leading community mental wellbeing

Queensland Alliance for Mental Health

National Mental Health Workforce Strategy

Submission

September 2021

Queensland Alliance for Mental Health

Queensland Alliance for Mental Health (QAMH) is the peak body representing the Community Mental Wellbeing Sector in Queensland.

QAMH advocates and supports member organisations to foster better outcomes for people experiencing mental health issues. It is committed to promoting the unique value the Community Mental Wellbeing Sector offers to the health care continuum within Queensland.

QAMH is proud to work with its members and key partners, to influence system reform and enhance the contribution that the Community Mental Wellbeing Sector plays in people's lives.

A note on language

QAMH intentionally refers to the community managed mental health sector as the Community Mental Wellbeing Sector to emphasise the unique contribution and preferred future direction of the sector as outlined in our Wellbeing First Report. This includes non-government, not-for-profit community-based mental health organisations that provide psychosocial supports and access to natural supports in the community.

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Background

The Community Mental Wellbeing Sector forms a crucial part of the mental health service system in Queensland and across Australia. In Queensland, the community mental wellbeing workforce experiences a significant number of challenges, from inadequate funding to recruitment and retention. QAMH recognises these issues are not unique to Queensland, nor are they new. Integration within and across systems is crucial, and it is important for the Community Mental Wellbeing Sectors role to be recognised and embraced in the context of the broader mental health service system to be most effective in meeting the needs of the community.

QAMH welcomes the development of the National Mental Health Workforce Strategy (draft Strategy) and appreciates the opportunity to provide a response. Our response to this public consultation has been informed by our members and our extensive knowledge of the Community Mental Wellbeing Sector in Queensland.

We have addressed the consultation questions below.

Our response

Consultation Question

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

Whilst QAMH don't disagree with the aim of the draft Strategy, 'to develop an appropriately skilled mental health workforce of sufficient size, that is suitably deployed to help Australians be mentally well by meeting their support and treatment requirements at the time and in the way that best suits their need', we believe the details of the proposed Strategy do not reflect the need for generational reform that the Commonwealth, state and territory governments have committed to. The draft Strategy indicates that we need new thinking and innovation to create a person-centred system that takes a holistic view of being mentally well.

Our view is that if we are aiming for fundamental change that works to support people to stay well early in the trajectory of distress, rather than the current approach of responding to illness and crisis, that this may require some different philosophies and skills sets. This might mean that we need to support skillsets that work with people through a coaching lens helping them build on their natural

supports and community resources, without first requiring them to present through a medical pathway. Much of the draft Strategy presented looks to build more of the same clinical skills that have built the current system through an illness lens, rather than supporting a new generation of workers who can support wellbeing work in the early intervention space. Whilst we note that peer workers and psychosocial support workers are included in some of the sections, the strategies largely use mechanisms that build a medical/clinical workforce (e.g., pre and post graduate placements, supervision etc).

QAMH is the peak body for the not-for-profit Community Mental Wellbeing Sector who have traditionally delivered psychosocial supports within the community. Many of these organisations have grown and developed a skilled workforce based on coaching techniques and models which support people to live well in their communities. They do this with limited funding and to this day there is a lack of robust data that describes the training and development of the workforce, although evidence is building on the effectiveness of this approach.

QAMH recognises many of the challenges identified in the Background Paper align with the key challenges identified by our member organisations in a recent review we conducted of the workforce issues facing our sector in QLD. This includes recruitment particularly in regional areas, workforce retention, skill developments and attractiveness and awareness of careers in mental health. Priority area one does not include the community mental wellbeing workforce as a priority for carving pathways and attractiveness into the sector, and this needs to be included to attract people to all parts of the service system.

Consultation Question

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

The aim and objectives of the draft Strategy acknowledges 'Supporting Australians to be mentally well is no longer restricted to supporting suicidality, mental distress and/or mental ill-health, but encompasses prevention and early intervention to promote mental wellbeing and assist people at risk' (p.4). As indicated in our first response, QAMH strongly supports this change in focus and believes the community mental wellbeing workforce is well positioned to provide both practical and early intervention approaches tailored to meet local community needs and actively support wellbeing. However, the draft Strategy fails to recognise that to achieve this, the mental health workforce first

requires a fundamental shift in philosophy across the mental health ecosystem (clinical, non-clinical, public and private services) and at all levels of government. That is to shift from primarily managing illness to actively supporting wellbeing.

We are pleased to see that the psychosocial and peer workforces are included in the first iteration of a National Mental Health Data Strategy. However, it is noted that there is currently no data source available for a number of the community-based workforces including the psychosocial and peer workforces. This needs to be made a priority with specific strategies and resources identified to rectify this lack of data. Only when this is done will we be able to fully utilise the right skills at the right time across the mental health service system. Only when we can clearly articulate the full scope of practice for the Community Mental Wellbeing Sector can we then build strong career pathways to sustain and build a contemporary workforce for the future.

