Royal Commission into Defence and Veteran Suicide - Submission and Proposed Recommendations

Submission by the

Australian Physiotherapy Association (APA)

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1. Executive Summary

Introduction

The Australian Physiotherapy Association (APA) welcomes this opportunity to respond to the Royal Commission into Defence and Veteran Suicide. The APA's submission is designed to provide constructive recommendations and considerations to improve the mental health care provided to current serving Australian Defence Force (ADF) members and Veterans. As some of the Terms of Reference are outside of the scope and expertise of the APA, our submission sets out important general principles and issues, then addresses those ToR where we can add value and substance to your inquiry.

Therefore, through this submission, our aim is to bring attention to the important role of physiotherapy in building better mental health and the key requirements to facilitating this essential care. The overarching goal of physiotherapy is to improve health, and physiotherapists know first-hand the reciprocal relationship between physical and mental health. There is a strong link between poor physical health and mental health problems—it is very hard to stay psychologically healthy when our bodies let us down. However, the health system fails to make these vital connections with more accessible and adaptable entry points needed to connect the physical and mental health needs of patients.

APA Position on Mental Health and Suicide

Building on the existing evidence

The APA draws the Commission's attention to the overwhelming evidence available on improving mental health and well-being and alleviating suicide, including (but not limited to):

- Productivity Commission Inquiry Report into Mental Health;
- Report of the National Suicide Prevention Office;
- Royal Commission into Victoria's Mental Health System;
- National Mental Health Workforce Strategy;
- *The Hidden Toll* - Senate inquiry into suicide in Australia; and
- Final Report from the Select Committee on Mental Health and Suicide Prevention.

The many previous inquiries this Commission will likely reference, along with the dozens of other inquiries, investigations and reports, all reach similar conclusions – that Australia's mental health care system is failing to provide the holistic care needed to alleviate suicide and support those needing mental health treatment and support.

A reoccurring theme of these inquiries is that addressing mental illness and suicide prevention must progress beyond the rigid bio-medical framework. We need to learn from lived experience, incorporate co-design in relevant health policies, and consider the environmental and societal pressures on serving and separated members of the ADF.

Biopsychosocial model of care

To strengthen outcomes there is a need for health system redesign towards more effective care delivery to improve the patient journey.

A stronger value-based mental health system for ADF members and Veterans is reliant on a key system shift towards a more evidence-based mental health care model through the adoption of a biopsychosocial model of care. This, combined with strategic prioritisation towards access and outcomes alongside a diverse funding structure—to prioritise collaborative care, system integration and prevention—will lead to the improvement of treatment and care of some of our most vulnerable Australians.

Providers of mental health treatments and prevention services need to shift their thinking towards an individual wellness approach. This is neither radical nor novel - it is an approach used overseas and also by Aboriginal Controlled Community Health Organisations. The ACCHO model (see https://www.naccho.org.au/acchos) has seen substantial improvements in health and well-being from their holistic health approach that supports the social, emotional, physical and cultural wellbeing of Aboriginal and Torres Strait Islander peoples, families and communities.

ADF and Veterans' health care policies must begin the fundamental shift towards collaborative care that is personalised, coordinated and is not focused on bio-medical services alone. Key to reform success, in transforming our approach, is the need to involve people with lived experience, achieved through an experienced-based co-design approach to developing new models of care.

Investing in public health messaging to improve the understanding of the association between physical pain, mental health and pain management would be an important initiative to support undertaking substantial investment in integrated care. As previous inquiries have highlighted, alternatives to hospital treatment and medication are often more conducive to supporting people experiencing mental and physical pain. Current treatment models do not adequately support the complex challenges, and do not adequately recognise and support the importance of physical exercise, mobility and pain reduction. There is a need for new funding models that formalise public physiotherapy in an integrated health system.

Building the health care team

All health providers have an important role to play in mental health care and suicide prevention.

All Australians with mental health issues should have access to appropriate and professional mental health care based on their individual circumstances and needs. This includes access to allied health services that support people across the whole continuum of care. The role of physiotherapists in managing and treating pain, improving mobility and function, and enhancing quality of life, has not been properly recognised and incorporated into mental health and suicide prevention strategies.

