WAAMH

Western Australian Association for Mental Health

Western Australia Association for Mental Health Submission:

Development of the National Mental Health Workforce Strategy 2021-2031

Acknowledgements

We wish to acknowledge the custodians of the land on which WAAMH is based and works, the Wadjuk (Perth region) people of the Nyoongar nation and their Elders past, present and future. WAAMH acknowledges all people with lived experience of mental health issues and mental distress, for their strength and courage to challenge and face each day.

Contact

For further information or questions about this submission, please contact Dr Elizabeth Connor, Senior Policy Officer, at econnor@waamh.org.au

Background

The Western Australian Association for Mental Health (WAAMH) is the peak body for the community mental health sector in Western Australia, and exists to champion mental wellbeing, recovery and citizenship. WAAMH recognises a continuum of supports – built on principles of human rights, recovery, co-production, personalisation and choice, social inclusion and cultural connection – are essential to the promotion, protection and restoration of mental wellbeing. WAAMH promotes, advocates for and further develops this network of supports.

WAAMH's membership comprises community-managed organisations providing mental health services, programs or supports and people and families with lived experience of mental health issues and suicide, with whom WAAMH engages in genuine partnership. WAAMH also engages in a wide network of collaborative relationships at a state and national level, with individuals, organisations and community members who share its values and objectives.

WAAMH appreciates the opportunity to provide input to the development of the National Mental Health Workforce Strategy 2021-2031.

This feedback has been prepared by senior WAAMH staff and lived experience stakeholders. This response has been informed by our ongoing engagement with community members, people with lived experience, non-government organisation mental health service providers and WAAMH's strategic objectives and ongoing advocacy priorities, as well as the broader non-government sector.

Feedback

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

WAAMH supports the identification of a number of challenges facing or impacting on the mental health workforce, including:

- Utilisation of the entire mental health workforce
- Distribution disparities of mental health workforce, especially in regional and remote areas
- Collection and use of data
- Appropriate skill and the need for professional development opportunities for staff working in the mental health sector and more broadly
- An acknowledgment of the systemic factors that can impact on and determine workforce skills and capacity issues.

However, WAAMH believes that a number of issues have been missed, or not addressed adequately, including:

- National Disability Insurance Scheme mental health/ psychosocial disability workforce
- Mental health prevention-specific workforce
- Integration/collaboration across clinical and non-clinical spaces
- Remuneration for and practical barriers to accessing professional development and skills training opportunities

These issues are addressed further in subsequent questions.

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

While the aim and objectives of the draft Strategy are broadly fit for purpose, WAAMH suggests that a focus on sustainability and supporting the mental health workforce should be strengthened throughout these statements.

As an example, while the development of training opportunities, and offering subsidies and financial support to priority groups is important for increasing skills and capacity in the sector – there is also a significant support piece to be addressed. Systems should ensure that contracts with individuals (and funding provided to organisation to support these positions) include professional development plans and that workers can be financially and logistically supported to attend training without compromising their work time or requiring out of hours commitments (which for some people will not be possible).

WAAMH suggests the following additions to the Aim of the draft Strategy:

To develop, support and sustain 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 meets their needs.

With regards to the Objectives, a suggested edit to Objective 5 is:

Could be changed to "The mental health workforce is supported and retained in the sector"

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

WAAMH has identified the following areas that should be addressed in the Strategy:

- Mental Health Prevention workforce
- NDIS mental health/psychosocial workforce
- Remuneration and support for Professional Development

These matters are addressed below.

Mental Health Prevention workforce
Numerous plans and strategies at a national and state level (including the Better Choices. Better Lives WA Mental Health and AOD Services Plan 2015-2025, and the Productivity Commission Mental Health Inquiry Report) have identified the need to balance the mental health system, with a focus on prevention and community-based supports. In WA, The Plan, which is based on the National Mental Health Service Planning Framework, sets out targets for investment in distinct streams of mental health service delivery. According to The Plan, 5% of the WA mental health budget should be invested in prevention by 2025. Similarly, the Prevention Coalition for Mental Health has specified the need for 5% of the national mental health budget to be invested in prevention.

As part of this balancing and increase in investment, there must be a recognition that specific skills are required to develop, deliver and evaluate effective preventative, public health and health-promotion initiatives in the mental health space[1]. Despite this, there is no recognition in the draft Strategy of the mental health prevention workforce.

The risk of failing to invest in a prevention-specific workforce (including training options and career pathways) is that prevention work is subsumed within other roles (which may not have the requisite expertise), and that organisations attempt to deliver prevention work as an addition to their core business, without financial or operational support, and potentially without a clear evidence base or structured approach at a system level.

