EXERCISE & SPORTS SCIENCE AUSTRALIA

Inquiry into the opportunities to improve mental health outcomes for Queenslanders

Mental Health Select Committee
Queensland Government

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EXERCISE & SPORTS SCIENCE AUSTRALIA (ESSA) SUBMISSION

RE: INQUIRY INTO THE OPPORTUNITIES TO IMPROVE MENTAL HEALTH OUTCOMES FOR QUEENSLANDERS

Committee Secretary
Mental Health Select Committee
Parliament House
George Street
Brisbane, Qld. 4000

Dear Committee Secretary,

Thank you for the opportunity to provide feedback in relation to the Mental Health Select Committee's Inquiry into the opportunities to improve mental health outcomes for Queenslanders.

Exercise & Sports Science Australia (ESSA) is the peak professional association for exercise and sports science professionals in Australia, representing more than 10,000 members comprising university qualified Accredited Exercise Physiologists (AEPs), Accredited Exercise Scientists (AESs), Accredited Sports Scientists, and Accredited High-Performance Managers.

This submission will focus on how managing physical health contributes to supporting better mental health. Exercise professionals have a role in working with multi-disciplinary teams to prevent mental health conditions and treat people with mental illness, improving outcomes across the life span.

ESSA gives permission for this submission to be published in full or in part and welcomes the opportunity to provide further detail or appear before the Committee if invited. Please contact ESSA Policy & Advocacy Advisor, Judy Powell, on [redacted] or at [redacted] for further information or questions arising from the following submission.

Yours sincerely

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1.0 ABOUT ACCREDITED EXERCISE PHYSIOLOGISTS AND ACCREDITED EXERCISE SCIENTISTS

Accredited Exercise Physiologists (AEPs) are four-year university degree qualified allied health professionals. They provide services to people across the full health spectrum, from the healthy population through to those at risk of developing a health condition, and people with health conditions, a disability, and aged related illnesses and conditions, including chronic, complex conditions [1]. Exercise physiology services are recognised by Australian compensable schemes including Medicare, the National Disability Insurance Scheme (NDIS), Department of Veteran Affairs (DVA), workers' compensation schemes and most private health insurers. Australia's exercise physiology profession comprises approximately 7,000 AEPs, with over 1600 of these in Queensland.

AESs are three-year university degree qualified professionals who deliver exercise programs to Australia's well populations to prevent chronic disease, injury and disability, and improve health, fitness and performance. They empower, motivate and coach clients to adopt long-term behavioural changes. AESs work in numerous sectors spanning allied health as Allied Health Assistants (AHAs); the NDIS as Therapy Assistants; personal trainers in the fitness industry; coaches in sporting organisations; and as program coordinators in education and corporate health. There are more than 700 AESs working in Australia today.

2.0 SUMMARY OF RECOMMENDATIONS

Recommendation 1: That each Hospital and Health Service within Queensland Health employ a minimum of one Accredited Exercise Physiologist in each community mental health site to provide specialist physical health care (including individual and group-based clinical exercise treatment) to help reduce the incidence of physical comorbidities in people with mental health conditions.

Recommendation 2: That each Hospital and Health Service within Queensland Health employ Accredited Exercise Physiologists to deliver specialist physical health care in psychiatric residential facilities, and acute inpatient settings to help reduce the incidence of physical comorbidities in people with mental health conditions.

Recommendation 3: That each Hospital and Health Service within Queensland Health broaden the professions recognised as allied health case managers to include Accredited Exercise Physiologists.

Recommendation 4: That Hospital and Health Services in Queensland provide more opportunities for the engagement of Accredited Exercise Scientists as allied health assistants to provide exercise treatments on behalf of AEPs and physiotherapists.

Recommendation 5: That Exercise Right content be incorporated within State health websites to increase literacy around mental ill-health and physical activity to support those at risk of a mental health condition and those with a mental illness to become more active.

Recommendation 6: That the Queensland Government pass the *Health and Other Legislation Amendment Bill 2021*, allowing access to The Viewer for self-regulated health professionals such as Accredited Exercise Physiologists.

Recommendation 7: That funding be provided to trial social prescribing pilot programs which utilise AESs and AEPs as link workers.

Recommendation 8: That the Queensland Government via the Health Council requests that the Minister for the NDIS

- **mandates:**
  - **a minimum level of knowledge of each NDIS therapeutic support and allied health profession for internal NDIA decision-making staff, including planners and Local Area Coordinators**

- **ongoing planner training to ensure planners' knowledge of therapeutic supports and allied health professions is regularly updated, in accordance with new and emerging evidence and**
- **the employment of planners who have qualifications and/or experience in health or human services and**

- **provides support to planners to develop a strong understanding of the complex needs associated with participants' disabilities.**

Recommendation 9: That the Queensland Government via the Health Council advocate to the Australian Government that it needs to provide dedicated access to a range of allied health services, including exercise physiology, in each Residential Aged Care facility.

Recommendation 10: That the Queensland Government implements a health literacy program targeting older people and those with chronic conditions, including mental illness, to support better consumer decision making about access to exercise and lifestyle change programs, in consultation with ESSA and other relevant allied health peak bodies.

Recommendation 11: That the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase and allow equitable access to exercise physiology services as other mainstream allied health services in all levels of each of the 37 policies, including listing in polices separate from other disciplines.

Recommendation 12: That the Queensland Government commit to implementing exercise and nutritional pathways for people with severe mental illness using the same systems-level enablers used for smoking cessation pathways.

Recommendation 13: That the Queensland Government considers the formation of 'local' and 'area' Mental Health and Wellbeing services, similar to the Victorian model. These 'local' and 'area' Mental Health and Wellbeing services should engage university qualified exercise professions to deliver group-based exercise programs to support the needs of the community who have poor mental health or a diagnosed mental illness.

Recommendation 14: That the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase access to the HEAL™ program, by encouraging all private health insurers to offer the program within their policies.

Recommendation 15: That the Queensland Government advocates to Primary Health Networks to commission programs like the mental health version of the HEAL™ program which support physical health.

Recommendation 16: That the Queensland Government invest $200,000 in a mental health Exercise is Medicine© module.

Recommendation 17: That Queensland Health adopt a minimum standard of a AQF Level 7 in all 'physical health' allied health roles in mental health services.

Recommendation 18: That senior decision-makers and clinical leads in Queensland Health receive education on innovative models of care and scopes of practice of allied health professionals that deliver treatments improving the physical health of people with mental health conditions.

Recommendation 19: That the Queensland Government establishes cross district (borderless) clinical leads to support professional development of allied health professionals, especially sole junior practitioners.

Recommendation 20: That the Queensland Government invest in mental health-specific telehealth training for practitioners to ensure patient safety.

Recommendation 21: That the Queensland Government invest in activities to support consumer access and adaptation to the digital services that are available to people living with mental health conditions for ongoing care.

Recommendation 22: That Queensland Health, collects data on the delivery of mental Accredited Exercise Physiologists given that both exercise and dietary interventions are recommended as routine mental healthcare.

Recommendation 23: That the Queensland Government consider the development of policy to focus on financial incentives and drivers in rural and remote areas of identified need to:

- **establish flexible models of care**
- **encourage allied health professionals to relocate**
- **facilitate upskilling opportunities**
- **create viable career pathways.**

Recommendation 24: That the Queensland Government advocate to the Australian Government for the following options to deliver exercise interventions for people living with mental health conditions include:

- **creating a new item under the Medical Benefits Scheme (MBS) Better Access Initiative for AEPs to deliver individual and group services**
- **creating additional item codes under the MBS GP Mental Health Care Plans for the delivery of exercise interventions by AEPs**
- **providing funding to Primary Health Networks (PHNs) to commission AEP delivered exercise services like the recent funding for allied health group sessions in residential aged care facilities (RACFs).**

Recommendation 25: That the Queensland Treasurer supports the removal of GST on exercise physiology services at a Council on Federal Financial Relations meeting.

3.0 ECONOMIC AND SOCIETAL IMPACT OF MENTAL ILLNESS IN QUEENSLAND

People with mental illness have poor physical health, high rates of physical co-morbidities (e.g., cardiovascular disease and diabetes) and often have lower life expectancies. The high rate of physical co-morbidities impacts on the personal, social, and economic burden of mental illness across the lifespan.

Poor physical health outcomes are widely reported across populations with a mental illness [2, 3]. People with severe mental illness live between 10-32 years less than the general population and the relative risk of death is 2.2 times higher in people with mental disorders [3]. Every day, 28 Australians living with mental illness die prematurely of chronic physical health conditions, and most of these deaths are avoidable. In relation to their physical health, people living with mental illness have higher rates of smoking, sleep disturbance, physical inactivity and unhealthy diet compared to the general public and their health is often impacted by the side effects of common psychiatric medications [4].

Cost of illness studies confirm those with combined physical and psychiatric comorbidity have higher hospital costs, increased readmission rates, and higher total health sector costs compared with people without psychiatric diagnoses [5].

In December 2016, the National Mental Health Commission stated that the cost of mental ill-health in Australia each year was around $4,000 per person, or $60 billion in total [6].

According to the Equally Well Consensus statement, the total cost of physical illness in people living with severe mental illness in Australia is estimated at $15 billion a year [7]. Much of this cost is avoidable. Effective mental

health care, alongside quality physical health care, reduces hospital and emergency department admissions and takes the pressure off the whole health system. Low levels of physical activity are a critical modifiable risk factor contributing to the increased burden of poor physical health in this population.