APA members see current and former ADF clients experiencing a range of mental health issues. It is not unusual for patients to disclose their personal and other health concerns to a treating health provider. This is particularly relevant in circumstances where stress and anxiety is heightened and exacerbated. And yet, addressing mental illness and suicide prevention remains predominantly within the GP/mental health specialist domain. Within DVA policy, this has been exaggerated through the TCI (treatment cycle initiative) treatment policy. The outcome is a substantial burden and responsibility being placed on general practitioners, while not allowing multidisciplinary care teams to be efficiently utilised.

The APA calls for investment in expanding multidisciplinary mental health teams that offer diverse skills and expertise for both Defence and Veteran populations.

A properly funded and managed health system would see coordinated multidisciplinary and multi-sector teams that include general practitioners, psychiatrists, and mental health nurses working alongside allied health practitioners (physiotherapists, psychologists, social workers, and rehabilitation counsellors). These types of multidisciplinary models operate internationally and deliver higher quality health care and better outcome measures. The Department of Defence and the Department of Veterans' Affairs (DVA) must be more engaged and work collaboratively with the allied health sector to establish innovative models that address mental health treatment from both mental and physical perspectives.

Physical and mental health care

A person-centred approach is critical to bring physical and mental health back together.

We know that by enhancing physical health, we also promote mental well-being. It's time to unlock these benefits by formalising physiotherapy as part of the multidisciplinary team for Defence and Veteran personnel. The physiotherapy workforce is well positioned to deliver this care.

Physiotherapists are highly qualified Ahpra-regulated practitioners trained to work with people who have mental illness across all health settings, including hospitals, aged care facilities, disability services, and private practice. Physiotherapists are trained in multidisciplinary and interdisciplinary care. Physiotherapy is part of the suite of health care services that can improve mental health, and relieve the mental distress caused by chronic pain through improvements in managing and treating physical health.

The APA supports best practice in managing physical pain that contributes to mental distress. Best practice involves multidisciplinary, coordinated, quality care. Further, a highly pain-literate community will produce more effective health outcomes and reduce the demand on already stretched services. The APA supports mental health training for physiotherapists through endorsement of Mental Health First Aid Training and Suicide Prevention Trainings and development of Physiotherapy in Mental Health Career Pathways.

The APA calls for physiotherapy to be formally recognised in addressing the physical well-being of people with mental health conditions from across the lifespan.

Conclusion

The solution is to invest in, and expand, multidisciplinary mental health teams so they can deliver the diverse skills and expertise needed to provide mental and physical health care.

All health providers have an important role to play in mental health, and all health providers have a role to play in suicide prevention. Physiotherapists confront mental illness every day, and our members report what is widely known across the health system – which is that patients confide in their health practitioner and seek help for physical and mental health problems.

Physiotherapists are trained in multidisciplinary and interdisciplinary care, but Australia's mental health system limits this care by not properly investing in, and promoting, team-based care. To make the 'every door is the right door' approach a reality of the mental health care system, the role of physiotherapists will have to be formalised within multidisciplinary teams. In enabling service shifts, we can help build a resilient, educated community. A highly pain-literate community will produce more effective health outcomes and reduce the demand on already stretched services.

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2. APA Recommendations

APA members report seeing clients experiencing a range of mental health issues and even suicidality. It is not unusual for patients to disclose to a treating health provider, such as their physiotherapist, personal and other health concerns. This is particularly relevant in environments where stress and anxiety is heightened and exacerbated, such as the military, policing and emergency services activities. We know that ADF personnel and Veterans will benefit from person-centred approaches through funded teams enabled to collaborate and communicate and care together. This submission outlines the barriers and drivers to service delivery including a key requirement to formalise the role of physiotherapy in mental health care. The following recommendations would help drive a key shift towards prevention and primary care, and a greater focus on early intervention. We thank the Royal Commission for its work and attention.

