National Mental Health Workforce Strategy – Beyond Blue Response

Beyond Blue welcomes the opportunity to make a submission in response to the Draft National Mental Health Workforce Strategy. The mental health workforce is a key enabler of a reformed system particularly as the country navigates the widespread impacts of the pandemic. Any progress in creating better mental health care for individuals relies on a qualified and supported workforce across the mental health and suicide prevention systems. The Strategy will play a substantial role in determining how this current and future mental health workforce will be sustained over the next ten years.

Beyond Blue offers the following comments on the draft Strategy:

1. **The Strategy must be based on data and updated frameworks and forecasting of the community's current and future mental health needs.**

Work to expand and support the mental health workforce must be calibrated to current and future demand and be based on rigorous forecasting.

Beyond Blue is concerned that the scale of the workforce challenge ahead is not articulated clearly, and the starting point underpinning the Strategy is out of date. The National Mental Health Service Planning Framework (NMHSPF) is extensively referenced in the background paper to the Strategy, including shortfalls in workforce relative to demand. However, the Productivity Commission noted that a key shortcoming of the NMHSPF is the reliance on pre-existing ways of delivering services. It is not clear if it has been updated for the following significant factors impacting on the size and patterns of demand and consequent workforce needs:

- **The mental health and suicide risk impacts associated with COVID-19 and other disasters**. Usage has increased for a range of mental health services since March 2020[1]. We note the full effects of COVID-19 continue to emerge and there is likely to be a 'long tail' in demand for support in future. However, the workforce as it stands is unable to meet current demand. We must fill the shortfall between supply and demand as quickly as possible while preparing for predicted future uptake. Any coordinated response to bolster the workforce should be innovative and underpinned by the community's needs, informed by those most impacted by COVID-19.
- **Technological advancements**, which have been accelerated during the COVID-19 pandemic and will have significant impacts on models of care. The Productivity Commission's inquiry into mental health report, notes that this Strategy must examine the changes in workforce needs with the addition of technologies (p.708). Increased use of digital interventions will lead to shifts in how the workforce operates, and where the workforce will need to reallocate its skills and occupations. Innovations such as wide-scale telehealth will provide more opportunities for flexibility in service provision and collaboration of multidisciplinary teams. In addition, the Commonwealth has announced it will establish a national digital platform designed to free up demand on higher intensity supports when lower intensity support would be more appropriate; for example, by offering supported online treatment which can reduce the time commitment of health practitioners. All these need to be considered in regards to how we deliver effective services and integrate models of care accordingly.
- **Reform commitments announced by governments**, particularly the Commonwealth and Victorian Governments which will require significant additional workforce. There is significant risk of workforce being 'pulled' from other states into Victoria as it pursues more innovative and community-based models of care which are attractive to the workforce. We further note some initiatives will help to use workforce more efficiently like group therapy sessions under the MBS, announced in the 2021-22 Budget.

[1]AIHW 2021. The first year of COVID-19 in Australia: direct and indirect health effects. Cat. no. PHE 287. Canberra: AIHW.

For the Strategy to be successful in shaping the national mental health workforce of the future, we must get the starting point right. The scale of the challenge must be clearly defined. The forecasts must be up to date to ensure governments and other stakeholders understand the gap to be bridged and design proportionate responses.

We need to listen to the community to guide development and sustainment of the mental health workforce. This requires new and innovative thinking around how to scale up while ensuring we are bolstering services that are relevant, rather than aiming to expand indiscriminately. Incorporating broader economic aspects and community need for workforce planning in a structured way is challenging but ultimately necessary for workforce modelling and mobilisation. It will allow us to consider where and how to best leverage our existing capabilities.

Recommendations:
Recognising that the task of updating the NMHSPF is significant and ongoing, the Strategy should:

- Better recognise the dynamic environment and factors shaping the scale of the challenge – this should be outlined up front to frame the Strategy.
- Commit to updating the NMHSPF (or other framework or forecasting tool) as a matter of urgency now, and commit to ongoing updates which guide reform into the future.

To do this, Beyond Blue recommends expertise should be engaged across the Commonwealth and states. For example, the National Skills Commission (NSC), Treasuries and potentially the Productivity Commission. This would build on expertise acquired by the NSC from inquiring into the Care Workforce (due 30 September 2021) and the Productivity Commission through its Inquiry into Mental Health. It would help to ensure that data and forecasts for the mental health workforce are cognisant of related workforce demands in the disability, aged care and other related sectors.

The workforce data strategy (Priority Area 2.1) must also be agreed and implemented with urgency. Failure to do so risks not meeting the workforce needs of a reformed system. The Strategy acknowledges there is a lack of comprehensive mental health data which impedes workforce planning. This is needed particularly for occupations that are not regulated by the Australian Health Practitioner Regulation Agency (Ahpra) and for the community managed sector where nationally consistent data about the workforce size, education levels, and composition are not available.

