National Mental Health Commission

September 2021

Submission on the Consultation Draft: National Mental Health Workforce Strategy 2021-2031

Contents

[Introduction 3](#_Toc83726116)

[Vision 2030 3](#_Toc83726117)

[Summary of recommendations 5](#_Toc83726118)

[Section 1: This Strategy 6](#_Toc83726119)

[Background 6](#_Toc83726120)

[Scope 6](#_Toc83726121)

[Components of care 6](#_Toc83726122)

[Definition of the mental health workforce 6](#_Toc83726123)

[Lived Experience 7](#_Toc83726124)

[Aim 7](#_Toc83726125)

[Objectives and priority areas for action 8](#_Toc83726126)

[Temporal planning 8](#_Toc83726127)

[Section 2: Careers in mental health are, and are recognised as, attractive 8](#_Toc83726128)

[Stigma and discrimination 8](#_Toc83726129)

[Section 3: Data underpins workforce planning 9](#_Toc83726130)

[Section 4: The entire mental health workforce is utilised 9](#_Toc83726131)

[Working to top of scope 9](#_Toc83726132)

[Roles and responsibilities 10](#_Toc83726133)

[Skills and competencies 10](#_Toc83726134)

[Generalism 10](#_Toc83726135)

[Section 5: The mental health workforce is appropriately skilled 11](#_Toc83726136)

[Section 6: The mental health workforce is retained in the sector 11](#_Toc83726137)

[Culture 12](#_Toc83726138)

[Section 7: The mental health workforce is distributed to deliver support and treatment when and where consumers need it 12](#_Toc83726139)

[Maldistribution 12](#_Toc83726140)

[Section 8: Implementation of the Strategy 13](#_Toc83726141)

[The rural and remote mental health workforce 14](#_Toc83726142)

[Vision 2030 consultation priorities for consideration 14](#_Toc83726143)

[References 15](#_Toc83726144)

# Introduction

The National Mental Health Commission (the Commission) welcomes the opportunity to provide a submission on the consultation draft of the National Mental Health Workforce Strategy 2021-2031 (the Consultation Draft). The Commission acknowledges the purpose of the National Mental Health Workforce Strategy 2021-2031 is to consider the quality, supply, distribution, and structure of the mental health workforce. It is also intended to identify practical approaches that could be implemented by Australian governments to attract, train, and retain the workforce required.

Unfortunately, the Commission feels the Consultation Draft falls short of adequately addressing its intended purpose. The Consultation Draft focuses too heavily on the known challenges facing Australia’s mental health system and there is a fundamental gap in the provision of targeted strategies to address the underlying causes of these challenges. It is difficult to see how some of the actions identified will address these underlying causes and barriers and support the achievement of the identified priority areas.

The Consultation Draft does not adequately reflect the changes or recommendations provided by key mental health publications, namely the Productivity Commission inquiry into mental health final report, the Royal Commission into Victoria’s mental health system, the National Suicide Prevention Adviser’s final advice, and the Vision 2030 Blueprint Consultation Report. There is also a wealth of contemporary international evidence and models that can and should be applied in the final Strategy.

In January 2021, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) released the Rural Psychiatry Roadmap 2021-31 (the Roadmap). The Commission suggests the Department of Health and the National Mental Health Workforce Strategy Taskforce (the Taskforce) consider the Rural Psychiatry Roadmap, which can be adapted for many mental health professions. The Roadmap is a good example of strategic recommendations that address the root causes of challenges experienced by professions, in this case rural psychiatrists. The Roadmap conveys a national and collaborative approach to governance, the need for cultural change, an emphasis on partnerships, and increased investment – all with targeted activities mapped against timeframes. The Roadmap is included at **Attachment A**.

