NATIONAL RURAL HEALTH ALLIANCE LTD

5 April 2019

Productivity Commission
Mental Health Inquiry
mental.health@pc.gov.au

Dear Sir/Madam

Please accept this submission in response to the Productivity Commission's inquiry into mental health in Australia from the National Rural Health Alliance.

The National Rural Health Alliance undertook a survey of the rural, regional and remote workforce to determine what the mental health training needs are. The submission provides analysis and discussion based on the survey results.

We will gladly answer any questions you have regarding this submission.

Best regards

Mark Diamond
Chief Executive Officer
National Rural Health Alliance

NATIONAL RURAL HEALTH ALLIANCE LTD

Submission to the Productivity Commission Inquiry into Mental Health

April 2019

National Rural Health Alliance
PO Box 280
DEAKIN WEST ACT 2600

Table of Contents

1. Introduction 2

2. Overview of the Rural, regional and remote workforce training needs to improve mental health care, services and health outcomes survey 4

3. Survey Results 5

Demographic characteristics 5
Disciplines and roles 6
Knowledge and confidence with dealing with mental health issues 7
Training costs 8
Challenges in meeting your mental health training needs 8
Additional training and skills needed 9
How could training and continuing professional development be improved 12
Other comments from respondents 14

4. Conclusion 15

5. Appendices 16

Appendix 1: List of Member Body Organisations 16
Appendix 2. Rural, regional and remote workforce training needs to improve mental health care, services and health outcomes survey questions 17

1. Introduction

The National Rural Health Alliance (the Alliance) welcomes the opportunity to provide this submission for consideration by the Productivity Commission's inquiry into mental health.

The National Rural Health Alliance is comprised of 38 member organisations. It is committed to improving the health and wellbeing of the almost 7 million people living in rural, regional and remote Australia[1].

Our membership is diverse and geographically dispersed and this reflects the complex nature of rural health. Members include consumer groups, Aboriginal and Torres Strait Islander peak body organisations in the health sector, health professional organisations and service providers. For a full list of our members see Appendix 1.

Mental health and wellbeing of people in rural and remote areas is a high priority issue for the Alliance. Of particular concern is the ongoing inequity in funding for mental health services for rural, regional and remote areas, the absence of services when they are clearly needed and the ongoing fragmentation and lack of a coordination to support the workforce that does exist.

In this submission, the Alliance has focused specifically on addressing questions raised by the Productivity Commission with regards to training needs of the workforce, as per the *Social and Economic Benefits of Improving Mental Health Issues Paper*.

> *How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness? What can be done to increase its take up? (Productivity Commission, 2019 pg. 17)*

Findings from the survey and feedback from health professional working in the field are summarised as follows:

- 393 people responded the survey.
- The majority of respondents lived and worked in a rural or regional place.
- Respondents came from diverse range of groups and disciplines. The majority were from allied health, nursing and medicine (GPs). However, there were respondents who were mental health consumers, carers, or working in non-health sectors such as education, local government, volunteers and non-government/not for profit organisations.
- There are many areas where respondents indicated they needed more training. These included working with adolescents and children, Aboriginal and Torres Strait Islander people, suicide prevention and self-harm and dealing with severe and enduring mental illness.

[1] Throughout this submission references to remoteness areas are based on ASGC-RA, in which category 1 is Major cities, 2 is Inner regional areas, 3 Outer regional, 4 Remote and 5 Very remote. Because of small numbers, Remote and Very remote are often reported jointly. In the submission, references to 'regional areas' mean Inner plus Outer regional; and references to 'remote areas' mean Remote plus Very remote.

1) There is a dire need for mental health training to be provide in rural, regional and remote areas and the workforce need to be supported to attend training from whatever sector or setting they work in.
2) Professional development costs need to be incorporated into organisational budgets, with clear planning on leave days and backfilling.
3) There were specific concerns that training was mainly concentrated in the major cities and thus benefiting only a fraction of the workforce. Face to face training provided locally is preferred over online courses or webinars.
4) The costs associated with training were thought to be too high and prohibitive for most workers in rural and regional areas. Training should be fully covered or heavily subsidised and delivered on site in rural, regional and remote areas enabling more people to attend.
5) Most people indicated that they just did not have the time to attend training or for study due to work and other life demands. This indicated the need for professional development and training to be integrated as core business, not as a special event or ad hoc training. Training needs to be incorporated into on site will not only cut cost but address one issue of time constraints related to travel time and cost.
6) The workforce could be further supported to develop their skills through shadow work in order to gain more experience in working in this space.

2. Overview of the Rural, regional and remote workforce training needs to improve mental health care, services and health outcomes survey

The purpose of the survey is to find out what are the mental health training needs of the rural, regional and remote workforce to improve mental health care services and health outcomes.

