NORTHERN TERRITORY
MENTAL HEALTH
COALITION

National Mental Health Workforce Submission – September 2021 - NTMHC

Acknowledgment

We acknowledge the Traditional Owners of the land on which we live, work, and walk.

Introduction

The Northern Territory Mental Health Coalition (the Coalition) is the peak body for community run mental health organisations (CMOs) in the Northern Territory (NT). The Coalition welcome the opportunity to offer input into the Mental Workforce Strategy and trusts that this submission will be of helpful assistance.

For further information or clarification, please contact Policy Officer, April Kailahi, phone: 08 8948 2246; email: policy@ntmhc.org.au

Recommendations

In regards to the Draft National Mental Health Workforce Strategy (the Strategy), the NT Coalition recommends

1. An acknowledgment of the unique challenges faced in the NT. The Strategy should include a more specific NT, rural and remote appropriate strategic document (a companion document).
2. The inclusion of a recognition of the role of mental health determinants and interrelated factors. The Strategy should account for interrelated areas (health and non-health) such as alcohol or other drugs, family violence, homelessness, unemployment, physical health, grief and trauma, unstable housing, homelessness, disproportionately high rates of imprisonment and suicide and drug and alcohol use.
3. The inclusion of analysis of workforce frameworks beyond urban areas of Australia, noting NT overwhelmingly consists of regional, rural and remote communities and that the National Strategic Framework for Rural and Remote Health was never put into use.
4. The inclusion of a discussion on whether development and retention and a reduced focus on recruitment and attraction is more suitable. The Strategy ought to acknowledge that a more sustainable workforce approach lies in building human resources - study, training, professional development, supervision, mentoring and rotational placements and so on.

5. The inclusion of a brief analysis on the return on investment (ROI) of different governmental approaches to mental health workforce - past, current, and future – and a ROI comparative analysis on ROI of an approach that focuses on retention and an approach that focuses on attraction.
6. A more consistent use of key terminology. Key words and concepts that reflect modern practice and understandings of mental health such as 'trauma-informed', 'recovery oriented' and 'culturally sensitive' are currently only in the introductory paragraphs.
7. The inclusion of the following priorities:
    a. Rural, regional and remote areas – capacity-building, locally grown, incentivising
    b. NDIS – complexity, resourcing, interplay with psychosocial disability
    c. Rights of the person - consistency and clarity across the 8 State/Territory Acts
    d. Pay and conditions – professional development, competitiveness, resources
8. That there be recognition of the role of non-health disciplines and professions can play in boosting the attractiveness of working within the mental health sector such as marketing, media, communications and public relations.
9. There be a multidisciplinary approach that includes a campaign or public awareness strategy, with sound funding. A broad campaign to help de-stigmatise the mental health sector and create positive workplaces and community attitudes is paramount to remedying the shortages and maldistribution in the mental health sector.
10. Data for modelling be treated as an essential component and that basic variables in demand modelling must be accounted for and reflected in the Strategy:
    a. Number of positions that are unfilled;
    b. Fluctuation required to provide best practice treatment and staffing practices to the whole population;
    c. Mental health, treatment trends and demographic trends which impact of workforce requirements;
    d. Consumer socioeconomic and employment status;
    e. Geographic remoteness and socioeconomic status; and the

f. Health status of consumers.[1]

11. Resourcing a strong focus on systems evaluation, which takes into account social determinants and how the sectors work together to create a holistic approach to the social and emotional health of an individual.

12. An added emphasis on development of dual competencies: clinical and cultural, community-based mental health, addiction services and a recovery approach that accounts for cultural elements.

13. An added emphasis on the need for greater support for wrap-around and stepped care where these models are appropriate and place-based and non-clinical care where the former models do not work.

14. A stronger consideration of the role of modern technology, existing and emerging technological infrastructure, perhaps using COVID-19 as a case study, which can help people access mental health supports without having a face-to-face professional.

