Submission to the Department of Health on the National Mental Health Workforce Strategy Consultation Draft

September 2021

Allied Health Professions Australia

This submission has been developed in consultation with AHPA's allied health association members.

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About AHPA and the allied health sector

AHPA is the recognised national peak association representing Australia's allied health professions. AHPA's membership collectively represents some 130,000 allied health professionals and AHPA works on behalf of all Australian allied health practitioners, including the largest rural and remote allied health workforce numbering some 14,000 professionals. AHPA is the only organisation with representation across all disciplines and settings.

With over 200,000 allied health professionals, allied health is Australia's second largest health workforce. Allied health professionals work across a diverse range of settings and sectors, providing services including diagnostic and first-contact services, preventive and maintenance-focused interventions for people with chronic and complex physical and mental illnesses, supporting pre- and post-surgical rehabilitation, and enabling participation and independence for people experiencing temporary or long-term functional limitations. Allied health also provides an essential bridge between the medical sector and social support systems such as aged care and disability, where it can represent the key formal health support in a person's life.

AHPA provides representation for the allied health sector and supports all Australian governments in the development of policies and programs relating to allied health. AHPA works with a wide range of working groups and experts across the individual allied health professions to consult, gather knowledge and expertise, and to support the implementation of key government initiatives.

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

The aim needs to be expanded via a demonstrated understanding of person-centred and holistic mental health to include an emphasis on physical health, prevention, and early intervention from the time of first diagnosis or appearance of signs of subclinical mental health issues. Other than this, it is difficult to answer this question in any detail, because the aim is expressed in such general and brief terms. See our subsequent responses, especially to Question 2.

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

Overall, the aim and objectives as currently iterated do not provide a practical strategic framework for development of an Implementation Plan to provide the Australian community with the mental health workforce it needs. In summary, the deficiencies are due to:

- some false foundational assumptions concerning the nature of current workforce challenges;
- lack of specific detail and only brief references to terms like 'innovative' and 'person-centred' without elaboration to demonstrate understanding, and with no focus on in-depth causes of the issues such as labour market shortages;
- despite the 'Background' section in the Consultation Draft, a failure to sufficiently draw upon and integrate the broader context of previous mental health inquiries and concurrent strategies;

- lack of understanding about the different roles of professionals in the mental health sector (for further detail see our response to Question 3);
- the medico-centric tone of the Consultation Draft, which does not reflect the contemporary workforce landscape;
- failure to recognise that considerations of physical and mental health should be integrated at all stages; and
- lack of recognition and understanding of allied health expertise and skillsets (see our response to Question 3).

AHPA specifically addresses Objectives 1, 3, 5 & 6 in our responses to Questions 5, 3, 6 & 8 respectively.

We welcome Objective 2 (Data underpins workforce planning), including the commitment to accessing data on professions not regulated by AHPRA. AHPA has consistently argued that it is impossible to plan for future allied health service provision, including identifying specific shortfalls and particular practice and sector gaps, without having a detailed map of allied health professionals around Australia.

The conclusion of the 2010 Workload Measures for Allied Health Professionals Final Report remains apt:

> 'Comprehensive and accurate information on the numbers and workload of the allied health workforce is urgently required for national workforce planning. If such data are not improved, then it will continue to be impossible to conduct national workforce planning for these groups in Australia. [reference omitted] Without complete and accurate allied health workforce data and expanding research capacity, the evidence base required by funding bodies and workforce planners to invest, is absent.' [1]

To understand the current and future allied health mental health workforce, we therefore need a workforce dataset that aggregates all current data sources to form a meaningful picture of the Australian allied health workforce at national, regional and local levels.

Accordingly, possible implementation activities associated with the Strategy should also incorporate consideration of the recommendation of the National Rural Health Commissioner, that the Commonwealth should develop a National Allied Health Data Strategy which includes building a geospatial Allied Health Minimum Dataset that incorporates comprehensive rural and remote allied health workforce data.[2]

AHPA also strongly recommends that music therapists, exercise physiologists, and art therapists be added to the list of suggested occupations for inclusion in the first iteration of a National Mental Health Data Strategy.

