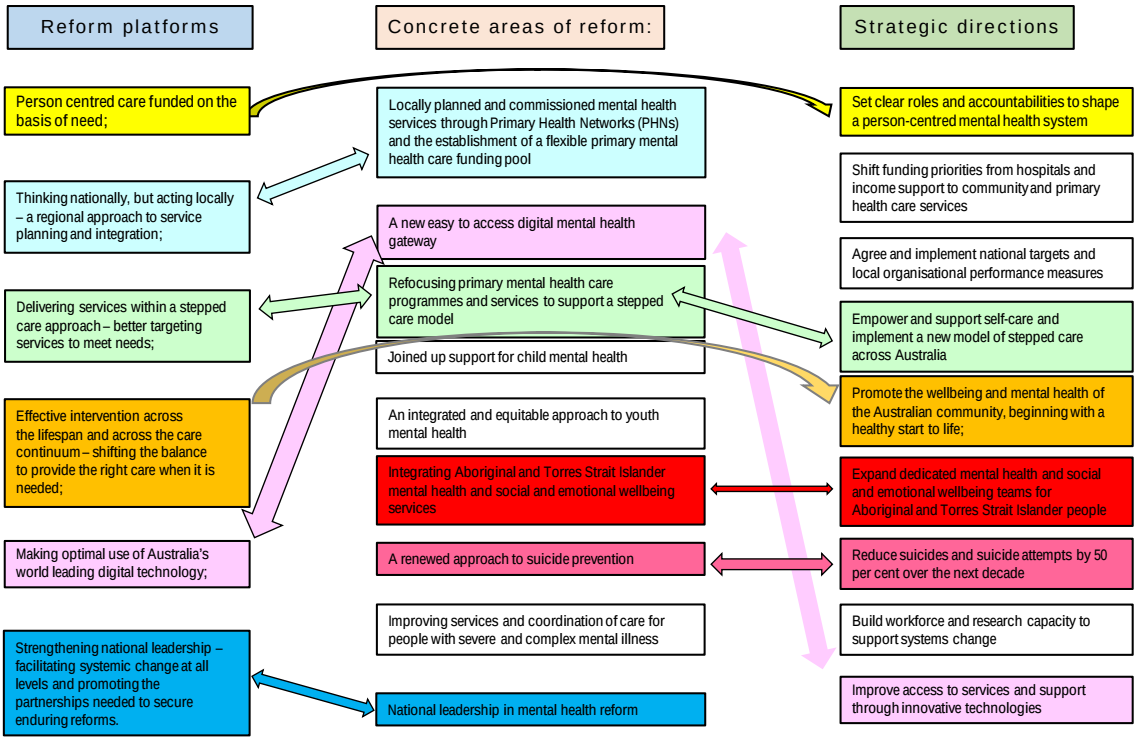


Figure 1. Interrelationships between platforms, areas of immediate action and strategic directions of reform.

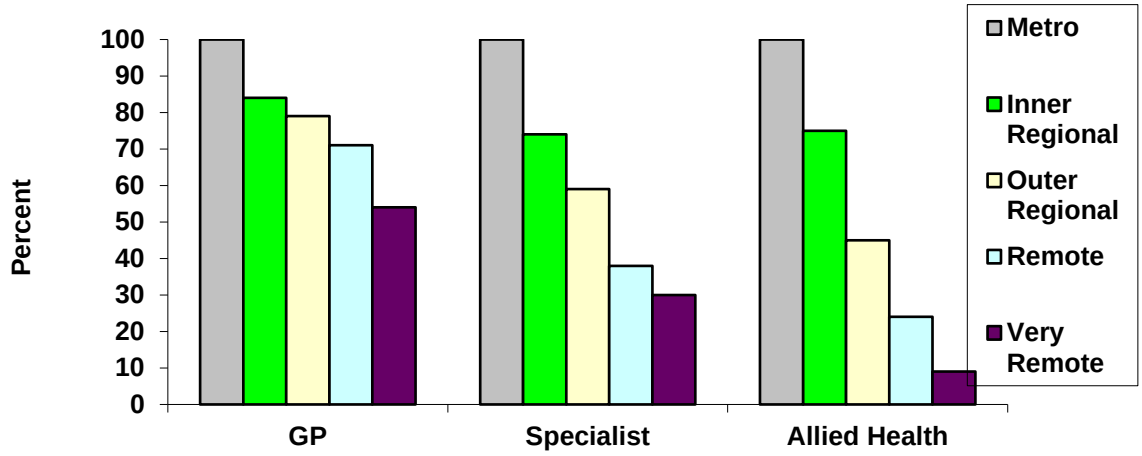
1. Person-Centred Care Funded on the Basis of Need

Concrete area: Set clear roles and accountabilities to shape a person-centred mental health system

Strategic direction: Locally planned and commissioned mental health services through Primary Health Networks (PHNs) and the establishment of a flexible primary mental health care funding pool.

This reform platform is strongly supported.
Person-centred care implies that care is focussed on the individual **and funding each individual** with need regardless of where they live.
Previous attempts at this model such as ATAPS have **resulted in provider-centred funding**. The relative lack of service providers resulted in lack of funded services for rural Australians. The proposed Government model through the use of Primary Health Networks and a flexible funding pool offers the opportunity for people living with mental illness in rural communities to receive their fair share of Commonwealth mental health funding, and is therefore strongly supported. It is a significant reform.

Figure 2. Services received by rurality.



Regional, rural and remote Australians represent almost 30% of the population, yet receive far less than that proportion of mental health funding. In order to meet this reform priority in regional, rural and remote settings we recommend rural Primary Health Networks receive their **fair share of mental health funding on a per-capita basis**. Notwithstanding the additional costs of service delivery in rural settings, equity of funding would represent a major advance in mental health care in rural Australia.

1.1.1 Recommendation: People living with mental illness in rural settings receive their fair share of Commonwealth and state mental health funding. This includes Commonwealth funding to rural Primary Health Networks.

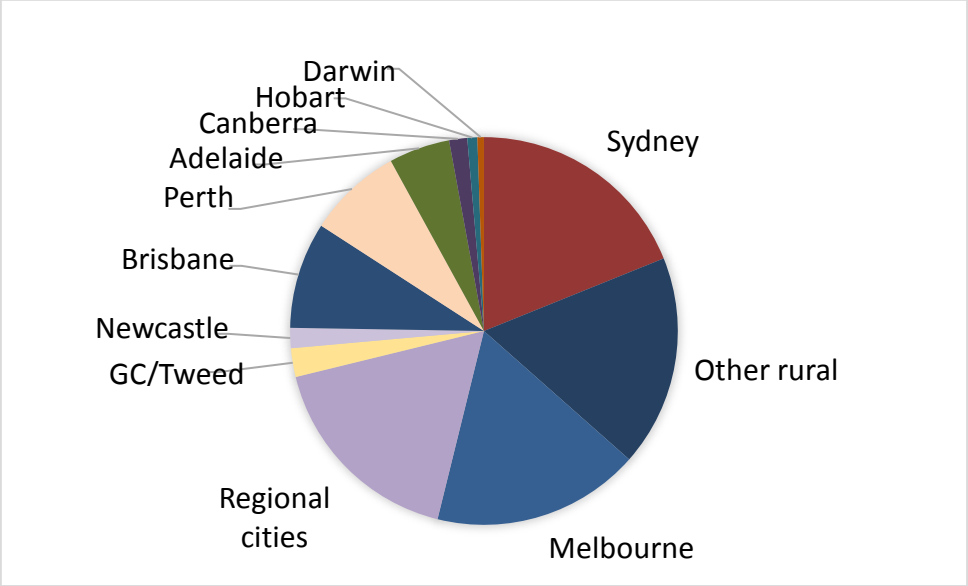
1.1.2 Recommendation: The flexible funding pool is used to counterbalance the lack of service providers in rural settings and supports place-based funding and service delivery models.