Part of the solution to improve the quality of life of people with mental health conditions and reduce health care costs is to provide access to exercise and dietary interventions as part of routine mental healthcare [5].

4.0 CURRENT NEEDS OF AND IMPACTS ON THE MENTAL HEALTH SYSTEM IN QUEENSLAND

A whole of person approach to healthcare requires holistic consideration of the person, including physical and mental health. There is an increasing body of evidence promoting the efficacy of exercise interventions for both the psychological and physical health outcomes of people experiencing mental illness and as such, exercise interventions are appropriate as a form of treatment and pathway to recovery from a mental illness.

Current mental health funding models do not support widespread access to lifestyle interventions like exercise, despite exercise and diet being core lifestyle interventions in the prevention and management of physical health conditions in the general population. Limited dedicated funding exists to support people to exercise when they are experiencing a mental illness, despite evidence that large savings can occur from such programs. A 2015 Deloitte Access Economics report estimated total annual savings, in avoided health system costs, due to Accredited Exercise Physiologist exercise interventions to be $2,239 per person living with a mental health condition [8].

Overall, there is a lack of access to physical health therapies for Queenslanders at risk of mental health conditions and those will mental illness, with innovation required to incorporate physical health services. The implementation of and change management processes associated with innovative service delivery models requires appropriate resourcing and without that innovation, is unlikely to succeed.

The importance of including exercise interventions for improving physical health outcomes, for people living with a mental illness, has been established in clinical research [9]. A recent systematic review reported that exercise improves symptoms of anxiety, stress and depression; decreases inflammation; and improves psychological, physiological and immunological functions [10].

Exercise has been shown to improve the following symptoms of those suffering with mental illness:
• Decreased symptoms of depression, anxiety, stress and schizophrenia [11-15]
• Decreased social isolation [16]
• Improved sleep quality [17, 18]
• Increased engagement with treatment and service utilisation [19, 20]
• Reduced cravings and withdrawal in substance use disorders (SUD) and alcohol addiction [21-23]
• Increased self-esteem [24]
• Improved quality of life [11] [25, 26]

One of the recommended priority Actions from the *Productivity Commission Mental Health Inquiry Report* focuses on the physical health of people living with mental illness [27]:

"ACTION 14.1 — IMPROVING CARE FOR PEOPLE WITH CONCURRENT MENTAL ILLNESS AND PHYSICAL HEALTH CONDITIONS" with the action that Australian, State and Territory Governments should introduce the reforms outlined in the Equally Well Consensus Statement (start now) and start later
"- requiring all mental health services to screen for physical health conditions that people with mental illness are at higher risk of developing
– requiring all mental health services to directly provide, or refer consumers to other services that provide prevention and lifestyle interventions, including interventions aimed at improving diet and increasing physical activity ……..
– ensuring workers in the mental health sector have access to the training and support they need to provide person-centred, effective and coordinated care to people with

comorbidities
– working with professional colleges, associations, and education providers to ensure that mental health services and workers have access to comprehensive guidelines and other resources on physical health in people with mental illness
– ensuring people with mental illness and their carers have access to information on physical health problems, managing medications and their side-effects, and the range of care and treatment options available to them".

Similarly, the inclusion of prevention and exercise and diet lifestyle interventions as a component of care is consistent with The Royal Commission into Victoria's Mental Health System [28]. Volume 1 of the final report, titled A New approach to mental health and wellbeing in Victoria, outlines support for quality features of extended rehabilitation services to engage 'An enriched multidisciplinary workforce to address holistic health is integrated in every model of care - employment support, exercise physiology, nutrition, wellbeing/coaching and advocacy are relevant examples.' It was noted that some services already employ physical health clinicians as part of their multidisciplinary teams, such as speech pathologists and Accredited Exercise Physiologists.

Access to supervised exercise sessions has clearly demonstrated superior outcomes compared to non-structured, un-supervised exercise in populations living with mental illness [29]. AEPs and AESs are trained to motivate and encourage behaviour change, including regular physical activity and social engagement, in those experiencing apathy and fatigue, which are common experiences of people with mental illness [30-32]. In addition, AEPs are qualified to understand and treat the symptoms and presentations of mental illness by prescribing the appropriate level and type of physical activity, and enabling social engagement, to ensure adherence to therapy and generate sustainable client health outcomes.

The employment of 'physical health' clinicians (which includes AEPs) as part of standard multidisciplinary allied health teams within Mental Health services and group exercise classes should be considered as essential standard best practice care within mental health programs, especially within any prevention and early intervention programs. By addressing comorbidities associated with mental health conditions, as well as providing mental benefits from exercise, AEPs can play a large role in reducing both long- and short-term reliance on Queensland's public health system for this cohort.

The Consensus statement on the role of Accredited Exercise Physiologists within treatment of mental disorders highlights the key role that AEPs have in treatment of individuals in a variety of settings including psychiatric residential facilities, acute inpatient settings and community centres where programs are successfully integrated into normal care [33]. Such physical activity programs show improvements in the patient's psychological well-being, with reduced psychiatric symptoms, as well as improvements in fitness and, therefore cardiometabolic health [33]. Given these benefits, incorporating the roles of AEPs across all mental health services from both inpatient through to community-based settings is vital to ensure physical activity becomes part of usual care. Barriers that may normally prevent access to physical activity such as service access, poor motivation, stigma and poor physical health [34] can all be addressed by the appointment of exercise professionals who are trained in the delivery of exercise interventions in this population and can help support and maintain long term behavioural change.

Currently, mental health case management positions within Hospital and Health Services are restricted to nurses, social workers, psychologists, occupational therapists and in certain settings, to speech pathologists. It is important that AEPs are included in the case management workforce as AEPs offer significant value in delivering specialist exercise services and physical health care to manage the symptoms of mental illness and protect the physical health of people with mental health conditions. AEPs are also highly skilled in behavioural lifestyle counselling and holistic care across the spectrum of health care.

The Lancet Psychiatry Commission proposes that future lifestyle interventions in mental health care must adopt core principles, exemplified in a gold standard program, the Diabetes Prevention Program (DPP), by ensuring that exercise interventions are delivered at an 'early intervention' stage by qualified exercise professionals (with a university qualification in exercise prescription, such as an AEP), and by providing sufficient access to supervised exercise services [5].

The key principles of the DPP which should also underpin “holistic person-centred” in the Australian mental health system are “individual case managers; frequent face-to-face contact with participants; a structured educational component that includes behavioural self-management strategies; supervised physical activity sessions; a maintenance intervention that combines group and individual approaches, motivational strategies, and individualisation through a so-called toolbox of adherence strategies” [5].

Accredited Exercise Scientists can work alongside AEPs to deliver exercise programs to those with mental illness. AESs already receive referrals from AEPs to work as exercise professionals (supporting clients with private funding) and could also work as Allied Health Assistants (supporting clients in the public system). Allied health assistants help to reduce the workload on allied health professionals by delivering exercise-based interventions that have been prescribed by a health professional qualified in clinical exercise prescription (e.g. an AEP or a physiotherapist). Utilising AESs throughout the Queensland Health workforce would help reach a more significant number of clients and allow for greater exercise uptake as an intervention for treatment and recovery.

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Recommendation 4: That Hospital and Health Services in Queensland provide more opportunities for the engagement of Accredited Exercise Scientists as allied health assistants to provide exercise treatments on behalf of AEPs and physiotherapists.

5.0 OPPORTUNITIES TO IMPROVE ECONOMIC AND SOCIAL PARTICIPATION OF PEOPLE WITH MENTAL ILLNESS

The Being Equally Well Policy Roadmap, a landmark national policy released in August 2021 on better physical health care for people living with serious mental illness, is based on the premise of the equal value of mental and physical health care and calls for an advocacy campaign on the “‘parity of esteem’: equal value of mental and physical health” [35].

5.1 Across the care continuum from prevention, crisis response, harm reduction, treatment and recovery.

The Australian healthcare system is insufficiently orientated towards the prevention of chronic disease, including mental illness. The current focus on episodic, acute health care models does not support widespread access to preventative interventions, such as exercise as an integrated component of routine care. This is further compounded by the multi-layered and fragmented Australian health system that creates a significant obstacle to the implementation and support of prevention initiatives. There needs to be a stronger and more coordinated cross-sectoral focus on preventative health initiatives targeting at-risk populations, such as those at risk of developing a mental illness. Importantly, these initiatives need to be sustained, with reduced focus on short-term outcomes.

One way to improve economic and social participation of people with mental illness is by supporting health literacy initiatives across the care continuum enables social and economic participation of people. Provision of both easily accessible evidence-based information and education regarding improving an individual’s health and well-being is paramount for meaningful change. Improving the mental health literacy of those who work in mental health and that

of community members who support those with mental health in becoming more physically active can be achieved by the sharing of pre-existing resources.

Exercise Right is one of Australia's largest free evidence-based resource hubs providing public health information in an array of easy-to-understand formats, spanning videos, blogs, factsheets, case studies, infographics and articles. Funded, developed and promoted by ESSA to support a more active nation, Exercise Right resources are tailored to specific population groups, including those with mental illness. Each resource has been prepared by ESSA's Accredited Exercise Professionals, is based on contemporary evidence and practice, and has been explicitly designed to promote the lifestyle benefits of physical activity and a healthy diet.

