AMA response to National Mental Health Workforce Strategy Consultation Draft

30 September 2021

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

The AMA supports the overall aim of National Mental Health Workforce Strategy Consultation Draft (the draft strategy) and the commitment to improve the function, size and distribution of the Australian mental health workforce. Addressing the current shortfalls requires targeted measures to support an appropriately sized, skilled and resourced workforce able to deliver high quality, recovery-focused mental health services in a safe and secure environment. Achieving this aspiration requires targeted funding and policies across community, general practice, allied health, nursing and medical training and education pathways.

Regarding the specific wording of the aim itself: the AMA suggests that the aim be broadened to state '*develop and retain*', to be reflective of the broader workforce objectives of the strategy, noting the retention issues the draft strategy also attempts to address.

We note the draft strategy places an emphasis on innovation and does *"not prescribe a model of care"* (p.2) and agree that multiple and diverse place-based approaches are required to redress mental health workforce shortages and projected future needs. The draft strategy states that achieving the aim requires all mental workforce to work together – building on strengths and responding to changing community needs and ways of working. While the AMA broadly supports that aspiration, our advice in this submission will relate specifically to the medical workforce, GPs and psychiatrists.

An assumption underpinning the draft strategy is that it will foster new innovative collaboration across mental health professions. In sectors that are currently under resourced and struggling to meet demand, it is hard to see how this will grow without targeted and long-term investment to repair and rebuild mental health services. Public psychiatry is a compelling example of the impacts of long-term under resourcing from both a consumer and medical education and training perspective.

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

The AMA notes the following six objectives frame the draft strategy:

- Careers in mental health are, and are recognised as, attractive
- Data underpins workforce planning
- The entire mental health workforce is utlised
- The mental health workforce is appropriately skilled
- The mental health workforce is retained in the sector
- The mental health workforce is distributed to deliver support and treatment when and where consumers need it

The AMA suggests these objectives capture workforce issues theoretically, however, do not articulate an immediate response to redress the current urgent shortfall in mental health workforce and the flow on impacts of this on future planning.

We also note that achievement of these objectives is necessarily underpinned by community engagement and consultation that will be mapped out in later phases of the implementation. Without detailed mapping of diverse population needs, including Aboriginal and Torres Strait Islander peoples, rural and remote areas, people who identify as LGBTQIA+ and culturally and linguistically diverse groups, it is not possible to ascertain whether these broad objectives are going to deliver on future mental health workforce needs.

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

It may be beneficial to highlight a commitment to innovative approaches in the overall objectives, with some examples of what they may look like.

The AMA suggests that a commitment to investing in multidisciplinary mental health teams supports the objective of innovation well. Investment into multidisciplinary teams supports improved mental health outcomes and redresses some of the access and supply issues to services. The draft strategy picks up on this aspect of workforce in Objective 3 – The entire mental health workforce is utlised, but has scope to be expanded elsewhere.

From a medical perspective, the AMA recognises that enhanced GP clinic access to mental health supports will increase the ability of GPs to respond to patient needs within the clinic; in turn relieving pressure on other components of the health system and reducing fragmented service delivery.

A suggested workforce response is funding a mental health nurse (or other qualified mental health worker) within primary care to support earlier intervention, allowing the patients to access help before problems escalate to the point where they may require more intensive specialist mental health intervention. Further integration of other relevant community services such as drug and alcohol and domestic violence support services within GP clinics are examples of collaboration and innovation that could be considered within the scope of the draft strategy.

It is critical that the implementation phases consider how resourcing and investment can promote collaboration and innovation. The AMA suggests that investment in evidence-based nursing programs, integrated in GP clinics, and funded increased support by psychiatrists, and mental health nurses are examples that could be considered. We also suggest that flexible workforce incentive payments (for professions such as nurses, psychologists and other allied health professionals) would enable GP clinics to determine where the greatest mental health needs are in the community and what additional services would be best placed in their clinic.

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

The AMA notes that current inconsistencies in working conditions between states and territories, and how this is contributing to gaps in the psychiatry workforce in particular parts of Australia must be a key consideration as this workforce planning process moves forward. We will not make a

specific comment regarding how this may be responded to by states and territories but rather highlight the issues around psychiatry workforce as an urgent consideration in need of a national response.

The AMA sees a role for federal, state and territory governments to provide incentives and supports to build a critical mass of psychiatrists (including private psychiatrists) in regional and rural areas, where access to basic mental health care lags significantly behind urban areas. There must also be further consideration of rural trainee issues, including adequate supervision and support. It is imperative that an outcome from the draft strategy is an enacted plan to increase the number of psychiatrists, particularly in regional, rural and remote areas, and in sub-specialities including child, adolescent, consultation-liaison and old age psychiatry.

We further recommend that there is a specific need for an increased number of child and adolescent psychiatrists per 100,000 population to meet basic community needs for the population of young people in Australia. It is recognised that to achieve this necessary increase, significant additional resources are needed with recognition of regional and jurisdictional variation. Efforts to increase the supply of child and adolescent psychiatrists in regional and rural areas should be in keeping with overall strategies to increase rural workforce, rather than drawing resources away from already underserviced areas.

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

The AMA notes that the draft strategy recognises the urgent need to address perceptions of entering the GP and psychiatrist workforce and identifies immediate action being required within 12 months (Action 1.3.1, p.9). Further detail is required as to how this might be addressed.