### Vision 2030

In 2019, the Commission released the Vision 2030 Blueprint Consultation Report. Since this report, the Commission has undertaken consultation and research to progress the development of the forthcoming Vision 2030 Blueprint for Mental Health and Suicide Prevention. The Commission commissioned a report ‘Addressing the mental health workforce of the future’ which identified nine focus areas for improvement:

1. Supporting the multidisciplinary workforce, including the development of the Lived Experience (peer) workforce.
2. Enabling a multidisciplinary workforce to work to top of scope to increase efficiency, capacity, and greater job satisfaction.
3. Improvements to mental health education and training, including the broader health and social service workforces as well as the mental health sector.
4. Expanding the role of social services (including education, policing, justice and importantly drug and alcohol services) to better address the social determinants of health (safe and secure housing, financial security, improving living standards, participation in education, and employment).
5. Taking an integrated and inclusive approach in all sectors and governments. Primary health services, mental health services, disability services, aged care services, and various social services all need to work collaboratively.
6. Improving staff safety and wellbeing to reduce stress and burnout.
7. Addressing culture, values and attitudes, which are areas constantly reported as requiring attention.
8. Focusing on growing and sustaining the rural and remote workforce.
9. Considering opportunities to improve access to services and a broader range of allied health providers using technology and e-health.

These areas are addressed to varying degrees in the Consultation Draft. The Commission suggests the final Strategy align with these focus areas more closely, with deeper consideration given to:

* Improving mental health education and training in addition to improving the quality and quantity of mental health placements articulated in action 4.1.2.
* More targeted approaches to improving and supporting the mental health and wellbeing of the multidisciplinary workforce, including investing in staff wellbeing.
* Addressing stigma and discrimination and building a platform where culture, values and attitudes are overtly prioritised in policies across all workforces and workplaces.
* Improving access to, and the use of, technology and e-health beyond increasing availability (action 6.3.1), including developing the skills of the workforce in the use of digital mental health care.
* Focussing on *how* to grow and sustain the rural and remote workforce.

These suggestions are explored further in the remainder of this submission. Please note the Commission has not provided direct answers to the consultation questions as some of the issues and suggestions we raise cross questions and themes in the Consultation Draft. For ease, our submission follows the structure of the Consultation Draft with a final heading ‘The rural and remote workforce’ which relates to more than one section.

The Commission has made ten recommendations to support the development of the final Strategy.

Should you wish to discuss this submission in further detail, please contact Dr Alex Hains, Executive Director, Policy at [alex.hains@mentalhealthcommission.gov.au](mailto:alex.hains@mentalhealthcommission.gov.au).

# Summary of recommendations

**Recommendation 1:** The National Mental Health Workforce Strategy must provide a clear definition of the multidisciplinary mental health workforce and include specific approaches to how this workforce can be achieved.

**Recommendation 2:** The National Mental Health Workforce Strategy must include a more strategic approach to the professionalisation and development of the Lived Experience (peer) workforce. The Department of Health should draw on and refer to the Lived Experience (Peer) Workforce Development Guidelines in the Strategy.

**Recommendation 3:** The Consultation Draft’s priorities and actions are reviewed to better distinguish between strategic goals and the actions that will form part of the National Mental Health Workforce Strategy’s implementation plan.

**Recommendation 4:** The National Mental Health Workforce Strategy incorporates a temporal plan detailing the short, medium, and long-term approaches to achieve priorities and actions.

**Recommendation 5:** The National Mental Health Workforce Strategy must promote the systems approach of working to top of scope. It is necessary the Strategy clearly identifies approaches that address the barriers currently preventing the multidisciplinary workforce from working to top of scope.

**Recommendation 6:** The National Mental Health Workforce Strategy must include a strategic approach to investment as well as targeted approaches to funding and remuneration to address the maldistribution of the mental health workforce.

**Recommendation 7:** The National Mental Health Workforce Strategy is released with an implementation plan (or the first implementation plan of the series).

**Recommendation 8:** The National Mental Health Workforce Strategy includes a strategic approach to evaluation.

**Recommendation 9:** The National Mental Health Workforce Strategy should include a priority area to increase the capacity of the mental health workforce, including targeted short, medium, and long-term strategies. Cultural change and supporting the mental health and wellbeing of the workforce will need to be key focus actions.

**Recommendation 10:** The National Mental Health Workforce Strategy must include approaches for workforces to be actively recruited, appropriately trained, retained, and incentivised to take up rural and remote work and remain working in rural and remote communities.

