SARRAH

Services for Australian Rural and Remote Allied Health

8 October 2021

Amy Mehrton
Principal
ACILAllen

On behalf of the National Mental Health Workforce Strategy Taskforce

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cc: nmhws@acilallen.com.au

Dear Ms Mehrton,

**Services for Australian Rural and Remote Allied Health (SARRAH)**
**Submission: Draft National Mental Health Workforce Plan**

Thank you for the opportunity to provide feedback on the draft National Mental Health Workforce Plan and for allowing us the flexibility to provide the submission to you directly at this stage. We appreciate the consideration.

The answers to the questions posed in the on-line template are provided attachment to this covering letter, and organised to mirror the template.

Relevant contact details are set out below.

As background, **Services for Australian Rural and Remote Allied Health (SARRAH)** exists so that rural and remote Australian communities have allied health services that support equitable and sustainable health and well-being: including mental health services and support. SARRAH also supports Allied Health Professionals who live and work in rural and remote areas of Australia to carry out their professional duties confidently and competently in providing a variety of health services to people who reside in the bush. SARRAH maintains that every Australian should have access to health services wherever they live and that allied health services are fundamental to the well-being of all Australians. SARRAH is a national, multidisciplinary member association and has been operating for 25 years. SARRAH is the only peak body to be fully focused on rural and remote allied health working across all disciplines. (More information is available at http://www.sarrah.org.au/).

**Submission Contact Details – as requested**

Name *Allan Groth
Organisation * Services for Australian Rural and Remote Allied Health (SARRAH)
Email * Allan@sarrah.org.au
Do you consent to your submission being published? * Yes
If no, do you consent to being named as having provided a submission? * NA

SARRAH would welcome the opportunity to further assist the Taskforce and ensure equitable access to and optimal benefit from mental health services for people living in rural and remote Australia.

If you would like to discuss issues raised in SARRAHs submissions or require further information, please contact me at catherine@sarrah.org.au or allan@sarrah.org.au.

Yours Sincerely

Cath Maloney

Chief Executive Officer

**SARRAH SUBMISSION TO THE NATIONAL MENTAL HEALTH STRATEGY – 10 YEAR PLAN**

**Questions**

**1. To what extent does the aim of the draft Strategy address the key challenges facing Australia's mental health workforce?**

Overall the draft Strategy provides a strong basis for mental health workforce development and establishes a coherent framework for further detailed development and negotiated shared responsibility, deliverable activities and a reasonable expectation for political commitment and implementation.

There are several areas where we believe further work is needed, but these would align with and serve to reinforce the direction and priorities set within the draft Strategy.

**NOTE:** For ease of reference, the following comments include numerous excerpts from either the **Background Paper (BP)** or the **Consultation Draft (CD)** Strategy.

Mental and Physical health

*"The mental health workforce helps to build protective factors that support wellbeing, including social inclusion, healthy behaviours, engagement in meaningful roles and activities, and physical activity. Respecting and responding to the diversity of need means accommodating understandings of health and wellbeing that are appropriate for each individual, family and community.*

*A person-centred view of mental health recognises the indivisibility between physical, psychological, social, emotional and cultural wellbeing."*

- Comment: This is a welcome, but not unusual acknowledgment. The challenge is to have the point translate into / incorporated within a Mental Health workforce strategy and to seek/enable similar linkages and reinforcement from other health or related workforce strategies.
- To a large extent the draft Strategy does this well, however it is likely that this issue will need to be reinforced throughout the finalisation of the strategy and its ongoing implementation, necessitating engagement across relevant sectors.

BP page 7 - ***"For those affected by severe mental ill-health, average life expectancy is reduced, due mainly to untreated physical health conditions."***

This point could be further strengthened in the body of the draft Strategy or in an Attachment – citing implications and case studies – illustrating the mutually reinforcing value of mental health and physical therapies in maintaining good health;

- Examples might include people with mental health needs who may not necessarily acknowledge or want to present as having them (e.g. farmers, people who pride themselves on a sense of resilience but impacted by bushfire etc.) – who may consult a physical therapist (e.g. for back pain) and reveal the need for psychological or other supports;
- Such illustrative interactions could also highlight situations where (for example) physical therapists, are unable to treat a patient effectively as patient engagement requires behavioural and/or attitudinal support and change – and the patient's overall needs are best progressed through collaborative care involving a mental health specialist.
- Another example / case study might involve psychotropic medications being used for treatment with and without complementary cognitive or other treatments – drawing on issues highlighted in recent Royal Commissions as well as the Australian Atlas of Health Variation. This might highlight the risks of treatment options and impacts on patients where other treatments might be safer and more effective in combination with or as an alternative to medications, if the full mental health workforce capacity were available.