15. A stronger acknowledgement and proposed strategic response of the skilled migrant shortage created by Covid-19 and the impact on mental health workforce.

16. A broader scope of who is included in the mental health workforce.

17. The embedding and operationalising of:

    a. Co-design embedded from inception to delivery to evaluation;

    b. Consumer, carer and staff feedback loops;

    c. Individual is an expert in their own life;

    d. Recruitment of diverse staff;

    e. Placed-based workforces;

    f. 'Specialist' needs training – SEWB, LGBTQIA+;

    g. Monitoring and evaluation;

    h. Education, professional development and mentorship throughout all career stages;

[1] University of Queensland, National Mental Health Workforce Strategy 2020 - A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries, https://espace.library.uq.edu.au/view/UQ:c8a5a12

i. Transparency and accountability;

j. Active engagement; and

k. Holistic health frameworks.

18. A stronger acknowledgement of the practical challenges of the mental health workforce in rural and remote communities such as the lack of housing and broader infrastructure necessitates a workforce which consists of fly in fly out (FIFO) or drive in drive out (DIDO), which, if not supported adequately, may create additional significant and professional challenges.

Discussion Paper Question

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

The Northern Territory Mental Health Coalition (Coalition) commends the Australian Government for their commitment to a 10-Year National Mental Health Workforce Strategy (Strategy). It is important that the Australian Government adopts a strategic approach to mental health as it is an area of complexity and significance. The Coalition welcomes the opportunity to offer input into the drafting of the Strategy and trusts that this submission will assist its formation. The Coalition appreciates that the Strategy has positioned itself within the Social and Emotional Wellbeing (SEWB), holistic and person-centred framework.

<u>Appropriate to NT Context: Vast and Sparse, Rural and Remote, Diverse and Indigenous</u>

The Coalition feels that the Strategy does not address the unique challenges faced in the Northern Territory (NT). The NT presents a complexity unfound in other states and territories in Australia due to its geographical vastness, its cultural and linguistic diversity, its concerning social determinants of health and intergenerational trauma experienced by many Aboriginal people. A caveat indicating that the Strategy must be read in cohesion with a more specific NT appropriate strategic document may be needed. Unfortunately, the NT mental health workforce challenges and the NT approaches to those challenges are different to other states and territories. Resources for formation of the Strategy may be limited and it is understandable that the Strategy is meant to be broad, so it is relevant and accessible to all jurisdictions. However, it is broad up to the point of being non-accessible to those in the NT without a companion document.

The Strategy strikes a loose balance between being nationally consistent and locally driven and needs further details on how the particular and unique issues of such communities in the NT are addressed.

Interrelated Issues and Their Workforce Challenges

It is now widely understood that for each person, their mental health exists alongside a myriad of interrelated health, economic, social and cultural factors. The Australian Government should adopt a Strategy that considers workforce challenges in other related areas such as alcohol or other drugs, family violence, homelessness, unemployment, physical health, grief and trauma, unstable housing, homelessness, disproportionately high rates of imprisonment and suicide and drug and alcohol use.[2][3]

The Strategy must learn from and sit alongside the existing governmental workforce strategic documents. The Coalition argues that the workforce in certain areas, such as family violence (FV) or alcohol or other drugs (AOD), can often be considered as being part of the mental health workforce at times when they perform tasks and duties that largely influence the mental health of those they work with or work in tandem with those from in the mental health workforce as part of a multidisciplinary approach.

There are other strategic frameworks that ought to be reflected within the Strategy for their application beyond urban areas of Australia. Unfortunately, according to the National Rural Health Alliance, the National Strategic Framework for Rural and Remote Health has not been used by the Australian Government.[4]

Developing Those Here and Keeping Them Here

The Coalition argues that the strategy should look at addressing the alarming shortfall of the mental health workforce in rural and remote communities by adopting a stronger focus on development and retention and a lesser focus on recruitment and attraction.

