30 September 2021

Tania Ceglinski
MWRAC Secretariat
Health Workforce Division
Australian Government Department of Health

Via email: MWRAC@health.gov.au
Cc: Kathryn.Yuile@health.gov.au
nmhws@acilallen.com.au

Dear Ms Ceglinski,

Re: Draft National Mental Health Workforce Strategy 2021-2031

Thank you for inviting Medical Deans Australia and New Zealand (Medical Deans) to provide input on the Draft National Mental Health Workforce Strategy 2021-2031 (the Strategy). We appreciate this opportunity, and would welcome opportunities to provide further input as this progresses to its implementation.

Medical Deans welcomes the Strategy's focus on increasing the size and capacity of our mental health workforce, and in particular the need to increase the numbers working in community-based settings recognising that over half of general practice consultations relate to mental health matters[1]. Ensuring access to high quality mental health support and services for people experiencing suicidality, mental distress and/or ill health has never been more important, especially given the increase in demand for support during the COVID-19 pandemic. Fostering a preference for, and preparedness to join the mental health workforce is an important area for our members in their work developing and supporting our future doctors.

The key points where we feel the Strategy would benefit from including or further emphasising, which are detailed in our response to the survey provided, are that:

- mental health competencies and clinical placements need to be embedded throughout the training continuum, and aligned across the different stages of training,
- health student training needs to be embedded within the practice / business model for mental health services,
- investment and funding reform is needed to address the inadequate and insufficient provision of quality health training and supervision,
- the important role of primary care and General Practitioners in coordinating and delivering mental health support and services needs to be more fully recognised, and

[1] In 2020, 64 per cent of GP presentations were for psychological issues, including depression, anxiety and sleep disturbance. Royal Australian College of General Practitioners (2020) General Practice: Health of the Nation 2020, East Melbourne, Vic: RACGP Page 3.

- support for the health and wellbeing of our mental health workforce needs to be strengthened.

I would also like to draw your attention to a Discussion Paper recently released by Medical Deans, *Training Tomorrow's Doctors: all pulling in the right direction*. This paper sets out our vision for a medical education and training continuum that leads to an adaptable and supported workforce with the required capabilities, and in the right numbers, right places, and right specialties to serve the needs of the people of Australia and New Zealand. The paper highlights five key areas to help drive towards this, including:

- **Generalist skills at the forefront of being a doctor** – preparing our future doctors for medical careers that are based in healthcare teams and working across traditional care boundaries, with the skills and experience to adapt to ongoing disruption and innovation, and in models of care that support all health practitioners to work at the top of their scope of practice;
- **Connected and aligned training pathways that effectively support key transition stages** – identifying and facilitating opportunities to train in areas of workforce shortage;
- **Learning in and for our communities** – with sufficient opportunities to apply and further develop skills and interest in the community-based settings where healthcare is most commonly provided and most sorely needed;
- **Doctors working in the right places and the right disciplines** – within an education and training system that actively supports paths to careers in the regions and specialties where they're most needed, and facilitated by effective workforce planning and policy making;
- **A healthy workplace culture and environment** – vital to underpin all this, with embedded systems that safeguard patient care and the health of students and doctors.

Our response to your consultation includes many areas that are further explored in this Discussion Paper and hope it will be of some use.

Medical Deans would like to thank you again for the opportunity to contribute to this important work and reiterate our interest in being more closely involved with the work to develop and progress its associated Implementation Plan. Should you wish to discuss any of the comments provided in this submission or the ideas in our Discussion Paper, please contact Medical Deans' CEO, Helen Craig, at hcraig@medicaldeans.org.au.

Yours sincerely,

Richard Murray
President
Medical Deans Australia and New Zealand

MDANZ Submission to the consultation on the National Mental Health Workforce Strategy 2021-2031

Name: **Helen Craig**

Organisation: **Medical Deans Australia and New Zealand**

Email: **admin@medicaldeans.org.au**

Do you consent to your submission being published? * **Yes**

If no, do you consent to being named as having provided a submission? * **N/A**

RESPONSES TO SURVEY QUESTIONS

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

The aim and objectives provide a good overview of the challenges facing Australia's mental health workforce and we welcome the Strategy looking at the issues through an interprofessional lens.