2. The Strategy must be part of system reform and create a platform for change.

The Strategy must be connected to the system reform currently being implemented. It risks being fragmented if jurisdictions develop their own plans without linking it to national efforts. Beyond Blue recommends that the Strategy form part of the new National Mental Health and Suicide Prevention Agreement. Ideally it would become a schedule, linked to an agreed national outcome on workforce and associated priority actions to be delivered over rolling periods. To support this, the Strategy could be greatly enhanced with the inclusion of tangible actions that will be taken as part of the priorities.

3. Bridging the immediate gap in workforce requires new policy approaches and innovation.

There is a significant immediate gap in workforce relative to community need, and innovative responses are required to ensure this is filled pending the training and education of the clinical workforce, which takes many years. The Strategy should therefore identify immediate, innovative responses, rather than identifying potential actions for further consideration and work.

Examples of immediate potential actions include:

- Supporting the scale up of low intensity support offerings, like NewAccess, to immediately attract and mobilise additional workforce. The Productivity Commission found that up to 500,000 Australians could benefit from accessing lower intensity support than they currently access (e.g., through the costlier MBS Better Access, which also contributes to long wait times for those that

need support from a clinician). Training clinical service providers such as psychologists and psychiatrists takes time, and the costs involved are too high to generate sufficient numbers at a fast enough rate. This is in contrast to the NewAccess coach workforce, which is specifically trained to deliver low intensity interventions (with seven weeks of intensive training prior to engaging clients, then ongoing training and supervision over 12 months). The Strategy does not sufficiently explore alternatives to provide mental health services by non-clinical professions that are trained to implement clinically proven outcomes, and could better include these. The current PHN-by-PHN model of commissioning low intensity services is impacting the speed of rollout and limits efficiencies of scale in delivery. This is an example of how policy and funding settings could be changed to support a more diverse and more immediately accessible workforce to meet the needs of the community who are struggling with their mental health to get back on track, rather than deteriorate until clinical or crisis workforce is required.

- Considering innovative ways to surge the workforce immediately. For example, during the initial COVID-19 outbreak in 2020 Ahpra established a pandemic response sub-register to enable non-practising and retired health practitioners to return rapidly to the workforce and assist the health response. Given the very long wait times to access clinicians, measures such as this should be considered.
- Leveraging employment programs (such as Job Active) to raise awareness and facilitate pathways into mental health careers, particularly for Australians searching for work who could fulfill peer workforce and low intensity roles. The National Careers Institute should also be harnessed to emphasise the significant and growing opportunities in mental health.
- Advocating for greater policy changes. The priority action to develop training modules to support provision of integrated and multidisciplinary care (Priority Area 4.1) needs to be complemented with policy change – current fee for service funding arrangements through the MBS inhibit this.

4. The Strategy must align with workforce activities and reforms in other sectors

Mental health and suicide prevention reform call for a cross-sectoral approach. The Strategy does a good job of outlining related workforce work and strategies. However, it does not make clear how they interrelate with the Strategy or how alignment will be achieved. The relationship between these should be clarified. Other relevant strategies and work underway includes the Care Workforce study by the National Skills Commission (due to Government by 30 September); the parliamentary inquiry into the provision of general practitioner and related primary health services to outer metropolitan, rural and regional Australians; the National Children's Mental Health and Wellbeing Strategy; and the 10-year Primary Care Strategy and National Preventive Health Strategy.

There is also a limited flexibility for cross-sector movement in the broader care workforce, which means it can be harder to fill gaps when there are substantial shifts in the workforce. Significant competition across sectors in attracting workforce (particularly the non-clinical workforce such as coaches and the peer and lived experience workforce) and how state-wide developments impact the national workforce should also be acknowledged and addressed. A more responsive workforce is needed to allow for scaling and surge across sectors when necessary.

Some examples of opportunities for alignment and collaboration are below:

- The Strategy should utilise findings from the National Skills Commission's Care Workforce Labour Market Study where possible to identify opportunities for attraction and retention of the current workforce and incorporate these as specific actions to undertake. The upcoming Care Workforce Strategy should be consulted, and its strategies considered to see how they may impact on the mental health workforce.
- There should be incentives for the workforce in the form of qualifications that are portable across jobs and sectors where there is relevant overlap. Establishing a set of core competencies in 'job families' allow flexibility for the workforce to move between similar roles and enable career progression. Examples to incentivise through qualifications include creating a 'skills passport' or establishing 'micro-credentials' such as in the NDIS National Workforce Plan. A consistency in qualifications mean there

can be an easy shift for people moving between similar sectors (such as aged care or disability), which allow for further flexibility, and progression, in career opportunities.