Exercise Right is recognised as an official partner of Healthdirect Australia, a national, government-owned, not-for profit organisation that supports Australians in managing their own health and well-being through a range of multichannel health information and advice services. The Healthdirect website continues to be the number one Australian online source of health information, with more than 60 million sessions in 2020-21 [36].

Improving health literacy of people with mental health conditions was also highlighted as a strategy in the Royal Commission into Victoria's mental health system stating [28]: 'Helping people to manage their physical health by building their health literacy and supporting them to adopt healthy ways of living while respecting their decision-making autonomy and preferences in relation to their physical health.'

To support health professionals, existing tools like the HealthPathways, a web-based portal with evidence-based information on the assessment and management of common clinical conditions including referral guidance (facilitated by Primary Health Networks) can be strengthened for use in supporting the development of local area, multidisciplinary communities of practice for workforces needing support.

Training through programs such as Exercise is Medicine© (EIM ©) also supports health professionals to increase literacy on the role physical activity plays in the prevention, management and treatment of chronic disease, and includes how to prescribe exercise to patients by applying behavioural change strategies. More information is provided in section 9.0 of this submission where workforce improvement is discussed.

Recommendation 5: That Exercise Right content be incorporated within State health websites to increase literacy around mental ill-health and physical activity to support those at risk of a mental health condition and those with a mental illness to become more active.

Effective coordination and integration of health care services including mental health services is a key predictor to the hospitalisation of patients with chronic disease. A significant proportion of potentially preventable hospitalisations (PPHs) and preventable hospital re-admissions can be avoided through patient education, behaviour change, lifestyle intervention, pharmaceuticals and/ or access to appropriate primary healthcare [37]. Strategies that increase the engagement of the allied health workforce will ensure individuals with chronic and mental health conditions are supported to remain stable and self-manage without reliance on hospital-based care or frequent medical intervention.

Increased engagement of allied health in community and primary health care settings facilitates superior continuity of care for discharged hospital patients and individuals at risk of hospital admission. Allied health treatment (including access to exercise physiology services) can effectively improve symptom management, detection of risk factors, appropriate intervention, and patient self-management [38].

Specifically, AEPs take a person-centred approach to manage chronic health conditions, including cardiovascular disease, mental health conditions and type 2 diabetes [39], which contribute to PPHs. This approach involves a combination of elements and strategies designed to improve health status and support behaviour change, including clinical exercise treatment, education, advice, and support to achieve a particular outcome, which includes long-term positive lifestyle changes.

Working towards a system that removes barriers to collaboration across client care can ensure that those with mental ill-health are not only treated for their mental health condition/s but that they also receive care for any physical health comorbidities and that this care is centralised around the person. Person-centred care is holistic, ensuring that patient physical, mental and psychosocial health and wellbeing is taken into account in both patient and clinician decision making and in the delivery of care. People living with mental illness, their families and other support people should be empowered by understanding their rights, be active partners in planning for their care, and be equipped with the knowledge and tools to advocate for, co-design, and partner to provide and monitor, quality health care.

Developing well supported and funded person-centred integrated care can help reduce the burden of physical ill-health on those with mental illness and reduce health cost expenditure. The Lived Experience 'Missing Middle' reports call for better integrated care though persistent follow up, consistency, continuity and coordinated support [40].

One barrier currently in existence in the system relates to the ability for treating health professionals to access patient records when they transition from the hospital sector to the community sector. The Viewer is a Queensland Health database where information about patients is stored on a read-only, web-based platform. The information includes personal details, admission and discharge history, pathology and medical imaging reports, and other information relating to a patient's medical history at a Queensland public hospital. The Viewer is currently only available to authorised Queensland Health clinical and support staff, and general practitioners external to Queensland Health.

Extending access to The Viewer to registered allied health practitioners both internal and external to Queensland Health, regardless of how they are regulated or the type of facility/organisation they work for, will ensure that these practitioners have timely access to important clinical information that could impact advice and treatment of a patient's clinical condition and may reduce unnecessary duplication of tests and procedures.

Queensland's current legislation limits healthcare worker access to The Viewer and therefore inhibits full and proper patient care. At the time of writing this submission, the *Health and Other Legislation Amendment Bill 2021 (Qld)* has been introduced into the Parliament in December 2021. The Bill was referred to the State Development and Regional Industries Committee for consideration and report to the Legislative Assembly by 11 February 2022. If passed in its current format, the *Bill* would extend access of The Viewer to a specified list of health professionals such as exercise physiologists who are self-regulated allied health professions, meeting the benchmark standards set by the National Alliance of Self-Regulating Health Professions (NASRHP). There is no guarantee that the Bill will be passed and this barrier removed to facilitate better integration and coordination between the acute and community sectors.

Recommendation 6: That the Queensland Government pass the *Health and Other Legislation Amendment Bill 2021*, allowing access to The Viewer for self-regulated health professionals such as Accredited Exercise Physiologists.

5.2 Across sectors, including Commonwealth funded primary care and private specialist mental health services, non-government services and services funded by the NDIS

There is considerable opportunity for increased utilisation of exercise professionals across a variety of sectors to improve the physical health of people at risk of a mental health condition and for those with a diagnosed mental illness. As noted, earlier exercise professionals are already delivering services privately and in multiple compensable schemes for all ages and across the continuum of care.

The Lancet Psychiatry Commission recommends that lifestyle interventions be implemented as a standard component of mental health care from the time of first diagnosis to prevent the deterioration of physical health typically observed in this population, rather than wait until any physical co-morbidities have manifested [5]. Suggestions for implementing this may be in the form of integrated and co-located physical and mental health care and ensuring people have access to evidence-based lifestyle interventions delivered by qualified professionals [41].

A crucial aspect of integrated and co-located care is that it allows for collaboration and communication across disciplines to reduce medical and psychiatric care compartmentalisation. To achieve this, both co-location of services and further training are warranted [42].

Models of care are expanded on in section 10.0 of this submission.

5.2.1. Primary Care

The Royal Australian College of General Practitioners (RACGP) in its annual report General Practice Health of the Nation 2021, highlights that more and more patients are presenting with mental health concerns and for the fifth consecutive year, psychological conditions were the most reported reason for patient presentations. Over 1300 General Practitioners (GPs) participated in the survey with 70% selecting psychological in their top three reasons for patient presentations [43]. Despite the strong link between mental and physical health, an Australian study has found only 1.6% of GP referrals were made to AEPs for mental health conditions [44].

There is a need to better recognise and formalise the role of exercise physiology in mental health care in the primary care setting. One solution to increasing access is to strengthen the Better Access Medicare initiative by expanding the multi-disciplinary approach to include allied health professionals that improve the physical health of people with mental health conditions. Enabling access to dietetic and exercise physiology services presents an opportunity to take a person-centred approach to delivering outcomes for people with mental health conditions. This is discussed further in section 10.2 and a recommendation has been provided.

Additionally, whilst focusing on the physical health of people living with mental illness, the Productivity Commission indicated that the Australian Government should “promote and fund further trials of social prescribing as alternatives to other clinical interventions.”[27]

Clinical care only accounts for 20 per cent of the factors influencing an individual’s longevity and quality of life [45]. The need to focus on the remaining 80 per cent of factors (healthy behaviours, social and economic support and the physical environment) are becoming more critical as governments recognise the importance of the determinants of health in supporting health and wellbeing.

Strategies need to be developed to support the mental health workforce to contribute to addressing the system-level causes of poor health and liaise and refer to the social services workforce to address issues like housing. Consideration should be given to prioritising the role of link workers in social prescribing. University qualified exercise professionals such as AESs and AEPs are skilled in behaviour change and are therefore well placed to work as link workers in social prescribing models of care.

Recommendation 7: That funding be provided to trial social prescribing pilot programs which utilise AESs and AEPs as link workers.

5.2.2. National Disability Services Scheme

ESSA members have previously reported claims from planners that AEP supports are only relevant for people with a physical disability. However, research evidence highlights that exercise therapy is beneficial for many cognitive and psychosocial disabilities as well. For example, various forms of exercise therapy have been proven to provide behavioural, emotional and social benefits for people with Autism Spectrum Disorder [46-50].

Exercise is also shown to improve the lives of people with psychosocial disability by improving both their mental and physical states [30]. AEPs are qualified to treat the symptoms and presentations of mental illness by prescribing the appropriate level and type of physical activity, as people with severe psychosocial disability are not recommended the same level of physical activity as the general population [51].

The lack of planners’ understanding about the role or value of allied health is currently one of the most significant issues that AEPs report in relation to their ability to successfully provide services to NDIS participants and has been highlighted by many other allied health peak bodies. The National Disability Insurance Agency needs to ensure

these workers are appropriately trained and educated on each allied health scope of practice, so that funding allocations will ensure the best possible outcomes for NDIS participants. NDIS planners who chose to reduce participant plan funding or limit funds to services against allied health professionals' evidence-based recommendations see no repercussions for the reduction in functional capacity and health outcomes that these decisions cause to participants.

Recommendation 8: That the Queensland Government via the Health Council requests that the Minister for the NDIS

- **mandates:**
  - **a minimum level of knowledge of each NDIS therapeutic support and allied health profession for internal NDIA decision-making staff, including planners and Local Area Coordinators**
  - **ongoing planner training to ensure planners' knowledge of therapeutic supports and allied health professions is regularly updated, in accordance with new and emerging evidence and**
  - **the employment of planners who have qualifications and/or experience in health or human services and**
- **provides support to planners to develop a strong understanding of the complex needs associated with participants' disabilities.**

5.2.3. Aged Care

People aged 65 and older account for 47% of Queensland's PPHs [52], which is likely due to the higher rates of chronic disease in this cohort. Allied health professionals deliver interventions to older people in the aged care system that allow older people to maintain their health and wellbeing, resulting in a reduced need to access Queensland's public health system. Specifically, AEPs help older people to prevent and manage existing chronic disease, maintain mobility and prevent falls, optimise cognition and brain function and improve mental health through individually tailored exercise therapy [53].