Recommendation 1	Adopt a biopsychosocial model of treatment for mental health patients, through an evidence-based approach that incorporates lived experience, co-design and relevant health policies.
Recommendation 2	Physiotherapists are recognised and included in multidisciplinary mental health care for former and existing members of Australia's Defence Force.
Recommendation 3	Physiotherapists are employed in ADF and Veterans' mental health services, recognising that holistic health care involves physical and mental health diagnosis, treatment and management.
Recommendation 4	Investment in education across the mental health sector to raise understanding of the important role of physiotherapy in recognising, assessing and treating physical illnesses and painful conditions, and the positive impact improving physical health has on mental health.
Recommendation 5	Recognise chronic pain and physical ill-health as a condition that is included in Medicare subsidised treatments.
Recommendation 6	Funding for researchers, clinicians, and service delivery organisations to collaborate on a national collection framework for data on mental health and suicide prevention germane to Defence and Veteran populations. This national collection framework should include: • a central repository of current, harmonised and comparable data from all jurisdictions which is broadly available for research and service delivery planning; and • harmonised data reporting requirements for inclusion in service delivery contracts.

3. Mental health care system reform

A system in need of treatment

Every door is the wrong door

Physiotherapists see components of mental health in almost every patient's story, and yet they are unable to provide any assistance or advice other than to recommend their patient 'seeks help'.

When patients reach out - every door is the wrong door for them.

Governments and providers must work towards an '**every door is the right door**' health care structure to transform the mental health system to one in which people are supported, treated and managed mentally and physically by multidisciplinary and interdisciplinary teams. Integrated care works. The failures evident in ADF and Veterans' health care can be attributed, in varying ways, to the failure to provide services and supports that include physical, mental and social/environmental care seamlessly.

Fails to address complex health needs

Australia's mental health care system is failing to provide the holistic care patients and consumers need.

All Australians with mental health issues should have access to appropriate and professional mental health care based on their individual circumstances and needs. This includes access to allied health services that support people across the whole continuum of care.

Chronic disease and injury dominate the total burden of disease in Australia. We know that people living with mental illness experience significantly poorer physical health, including higher rates of chronic health conditions. But our health system fails to provide adequate physical health care for people with serious mental illness. There is an urgent need for funded care pathways to enable access to evidence-based physical health interventions encompassing services for the management of chronic conditions, such as diabetes and chronic pain.

There is a need to recognise chronic pain and physical ill-health as a condition that is included in Medicare subsidised treatments.

According to Painaustralia, major depression is the most common mental health condition associated with chronic pain, with among 30 to 40 per cent of people with a diagnosed mental health condition also presenting for treatment for chronic pain. Almost a third of Australian adults experiencing severe or very severe pain have high levels of psychological distress, estimated to be about three times the rate of those with mild pain, and six times the rate of those with no pain. One in five Australian adults with severe or very severe pain experiences depression or other types of mood disorders.

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Physiotherapy and mental health

Value of physiotherapy

Physiotherapy provides a significant impact on a person's ability to remain independent and to experience a full life.

Physiotherapy is an efficient, although often underutilised, part of the health system. As a profession, the health benefits and effectiveness of our interventions, and the value we provide to the health care sector are proven in the research literature. The cost-effectiveness of our interventions was also demonstrated recently through a cost-benefit analysis of 11 common conditions by the Nous Group.[1] The Report showed that physiotherapy offers cost-effective evidence-based health care delivering value to both the individual and to the health care system.

Many ADF patients and Veterans face challenges such as dealing with complex health needs including restricted mobility requiring physical health interventions tailored to their needs. Physiotherapy treatments enhance an individual's independence, function and mobility, along with promoting social inclusion by encouraging participation in the economic and social life of the community. Physiotherapy also delivers benefits at a societal level through second order productivity gains through reduced pain, productivity gains (return to work), longer life, and avoiding and/or delaying the need for costly disability care. We have a strong evidence base that supports targeting physiotherapy services in caring for high-need, high-cost patients, including across the public insurance schemes, representing better value that translates into high-value, cost-effective care.