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[2] Department of Health 2016, Primary Health Networks Mental Health and Suicide Prevention Needs Assessment NT PHN, https://www.ntmhc.org.au/wp-content/uploads/2016/09/2016-NT-PHN-Needs-Assessment-Mental-Health-and-Suicide-Prevention.pdf

[3] Nagel, T & Thompson, C 2006, 'Aboriginal mental health workers and the improving Indigenous mental health service delivery model in the 'Top End'', *Australian and New Zealand journal of psychiatry*, vol. 14, no. 3, pp. 291–294.

[4] National Rural Health Alliance, Why we need a new Rural and Remote Health Strategy, 2017 https://www.ruralhealth.org.au/sites/default/files/documents/nrha-policy-document/discussion-paper/need-new-rr-health-strategy.pdf

While there are shortfalls in the interim that need immediate filling with attraction of those living outside the area, the sustainability of a workforce approach lies in building human resources rather than moving them around.

The Coalition argues that those from the NT are far more likely to succeed in understanding the complexities of the NT than those moving to the NT. The Coalition also argues that there will be savings for the NT mental health sector, if money spent to bring people into the NT was used to consolidate the expertise of those working and living in the NT. The Coalition reasons that there needs to be a comparative analysis – one analysis of the return on investment when it comes to relocation assistance and another analysis on the return on investment when it comes to funds for retention assistance and stronger opportunities for study, training, professional development, supervision, mentoring and rotational placements and so on.

Territorians understand too well that despite there being incentives for those who choose to move to the NT, the transient nature of the NT population creates many workforce issues which have not been solved through past 'attraction' policies.

It is important to ask the right the question and to the right people. So, in the NT context, the question must be put to Territorians – *why are you leaving mental health work in the NT and what would help you stay?*

The Coalition argues that the Strategy ought to facilitate the development of stronger opportunities for the those in the NT mental health workforce and the future NT mental health workforce which is today's young Territorians.

On a micro level, if an existing employee is able to access opportunities that exceed those in other areas, than it is likely they will stay. On a macro level, a shift in funding from financial incentivisation for relocation to stronger opportunities for those who are in the mental health workforce in rural and remote areas. With a policy shift, regional Australia and the NT can grow their capacity to ensure that they can fund themselves to upskill and address their needs. With a leading approach to human resources, the NT mental health workforce can be sustainably boosted.

Covid-19 has shown that the flow of skilled labour can be shut off at any time. The Coalition argues for a strategy that ensures Territorians have a stronger reason to stay and work in 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 Coalition largely support the aim and objectives of the Strategy and suggests there are improvements that can be made to them. It is important that terminology be used consistently throughout the strategy. The draft strategy is excellent in that it includes key words and concepts that reflect modern practice and understandings of mental health such as 'trauma-informed', 'recovery oriented' and 'culturally sensitive'. However, the itemised objectives often do not include these terms. The terms are only found in the introductory paragraphs beforehand or descriptive paragraphs afterwards. The concepts are so significant that they must be named directly and assumptions that they will be addressed without express mention are potentially dangerous, otherwise we risk losing the fundamental change so needed in the mental health sector.

Understanding trauma works to create cultural safety for many people, including survivors of domestic violence, child abuse, LGBTIQA+ and an understanding of trauma within the cultural setting. The overrepresentation of Aboriginal people in the mental health system adds to the urgency of integrating a practice of trauma and culturally informed care. Aboriginal people have the highest rates of psychotic illness of any group in Australia. They are 1.8 times more likely to experience a psychotic illness and are hospitalised at 2.4 times the rate of non-Aboriginal people.[5]

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

A priority area should be, as discussed above, a locally grown rural and remote mental health workforce. The NT needs a specific focus on retention, rotation, and consolidation of expertise. While conceding that not all skill shortages can be serviced locally, it is still possible for future shortages to be minimised through stronger local rural and remote mental health workforce development from the outset.