5. The Strategy must include the suicide prevention workforce or ensure it aligns with any suicide prevention workforce planning.

Beyond Blue supports a joined-up approach to developing and growing the mental health and suicide prevention workforces, recognising they each rely on clinical and non-clinical workforces. As the Strategy itself says, these workforces overlap at the individual and occupational level; a nurse may need to provide support to someone experiencing suicidal distress in a mental health setting or a school, and would require training regardless of setting. With limited direct reference made to the suicide prevention workforce, it is unclear if they are included in the Strategy, or how there is alignment with suicide prevention workforce planning. While a single Strategy is preferred by Beyond Blue, if separate work is undertaken, the two must be complementary to reduce unnecessary complexity or fragmented workforce initiatives.

6. Supporting a multidisciplinary workforce that includes mental health promotion and prevention of mental illness.

The Strategy identifies the workforce as consisting of various clinical and non-clinical professions for mental health support and treatment. However, addressing mental ill-health needs to include the prevention of mental health conditions, the provision of psychosocial supports, and the promotion of wellbeing in the community as key pillars of how our mental health system operates, and what the future of the workforce looks like.

- There should be greater emphasis of the **critical role of prevention in the mental health workforce**. The National Preventive Health Strategy identifies the link between mental health outcomes and preventive strategies, noting the need to focus on protective factors for positive mental health and wellbeing. This Strategy should embed the core principle of prevention in the aim, and reference that the mental health workforce will be composed of those who do preventative work, not just those delivering treatment.
- Similarly, the importance of **preventative efforts needs to be embedded in the work done by all those in the mental health workforce**, as well as those working in other settings (e.g. those providing health and social services at a preventative level, school staff). Education and training around mental health promotion and prevention should be provided for the mix of clinical and non-clinical professions that make up the workforce and embedded in qualifications. These should also be implemented for non-clinical professions that work outside the mental health sector; for example, Be You provides professional learning that supports educators to promote wellbeing and better recognize and respond to children and young people with mental health issues.

7. Recognising the value of a lived experience peer workforce and its input alongside community and clinical professionals is critical.

As identified in the Strategy, the **role of the peer workforce in the mental health system cannot be understated**, and it is vital that the peer workforce can develop skills and capabilities, as well as defined career paths within the sector. The workplace adjustment framework presented in the Strategy as a possible implementation example (Priority Area 5.4) should be applicable across a variety of different roles, to allow for more opportunities in different workplaces and career progression. Further guidance may be provided with the release of the NMHC's Peer Workforce Development Guidelines, which can be used as a tool to inform the progression of the peer workforce specifically.

- People with lived experience of mental ill-health and suicide must be involved when developing implementation plans for the Strategy. The Strategy should identify ways to commence this process of collaborative planning and embed input.

- A peer workforce peak body is critical to advocate for the peer workforce. Seed funding should be provided to establish this peak body for peer workers and allow for training and networking opportunities.

8. **Looking after the mental health of the mental health workforce.**

Although the 'staff retention' pillar outlines the necessity for supervision, staff wellbeing goes beyond this, especially when taking the diversity of the workforce and the various challenges faced by different professions into consideration. Strategies aimed at increasing and maintaining staff wellbeing need to be explicitly included to combat rates of burnout, absenteeism and decreased health - all of which are likely to be challenged by the pressures associated with COVID-19.

- The promotion of staff wellbeing in the workplace should be a priority. The Strategy should incorporate the pillars of the National Workplace Initiative as starting points for workplaces to align with a nationally consistent approach.

- Adjustments for the workforce should be embedded into workplace practice. Support and retention are especially relevant when identifying a need to grow the lived experience peer workforce. With lower levels of entry-level skills training, the identification of barriers in completion and subsequent adjustments that can be made for completing training and workforce maintenance should be prioritised, to better understand what provisions may be needed.

- The stigma and discrimination associated with mental illness can be a significant barrier to participating in employment, extending beyond simply attracting people to the workplace. Reducing stigma and discrimination in the workforce contributes to the quality of workplace conditions as well as the service provided to people engaging with the workforce. As well as addressing stigma for those outside of the workforce, there should be a focus on how stigma is addressed internally, especially when considering the inclusion of a preventative lens on mental health.

Other comments

- While the Background notes the need for holistic, person-centred and trauma informed care, there is limited reference to this in the body of the Strategy, and how these principles of care will be implemented. This should also not be restricted to a single population (e.g. Aboriginal and Torres Strait Islander mental health workers), but embedded across how all of the mental health workforce operate.