Planning and funding allocation should take account of 3 factors: resource allocation, service modelling and local governance.

1.2 Resource allocation

The **National Mental Health Services Planning Framework** provides an evidence-based, population–based tool for needs analysis, service planning and funding of services across the lifespan and the mental health service spectrum. It also incorporates loadings for Aboriginality and rurality. The National Rural Health Alliance strongly requests the timely release of this tool to inform regional service planning and funding accountability.

Figure 3. Population by city and region (ABS, 2014).



As illustrated in Figure 3 the proportion of people living in regional and rural Australia is approximately equal to that in Sydney and Melbourne combined. **Rural Australians comprise almost 30% of the total population.**

1.2.1 Recommendation: The Mental Health Service Planning Framework is released in a timely fashion and used to inform service planning and funding allocation to regions.

1.2.2 Recommendation: This tool is used to analyse and monitor national mental health expenditure disaggregated by rurality.

1.3 Development of place based, state linked, service models

There are approximately 680 Australian towns with populations between 1,000 and 20,000, comprising approx. 14% of the total population. Using the National Mental Health Services Planning Framework, it is apparent that the full spectrum of mental health services cannot be located in each community. Tertiary mental health services across child, adult, older persons and forensic mental health practically need to be based in larger regional centres or capital cities. Likewise, the populations of many rural towns are not sufficient to warrant a full time psychiatrist.

This speaks to the necessity to develop stepped care models which are place-based but also articulated to larger regional centres and cities. Policy work is required in this area to integrate the National Mental Health Services Planning Framework with the stepped care model, to plan how people living with mental illness in cities of up to 20,000 population can access the full range of mental health services.

1.3.1 Recommendation: Work is done to develop and specify the elements and principles of a stepped care model in regional, rural and remote communities. This should incorporate locally based services and those delivered from major cities.

1.4 Governance

Experience shows that when funds are centrally administered and controlled they tend to be centrally expended. In times of high service demand and/or staff shortages, support to outlying and rural communities is inevitably reduced. Rural communities are left with unreliable and/or unavailable services. Far too frequently we see that services funded on the basis of **rural and** metropolitan populations are available to **only metropolitan** people living with mental illness. In practice, this situation is manifest in cessation of fly-in fly-out specialist services, cancellation of telepsychiatry services and blocked access to tertiary inpatient beds.

The planning process is seriously compromised when, using a stepped care model, funded tertiary services are not available to rural people.

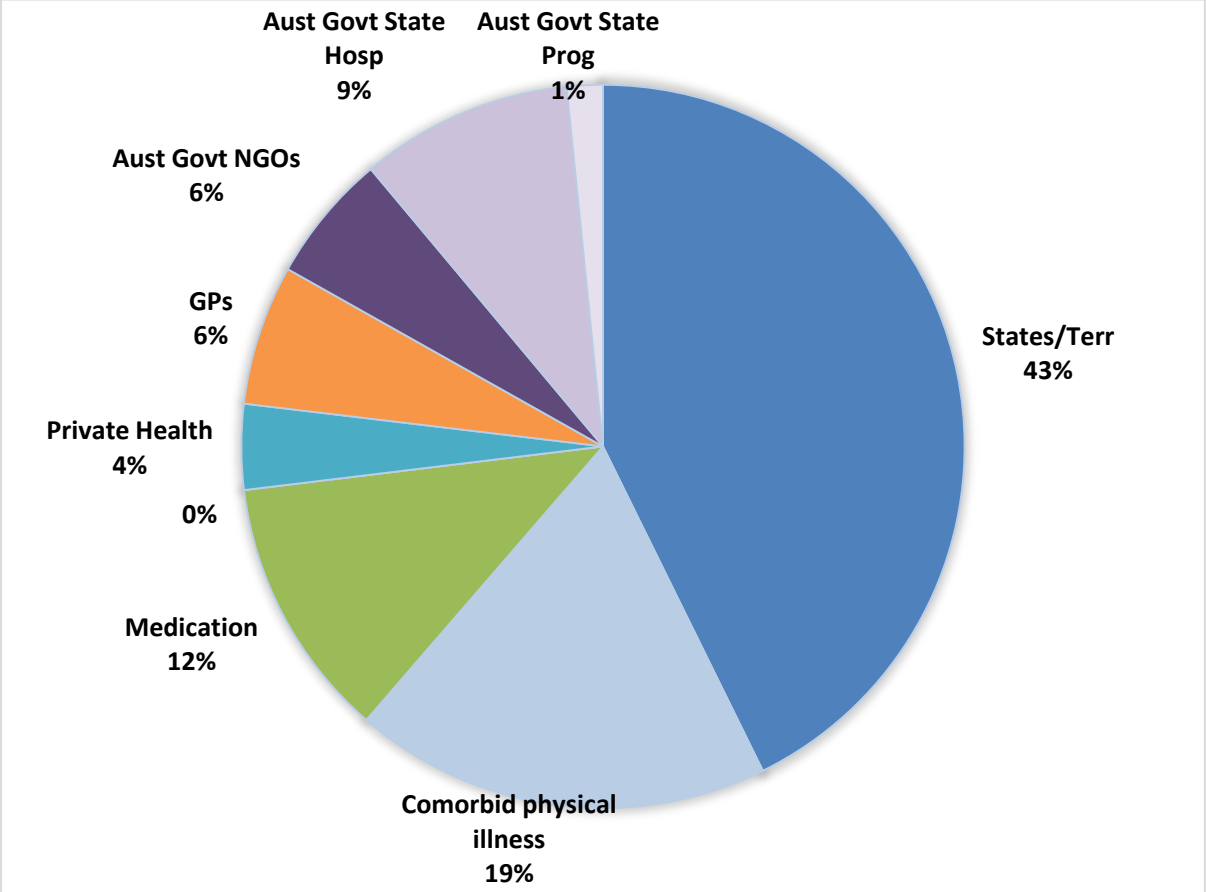
Successful implementation of this reform direction requires service accountability mechanisms whereby centrally delivered services are financially accountable for their responsibility to rural areas. Whilst this does represent another layer of accountability, experience shows that it is absolutely necessary in order to ensure rural people get fair and reliable access to these services. If a central agency is repeatedly unable to deliver on their service obligations to rural people, then this funding should be redirected to that rural region to be flexibly applied to provide the best alternate support.