The survey was developed by the Alliance and was opened from Friday 22nd March– until close of business Tuesday April 2nd 2019.

Recruitment of respondents to the survey was via sample of convenience and snowball technique. Invitations to participate in the survey were distributed to the Alliances' email database recipients and via Twitter. Respondents were able to complete the survey via survey monkey or for delegates attending the National Rural Health Conference in Hobart, in hard copy.

Survey questions were a mix of open-ended responses, selecting a choice of responses and rating scales. Questions were framed around knowledge and confidence, key challenges in accessing training. Costs of previous training, preferences for future training needs and suggestions as to how training and professional development can be improved.

For survey questions please see Appendix 2.

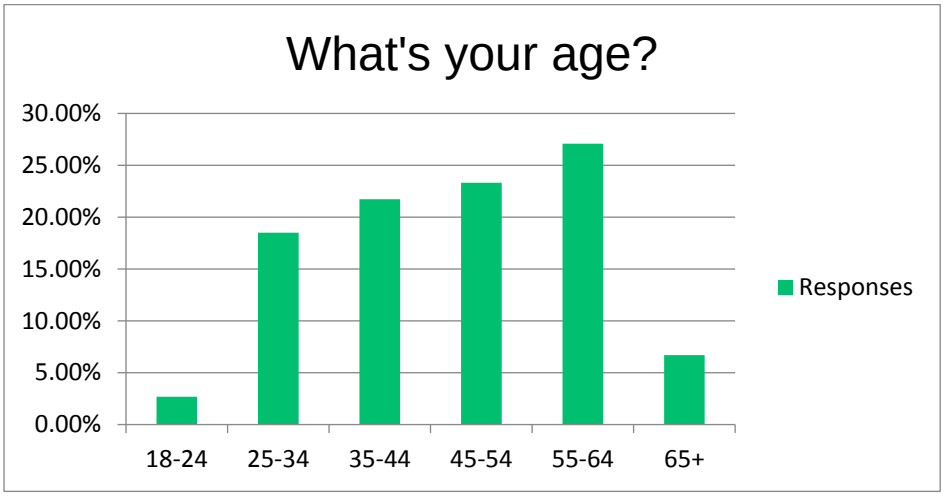
3. Survey Results

This section provides a summary of the survey results. There were 393 surveys (n=393) completed 373 via Surveymonkey and 20 via hard copy. Hard copy data were added to Surveymonkey data and included in the analysis.

Demographic characteristics

Over 50% of respondents were aged over 45 years of age. 80% were female, 19% male and one respondent identified themselves as other.

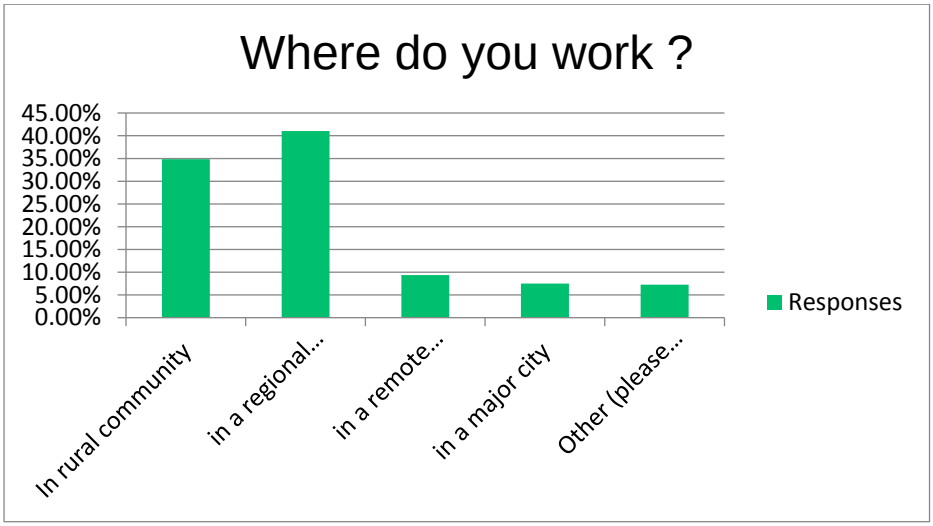
Figure 1 Question 4 Where do you live?



The majority of respondents indicated they lived in regional or rural community with 40.86% living in a regional community (n=152) and 38.71% living in rural community (n=144).

The majority of respondents also indicated that they worked in a regional community (41.02% n= 153) or rural community (34.85% n= 130).