Diagram 1 | Physiotherapy | Individual and health system benefits

Key benefits

Better care

Where physiotherapy is more **clinically effective** than standard or alternative treatments:

- Chronic obstructive pulmonary disease
- Parkinson's disease
- Stress urinary incontinence

Reducing hospital admissions

Where physiotherapy reduces **hospitalisations** or where patients can be managed **without surgery**:

- Osteoarthritis of the knee and hip
- Orthopaedic outpatient services
- Emergency department services

Reducing chronic pain burden

Where physiotherapy provides an economic benefit in reducing **chronic pain**:

- Chronic neck pain
- Back pain
- Tennis elbow

Greater mobility

- Cerebral palsy
- Falls prevention

Enhanced outcomes

Where physiotherapy generates **societal benefits** through second order productivity gains:

- Reduced pain
- Greater mobility
- Return to work
- Longer life
- Avoided disability

[1] Nous Group. (2020). *Value of Physiotherapy in Australia*. Available at https://australian.physio/sites/default/files/Report_FA_WEB.pdf

Impact of pain

Addressing the impact of pain, and its association with mental ill-health, is fundamental to the practice of physiotherapy.

Mental illness and chronic pain places significant burdens on individuals and the Australian health care system. Untreated, or inappropriately treated pain, is a recognised factor in mental ill-health. Any person with reduced or poor physical mobility, loss of function, or experiencing chronic pain, is less able to participate in aspects of life, including work, social activities, family activities, exercise and travel.

Physiotherapists have a fundamental role in restoring physical function and the restoration of occupational roles which have significant impacts on mental health. As APA members report, for ADF personnel, it may not just be about pain specifically. In fact it may not be about pain at all in some cases. This can become evident in transitional arrangements where an ADF member is discharged due to critical injury. This individual may no longer be capable of performing physical tasks that have defined their working life (within the ADF) which may impact their perception of self, their vocational opportunities post-active service, recreational opportunities, perception of roles within the family unit and so on. In these contexts, physiotherapists play a fundamental role in functional restoration.

Improving help seeking behaviour

The physiotherapy workforce is well positioned to help build a resilient, educated community.

A highly pain-literate community will produce more effective health outcomes and reduce the demand on already stretched services. Forming trusting and ongoing relationships between patients and health care practitioners is the aim of general practice, and developing these continuous relationships is also the goal of physiotherapists.

Case Study

The APA hears the same message from our practitioners - that patients are more likely to disclose mental illness, suicidality and other health issues within the confines of treatment sessions. As one former ADF client told us, they feel “relaxed” with their physiotherapist, and as they make them feel physically better, they form trusting relationships, and look to that particular health provider for help.

Case Study: Former Vietnam Veteran corresponding with the APA.

“After I was diagnosed it wasn’t a psych who repaired me it was a physiotherapist and since then a number of exercise physiologists. As I lay on the table I would talk and my physio would talk back and there was a healing process taking place and then she set me exercise goals which added to the process.

With 29,000 members you are in a unique position to make a massive difference in this space. You have the basic tools which might need a bit of tweaking and I would imagine that you are easily accessible to every person in the country that has a mental health problem. As far as the military and veterans go, DVA is promoting that physiotherapist treatment costs are covered by them. Food for thought.

The APA could engage with [exercise expert] who in conjunction with your people can come up with exercise programmes which you can promote. I would think that DVA and Defence endorsement should be easy. You would be getting people back on their feet, most likely saving lives and adding to national productivity.

The one big problem in this space is that there are hundreds if not thousands of well-meaning entities working in isolation. They all have good intentions but the right hand never knows what the left hand is doing and the end result is a mish-mash of ideas which does tend to impede progress.

If we can get a green light and advice from them which to me shouldn’t be a problem, we then move forward. Why would they disagree with an extra 29,000 helpers?

Personally, I think physiotherapists with some empathy can play a massive part in recovery. With 29,000 physios in the country there must be some sort of role to play.”

