NATIONAL MENTAL HEALTH WORKFORCE STRATEGY CONSULTATION DRAFT

ORYGEN SUBMISSION

ORYGEN

Orygen is the world's leading research and knowledge translation organisation focusing on mental ill-health in young people. At Orygen, our leadership and staff work to deliver cutting-edge research, policy development, innovative clinical services, and evidence-based training and education to ensure that there is continuous improvement in the treatments and care provided to young people experiencing mental ill-health.

Orygen conducts clinical research, runs clinical services, supports the professional development of the youth mental health workforce and provides policy advice relating to young people's mental health. Our current research strengths include: early psychosis, mood disorders, personality disorders, functional recovery, suicide prevention, online interventions, neurobiology, and health economics.

Orygen welcomes the opportunity to review the Consultation Draft Strategy and contribute to the final Strategy. Development of the youth mental health workforce component is critical due to the opportunity for early intervention and the scale of need in terms of numbers of people, as well as severity of illness. The National Mental Health Workforce Strategy background paper recognised that the majority of mental ill-health is onset before the age of 25 years. This early stage, when the majority of symtoms emerge needs to be a primary focus of the priorities, objectives and actions in the workforce strategy, over the short, medium and long term. The importance of responding to mental health early has benefits for young people, their families and community, the future health budget and wider economy, and the mental health workforce.

2. TO WHAT EXTENT DO THE AIM AND OBJECTIVES PROVIDE A STRATEGIC FRAMEWORK TO DEVELOP THE MENTAL HEALTH WORKFORCE THE AUSTRALIAN COMMUNITY NEEDS?

The objectives in the Consultation Draft Strategy (the Strategy), and the underlying priority areas and actions, address a number of persistent workforce issues. Within the six objectives, there is a need for further priority areas and additional action items to address gaps in the current Strategy.

The inclusion of the lived experience workforce, including peer workers recognises the important and increasing role for this trained workforce alongside other mental health professionals. A lack of definitional consistency for the lived experience workforce within the Strategy and the sector needs to be addressed. Peer workers are one component of the lived experience workforce. The training requirements, organisational structures and professional recognition for this workforce are still developing.

The Strategy does not adequately address the development needs of the lived experience workforce. Consideration of the support required for lived experience workforce development needs to be considered in each priority area and developed in consultation with the workforce. This is particulary pertinent for young people. For example, the cost for undertaking a Certificate IV in Mental Health Peer Work can be in excess of $10,000. This cost will be beyond the means of most young people. The Strategy needs to incorporate targeted assistance to support participation in training and education to support workforce development where it is required. The Victorian government has made

this qualification free in reposnse to recommendation 6 from the Royal Commission into Victoria's Mental Health System.

The Strategy sidesteps the requirement for an integrated implementation plan as part of such a strategy document. By ignoring implementation as a consideration, the practicalities and feasibility of the proposed priority areas and actions do not recognise what will be required nor potential barriers for implementation. Previous workforce strategies have identified what needs to be done, this part is agreed; what is needed is the how to do it and a commitment to the scale of resourcing required. Similarly, the absence of leadership in the Strategy as firstly, an enabler of workforce development (including implementation), and secondly, as a component of career attractiveness and retention, is a barrier to both implementation of the Strategy and its longevity.

IMPLEMENTATION

The Strategy indicates that development of an implementation plan is separate to the Strategy. The subsequent implementation plan is to be a collaborative process to address the objectives of the Strategy. The implementation plan will include timelines, governance arrangements and monitoring and evaluation requirements.

The disjoint between workforce strategies and implementation plans have been a primary factor in the failure of previous workforce strategies. Considering that implementation (as well as resourcing requirements) has been placed outside the scope of this Strategy, it is, unfortunately, likely to face a similar fate. There remains, however, an opportunity for the Strategy to expand on an indicative implementation timeframe identified in some actions.

Including a time horizon for all actions in the final Strategy would provide direction for the development of an implementation plan. This direction would provide a starting point for implementation and a foundation for successful reform. A three-stage time horizon for implementing the actions would identify priority, the scale of the task and an order of staged development.

ACIL Allen has the opportunity to advance workforce reform through providing a time horizon for implementation and transfer momentum into the next stage. Without this minimum structural basis, the Strategy risks repeating the same mistakes of past mental health workforce strategy documents.

Service demand

The actions in the Strategy and in this submission cannot be implemented separately from consideration of the impact of service demand. Unmet service demand and workforce shortages are intersecting policy challenges. The pressures of meeting service demand placed on mental health professionals and support staff by management and themselves contribute to burnout and compound workforce challenges.