We generally support the focus of Objective 4 (The mental health workforce is appropriately skilled), while noting that:

- with respect to Action 4.1.1 see our response to Question 7;
- Action 4.1.2 requires targeted funding and training to be successful (see our response to Question 5), and should include the full relevant range of allied health professions;

[1] Quoted in Report for the Minister for Regional Health, Regional Communications and Local Government by the National Rural Health Commissioner, *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* (June 2020) ['NRHC'], 26.
[2] NRHC, Recommendation 3.

- Action 4.2.1 should include allied health assistants in the list of key occupations impacted; and
- Action 4.3.1 should include the full relevant range of allied health professions.

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

The Strategy needs to be informed by a clear recognition and understanding of the full range of allied health expertise and skillsets engaged in the mental health sector. It is somewhat ironic that Objective 3 is for utilisation of the entire mental health workforce, when the Consultation Draft does not consistently refer to allied health or specific allied health professions, and proposed workforce strategies are not tailored to the particular needs of allied health providers.

For example, the Consultation Draft:

> 'distinguishes between people who work exclusively in the mental health sector (for example Aboriginal and Torres Strait Islander mental health workers, mental health nurses and psychiatrists) and those working in other health settings who frequently treat, interact with, care and support people experiencing suicidality, mental distress and/or ill-health (for example allied health. . .)' (p3).

Although a footnote qualifies this with the statement that 'occupations may work across settings. For example, allied health workers may work exclusively in the mental health sector or in health settings' (p3, fn 2), there is no clear acknowledgment that allied health practitioners like psychologists, mental health social workers, mental health occupational therapists and eating disorder dietitians work exclusively in mental health.

Other allied health professionals such as music, art, dance, movement and drama therapists, and rehabilitation counsellors, are not referred to at all in the Consultation Draft. If the overall aim is to enhance the workforce, then we must consider all those professionally trained workers who already exist and work – or could be employed – in the field.

Key allied health professions that apply a holistic concept in their provision of mental health services include physiotherapy, exercise physiology and speech pathology. For example, physiotherapy practitioners recognise the considerable impact that physical pain can have on mental health. Speech therapists understand that there is a well-documented link between communication and swallowing difficulties, and mental health. There is also growing evidence of the mental health treatment and prevention role afforded by diet and exercise interventions, and allied health professions such as dietitians and exercise physiologists are best placed to deliver these.

A diverse range of allied health professions can also improve functionality and quality of life, assist with reablement and self-management, and reduce the likelihood of complications and hospital admissions in many physical conditions that contribute to poor mental health.

The Consultation Draft describes itself as

> 'view[ing] mental health through a social and emotional wellbeing lens and conceptualis[ing] the mental health workforce accordingly, recognising the indivisible connection between people's physical, psychological, social, emotional and cultural wellbeing' (p3).

Despite this claimed appreciation of a holistic approach to mental health, the Consultation Draft fails to consistently recognise the distinct contributions by various allied health professions to mental health treatment and support.

The Consultation Draft notes that in addition to health practitioners regulated by AHPRA – as is the case for many allied health professionals – there are professional peak bodies and colleges that administer self-regulated occupational schemes (p4). However, there is no acknowledgment that many self-regulated practitioner peak bodies, including for allied health occupations, are also members of the National Alliance for Self-Regulating Professions (NASRHP), and therefore, like AHPRA-registered professions, require accredited university courses of study, must meet national competency standards, have very clear scopes of practice, and are subject to robust and enforceable regulatory mechanisms.

AHPA is therefore not convinced that lack of clarity in scopes of practice and misalignment with regulation are key challenges to utilising the entire mental health workforce, as claimed under Objective 3 (pp14-18) – at least as far as this pertains to allied health. We refer to and endorse the recommendation of our member Exercise & Sports Science Australia, that a nationally consistent capability framework be developed to outline levels of practice detailing different capabilities and competencies, which both the clinical and non-clinical workforce can use as a guide for self-reflection and self-development.