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Collaborative, multidisciplinary care

Driving integration forward

We cannot emphasise enough the importance of promoting multidisciplinary/integrated team approaches, including physiotherapy and other allied health professions such as psychology, within general health diagnosis and treatment of ADF personnel and Veterans. Those experiencing mental ill-health often experience difficulties in accessing appropriate health care treatment. This is due to multiple factors, including:

- lack of access to appropriate health expertise (especially in regional and rural areas);
- financial constraints;
- physical restraints (lack of mobility and function);
- unawareness of appropriate services and supports;
- inadequate knowledge of GPs/specialists in the benefits of physiotherapy/ physical care; and
- reluctance to engage with different service providers.

Multidisciplinary team approaches, which are used overseas, is a recognised evidence-based approach to improve access to much needed supports and services.

The APA recommends the Commission seeks further information on multidisciplinary/integrated care and how this can be applied to Defense and Veterans health care.

Concurrent physical and mental health problems

Multidisciplinary models of care enable the sharing and transfer of skills. Even within Australia's existing system it is possible to modify the structures to reform how 'responsibility' of patient care is understood and managed. This may require investments in education and training, however, this would be a small consideration given that over $10 billion is expended on mental health each year.

Adopting this type of approach better addresses the high rates of mental illness among the cohort of people with long-term physical health problems. People experiencing more severe types of mental illness have a reduced life expectancy and commonly report poor physical health and lack of appropriate exercise and activity. According to an AIHW report, *Physical Health of People with Mental Illness* (July 2020) people experiencing mental illnesses are more likely to develop physical illness and tend to die earlier than the general population[2]. From available data, such as the National Health

[2]AIHW. (2020). *Physical Health of People with Mental Illness.* Available at: https://www.aihw.gov.au/reports/australias-health/physical-health-of-people-with-mental-illness

Survey, we know that Australians experiencing mental illness are much more likely to report having a chronic medical condition such as chronic back problems, arthritis, and pain.

It should be, to use a colloquialisms, 'a given' that health systems support people with psychological conditions along with their physical health. This is not just cost effective, it is also far better for the patient to have holistic, team-based care rather than navigate between the mental and physical arms of the health system. Multidisciplinary and interdisciplinary teams working together to understand, diagnose and treat individuals can only be achieved if primary care and MBS reforms include Ahpra-regulated allied health practitioners, such as physiotherapists.

Reforming primary care

The APA acknowledges that part of the problem in reforming primary care and the MBS is the paucity of robust data on the physical health and well-being of people experiencing mental illness. This lack of information, also identified by the AIHW, is not, however, a reason to exclude physiotherapy and other allied health providers from funded multidisciplinary team care. The lack of data reflects historic under-investment in research. Yet too many inquiries and investigations into mental health (including those set out in the Terms of Reference) remain tightly focused and have not properly examined how co-design can improve outcomes and reduce costs. This is particularly relevant to community care and the way Primary Health Networks (PHNs) commission and fund services.

The APA supports a co-design approach and recommends the Commission undertake further examination of co-design in mental health and how it can be applied to Defence and Veterans' health care.

The APA is familiar with the obstacles and barriers for the development and practical implementation of multidisciplinary/integrated care, and working alongside medical practitioners to improve patient health. However we also know, both from the APA's Value of Physiotherapy in Australia[3] report, and numerous studies, data sets and patients' preferences, that long standing cultural and practice 'fences' that relegate allied health to secondary or lesser status in the health system are certainly not benefitting patients.

There is a pressing, critical need to integrate community care through the funding of services that make available appropriate mental health and physical health services and treatment, working in a coordinated, integrated environment. This applies both in general, and specifically to ADF personnel and Veterans who seek help within the wider health system.

[3] Nous Group. (2020). *Value of Physiotherapy in Australia*. Available at https://australian.physio/sites/default/files/Report_FA_WEB.pdf

4. APA's response to specific Terms of Reference

This Royal Commission presents an unprecedented opportunity to construct a system to meet the needs of ADF personnel and Veterans. Evidence tells us that integrated responses to complex needs produce better outcomes but we need new approaches to fund team-based care to deliver best health and system outcomes. It is by making a key shift to integrate physical and mental pain treatments that we will advance new pathways to recovery.