Figure 2 Question 5 Where do you work

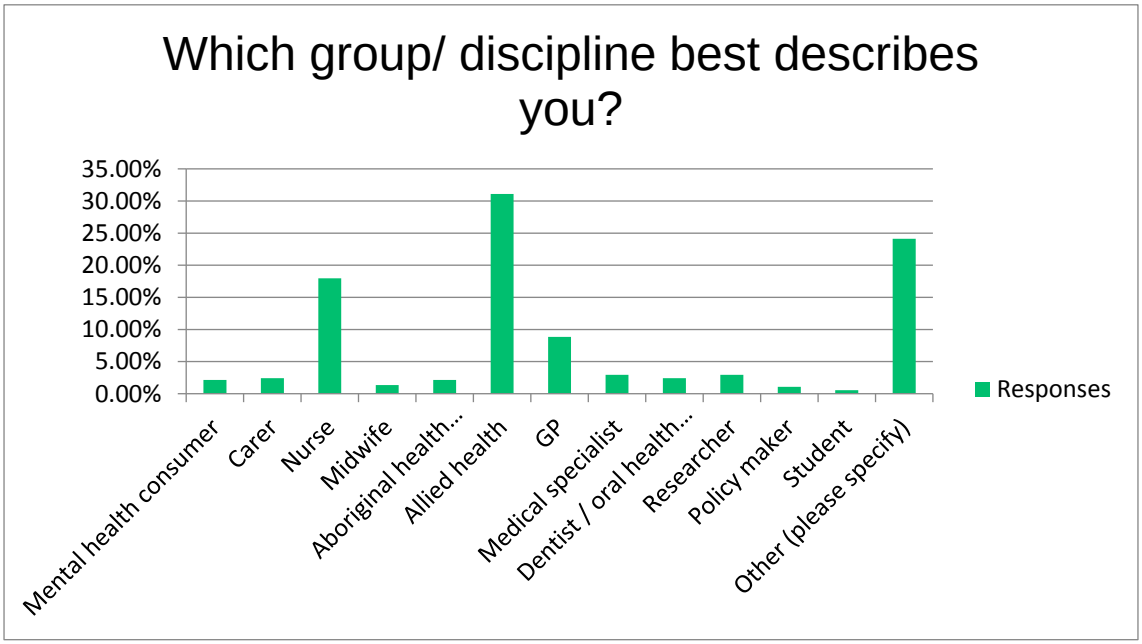


Disciplines and roles

Respondents were asked to indicate which group or discipline best described them.

Over a third of respondents (31.1 %) were from allied health professions. The next largest groups were from 'other' (24.13%), nursing (17.96 %) and General Practitioner (8.85%). Of note, there were 8 mental health consumers and 9 carers who also completed the survey. The 'other' category were further grouped into mental health workers and service providers, educators, managers, advocacy and not for profit groups, administrators and government workers.

Figure 3 Question 3 Which group/ discipline best describes you?



With regards to the role respondents have in their communities' results were classified in the following broad categories:

- Mental health service provision
- Allied health
- Educators
- Managers
- Policy and Research
- Consumer and Carer
- Volunteers, advocacy and lobbying

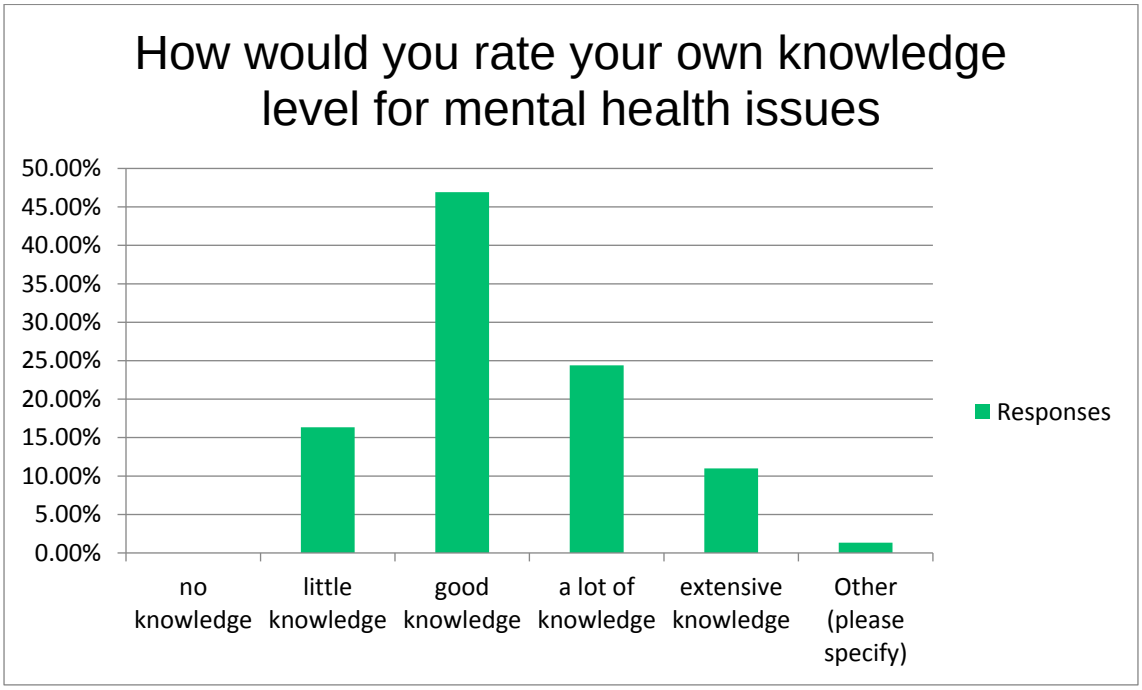
This wide range of professionals working in mental health underscores the importance of a multidisciplinary approach to mental health. These professionals require continuing support to enable them to operate effectively in their different areas of specialty. As most have requested in the survey, support is needed in the form of funding to participate in mental