However, access to allied health services, including exercise physiology, under the current aged care system is limited, particularly in residential aged care (RAC). The Royal Commission into Aged Care Quality and Safety reported that just 2% of home care funding was spent on allied health care and that those in RAC had insufficient access to allied health care [54].

The Royal Commission recognised that RAC was lacking adequate allied health access, with Commissioner Briggs recommending in Recommendation 38 (b) that all approved aged care providers be required to employ or engage at least one professional from each of the allied health professions, including an AEP [55]. Unfortunately, the Australian Government has not adequately demonstrated a commitment to implementing the Royal Commission's allied health recommendations in RAC.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) identified that almost 60% of adult Australians have low individual health literacy levels and this can affect their capacity to make decisions and manage their health. The impact of low health literacy levels has been observed in the Commonwealth Home Support Program, where people often prioritise domestic assistance and personal care over allied health interventions that have the potential to prevent functional decline, improve mental and physical wellbeing and increase capacity to complete tasks independently.

This suggests that there is a need to improve the health literacy of older Australians, so that they may be better informed in relation to utilising their Commonwealth Home Support Program funding for allied health services, as funding within this program is spent at the discretion of the older Australian.

One example of a program that can increase the health literacy of older people is the Exercise Right for Active Ageing program. This is a national program designed for Australians aged 65 years and older, and Indigenous Australians 55 years and older. Funding from the Australian Government's Move it AUS – Better Ageing Grants Program subsidises 12 group exercise classes delivered by an AEP or an AES. The program began providing exercise classes in August 2019 and is scheduled to finish on 30 June 2022.

Recommendation 9: That the Queensland Government via the Health Council advocate to the Australian Government that it needs to provide dedicated access to a range of allied health services, including exercise physiology, in each Residential Aged Care facility.

Recommendation 10: That the Queensland Government implements a health literacy program targeting older people and those with chronic conditions, including mental illness, to support better consumer decision making about access to exercise and lifestyle change programs, in consultation with ESSA and other relevant allied health peak bodies.

5.2.4. Private Health Insurance

Given the potential for exercise physiology to reduce PPHs relating to a broad range of chronic conditions, including mental health conditions, it is in the best interests of the Queensland Government to increase access to AEPs within the private health care system.

ESSA notes that although exercise physiology is available in 35 of the 37 available Australian Prudential Regulatory Authority listed private health insurance policies, each policy has various levels of cover, and exercise physiology is not accessible at all levels of 'extras' policies creating an accessibility issue within private health. Additionally exercise physiology is often combined in policies with physiotherapy and whilst physiotherapists prescribe exercise, to improve, maintain, or prevent decline of health related status and function, with a focus on people with complex, chronic conditions and co-morbidities and is therefore a different treatment to physiotherapy and should be listed separately. Exercise physiology treatment includes addressing psychosocial elements [1] through education and advice and focusing on behavioural change and self-management.

Recommendation 11: That the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase and allow equitable access to exercise physiology services as other mainstream allied health services in all levels of each of the 37 policies, including listing in polices separate from other disciplines.

6.0 THE EXPERIENCE AND LEADERSHIP OF PEOPLE WITH LIVED EXPERIENCE OF METNAL ILLNESS, PROBLEMATIC SUBSTANCE USE AND SUICIDALITY AND THEIR FAMILIES AND CARERS

In 2021, Lived Experience Australia released a report, titled 'The Missing Middle' [40]. The report explored why people slip through the gaps or do not receive the mental health care they need. Over 500 consumers and carers from across Australia shared their experiences in a survey and some of the key findings are noted here:

- "41% of consumers and 47% of carers could not access mental health services when they were needed
- Difficulties in navigating the mental health system, or meeting eligibility requirements, is a major reason consumers do not receive the care they need."

Other feedback points to a fragmented, disjointed system with:

- "Lack of communication and collaboration between health professionals results in people having to re-tell and re-live their trauma, and a lack of consistency in their mental health support.
- Strategies suggested by both consumer and carer respondents to support engagement or re-engagement with mental health services included better quality providers, staff training, availability of peer workers with lived experience, affordability, persistent follow up, consistency, continuity and coordinated support."

The following ESSA case studies highlight the lived experience of people with mental illness and how engaging with interventions to improve physical health can improve mental health outcomes.

Case Study One: Post Traumatic Stress Disorder Case Study

Nell has been a paramedic for the past 20 years and seen many traumatic incidences whilst treating patients at work. She started noticing increased anxiety surrounding going to work and found herself avoiding watching TV shows that included violence. She also had poor sleep hygiene (often waking throughout the night due to night terrors), was getting irritable quickly and often felt depressed.

Nell decided to chat to her GP and her manager and they recommended she take some time off work to focus on her health. Nell started seeking help from a local psychologist and psychiatrist who placed her on some medication.

After being off work for some time, Nell started becoming highly sedentary. She was no longer leaving the home to take the dog for a walk or attend her local gym like she used to. Consequently, she gained weight and was diagnosed with pre-diabetes. Being a paramedic, Nell knew that her sedentary behaviour was having a poor impact on her physical health so she started walking her dog again. Unfortunately, Nell fell out of this routine after 3 days as she felt increased anxiety when leaving the home and also felt negatively about her body image and poor cardiorespiratory health.

Luckily, she got some assistance from a friend who was an AEP. With this support, she decided to try exercise once again. This time, she recognised the need to set some goals to ensure she was able to stay on track and benefit her physical, psychological and social health outcomes.

Case Study Two: Post Traumatic Stress Disorder

Following his service in the army, David had to get a total knee replacement and suffered from hypertension and PTSD. He could only walk for 15 minutes before having to sit down, he would decline to engage with his kids when they wanted to do something and he couldn't help his wife much at all with simple things like shopping or around the house.

David reached a dark time of his life, becoming a very negative person with his head always down. He was struggling to adapt back into society after the army, and his mental and physical well-being continued to decline. After being hesitant to ask for help, David reached out to AEP, Alexander. Alex supported David both physically and mentally.

David is now in the best shape of his life and he has never been in a better headspace. "If I hadn't come into see Alex, I wouldn't be anywhere near as far along the journey to what I am now. I don't know where I would be without him."

Listen to David share his uplifting story https://vimeo.com/manage/videos/560719728

Case Study Three: Autism with anxiety

16-year-old Perry Collins started to see AEP, Jaiden, to help improve his overall confidence and to help with his anxiety and autism spectrum disorder. At the time, Perry felt negative about his physical appearance. He would always wear baggy, double layered clothing (even in summer) and would feel really self-conscious. Mentally, this left him in a bad place.

Since his engagement in an exercise program with Jaiden, Perry has made great progress, improving his mental and physical health. "Exercise has changed my life and so much more than just physically."

"It has really helped with my mental health and it's made me feel more alive."

Here is Perry's story https://vimeo.com/manage/videos/560726247.

Case Study Four: Substance Abuse and Suicidal ideation

42-year-old Brett is an above the knee amputee, who really struggled to cope following his accident.

Turning to a lot of drinking at the time, Brett doesn't know where he would be if he had never met AEP, Carl.

"The changes in my life through what we are doing is beyond anything."

"Exercise has definitely changed my life."

Brett is now going for a world ranking in the amputee golf category and he continues to break personal records with Carl and the team around him.

Brett's journey is inspiring and is an incredible example of how much exercise can impact someone's life.
https://vimeo.com/manage/videos/560718749

The active sharing of stories from people with lived experience can help those with mental health conditions and their carers consider solutions. Exercise Right is one of many resources where lived experience stories are shared and it presents an opportunity for people with mental health conditions, their carers and families to increase their health literacy. Refer to the recommendation in 5.1 in relation to increasing access to resources such as Exercise Right.

7.0 THE MENTAL HEATLH NEEDS OF PEOPLE AT GREATER RISK OF POOR MENTAL HEALTH

People with multiple chronic diseases (multimorbidity) experience high levels of psychological distress and lower quality of life, as well as increased use of health services, leading to increases in costs [56-58]. Those at greater risk of multimorbidity and therefore at greater risk of poor mental health include people who are:

- aged over 60 years [57]
- socioeconomically disadvantaged [56]
- Aboriginal and Torres Strait Islanders [59]

Conversely, those with substance use or mental health disorders are at higher risk of multimorbidity [7].

Additionally, people with mental illness are more likely to smoke cigarettes, have a poor diet and be physically inactive, whilst the medication is a risk for obesity and metabolic conditions. Combining lifestyle interventions with first line medication is endorsed by international guidelines such as the *early intervention framework for patients on psychotropic medication* [60]. In recent years mental health services have introduced smoking cessation pathways, however other lifestyle interventions such as exercise and nutrition have not received the same attention.

This highlights the need for mental health services to place prevention and management of multimorbidity at the core of service development and delivery.

Recommendation 12: That the Queensland Government commit to implementing exercise and nutritional pathways for people with severe mental illness using the same systems-level enablers used for smoking cessation pathways.