In particular we welcome the aim to base more mental health services in community settings; to meet the increased demand for these services, ensure they are accessible to those in need, and realise the efficiencies and effectiveness that can be gained from better utilising primary care and similar organisational structures and services.

The Strategy acknowledges the fundamental need for quality supervision and training – for both student placements and during prevocational training – and for a substantial increase for this in general practice and other community-based settings such as non-emergency psychiatry, moving away from the overemphasis on hospital-based care.

However, the Strategy would benefit from an explicit recognition that **health student training needs to be embedded within these community-based models of practice** for it to be effective for both the student/trainee and the health service. It cannot be an add-on.

At the moment, this is not the case for services such as Headspace, as they are often established around the model of visiting specialists with no structure or resourcing in place to support students having a role in the healthcare team provide patient care or for students to be provided with a guided and supported learning experience. Immersive and experiential learning is crucial for health students' education and a necessary aspect of ensuring medical and other health profession graduates are ready for their next step as junior doctors, nurses, allied health, and Aboriginal Mental Health Workers.

It has also been reinforced these last 18 months the valuable role that health students, especially those in their later clinical years, play in contributing to the healthcare team and patient care. Where student learning is embedded in the model of practice, they have been able to step up as active and valued participants in the surge workforce that health services have needed. Not only has this benefitted health services and patient care, students closer involvement as part of the team has benefitted their learning and preparation for practice – for example, as seen in the evaluation of the NSW Health Assistant in Medicine role[1] for final-year medical students.

[1] https://www.health.nsw.gov.au/workforce/medical/Pages/aim-evaluation-report.aspx

An increase to the availability of training placements in community-based settings is urgently needed for health students and interns. This is vital to enable early and positive experiences of mental health care to encourage young doctors to seek a career in this area, and to provide exposure to a clinical experience that is more akin to the type of future practice that is most needed, that is, providing care to people in the community rather than focusing early training on those admitted into hospitals' acute psychiatry wards.

To achieve this, and many of the actions recommended, we feel the Strategy needs a stronger focus on addressing the structural barriers currently in place; in particular the need for systems-level funding reform. The need for this is recognised in the draft recommendations to inform the Primary Health Care 10 Year Plan and we strongly suggest it also needs to be is explicitly included and addressed in this Strategy. We also strongly urge that work is undertaken to ensure that both these vital Strategies are clearly aligned in their aims and support each other in their implementation.

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

Medical Deans supports the priority areas and actions in the Strategy, and believe this will provide a useful framework to further build capacity in the mental health workforce. However, we note a few, key areas that are essential to providing mental health care which would benefit from greater emphasis in the Strategy:

- ensuring mental health competencies and placements are embedded throughout the training continuum, and aligned across the different stages of training
- recognising the important role of primary care and General Practitioners in coordinating and delivering mental health support and services.
- strengthening the support for our mental health workforce to support their health and wellbeing.

These are discussed further in question 3 below.

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

<u>Mental health competencies and placements embedded throughout the training continuum</u>

As the Strategy states, providing mental health services requires an integrated, multidisciplinary approach. To achieve this, we need to ensure that all health workers have the competencies required to identify and support people experiencing suicidality, mental distress and/or ill health where required, not solely those who specialise in mental health. However, the Strategy has a strong focus on attracting and training graduates in specialised mental health careers, and misses an opportunity to ensure the wider medical workforce is also equipped to recognise early signs, and provide or coordinate basic mental health services.

We suggest amending priority area action 4.2.2. to emphasise the need for *all medical students* to access high quality education and training in mental health, and for clinical placements across a range of settings and locations. This would build capacity among the entire medical workforce to support our communities, and help ameliorate the pressures placed on the mental health workforce with the growing mental health needs in our communities.