BP - page 8 - ***"Disasters, such as the bushfires and COVID-19, significantly impact our lives and greatly affect the mental health of many Australians. Some of the consequences include loneliness, increased***

***anxiety and distress, depression, poor sleep quality and increased drug or alcohol consumption, job insecurity, unemployment and additional stressors."***
Comment: While there was considerable effort to provide immediate mental health care services in the wake of recent bushfires and other disasters that support:

- may not have adequately covered the period over which much of the trauma may have been felt or manifested; also
- noting the comments on physical health above, with the exception of medical services, few if any physical therapies were included or supported in the response: potentially exacerbating or limiting the beneficial impact of other treatments.

These issues warrants more attention in the Strategy.
<u>The person or the illness: identifying structural systems issues</u>
BP - Page 6 ***"The most common conditions in Australia are anxiety disorders (14.4% of the population), affective disorders such as depression (6.2%), and substance abuse disorders (5.1%) and eating disorders (estimated between 4 and 16%)."***
The example of eating disorders highlights imbalances and patchiness in our current system, notably the focus on specific disorders rather than the overall needs of patients on a continuum of their care as a person, or the population as a whole.
**Re: eating disorders**, the Commonwealth recognised the significance of the issue and the need for substantial, multi-professional care when they introduced from 1 November 2019
Eligible patients are able to receive (among other MBS subsidised treatments) up to 40 psychological treatment services and up to 20 dietetic services in a 12 month period. This is not to question the seriousness of eating disorders or the value of enabling adequate treatment. However, from a health systems and patient-centric viewpoint:

- Do other illnesses present similar risks to patient health and wellbeing and warrant greater levels of support?

Noting the impact of eating disorders on subsequent mental and physical health can be wide reaching and extremely serious (see – here), what is the basis on which a person who may have multiple morbidities, which may have developed or been exacerbated as a result of having an eating disorder is generally restricted to 5 subsidies AHP services per annum.

- While this is primarily an MBS funding issue, it has clear workforce development and service delivery implications which may be instructive to explore in progressing the Strategy

In shaping health workforce and other long-term strategies (which presumably will guide investments, service configurations and access parameters, it is vital, as a means of improving health and wellbeing as well as sustainability, toward the entire needs of people and ensure our workforce and service systems are oriented to support that.
The proposed Strategy includes very positive steps in that direction, however there is scope to ensure this aspect of the strategy is reinforced.

<u>Collaboration across services and systems</u>: a key challenge – for government and others.
BP Page 7 – ***"People experiencing moderate conditions typically require specialist clinical services, while people with severe mental health conditions require a coordinated care approach, which may include hospital-based care."***

- Is coordination adequately supported – nationally, regionally or locally?
- Do the funding and program conditions support or hinder collaboration?
- Do they contribute directly to fragmentation, lack of continuity in care and service gaps?

These questions appear to be well understood and recognised in the background and as informing the development of the draft Strategy, they have not been brought out and dealt with as explicitly as they may need to be in order to ensure they are considered properly. Obviously, addressing these issues will entail difficult and challenging negotiations, but they are get to core issues that impact system effectiveness.

**2. To what extent do the aim and objectives provide a strategic framework to develop the mental health workforce the Australian community needs?**

Broadly the aim and objectives of the draft Strategy are very clear, logical and provide a framework for substantial improvement in mental health workforce and service capacity – provided there is commitment to resource, implement and broad acceptance of responsibility for it.

SARRAH strongly supports the statement from page 15 of the draft Strategy:

"**The priority areas and actions identified below represent significant programs of work. They are inter-related and should be viewed as a holistic, integrated approach …"**

Objective 1 - Careers in mental health are, and are recognised as, attractive

Includes *"increasing awareness of the training pathways that lead to careers in mental health"*

Need to add to this that a) training courses and pathways need also to be available – not only on scope but not offered within a reasonable distance – genuinely accessible. So more on pathways and definitely more on other practical issues such as the availability and support for clinical placements – essential and simply not that available. Needs to be addressed realistically and comprehensively.

BC - Page 20 ***"While enrolments in education and training programs that can lead to employment in mental health have generally been increasing over time, existing workforce shortages are likely to be exacerbated by increasing demand for mental health services."***

The Strategy is right to note the increasing pressure for workforce due to growing demand, but this issue needs to be also understood in terms of the escalating pressures from other sectors facing similar workforce shortages (especially in rural and remote Australia), such as through already under-serviced and growing NDIS demand and increasing requirements of a growing aged population. The compounding demand vs supply implications of these coincident developments must be considered and addressed coherently by Governments. This Strategy should remind and reinforce the need for coherent, long-term workforce development structures and pathways.

Objective 2 – Data underpins workforce planning

We strongly support development of an urgent and comprehensive health workforce database.