[1] Prevention Coalition. (2020)

WAAMH suggests that the prevention workforce should be identified in the Strategy and throughout the priority areas and actions. Priority areas of particular relevance include: 1.2, 3.2, 4.1, 4.2.

NDIS mental health/psychosocial workforce.
WAAMH notes that the NDIS mental health/ psychosocial disability workforce is essentially absent from the draft Strategy, and suggests that details and issues related to this workforce need to be further acknowledged and addressed.

"Disability workers" are mentioned once on page 22, but no further details about what this means are given.

WAAMH is engaged in the NDIS space and understands that there is a demand for psychosocial support workers. However, specific training in this area is currently not widely accessible and as such, many people employed in these roles do not have specific skills in this area. In addition, the current NDIS funding model is not sufficient to allow for training and professional development, and supervision, ongoing support and debriefing to be provided to existing or new workforce to ensure that these skills are acquired and maintained. The consequence of this scenario is significant risk for employers, staff and consumers alike.

It is important that the nuances of mental health and the recovery-oriented, trauma-informed and person-centred approaches and skills required as part of contemporary and human-rights based care and support are not lost in the discussion of disability workforce generally. Training opportunities need to be consumer and carer informed, led or co-developed. It is important that training shares these perspectives and needs, and comes from the knowledge of people with lived and learnt experience and expertise.

Mental health and psychosocial disability have been acknowledged as an emerging and significant area for the NDIS and the disability sector, and as such mental health sector expertise needs to be a major part of the conversation; there needs to be a solid foundation in mental health in terms of training and skills acquisition, and workers need to come to understand the disability elements of mental health from this perspective.

Remuneration and support for Professional Development
WAAMH notes that the need for professional development opportunities to be developed and provided is addressed in the draft Strategy. Low levels of remuneration and issues with contracting for professional development and training is also mentioned in the narrative of the draft Strategy, but there are no commensurate actions to reflect the remuneration element of this issue and support this narrative.

This applies to Objective 5 and Action 5.3.3 (Require that service providers support staff access to continuing professional development). The draft Strategy needs to be realistic about the financial implications of providing these opportunities and ensure that remuneration and funding for organisations to provide this type of support is facilitate. Professional development opportunities need to be supported financially by commissioning and funding bodies. This applies across all sectors but notably in the non-government sector, which relies heavily on government commissioning bodies for funding and sustainability.

Integration/collaboration across clinical and non-clinical
WAAMH suggests that the issue of integration and collaboration across clinical and non-clinical sectors could be more thoroughly addressed in the draft Strategy.

In particular, WAAMH suggests that this would apply to elements of the draft Strategy that address the Lived Experience/ Peer workforce, the community-based mental health workforce and non-clinical mental health workforce, including issues of scope of practice, workforce utilisation and skills.

WAAMH has identified the issue of integration and collaboration across clinical and non-clinical sectors as a key concern in the WA context. While some integration and collaboration across these spaces occurs, in WAAMH's experience there is a persisting siloing in approaches generally, with the following issues noted as contributing to this picture:

- a lack of understanding in the clinical space of what the non-clinical, community support-based services can provide
- a lack of trust by clinical workforce in non-clinical services and supports
- lack of awareness in clinical spaces of the service and support options available in the community
- lack of referrals from clinical services to existing non-clinical, community support services
- lack of funding for community-based services and supports leading to limitations on capacity to take on new referrals, leading to a perception that services are not equipped or do not have the right skills to take on referrals
- persistence of the dominant biomedical model, with apparent reluctance to integrate non-clinical approaches.
- lack of requirement for all levels of service to be co-designed and co-delivered. This would; meet "nothing about us without us", ensure evidence based design & delivery that is built on both academic and experiential expertise, better meet the needs of service users, support people & staff, and deliver better service user retention & efficacy of supports.
- lack of vision of mental health in a rights-based framework as advised by the World Health Organisation

As such, WAAMH suggests that there may need to be an integration and collaboration piece here concerned with educating mental health professions in all sectors about the roles and value of other parts of the system; for example, ensuring that clinical practitioners recognise and understand the scope of practice and value that non-clinical, community based and lived experience/ peer worker roles can offer.

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?

WAAMH supports this approach and believes that the draft Strategy does address this sufficiently. However, the draft Strategy overall is very high-level, and as such the key to this approach will be in the implementation of the final Strategy once it is completed.