Mental health competencies and placements should be embedded throughout training, including in community-based practice, from the start and we suggest the activities developed to implement this strategy emphasise this.

We also need to tap into more flexible and contemporary approaches to training where appropriate. During 2020, in response to the challenges caused by the COVID-19 pandemic, we saw increased flexibility from regulators with their recognition that there was both a need and benefit in moving away from the traditional ward rotation-based approach, which requires students and interns to undertake placements in specific disciplines, to longer placements in more general wards. This approach provides exposure to a broader range of patients and in the main provides the students/interns with similar learning experiences, and comes with the benefit of students becoming more embedded within – and therefore more valuable to – the healthcare team and patient care. If there are 'gaps' in students being exposed to particular and necessary clinical situations, then these can be dealt with and organised specifically.

Applying this approach would provide students and interns with training experiences exposing them to non-acute mental health care, and enable them to learn, develop and apply their skills relevant to mental health across a range of scenarios, with a wider and arguably more 'usual' range of patient presentations and issues, and while engaging with different members of a multidisciplinary team.

Important role of primary and preventative care

The Strategy highlights that mental health is an area where our population will demand greater levels of care and require integrated, coordinated, team-based care. Primary care sits at the centre of where most mental health care services are delivered, with over half of general practice consultations relating to mental health matters[2]. Often, GPs are the first point of contact with patients seeking mental health support and are responsible for delivering or coordinating care. A well-supported primary care sector is the necessary foundation to a well-resourced, efficient and responsive mental health workforce and central to achieving the outcomes Government seek. This is also strongly emphasised in Recommendation 1 of the Australian Government's Draft recommendations from the Primary Health Reform Steering Group that will inform the Primary Health Care 10 Year Plan.

However, the Strategy is largely silent on the role of primary care in delivering community-based mental health services. We suggest the Strategy include an additional priority under Objective 3 – the entire mental health workforce is utilised – that emphasises the important role of primary care, and especially General Practice, in coordinating and delivering integrated mental health support and services. This is particularly the case in regional, rural and remote communities.

We also need to focus far more on preventative care delivered in the community. Whilst prevention is mentioned in the background and aim, it is missing from the actions. We suggest the Strategy includes an additional priority under Objective 4 – The mental health workforce is appropriately skilled – that focuses on aligning the education and training of our mental health workforce with the needs of the population, recognising the need for a greater focus on preventative care, and care for people with long-term, chronic or comorbid conditions.

[2] In 2020, 64 per cent of GP presentations were for psychological issues, including depression, anxiety and sleep disturbance. Royal Australian College of General Practitioners (2020) General Practice: Health of the Nation 2020, East Melbourne, Vic: RACGP Page 3.

Supporting our workforce

Staff health is the cornerstone of any sustainable and self-sufficient workforce. The mental health workforce is often under significant pressure, as the Productivity Commission's 2020 Inquiry into Mental Health notes "*being in the mental health workforce involves high risks of mental illness, suicidal ideation, burnout and cynicism…These risks are accentuated during the training stage of a medical degree*"[3]. In addition, a 2018 survey found psychiatrists working in the public sector had higher rates of concerns about burnout, with more than 80% citing this as a negative aspect of their experience[4]. This has multiple negative impacts for the workforce: an unhealthy workplace culture, reduced productivity, attrition of staff and a negative perception among students and trainees of mental health careers.

The recently released World Health Organisation's guideline on health workforce development, attraction, recruitment and retention in rural and remote areas[5] specifically highlights the importance of providing psychosocial and mental health support for rural mental health workers, to create a safe and secure working environment for this critical workforce. Attracting, recruiting and retaining a sustainable mental health workforce in rural areas, as outlined in Objective 6, will be heavily influenced by the culture of those workplaces.

Our medical students and doctors need to be working in a positive, supportive culture. We found the Strategy noted this point, but did not provide tangible actions to address it. This is a missed opportunity to demonstrate how we can both attract professionals to the mental health workforce and create a supportive workplace that enables them to have fulfilling careers that prioritises their health as well as those they serve.