# Section 1: This Strategy

## Background

### Scope

The Commission is concerned the current scope of the National Mental Health Workforce Strategy 2021-2031 is too narrow to adequately address the challenges of the mental health workforce and suggests the Strategy include:

* The identification and definition of the multidisciplinary workforce
* Methods for retaining the current workforce
* A better understanding of the competencies (knowledge, skills, and abilities) necessary now and in the future
* An understanding of the intersection of roles and functions
* A focus on culture, including the need for cultural change
* A strategic approach to investment
* Short, medium, and long-term solutions

### Components of care

The Commission notes that Vision 2030’s components of care, as stated in the Vision 2030 Blueprint Consultation Report, have been used in the Consultation Draft. While the definition used to communicate the components of care is accurate, it is unclear how the components of care are applied throughout the Consultation Draft. The Consultation Draft states that there should be clear linkage between the core components of care, the National Mental Health Service Planning Framework, and various occupational scopes of practices, however the linkage throughout is unclear. If these are to be referred to and used in the final Strategy, it is suggested there is clear and consistent application throughout.

## Definition of the mental health workforce

The Consultation Draft does not adequately define the mental health workforce. While understanding the need to consider broader workforces, the lack of a formal definition limits consideration of critical roles such as General Practitioners (GPs) and allied health workers. Additionally, there is a need for better inclusion of the Lived Experience (peer) workforce, allied health workforce and emerging workforces.

The Commission acknowledges the literature review undertaken to inform the development of the Consultation Draft identified the challenges in defining the mental health workforce and the various ways it is currently defined across jurisdictions and systems. The literature review also identified that useful approaches to defining the mental health workforce can be seen in international examples, such as the ‘skills level’ approach used in Scotland, which also aligns with a stepped care approach to service planning.[[1]](#endnote-2)

The Commission recommends the Strategy clearly defines the multidisciplinary mental health workforce. A definition would be beneficial in assisting national, state and territory policies and plans, data collection, research, and evaluation. Beyond the mental health sector, there are a number of inquiries and studies that would also benefit from our sector’s leadership and direction. For example, the National Skills Commission is currently undertaking a labour market study of the care workforce, including examining the needs of the care and support workforce in relation to mental health care. Guidance as to what constitutes the mental health workforce would be invaluable and would promote consistency across sectors.

The Commission suggests the Department of Health and the Taskforce consider defining the multidisciplinary workforce as one that extends beyond traditional clinical disciplines (psychiatrists, psychologists) to appreciate the contributions a wide range of professionals make across all types of care in the stepped care model, from frontline prevention and identification through a range of treatments, to recovery support and research. The multidisciplinary workforce includes a wider range of clinicians (psychological, allied health, nursing, midwifery, general practice and medical), as well as community support professionals, Lived Experience professionals, and front line or emergency responders. It also includes new and emerging workforces such as Lived Experience (peer) workers, psychosocial support workers, and students in training.

Steps required to achieve a successful multidisciplinary workforce are discussed in further detail in the remainder of this submission. They include:

* Clearly identified [roles and responsibilities](#_Roles_and_responsibilities) that encourage professional recognition with flexibility in scope and a culture of collaborative practice and team approaches.
* Resources to enable professions to work to their full scope of practice, focusing on their [top of scope](#_Working_to_top) and best utilising their skills in a multidisciplinary environment.
* [Recruitment and career pathways](#_Section_5:_The) in mental health specialisation across all aspects of the workforce.
* Appropriate mental health training from primary qualifications to ongoing or specialised professional development and in-role training, including in cultural competence, trauma, and human rights.
* [Retention](#_Section_6:_The) and incentivisation of taking up mental health specialisations.
* Work and life supports built into employment contracts for people working in [rural and remotes](#_The_rural_and) settings.
* A combination of local and innovative ways to use workforces where a local workforce is not available or insufficient.

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| **Recommendation 1:** The National Mental Health Workforce Strategy must provide a clear definition of the multidisciplinary mental health workforce and include specific approaches to how this workforce can be achieved. |

### Lived Experience

Lived Experience (peer) workers play an important role in building recovery-oriented approaches to care. Currently, peer workers are regarded as a valuable but underutilised part of the mental health workforce. The final Strategy needs to include a stronger focus on the Lived Experience (peer) workforce including a strategic approach to professionalisation and development of the workforce with the same supports and accountabilities as other disciplines.