The draft Strategy is the case for data development. **From page 11, CD:**

***"Availability and use of such data will support forecasting and monitoring of strategies that encourage workforce development and growth. There is an acknowledged lack of comprehensive mental health workforce data which impedes workforce planning. This is particularly apparent for occupations that are not regulated under Ahpra and for the community managed sector where nationally consistent data regarding workforce size, education levels and composition by occupation are not available."***

The shortcomings and gaps in Australia's health workforce holdings have been well known for more than a decade and possibly several decades. The critical value of this data in terms of workforce and service planning and distribution is also well understood, as is the implication that without it many Australians will continue to have inadequate and inequitable access to services which impact negatively on their quality of life and in many cases contributes to avoidable distress, hospitalisations, complications and even premature death.

Current work to address data gaps, while welcome, does not appear to have the urgency or investment commensurate with the implications associated with the lack of this information for planning and service delivery. This is a matter of priority and continuing to acknowledge gaps without very specific, tangible, time-limited, reported, accountable and resourced efforts to address those gaps amounts to systematic negligence. It represents a conscious decision to accept the continuing inequality and the increased risks for people impacted by it and cannot be seen or treated as an academic exercise.

The structure and actions identified (Figure 3.1, page 11) provide a good basis for action. However, there are several points that need to be made clear in the Strategy and/or clarified:

- Much of the data development work identified in this Strategy depends on addressing underlying data gaps, especially for professions not regulated through Ahpra – for example, Social Workers, Speech Pathologists, Dieticians, Aboriginal and Torres Strait Islander Health Workers, Allied Health Assistants and other VET trained health workers etc.
- The draft Strategy is clear on the background but must advocate for a whole of health workforce approach, not limited to the 'mental health' workforce.

BP Page 12 - ***"An analysis of national mental health workforce demand and supply using the National Mental Health Service Planning Framework (NMHSPF) to better understand current and future mental health workforce supply and demand, conducted by the University of Queensland — A labour market analysis to review of workforce trends for different occupations within the mental health workforce, conducted by ACIL Allen".***

- Comment: Having not seen the documents it is difficult to comment on the predicted /estimated workforce demand and other factors, however we note the gaps in current workforce data raises concerns. That said, the effort is warranted and a) further strengthens the case for immediate action to rectify these gaps and b) in no way should be used as a reason to slow develop of workforce, especially as additional capacity is needed. Strategies to re-balance workforce can occur subsequently, but the immediate need is for action on both fronts.

Re: Action 2.1.1 (page 12 CD) – we recommend adding a specific action to prioritise identifying existing gaps and developing actions to address them – with that work oversighted by an independent group including workforce and service provider representatives.

Page 22 BP - ***"There is no nationally consistent approach to data that aligns to the broad definition of mental health workforce across all service settings. This is an important gap in understanding the range of occupations available to support people with mental illness, including their distribution and size. These challenges are compounded for those who work across sectors and settings, particularly as markets develop (such as the NDIS, which creates different employment patterns)."*** *And*
***Some occupations work across sectors (holding roles, for example, in aged care, mental health and disability) and in a combination of community and public settings. This can lead to inaccurate data on the number of the individuals available to provide treatment, support and care.***

- Comment: It is important to recognise the trend toward workers working across sectors may be challenging from a data-collection and presentation viewpoint, it is arguably and in many cases certainly a positive development in enabling the provision of care across communities, especially where constraints on workforce and services otherwise exist: such as in rural communities.
- Further consideration of this issue might include questioning whether the existing data collection mechanisms and focus are adequate to the reality of contemporary service demand and delivery and whether greater focus might be put to individual people/patient information (and systems that genuinely support the focus of practitioners on holistic care) and/or the practitioner, with less emphasis on the specific service setting or funding/program instrument.

Unfortunately, Ahpra registration is frequently mistaken (including by officials and other senior decisions makers) to include the breadth of qualified and highly skilled health professionals. This presents challenges to ensuring the entire health workforce is considered and included in decisions. The problem is reinforced as Ahpra is also the source of the Government's key workforce dataset, and these professions are invisible. As the BP states on Page 19 "*There is no national standardised data set on the supply of speech pathologists."* The value of this workforce in mental health is well described in the recent article from Croakey and suggests the impact the lack of these services have over the life course, especially in rural, remote and lower resource-rich communities.

- The Strategy might be well supported by a summary overview of the role and impact each of the professions has in terms of mental health care, to accompany the next iteration of the Strategy.

<u>Objective 3 - The entire mental health workforce is utilised</u>

The Strategy takes an appropriate, broad view of the mental health workforce. Comments elsewhere refer expand on the issue. Inevitably discussions of health professional roles, scopes of practice, expertise, teams etc. raise competing views and priorities, which need to be balanced in order to promote adequate, safe and effective service functioning and patient access, safety and quality. The Strategy raises these complex issues and broadly achieves a good balance. From the viewpoint of an organisation focused substantially on increasing access to services where they are in short supply, the