In line with the findings of the Productivity Commission's Inquiry into Mental Health, we suggest the Strategy add actions under priority area 5.3 – Improve workplace health, safety and wellbeing – that focus on investing in targeted services to foster a supportive and positive culture in our mental health workforce, recognising the stigma associated with seeking help in these high-stress environments. As the Productivity Commission's Inquiry notes, this should include: "*organisational leadership to improve workplace culture, raise job satisfaction, reduce stigma and promote a positive and safe workplace*"[6].

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?**

We support this approach and agree that it would, in principle, enable sufficient flexibility for different regions to develop and implement approaches based on the needs of their local communities and workforce.

[3] Productivity Commission (2020) Inquiry Report into Mental Health, Volume 2. Page 745.
[4] Productivity Commission (2020) Inquiry Report into Mental Health, Volume 2. Page 745
[5] World Health Organisation (2021) guideline on health workforce development, attraction, recruitment and retention in rural and remote areas.
[6] Productivity Commission (2020) Inquiry Report into Mental Health, Volume 2. Page 747

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 Strategy presents a clear and well-considered approach to the issues impacting the career choices of young doctors and their interest in pursuing a path into a mental health care practice, and articulates a useful series of priorities and recommendations.

We believe the Strategy would benefit from a stronger articulation and focus on the system-level reforms needed to ensure sufficient, quality training and supervision, and the importance of embedding the education and training of the mental health workforce within the models of practice across the range of health service providers. In particular, the Strategy needs to recognise the need for funding reform. We suggest this challenge is explicitly noted and a corresponding action to address it included in the Strategy. This would increase the utility of the Strategy as a roadmap to addressing common, systemic issues across the health sector that are negatively impacting the attractiveness of mental health careers, and provide clear and consistent pathways to achieving the above-mentioned actions at scale.

Whilst experiences in clinical placements and renumeration levels are critical, other factors also contribute to medical speciality decision making which are noted in the Background Paper but not addressed in the Strategy. These include the "hidden curricula", the influence of home and family commitments, clinical and hospital-based supervisors and role models throughout training, work/life balance, and the perception of a hierarchy of medical specialties. The Strategy would benefit from additional actions under priority area 1.2 that recognise the above complex factors that contribute to the attractiveness of a career in mental health throughout undergraduate and postgraduate training.

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?**

Please see our response to question 3, in regarding to supporting the mental health workforce.

We also recommend the Strategy include an explicit statement and recommendation to increase the active support for the mental health workforce to be able to pursue a well-rounded career that includes academic, research and leadership opportunities.

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?**

The Strategy demonstrates the breadth of expertise and support required in an integrated system of care and lists the individual professions that require change. However, if we are to support greater integration of care, we must pull these separate threads together. The Strategy would benefit from a greater emphasis on those responsible for coordinating care across multidisciplinary teams and across care boundaries.

General practice and generalist specialists play a critical role in coordinating community-based mental health services, whether in urban, regional or rural areas. This is recognised in the draft

recommendations from the Primary Health Reform Steering Group that will inform the Primary Health Care 10 Year Plan. It strongly supports "*an integrated and coordinated care system, including in aged care, community care, disability and mental health services, as well as other social support services linked to the determinants of health*" (Rec 1.3.3) and recommends funding reform to deliver this[7].

As above, we suggest the Strategy include an additional priority area under Objective 3 – the entire mental health workforce is utilised – that has an emphasis on the role of primary care and especially general practice, in coordinating and delivering integrated mental health support and services, especially in regional, rural and remote communities. This would better support an integrated approach to care, and better align this Strategy to the intent and vision of the Primary Health Care 10 Year Plan under development and to the recommendations in the Productivity Commission's Inquiry into Mental Health.

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?

The Strategy emphasises the need for expanding rural training capacity, developing localised pathways, and supporting health and care workers to train and work where needed by rural communities (actions 6.1.1-6.1.5), and Objective 6 highlights the challenges for workforce planning, models of care, and models of practice unique to regional, rural and remote areas.