1.4.1 Recommendation: Governance mechanisms are put in place to ensure regional populations have equitable access to centrally delivered services.

Conclusion

The reform platform of funding services on the basis of need is strongly supported. It is equitable, and if implemented, will result in a substantial increase in service access for people living with mental illness living in rural communities.

Figure 4. Mental health service expenditure by provider type (National Mental Health Commission, 2014).



However, it is noted that this is a **national** reform that relies on leveraging the **Commonwealth's 6% share** of direct mental health service delivery expenditure to influence the **94% of mental health services funded and delivered by states/territories and private providers** (GPs, private psychologists, psychiatrist and other private providers). The Primary Health Networks are to be the primary change agents for this reform. The capacity, experience, expertise and ability of the Primary Health Networks to successfully meet this expectation is uncertain and untested.

2. Thinking Nationally, Acting Locally – A Regional Approach to Service Planning and Integration

Strategic direction: Locally planned and commissioned mental health services through Primary Health Networks (PHNs) and the establishment of a flexible primary mental health care funding pool.

This reform direction is strongly supported.
The National Rural Health Alliance commends the National Mental Health Commission and the Commonwealth Government for this initiative. The following recommendations will assist in the effective implementation of these reforms in rural settings.

2.1 Service planning

Identify regional needs

Joined-up service planning is a good idea and the process itself facilitates improved local coordination. However, the risk of duplication is high. **Most states/territories and local health networks/districts already have population health planning departments with expertise and experience in this area**. Integrated service planning, avoiding duplication, is recommended.

2.1.1 Recommendation: To avoid duplication and to capitalise on existing expertise, consideration should be given to the Commonwealth and Primary Health Networks entering into integrated funding and partnership agreements to augment existing local health network/district and state mental health service planning capacity.

2.1.2 Recommendation: The Commonwealth funds sufficient mental health service planners with a rural focus. These planners would be based in the state and territory mental health planning units.

Identify service gaps

The comments above with respect to needs assessment apply equally to service gap analysis. Past experience of National Rural Health Alliance members indicates that in rural communities, service gap analysis is best conducted by involving local stakeholders and service providers. Even in small communities a variety of personnel (NGO, philanthropic, private practitioners) visit with very little local coordination or profile. To be valid, this process requires planners working with on-the-ground service partners. **On-site verification of needs/gaps analysis is a key to developing contextual relevance.** This partnership activity serves in and of itself as an enabler of improved service coordination.

2.1.3 Recommendation: Service gap analysis should be done in situ, involving as many local stakeholders as possible.

2.2 Integration

The National Rural Health Alliance applauds and supports this sentiment.
Integration means many different things to different people. It can occur horizontally across service providers, or vertically across the care spectrum. It can also occur across time and across the depth of commitment. Thus we have 4 dimensions of integration: 1) horizontal, 2) vertical, 3) process, and 4) progressive. Efforts at system reform often fail due to the absence of a shared understanding of what integration means, and, therefore, a haphazard approach to implementing 'integration'. Without a clear understanding of the intent of this reform direction it is difficult to provide targeted policy advice. The first 4 mental health plans have attempted to address various aspects of integration, but all without a clearly developed policy conception of integrations.

Table 1. The integration policy emphases of National Mental Health Plans.

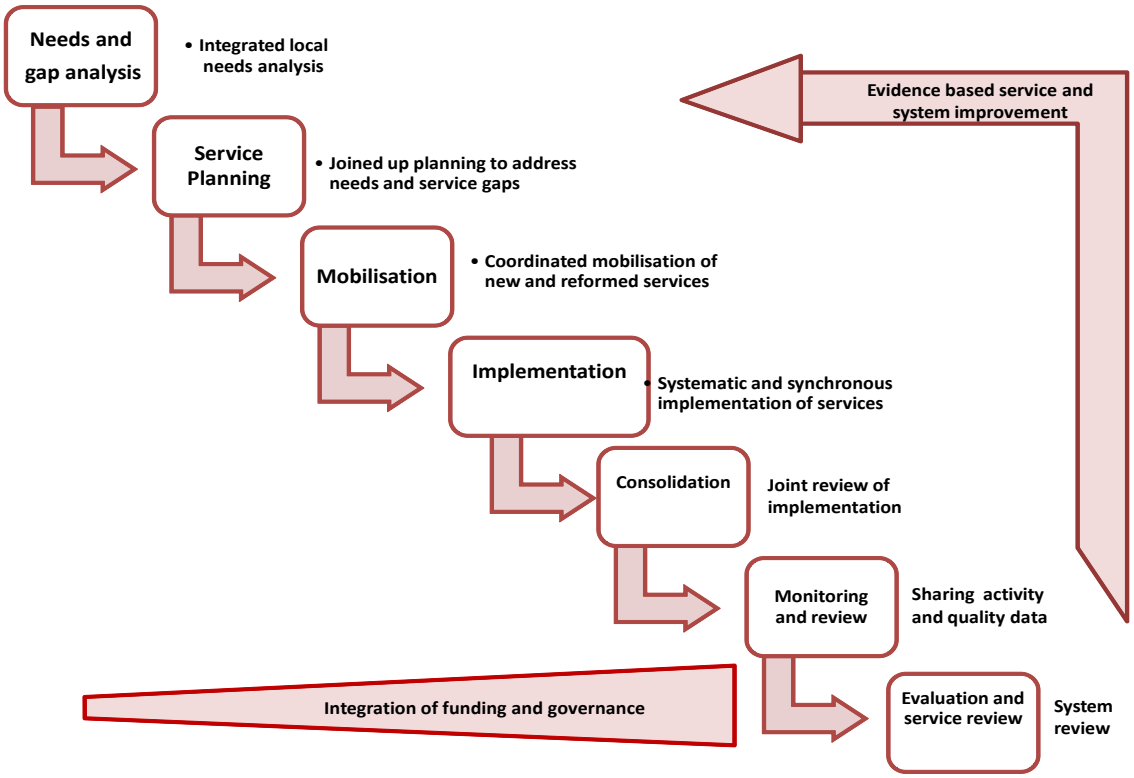
National Plan	Integration conception
One	Integration, intersectoral linkages
Two	Partnership arrangements
Three	Linkages, care pathways
Four	Coordination and continuity of care
Five?	Integration?

Progressive integration of care: A pathway to system reform

The National Rural Health Alliance recommends the model of Mental Health Progressive Integration of Care (MHPIC). This model specifies the stages of integration and progressively guides partner organisations through the stages of integration from needs analysis to system evaluation (see Figure 5).

Using the MHPIC allows integration to occur in a logical sequence with all partners involved in developing shared understandings and agreements at each stage. It also allows integration to occur in the other three dimensions in accordance with partner willingness and capacity. Failure to progress in this fashion is the reason for many system integration failures and why this is a still a priority after 25 years of recommendations. It is recommended the Primary Health Networks take on the role of regional integration lead. This model allows funders to schedule implementation and monitor integration progress in a transparent and concrete fashion.