emphasis tends to be facilitating access and enabling arrangements that optimise access. Consequently, our preference would be to note but not over-emphasise distinctions such as:
— ***people who work exclusively in the mental health sector*** *(for example Aboriginal and Torres Strait Islander mental health workers, mental health nurses and psychiatrists)* and
— ***those who work in other health settings who frequently treat, interact with, care*** *and support people experiencing mental distress and/or ill-health (for example allied health professionals, general practitioners (GPs) and nurses)*
The point is somewhat nuanced, but aims to keep the emphasis on patient need, inter-professional respect and collaboration. A stronger emphasis on distinctions can contribute to reinforcing inflexibilities across the workforce and between service structures which may cause blockages and gaps, beyond those required on the base of safety and scopes of practice.
Page 14 CD – Regarding scopes of practice and multi-disciplinary, team based services etc. ***–"While some occupations (such as general practitioners, nurses and psychiatrists) have documented and national scopes of practice, many other occupations do not – particularly emerging and self-regulated occupations and in the broader social and emotional wellbeing workforce. This lack of clarity and consistency raises barriers to the appropriate utilisation of some occupations within the mental health sector. It also creates challenges for multidisciplinary team care models, with limited clarity on how scopes of practice can be utilised to their fullest extent."***
As noted elsewhere, there may be a role for the Productivity Commission in further analysing this issue and re-visiting issues it considered in its major Health Workforce Report of 2005.

Objective 4 - The mental health workforce is appropriately skilled
SARRAHs chief concern in this regard is to ensure that (allied) health professionals, including mental health professionals are well equipped and supported to confidently and safely deliver care in rural and remote settings and to be confident doing so.
These are vital skillsets which complement necessary clinical skills and facilitate workforce distribution, attraction and retention.
SARRAH exists to provide these supports and advocate for rural and remote allied health professionals and the communities they serve. Many of those supports are more cross-professional. For instance, SARRAH developed the on-line *Transition to Rural and Remote Practice Toolkit,* a resource to support allied health professionals with establishing a practice in a rural or remote setting. The resource bridges the gap between training and becoming a rurally based allied health service provider. (The Toolkit is currently under Review, with resources being sought to update it).

Objective 5 - The mental health workforce is retained in the sector
Page 25 CD –***"There are incomplete data on the current retention rates of the mental health workforce which makes it difficult to quantify the scale of the issue for some occupations, however there are consistent issues that drive poor retention across the mental health workforce"***
***"There is a need for appropriate investment in both workforce availability and quality infrastructure to facilitate appropriate support and treatment."***
***"These issues are not experienced universally across settings, nor are they unique to the mental health sector, but do need to be addressed to improve retention."***
The issues identified in the Strategy are supported by and could draw further from available information, specific to the mental health workforce, but also more broadly. For instance, in terms of broader rural and remote health workforce, the Strategy could reference:

- The former NRHCs allied health report (2020), mentioned elsewhere; and
- Strategies for Increasing Allied Health Recruitment and Retention in Rural Australia – produced by SARRAH for the New South Wales (NSW) Ministry of Health, which considers strategies that have been proven effective increasing the efficacy of allied health rural recruitment and retention in Australia.

BP Page 25 – under Workforce Retention: ***Observations of under-resourcing and overwork, particularly in public settings, make mental health roles unappealing when other sectors may have better conditions.***

- Comment: Continuing focus on / resourcing directed toward high end and acute service provision in the public sector also reduces the capacity and focus on preventive and early intervention services and scope within that sector, potentially contributing to burnout with diminished opportunities within that service system to exercise full scopes of practice and capacity and direct them toward ameliorating the incidence and severity of illness and a sense of greater efficacy among professionals: a particular risk in more isolated services. While overall the Australian health system has shifted significant resources toward the less acute and preventive, early intervention areas of practice within public mental health care and across the broader health system Australia has yet to sufficiently shift toward a wellness model of care: which is reflected in Australia's low ranking among OECD countries, with a proportion spend on under 1.5% of health expenditure on prevention – around a third of the OECD average.

Page 26 (CD) - Action 5.1.1 – ***"Develop longer minimum service contract lengths for commissioned mental health services, including in rural and remote areas."***

- Comment: This is a major issue and warrants action. Funding bodies need to take account of the disruption to service continuation short-term and unnecessarily late or protracted funding and service negotiations can have on community service providers (in attracting and retaining skilled professionals) and the consequent impacts on people and communities, including service disruption and lack of continuity for often highly vulnerable people. Improving administrative processes, especially where there is a prima facie case and funding for continuing service provision, would help reduce disruptions and costs (e.g. avoidable turnover etc.) and improve the effective use of public funds.

Page 29 DC – *"Action 5.4.1 – Develop and implement mental health career pathways within and between mental health and health service settings."*

- Comment: Supported: this is also consistent with the need for greater flexibility and integration of service systems to better meet patient-centred care – and required in communities where available workforce and services are generally in short supply and viability is promoted by integrated services to meet community need.