The aim and objectives of the draft Strategy recognises the need for cross-sector collaboration and system-wide co-operation. QAMH strongly supports this, and from a community mental wellbeing workforce perspective, acknowledges that a range of responses will always be required to meet community needs. However, QAMH feels the aim and objectives are skewed towards building the clinical mental health workforce. To address this, it is important to recognise the historical misconception that the Community Mental Wellbeing Sector can provide psychosocial support only under the guidance of clinical services. As outlined in QAMH's Wellbeing First Report[1], 'this has led to an artificial tension between clinical and non-clinical settings' which 'keeps the wellbeing sector firmly in the realm of managing illness rather than supporting mental wellbeing.'

Addressing these challenges must be a priority if we are to truly develop a mental health workforce that the Australian community needs which recognises the full potential and scope of practice of the Community Mental Wellbeing Sector.

[1] Queensland Alliance for Mental Health. (2021). *Wellbeing First Report.* https://www.qamh.org.au/wp-content/uploads/Wellbeing-First-Report-DIGITAL.pdf

Consultation Question

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

QAMH supports the priority areas included in the draft Strategy and feels, overall, reflect the key challenges identified in both the Background Paper and the recommended actions outlined in our Community Mental Health Workforce Project[2].

However, QAMH believes it is important to raise the priority for the psychosocial workforce numbers and skills (priority areas under Objective 1 – *Careers in mental health are, and are recognised as, attractive* and Objective 4 - *the mental health workforce is appropriately skilled*). In our Community Mental Health Workforce Project[2], we found a key challenge is access to training including availability of relevant training, associated financial costs and backfilling staff shifts. It is crucial the Strategy supports funding that reflects the *true* cost of staff professional development in the community mental wellbeing workforce (see our response to Question 6 for more details).

The Community Mental Health Workforce Project[2] also identified a shortage of qualified and experienced candidates applying for jobs, and managers experienced challenges in recruiting and retaining qualified staff with relevant experienced. This was particularly challenging in regional and rural areas due to smaller candidate pool and professional isolation and when recruiting for specialist positions such as those supporting people from CALD, Aboriginal and Torres Strait Islander or LGBTIQ+ peoples. According to Community Mental Health Australia[3], the effectiveness of the workforce relies on the number, skills, cultural capability, and availability of workers and how these match the needs of the clients, both geographically and professionally. It is crucial that the significant challenges experienced by the psychosocial workforce is not overshadowed by other priority areas in the Strategy.

This could be strengthened through action *1.3.1 (create positive perceptions of working in mental health by improving the pre-service or post graduate placement experience of trainees),* by including psychosocial support worker graduate placements, including from TAFE. This should include all settings, with a specific focus on rural and remote areas. Similarly, action 4.1.2 *(support education and*

[2] Queensland Alliance for Mental Health. (2021). *Community Mental Health Workforce Project.* https://www.qamh.org.au/wp-content/uploads/Community-Mental-Health-Workforce-Report.pdf
[3] Community Mental Health Australia. (2015). *Developing the workforce*. https://cmha.org.au/wp-content/uploads/2017/04/ndis_workforce_report.pdf

training providers and service providers to improve the quality and quantity of mental health placements), should include support for psychosocial work placements.

QAMH believes it is critical to emphasise the importance for the entire mental health workforce to be utilised, including the community mental wellbeing workforce. QAMH's Wellbeing First Report[1] states that 'although some providers run multimillion dollar national organisations, the sector is made up of many small and large organisations that have often grown around a unique offering in a particular region. This evolution has resulted in inconsistent expectations of what the sector and its workforce can deliver. As such, the specialisation and unique contribution of the Community Mental Wellbeing Sector to individuals, communities and the wider mental health ecosystem is not well articulated and undoubtedly underutilised.' The Productivity Commission has also acknowledged the difficulty in encapsulating the role of a community mental wellbeing worker.[4] Data is limited regarding the size and composition of the community mental wellbeing workforce on both a national and state level, and scope of practice is not well understood.

Consultation Question

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?

While QAMH supports the draft Strategy's alignment with existing national strategies and reform agendas to promote consistency while avoiding duplication, it is also important to recognise and support localised approaches. It is particularly important to create local solutions to workforce shortages and have strategies for communities to develop a workforce that can respond to the specific needs of that community. The issues and solutions for regional and remote parts of Queensland might be significantly different to those of metropolitan areas.

[4] Productivity Commission. (2020). *Mental health [Productivity Commission Inquiry Report No. 95]*. https://www.pc.gov.au/inquiries/completed/mental-health/report

Consultation Question

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 location. To what extent does the draft Strategy provide a useful approach to addressing issues that impact on the attractiveness of the sector?