In addition, the National Mental Health Service Partnership Agreement will have a significant role in determining how this approach plays out. The draft Strategy talks about the need for shared responsibility for funding public, private and non-government mental health services. This will be strongly heavily guided by the final NMHSP Agreement when it is released, and so ensuring that the NMHSP Agreement also reflects this sentiment and captures the needs of states and territories accurately will be vital.

The NMHSP Agreement must enable States and Territories to address their own local and unique needs. In WA, the *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*[3] (The Plan) provides a clear roadmap for mental health funding and investment across five service streams, to achieve an optimal mix of service types and amounts to best support the WA community and ensure the most effective and sustainable mental health system and is based on the National Mental Health Service Planning Framework. The NMHSP Agreement must offer the flexibility to ensure that The Plan can be implemented and should support WA to progress toward this optimal service mix. This is particularly important given

that the injection of new funds is critical for growing the most under-resourced parts of the system, notably prevention and community support, and including workforce.

Regarding the “Potential implementation activity” for Priority area 3.2 (Develop a national governance process to oversee the review of scopes of practice, ensuring a mutually consistent approach across the mental health sector), WAAMH suggests that the governance structure and representatives involved in this process must include a broad range of clinical, non-clinical, allied health, prevention and lived-experience perspectives, to ensure that the structures and processes involved are fair, equitable, balanced and pragmatic.

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?

As for the previous question, yes, the draft Strategy provides some adequate approaches for this, but this concept is lofty to begin with, and the draft Strategy is very high-level, meaning that they key to achieving success in this area will be in the implementation.

Practically, any efforts to improve attractiveness will rely on the career options available *actually* being attractive and sustainable. This will take time and involve significant investment and financial commitment from government. This will apply across all sectors, and in particular in relation to careers in the non-government sector, where funding and commissioning arrangements will be vital in ensuring that roles are appropriately remunerated and supported.

In relation to this, WAAMH strongly supports the Possible implementation activity for Priority Area 5.1 (Align government funding across sectors relevant to the mental health workforce to improve consistency of salaries). There is currently a significant disparity in the level of salary offered to non-government employees compared to government; as an example from the WA context, a social worker role in a government context may be awarded a salary of upward of $100,000 per annum, or more, while the same role in the NGO context is funded by government for between $60,000 to $80,000 per annum. NGO salaries are consistently understood to be lower than government and private sector salaries, and this can lead to staff leaving NGO environments in search of more adequate remuneration. It is important that staff and organisations are supported by government to ensure that careers in all areas of mental health are attractive.

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?

In reference to this question, WAMH again strongly supports the Possible implementation activity for Priority Area 5.1 (Align government funding across sectors relevant to the mental health workforce to improve consistency of salaries). The issue of funding and salaries needs to be addressed in the NGO sector and in relation to the NDIS, to ensure that skilled workers supported and retained.

Similarly, WAAMH supports Action 5.1.1 (Longer minimum service contracts), particularly in the community support, NGO context. This recommendation aligns with recommendations from the Productivity Commission Mental Health Inquiry Report, which recommends that Governments should extend the funding cycle length for all psychosocial support programs from what is typically a one-year contract term to a minimum five-year term.

Funding arrangements should also ensure that workplaces are able to provide (and are therefore required to provide) supports for staff wellbeing, including wellbeing leave days, in-house wellbeing activities or similar.

WAAMH also endorses Priority Area 5.2 (Increase access to appropriate supervision for all mental health workforce"; it must be ensured that this applies to NDIS workers providing psychosocial supports.

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?

Integration/collaboration across clinical and non-clinical
As per question 3, WAAMH suggests that the issue of integration and collaboration across clinical and non-clinical sectors could be more thoroughly addressed in the draft Strategy.

In particular, WAAMH suggests that this would apply to elements of the draft Strategy that address the Lived Experience/ Peer workforce, the community-based mental health workforce and non-clinical mental health workforce, including issues of scope of practice, workforce utilisation and skills.

WAAMH has identified the issue of integration and collaboration across clinical and non-clinical sectors as a key concern in the WA context. While some integration and collaboration across these spaces occurs, in WAAMH's experience there is a persisting siloing in approaches generally, with the following issues noted as contributing to this picture:

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As such, WAAMH suggests that there may need to be an integration and collaboration piece here concerned with educating mental health professions in all sectors about the roles and value of other parts of the system; for example, ensuring that clinical practitioners recognise and understand the scope of practice and value that non-clinical, community based and lived experience/ peer worker roles can offer.

The role of peak bodies
WAAMH notes that the draft Strategy identifies the role of professional peak bodies in supporting the mental health workforce, but not that of sector peaks.

WAAMH suggests that general and sector peak bodies have a significant role to play in supporting the needs of the mental health sector workforce, and could be captured in the draft Strategy.