Leadership

Leadership will be integral to implementation of the National Mental Health Workforce Strategy. Leadership will be required to coordinate objectives across the mental health sector (and intersecting sectors); identify and address priority areas within health regions and services; and deliver actions. In addition to enlisting existing leadership in the aims of the Strategy, new leadership opportunities will emerge and future leadership will need to be fostered.

Many of the actions identified in the Strategy and among those suggested in this submission will require organisational change. Changes to organisational structures, practices and culture require leadership. Failure to identify the role of leadership inherent in the priority areas and related actions will be a barrier to implementation and will not support achievement of the Strategy's aims.

CAREERS IN MENTAL HEALTH ARE, AND ARE RECOGNISED AS, ATTRACTIVE

1.2 Increase the awareness of pathways into and within mental health

Increased awareness of mental health career opportunities will broaden the perspectives and horizons of students, graduates and professionals.

Actions:

- Include youth mental health modules as core subjects in medical and psychology courses. Involve practicing professionals in teaching to promote careers in youth mental health.
- Integrate applied learning in public mental health services for private practitioner CPD (and vice versa) to facilitate skill-sharing and mixed practice career pathways.
- Broaden exposure in high school through a health and wellbeing subject that covers the breadth of the mental health workforce and resourcing supported work experience positions.
- Public campaign promoting the value and satisfaction of working in the mental health sector and participation opportunities for a diverse population.
- Fund places for First Nations, culturally diverse communities and regional students in allied health courses.

DATA UNDERPINS WORKFORCE PLANNING

2.1 Develop and implement a data strategy to improve the reliability and comprehensiveness of mental health workforce data

Improved data collection is required to better understand the pipeline from education into employment to inform curricula design and incentives to increase enrolment rates to match workforce shortages.

Actions:

- Collect data on student enrolments and completion in mental health courses; the service context of practical placements; and graduate employment role and service.
- Collect data on private practice (including mix with public practice) to better understand levels of dual practice and career trajectories across public and private practice.
- Data collection must measure function or roles and discipline to better understand how workforce resources are allocated.

2.2 Enhance mental health workforce data system and planning models through the use of more reliable data

The value of workforce datasets to inform workforce development will be enhanced by understanding the alignment of (1) applied skills, (2) treatment need and (3) service context.

Actions:

- Adopt clear definitions of workforce roles (e.g. social and emotional wellbeing, mental health) and collect data on: the type of service provided; the level of intervention; and professional qualification.

- Structure data collection on the primary intervention provided and the level of mental illness most often treated (service context will inform this). Structure data collection to enable analysis of the alignment of interventions to treatment need.

THE ENTIRE MENTAL HEALTH WORKFORCE IS UTILISED

3.1 Identify components of care that meet the needs of consumers and carers and the competencies required to deliver them

The definition of competencies needs to be determined by evidence-based practice and reflect differences in the treatment and service needs of different demographics (i.e. young people 12 to 25 years of age). Definitions need to stipulate core and role-specific competencies.

Actions:

- Expand youth mental health platform for providing specific competencies:
  - Requiried youth mental health capacities are known
    - developmental trajectory, respond to preferences and needs (especially for 12-15 years)
  - Detailed youth mental health competencies have been developed (e.g. early psychosis)
  - Specific youth mental health platforms are required for building workforce capacity.

3.2 Define nationally consistent scopes of practice for the mental health workforce

Young people require developmentally appropriate treatments delivered in service settings acceptable to young people and delivered in a format that enables participation. Age and development trajectory will inform treatment and practice responses.

Actions:

- Nationally coordinate evidence-based, best practice guidelines for youth mental health. Incorporate guidelines into education, training and continuing professional development curricula.

3.3 Develop roles that utilise worker's full scopes of practice

'Full scope of practice' should include working with colleagues across professions, including service support staff in order to maximise the potential of multidisciplinary practice. Existing practices requires that working with the lived experience workforce needs to the explicitly identified as being within a professional's full scope of practice.

3.4 Ensure regulatory arrangements align with scopes of practice to support safe, high-quality practice

Regulatory arrangements need to recognise the value of practice experience and support safe, supported environments for graduate and early-career professionals to sustain workforce growth.

Actions:

- Practice experience and further training and education should be aligned with the stage of mental illness a health professional is employed to deliver.
- Graduates and early-career professionals are supported and supervised to develop practical experience as part of a progressive career pathway.

THE MENTAL HEALTH WORKFORCE IS APPROPRIATELY SKILLED

4.1 Strengthen the skills of the existing and future mental health workforce

Skill development is an investment in the mental health workforce. Skills are transferable and support maintenance of a national standard of care. National organisations with specific expertise and knowledge have a role to play in implementing and maintaining training in a national standard of care.

Action 4.1.4 illustrates the issue of role definition for the lived experience workforce within the Strategy and the sector. This action needs to more clearly identify whether it is the lived experience workforce being developed or the capacity of professional colleagues to work with them. Peer workers are one component of the lived experience workforce.

