Mental Health Inquiry
Productivity Commission
GPO Box 1428
Canberra City
ACT 2601

SUBMISSION: The Social and Economic Benefits of Improving Mental Health

We make this submission as an inter-professional team of senior clinicians who oversee the work of the Pain NT allied health team, and are the business owners and operators of the Pain NT consortium.

Executive Summary

Pain NT is a co-ordinated team of health professionals (physiotherapists, occupational therapists, psychologists and a remote rehabilitation physician), based in Darwin. While urban areas are now well serviced by pain treatment centres, remote Australia continues to grapple with isolation, access and limited opportunity for specialised professional development. Pain NT was established as an innovative approach to building local capacity in this context.

There are three parts to this submission: First, we review the consequences of pain-related mental ill health and best practice principles; Second, we consider successful initiatives from other parts of the country and reflect on the unique challenges associated with service provision in the Northern Territory (NT). Finally, we propose a number of systemic recommendations to improve mental health in the context of physical illness and injury based on our experiences of working with chronic pain in the NT.

In summary, our position is as follows:

- While *stepped care* is an appropriate approach for the majority of mental health presentations, effective pain rehabilitation requires a *stratified* approach which identifies and manages psychosocial risk <u>before</u> it becomes a mental health issue;
- For those injured at work or on the road, there is strong evidence to indicate that initiatives within the compensation system that incorporate financial incentives to encourage early detection of psychosocial risk and co-ordinated early intervention are effective at both at reducing costs and preventing the development of mental ill health. While successful programs have been trialled in other parts of the country, reforms that target early intervention are yet to be implemented within the NT compensation system;
- National service benchmark data from the Electronic Persistent Pain Outcomes Collaboration (ePPOC) is not representative of the diverse population in the Northern Territory, where over 30% are of Aboriginal or Torres Strait Islander (ATSI) background and a further 20% were born overseas, predominantly from non -English speaking countries. As such, we are yet to find ways to meaningfully incorporate the needs and experiences of our diverse NT population into national chronic pain data benchmarking;

Consequences of Pain-Related Mental Ill Health

Chronic pain has gained considerable attention over the last fifteen years as one of Australia's most costly health conditions. Seminal research suggested that around 3.24 million Australians were living with chronic pain (Blyth, et al., 2001), with this number projected to increase. The cost of direct health care for chronic pain is estimated to be over $73 billion dollars per annum (with this figure rising to $139.3 billion when quality of life impacts are included) (Bennett, 2019). Initial authoritative studies estimated that chronic pain results in at least 9.9 million missed work days per annum (van Leeuwen, et al., 2006). It is also closely associated with a range of mental health conditions and increased prevalence of suicide (Flor & Turk, 2012).

It has been estimated that up to 80% of people who have chronic pain miss out on treatment that could improve their health, quality of life and workforce participation (Pain Australia, 2010). This is particularly the case in rural and remote areas, where the impacts of pain related ill health and mental ill health are greater. People who live outside of major city areas are 23% more likely to experience back pain and 30% more likely to acquire a long-term health condition following injury (ABS, 2011). There is limited access to pain-specialised services in the Northern Territory, as these are predominantly located in the major cities of NSW, South Australia, Victoria, Western Australia and Queensland.

The National Pain Strategy, developed in 2010, highlighted inequities in Australia, both in service provision and pain-related quality of life impacts, including mental ill health, given that pain is associated with markers of psychosocial disadvantage. In particular, access to services in rural and remote areas, and for Aboriginal and Torres Strait Islander (ATSI) communities, and access for culturally and linguistically diverse (CALD) populations were highlighted. In the decade since inception, the *National Pain Strategy* has guided important advances and initiatives in pain rehabilitation nationally. However, many of these initiatives have not been implemented in the Northern Territory, where significant gaps remain.

Best Practice Principles

- **Stratified Care**

In the present inquiry's *Issues Paper* (2019), the Productivity Commission refers to the evidence regarding use of a stepped care approach to the management of mental health problems, including mental illness and mental ill health, and we acknowledge the strong and growing evidence base for this.