Figure 5. Progressive integration of Care (Roberts and Perkins, 2016).



The 2007 (Maasa) review of the National Integrated Health Trials, conducted between 2000 and 2005 revealed some significant lessons and challenges with respect to integration. These included:

1. The one who integrates calls the tune
2. Integration costs before it pays
3. You can integrate some services for some people, but you can't integrate all services for all people
4. Your integration is my fragmentation
5. You can't integrate a square peg into a round hole (e.g. GPs and state funded services).

2.2.1 Recommendation: The Commonwealth defines and operationalises 'integration' in mental health service delivery. Concrete reform targets with respect to linkage, communication, commissioning, coordination, and cooperation are developed consistent with the evidence on effective primary mental health care.

2.2.2 Recommendation: The Commonwealth uses the MHPIC model to guide planning, implementation and monitoring of mental health integration.

3. Delivering Services within a Stepped Care Approach – Better Targeting Services to Meet Needs

Strategic direction: (Refocusing primary mental health care programmes and services to support a stepped care model)

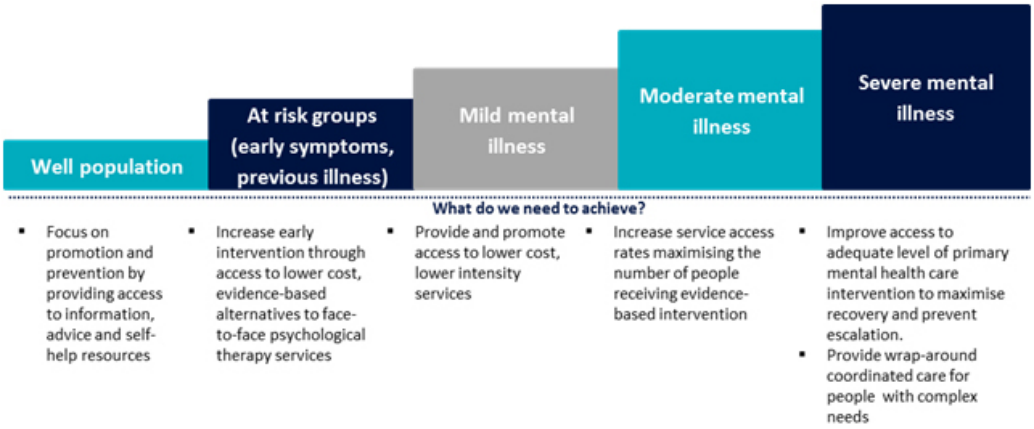
Concrete action: Empower and support self-care and implement a new model of stepped care across Australia

3.1 Stepped care

Using a stepped care model to reform services and offer people living with mental illness and clinicians a more complete range of care options is supported.

Stepped care is an important reform direction. It is **one of only two reforms that are mentioned as a platform, concrete action and strategic direction** (Figure 1). As such this is an identified priority area of Government reform. For the clinician in a rural setting, stepped care has always been a routine part of individual care planning. Clinicians coordinate the best care within the existing available service context (see Figure 7) on a case by case basis. The National Rural Health Alliance supports the development of the stepped care model and its use to analyse gaps and to inform rural service planning.

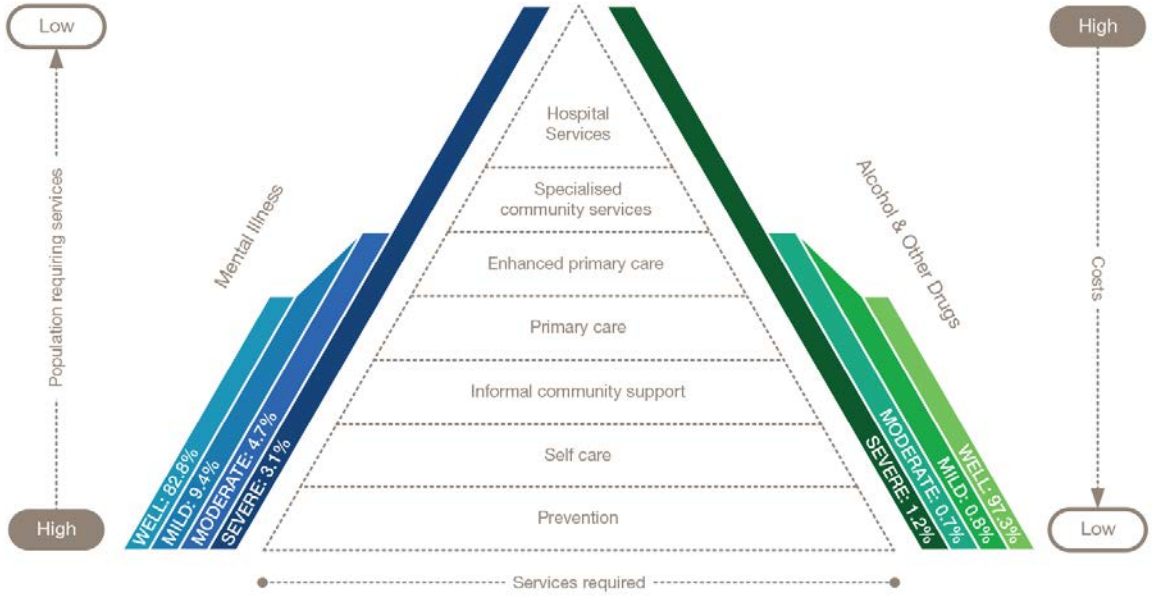
Figure 6. The Commonwealth stepped care model.



It should be noted the model presented in the Government Response (Figure 6) is a high level population distribution model of mental illness broadly describing the types of care. There is a no shared, widely accepted stepped care model. Many organisations, including Primary Health Networks, are currently doing policy development work in this area and will very likely arrive at different models. This poses a number of challenging questions:

- What will be the implications of a variety of stepped care models across Primary Health Networks and across Australia for service review and evaluation and for those clinicians, consumers and carers who navigate across different Primary Health Networks?
- How will a stepped care model be applied/actualised in smaller communities of 20,000 people and fewer?
- Given the states/territories are primarily responsible for service delivery funding, who will take responsibility for the identified gaps in the service spectrum uncovered by the Primary Health Networks using Commonwealth money?

Figure 7. The WA Mental Health Commission stepped care model. (WA Mental Health Plan, 2015).



The WA Mental Health Commission has adapted the WHO optimal mental health service mix pyramid to outline a broad conceptualisation of stepped care against mental health population distributions (Figure 7). The National Mental Health Commission Review has identified the following missing mental health service elements:

1. E health
2. Sufficient community mental health support
3. Vocational and education participation
4. Sub-acute and sub-acute recovery services.

The National Rural Health Alliance recommends further development work on a mental health stepped care model with an emphasis on access to the missing service elements (as listed above) for the 680 communities of population up to 20,000. The identification and development of the missing service elements in a stepped care model is essential to equity of access to services for the 30% of Australians not living in capital cities.