Confidence and competency are components of skilled practice and need to be realistically fostered and measured through training, practice and supervision.

Actions:

- The standard for practice skills and interventions should be evidence-based.
- Education and training is competency-based[1] and congruent with existing experience to support relevancy and engagement.
- Develop national models of training in youth-specific mental health treatment.
- Consult the lived experience workforce in developing training and professional development needs.
- Provide mental health bonded scholarships (or waiver of HECS fees) for allied health undergraduate courses to build workforce capacity (3-year service requirement).
- Participation in professional development be built into professional accreditation and licence renewal.

4.3 Support students from priority cohorts to complete mental health-related qualifications that reflect their communities' needs

Actions:

- Develop bridging modules for micro-credentialing for health workers from migrant communities.
- Fund places for First Nations, culturally diverse communities and regional students in allied health courses (Action 1.2).

4.4 Support access to continuing professional learning and professional development to ensure existing workers develop contemporary skills

Expanding and reinforcing the provision of best practice, evidence-based interventions and support is reliant on workforce training and professional development. Supporting participation in training and professional development is also an opportunity to incentivise practice to fill workforce gaps.

Actions:

- Develop national models of training and professional development, including youth-specific training.
- Provide secondments for middle-career mental health professionals to work in youth mental health.
- Provide mental health bonded scholarships (or waiver of HELP fees) for allied health graduate training to build an enhanced workforce capacity (1-year service requirement).
- Provide continued coaching and supervision following training to provide a supported environment for practicing new skills.

[1] Competency, rather than time spent learning is a better measure of confidence with new skills and knowledge before completion.

THE MENTAL HEALTH WORKFORCE IS RETAINED IN THE SECTOR

5.1 Promote funding reform to provide more secure employment arrangements

Secure employment arrangements are integral to workforce retention and the attractiveness of mental health careers (Objective 1).

Actions:

- National Partnership Agreements provide a framework for funding reform and commitment to medium-term investments to fund workforce development.
- Remove the Mental Health Nurses Incentives Program from the flexible funding pool of PHNs and quarantine this funding specifically for use on this initiative.
- MBS item for mental health nurses to deliver low-intensity mental health interventions and other interventions if credentialed in primary care.
- Incentivise employment to fill workforce gaps (location, illness stage) at a range of experience levels.

5.2 Increase access to appropriate supervision for all mental health workers / 5.3 Improve workplace health, safety and wellbeing

Providing supervision opportunities for early-career professionals and accountability measures for participation by mid- and late-career professionals underpins workplace health, safety and wellbeing. Role-modelling at all levels of practice and leadership is required to support participation and prioritise resourcing for supervision. Reflective practice supports individuals and team cohesion, helping to build confidence, capacity and strengths. Reflective practice should be embedded into mental health services.

Actions:

- Manage stressful work contexts, recognising that it is a factor of practice rather than a problem to fix.
- Fund a designated position(s) in every mental health service responsible for coordinating supervision and workplace health, safety and wellbeing.
- Lived experience workforce have the option of consumer perspective supervision in addition to in-service supervision.

5.4 Improve career paths within the mental health sector

Career pathways need to provide multiple streams for progress across practice, leadership, management and training. The singling out of the lived experience workforce in the possible implementation activity for priority area 5.4 reinforces division and would undermine the workforce integration.

Actions:

- Fund a designated position in every mental health service responsible for coordinating professional, skill and career development.
- Career pathways are transparent and recognise the value of experience in providing supervision, mentoring and training, balanced with continuing practice.
- Responsibility and autonomy in work planning and decision making be built into career pathways that reflect experience and competency.
- Opportunities to develop specialisation and leadership/mentor roles reflecting skill acquisition while remaining in practicing roles.

6.2 Enhance the use of integrated and flexible workforce models that reflect community strengths and needs, incorporating consumer and carer voice

Clarity is needed in the intended purpose of incorporating consumer and carer voices. Is this feedback from consumers about their care, or consumer and carer involvement in service design and delivery? Both are important and need to be recognised as distinct.

3. ARE THERE ANY ADDITIONAL PRIORITY AREAS THAT SHOULD BE INCLUDED?

While additional actions have been identified across the Strategy, Orygen have primarily identified additional priority areas for objectives four and five.

Career opportunities, pathways to qualified roles, and importance for professional recognition and supervision for people with lived experience need to be incorporated into the Strategy.

The priority areas that need to be considered for inclusion are:

1.4 The mental health workforce needs to be valued
4.5 Ensuring the delivery of appropriate and optimal interventions
4.6 Educating the future mental health workforce
4.7 Providing specific training in youth mental health
5.5 Return to practise programs
5.6 Facilitating mixed practice.