health training/activities; time made available to attend training; and increasing training opportunities for workers in rural, regional and remote areas.

Knowledge and confidence with dealing with mental health issues

Responses to the question how would you rate your own knowledge for mental health issues showed that majority of respondents indicated they had good knowledge (46.92%), a lot of knowledge (24.4%), or extensive knowledge. Few respondents indicated they felt they had little knowledge (16.35%). (see Figure 4)

Figure 4 Question 7 How would you rate your own knowledge level for mental health issues?



In relation to confidence in dealing with mental health issues, the majority of respondents indicated that they were either moderately confident (42.9%), very confident (27.61%) or extremely confident (5.36%). However, approximately one quarter of respondents did indicate that they had little confidence (17.16%) and or were not confident (6.97%).

Formal training in mental health

Responses indicated that 49.06% had undertaken formal mental health training. The majority of responses showed that the formal training they received in mental health was part of their undergraduate degree. For example, when training to be a Registered Nurse, Occupation Therapist or as part of Medical training.

Respondents who had post graduate qualifications in mental health had completed a range of qualifications such as Masters in Advanced Occupational Therapy; Professional Psychology; Community Development; Nursing and PhD in Psychology.

Below are further examples of qualifications within which mental health training was embedded:

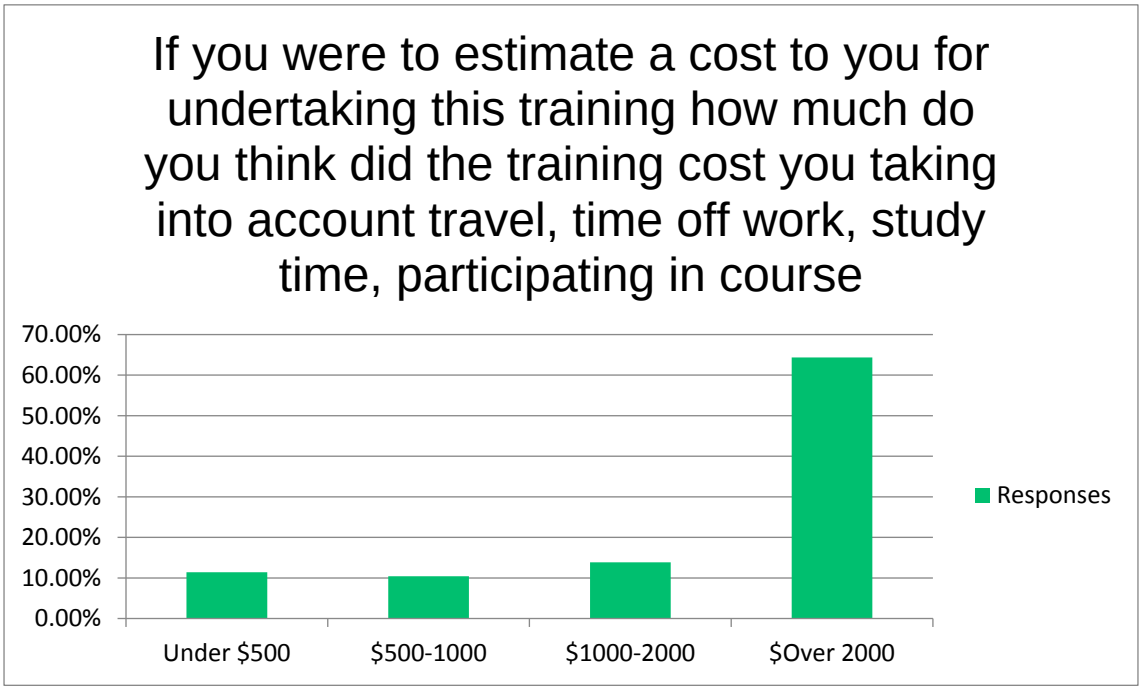
- *Certificate IV* covering: Alcohol and Other Drugs (AOD) and Mental Health; Community services; and Emotional intelligence
- *Continuous Professional Development (CPD) training courses* including trauma informed care, mental health first aid, eMentalhealth, intentional peer support, working with self-harming behaviours, youth sexual health, personality disorder interventions
- *Mental Health First Aid focusing on*: Youth mental health; Adult mental health and Aboriginal mental health.