However, when it comes to the prevention and management of mental ill health in the context of pain and injury, we note that stepped care is NOT the recommended approach. Instead, there is growing evidence, both local and internationally for **stratified care** (Linton, et al., 2018). While *stepped care* provides the same basic level of treatment to all, and steps up to more complex interventions as needed, *stratified care* categorises patients based on risk and then allocates treatment accordingly. This is important in the context of chronic pain, because psychosocial impacts (including mental ill health) can deteriorate quickly in the time it takes to "wait and see" if more intensive treatment is required. Meanwhile, changes in the nervous system (as a result of "neuroplasticity") occur over time, which further complicates recovery.

- **Health Provider Knowledge**

While, it can be challenging to navigate the health system at the best of times, people in pain are often required to engage with a range of providers who, for various reasons, are not always in close contact with each other. This often results in conflicting medical advice, which undermines treatment planning. The professionals typically involved may include pain and rehabilitation specialists, neurologists, physiotherapists, psychologists, pharmacists and general practitioners. In the compensation system, this process is further complicated by the inclusion of vocational rehabilitation providers, return to work co-ordinators, insurance claims managers and legal representation.

In addition, clinician beliefs and practice behaviours are not always aligned with contemporary evidence. There is a growing body of research to suggest that significant knowledge deficits continue to exist among health professionals in relation to chronic pain management, with some providers actually holding beliefs that interfere with the provision of optimal care (see, in particular, Houben, et al., 2004).

Examples of Best Practice Initiatives

The Global Access Partners (GAP) *Strategic Roundtable Report* (2016), details a range of promising initiatives that have been trialled within the compensation systems in New South Wales and Victoria. Both states have had well-established guidelines in place for over a decade, to enhance return to work outcomes following musculoskeletal injury. These essentially involve the exclusion of any underlying biomedical concerns (known as “red flags”), encouragement of a self-management recovery approach, prescription of only simple analgesics to manage short-term pain, and review of psychosocial risk factors (known as “yellow flags”) if recovery does not progress.

However, the practical implementation of these guidelines in both states was found to be often slow and unco-ordinated. For example, it was identified that physiotherapists lacked the confidence and skills to address psychosocial factors (once identified); and psychologists were often not introduced early enough or involved often enough to impact the recovery trajectory. Finally, a lack of collaboration and information sharing amongst all providers (including physiotherapists, psychologists and general practitioners), too often led to unco-ordinated, and often inefficient treatment.

Implementing the recommendations of the *National Pain Strategy* (2010) in Victoria, Worksafe Victoria and the Transport Accident Commission (TAC) joined forces to develop Network Pain Management Provider status for pain-specialised services. This initiative offered a higher fee for services delivered by health professionals with pain-specialised knowledge and experience, within particular timeframes and in collaboration with treating GPs. Early identification of psychosocial risk factors, including return to work barriers was incorporated in the process, along with regular case conferencing. A 2012 Worksafe/TAC evaluation of the program revealed that 41% of people who had been certified as unfit prior to joining a Network Pain Management program in Victoria were reclassified as fit for some kind of work duties upon completion; while half of those who were already back at work were able to increase their work hours at the end of the program. A subsequent Worksafe/TAC evaluation in 2015 found that injured workers in Victoria were accessing pain management

programs significantly earlier as a result of the Network initiative (an average of 1.5 years post injury), with this delay expected to continue to decrease in future.

In addition, Victorian GPs are now contacted by Worksafe and TAC clinical panel doctors to discuss work certification practices in the context of chronic pain, with information also provided to GPs via webinars and e-learning modules. Victorian physiotherapists have also been proactively contacted by clinical panellists and are now offered 3-hours of online training in return for increased remuneration and adherence to the Worksafe Clinical Guidelines. This has increased the number of physiotherapists with competence to write Work Certificates in Victoria.