Better inclusion in the final Strategy could include strategic approaches to foster an environment where peer workers are a valued part of the multidisciplinary team, receive appropriate education, training, and remuneration, and are integral to the delivery of care. In addition, the final Strategy should consider as part of the first objective (careers in mental health are, and are recognised as, attractive), the different pathways into and within the mental health workforce for peer workers compared to other disciplines.

#### **The Lived Experience (Peer) Workforce Development Guidelines**

Under the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), the Commission is leading the development of Lived Experience (Peer) Workforce Development Guidelines. The project will help support the peer workforce through providing formalised guidance for governments, employers and the peer workforce about support structures required to sustain and grow the workforce. Although local and regional peer workforce frameworks exist, the development of national guidelines will ensure consistency across Australia. National guidelines will also be a step towards professionalisation of the peer workforce. The Lived Experience (Peer) Workforce Development Guidelines will be released by the Commission shortly. A summary of the Guidelines has been provided to the Taskforce.

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| **Recommendation 2:** The National Mental Health Workforce Strategy must include a more strategic approach to the professionalisation and development of the Lived Experience (peer) workforce. The Department of Health should draw on and refer to the Lived Experience (Peer) Workforce Development Guidelines in the Strategy. |

## Aim

The Commission suggests the aim of the Strategy is broadened to include wellbeing, including the mental health and wellbeing of the workforce itself. Currently the aim focuses on treatment and care and would benefit from the inclusion of sustainable recovery. The mental health and wellbeing of the workforce also needs to be promoted here. Further detail on the mental health and wellbeing of the workforce is discussed at [Section 6: The mental health workforce is retained in the sector.](#_Section_6:_The)

## Objectives and priority areas for action

The information provided to support the identification of priority areas and actions is valid, however there are also well-known barriers to achieving the priority areas and actions that are not sufficiently addressed by the Consultation Draft. There is substantial risk that the final Strategy will therefore not provide the necessary approaches to achieve change.

For example, Priority Area 4.1 recognises the importance of providing students, trainees and interns with high quality training, including mental health placements across a range of settings and locations. The action to support education and training providers and service providers to improve the quality and quantity of mental health placements might address a larger contextual challenge, however does not adequately address the fundamental barriers to students and trainees undertaking placements – affordability, choice, and incentives to undertake placements in rural and remote areas.

Additionally, there is no consistency as to how the priority areas and actions are described. Implementation activities have been identified against some, but not all, of the priorities, while some priority areas provide ‘explanation’ notes. The final Strategy would benefit from more of this explanatory analysis and further elaboration could emphasise the actions required for change.

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| **Recommendation 3:** The Consultation Draft’s priorities and actions are reviewed to better distinguish between strategic goals and the actions that will form part of the National Mental Health Workforce Strategy’s implementation plan. |

### Temporal planning

While the Commission appreciates a number of implementation actions are yet to be developed, the lack of a temporal plan in the Consultation Draft makes it difficult to understand the time period and sequence of achieving the stated priorities and actions. In practice, many of the required implementation activities will not be undertaken concurrently or immediately. Therefore, the final Strategy needs to articulate the intended progress across the short, medium and long term. Given the significant demands experienced across the mental health system, the final Strategy needs to clearly articulate how we get there as quickly as possible.

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| **Recommendation 4:** The National Mental Health Workforce Strategy incorporates a temporal plan detailing the short, medium, and long-term approaches to the achievement of priorities and actions. |

# Section 2: Careers in mental health are, and are recognised as, attractive

### Stigma and discrimination

The Commission notes addressing stigma and discrimination as a means of attracting people into the workforce has been included in this section of the Draft Consultation. However there is a need for the Strategy to continue to reduce stigma and discrimination in the workplace through developing and implementing training programmes that build awareness of, and knowledge about the impact of stigma and discrimination, as outlined in the Fifth National Mental Health and Suicide Prevention Plan Implementation Plan.[[2]](#endnote-3)

There needs to be a strategic approach to the active promotion for all workplaces to adopt a culture where stigma and discrimination are not tolerated. Addressing stigma and discrimination experienced by the peer workforce also needs to be a priority. Lived Experience work needs to be supported and embedded as an integral part of the way all mental health services are delivered. The challenge is not simply to create new jobs or recruit new workers, but to embed a new source of knowledge and new ways of thinking about mental health, into an established service system. A commitment to change, collaboration, and co-development is essential. The National Lived Experience (Peer) Workforce Guidelines outlines the underpinning values and principles of designated Lived Experience work and provides clarity to understand authentic Lived Experience practice, different types of Lived Experience work, and direction on how non-designated colleagues and managers can best support Lived Experience workforce development. There is a need to educate non-peer workers on the functions, values and role of mental health peer workers. This was raised by the Productivity Commission who recommended the development of a program to educate health professionals about the role and value of peer workers in improving outcomes.