3.1.1 Recommendation: The Commonwealth further develops the model of stepped care, with a particular emphasis on principles of stepped care for rural communities of up to 20,000 population. (The National Rural Health Alliance would be happy to work with the Commonwealth to help develop the overall model and its application to rural towns.)

3.1.2 Recommendation: The identification of service gaps (outlined in Section 2) is done within the framework of a stepped care model.

3.2 Acute care

The National Rural Health Alliance agrees in principle with shifting some funding from the acute mental health care sector to the community based care sector. It does voice its

concern that this shift will potentially further disadvantage rural people who require inpatient care. This group already suffers from unfairly low levels of access to acute inpatient care. The further reduction of acute care options risks making this situation worse for rural Australians.

3.3 Subacute care and recovery centres

Sub-acute/recovery centres comprise an important element of a stepped care model in major rural centres. This model has progressively been rolled out in Victoria (PARC Units), NSW (Recovery Centres/subacute units) and in SA (rehabilitation units). Such centres have proven cost efficient and can be used to avoid transfer and admission to an acute unit, which is often in another city far from home. They can be used as a step down from inpatient care, smoothing and supporting and equipping the person living with mental illness to transition back into the community.

The consideration of these units being run by NGOs in partnership with public mental health services is encouraged as emerging evidence suggests they promote:

- More efficient use of public money
- Less social distance between staff and consumers and more egalitarian care
- A commitment to peer workforce employment and development
- A greater commitment to recovery-oriented practice
- A rural workforce development program – with many workers attaining their Certificate 4 in social and community care and then upgrading to degree level professional training.

This is an important, but largely missing stepped care element in most rural and regional cities of 10,000 plus that would significantly enhance mental health care, in these regions.

3.3.1 Recommendation: The introduction of sub-acute/recovery centres in cities of greater than 10,000 population be considered consistent, with the National Mental Health Services Planning Framework.

3.4 E-mental health and its relationship to stepped care

E-mental health is a rapidly developing area, which covers many levels of stepped care. It is one of two reforms that transcend concrete actions, platforms and strategic directions. As such, as a key government reform direction, it will be dealt with in detail in Section 5.

3.5 Promotion, prevention and early intervention

This element of mental health care will be addressed in Section 4. Contrary to popular perception promotion, prevention and early intervention actions can and should be applied the people living with mental illness across the illness spectrum (primary, secondary, tertiary) and across the age spectrum. These issues will be dealt with in further detail in Section 4.

4. Effective Early Intervention Across the Lifespan - Shifting the Balance

Concrete actions: Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life

4.1 Promotion, prevention and early intervention

The National Rural Health Alliance supports this platform of reform.

Whilst the National Rural Health Alliance strongly supports this reform, it is noted that promotion, prevention and early intervention has been a priority recommendation of every national mental health plan, roadmap, strategy and most state mental health plans since 1992. Despite this clear policy position, the proportion of funding allocated to these areas has actually decreased over the last 25 years. Some possible reasons for this include:

1. There is a lack clear, shared policy understanding in this area
2. There is a lack of guidance on what constitutes evidence-based mental health promotion prevention and early intervention
3. There is no quarantined funding for promotion, prevention and early intervention.

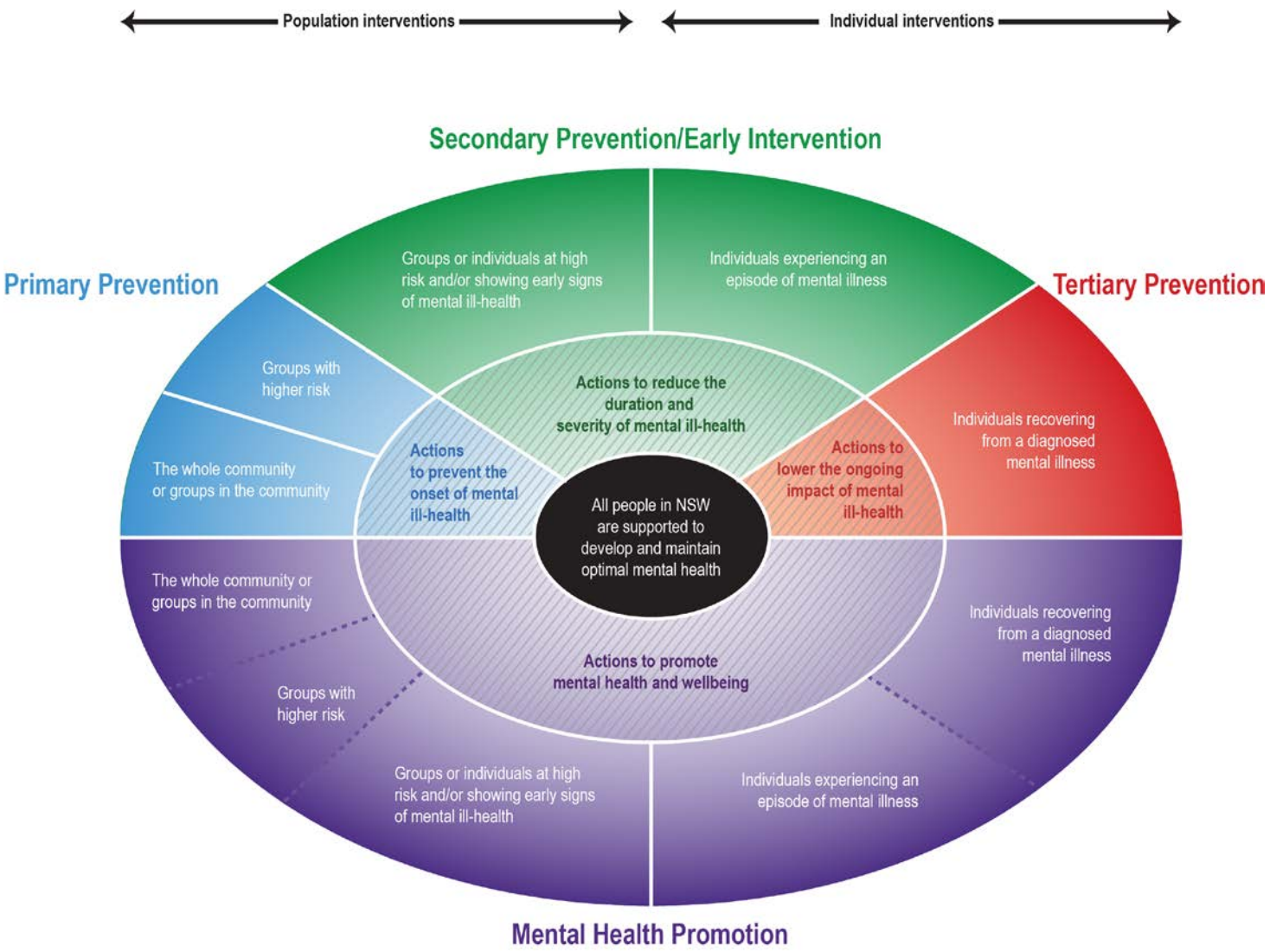
The operationalisation of the concepts and definitions of promotion, prevention and early intervention would assist reform. For example, there is lack of clarity around the meaning of primary, secondary and tertiary mental health prevention, let alone the operationalisation of these concepts. National leadership in summarising the evidence base, developing and operationalisation of models in this area would greatly assist reform.
The responsibility for promotion, prevention and early intervention cuts across all sectors. This includes NGOs, philanthropic organisations, local councils, state and commonwealth agencies. A clear, shared model and planned, coordinated action in promotion, prevention and early intervention is sorely needed.