In NSW, the Work Injury Screening and Early intervention (WISE) study, arising from collaboration between a consortium of stakeholders (including icare, NSW Health, EML and the University of Sydney) has shown similarly promising results (APS, 2016). The study recruited health workers with significant knowledge and experience in the management of work-related soft tissue injuries; workers were screened for psychosocial risk within one week of injury notification; and referred to a psychologist, who was required to see them within two weeks and liaise with both the treating GP and workplace. An independent assessment by a qualified occupational physician occurred between four and eight weeks post injury to confirm the soft-tissue injury diagnosis with the treating GP; and, if the patient was also being treated by a physiotherapist, an independent physiotherapy review (involving liaison with the treating physiotherapist) was conducted at eight weeks. A workplace case conference was offered if the worker had not returned to work within eight to nine weeks; and the insurance claims team and workplace RTW co-ordinators were provided with training and problem-solving assistance by the WISE research team. Significant reductions in both days off work and claims costs were achieved.

In both Victoria and NSW, pain services and providers are encouraged to adopt a set of standardised outcome measures and benchmark these against the national average via the Electronic Persistent Pain Outcomes Collaboration (ePPOC)[1], managed by the University of Wollongong. If the needs and experiences of the diverse NT population could be meaningfully incorporated into national chronic pain data benchmarking, pain services in the NT would also benefit from this initiative.

Thus, in summary, there is evidence to suggest that incentives that build GP and physiotherapist confidence and skill in assessing and managing psychosocial risk, ease access to timely mental health intervention (from pain-specialised mental health providers) and promote communication and collaboration between all stakeholders involved in the management of an injured worker, improve treatment outcomes and reduce claim cost – all by intervening before mental ill health becomes mental illness.

Gaps in the Northern Territory

Recovery from injury is complicated in remote Australia by unique geographical and systemic factors that increase the risk of long-term disability. These include often complex injury presentations, given the geographical isolation and subsequent delay in accessing appropriate treatment; and sometimes limited specialised health provider knowledge. This contributes to poor (or late) assessment of psychosocial and return to work barriers, a de-

[1] https://ahsri.uow.edu.au/eppoc/index.html

emphasis on patient experience (for example, in relation to pain experience) and disregard of small but significant treatment gains. In addition, in our experience, the Worker's Compensation and Motor Accident Compensation systems in the Northern Territory suffer from the same difficulties that existed in other parts of Australia at the time the *National Pain Strategy* (2010) was developed. Specifically, there are Clinical Guidelines in the Northern Territory for the management of musculoskeletal injury (NT Worksafe has adopted the Victorian Worksafe Guidelines), however the implementation of these is often inconsistent and delayed, leading to the development of avoidable mental ill health and pain-related disability.

Given that the Northern Territory has a highly transient population, high levels of staff turnover can mean that patients sometimes miss out on important recovery messages. Continuity of care can be difficult to maintain and records are not always easily transferred. In addition, while mainstream general medical and allied health services exist in Darwin and the regional centres, this is not the case in the rest of the NT. In remote areas, Aboriginal Medical Services, including the Aboriginal Community Controlled Health Services (ACCHs) and Northern Territory Government Remote Health Services provide healthcare to more than 80 remote Northern Territory communities.

Finally, the population in the Northern Territory is uniquely diverse, with over 30% of people being of Aboriginal or Torres Strait Islander (ATSI) background and a further 20% born overseas, predominantly from non -English speaking countries (NTPHN, 2018). This language and cultural diversity has the potential to increase the risk of psychosocial complexity following physical injury or illness, particularly for those involved in the compensation system. In addition, standardised outcome measures (such as those collected by ePPOC), are not appropriate for use on these diverse populations and have little validity or utility without careful consideration of cultural factors, including the ATSI cultural domains of social and emotional wellbeing (Dudgeon, et al., 2014).

Yet, while we acknowledge that pain rehabilitation in remote areas presents distinct challenges that are different from those in urban settings, we believe that these challenges are not insurmountable. Innovative application of established pain management principles, and learnings from successful initiatives and systemic reforms elsewhere, have the potential to improve service access and local provider capacity in the Northern Territory, if considered in light of local resources and context.