Legislative and policy frameworks

Strengthened pathways

The APA draws the Commissions' attention to three policies generated by DVA which have a significant and challenging impact on physiotherapists and Veterans who seek assistance from our profession:

1. The introduction of the TCI (treatment cycle initiative) and associated framework.
2. Pricing changes progressively introduced to provide different pricing structures within the allied health sector.
3. Concurrent treatment policy that does not allow two treatment providers to help a Veteran on the same day for the same condition, for example an exercise physiologist and a physiotherapist.

Within ADF medical support services, physiotherapists play an important role in the management of injuries and injury prevention. This is an integral part of supporting the most important resource within the ADF.

Currently in the ADF, physiotherapists work under four main employment areas:

1. Off base service delivery (through the BUPA / ADF contract)
2. On base as a contractor to the BUPA / ADF contracted services
3. On base as a Defence employee (APS)
4. On base / on exercises or deployments as an ADF member

Physiotherapists therefore play an important role within ADF multidisciplinary teams; however, as noted above, multidisciplinary/integrated health care is rarely available in the wider community health environment. This means, in effect, a two-tier system where current ADF personnel are afforded integrated care yet some Veterans and former ADF personnel may struggle to navigate the siloed health bureaucracy and confusing referral pathways to appropriate care.

Currently, physiotherapists' role in the care team for Veterans varies depending on location of services and the set-up of the clinical setting. For example, if a Veteran chooses to see a physiotherapist in a stand-alone physiotherapy clinic, then the role the physiotherapist plays is consistent with current service arrangements in Primary Health care.

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Systemic issues

Transitional arrangements

Transitional arrangements are reported as a point of frustration and the highest period of risk for those exiting the ADF.

APA physiotherapists report that transitional arrangements do not adequately provide services for Veterans, nor do they predict and accommodate for the specific needs of this population. Exiting ADF personally can feel 'lost' as they are removed from a framework that has provided (at least) some level of security. There is a service vacuum in comparison to what they are familiar with and what they have experienced within the ADF.

Valuing skills

DVA continues to reinforce the traditional paradigm of the GP as gate keeper in Veterans' care. This is even more evident with the TCI.

This approach does not recognise the role of physiotherapists and other allied health professionals as experts in the delivery of holistic care to Veterans. Physiotherapists should be able to direct care in consultation with the GP and other supports for the Veteran cohort. The current model creates barriers and delays that can exacerbate frustrations with getting the right care, and potentially negatively impact Veterans at risk. For example, where a physiotherapists is working in conjunction with a psychologist to manage a Veteran's physical and mental well-being, they should be able to establish care plans in consultation with the Veteran, rather than rely on "quasi endorsement" by the GP who may have less awareness of the specific details of the agreed plan.

Fees and pricing

The APA also recommends an immediate change of the current fee structure and pricing model by the DVA for allied health providers to support Veterans.

The key outcome would be to have pricing parity between allied health providers as an initial change, and then implement necessary changes to the process of screening and identification of issues.

DVA should embrace and remunerate appropriate collaboration between providers to support integrated care. Good outcomes are achieved by properly coordinated and planned care. The Department has continued to underfund antiquated sessional models of care that do not facilitate integrated care planning. The APA supports direct funding of care planning and integrated care models.

Screening and outcome measurement framework

A reformed screening and outcome measurement framework would ensure that not every Veteran is placed in the same treatment category.

The current TCI policy and framework may work for some and be effective for DVA in managing fiscal constraints, but our experience is that making Veterans retell their histories and try to build trusting relationships with numerous health care providers is part of the problem this Commission is trying to address.

The current model for allied health services within the DVA is homogenous, despite the fact that Veterans are an extremely heterogeneous population. A very significant proportion of supported Veterans are aged 80 or over. The needs of this group of Veterans are demonstrably different to those of the emerging Veterans cohort. It is therefore essential DVA delivers an agile system that acknowledges the need of different cohorts and responds with specifically tailored systems and models of care that meet the clinical requirements of the varied groups within the Veteran population. The limitations of one-size-fits-all models is evident by the need for this Royal Commission and other inquiries into mental health and suicide prevention.