Other supports could be identified specifically among the actions to support retention, including:

- Remote supervision (especially for isolated and relatively inexperienced remote practitioners), networked communities of practice and support – with support to develop and sustain these;
- The Mental Health Professions Network (MHPN), which presumably would be well placed to contribute to/expand upon proposed *Action 4.4.3 – Support the development of local area, multidisciplinary communities of practice for workforces needing support.*
    - It is not clear whether the MHPN has been involved in the development of the Strategy (directly or through its member bodies) but might usefully be engaged going forward.

Objective 6 - The mental health workforce is distributed to deliver support and treatment when and where consumers need it

Again, a key resource to inform this work would be the Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia (June 2020)

SARRAH welcomes the discussion and actions recognising the need for local planning, service and workforce development initiatives from page 30 of the Consultation draft.

> *"The extent to which national planning processes are linked to local planning is limited."*
> *"Staffing mental health services in rural and remote locations poses specific challenges. Though the ideal solution to developing the local workforce is to attract and train local people, place-*

*based approaches are limited due to the attractiveness of the sector and availability of locally based training opportunities."*
*"The following priority areas stress the criticality of linking mental health workforce planning to the needs of consumers and carers at the local level through local mental health service planning.* ***This is increasingly important in areas where workforce shortages are more acute such as rural and remote locations.*** *An integrated, coordinated planning approach is needed…."*

The proposed actions are positive and provide scope for innovative development as well as expansion of service and workforce models which would enable local service and greater local workforce. Existing innovative models that could potentially contribute to the Strategy include:

- Further development of the Allied Health Rural Generalist Pathway;
- Enabling remote and distributed service models involving skilled Allied Health Assistants and others (including direct care and to enable and support patient engagement with an allied health or other practitioner through technology);
- Expansion of workforce development pathways and models, such as the IAHA National Health Academy model

Specific comments:

- Page 21 (4.1.2) - CD – We note, as an example, that the identification of specific ***settings and roles category*** areas provides an overview, however some aspects of it may need to clarified or require further explanation – e.g. OTs and Social Workers are identified as a priority in the 12-24 month period, but not immediately, despite existing shortages in rural and remote Australia. They are also identified as being needed across all settings (not just Rural and Remote); which may – without some qualification, suggest a lesser focus on targeted effort is required in areas of greatest e.g. rural and remote. This might be amended to indicate both "need everywhere and especially in R&R"?
- Action 4.3 – we support the Action, but are unclear as to why it is limited to the groups identified and not others (e.g. allied health) where scholarship programs have been discontinued which previously enabled people inclined to practice in areas of geographic need to pursue that course.

**3. Are there any additional priority areas that should be included?**

- As noted elsewhere, the importance of improving access to services and workforce to meet the full health needs of people with mental illness (physical and mental) is vital to improve their health and wellbeing.
- We note later in the submission, the value of establishing clear governance, implementation and performance structures, including independent and broad representation.

- CD page 6 – *"The final Strategy will need to be supported by an Implementation plan (or series of plans) that will be developed collaboratively by the Commonwealth, state and territory governments, peak professional bodies and colleges, regulators, and educational institutions to address the objectives of the Strategy."*
- *"The implementation plan will also include timelines for implementation, governance arrangements, and monitoring and evaluation requirements."* (CD page 6)

There are many examples of good strategies with objectives, priorities and broad support that have not been implemented fully or in part.

- **It is crucial that the Strategy be implemented** and this is a very clear expectation of the Strategy. As such, the strategy development group might consider identifying **"Implementation" as an objective in its own right.**
- SARRAH would welcome the opportunity to be involved in the implementation of the Strategy.

**4. The draft Strategy seeks to balance the need for nationally consistent approaches that support the reform agenda with sufficient flexibility for states, territories and service providers to pursue priorities that reflect their specific contexts and challenges across occupations and settings (public, private and community-based). To what extent does the draft Strategy achieve an appropriate balance?**

The draft Strategy raises the most critical issues within its scope to facilitate the necessary collaboration with flexibility and scope to work within regions and communities impacted.

To a large extent the draft Strategy points to where these issues must be deal with and facilitated, notably:

- Across the Commonwealth and jurisdictions
- Between portfolio areas – and issues
- The crucial local component – which must include all key services (including representatives to champion services that are not available in communities but should be available).

***"Commonwealth, state and territory governments – share responsibility for funding public, private and non-government mental health services, delivery of public mental health services (state and territory governments), implementation of prevention and early intervention programs, administration of quality and safety mechanisms, funding and quality assurance of relevant vocational and tertiary education providers"*** **CD page 4**

- The importance of a genuine shared and collaborative commitment between and across the Commonwealth, States and Territories cannot be over-stated. Failure to act consistently and collaboratively means the Strategy will not be delivered or succeed.
- Governments must be accountable for leadership and progress and must facilitate it. They need mechanisms to deliver it – and which are robust enough to deal effectively with tensions and disputes, which the mechanism must be able to withstand and continue to work.