Another priority area should be remuneration and conditions, specifically for the non-clinical workforce. Remuneration and conditions are crucial components to the growth and sustainability of the undervalued and underpaid mental health workforce in the NT and rural and remote Australia as a whole. Adequately rewarding staff will attract new workers and, perhaps more importantly, retain skilled workers.[6]

Another priority area is the National Disability Insurance Scheme (NDIS). A growing number of psychosocial needs are being meet through NDIS providers. During our consultations we heard

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[5] Westerman, T 2021, 'Culture-bound syndromes in Aboriginal Australian populations', *Australian Psychological Society*, pp. 1–17.

[6] Northern Territory Human Services Industry 10 Year Plan, https://www.nthsip.com/the-plan

of providers who are struggling to make a viable business model and providers have had to cut back on wages, casualise staff and cut back on middle-management which results in less quality assurance and training. There is a clear overlap with the NDIS workforce and the psychosocial needs of participants and it is unclear where psychosocial supports fits into the Strategy.

Another priority area should be the rights of Australians. Considering the evolution of mental health legislation in many jurisdictions, it would be good to understand how the framework will work with the fact that there are eight different pieces of legislation governing the rights of Australians when it comes to their mental health.

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?**

As noted above, the NT presents a complexity which underscores the need for a contextualised strategy. Throughout our consultations, we heard of people waiting up to eight months to see an occupational therapist or paediatrician in order to get an assessment, in the metropolitan area of Darwin. Those who live in rural and remote communities in the NT have even greater trouble accessing services. For students needing placements, there are not enough organisations who have the resources to bring a student onboard and provide them with the needed training, supervision and mentoring needed. Our consultations revealed the use of innovative methods such as video link with a supervisor from another state are often key. This method does have limitations, however there should be a greater emphasis on technological infrastructure to help support innovative supervision practices.

Also as noted above, the Strategy needs stronger recognition of the role of mental health determinants and interrelated factors - social, economic, political, and cultural and so on.[7] This recognition is reflected in the various plans and frameworks across the country including the NT. The analyses put forward by the NT needs to be touched on directly and expressly because of their complexity. Determinants, which are specific to the NT context, must be factored into and accounted for, in order for an NT mental health workforce to sustainably succeed.

[7] Lewis, L 2009, 'Introduction: Mental Health and Human Rights: Social Policy and Sociological Perspectives', *Social policy and society: a journal of the Social Policy Association*, vol. 8, no. 2, pp. 211–214.

The Senate Community Affairs Reference Committee Inquiry into the accessibility and quality of mental health, showed that policy mimicry in rural and remote communities does not work. For example, services in rural and remote Australia are not equipped for the stepped-care model, which is still the desired model for PHNs.[8]

This is also the case for the National Mental Health Services Framework, which, as noted by the WA Health Alliance "is not suited to respond to the mental health needs of 'sparse and disparate populations' in rural and remote Australia and that refinement of that framework for rural and remote settings is 'several years away".[9]

In summary, a rural and remote mental health workforce strategy is needed to differentiate itself from a more southern context. Baring the establishment of a separate strategy, the National Strategy must recognise the complexity of the Northern Territory.

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?**

Although the Strategy touches on many of the issues which detrimentally impact upon the attractiveness of the sector, it fails to clearly identify approaches to remedy this. The Strategy ought to identify the role that non-health disciplines and professions can play in boosting the attractiveness of working within the mental health sector such as marketing, media, communications and public relations. The strategy ought to state that there will be a multidisciplinary approach that includes a campaign or public awareness strategy, with sound funding. A broad campaign to help de-stigmatise the mental health sector and create positive workplaces and community attitudes is paramount to remedying the shortages and maldistribution in the mental health sector.

The Strategy should also ensure that those working within health and health-related disciplines are in a better position to undertake some promotion and community engagement tasks, through an inter-sector campaign. It is important to involve people from outside health professions because of their skills in promotion, marketing and addressing stigma through effective communications. However, it is important to not completely outsource such a task.

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[8] Parliament of Australia, Senate Community Affairs Reference Committee Inquiry into the Accessibility and Quality of Mental Health in Rural a& Remote Australia,
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report

[9] Ibid

Those who work in the sector have the strongest understanding of what makes their work fulfilling and impactful.