The APA urges the Commission to examine international suicide prevention programs to assess how adaptable and flexible approaches designed specifically for at-risk populations can be applied in this context. We also recommend examining how tailored service delivery removes barrier to physiotherapy and other allied health care and enhances best practice care to these population groups.

Continuity of care

Service provision needs to be multidisciplinary and effectively coordinated which is reliant on investment in evidence-based models of collaborative care.

Every inquiry into mental health and suicide brings to the fore how critical continuity of care is. This is why multidisciplinary/integrated care teams are favoured as a way to provide holistic care and less reliance on one practitioner. For example, in Brisbane, Go2Health provides a multidisciplinary support service that also values connecting with their client through their transition from service to civilian life. In this submission, we will not go into the full service model detail but it is worthy of mention as evidence-based high value care. Unfortunately, the current funding model does not support this type of care.

Further, the APA is frustrated that physiotherapy is oftentimes seen by DVA as short-term health care, despite the clear evidence supporting sustained high level therapies that promote physical health (in the context of chronic illness) and mental health.

This Commission should also examine models of collaborative care that are currently working, and note that there are very few examples of multidisciplinary care available for people living in remote and rural locations.

Integrating physical and mental pain treatments

The relationship between chronic pain, mental distress, and suicide is well established. For instance, Voluntary Assisted Dying (End of Life) legislation exists in some Australian jurisdictions, permitting people to end their life legally if ongoing suffering from a terminal illness cannot be relieved in a manner that the person finds tolerable. The definition of suffering (in some jurisdictions) includes physical and non-physical (psychological, existential) suffering.

The extensive literature on suicide traverses documented situations of suicides completed to end 'pain' be it mental, physical or both. A glaring gap in Australia's health system is the way pain is siloed as being a physical manifestation, or a mental health disorder, when 'pain' affects both mind and body, and cannot be treated separately.

Therefore, those treating pain must be integrated within the overall care of people who may be 'at risk' of suicide and/or severe mental health problems. It is obvious that the high rates of suicide among current and former military personnel is associated with both physical and non-physical pain. And yet the Australian health system does not have a delineated, structured or trained workforce to provide holistic support.

If there is one recommendation the APA wants this Commission to take on-board, it is the immediate need to reform the health care system to integrate health practitioners treating ADF personnel and Veterans so that physical and mental health care is assimilated.

Workforce strategies to build integrated care

The Commission should note that the solutions to improving ADF and Veterans mental health and alleviating suicide rely on the implementation of workforce strategies that build and maintain health teams with a strong focus on continuity of care.

Those responsible for ADF and Veterans' health need to fully understand labour market dynamics and trends, particularly those factors generating wage suppression and poor career pathways. The disparity between the remuneration of psychiatrists, psychologists, and GPs, and allied health workers whose contribution is, in many areas, of equal importance and value to patients, must be addressed through workforce strategies. For instance, pay differentials among those supporting this cohort do not necessarily reflect the roles and responsibilities of diagnosing, treating and helping people with mental health issues, PTSD, and suicidality. It is critical that these issues are specifically addressed through a comprehensive workforce strategy that addresses:

- pay and conditions;
- career pathways; and
- the valuing of allied health and peer workers.

Key reform requirements

The APA is concerned that there is not sufficient 'flexibility' - the current system is patchwork, working well in some places but inconsistent, expensive and not meeting demand in others.

The 'balance' that needs to be achieved is providing appropriate mental and physical health care to patients where and when they need it. As noted previously, APA members report that a majority of their patients express some mental health concerns during treatments. To put this another way, we have a highly qualified health workforce of around 30,000 that is for the most part 'unused' in mental health care. And, to reiterate, the outcome is that every door becomes the wrong door for Veterans (and others) - turned away to navigate the complex and costly referral maze at the very time they reach out and ask for help.