8.0 HOW INVESTMENT BY THE QUEENSLAND GOVERNMENT AND OTHER LEVELS OF GOVERNMENT CAN ENHANCE OUTCOMES FOR QUEENSLANDERS REQUIRING MENTAL HEATLH TREATMENT AND SUPPORT

Exercise programs have been proven to build resilience which enhances well-being, prevents mental health conditions including depression and anxiety [61, 62] and promotes positive responses to acute psychological and

psychosocial stress [63]. The inclusion of funding for exercise programs within the health care system can help develop resilience and provide a method of coping during times of distress for those in the community. Additionally, exercise has been shown to reduce the stigma and minimise barriers for community-based clients using mental health services. Exercise is a normalised activity, particularly for young people and therefore, can act as a facilitator ensuring greater engagement with mental health services [19, 20]. Providing access to exercise interventions within the health care system can help improve resilience and provide greater community engagement with mental health services.

Queensland has the opportunity to learn from existing interventions that have successfully embedded dietitians and AEPs into the multi-disciplinary team. The South Eastern Sydney's Local Health District's Keeping the Body in Mind program) is a great example of an intervention that has shown early outcomes of managing weight gain adoption of healthy lifestyle change that is sustainable for over 12 months in about half of the intervention group [64]. The need for ongoing support for many people with mental illness means that discontinuing healthy lifestyle interventions may lead to long-term multi-morbidity.

A lifestyle modification program which has been adapted to support people with mental health conditions is the Healthy Eating Activity and Lifestyle (HEAL^{TM}) program. The *2020 HEAL^{TM} Evaluation Report* [65] shows that the program is successful in improving and maintaining most health-related behaviours and outcomes at 8 weeks, 5-month follow-up and 12-month-follow up. This program is now available for eligible customers of Bupa, Medibank, HCF, Teachers Health Fund and the Nurses Health Fund. By providing access to healthy behaviour promoting programs such as HEAL^{TM} more broadly, private health insurers and public health systems may reduce their healthcare expenditure [66-68]. Recent funding has been secured through the Hunter New England Central Coast PHN and Sport Australia to deliver the mental health version of HEAL^{TM}.

The Royal Commission into Victoria's mental health system recommended the formation of 'local' and 'area' Mental Health and Wellbeing services to cater for the needs of the community who have poor mental health or a diagnosed mental illness [28]. Volume 1 of the final report states that 'Access to local, community mental health and wellbeing services is the foundation of the Commission's reform'. Furthermore, it is noted that the intention is that these services, 'are delivered through a range of modes and in ways that are accessible and responsive to the diversity of local communities' [69]. As noted by the Commission, community-led initiatives involving social connection such as group-based exercise, demonstrated the most positive impacts on mental health and wellbeing.

Exercise interventions when completed in a group setting, foster social connections and feelings of belonging [70]. The evidence and practice review undertaken for the recent The Royal Commission into Victoria's Mental Health System reinforces this with evidence of community-led initiatives involving strongest social connection and distilled the common elements of successful initiatives [28]. The review found that group-based exercise, support groups and intergenerational programs (that is, activities that facilitate interaction between members of younger and older age groups) demonstrated the most positive impacts on mental health and wellbeing. As noted in section 4.0 group-based clinical exercise treatment should be considered as essential standard best practice care within mental health programs, especially within any prevention and early intervention programs [69].

Further to this, guides published by the Royal Australian and New Zealand College of Psychiatrists and the Mental Health Commission of NSW recommend referral to, or engagement with, dedicated allied-health professionals with expertise in exercise prescription, specifically AEPs, to promote improved health outcomes of people living with a mental illness [71]. To assist with appropriate referral to exercise physiology for mental health, ESSA has developed a *Consensus Statement on the role of Accredited Exercise Physiologists within the treatment of mental disorders: A Guide for mental health professionals* [72].

Recommendation 13: That the Queensland Government considers the formation of 'local' and 'area' Mental Health and Wellbeing services, similar to the Victorian model. These 'local' and 'area' Mental Health and Wellbeing services should engage university qualified exercise professions to deliver group-based exercise programs to support the needs of the community who have poor mental health or a diagnosed mental illness.

Recommendation 14: That the Queensland Government via the Health Council advocates to Private Healthcare Australia that private health insurers increase access to the HEAL™ program, by encouraging all private health insurers to offer the program within their policies.

Recommendation 15: That the Queensland Government advocates to Primary Health Networks to commission programs like the mental health version of the HEAL™ program which support physical health.

9.0 SERVICE SAFETY AND QUALITY, WORKFORCE IMPROVEMENT AND DIGITAL CAPABILITY

There are a range of initiatives that could be implemented to support workforce and resource health professionals to deliver safe and effective services, addressing both mental and physical health needs. Some immediate initiatives in relation to physical health needs of people with mental health conditions could include:

- upskilling current mental health practitioners and GPs
- standards of training for safety and quality
- clinical leadership, scope and pathways
- telehealth use, standards and safety
- data

9.1 Upskilling current mental health practitioners and GPs

Health professional training on non-pharmacological interventions requires improvement. As per the Productivity Commission Inquiry report actions [27], medical training and continuing professional development for GPs and other health professionals should incorporate information on non-pharmacological interventions. A skilled mental health workforce should be developed to deliver evidenced informed models of care which treat both physical and mental health symptoms simultaneously and offer evidence-based multidisciplinary lifestyle programs as a standard component of mental healthcare from the time of first diagnosis or appearance of signs of subclinical mental health issues.

The curriculum for health professionals, including dietitians, physiotherapists, and exercise physiologists should be updated to reflect the increasing role for such professionals within mental health teams. To successfully incorporate allied health professionals with expertise in nutrition, physical activity and behaviour change, introductory training in psychopathology and the principles of working with patients with mental illness should also be provided.

There is training in Australia already being delivered to support the provision of integrated and multi-disciplinary care including healthy lifestyle behaviours. Exercise is Medicine (EIM)© is an existing professional development program targeted at General Practitioners (GPs) and other health professionals to increase literacy on the role physical activity plays in the prevention, management and treatment of chronic disease, and includes how to prescribe exercise to patients by applying behavioural change strategies.

EIM workshops are accredited with the RACGP, the Australian College of Rural and Remote Medicine and the Australian Primary Health Care Nurses Association and has previously received Australian Government funding to deliver modules via Primary Health Networks. These workshops empower GPs and health professionals with the knowledge and skills to integrate physical activity and exercise into part of standard chronic disease prevention and management, with the potential to reach large groups of the community, increase community physical activity levels and reduce healthcare costs.

Developing an advanced level Exercise is Medicine© program specifically for GPs and mental health practitioners would provide much needed continuing professional development (CPD) in this area while increasing referrals to exercise professionals to aid the prevention and treatment of mental illness. With a modest investment, a mental health EIM module could be developed to further deepen the mental health workforce's understanding of exercise as a lifestyle intervention to support physical health for those living with a mental health condition. Funding of

$200,000 would provide the development of an advanced level mental health program which would enable the delivery of 100 complimentary workshops to GPs and mental health professionals.

Recommendation 16: That the Queensland Government invest $200,000 in a mental health Exercise is Medicine© module.

9.2 Standards of training for safety and quality

As the peak body for exercise professionals including Accredited Exercise Physiologists and Accredited Exercise Scientists, ESSA advocates for utilisation university trained exercise professionals who have a minimum of a bachelor's degree that meets the Australian Qualification Framework (AQF) Level 7 requirements.

Both AESs and AEPs are trained to work with populations either at risk of developing a mental health condition or who have been clinically diagnosed with a mental illness, respectively. Both professions have the knowledge, skills and competencies to design, deliver and evaluate safe and effective exercise interventions within their respective population groups. The delineation between university-qualified versus Certificate III or IV qualifications in how they can work with at risk stable or unstable populations is outlined in the following table:

Table 1: Comparison of university-qualified versus Certificate III or IV qualifications for exercise professionals

Adult Pre exercise screening tool	Assessment (initial assessment of client)	Prescription (designing the program)	Program (taking the client through the program, giving instruction on how to do the exercises)	Supervision (Supervision of client when undertaking a session)
Low risk	Cert 3	Cert 3	Cert 3	Cert 3
Medium risk	AES	AES	Cert 4	Cert 4
High risk (stable)	AEP	AEP	AES	AES
High risk (unstable)	AEP	AEP	AEP	AEP

Recommendation 17: That Queensland Health adopt a minimum standard of a AQF Level 7 in all 'physical health' allied health roles in mental health services.

9.3 Clinical leadership, scope and pathways

Multiple national and international guidelines provide treatment options for improving the integration of physical and mental health, across various health and social care settings [73-77]. The Addiction and Mental Health Services Branch of Queensland Metro South Health has developed an Addiction and Mental Health Services Therapy Capability Framework which has four levels of practice detailing different capabilities for four therapies, including physical health at four levels: Foundation Practitioner, Practice informed Practitioner, Practitioner and Advanced Practitioner [78].

The physical health framework assists planning for learning and supports confident practice of Physical Health Care (PHC) interventions, and promotes supervision and, most importantly, consumer and carer access to evidence-based mental health and addiction services.

Job roles already exist that utilise full scope of practice. The more critical issue is that many allied health professionals working in mental health are often supervised by nurse managers and other service leaders who do not always understand the full scopes of practice for newer allied health professions, like AEPs.