From the community mental wellbeing workforce perspective, QAMH believes the Strategy could provide a useful approach for addressing issues that impact on the attractiveness of the sector if it is inclusive of all parts of the service system, clinical and non-clinical. This is a key issue and aligns with the key findings and proposed solutions identified in our Community Mental Health Workforce Project.[2] This includes:

- Challenging stigma and focus on values alignment in promotional activities, and
- Promotion of the sector as a career of choice: identify opportunities to promote the Community Mental Wellbeing Sector to secondary school students, undergraduates, and the existing workforce, as an attractive career of choice.

Further detail is provided in our response to question 6.

Consultation Question

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?

QAMH recognises retention of existing highly qualified and experienced mental health workers as a key challenge across the community mental wellbeing workforce. The key actions to improve retention reflect the key recommendations made in QAMH's Community Mental Health Workforce Report[2], which include:

- Challenge stigma and focus on values alignment in promotional activities. This aligns with *priority area 1.3 – Address the stigma and negative perceptions associated with working in mental health*.

- Explore innovative recruitment and retention approaches further – consider remote supervision, joint appointments, collaborative recruitment, and training. This aligns with *priority area 5.2 – Increase access to appropriate supervision for all mental health workers*.
    - QAMH note that action 5.2.1 – *specify supervision and support requirements for those in the mental health workforce* does not include psychosocial support workers for either immediate or further action. We found practical training and supervision to be a key challenge identified by frontline workers in our Community Mental Health Workforce Project[2]. We strongly recommend both psychosocial support workers and lived experience (peer workers) are reflected in this action.

Furthermore, the Community Mental Wellbeing Sector suffers from limited and short funding cycles, creating barriers to attracting, retaining and developing a skilled workforce. We applaud priority areas such as *5.1: Promote funding reform to provide more secure employment arrangements*, to address this major challenge, however, it must recognise the *true* cost to not for profit organisations of developing and maintaining a skilled workforce in the Community Mental Wellbeing Sector, as well as addressing the value of the work through appropriate remuneration.

Consultation Question

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?

QAMH strongly supports the acknowledgement that there is a need for improving integration of care and supporting multidisciplinary approaches. Our response to this consultation question is reflected in more detail in question 2 and 3.

Consultation Questions

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?

See response to consultation questions 5 and 6.

Consultation Question

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?

QAMH recently completed a project[5] to identify changes to the mental health service system that occurred during the pandemic and understand peoples' experiences of these. We found an enabler to care during the pandemic was the flexibility in funding models, including grants, and existing contracts, which enabled service changes and innovations to meet individual needs during lockdown, giving people more choice and control. To encourage and support innovation in service delivery models, the Strategy should advocate for flexible funding models.

Consultation Question

10. Is there anything else you would like to add about the Consultation draft?

Telehealth

Priority Area **6.2** – *Increase the availability and appropriate utilisation of telehealth* – on page 34 (which should be listed as priority area **6.3, not 6.2**) is also relevant to the Community Mental Wellbeing Sector, yet the relevant action (action 6.3.1) only recognises the clinical workforce as the 'key occupations impacted.' The relevance of telehealth, and the importance of digital literacy across the mental health workforce has been put into the spotlight throughout the pandemic. This is demonstrated through QAMH's recent project[5] outlining the changes to the mental health service system that occurred during the pandemic, where one recommendation is to 'Integrate telehealth into the mental health service system with consideration of the following:

- The flexible integration of telehealth into funding contracts and performance reporting to enable choice for people who access mental health services, and those who support them.
- Ensure best-practice standards (including privacy and confidentiality), and support for service providers (such as guides and training programs)'

[5] Queensland Alliance for Mental Health. (2021). *Mental Health Service System Changes: Experiences of COVID-19 Project.* https://www.qamh.org.au/wp-content/uploads/Project-ID-77034_Final-Report.pdf

This is very similar to action 6.3.1 which states 'Increase the availability and appropriate utilisation of telehealth through creation of clear practice guidelines. This should encompass safety and quality parameters for both service users and providers, including supervisory arrangements and investment in the infrastructure.' We strongly recommend that the community mental wellbeing workforce is reflected in this action.

Additional comments

- QAMH have identified a number of actions in the draft Strategy that simply restate the related priority area for action. For example, priority areas for action 3.2 states: 'Identify components of care that meet the needs of consumers and carers and the competencies required to deliver them.' While related actions simply state: '3.1.1 Identify components of care that meet the needs of consumers and carers' and '3.1.2 Define the competencies required by the mental health workforce to deliver the components of care.' This also occurs for priority area for action 1.2 and action 1.2.1.
- Action 4.3.1 states 'explore opportunities to prioritise access to training for the mental health workforce through increased subsidies and the use of traineeships.' However, QAMH feels 'explore' is too vague and does not identify *how* this will be achieved.