Page 4 CD – in identifying roles and responsibilities: the strategy should acknowledge that precarious, short-term, delayed and (sometimes competitive) funding processes can contribute to undermining the capacity of service providers to deliver care and outcomes, and that such situations should be avoided. ***The extent to which national planning processes are linked to local planning is limited. Consultations identified the need for a locally-led process, contributing understanding of local issues, to ensure all issues are identified and suitable strategies are developed for all types of occupations and settings.***

- Comment: Local planning and the capacity to support it - including with independent, external assistance and representation where necessary; local data; flexibility, support security and timeframes that support service and workforce development and the investments required to are essential.

**5. The draft Strategy provides a high-level roadmap to improve the attractiveness of careers in mental health, with implementation approaches differing across occupations and locations. To what extent does the draft Strategy provide a useful approach to addressing issues that impact on the attractiveness of the sector?**

The Strategy provides a sound basis to work from, noting comments elsewhere about the need to ensure growth in an environment where other areas of the health and social support system are also facing workforce shortages and are attempting to increase the attractiveness of their sectors. In that context and with substantial existing workforce shortages, a major, national and broadly based workforce development commitment is needed: to which this Strategy would be a major driver and component.

Page 10 CD ***"The availability, quality and range of settings in which clinical placements and internships are undertaken are important in providing trainees with positive experiences of the mental health sector, leading to greater numbers of students / trainees / interns who are likely to consider careers in mental health."***

- A fundamental constraint/limitation on clinical placements across many professions (and certainly allied health) is that clinical placement and supervisory capacity does not matched

contemporary or emerging service settings – i.e. where more current students are likely to practice. There have been efforts to contemporise placement capacity (especially in medicine) but for many allied health professions and others, clinical placement capacity remains overly dependent on large acute settings with comparatively little capacity or support to expand placements into community based or other settings. This especially relates to small rural and remote practices and for the community controlled sector where funding structures constrain the engagement of allied health professionals and hence constrain other service and placement capacity. Compounding this, potential revenue streams upon which these services depend do not (in the main) provide or allow for funding to facilitate training. Consequently, areas where capacity to meet service demand is most stretched are unlikely to be able to take students and if they do there may be greater risks of the experience deterring the student from returning to practice in these settings.

- There may be exemplars where these problems have been managed or addressed. If so, they could be supported and further promulgated under this Strategy. Detailed comments:

In several of the Actions (example 1.2.1 on page 9) we note that Occupational Therapists are not included among the professions identified for priority action to attract them into mental health - given the need for these professionals, especially in rural and remote Australia it is not clear why they are not included.

- Against the same action Social Workers and Psychologists are not listed: while it is likely people in these professions, or contemplating entering them, would be reasonably aware of mental health issues, there remains an acute shortage of both, most markedly in rural and remote Australia. Consequently, it is not clear why they have not been highlighted as priority groups for action (and was there adequate representation on the Committee or working groups?)
- If there is a rationale for this, it should be made explicit against this action and others where similar issues apply.

**6. A key issue for the mental health workforce is maintaining existing highly qualified and experienced workers. To what extent does the draft Strategy capture the key actions to improve retention?**

We refer to several documents already cited in our submission, including Strategies for Increasing Allied Health Recruitment and Retention in Rural Australia (SARRAH).

There appears to be increasing recognition that workforce development, attraction and retention is best supported by well-integrated structures and pathways and opportunities for local development and innovation.

Page 23 (CD) - ***PRIORITY AREA 4.3 – Support students from priority cohorts to complete mental health-related qualifications that reflect their communities' needs This priority area acknowledges that some cohorts in society are under-represented in the mental health workforce and may need additional support to access and complete the education and training required to work in the mental health sector***

*BP Page 24 (and page 28)* ***–"Building the mental health workforce pipeline begins with entry level training. Low completion rates are experienced in courses that train Aboriginal and Torres Strait Islander health and mental health workers, lived experience (peer) workers, and psychosocial support workers."***

- Comment – These excerpts identify real issues but also raise the importance of questioning broadly held assumptions and being aware of innovative developments.
- A notable example of an highly developed and integrated approach to address the issues identified above is the work of Indigenous Allied Health Australia (IAHA) and the progress they are making, contributing to the growth and development of the Aboriginal and Torres Strait Islander allied (and other) health workforce. (See IAHA). IAHAs approach emphasises and draws on the strengths or culture and community and works with students and members to provide the supports needed to succeed. As a consequence IAHA membership has grown rapidly, their

reach into schools to promote pathways and school retention is proving successful and their university student members' retention and graduation rates are higher than for the other university level allied health student cohorts.

- The Strategy could draw on examples, such as this (or SARRAHs implementation of the Allied Health Rural Generalist Pathway into private and community settings), to illustrate the sort of workforce development and retention approaches that could apply in supporting growth, attraction and retention of the mental health workforce.