Aligning NT Services with the National Pain Strategy

- **Innovative Partnerships**

The NT Primary Health Network (PHN) has identified the development of locally responsive, sustainable models of care, as a strategic workforce priority; along with the development of the Aboriginal and Torres Strait Islander clinical *and* non-clinical workforce (NTPHN, 2018). The establishment of *non-hierarchical* partnerships to facilitate access to training and foster innovation in service development and delivery has been helpful to our Darwin-based team in overcoming some of the challenges of remote pain rehabilitation. In addition, we have established connections with colleagues in Alice Springs and several of the ACCHs in light of our collective need for pain rehab innovation and concerns about the current inequities in access to and delivery of pain rehabilitation services.

In addition, considerable resources have been invested in the design and development of training packages to upskill allied health professionals in urban areas. In the Northern Territory, a more flexible approach, for example, the development of a Certificate III or IV qualification, would be a more effective way to disseminate key pain treatment and recovery messages to a less highly qualified and more transient workforce, particularly in remote areas.

Advocacy organisations with a specific focus on remote service provision such as SARRAH (Services for Australian Rural and Remote Allied Health[2]) have produced a number of proposals specifically targeting the issue of access to allied health services in remote areas, including the development of a *Generalist* pathway to equip practitioners with the skill and resourcefulness to meet the health (and mental health) needs of remote communities. In our experience, community relationships and cultural competency are *at least* as important as knowledge and certification in the use of mainstream interventions in the context of chronic pain. As such, in keeping with the priorities of the NTPHN, it would be far more efficient and effective for those with pain expertise to partner with local health professionals (particularly those who have connections with remote Aboriginal communities) to bridge any gaps in their pain-specific knowledge and practice, than it would be to engage external providers and services.

- **Systemic Incentives**

Finally, for those with chronic pain following a compensable injury, the Worker's Compensation and Motor Accident Compensation schemes in the Northern Territory are yet to introduce the systemic practices and incentives that have been successfully trialled in other parts of the country. The introduction of initiatives to increase provider focus and confidence in the assessment and management of psychosocial risk following injury; promote timely access to pain-informed mental health focussed practitioners; facilitate collaboration and reduce delays in accessing pain-specialised treatment will align practice in the NT with the recommendations of the *National Pain Strategy* (2010).

Based on the GAP *Strategic Roundtable Report* (2016), this will be achieved by: identifying and gathering key stakeholders, reviewing best practice principles and data (including cost savings) from successful initiatives elsewhere, and facilitating collaborative consideration of how these learnings can be applied to the Northern Territory context.

[2] http://www.sarrah.org.au

In summary:

- **Stratified Care.** While *stepped care* is an appropriate approach for the majority of mental health presentations, effective pain rehabilitation requires a *stratified* approach which identifies and manages psychosocial risk before it becomes a mental health issue;
- **Compensation System Incentives for Early Intervention.** For those injured at work or on the road, there is strong evidence to indicate that initiatives within the compensation system that incorporate financial incentives to encourage early detection of psychosocial risk and co-ordinated early intervention are effective at both at reducing costs and preventing the development of mental ill health. While successful programs have been trialled in other parts of the country, reforms that target early intervention are yet to be implemented within the NT compensation system;
- **NT Population Diversity in National Dataset.** National service benchmark data from the Electronic Persistent Pain Outcomes Collaboration (ePPOC) is not representative of the diverse population in the Northern Territory, where over 30% are of Aboriginal or Torres Strait Islander (ATSI) background and a further 20% were born overseas, predominantly from non-English speaking countries. As such, we are yet to find ways to meaningfully incorporate the needs and experiences of the diverse NT population into national chronic pain data benchmarking

Thank you for your consideration of our submission. We welcome the opportunity to contribute to a constructive and positive review of the *Social and Economic Benefits of Improving Mental Health.*

We would welcome the opportunity to contribute further.

Best regards

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Pain NT (http://www.painnt.com.au) is a collaboration between:

www.innovativerehab.com.au www.industryhealthsolutions.com www.custommadephysio.com.au

PainNT

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