In some cases too, mental health training, for example antenatal mental health screening, was provided in the form of day courses, seminars, workshops, and on the job-training

Training costs

The majority of respondents that had formal training indicated that the training had cost them over $2000 to undertake the training as outlined in Figure 5. Comments made by some respondents also indicate that when taking into account all training costs and time off work (with no income) the cost to them was in excess of $100,000.

Figure 5 estimated costs of formal training



Challenges in meeting your mental health training needs

Although challenges varied, by far the most common challenge noted was that of lack of time to attend and study time for mental health training or professional development. This was expressed in different ways including: - fitting 'training' into caseload; competing demands; no time to study; and family demands (e.g. single parent, small children at home, caring for dependent children).

Other challenges faced include:

- Lack of availability of training in rural, regional, and remote
- Cost to the organisation of providing training to staff across Australia
- No support from the organisation (to attend training)
- Inability to identify relevant training
- Location of training not accessible for rural, regional and remote participants

Some challenges are specific to work arrangements as the quote below suggests:

- *Our contracts have KPI figures we are required to reach, which does not deduct or subsidise training. So, each time we have training, it impacts on figures and reaching the desired target.*

Figure 6 Question 12 What are your challenges in meeting your mental health training needs?

Additional training and skills needed

> *"All mental illness has complexities. Understanding and having knowledge of what they can be, where to find the most useful resources is a challenge".*

This statement aptly summarises the complexities around mental health. These complexities determine the type of training and skills that can help mental health workers in their work.

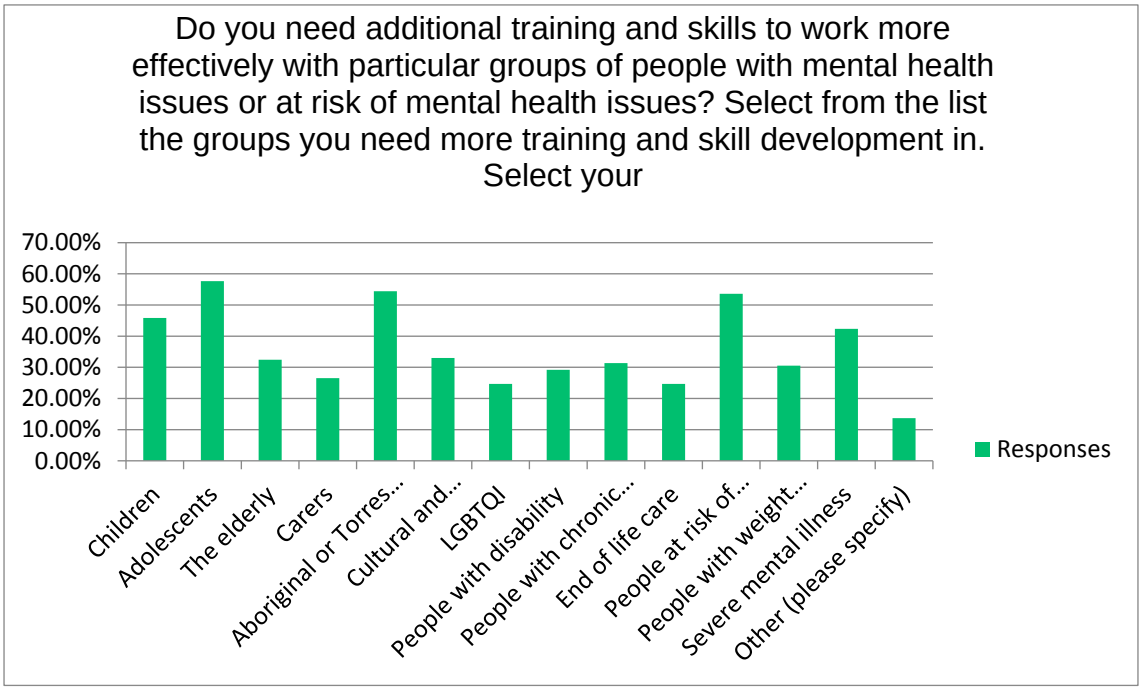
Respondents indicated that they need more training in range of topics are and some specific population groups. The highest numbers of choices were made for training in working with adolescents (57.64%), Aboriginal and Torres Strait Islander people (54.2%), people at risk of suicide and self-harm (53.62%) and children (45.84%).