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?

It is not possible to answer this question – see our comments in response to Questions 2, 3 & 5.

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?

While visibility of and pathways to a mental health career may be relevant at high school level for some careers like psychology and counselling, they are more relevant at tertiary level or once a qualified allied health practitioner commences working. Nevertheless, we note that allied health is not visible at all in Action 1.2.1, despite significant shortages in psychology, occupational therapy, speech pathology and smaller workforces such as music and art therapies.

In the experience of most allied health professionals working in mental health, the attractiveness of the sector is not a key limiting factor in workforce recruitment. Instead, we agree that as the Consultation Draft identifies (p7), the quality and variety of student placements is an important factor in supporting potential recruitment (and therefore properly belongs in Objective 4, not Objective 1).

Supervision is much more likely to be compromised, or simply unavailable, due to lack of infrastructure resources, rather than limited by poor supervisory skills. The problem must be addressed by targeted Government funding. The other main contributing factor to placement difficulties is the present lack of opportunity for allied health placements in most mental health

facilities. The same medico-centric approach and associated lack of consistent visibility of allied health that we have identified in the Consultation Draft means that only a few of all potential mental health professions are employed in such facilities, creating a 'chicken and egg' situation.

We therefore support Action 1.3.2, but strongly recommend that it also encompass speech pathologists, music therapists and exercise physiologists.

Implementation must also include research and training to build awareness of the value of diverse evidence-based allied health practice in the mental health sector, in order to enhance the composition of multidisciplinary teams. Ongoing professional supervision, support and debriefing within such teams are essential.

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?

We generally support the actions outlined in Objective 4, while noting that enhancing supervision supports and standards, and supporting professional development, require designated funding. It is also unclear what 'Allied health workers' means in Action 5.1.1. Mental health social workers should be included as occupations for immediate action under Action 5.2.1.

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?

Both the Strategy and the Implementation Plan must actively address the inappropriately restricted nature of the present medico-centric mental health sector. They can achieve a shift toward a more genuine multidisciplinary approach by comprehensively adopting a more holistic view of mental health that aligns with contemporary evidence about the benefit of different treatment types and modalities. This should include building in attention to 'dashboard' outcomes so that the focus is on the person and the outcome, not the practitioner.

A genuinely integrated future mental health system will rely on seamless transitions to and from quality secondary care and tertiary care sectors and within primary care, so that people receive a continuum of mental health services according to their needs and as needed throughout the life course. To achieve these goals, the Strategy and the Implementation Plan should operationalise the removal of barriers to collaboration and improvement of coordination between health and other sectors such as education and justice.

The mental health sector can also learn from allied health's model of strength, flexibility and adaptability in professional diversity, which is ideally suited for a future mental health system that is organised around multidisciplinary care teams and values interprofessional practice collaboration. The term 'interprofessional practice' encapsulates more than an additive model of practitioners from different disciplines, and is defined as:

> 'the spectrum of care models from multi-disciplinary to transdisciplinary within a system that has mechanisms in place to activate the appropriate team to meet patient needs and preferences, from traditional GP-nurse teams and variations of this such as GP-

physiotherapist teams to chronic disease models and other team-based care involving combinations of health and other professionals [including various allied health].'[3]

Irrespective of the specific care model, a more seamless and integrated system requires investment that goes beyond episodic direct service provision and also funds multidisciplinary care planning, shared care plans, and care coordination activities such as case conferencing. Commitments to develop innovative equitably funded models, including block, blended and bundled approaches, and to provide greater support for providers and practices, including innovative models for multidisciplinary and intersectoral team care, will be necessary to enable consistent and high quality of mental health services, regardless of postcode.