Peak bodies such as WAAMH can and do play an important role in providing sector, professional and workforce development opportunities. Peaks have a strong connection to their sector and can provide a conduit for communication between the sector and government. To fulfill this role

successfully, peaks should to be acknowledged and supported by funding and commissioning bodies to effectively engage with the sector and provide these opportunities in a comprehensive and sustainable way.

Peak bodies can be encouraged and supported to reflect diversity within all levels of governance and at organisational level, with consumers and carers in positions across the organisation.

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?

While the draft Strategy includes a number of high level actions to address these shortages, the specifics of these approaches are not captured.

There needs to be explicit acknowledgement of the financial implications of achieving a more balanced distribution of mental health workforce across regional, rural and remote locations; attracting mental health workforce to these areas will likely require incentives and supported approaches to facilitate people moving to these locations and maintaining engagement over time.

Commissioning and contracting also needs to ensure services are developed and delivered using local, place-based services and approaches. Opportunities (such as tender processes) need to be accessible for smaller, locally-based organisations, and should be designed so that local organisations, which have knowledge of and connection to their local communities, can realistically and competitively apply to provide services in regional areas. Commissioning practices should avoid large service providers dominating in this market, rolling out services into regional areas that they are not familiar with and relying on transient workforce in and out of these areas, without local knowledge and connections.

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?

Innovation should centre on the pursuit and achievement of person-centred, trauma- informed approaches that take a holistic view of being mentally well and provide people with the right mix of clinical and non-clinical services.

Collaboration and integration of clinical and non-clinical approaches should be encouraged and supported. For example, clinical teams could work with the non-clinical teams on the recovery models that they are using. An example of this is that the non- clinical teams might work off a “Star model” to look at supporting a person’s individual goals, while clinical teams have their own documentation. Similarly, NDIS service providers will work on the person’s NDIS-stated goals, while a mental health clinic or accommodation service will work on different goals, making the recovery journey overwhelming and unachievable for the individual. More effective collaboration and coordination of approaches could allow for optimisation and enhanced service delivery.

Innovation should also capture co-designed and co-delivered initiatives and programs, and knowledge partnerships with people with lived experience, families and carers.

10. Is there anything else you would like to add about the Consultation Draft (1,000 word limit)?

- As previously mentioned, WAAMH strongly suggests that the power of this draft Strategy will be in the implementation. As such, development and delivery of implementation plans should be timely, while balancing the need for thorough consultation and considered approaches.
- WAAMH is also aware that a local, state-based implementation plan for the WA Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025 is being

developed. The national strategy should align with and allow flexibility for localised, needs-based state and territory-based approaches.

- The final Strategy needs to ensure that it supports a balancing of the mental health system nationally and state and territory levels, with a focus on prevention and community-based supports. Workforce requirements in the prevention and community-based service streams will increase as this balance is established, and the strategy must capture these shifts. Including the need for prevention workforce in the final strategy is essential.
- There must be a focus on co-production, co-design and co-delivery. The Strategy should enable doors to be opened to seeing “evidence-based” as not only meaning academic research, but also including lived experience as evidence and expertise.
- WAAMH supports Objective 2 and the focus on effective and comprehensive data collection and use. However, the there needs to be an acknowledgement of the financial and logistical implications of this for all parts of the mental health system, including the community-based and NGO sectors. With a growing focus on outcomes-based evaluation and data collection, there are also other conversations and changes occurring in the data space in WA, and nationally, which should be considered in conjunction with any emerging workforce data plans. Organisations will need to be supported by funding and commissioning bodies to implement systems to collect and report on data. Importantly, the concept of “outcomes” and the definition that accompanies this must be co-defined with people with lived experience.
- Workforce planning and distribution also needs to take a systems approach, looking at other parts of the mental health system and infrastructure requirements (for example, training places and hospital environments) to ensure that bottle necks do not develop with people being trained and looking for work placements or avenues for further professional development or career progression opportunities that do not exist or are insufficient in number.
- From an implementation point of view, WAAMH would like to understand how the national Mental Health Commission proposes to realise this national strategy. Our understandings of the development process are that the WA Mental Health Commission have not been actively engaged in the development process, and have concurrently been developing an implementation plan for the existing state-based WA Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025 (with no connection between this process and the national process). What mechanisms for implementation will the Federal government have to facilitate the implementation of the final Strategy, aside from the National Mental Health Service Partnership Agreement (which is notably absent form the draft Strategy in its current form)?
- It is important that supervision (Group supervision within teams and individual supervision that is regular) is facilitated, funded and made accessible for all mental health workforce.