Other actions that could be taken to significantly improve workforce attraction and retention would be to address issues such as that identified on page 27 of the Background Paper – ***"There is a high proportion of short-term contract positions in the mental health sector, particularly in community based mental health services."***

**7. The Productivity Commission and other inquiries have identified the importance of improving integration of care, and supporting multidisciplinary approaches. How can the Strategy best support this objective?**

Previous comments on the need for a whole of health workforce dataset will help, as will strengthening the focus on person-centred care and the emphasis on complementary mental and physical health and wellbeing.

The draft Strategy notes links to a relatively small number of national (Commonwealth) Strategies and Plans and more detailed analysis of various jurisdictional mental health workforce plans.

Unfortunately, coordination of action across such Plans has often been difficult to achieve. Nonetheless, there would be value in a mapping exercise to detail existing synergies across a fuller range of health workforce and related service plans, commencing across the Commonwealth. Several are identified on page 8 of the Background Paper. Specific areas of synergy/overlap could be identified and other key documents might be added, including:

- Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia (June 2020)
- The Evaluation of the RHMT Program (and any subsequent response);
- The anticipated Care Workforce Labour Market Survey due to be presented to Government by the National skills Commissioner.

A further option would be for the strategy to include a Recommendation for this matter to be referred to the Productivity Commission for further analysis and report, noting the opportunities for coordinated action to build the health workforce and, possibly, with reference to the reform objectives associated with the Commissions Health Workforce Report of 2005.

The Commission might also be charged with reviewing other workforce reform, including the work previously undertaken by Health Workforce Australia as a means of informing broader, coordinated workforce development.

**8. There are recognised shortages across the mental health workforce, including maldistribution across metropolitan/regional locations and settings. To what extent does the Strategy address the issues and supports required to improve workforce distribution?**

SARRAH Recommends the Strategy note and refer to the Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia (June 2020)

BP page 13 – ***"While workforce shortages are most consistently seen in remote and very remote areas, some workforce types met or exceeded NMHSPF targets in these regions (Aboriginal and Torres Strait Islander mental health workers). Workforce shortages in rural areas may sometimes result from clustering of available workforce in larger regional towns and cities, requiring consumers to travel to access services."***

- Comment: This is a reasonable point. It is true this is possible and undoubtedly some service provides delivering into more remote areas may base themselves in MM3 or similar centres, but the available data (where it exists) and the health outcomes data, which clearly demonstrates poorer outcomes in less well services rural and remote areas illustrates these discrepancies are real. As such, caution is needed to avoid inferring workforce shortages are less severe than they are (and risk having their priority further reduced), especially given insufficient action is being taken to address them.

Some of the analysis in the Background Paper may warrant reconsideration. Acknowledging the Committee may have had access to data not available otherwise, some appears at odds with other data and could be misleading. One area of possible concern is on page 16

- ***"Supply: There are 1,738 FTE occupational therapists providing mental health care. While there is a shortage, the shortfall is not significantly below required levels (76% of the NMHSPF target reached) and the occupational therapy workforce is relatively young (average age of 37 years). Distribution is also relatively well aligned with NMHSPF targets."***
- Public data shows Occupational Therapy workforce distribution by MM region (2019) on an FTE per 100,000 population basis as being:

| | OTs |
|---|---|
| National | 70 |
| MM1 | 75.4 |
| MM2 | 77.1 |
| MM3 | 75.8 |
| MM4 | 51.6 |
| MM5 | 19.1 |
| MM6 | 44.8 |
| MM7 | 26.7 |

- That is, as with most allied health professions especially, OT workforce numbers are heavily skewed toward metropolitan area.

Another area for possible review, is on Page 18 of the BP:
"*Supply: There are no national FTE counts for the supply of social workers. Based on the Mental Health Establishments National Minimum Data Set (MHE NMDS), there are 2,401 FTE social workers in state and territory-funded inpatient and community setting, which is above set levels (115% of the NMHSPF target reached).*"

- For Social Workers the public sector figures may provide a reasonable indication of workforce distribution, but without national information and given feedback from rural and remote stakeholders, including community based service providers, that this workforce is difficult to attract and retain this may infer the workforce is better matched to demand than it is.

***Viability of private practice***
*There are diverse factors that influence the viability of private practice, including the level of awareness of roles, the nature of funding arrangements, and the scale of the market. When combined, these factors limit the viability of private practice for roles including counsellors and psychotherapists, mental health nurses, occupational therapists and the vocationally trained workforce in particular. Current Medical Benefits Scheme (MBS) settings do not encourage GPs to specialise in mental health as the rebates for many mental health consultations are less than the rebates for other services, despite the increased time required to deliver them.*

- Comment

This area deserves considerably greater attention if it is to be addressed and contribute substantially to increased mental health workforce and service capacity in high needs/low workforce areas. For allied

health practitioners, at least, maldistribution is in part due to the lack of funding and systems supports to enable service viability to meet community need. A range of services and supports currently available to GPs (for instance) are not available to other professions and MBS limitations can serve to reinforce this situation.
Other potential funding sources, such as the NDIS and aged care servicing can (and has in some cases) strengthened viability. This may mean practitioners work across multiple service systems – more generalist service provision – which is often encouraged and should be seen as a potential benefit to mental health service delivery capacity rather than a risk to it in many settings.
The perception that private allied health practice is not viable in rural and remote Australia appears to have traction in some quarters and may be used as an argument to promote particular service options, however, the available data (and numerous innovative models) demonstrate private rural practice is conducted by thousands of mental health and other allied health practitioners.
The option of working independently and with a choice of practice is a major incentive to many rural practitioners, and potential service providers: it should be promoted.