4.1.1 Recommendation: The Commonwealth

- **reviews and revises the (2000) promotion prevention and early intervention framework**
- **operationalise and provide examples of primary, secondary and tertiary prevention in mental health**
- **develop an overarching national framework (including awareness and anti-stigma campaigns) within which Primary Health Networks can coordinate and deliver local promotion, prevention and early intervention responses.**

The framework presented in Appendix 1 outlines a model within which specific interventions can be targeted across each component of promotion, prevention and early intervention. This model demonstrates that early intervention and health promotion focus can and should apply across the entire spectrum of mental health and across the lifespan.

Figure 8. Better mental health: A new model of promotion, prevention and early intervention (Roberts, 2011).



4.2 School-based promotion, prevention and early intervention

Rural communities are often challenged by a shortage of specialist mental health professionals. On the other hand, school based infrastructure is well developed and relatively equitably dispersed. School provides a universal coverage and a well-developed infrastructure into which evidence-based promotion, prevention and early intervention programs can be introduced.

4.2.1 Recommendation: Investment in sustainable school-based programs is prioritised. These programs should have the following elements:

- **Curriculum-based mental health promotion and prevention**
- **School counsellor training and support – to identify at risk students**
- **Links to specialist child and adolescent mental health services for early referral of youth experiencing mental illness.**

4.3 Challenges

Despite being a national and jurisdictional priority, little progress has been made in promotion, prevention and early intervention over the last 25 years. The need for acute, and secondary community mental health services is pressing and tends to predominate. Local service providers face enormous pressures to respond to these pressing and urgent needs, usually at the expense of promotion and prevention initiatives. **In times of fiscal tightening the first program area to be cut is usually promotion, prevention and early intervention**.

4.3.1 Recommendation: A proportion of mental health funding is quarantined for promotion, prevention and early intervention initiatives. (The WA Mental Health Commission set this at 5% of total funding.)

4.3.2 Recommendation: Rural Primary Health Networks are allocated their fair per capita share of available promotion, prevention and early intervention funding.

5. Digital Mental Health Services – Making Optimal Use of Australia's World Leading Technology

Strategic direction: A new easy to access digital mental health gateway
Concrete action: Improve access to services and support through innovative technologies

The National Rural Health Alliance, in principle, strongly supports this reform initiative.
This is one of only two reform initiatives that appear across the platforms, concrete actions and strategic directions of reform.
Digital mental health and e-mental health provide an opportunity to enhance service access in rural communities. The Government Response outlines or implies e-health initiatives across the domains of stepped care. Those relevant to rural mental health are outlined below.

5.1 First point of contact – telephone services

This reform is strongly supported.
Many rural areas have been effectively operating these state funded services for over 8 years. Such services have been extensively evaluated and found to be as clinically effective and cost efficient.[1-10] The Government Response raises many questions concerning governance and funding. Some state governments have invested heavily in this area and have well developed infrastructure and service models. Others states have not. This will present a challenge in the process of rolling out a single national phone line. Additionally, the question arises as to what will happen if call volumes rise dramatically, placing further impost on limited state-funded services.

5.1.1 Recommendation: The Commonwealth immediately begins service model development and negotiation with jurisdictions on integrating a single mental health phone line, nationally, and across jurisdictions, local health districts and Primary Health Networks.

5.2 Self-care resources, advice and treatment options

This reform solution is **VERY STRONGLY supported.**
Jurisdictional website resources are limited and of variable quality. State developed and online resources for consumers and carers are by and large absent. Given the current capacity constraints across states, the development, endorsement and availability of on-line resources within the state and territory service models will require time. It would also constitute considerable duplication of effort.

5.2.1 Recommendation: The Commonwealth Government demonstrate national leadership in auspicing and developing online resources that are linked to jurisdictional websites.

5.3 Online mental health services

This reform solution is **strongly supported.**
Whilst the development of online mental health services will require significant additional policy work to be implemented nationally, the prospect of online mental health services that can be accessed by rural and metropolitan people living with mental illness and their carers is welcomed.

5.4 Protecting crisis services

See above. This reform solution is **strongly supported.**
Some rural districts have well-developed emergency and crisis tele-video support services with proven effectiveness.[1-10] Part of the success of these programs has been the local integration of services. Guiding the patient journey from first contact to in-patient admission (if necessary) is a complex process, involving GPs, regional health staff, family, police, inpatient and ambulance personnel. The ability of the mental health professional on the phone to effectively manage the patient journey should be protected.

5.5 Implementation issues and challenges

There are many implementation issues that need to be dealt with before these reforms are implemented as part of national reform in mental health.

5.5.1 Change management

Many states have existing single mental health phone numbers which have been widely promoted and have high levels of clinician and community awareness. The transition to a single national number will need to take place over an extended period of time supported by a comprehensive communication strategy.

5.5.2 Scalability.

Evidence suggests (Humphreys, 2005) that appropriate advice, understanding the service context of the callers, can only scale up to regions of approximately 500,000 in rural Australia. With larger population catchments, the advice suffers from lack of up-to-date service context. Past examples of how lack of knowledge of a community's service context can lead to advice such as 'catch a cab to the nearest hospital,' where both the cab and hospital are over 200 km away.

5.5.3 Technology

Technological solutions, rely on available technology. Many rural Australians continue to report poor fixed line and mobile phone service and substandard internet access. It is hoped the commissioning of the Australia's new communication satellite will rectify this situation, and make this solution plausible for rural Australians. This point bears re-emphasis, as the lack of physical access to on-the-ground services for rural Australians highlights the need for technology to enable remote access to virtual services.

5.5.4 Service context and change.

To keep a national telephone portal and resource directory up-to date will require regular, frequent revision and significant investment. The services available in small to medium size rural communities can change regularly on a month by month basis. GPs and NGOs come and go, and fly-in fly-out schedules often change with little or no notice. Across the 730 communities with populations of between 1,000 people and 200,000 people, keeping a national service provider database current, and avoiding adverse clinical outcomes due to obsolete service data comprises a significant regeneration burden.

6. Strengthened National Leadership – Facilitating Systemic Change

Strategic direction: National leadership in mental health reform

The Commonwealth accepted this recommendation from the National Mental Health Commission's Review of Mental Health Services. The Government Response outlined 4 key areas of national leadership: 1) supporting regional integration, 2) primary mental health care as a plank of reform, 3) increased consumer and carer participation, and 4) funding surety and data collection. These are addressed below with an emphasis on rural mental health.