Funding must also be allocated for governance and interdisciplinary collaboration and partnerships. To achieve this change in interprofessional practice, mental health provider organisations must work with professional groups to agree on a national competency framework for collaborative practice. They must identify changes to education programmes to support the development of interprofessional collaboration competencies in the workforce, including embedding collaboration and teamwork capabilities in student curricula.[4]

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?

Mental health services, including allied health, are unevenly distributed not only in rural and remote areas but also in metropolitan and regional areas, with the result that those most in need are the least likely to have affordable access. To improve service planning, issues such as resistance to supporting new models of care together with a lack of understanding of allied health scopes of practice must also be addressed. Action 6.1.1 should therefore include the full relevant range of allied health professions.

The rationale and implications of Action 6.2.1 are not clear. While AHPA supports the principle of utilising the competencies of all workforces to their full scopes of practice in order to maximise existing workforce capacity, we are strongly opposed to any proposal that at best requires significant training investment and at worst inappropriately substitutes less qualified personnel, such as recovery coaches and peer support workers as an overflow workforce.

In the allied health sector for example, it is recognised that allied health providers in mental health are professionally trained and accredited, and therefore not interchangeable with the allied health assistant workforce. An allied health assistant working under a delegation framework can be invaluable, but treating them as cheap substitutes for qualified allied health professionals risks client safety.

Any proposed action to expand the scope of workers who are less qualified and regulated should require a thorough process to identify and define the roles of different existing mental health workforces, in order to ensure that the mental health system is making the best use of available professionals.

[3] *Hidden in plain sight: Optimising the allied health professions for better, more sustainable integrated care*, New Zealand Institute of Economic Research report to Allied Health Aotearoa New Zealand (23 June 2021), 1-2.
[4] *Hidden in plain sight*, 42-45.

The proposed actions also lack sufficient detail. Key issues, particularly in rural areas, include the challenge of recruiting practitioners, particularly from some professions, lack of education and work placement opportunities in areas with need, professional isolation and lack of peer support; as well as a more complex and diverse range of clinical expertise being required. We note that the challenges of delivering coordinated care to rural and remote regions have been known for at least 50 years and that the National Rural Health Commissioner's recommendations are yet to be fully implemented.[5]

With regard to individual mental health professions, in-depth mapping and analysis is necessary to ascertain whether particular types of workforce shortages require specific training and support actions.

It will be critical to ensure that workforce actions provide funding and support for specific workforce interventions where there is only limited or no access to services. Returning to the rural focus, recent initiatives such as the Allied Health Rural Generalist Workforce and Education Scheme ('AHRGWES') demonstrate that it is time to abandon limited pilots and instead identify and roll out a range of bold approaches with commitments to ongoing evaluation, tailoring and funding. For example, budget items must be allocated in the AHRGWES for student placements, scholarships for Allied Health Rural Generalists working in private practice and non-government organisations, mentoring and supervision, as well as, where appropriate to local context, for backfilling, travel and accommodation.

While solutions that might work in some areas are likely to need to be at least adapted for elsewhere, there is utility in considering, adapting and expanding this type of model of training and support, provided that funding is secure, ongoing and tailored to the service.

Another possible example might be along the lines of proposed Rural Area Community Controlled Organisations (RACCHOs),[6] themselves influenced by the success of Aboriginal Community Controlled Health Organisations and community health centres. As with training and student placements, these preferred models or 'provider hubs' should be multidisciplinary, shaped to local context (including outside rural areas) and adaptable.

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?

See our responses to Questions 3, 7 & 8.

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

There must be funded support for ongoing research into broad holistic approaches to mental health care, including evaluation of interprofessional practice collaboration. This would not only identify and demonstrate value, but would also provide direction for further training.

[5] NRHC, Recommendations 1-3.
[6] https://www.ruralhealth.org.au/sites/default/files/Infographic-proposal-for-better-health-care-a4v2.pdf .

In the absence of the Taskforce's direct engagement with the broader allied health sector, it will be essential to ensure that the Department of Health engages with AHPA and its members in the implementation, including monitoring and evaluation, of the Strategy.