Senior decision-makers often tend to stick to the status quo which limits system change in relation to the employment of those from newer allied health professions and limits the development of innovative models of care. Budget pressures and inflexibility within the system occasionally result in fully qualified allied health professionals

being employed in lower graded positions (e.g., AEPs being employed as occupational therapy assistants to build the capacity of a unit).

These issues highlight the challenges for AEPs to be fully supported and utilised in public mental health services in Queensland. Creative solutions also need to be found to provide professional mentorship for private practitioners working in mental health, possibly via peak professional bodies.

Recommendation 18: That senior decision-makers and clinical leads in Queensland Health receive education on innovative models of care and scopes of practice of allied health professionals that deliver treatments improving the physical health of people with mental health conditions.

Recommendation 19: That the Queensland Government establishes cross district (borderless) clinical leads to support professional development of allied health professionals, especially sole junior practitioners.

9.4 Telehealth use, standards and safety

Technology is a crucial enabler for access to health care and, therefore a high priority. Allied Health Professions Australia's recent Digital Health Adoption Study 2021 indicates that exercise physiologists are one of the allied health professions most ready for increased digital health adoption, with a majority (86%) using an electronic record system to record patient notes, and two thirds indicating that the technology used by their practices is up to date.

The report further highlights that: "Exercise physiologists also report the highest number of benefits from digital health, and the fewest number of barriers. Efficiency is overwhelmingly the main driver of value, with 72 per cent indicating that digital health technologies improve efficiencies in their practices and provide faster access to information. Improved collaboration with other healthcare providers is also perceived as a major benefit amongst exercise physiologists."

There is great capacity for AEPs to deliver telehealth services for mental health consumers, especially given the evidence for the effectiveness of exercise in the prevention and treatment of mental health conditions. However, training in telehealth delivery, specifically for mental health consumers needs to be developed, trialed, and evaluated.

Recommendation 20: That the Queensland Government invest in mental health-specific telehealth training for practitioners to ensure patient safety.

Recommendation 21: That the Queensland Government invest in activities to support consumer access and adaptation to the digital services that are available to people living with mental health conditions for ongoing care.

9.5 Data

Currently, there is a lack of data and poor understanding of how those health professions which self-regulate under the umbrella of the NASRHP operate. It is recognised that data underpins workforce planning and consideration needs to be given to working with the NASRHP, a formal independent body providing a quality framework of best practice common standards for self-regulating health professions (including audiologists, dietitians, Accredited Exercise Physiologists and speech pathologists).

Work is underway to improve allied health data with a gap analysis project announced in the 2021-2022 Budget to improve the visibility, transparency and impact of allied health services, particularly in the aged care sector. It is expected that this project will include a review of all allied health data sources across government.

Recommendation 22: That Queensland Health, collects data on the delivery of mental Accredited Exercise Physiologists given that both exercise and dietary interventions are recommended as routine mental healthcare.

10.0 MENTAL HEALTH FUNDING MODELS IN AUSTRALIA

Mental health funding models need to reflect and embed the relevant recommendations from key landmark reports from the Productivity Commission and the Victorian Royal Commission which call for an expanded workforce to deliver evidence informed models of care.

10.1 Rural and Remote

A recent study on exercise physiology services in rural and remote areas found the service growth trajectory for Accredited Exercise Physiology service provision in metropolitan regions far exceeds that in all other geographic regions and that disparities in metropolitan and rural/remote workforce distribution for AEPs have worsened over time [79].

Many allied health services for people living with mental health conditions are more often integrated within primary health services operating for specific target groups (Culturally and Linguistically Diverse People, indigenous, low income etc).

Generally speaking, these providers are not-for-profits who aggregate and pool funding from a variety of sources (e.g. MBS, National Disability Insurance Scheme, Carer Gateway) overlaid with program and/or recurrent funding from the Australian Government, state governments for contracted service provision and/or philanthropic trusts.

Patients normally enter the service via one intake point and are cross referred for other internal services.

These not-for-profits, whilst they probably provide the best models of integrated multidisciplinary primary mental health care, struggle financially because they mainly bulk bill and have patients that cannot afford co-payments.

Not-for-profit providers could be better supported to provide high quality integrated care through either increased practice incentive payments that consider the postcodes of their patients OR a loading on MBS items, possibly using the ABS Socio-Economic Indexes for Areas (SEIFA). These providers could also be supported with practice incentives for fixed term graduate entry schemes for allied health which would help bridge the gap with starting salaries within private practices.

Similarly, additional loadings for MBS services delivered to rural and remote patients would help improve the viability for practitioners to relocate to rural and remote areas.

There also exists a need to better support the use of integrated and flexible workforce models including expansion of the existing Workforce Incentive Program (WIP) – Practice Stream funding model through the MBS. Furthermore, the current model is inflexible as it requires direct employment and co-location of allied health professionals only within general practices. WIP subsidies should be extended to allied health business owners as well as being available for general practice owners so the broader local primary health care system can be strengthened. This program currently excludes AEPs from employing AEPs (and other allied health professionals employing other allied health professionals) in rural areas.

ESSA supports the Australian Medical Association's position of lifting the caps on subsidies available through the Practice Stream WIP to better support the employment of nurses, pharmacists, and other allied health professionals to support enhanced access to GP-led team-based patient care in rural areas so larger practices can employ the same ratio of nursing and allied health staff as smaller practices [80].

For rural and regional locations, some of the following could be considered for recruitment and retention.

A range of other financial drivers could be explored to recruit allied health professionals in areas of identified need. These could encompass the development or increased utilisation of packages providing benefits like relocation grants and incentives such as remote salary loadings or accommodation subsidies. Another example of an incentive used to entice teachers to relocate to rural areas is the remittance of High Education Loan Program

(HELP) fees – this covers loans related to HECS, full fee-paying places or a combination of both and is offered through Study Assist.

There are successful models of public-private partnerships. An innovative public–private partnership model of allied health service delivery has been found to be successful in improving access to physiotherapy services in rural areas. Murrumbidgee Local Health District, a large public rural health organisation, contracted a private physiotherapy business to implement a public–private partnership (PPP) to supply physiotherapy to hospital inpatients, aged care facility residents and outpatients in four outer regional Australian towns.

Outcomes of the PPP showed that all participants described the model as being successful. Elements of success included improved access to local services, a coordinated effort to meet the needs of the community, a service that is financially viable and a skilled and satisfied workforce. Mechanisms to successfully implement the service delivery model included use of multiple (but consistent) resources, motivated stakeholders, content of the contract and referral schedule, streamlined administration processes for contracting and accounting, the workforce model, processes for managing private therapists in a public setting, processes for communication and consistency of stakeholders [81, 82].

Recommendation 23: That the Queensland Government consider the development of policy to focus on financial incentives and drivers in rural and remote areas of identified need to:

- **establish flexible models of care**
- **encourage allied health professionals to relocate**
- **facilitate upskilling opportunities**
- **create viable career pathways.**

10.2 Better Access initiative and Primary Health Network funded programs

To ensure that a whole of person approach is taken in the treatment of patients with mental illness, exercise should be considered a form of treatment available as part of the Better Access initiative. Including AEPs in the Better Access initiative can provide an adjunct treatment to counselling and pharmacological therapies. Psychological therapies focus on changing a person's thought processes or behaviour to assist with a change in mental illness symptoms. Exercise as an adjunct therapy to psychological and pharmacological therapies has also been shown to be effectively reduce mental illness symptoms [55].

Gaining approval for new MBS items for AEPs is possible via the Medical Services Advisory Committee (MSAC) or direct Ministerial approval. However, the MSAC process is arduous and relies heavily on clinically relevant benefits for emergency department presentations, hospital admissions or hospital length of stay for patients. It has not proven conducive to approving new allied health items to date. For example, the Lung Foundation Australia made two separate submissions over a three-year period to create specific items for pulmonary rehabilitation for the management of chronic lung diseases. MSAC did not support any of these submissions on the basis that evidence was insufficient.

Furthermore, the recently completed review process by the MBS Review Taskforce has not recommended any new allied heath items be established nor existing items be extended. The Taskforce supported the rationale for many recommendations for new items but advised more research is needed to develop an appropriate evidence base to support the proposed new items. Notwithstanding that there is a large body of contemporaneous research evidencing the outcomes of allied health services, it is noted that the additional GP items that were approved did not require evidence to support those changes.

An investment to commission services via PHNs appears to be a swifter mechanism to adopt in the short term. To estimate the cost of introducing exercise physiology mental health services, a Medicare Item report was generated using the current Occupational Therapy (OT) items (MBS items 80125, 80130, 80135, 8014, 80145, 80126, 80136, 12 80146). OT is one of the most closely aligned allied health therapies to exercise physiology as both professions are recognised as 'physical therapies' under the new COVID-19 Temporary MBS Allied Health Services for RACFs.

The total benefits paid out for OT MBS Focused Psychological Strategies items were as follows:

Table 2: Expenditure on OT MBS Focussed Psychological Strategies between 2015-2016 to 2018-2019
2015-2016 $4,265,487
2016-2017 $ 4,708,232
2017-2018 $ 5,019,583
2018-2019 $ 5,191,125

There are currently over 7,000 practising AEPs in Australia, which is around 29 per cent of the 23,839 OTs with general registration as of July 2020. A comparable investment in AEP services of around 25 per cent of what is spent on OT services would be $1,500,000 per annum. Figures for 2019-2020 were not taken considered due to COVID-19 interruptions to regular care.