This connects closely to Objective 5 (along with addressing the factors that decrease the attractiveness of working in the mental health sector.) The Commission proposes a better structural connection between Objectives 3 and 5 as some of the priorities raised in this section impact on the retention of the workforce.

# Section 3: Data underpins workforce planning

The Commission suggests the Department of Health and the Taskforce consider the inclusion of vacancy data to underpin workforce planning and provide an accurate picture of workforce shortages. Currently the Internet Vacancy Index is the only publicly available source of detailed data on online vacancies. This data source is limited to online job advertisements lodged on SEEK, CareerOne and Australian JobSearch and traditional mental health workforces such as psychologists and psychiatrists. Therefore, it is not an accurate picture of all vacancies in the mental health workforce labour market and vacancy rates remain a data gap.

# Section 4: The entire mental health workforce is utilised

## Working to top of scope

The Consultation Draft refers to professions working to their full scope of practice. This means practitioners are only enabled to apply the skills, competencies and knowledge set by their professional regulatory body (for example, the Nursing and Midwifery Board of Australia) or in some cases their state’s legislation.[[3]](#endnote-4) This is a restricted way of viewing only the necessary skills and competencies a practitioner would need to do their job and does not capture the breadth required to achieve Objective 3 of the Strategy.

The Commission recommends the final Strategy promotes working to top of scope. This concept has been defined by Te Pou (a national workforce centre for mental health, addiction and disability in New Zealand) as follows:

“At a systems-level, working to top of scope means optimising workforce capacity and effectiveness through validating and maintaining current best practice; developing new roles and new ways of practising; and ensuring that policy, provider, and service environments support these new roles and practices to succeed.

At an individual and practice level, working to top of scope means enhanced opportunities and capacity to utilise specialised knowledge and expertise in a way that is efficient, adaptive, collaborative, holistic and ethical, and fundamentally supports the service user and their wider family.”[[4]](#endnote-5)

Working to top of scope is about optimising workforce effectiveness and facilitating the workforce being able to reach its full potential. It focuses on creating supportive work environments, ensuring workforces have the information and resources to enable workers to do their best work, and improving job satisfaction. This results in a well-supported workforce that is more capable and responsive to need.

Workforces need to be sufficiently resourced to work to top of scope – this means enhancing opportunities and capacity to utilise specialised knowledge and expertise in a way that is efficient, adaptive, collaborative, holistic and ethical, and fundamentally supports the service user, their families and carers.

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| **Recommendation 5:** The National Mental Health Workforce Strategy must promote the systems approach of working to top of scope. It is necessary the Strategy clearly identifies approaches that address the barriers currently preventing the multidisciplinary workforce from working to top of scope. |

## Roles and responsibilities

There is a need for disciplines to better understand how their scope of practice contributes to the overall work of the mental health workforce. This lack of understanding currently contributes to the siloed culture of mental health care and inversely, genuine integration and collaboration depends on mutual understanding and appreciation of the role of everyone involved.

The Commission therefore suggests a more strategic approach would be to define roles and responsibilities to provide clarity as to how the mental health workforce can work together as a team. This includes focusing not only on the skill-mix required within a single service team, but also the opportunities for teams that are co-located, virtual, and include tertiary consultation supports. Furthermore, roles and responsibilities should be aligned with competencies. Currently, there are no core competencies to ensure consistency of mental health care across different professional disciplines.

### Skills and competencies

To be effective, the environment and service system needs to be enabled to allow the workforce to enact new skills, work to top of scope, be innovative in roles, and be supported by cultures of learning and wellbeing. The Commission suggests considering the mental health workforce across the stepped care model to identify the different competencies and skills required. Doing this emphasises the importance of mental health training for workforces such as GPs and nurses. The final Strategy also needs to consider that while these occupations are examples of professions with long-established and mature regulatory schemes, they are not regulated in terms of mental health competencies.