While we agree that a long-term response is required to ensure a sustainable medical workforce for mental health, we would like to see more concrete policy proposals to engage with. The example implementation activities against priority areas 1.2 and 1.3 (p.10) may be useful in a suite of broader targeted measures to encourage more medical graduates into mental health specialty training. The AMA suggests that more concrete proposals are required to offer a constructive response to this question.

The AMA encourages further detailed advice from RACGP, ACRRM and RANZCP to inform new policy proposals. It would be helpful for this aspect to workforce planning to be underpinned by data on current training pathways and projected profession shortfalls against demand for services in the immediate, medium and long term.

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?**

The AMA supports the characterisation in the draft strategy of some of the barriers impacting on mental health workforce retention:

> *"There is a need for appropriate investment in both workforce availability and quality infrastructure to facilitate appropriate support and treatment. Fatigue and burnout were reported to be high through stakeholder consultations as a product of workload levels and*

the stress of workplace violence, physical / verbal abuse and aggression from patients. Unsuitable physical infrastructure can limit the way in which support and treatment are provided, particularly in rural communities, while also impacting on incidences of violence. These issues are not experienced universally across settings, nor are they unique to the mental health sector, but do need to be addressed to improve retention." (p.25)

There is a critical shortage of psychiatrists in Australia, which was to some extent acknowledged in the 2021 Federal Budget through the investment of $11 million into 30 new psychiatry training places by 2023. While this welcome, it still falls short of the Department of Health's own modelling in a 2016 report, which projected a future undersupply of 125 by 2030 for the psychiatry workforce. To meet the expected undersupply projected by 2030, the new intake would need to increase from the projected 197 to 200 in 2016 up to 269 in 2025, which equates to an average annual increase of 3.3%.

The AMA recommends that this strategy build on this preliminary investment by developing a long-term plan, supported by adequate resourcing to redress this critical workforce issue.

We note that Action 4.1.2 (p.21) identifies the quality of psychiatry placements as requiring immediate action within the next 12 months. It is unclear what options are being considered to improve psychiatry education and training to support longer term workforce retention priorities.

With regard to Action 4.2.2 (p.22), the AMA maintains that GPs are the most well-placed to coordinate mental health care treatment pathways. GPs are frequently the first point of contact on someone's mental health journey, and they need to be equipped and resourced to provide and manage appropriate and ongoing care and treatment pathways.

The 2021 Federal budget announced $15.9 million to support GPs and other practitioners provide primary mental health care through training and other supports. The AMA suggests a targeted investment into the broader mental health workforce including mental health nurses, counselling services and other mental health workforce supports would better support GP clinics deliver optimal mental health care.

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?**

In addition to our response to Question 3:

The AMA wants to see more investment and commitment to grow medically governed multi-disciplinary teams to support mental health care through GP clinics and psychiatry practice. We support the specific composition of these services being responsive to local needs. 'Wrap-around' service delivery models have the potential to offer better return on investment and health outcomes than investing in siloed service delivery models, particularly in rural, regional and remote areas.

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?**

In addition to remarks already made on medical workforce shortage:

The AMA notes that the top line issues impacting on the GP and psychiatrist workforce are reflected in the background paper to the draft strategy and welcome this acknowledgement. We support the statements in 6.1.3 (p.31) regarding GPs often being the first point of contact into the mental health system, and agree that the MBS currently does not incentivise mental health consultations compared to broader MBS items.

We also acknowledge and agree with the statements made in 6.1.5 (p.31) of the background paper regarding the issues of workforce growth and retention in psychiatry; visibility of these issues is an important and essential foundation for development of subsequent policy responses.

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?**

In addition to our response to Question 3:

The AMA recommends that specific investment in developing capacity in mental health support services within GP and private psychiatrist practices such as embedding accredited mental health nurses and social workers would be beneficial. These 'wrap-around' services have the potential to offer better return on investment and health outcomes than investing in siloed service delivery models, particularly in rural, regional and remote areas.

Similar investment in psychiatry services including private psychiatry through Medicare enhancement to embed mental health nurses and social workers in psychiatric practices will improve complementary (to public mental health service) capacity.

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

While the overall intent of the background paper and draft strategy suggests a comprehensive understanding of the key issues underpinning mental health workforce shortages, the AMA is concerned that the final section (8) of the draft strategy contains scant information on the implementation phase/s. We suggest there are some dependencies and assumptions within the draft strategy for a successful implementation that are not fully understood or developed at this time:

- Constructive engagement with federal, state and territory jurisdictions is required for large parts of the implementation and it is unclear what levers will be drawn on to facilitate this. The path forward is not articulated.
- The draft strategy has a substantial reliance on the sector to collaborate and innovate without targeted strategies or incentives;
  "All sectors will need to cooperate to deliver priority action areas from their respective mandates, ensuring that system-wide collaboration helps to expand and improve the broadly defined mental health workforce." (p.4)
- Accountabilities for setting workforce targets, delivery of policy measures, timeframes, milestones, monitoring and evaluation within the draft plan are unclear.
- A pattern of Federal funding investment (per the 2021 Federal Budget) towards digital platforms and away from medical workforce and existing mental health service delivery models has the potential to create more fragmentation in the system and additional pressures on the existing mental health workforce. In order for the draft strategy to make

any substantive impact on future mental health workforce – it must be backed up with appropriate long-term resourcing from all levels of government.