6.1 Regional Integration, cross sectoral and activities beyond the health portfolio

The National Rural Health Alliance supports this reform initiative.
The Alliance seeks advice on:

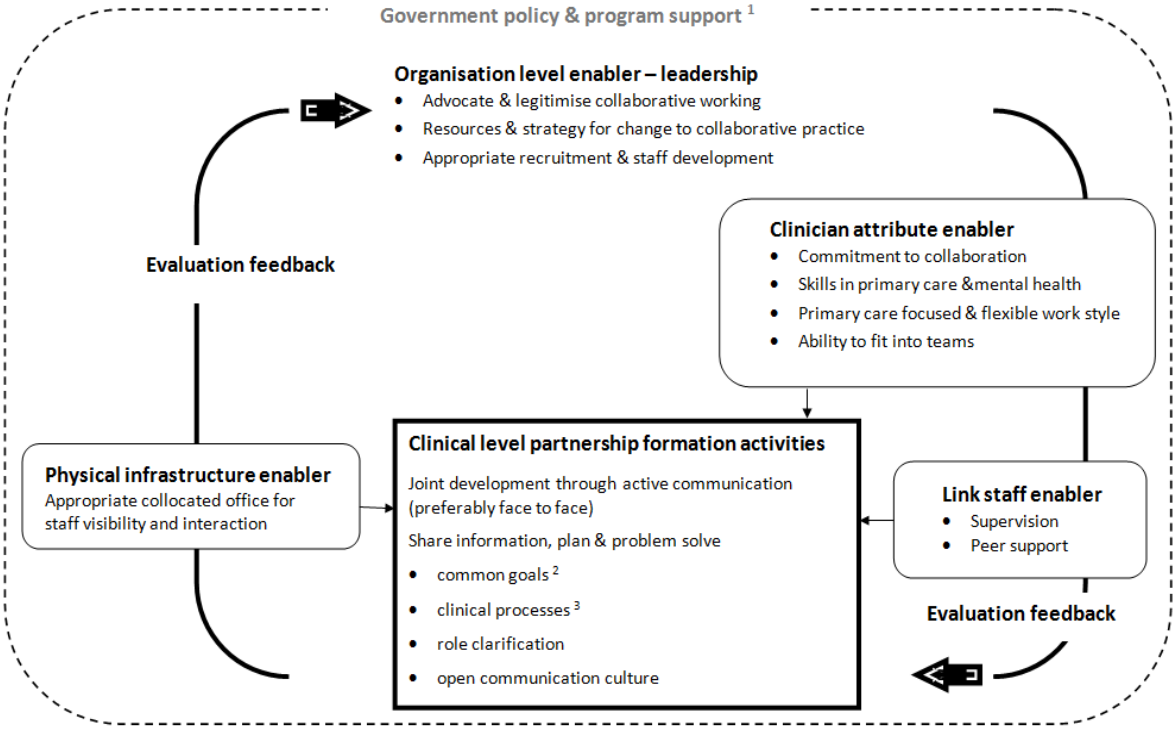
- The Commonwealth's planned actions and initiatives in rural and regional level that will contribute to this reform initiative.
- How this policy will be integrated into the stepped care model.
- How this policy will be advanced in the 5th National Mental Health Plan.

6.1.1 Recommendation: Advice is sought on how national leadership will be displayed in cross-portfolio approaches to mental health care in rural communities.

6.2 Primary Mental Health Care

The National Rural Health Alliance strongly supports this reform direction.
In 2009, the Commonwealth commissioned emeritus Professor Fuller (a Deputy Editor of the Alliance's Rural Journal of Health) *et alia* to conduct an international review of the evidence base on characteristics and enablers of effective primary mental health care. A summary of this work is presented in Figure 9. (This work is extensively referenced by the New Zealand Mental Commission.) The further development and dissemination of this work to ensure primary mental health structures and integration reform activities are evidence based is recommended. This peer reviewed policy work, if developed as an implementation guide, could provide an invaluable resource to inform the implementation of evidence based primary mental health care.

Figure 9: Evidence-based characteristics of primary mental health care.



Based on an extensive systematic review of the international evidence on primary mental health care Fuller et al. (2011) created a taxonomy of 4 broad and 10 linkage or collaboration strategies (Table 2).

Table 2. Characteristics of effective primary mental health care.

Linkage Category	Service Linkages
Direct Collaborative Activities	• Link working (organisational tasks connecting two or more services) • Co-location • Consultation liaison • Care Management
Agreed Guidelines	• Specific Treatment Protocols • Stepped Care
Communication Systems	• Enhanced communication (using formal processes) • Enhanced referral (expedited access etc) • Electronic Communication (telephone/video 2 or more people)
Service Agreement	• Service of formal work agreement (eg a Memorandum of Understanding or Service Level Agreement).

6.2.1 Recommendation: Existing research on evidenced based primary mental health care interventions be developed into an implementation and commissioning guide for Primary Health Networks, jurisdictions and NGOs.

6.3 Consumer and Carer Participation. (Engage Carers and Consumers)

The National Rural Health Alliance strongly supports this reform
Consumer and carer participation is both a reform platform and strategic direction.
We believe that the recognition of the importance of consumer and carer participation at all levels will be one of the most significant, valuable and lasting reforms, which, of itself, will introduce a profound reform mechanism that will transcend reports, strategies and plans.

We commend the National Mental Health Commission for its commitment to and strong engagement of consumers and carers, and to their presence at every level of its governance. We also recommend that this commitment be mirrored nationally through consumer and carer representation on the Mental Health Drug and Alcohol Principal Committee and in the co-design and production of significant Commonwealth and national policy and planning documents, such as the Government Response, the Suicide Prevention Plan and the Fifth National Mental Health Plan.

The adoption of this reform principle has been variable in many jurisdictions. The importance of representing the views of rural consumers and carers is not to be overlooked, given they represent the 30 percent of people living with mental illness who live in rural communities.

6.4.1 Recommendation: The development of a national carer and consumer framework is progressed as soon as possible. This framework should consider fair representation of rural consumers and carers.

6.5 Funding surety over longer periods and data collection

The National Rural Health Alliance very strongly supports this reform initiative.
Workforce 'churn' presents a significant issue in rural communities and short-term funding is a major contributing factor to rural workforce churn. This workforce churn also has a broad detrimental effect on rural communities overall. Funding surety and longevity is especially important in rural areas, where alternate employment options are limited. Employees prefer and seek longer term contracts and job security. Short-term mental health contracts denude rural towns of their mental health workforce capacity and experience.

6.5.1 Recommendation: Funding surety and longevity is made a priority for rural communities.

6.5.2 Develop evidence base

Practice based evidence from rural and remote settings is sorely lacking. Investment in mental health research capacity and infrastructure disproportionately goes to the capital cities. This leads to a lack of research in rural mental health, which in turn leads to a lack of investment rural and remote models of mental health care. Developing and investing in rural research capacity is vital to the well-being of rural communities. **With almost 30% of the population rural communities should receive their fair share of the mental health research dollar.** Rural mental health infrastructure already exists in the form of the Centre for Rural and Remote Mental Health (University of Newcastle), Adelaide University Rural Mental Health Observatory, and the mental health academic programs existing in university Schools of Rural Health located throughout Australia. This existing infrastructure and capacity should leveraged and built upon.