Some respondents provided an additional list of training needs of this training, in addition to that noted above, in question 13 (and some are reiterated again in Question 14 results as outlined below) in the following areas:

- Addiction/Alcohol and other drug users
- Assisting workers (the workforce) who have a mental health illness
- People from trauma backgrounds
- Farming families
- People with comorbidities
- People escaping domestic violence
- Aboriginal and Torres Strait Islander people
    - Homeless people
    - LGBTQI
    - Clients in the penal system
    - Parents and family members
    - Young adults
    - People with eating disorders
    - People experiencing grief and loss

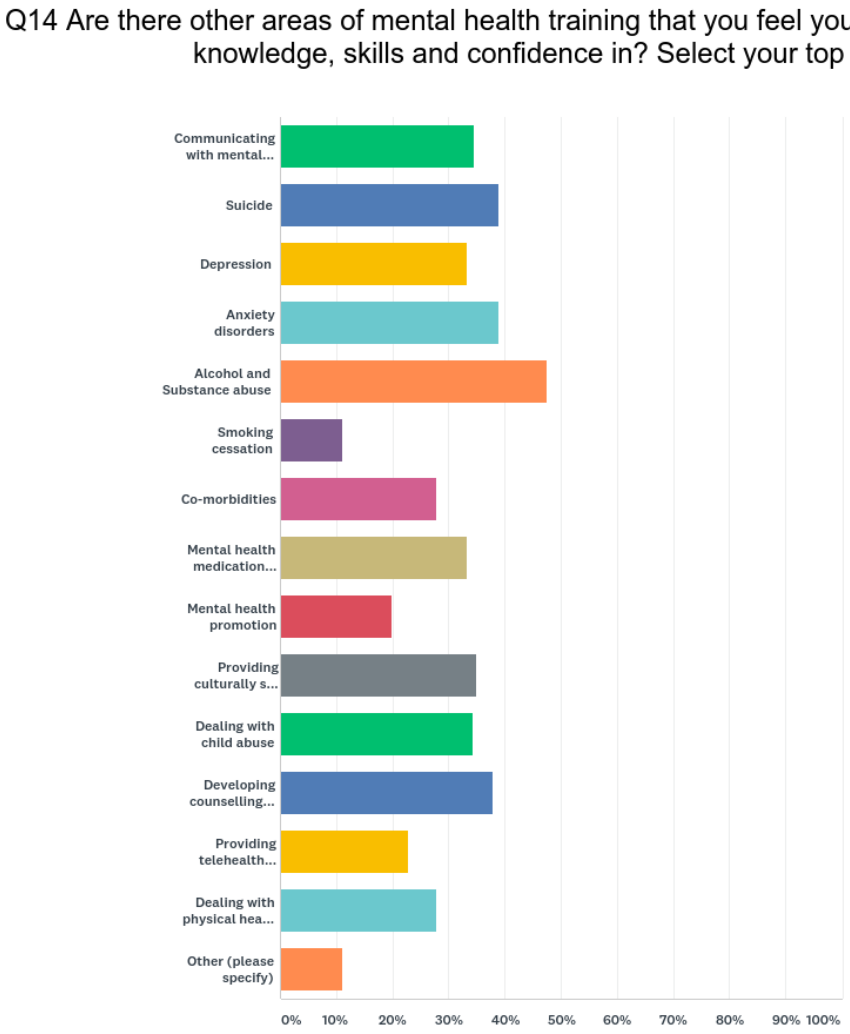
      People with intellectual disability and cognitive impairment

Figure 7 Question 13 Do you need additional training and skills to work more effectively with particular groups of people with mental health issues or at risk of mental health issues?



Respondents indicated an interest in developing knowledge, skills and confidence in the wide range of areas indicated in Figure 8 but most commonly in alcohol and substance abuse (47.45%), suicide (38.87 %), anxiety disorders (38.87%), developing counselling skills (37.80%) and providing culturally safe care (34.85%).

Figure 8 Question 14 Are there other areas of mental health training that you feel you need to develop knowledge, skills and confidence in?