Regional health education and training needs to be determined, delivered, and supported by those working in and for the rural communities, and undertaking this work in an integrated, aligned and locally driven manner requires strong regional governance.

For these reasons, Medical Deans has long advocated for a "flipped" training model in regional and rural Australia that moves away from applying metro-centric approaches in rural areas. Planning, capacity building, facilitation, management and support of rural training needs to be done by those with local knowledge, relationships and connections. We need regional structures and appropriate regional governance to enable this to occur.

Region-led governance is reflected in the Productivity Commission's Inquiry Report into Mental Health which recommends Government enable "*regional decision making, founded on comprehensive regional level planning of needs and services to eliminate gaps in care*"[8]. This is also reflected in Recommendation 3 of the draft recommendations for the Primary Health Care 10 Year Plan to prioritise structural reform in rural and remote communities "*to support a community connected approach built around the strengths of rural and remote communities*"[9].

The Strategy should ensure it is aligned with this clear direction, presented in the above-mentioned two documents.

[7] Primary Health Reform Steering Group (2021) Discussion Paper to inform the development of the Primary Health Reform Steering Group recommendations on the Australian Government's Primary Health Care 10 Year Plan. Page 3.
[8] Productivity Commission (2020) Inquiry Report into Mental Health, Volume 1. Page 56.
[9] Primary Health Reform Steering Group (2021) Discussion Paper to inform the development of the Primary Health Reform Steering Group recommendations on the Australian Government's Primary Health Care 10 Year Plan. Page 18.

Embedded health workforce education and training within regional and rural health services is vital to addressing this challenge. Students and trainees cannot aspire to be what they cannot see. Early, ongoing, and supported training in and for rural communities is a fundamental aspect to effective health workforce development.

We also note that general practitioners are absent from the list of occupations for the actions in Objective 6. As noted above, we suggest greater emphasis is provided on building capacity across primary care to coordinate appropriate, integrated care for people seeking mental health support and treatment services in regional, rural and remote areas. This should include using blended delivery models, leveraging telehealth and developing targeted pathways for General Practitioners and Rural Generalists.

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?

As noted above, the strategy's definition of the mental health workforce demonstrates the breadth of expertise and support required in an integrated system of care. To encourage innovation in service delivery models, as explained in our responses to questions 1 and 8, the Strategy needs to outline how Government will address the key persisting challenges – inadequate funding and insufficient infrastructure to enable community-based placements, and stronger regional governance to facilitate and manage rural training.

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

Workforce implications of large-scale rotations

Medical Deans strongly supports the Strategy's inclusion of more placements in community-based mental health settings in prevocational training. We note there may be flow on effects impacting the medical workforce when implemented at scale. In Victoria for example, a new psychiatry rotation for Junior Medical Officers (JMOs) was introduced this year, and is intended to become mandatory for all JMOs by 2023. Whilst an extremely positive step, it understandably creates gaps in hospital workplace rosters that require backfilling. Whilst not essential to include in this Strategy, we suggest such flow on effects be considered in the development of the Implementation Plan.

Improving data

Medical Deans strongly supports the strategy's call for better data and building a stronger evidence base for workforce planning. Whilst improving data collection is vital, we need to ensure we don't risk trying to formulate too precise an answer and delay taking action on steps where enough is known and where there is already strong evidence; for example, investing in non-acute community-based mental health services for medical programs and prevocational training. Work to prepare and build the infrastructure and systems needed should not be further delayed.

In addition, we suggest data related to students be included in the table on page 13. Each year, Medical Deans surveys final year students asking about their background, medical school experience, and any early preferences for their future career. These Medical Schools Outcomes Database Reports examine trends across the most recent 5 years, providing a valuable and unique source of data for medical workforce planning. Medical Deans also releases an annual Student Statistics Report each year which provides snapshot and trend information about commencement, enrolment and graduate medical student data across Australia and New Zealand. Both these sources of data provide useful insights about the size of the future medical workforce and early interest in mental health and rural careers.