CAREERS IN MENTAL HEALTH ARE, AND ARE RECOGNISED AS, ATTRACTIVE

1.4 The mental health workforce needs to be valued

Attractive careers in the mental health sector will be underpinned by a valuing of the workforce. A driving motivation for many people who embark on careers in the mental health sector is a vocational call to care for people, which reflects an inherent valuing of people and their wellbeing. A visible and practical valuing of the workforce will help sustain this motivation.

An experience of being valued is more than remuneration – although that is a component. It also includes workplace culture, opportunities for leadership, investment in the working environment and support resources, and employment security.

Actions:

- Minimum three year contracts for the mental health workforce (and, therefore, a minimum term for commissioning and program funding).
- Workload expectations are set by realistic, healthy professional practice, with organisational structures to address the pressure of unmet service demand. Service delivery KPIs in service contracts reflect this action.
- Review existing built environments and implement a five-year renewal program.

THE MENTAL HEALTH WORKFORCE IS APPROPRIATELY SKILLED

4.5 Ensuring the delivery of appropriate and optimal interventions

Delivery of appropriate, optimal and evidence-based interventions is critical to maximising workforce capacity. Achieving the aims of this priority area will require a reset of expectations of what mental health treatment is and awareness of options other than one-on-one sessions.

This priority area be titled: *Ensuring the delivery of appropriate, optimal and evidence-based interventions.*

Actions:

- Monitoring and reporting on the delivery of appropriate, optimal and evidence-based interventions.
- Promoting awareness of the different models of intervention and appropriateness for level of illness and best practice care.
- Integrate alcohol and other drug treatment within mental health services.
- Workforce planning and allocation based on experience, qualification and competency.

4.6 Educating the future mental health workforce

Constraints on the available workforce can be addressed in part through developing the workforce pipeline. Prioritising education in the Strategy and embedding the reforms identified in other priority areas will maximise the impact of the identified actions and the longevity of the Strategy. By building into education, these reforms are seeded at the very beginning of a person's career formation.

Actions:

- Expand the provision of Commonwealth-funded places for postgraduate, allied health and mental health-related Certificate IV courses.
- Fund scholarships for professions with identified national shortages and match placements to geographic areas with an identified shortage.
- Bonded periods of service should be a minimum of 66% of course duration with a pro-rata part-time commitment option provided to enable flexibility.
- Implement education and training curricula (co-led by workforce) on working with lived experience workforce.

4.7 Providing specific training in youth mental health

Young people receive only one mention in the Strategy. This is despite acknowledgement in the background paper that young people experience high levels of illness onset and prevalence rates. Furthermore, young people require specific, developmentally appropriate interventions.

The final Strategy will be incomplete without a national plan for developing the youth mental health workforce. Without such a focus, the Strategy risks long-lasting workforce gaps and increased future service demand for adult mental health services, requiring treatment for higher levels of illness severity that would be better addressed when young people first develop mild to moderate symptoms.

Develop workforce skills to deliver evidence-based, developmentally appropriate interventions and workforce size that reflects the high rates of mental health prevalent in young people (aged 12 to 25 years).

Actions:

- A national organisation be resourced to develop and implement a workforce education and training program in youth mental health interventions for vocational, undergraduate and postgraduate education and continuing professional development.
- Continuing education programs provided through headspace or CYMHS service, with the option of pro-rata provision for part-time placements.

THE MENTAL HEALTH WORKFORCE IS RETAINED IN THE SECTOR

5.5 Return to practise programs

Mental health graduates and professionals may not start or leave (respectively) practice for a variety of reasons. Supported return to practise programs need to recognise these reasons and be tailored to meet different needs (e.g. parenting, returning from retirement, combining management and practice).

Actions:

- Flexible work arrangements (return to work, graduate education and training, mixed public and private practice).
- Funded micro-credentialing to update skills, linked with employment opportunities.

5.6 Facilitating mixed practice

Enabling mental health professionals, the option to practice in a variety of practice settings would provide opportunities for developing different skills and experience and a more rounded professional capacity. Furthermore, mixed practice across public health system, NGO operated services and private practice would provide opportunities for variety and interest in an individuals practice experience, and the cross pollination of organisation cultures. These changes would have the potential to contribute new ideas to workplaces and sustain an individual's enthusiasm and energy for their practice and careers. Facilitating the option of mixed weekly practice or movement between practice settings is intended to increase workforce options, not an end to full-time positions.

Actions:

- Training opportunities and continuing medical education funded with pro-rata public service requirements to attract private practitioners.
- Develop service models that combine opportunities of public, NGO and private practice that recognise the differing pressures across service contexts and geographical location.

CONTACT ORYGEN

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