There were concerns over the lack of skills in certain areas, as one respondent notes:

> *Although I've personally studied to fill any gaps I've noticed, my university training was insufficient for providing training in emotional dysregulation, strategies to help with alcohol and substance abuse, and general trauma.*

When asked to specify the other areas they felt they needed to develop their skills, respondents mentioned the following areas:

- Post-traumatic stress disorders (PTSD),
- Lesbian, Gay, Bisexual, Transgender, Intersex (LGBTI)
- Management of staff with mental health issues,
- Supporting staff to manage all the different areas,
- Eating disorders
- Borderline personality disorders.

How could training and continuing professional development be improved

In previous questions, respondents indicated that the majority of their mental health training was obtained during their undergraduate degree. However, it is clear from respondents' additional comments that this foundational theoretical knowledge needs to be enhanced with ongoing and well supported professional development. Also, there were comments that the mental health coursework in their undergraduate degree was not covered in enough detail to equip them to be feel confident to work with mental health clients in the workplace. The quote (above) emphasizes the need for continuing professional development for professionals working in the mental health space.

Respondents to the survey thought training and continuing professional development could be improved in different ways such as:

Structure of training and mode of delivery*:*

- Access to training and costs were key issues addressed in the challenge's respondents had in accessing training. The majority of respondents made comments that training options need to be local, or at the least and cost prohibitive, preferably with no out of pocket costs to the workforce.
- Face-to-face training (rather than online) was more preferred as this allows more human interaction.
- Online training was seen to be problematic due to poor or unreliable connectivity in rural and remote areas.
- Some respondents requested bedside training as well as training provided to all workplaces through continuous professional development.
- Training needed to be tailored to take into account the differing knowledge levels of training participants. More in-depth training could be provided for those that already had skills.

The type of training to be provided*:*

One of the main purposes for training was to update skills in working in the area of mental health. Training could also focus on specific areas such as suicide prevention and raising cultural awareness of Aboriginal culture and culturally safe care.

Where training could be provided*:*

High costs of training tend to prohibit health professionals from attending training. Respondents therefore requested that training be provided onsite to alleviate costs, as one respondent said:

> *Bring the training to us. Most workers are from NGO's (*Non-Government Organisations) *that can't afford or don't provide opportunities. Unlike cities, we do not have additional services we can refer to*.

There was constant mention of the regional disparities in training opportunities where workers in major cities had better opportunities compared to their colleagues in rural,

regional and remote areas. Providing onsite training in these areas could overcome these disparities.

Mental health was increasingly becoming an issue of concern in farming areas due to the drought and as such, there were calls for more mental health training in these areas.

Target groups for training:

Respondents suggest that training in mental health should be provided for all health professions. There were also respondents who are not health professionals and work in other sectors or settings such as in education sector, local government or community services. These respondents also would like to have equitable access to ongoing support for mental health training.

> *Quote 1: … everyone has responsibility to care for MH despite presentation reason*
>
> *Quote 2: Everyone should have access to some sort of first aid training/support particularly in rural, remote and regional areas*
>
> *Quote 3: It needs to be for everyone. Not just people that have attended university. Not just for carers. The more trained up we are as a Aboriginal community the better supported our community will be*

Quite often the mental health of those providing services is not taken into consideration. Mental health training, respondents suggest, should address the mental health needs of those health professionals and other workers with a role in mental health.

Supports needed*:*

- ***Funding***: There was strong feedback from respondents that funding needs to be made available to enable the workforce to access training to provide them with the opportunity to acquire and maintain their skills in mental health. Funding should cover costs associated with attending training (travel, accommodation, study time) as well as scholarships for graduate training.
  There were requests to improve training for health workers and peer workers caring for people with a mental illness by "*offering scholarships or sponsoring MH clinicians to undertaking post grad study"*.

- ***Time***: Apart from high training costs, lack of time to attend training could be a huge barrier.

  > *Of course it (training) could be improved, but how is a difficult question. Many people are either isolated for extended periods, or burnt out, expecting people to do additional professional (or nonprofessional) development in own time is not acceptable as people are over worked with multiple responsibilities… there needs to be a structured and professional development program that incorporates all required learning…*

  The issue of time could be addressed by "organising backfill for leave to attend training".

- ***Resources***: In some cases workers have the knowledge to deal with mental health issues however, they do not have the resources needed to do their work effectively or keep up to date with emerging research and best practice. Also, access to "evidence-based online resources" was suggested as another way in which some respondents could access resources for their professional development.
- ***Language services***: Suggestions were made for interpreters and translators to be available to assist with working with clients from non-English speaking backgrounds.
- ***Incentives and remuneration*****:** Some respondents suggested that providing higher level of remuneration and incentives could assist in achieving an increase in and maintenance of the mental health workforce.
- ***Shadow work****:* Respondents also suggested that providing opportunities for the workforce to shadow work as supernumerary to gain experience by working temporarily in alternative workplaces could assist with skill development.
- ***Continuing professional development***: This is seen as an essential part of providing mental health care.