**9. Adopting a broad definition of the mental health workforce provides a platform for innovation to ensure all occupations are able to work effectively. How can the Strategy encourage innovation in service delivery models and workforce optimisation approaches?**
As noted earlier, the Strategy could incorporate directly or by reference to a more dynamic (updateable) resource, examples of innovation, collaboration models of workforce development and/or service delivery.
Broader issues of inter-professional working arrangements and scopes of practice are important in mental health care but apply across all health and related service settings and the Strategy could helping recommend or call for a national review of these issues (similar potentially to the Productivity Commissions' Health Workforce Report of 2005 which was closely associated with the last wave substantive national health workforce development agenda.
We note the MH workforce as represented in the diagram on page 3 of the CD is considerably more inclusive than was identified in the Background Paper and welcome the expansion.

**10. Is there anything else you would like to add about the Consultation Draft (1,000 word limit)?**
***"This is an important moment of reform for Australia's mental health system."*** Opening sentence of policy context BP page 8.
Consultation Draft (CD), page 1 - ***Commonwealth, state and territory governments recognise the need for generational reform of Australia's mental health system to support improved mental health outcomes across the community.***
***Successful implementation of the reform agenda will depend on the presence of a broadly defined, appropriately skilled workforce, working collaboratively with consumers and carers and one another across occupations, organisations and service settings.***
BP - page 9: ***The Productivity Commission acknowledges that a well-functioning mental health system depends on high quality workers with the right skills in the right places and recommends that this Strategy aligns the skills, costs, cultural capability, substitutability, availability and location of mental health professionals with the needs of consumers."***

- The draft Strategy is a long-term plan: which is essential in any workforce development effort. Unfortunately, the Australian experience of health and related workforce development has been ad hoc and variable - vigorous and collaborative at times, unconnected and/or absent.
- This situation has high human and resource costs, including for the workforce this Strategy aims to reinforce, build, attract and retain.
- The Strategy needs a substantial degree of bipartisan support, inter- and intragovernmental commitment and engagement of all key sectors. There are many well developed health and other workforce strategies than were developed to address and prevent the challenges identified by this Strategy.

Explicit recommendations and expectations of progress

The draft Strategy provides a coherent framework and specific areas for action. There are areas for potential improvement but it provides the basis for improving the size, capacity and coverage of the Australian mental health workforce to better meet and hopefully avert some future demand.

- Recommendations must remain as explicit, practical, actionable and measureable as possible.
- For example, it is not enough to note, understand or accept the impact of workforce maldistribution, for example: it exists, has an (often heavy) impact, is a shared responsibility with governments having leadership roles, is long-standing and has not been addressed.

Mechanisms to oversight, drive and be accountable for progress

The Strategy has a greater chance of being progressed if there is a clear and probably multi-tiered oversighting governance, implementation and reporting structure, with substantial and widely representative, independent and expert membership. This should include intergovernmental, intragovernmental, multi-sectoral and objective analysis and reporting structures, possibly including the Productivity Commission.

This aspect of the strategy is fundamentally essential to implementation and effective progress.

Page 9 BP Commonwealth Budget commitments: The focus on Budget commitments tends to emphasise outlays or inputs rather than outcomes or impacts and may, without clear and identifiable measures of progress, distract or obscures matters, including the effectiveness of differing approaches and the effectiveness of targeting measures, for example. Of course financing is fundamental, but the level of funding is not a proxy for the effectiveness of the service or the achievement of objectives.

The Strategy might be a more appropriate place to raise, recommend or include to the extent possible, the need for longer-term econometric modelling that identifies and establishes mechanisms for tracking the downstream benefits of well targeted health and associated investments (several of which are identified in the draft papers).

Importantly, similar work provides the basis for key strategy documents, such as the Government's Intergenerational Report, the underpinnings for Government decisions to introduce the NDIS and most major policies and program commitments. Complex matters, such as mental health workforce development and service provision – which can be assumed to be a core community service need going forward – warrants similar consideration. This could inform future iterations of the Strategy and associated investments and demonstrate the equivalent of Return-On-Investment (ROI), which would ordinarily support major workforce development.

Finally – in relation to rural and remote allied (mental) health service capacity at least - the Strategy should refer to and incorporate as appropriate the Recommendations of the previous National Rural Health Commissioner in his *Report for the Minister for Regional Health, Regional Communications and Local Government on the Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* (June 2020).