Importance of improving integration of care, and supporting multidisciplinary approaches

The APA supports the Productivity Commission's recommendations on integration of care as absolutely necessary to support the Strategy's objectives. Integration and multidisciplinary approaches also require fundamental restructures and reforms to Medicare and fee-for-service models. Supporting extended scope physiotherapists as primary practitioners able to refer to specialist medical practitioners will better utilise the existing workforce. Unless this is undertaken and referral pathways and access to appropriate allied health is opened-up, the aims and objectives of any broader strategic pieces may not be fully realised.

Addressing the issues and supports required to improve workforce distribution

While funding and other incentives are recommended, other factors, such as the impact of climate change and environmental factors, lifestyle, and family and social life considerations require a whole-of-government approach. The maldistribution of health care practitioners is almost at crisis levels, creating a multi-tiered system with access to appropriate care diminishing the further one lives from a metropolitan area.

Utilising and including integrated, collaborative care teams, including Ahpra-regulated physiotherapists in care, is one solution. Enabling the Primary Health Networks (PHNs) to advance allied health-led models of care to address service delivery challenges in rural areas is also a priority. This requires more flexibility in service design and funding to enable rural allied health service provision.

Innovation in service delivery models and workforce optimisation approaches

The greatest opportunity lies in testing new models of care in addressing unmet need and supporting a sustainable workforce to deliver these. This will bring the diverse range of skills and expertise required in meeting current and future need across a range of functions. PHNs remain a viable potential funding channel, however, these entities currently lack a mandate to drive innovations beyond general practice. Through further reform, PHNs provide an existing structure to drive system-wide changes for developing and testing new models of care in mental health.

5. Summary

There is an urgent need to formalise the role of physiotherapy in mental health care.

As the APA submission stresses, the current systems need to acknowledge the indelible link between physical and mental wellbeing. Physiotherapists have a fundamental role to play in the integrated management of Veterans with primary mental health conditions and in those with complex physical and mental illness.

The APA calls for enhanced engagement between mental health services, general practice, and physiotherapy to address and improve physical activity, mobility, exercise, and pain relief for patients and health care consumers. In bringing physiotherapy into integrated care teams, we call for a national funding commitment to expand access to mental health care to facilitate holistic care. This includes expanding funding through Medicare access to private physiotherapy – recognising the benefit of physiotherapy-led interventions in chronic pain and physical ill-health.

Physiotherapists are experts in aspects of physical health care and can offer expertise in prescribing individualised exercise programs, which can improve mood, promote wellbeing and address co-morbidities associated with mental health diagnoses.

The APA alone represents more than 30,000 members who conduct more than 23 million consultations per year. At a time when the demand for mental health care is escalating and the mental health force is struggling to meet current needs, effectively utilising the existing allied health workforce, including physiotherapists, would deliver enormous benefits to patients.

Further reading list

The Commission may be interested in material relevant to how physiotherapists utilise psychologically informed interventions in practice:

- Cowell et al (2021). *Physiotherapists' Approaches to Patients' Concerns in Back Pain Consultations Following a Psychologically Informed Training Program*, Qualitative Health Research, 31 (13), p 2486-2501.
- Kedroff et al (2019). *Cognitive behavioural therapy-informed physiotherapy for patellofemoral pain: A feasibility study*, Musculoskeletal care, 17(4), p382-389.
- Godfrey et al (2020). *Physical Therapy Informed by Acceptance and Commitment Therapy (PACT) Versus Usual Care Physical Therapy for Adults with Chronic Low Back Pain: A Randomized Controlled Trial*, J Pain, Jan-Feb 21(1-2), p71-81.
- Kinney et al (2020). *The impact of therapeutic alliance in physical therapy for chronic musculoskeletal pain: A systematic review of the literature*, Physiotherapy Theory Practice, 36 (8), p886-898.

6. About Australian Physiotherapy Association (APA)

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing, and that the community recognises the benefit of choosing physiotherapy.

The APA is the peak body representing the interests of Australian physiotherapists and their patients. It is a national organisation with state and territory branches and specialty subgroups. The APA represents more than 30,000 members who conduct more than 23 million consultations each year. The APA corporate structure is one of a company limited by guarantee. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.