Recommendation 24: That the Queensland Government advocate to the Australian Government for the following options to deliver exercise interventions for people living with mental health conditions include:

- **creating a new item under the Medical Benefits Scheme (MBS) Better Access Initiative for AEPs to deliver individual and group services**
- **creating additional item codes under the MBS GP Mental Health Care Plans for the delivery of exercise interventions by AEPs**
- **providing funding to Primary Health Networks (PHNs) to commission AEP delivered exercise services like the recent funding for allied health group sessions in residential aged care facilities (RACFs).**

10.3 Removal of Goods and Services Tax (GST)

Cost is a significant barrier for people living with a mental illness in seeking treatment. Exercise physiology (EP) services meet the Australian Taxation Office's criteria for 'other health services', yet exercise physiology services are not exempt from the goods and services tax (GST). When the GST legislation was passed in June 1999, the exercise physiology profession was still in its infancy.

ESSA has long been campaigning to remove the Goods and Services Tax (GST) from exercise physiology (EP), as exercise physiology services are not "Eligible Health Services" under the GST Act.

Importantly, there are existing policy inconsistencies between Federal taxation and private health insurance laws. From 1 April 2019, 2 x natural therapies (naturopathy & western herbal medicine) were excluded from the definition of private health insurance general treatment and no longer receive the private health insurance rebate as part of a general treatment policy under the Private Health Insurance (Complying Product) Rules. Both natural therapies continue to be GST exempt.

At present, Accredited Exercise Physiologists (AEPs) are the only stand-alone allied health professionals delivering Medicare chronic diseases management (CDM) services that attract GST for most services outside Medicare.

In 2019-2020, WorkCover Queensland paid out $11,333,724 in exercise physiology benefits incurring a $1,133,372 GST liability. [83]

ESSA understands the Council on Federal Financial Relations (CFFR) is planning to consider the findings from a GST Policy and Administrative Committee (GPAS) review and ESSA's proposal to remove GST from EP services at a CFFR meeting in early 2022 (end of Feb/early March).

Recommendation 25: That the Queensland Treasurer supports the removal of GST on exercise physiology services at a Council on Federal Financial Relations meeting.

10.4 Hospital and Health Services

Refer to Section 4.0 of this submission and recommendations 1, 2, 3 and 4.

10.5 Community-led services

Refer to section 8.0 and recommendation 13.

11.0 RELEVANT NATIONAL STATE POLICIES, REPORTS AND RECENT INQUIRIES INCLUDING THE PRODUCTIVITY COMMISSION MENTAL HEATLH INQUIRY REPORT

- Equally Well: Quality in Life, Equality in Life, National Mental Health Commission
- Fifth National Mental Health and Suicide Prevention Plan, Department of Health, Australian Government
- Productivity Commission Inquiry into Mental Health, Australian Government
- Being Equally Well: A national policy roadmap to better physical health care and longer lives for people living with serious mental illness, Mitchell Institute.
- Improving the physical health of consumers of mental health and alcohol and other drug services. Queensland Health, Mental Health Alcohol and Other Drugs Branch (2021)
- The National Safety and Quality Health Service Standards (2nd edition), Australian Commission on Safety and Quality in Health Care
- Comprehensive Care – Partnerships in Care and Communication: Documentation Framework, Queensland Health, Mental Health Alcohol and Other Drugs Branch
- Co-occurring substance use disorders and other mental health disorders: policy position statement for Mental Health Alcohol and Other Drugs Services, Queensland Health, Mental Health Alcohol and Other Drugs Branch
- Chief Psychiatrist Policy – Treatment and Care of Patients, Queensland Health, Mental Health Alcohol and Other Drugs Branch
- Practice Guidelines for Clinical Treatment of Complex Trauma, Blue Knot Foundation, National Centre of Excellence for Complex Trauma
- Aboriginal and Torres Strait Islander Cultural Capability Framework, Queensland Health
- Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy, Queensland Health
- Queensland Health Information sharing between mental health staff, consumers, family, carers, nominated support persons and others, Queensland Health
- Mental Health Services in Australia, AIHW
- Royal Commission into Victoria's Mental Health System, State of Victoria

12.0 REFERENCES

1. Exercise & Sports Science Australia, *Accredited Exercise Physiologist Scope of Practice*. 2021.
2. De Hert, M., et al., *Cardiovascular disease and diabetes in people with severe mental illness position statement from the European Psychiatric Association (EPA), supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (ESC).* European psychiatry, 2009. **24**(6): p. 412-424.
3. De Hert, M., et al., *Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care.* World psychiatry, 2011. **10**(1): p. 52.
4. Rosenbaum, S., et al., *Redefining mental healthcare: going multidisciplinary to manage multimorbidity*. 2020, BMJ Publishing Group Ltd and British Association of Sport and Exercise Medicine.
5. Firth, J., et al., *The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness.* The Lancet Psychiatry, 2019. **6**(8): p. 675-712.
6. Parliament of Australia. *Mental health in Australia: a quick guide*. 2019; Available from: https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1819/Quick_Guides/MentalHealth#:~:text=%20Mental%20health%20in%20Australia%3A%20a%20quick%20guide,funding%20and%20regulating%20mental%20health%20services...%20More%20.
7. National Mental Health Commission, *Equally Well Consensus Statement: Improving the physical health and wellbeing of people living with mental illness in Australia*. 2016: Sydney.

8. Deloitte Access, E., *Value of Accredited Exercise Physiologists in Australia*. 2015.
9. Lederman, O., et al., *Consensus statement on the role of Accredited Exercise Physiologists within the treatment of mental disorders: a guide for mental health professionals.* Australasian Psychiatry, 2016. **24**(4): p. 347-351.
10. Mikkelsen, K., et al., *Exercise and mental health.* Maturitas, 2017. **106**: p. 48-56.
11. Rosenbaum, S., et al., *Physical activity interventions for people with mental illness: a systematic review and meta-analysis.* The Journal of clinical psychiatry, 2014. **75**(9): p. 964-974.
12. Stanton, R. and P. Reaburn, *Exercise and the treatment of depression: a review of the exercise program variables.* Journal of Science and Medicine in Sport, 2014. **17**(2): p. 177-182.
13. Firth, J., et al., *A systematic review and meta-analysis of exercise interventions in schizophrenia patients.* Psychol Med, 2015. **45**(7): p. 1343-1361.
14. Stanton, R., B. Happell, and P. Reaburn, *The mental health benefits of regular physical activity, and its role in preventing future depressive illness.* Nursing: Research and Reviews, 2014. **4**(1): p. 45-53.
15. Stanton, R. and B. Happell, *Exercise for mental illness: a systematic review of inpatient studies.* International Journal of Mental Health Nursing, 2014. **23**(3): p. 232-242.
16. Richardson, C.R., et al., *Integrating physical activity into mental health services for persons with serious mental illness.* Psychiatric services, 2005. **56**(3): p. 324-331.
17. Youngstedt, S.D., *Effects of exercise on sleep.* Clinics in sports medicine, 2005. **24**(2): p. 355-365.
18. Rethorst, C.D., et al., *Does exercise improve self-reported sleep quality in non-remitted major depressive disorder.* Psychol Med, 2013. **43**(4): p. 699-709.
19. Curtis, J., et al., *Evaluating an individualized lifestyle and life skills intervention to prevent antipsychotic-induced weight gain in first-episode psychosis.* Early intervention in psychiatry, 2016. **10**(3): p. 267-276.
20. Vancampfort, D., et al., *Promotion of cardiorespiratory fitness in schizophrenia: a clinical overview and meta-analysis.* Acta Psychiatrica Scandinavica, 2015. **132**(2): p. 131-143.
21. Wang, D., et al., *Impact of physical exercise on substance use disorders: a meta-analysis.* PloS one, 2014. **9**(10): p. e110728.
22. Giesen, E.S., H. Deimel, and W. Bloch, *Clinical exercise interventions in alcohol use disorders: a systematic review.* Journal of substance abuse treatment, 2015. **52**: p. 1-9.
23. Glass, T.W. and C.G. Maher, *Physical activity reduces cigarette cravings.* British journal of sports medicine, 2014. **48**(16): p. 1263-1264.
24. Krogh, J., et al., *The effect of exercise in clinically depressed adults: systematic review and meta-analysis of randomized controlled trials.* The Journal of clinical psychiatry, 2010. **72**(4): p. 529-538.
25. Vancampfort, D., et al., *Health-related quality of life and aerobic fitness in people with schizophrenia.* International journal of mental health nursing, 2015. **24**(5): p. 394-402.
26. Schuch, F.B., et al., *Exercise and severe major depression: effect on symptom severity and quality of life at discharge in an inpatient cohort.* Journal of psychiatric research, 2015. **61**: p. 25-32.
27. Productivity Commission, *Mental health: Productivity Commission inquiry report.* 2020.
28. State of Victoria, *Royal Commission into Victoria's Mental Health System, Final Report, Summary and Recommendations*, in *Parl Paper No. 202, Session 2018-21*. 2021: Melbourne.
29. Rosenbaum, S., et al., *How can we increase physical activity and exercise among youth experiencing first-episode psychosis? A systematic review of intervention variables.* Early intervention in psychiatry, 2016. **10**(5): p. 435-440.
30. Schuch, F.B., et al., *Exercise improves physical and psychological quality of life in people with depression: A meta-analysis including the evaluation of control group response.* Psychiatry research, 2016. **241**: p. 47-54.
31. Sancassiani, F., S. Machado, and A. Preti, *Physical activity, exercise and sport programs as effective therapeutic tools in psychosocial rehabilitation.* Clinical practice and epidemiology in mental health: CP & EMH, 2018. **14**: p. 6.
32. Knapen, J., et al., *Exercise therapy improves both mental and physical health in patients with major depression.* Disability and rehabilitation, 2015. **37**(16): p. 1490-1495.
33. Lederman, O., et al., *Embedding exercise interventions as routine mental health care: implementation strategies in residential, inpatient and community settings.* Australasian Psychiatry, 2017. **25**(5): p. 451-455.
34. Fibbins, H., et al., *Incorporating exercise professionals in mental health settings: An Australian perspective.* Journal of Clinical Exercise Physiology, 2019. **8**(1): p. 21-25.
35. Morgan, M.P., D; Hopwood, M; Castle, D; May, C; Fehily, C; Sharma, A; Rocks, T; McNamara, K; Cobb, L; Duggan, M; Dunbar, JA; Calder, RV., *Being Equally Well: A national policy roadmap to better physical health care and longer lives for people living with serious mental illness*. 2021, Mitchell Institute Victoria University: Melbourne.
36. Health Direct Australia, *Annual Report: Financial year 2020-2021*. 2021.