One way to equip these skills is through the subsidising of short-term courses on such skills for those in the mental health workforce. For example, the Strategy could include discussions of a release of online accredited free short-term courses in particular areas such as indigenous culture, board governance, financial management, IT and so much more. The Coalition argues that people will be encouraged to stay in the NT mental health workforce if employers are able to demonstrate that employees will be fully complemented with opportunities to grow their soft and hard skill set.

The Strategy should also push for a system wide examination of educational offerings - for those about to enter into TAFE and/or university, those who are in the workforce, including those who have been in the workforce for a long time. It is important that mental health elective, core units and courses as a whole are reviewed for their return on investment and whether there may be a stronger return on mandated training (pre-service or not) for those entering or in the workforce.

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?**

An important key element to rectifying the mental health workforce is reliable, verifiable data, which has been given much consideration in the framework. Data is integral to creating a strong workforce, however at present, the mental health workforce is practically invisible and needs a range of measures embedded into data collection such as:

- Longitudinal or time series data, which allows for an estimation of the probabilities of transition (moving in and out of the workforce);
- Response rate – Response rates to surveys are never at 100% and therefore data needs to be adjusted;
- Specific indicators to measure rural and remote context; and those
- Not in the workforce – who are qualified and out of the workforce (and therefor what policies do we need to attract people back to the workforce).[10][11]

[10] University of Queensland, National Mental Health Workforce Strategy - A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries,

[11] Miller ME, Siggins I, Ferguson, M & Fowler G 2011, 'National mental health workforce literature review', Melbourne, Department of Health.

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A fundamental shift must happen with the mental health workforce and the Coalition applauds the commitment towards this shift, however data for modelling should be the essential component before any strategic plan. When gathering data, essential basic variables in demand modelling must be included to account for:

- Number of positions that are unfilled;
- Fluctuation required to provide best practice treatment and staffing practices to the whole population;
- Mental health, treatment trends and demographic trends which impact of workforce requirements;
- Consumer socioeconomic and employment status;
- Geographic remoteness and socioeconomic status; and the
- Health status of consumers.[12]

Data and evaluation are essential to the success of the Strategy and the success of a thriving mental health workforce. The current lack of systems evaluation has put the sector at a disadvantage. Evaluation should be embedded into every aspect, from inception to implementation and beyond. Evaluation drives reform and without it we are in the dark. The sector requires evaluation that will look at the interconnectedness of the various sectors e.g., mental health and housing. How do these two sectors work together and where are the gaps?

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?**

Service provision in the Territory is wide ranging and diverse. There is an increase in demand for services which are growing in complexity of the populations needs.

The strategy must emphasise the importance of dual competencies: clinical and cultural, community-based mental health, addiction services and a recovery approach that accounts for cultural elements.

The Strategy needs to emphasise greater support for wrap-around and stepped care where these models are appropriate and a greater emphasis on place-based and non-clinical care where the former models do not work.

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[12] University of Queensland, National Mental Health Workforce Strategy 2020 - A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries, https://espace.library.uq.edu.au/view/UQ:c8a5a12

This is where localised capacity building skills of not only mental health workers, but peak bodies and the human resources of mental health organisation are essential. Building the capacity of an organisation from the inside to be able to innovate and pivot when needed is key to the mental health workforce in the NT. The fluctuating demographics and geographical challenges require workers and organisations who are multidisciplinary.

The Strategy ought to consider the role of modern technology, which can help people access mental health supports without having a face-to-face professional. The Strategy must address the concerns expressed that there are not enough adequate resources and infrastructure that are appropriate for the NT – for example, the use of Telehealth in rural and remote areas is underutilised due to inadequate privacy, cultural security, and translators.

Rural and remote communities have unique risk factors, which need innovative and multidisciplinary approaches. Working with local industries to create and facilitate better technological infrastructure to address the issues of isolation in rural and remote communities and build social capital and connectedness is an important integration of care.