6.5.3 Recommendation: Research into rural mental health receives its proportionate per capita share of research funding.

6.5.4 Recommendation: Consideration is given to linking and enhancing existing rural mental health research infrastructure.

6.6 Data collection and measurement

The National Rural Health Alliance strongly supports commitment to national data collection and system monitoring.

It is noted that much of the data collection and monitoring development work and infrastructure already exists in jurisdictions, with agreements already in place to collect, collate and publish this nationally. It is also noted that the ABS and AIHW do excellent work in this area, and usually disaggregate data by rurality. The National Rural Health Alliance commends the ABS and AIHW for their recognition of rurality in data analysis and reporting. However, it appears data collection protocols for the rapidly expanding Primary Health Networks and NGO sector are yet to be developed. Establishing these protocols and processes for the NGO and Primary Health Network sectors which align with existing data collection protocols represents a vital next step in national data collection and monitoring of mental health system performance, including performance in rural areas.

6.6.1 Recommendation: Data collection protocols for NGOs and Primary Health Networks is developed urgently and this data is disaggregated by rurality.

6.6 National leadership in mental health reform

"National reform relies on local leadership"

Reform requires both good policy and good people. That is, the reform platforms need to be well-developed and operationalised, and the local leadership capacity needs to be in place to lead the change necessary to achieve reform. A well-developed policy platform without investing in the people charged with implementing the reform is doomed to fail.

6.6.2 Develop existing and emerging leadership in mental health

Current and future leaders are the people responsible for and therefore critical to the implementation of national reform and implementation of state/territory and national mental health plans. Local and national leaders will also be responsible for driving future reforms and plans.

For reform to be led nationally and implemented locally, leadership capacity needs to be developed. Most people in mental health leadership are clinicians with no formal training in management or leadership. This is especially the case in rural areas where there are limited opportunities for mentoring, support and formal education.
Leadership development could target priority groups such as:

- ATSI groups
- Carers
- Consumers/peer workers
- Rural managers

The development of a national mental health leadership development strategy would require further policy work but might include components such as

- Scholarships for **formal study in mental health leadership** – with institutions with a good understanding of mental health policy
- The development of leadership mentoring programs
- Establishment of a national mental health leadership network
- Development of a mental health leadership webinar series
- Mental health leadership forums and workshops.

6.6.3 Recommendation: A national mental health leadership development strategy is developed.

6.7 Develop national mental health policy.

The reform planning process, whilst national, is primarily driven by the Commonwealth. Ironically there is an absence of integration in national mental health policy development.

States and territories invest millions of dollars per annum developing mental health policies, resources and guidelines. Most of this policy development effort is duplicated and there is a lack of national collaboration. Coordination efforts are limited, spasmodic and selective. This represents a waste of limited mental health funding and often results in inconsistent of policy and practice guidelines of variable quality across the 8 jurisdictions. This creates problems for those clinicians, mental health professionals, consumers and carers who traverse state and territory boundaries. It also produces policy of sub-optimal quality.

National reform relies on good national policy and nationally accepted models. Currently in Australia (with a few exceptions) policies are underdeveloped, variable and not accepted nationally.

With respect to the current proposed national reforms, many of the central planks have not yet undergone rigorous policy development work, let alone operationalisation or national agreement. In the current reform context this applies to the concepts of:

- Integration
- Promotion, prevention and early intervention
- Stepped care
- Primary mental health care
- Digital mental health

All of these are key reform concepts. None of these have well-developed policy statements or guidelines.

Without national leadership and consensus, regional planning and implementation will lead to a patchwork of models across Primary Health Networks and to varied policy positions of jurisdictions. With 31 Primary Health Networks across 8 jurisdictions this could result in 428 policy permutations! The Commonwealth will be required to monitor and report on this reform implementation.

Effective national reform requires careful policy development to arrive at a national understanding and consensus. The alternative is sending reform initiatives into a policy miasma.

A National Mental Health Policy Institute jointly governed and funded by the Commonwealth and jurisdictions would comprise an example of national leadership in reform and integration. It could more efficiently use resources currently dedicated to policy development in the jurisdictions, and would result in:

- Consistent national policy
- Nationally agreed policy positions
- Increased efficiency with reduced duplication
- Better policy
- An example of national leadership and integration.

Some of the roles and functions of this institute could include:

- Reviewing and endorsing on-line resources for the national website.
- Development of national clinical guidelines in areas such as physical health and mental illness.
- National policy development.

6.7.1 Recommendation: A National Mental Health Policy Institute is established.

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Appendix 1. A taxonomy of promotion prevention and early intervention

Focus	Domain	Target groups	Definition	Terms from the literature
Actions to promote mental health and wellbeing.	Mental Health Promotion	Individuals experiencing or recovering from a diagnosed mental illness.	Interventions to enhance social, emotional and spiritual wellbeing and quality of life for people with diagnosed mental illness. Initiatives can occur within mental health services or in the community and include recovery as a key component.	Mental Health Promotion; Recover
		The whole community or groups in the community.	Interventions to enhance social, emotional and spiritual wellbeing and quality of life. Initiatives can occur with the whole population or selected groups and can occur in any setting (including schools, workplaces, the home).	Mental Health Promotion.
Actions to prevent the onset of illness.	Primary Prevention	The whole community or groups in the community.	Interventions work by focussing on reducing risk factors and enhancing protective factors in whole communities regardless of their level of risk.	Universal Preventio Primary Prevention.
		Groups at higher risk.	Interventions work by focussing on reducing risk factors and enhancing protective factors to prevent the onset of a problem or illness in groups known to be at increased risk.	Targeted Preventio Primary Prevention.
Actions to intervene early to reduce the duration and severity mental ill-health.	Secondary Prevention	Groups or individuals at high risk and/or showing early signs of mental ill-health.	Early identification of individuals showing signs of mental health problems or illnesses and clear pathways to appropriate services.	Indicated Preventio Early Intervention (prevention focusse Case identification.
		Individuals experiencing an episode of mental illness.	Interventions work by focussing on reducing risk factors and enhancing protective factors to lower the severity and duration of an illness through early evidence-based treatment.	Early Intervention (treatment focussed Secondary Preventi Early Treatment.
Actions to reduce the ongoing impact of mental ill-health.	Tertiary Prevention	Individuals recovering from a diagnosed mental illness.	Interventions work by focussing on reducing risk factors and enhancing protective factors to reduce the impact of an illness through rehabilitation and relapse prevention.	Tertiary Prevention, Rehabilitation; Rela Prevention; Longer-term Care.

From Roberts, R.J. (2011). Building Better Mental Health: A New Model of Promotion, Prevention and Early Intervention.