37. Muenchberger, H. and E. Kendall, *Determinants of Avoidable Hospitalization in Chronic Disease: Development of a Predictor Matrix.* 2008.
38. Withrow, D. and D.A. Alter, *The economic burden of obesity worldwide: a systematic review of the direct costs of obesity.* Obes Rev, 2011. **12**(2): p. 131-41.
39. Pearce, A. and G. Longhurst, *The Role of the Clinical Exercise Physiologist in Reducing the Burden of Chronic Disease in New Zealand.* International Journal of Environmental Research and Public Health, 2021. **18**(3): p. 859.
40. Lived Experience Australia, *The 'Missing Middle' Lived Experience Perspectives*. 2021: Marden.
41. Rosenbaum, S., et al., *Redefining mental healthcare: going multidisciplinary to manage multimorbidity*. 2021, BMJ Publishing Group Ltd and British Association of Sport and Exercise Medicine. p. 7-8.
42. Lambert, T.J., D. Velakoulis, and C. Pantelis, *Medical comorbidity in schizophrenia.* Medical journal of Australia, 2003. **178**(9): p. S67.
43. RACGP, *General Practice: Health of the Nation 2021*. 2021.
44. Craike, M., et al., *General practitioner referrals to exercise physiologists during routine practice: A prospective study.* J Sci Med Sport, 2019. **22**(4): p. 478-483.
45. Hood, C.M., et al., *County health rankings: relationships between determinant factors and health outcomes.* American journal of preventive medicine, 2016. **50**(2): p. 129-135.
46. Yilmaz, I., et al., *Effects of swimming training on physical fitness and water orientation in autism.* Pediatrics International, 2004. **46**(5): p. 624-626.
47. Elliott, R.O., et al., *Vigorous, aerobic exercise versus general motor training activities: Effects on maladaptive and stereotypic behaviors of adults with both autism and mental retardation.* Journal of autism and developmental disorders, 1994. **24**(5): p. 565-576.
48. Powers, S., S. Thibadeau, and K. Rose, *Antecedent exercise and its effects on self-stimulation.* Behavioral Interventions, 1992. **7**(1): p. 15-22.
49. Healy, S., et al., *The effect of physical activity interventions on youth with autism spectrum disorder: A meta-analysis.* Autism Research, 2018. **11**(6): p. 818-833.
50. Zhao, M. and S. Chen, *The effects of structured physical activity program on social interaction and communication for children with autism.* BioMed research international, 2018. **2018**.
51. Vancampfort, D., et al., *Integrating physical activity as medicine in the care of people with severe mental illness*. 2015, SAGE Publications Sage UK: London, England. p. 681-682.
52. Queensland Health, *The Health of Queenslanders 2018*. 2018. p. 41-46.
53. Raynor, A.J., et al., *It's not just physical: Exercise physiologist-led exercise program promotes functional and psychosocial health outcomes in aged care.* Journal of aging and physical activity, 2020. **28**(1): p. 104-113.
54. Royal Commission into Aged Care Quality and Safety, *Final Report - Executive Summary*. 2021.
55. Royal Commission into Aged Care Quality and Safety, *Final Report - List of Recommendations*. 2021.
56. Barnett, K., et al., *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study.* The Lancet, 2012. **380**(9836): p. 37-43.
57. Marengoni, A., et al., *Aging with multimorbidity: a systematic review of the literature.* Ageing research reviews, 2011. **10**(4): p. 430-439.
58. Prados-Torres, A., et al., *Multimorbidity patterns: a systematic review.* Journal of clinical epidemiology, 2014. **67**(3): p. 254-266.
59. Randall, D.A., et al., *Multimorbidity among Aboriginal people in New South Wales contributes significantly to their higher mortality.* Medical Journal of Australia, 2018. **209**(1): p. 19-23.
60. Curtis, J., H.D. Newall, and K. Samaras, *The heart of the matter: cardiometabolic care in youth with psychosis.* Early intervention in psychiatry, 2012. **6**(3): p. 347-353.
61. Childs, E. and H. de Wit, *Regular exercise is associated with emotional resilience to acute stress in healthy adults.* Frontiers in physiology, 2014. **5**: p. 161.
62. Vanhove, A.J., et al., *Can resilience be developed at work? A meta-analytic review of resilience-building programme effectiveness.* Journal of Occupational and Organizational Psychology, 2016. **89**(2): p. 278-307.
63. Mücke, M., et al., *Influence of regular physical activity and fitness on stress reactivity as measured with the trier social stress test protocol: A systematic review.* Sports Medicine, 2018. **48**(11): p. 2607-2622.
64. Teasdale, S.B., et al., *The effectiveness of the Keeping the Body in Mind Xtend pilot lifestyle program on dietary intake in first-episode psychosis: Two-year outcomes.* Obesity research & clinical practice, 2019. **13**(2): p. 214-216.
65. Exercise & Sports Science Australia, *Healthy Eating, Activity & Lifestyle (HEAL™): Helping participants achieve significant health improvements in 2020*. 2020.
66. Bauer, U.E., et al., *Prevention of chronic disease in the 21st century: elimination of the leading preventable causes of premature death and disability in the USA.* The Lancet, 2014. **384**(9937): p. 45-52.

67. Allender, S. and M. Rayner, *The burden of overweight and obesity-related ill health in the UK.* Obesity Reviews, 2007. **8**(5): p. 467-473.
68. Lee, A., *Health-promoting schools.* Applied Health Economics and Health Policy, 2009. **7**(1): p. 11-17.
69. state of Victoria, *Royal Commission into Victoria's Mental Health System, Final Report, Volume 1: A new approach to mental health and wellbeing in Victoria, Parl Paper No. 202, Session 2018-21 (document 2 of 6)*. 2021.
70. Bauman, A., et al., *Updating the evidence for physical activity: summative reviews of the epidemiological evidence, prevalence, and interventions to promote "active aging".* The gerontologist, 2016. **56**(Suppl_2): p. S268-S280.
71. Royal Australian New Zealand College of Psychiatrists, *Keeping Body and Mind Together. Improving the physical health and life expectancy of people with serious mental illness*. 2015.
72. Lederman, O., et al., *Consensus statement on the role of Accredited Exercise Physiologists within the treatment of mental disorders: a guide for mental health professionals.* Australas Psychiatry, 2016. **24**(4): p. 347-51.
73. World Health Organisation, *Guidelines for the management of physical health conditions in adults with severe mental disorders*. 2018: Geneva.
74. Stubbs, B., et al., *EPA guidance on physical activity as a treatment for severe mental illness: a meta-review of the evidence and Position Statement from the European Psychiatric Association (EPA), supported by the International Organization of Physical Therapists in Mental Health (IOPTMH).* European Psychiatry, 2018. **54**: p. 124-144.
75. Rosenbaum, S., et al., *Role Of Physical Activity In Closing The Life Expectancy Gap of People With Mental Illness: 2934 June 2 2: 45 PM-3: 00 PM.* Medicine & Science in Sports & Exercise, 2017. **49**(5S): p. 842-843.
76. Faculty of Sport and Exercise Medicine UK *Position Statement: The Role of Physical Activity and Sport in Mental Health*. 2018.
77. Imboden, C., et al., *Swiss Society for Sports Psychiatry and Psychotherapy SSSPP. Position Paper: Physical activity and mental health. Sport & Exercise Medicine Switzerland. 2020; 68: 14-18. doi: 10.34045*. SEMS/2020/21.
78. Metro South Addiction and Mental Health Services, *Therapy Capability Framework*, Q. Government, Editor. 2020.
79. Stanton, R. and S. Rosenbaum, *Temporal trends in exercise physiology services in Australia—Implications for rural and remote service provision.* Australian Journal of Rural Health, 2019. **27**(6): p. 514-519.
80. Australian Medical Association, *Delivering better care for patients: The AMA 10-year framework for primary care reform*.
81. Farquhar, E., A. Moran, and D. Schmidt, *Mechanisms to achieve a successful rural physiotherapy public-private partnership: a qualitative study.* Rural and Remote Health, 2020. **20**(3): p. 5668-5668.
82. NSW Government HETI, *Investigating a Public-Private partnership model of Physiotherapy service delivery in a rural setting: a Constructive Inquiry*. 2020.
83. WorkCover Queensland, *Utilisation of EP services*, J. Powell, Editor. 2020.