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 NT branch of Royal Australian and New Zealand College of Psychiatry (RANZCP) has acknowledged that staff practicing in the NT are at greater risk of burnout and poor morale. Mental health related stigma among health professionals is of big concern. During consultations the Coalition heard that staff working in the mental health department of the hospital have experienced poor treatment and stigma by other non-mental health staff. The sometimes toxic and high-pressured environments in which people work is contributing to workforce demands.[13]

The Productivity Commission report (2020) voiced the importance of the availability of high-quality workers with the right skills for a functioning mental health system. Staff need to be allocated to tasks that use their skills efficiently, and the shortage of psychiatrists and mental health nurses, underutilisation of peer workers, negative workplace cultures in some services

[13] RANZCP, Principles for the treatment of persons found unfit to stand trial, https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/persons-found-unfit-to-stand-trial#:~:text=According%20to%20the%20Principles%20for,treated%20in%20the%20least%20restrictive

expose workers to stigma, stress, and burnout, leading to high staff turnover and poor outcomes for consumers.[14]

The Strategy must adequately address the skilled migrant shortage created by Covid-19 and the impact on mental health workforce. Not only is there maldistribution, but the skilled migration tap has also been effectively cut off for 18 months. Whilst it was always difficult to attract and retain mental health workers to the NT, it is concerning that this elephant in the room has not been addressed.

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?**

Drawing upon works from another jurisdiction needs to be done so with great care, especially for the context of the NT. Notwithstanding the need for careful consideration, when looking at what the Scottish government's definition there is a holistic quality that is desired. The Scottish Government's National Mental Health Plan acknowledges that improving mental health is not only the preserve of the NHS, but that of the wider society. Poverty, justice, education, social security, and employment are interlinked with mental health and wellbeing; "mental health is inseparable from physical health and related to all the wider aspects of public health and health inequalities."[15]

The Scottish Government's National Mental Health Plan recognises that their strategy's context is situated in the wider societies views on mental health; as well as the good work that is embodied within safety, health, wellbeing, human resources, policy, practice and procedures.[16] With this in mind, it is important to broaden the scope of who is included in the mental health workforce.

This is important in the context of rural and remote communities in the NT where the diversification of skills is paramount because of the lack of services. For example, mental health issues are predominantly disorders of the young and school staff, parents, and carers have a role to play in the preventative space. Each of these cohorts needs to be equipped with

[14] Productivity Commission 2020, Mental Health, Report no. 95, Canberra

[15] Scottish Government's Mental Health Strategy 2017-2027, file:///C:/Users/NTMHC%20User/Downloads/00516047%20(1).pdf

[16] ibid

the right knowledge and tools.[17] They are all a part of the broad and diversified mental health fabric and therefore, need to be considered.

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

Key elements which must be embedded into the Strategy and operationalised are:

- Co-design embedded from inception to delivery to evaluation
- Consumer, carer, and staff feedback loops
- Individual is an expert in their own life
- Recruitment of diverse staff
- Placed-based workforces
- 'Specialist' needs training – SEWB, LGBTQIA+
- Monitoring and evaluation
- Education, professional development and mentorship throughout all career stages
- Transparency and accountability
- Active engagement
- Holistic health frameworks

There are also practical elements of the mental health workforce in rural and remote communities which need to be addressed, for example, housing workers. The lack of housing and broader infrastructure necessitates a workforce which consists of fly in fly out (FIFO) or drive in drive out (DIDO), which, if not supported adequately, may create additional significant and professional challenges.[18]

[17] Miller ME, Siggins I, Ferguson, M, & Fowler, G 2011, 'National mental health workforce literature review', Melbourne, Department of Health.

[18] Rose Sutherland, C. et al. 2017, 'Experiences of Fly-In, Fly-Out and Drive-In, Drive-Out Rural and Remote Psychologists'; *Australian psychologist*, vol. 52, no. 3, pp. 219–229.