Working in multidisciplinary teams requires competencies in teamwork, planning, and communication – required to foster collaboration, ensure that all providers in the team know what their role is, and are supported to undertake that role. Digital and technology competencies are also required, not only in terms of being able to deliver care through online avenues (i.e., telehealth and digital platforms) but also when working within teams that span locations.

Competencies in suicide prevention for mental health workforces are also critical noting that suicide prevention care is also provided through mental health services. Currently, suicide crisis intervention training is not a requirement of psychology or mental health nursing. The final Strategy should include contemporary practice in suicide prevention for professions with consideration of a range of suicide prevention and mental health therapies, safety planning, pharmacological interventions and anti-depressant use.

### Generalism

A model for further consideration is the principle of generalism. Currently, the workforce and health services in mental health are structured around specialisations. This contributes to the siloed approach of the workforce. A generalist approach and the expansion of roles and responsibilities for all health workers could enable the specialised mental health workforce to work to top of scope.

# Section 5: The mental health workforce is appropriately skilled

During 2020, the Commission undertook considerable consultation with key stakeholders, including lived experience peaks bodies; mental health sector peak bodies and their members; peak professional associations; peak private health groups; research and academia; clinical experts; state, territory, and federal governments; Primary Health Networks, Local Health Networks; service providers; and peak bodies and organisations representing identified priority populations.

The following input was received from participants during the consultation. It identifies several cultural and system barriers including training, career pathways and appetite for risk from the perspective of participants. The Commission proposes the Department of Health and the Taskforce consider the following input as it considers the education and training opportunities as part of Objective 4.

Training and career pathways

* While a lot of money is put into training and education, the quality is variable and does not translate into changes in practice.
* For peer workers, the mental health qualification (Certificate IV) is a big undertaking, and the fees can be restrictive. There needs to be a more graduated access pathway with qualification levels prior to the Certificate IV, as well as employment opportunities for people who have completed the Certificate IV qualification.
* Placements and practical training are often not effective. For some disciplines, there are no financial incentives for students to undertake placements in rural areas; there is insufficient financial support for some students’ travel, accommodation and access to information technology[[5]](#endnote-6) which is a hindrance; and there are a disproportionate number of placements in tertiary care when the majority of mental health care and support is provided primary care settings.
* The system does not recognise non-traditional professions well or understand their capacity to work in this space resulting in limited career pathways. For example, graduates of the Bachelor of Health Sciences (Mental Health), which is open to Aboriginal and Torres Strait Islander students only, struggle for recognition.

Appetite for risk

* There is a culture of risk avoidance that prevents people from working to top of scope or broadening their scope.
* The role of knowledge translation and implementation of new skills needs to be considered. Participants provided the example that when staff were sent off for training, they were unable to then implement their new knowledge and skills because ‘that was not the way things were done’ at their workplace.
* Solutions need to be inter-disciplinary and inter-jurisdictional, noting the role of regulators and state and territory laws that define a profession’s scope of practice and can impede working to top of scope.

# Section 6: The mental health workforce is retained in the sector

While the Consultation Draft considers some of the consistent issues that drive poor retention across the mental health workforce, the Department of Health and the Taskforce need to identify, consider, and address factors affecting capacity such as staff absenteeism, difficulty recruiting to vacant positions that are already funded, workers compensation claims, and inefficiencies in the workplace.

Stress and burnout are reported across all health professions, with particularly high rates in mental health. Practitioners may not have access to the supports that they require to maintain their own mental health, particularly those working in rural and remote areas.[[6]](#endnote-7)The wellbeing of the mental health workforce is therefore an important consideration and while it has been included as a priority area for action in the Consultation Draft, the related actions do not adequately address what is needed for a workforce to be supported and well.

There is a growing body of knowledge in relation to supporting the mental health and wellbeing of staff within the workforce with clinical supervision and mentoring identified as essential elements for workforce support and development. Too often, clinical supervision is not provided, prioritised or consistently implemented. The Commission notes the inclusion of supervision as a priority area, however, there needs to be a targeted approach to its implementation beyond the review of guidelines and specification of standards. Additionally, programs such as the Workforce Incentive Program are valuable as they not only provide flexibility for primary care practices to respond to local need, the team-based model of care can reduce stress and burnout that result from high workloads and practitioner shortages.

Investing in staff wellbeing can lead to improvements in productivity and boost retention. A strategic approach to the prioritisation of the wellbeing of the mental health workforce is required, with consideration given to an investment in supervision, mentoring and integrated care approaches that promote wellbeing, all of which require resources and time to be allocated.

### Culture

The consideration of culture on the mental health and wellbeing of the workforce is a critical gap in the Consultation Draft. The mental health workforce’s exposure to multiple stressors and high-pressured environments can contribute to negative workplace culture in some services, particularly in the public sector. Stressors can include high workloads, overwork and stress from workplace shortages; resource limitations; fear of making clinical errors; and exposure to violence. Factors such as a lack of financial rewards, feeling undervalued and increasing bureaucracy and paperwork can also contribute to a negative culture within the mental health workforce. The mental health workforce also face heightened risk of mental illness, suicidal ideation, burnout and cynicism, and stigma and discrimination has been found to deter mental health professionals from seeking help.

The final Strategy needs to build a platform where culture, values, and attitudes are front and centre of mind and policy across all workplaces. There needs to be emphasis and commitment to shared values and attitudes throughout the system by all employees and this needs to begin at the strategic policy level.

The Department of Health and the Taskforce might like to consider the work of Sidney Dekker and the concept of a just culture which promotes the need to develop a culture of trust, learning and accountability. This concept has been applied internationally and has the potential to increase staff satisfaction and address barriers to capacity.

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| **Recommendation 9:** The National Mental Health Workforce Strategy should include a priority area to increase the capacity of the mental health workforce, including targeted short, medium, and long-term strategies. Cultural change and supporting the mental health and wellbeing of the workforce will need to be key focus actions. |

# Section 7: The mental health workforce is distributed to deliver support and treatment when and where consumers need it

## Maldistribution

The allocation of current resources across the mental health system is not optimal, resulting in practitioners not working to top of scope and not working in areas of greatest need. There are a number of factors contributing to the maldistribution of the mental health workforce. These include funding models; remuneration models; employment requirements; the variety of employment standards and qualifications that exist across states and territories; pre-service and service training pathways; and registration and professional recognition requirements. While the Consultation Draft addresses some of these, there remain areas not adequately addressed.

The movement of mental health professions from public to private settings is a continuing trend, particularly amongst psychiatrists and psychologists. Factors contributing to this include a lack of funding and resourcing in the public system resulting in an over-stretched public system, and a lack of professional development and career progression opportunities.

Maldistribution leads to significant variations between the workforce in public and private mental health and health settings. These variances are driven by remuneration models but also by the systemic differences between private and public health and how these impact on models of care. To address this, there needs to be a balanced and complementary offering between service delivery in private care with that provided in public care. Not doing so will result in people continuing to receive different levels and types of care in both settings.

It is necessary to build the capacity of the primary health care sector to significantly and pragmatically increase service access to a greater proportion of persons with mental ill-health and improve the delivery of mental health promotion and the likelihood of earlier intervention. This includes developing the mental health competence of GPs and collaborative teams to provide them with appropriate support services and decision-making tools to assess and manage the mental health needs of their patients.

There is also a need to address system barriers (such as the Better Access scheme) that are preventing the expansion of the community and primary care workforces, particularly in mental health. By way of example, the Better Access scheme currently excludes mental health nurses who are a critical part of the mental health workforce. The Better Access scheme has also led to the geographic maldistribution of service providers – with data showing a tendency for providers to cluster in areas of relative socio-economic advantage. With s 51(xxiiiA) of the Australian Constitution allowing doctors to set their own fees, affordability is a real and persistent issue for those who cannot afford ‘gap’ payments over and above the standard MBS rebate.

The maldistribution of mental health professionals has also resulted in a shortage of professionals in rural and remote areas, and a high concentration in urban areas. The rural and remote mental health workforce is discussed in the [final section](#_The_rural_and) of this submission.

Notably absent from the Consultation Draft is a strategic approach to investment, including consideration of the time taken to develop the workforce. The final Strategy needs to include an approach that commits governments as well as the private sector to invest in the growth and development of the workforce.

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| **Recommendation 6:** The National Mental Health Workforce Strategy must include a strategic approach to investment as well as targeted approaches to funding and remuneration to address the maldistribution of the mental health workforce. |

# Section 8: Implementation of the Strategy

In its National Report 2019, the Commission made a recommendation for the Australian Government to produce a clear implementation plan to accompany the development and release of the National Mental Health Workforce Strategy. The Commission notes the intention of the final Strategy to be supported by an implementation plan (or series of plans). Some actions in the Consultation Draft are identified as priorities within 12 months of the Strategy commencing. As such, the Commission affirms its recommendation for the implementation plan (or the first in the series) to be released at the same time as the final Strategy.

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| **Recommendation 7:** The National Mental Health Workforce Strategy is released with an implementation plan (or the first implementation plan of the series). |

The Consultation Draft lacks a strategic approach to evaluation. It is necessary the final Strategy articulates an approach to evaluation, including implementation and associated timeframes, and who will be responsible for the evaluation of the Strategy.

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| **Recommendation 8:** The National Mental Health Workforce Strategy includes a strategic approach to evaluation. |

# The rural and remote mental health workforce

Ongoing challenges remain in recruiting and retaining a multidisciplinary mental health workforce to rural and remote Australia. Critical workforce shortages are evident across the mental health workforce in rural communities including mental health nurses, psychologists, and psychiatrists. The lack of mental health services and workforce means many primary health care professionals have roles and responsibilities that require additional knowledge, training, skills and competencies compared to their metropolitan counterparts.

Challenges in recruiting and retaining the mental health workforce in rural and remote communities were detailed in the 2018 Senate Inquiry into the accessibility and quality of mental health services in rural and remote Australia (2018 Senate Inquiry). As part of the Vision 2030 consultation, the Commission held a rural and remote roundtable that included discussion on workforce issues. Participants expressed the 2018 Senate Inquiry provided adequate solutions to these challenges; however time and funding certainty have been significant barriers to their implementation.

The Rural Psychiatry Roadmap 2021-31 (Attachment A) also sets out a strategic direction and practical recommendations to address workforce challenges in rural and remote Australia. While focused on the psychiatry workforce, the change needed to address the inequalities in service provision between rural and remote and metropolitan areas pertain to broader workforces. This includes the need for investment, improvements in training opportunities, and equipping the workforce with the range of skills and competencies required to meet the needs of the community,

The 2018 Senate Inquiry recommended the development of a national rural and remote mental health strategy, including addressing the issues of workforce shortages in rural and remote communities. While the Government supported the recommendation, the decision taken regarding workforce was to include it in the National Mental Health Workforce Strategy. The final Strategy therefore needs to ensure a strategic approach to the rural and remote workforce that facilitates all three levels of government working together and promoting local leadership in workforce planning. The Commission acknowledges there are actions that pertain to rural and remote communities, however the lack of a dedicated focus on the rural and remote workforce in the Consultation Draft is an oversight, and it remains unclear how rural and remote workforce issues are going to be addressed in the final Strategy.

### Vision 2030 consultation priorities for consideration

The Commission suggests the Department of Health and the Taskforce consider the following contributions in its development of priorities and actions for rural and remote communities in the final Strategy.

Participants at the Vision 2030 rural and remote roundtable identified the importance of career support and development opportunities (including supervision and mentoring opportunities) for rural and remote service providers. Consideration needs to be given to communities that are not residential, for example transportation communities and fly-in-fly-out workers, and how they can be incorporated into the system. Emphasis was placed on the need for development of a self-sufficient ‘home-grown’ workforce that does not rely on locums.

Participants particularly emphasised that the allocation of additional service funding without consideration for the available workforce in those rural and remote communities can be problematic and is likely to result in redistribution of the existing mental health workforce without increasing their overall capacity.

Many innovative solutions were raised by participants including work and training packages, integration of supervision and mentoring opportunities across professional groups and implementation of a multidisciplinary focus.

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| **Recommendation 10:** The National Mental Health Workforce Strategy must include approaches for workforces to be actively recruited, appropriately trained, retained, and incentivised to take up rural and remote work and remain working in rural and remote communities.  The Commission notes that while we have referred to rural and remote communities collectively, regional, rural, and remote locations often face different challenges and these need to be considered in the development of the Strategy. |

# References

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