Other comments from respondents

Question 16 was an open-ended question asking 'Are there other comments you would like to make about mental health training?' The following is a summary of key points made by respondents.

Respondents indicated that training in mental health needs to:

- be provided across disciplines (as opposed to some and not others). There were concerns that some professions such Dentistry were overlooked in the provision of mental health training. In addition, local mental health professionals could train e.g. local allied health professionals and resident medical officers.
- focus on the determinants of health will ensure that people with a mental illness are supported to change their circumstances leading to better mental health outcomes - *"We are medicating people for being poor".*
- be collaborative, for example "*within true clinical practice such as integrated (not separated) with clinical acute care presentations and acute wards in the remote and rural context."*
- be multifaceted – so it includes other factors contributing to poor mental health outcomes such as the impact of domestic violence – "*which is higher and less resourced in rural and remote…"*
- be credentialed? – i.e. training could be offered so it leads to mental health credentials. It could be aligned to a framework endorsed by e.g. "*the Australian Health Practitioners Regulation Authority (AHPRA) or the Professional Boards / bodies".*

4. Conclusion

The findings of this survey provide clear evidence of the compound challenges faced by health professionals and other workers in working with (or at least preparing to work with) people with mental illness and the essential need for ongoing professional development.

As some respondents clearly stated, mental health and mental illness is complex. It is so complex that it cannot be left to a few individuals to deal with and requires sharing of knowledge from a multi-professional approach to address the many presenting issues.

This survey also clearly shows that efforts made by different employers in providing access to training and professional development are far from consistent. Most respondents noted that they had undertaken some form of mental health training (albeit at different levels) mostly as part of their undergraduate and higher degree training. Many others indicated having received mental health training on the job or part of continuous professional development in one day seminars or online. Respondents were well aware of the benefits from the training and at the same time, had a greater appreciation of the magnitude of mental health, their skills deficits, and the kinds of supports they needed to perform more effectively and efficiently in the mental health space.

In summary:

- There is a dire need for mental health training to be provided in rural, regional and remote areas. The workforce needs to be supported to attend training from whatever sector or setting they work in.
- Professional development costs need to be incorporated into organisational budgets, with clear planning on leave days and backfilling.
- There were specific concerns that training was mainly concentrated in the major cities and thus benefiting only a fraction of the workforce. Face to face training provided locally is preferred over online courses or webinars.
- The costs associated with training were thought to be too high and prohibitive for most workers in rural and regional areas. Training should be fully covered or heavily subsidised and delivered on site in rural, regional and remote areas enabling more people to attend.
- Most people indicated that they just did not have the time to attend training or for study due to work and other life demands. This indicates the need for professional development and training to be integrated as core business not as a special event or ad hoc training. Training needs to be incorporated on site. This will not only cut costs but address the issue of travel time and cost.
- The workforce could be further supported to develop their skills through shadow work in order to gain more experience in working in this space.

5. Appendices

Appendix 1: List of Member Body Organisations

National Rural Health Alliance - Member Body Organisations
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)
Australasian College of Health Service Management (rural members)
Australian College of Midwives (Rural and Remote Advisory Committee)
Australian College of Nursing - Rural Nursing and Midwifery Community of Interest
Australian College of Rural and Remote Medicine
Australian Healthcare and Hospitals Association
Allied Health Professions Australia Rural and Remote
Australian Indigenous Doctors' Association
Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
Australian Physiotherapy Association (Rural Members Network)
Australian Paediatric Society
Australian Psychological Society (Rural and Remote Psychology Interest Group)
Australian Rural Health Education Network
Council of Ambulance Authorities (Rural and Remote Group)
CRANAplus
Country Women's Association of Australia
Exercise and Sports Science Australia (Rural and Remote Interest Group)
Federation of Rural Australian Medical Educators
Isolated Children's Parents' Association
National Aboriginal Community Controlled Health Organisation
National Rural Health Student Network
Paramedics Australasia (Rural and Remote Special Interest Group)
Rural Special Interest Group of Pharmaceutical Society of Australia
RACGP Rural: The Royal Australian College of General Practitioners
Rural Doctors Association of Australia
Rural Dentists' Network of the Australian Dental Association
Royal Far West
Royal Flying Doctor Service
Rural Health Workforce Australia
Rural and Indigenous Health-interest Group of the Chiropractors' Association of Australia
Rural Optometry Group of Optometry Australia
Rural Pharmacists Australia
Services for Australian Rural and Remote Allied Health
Speech Pathology Australia (Rural and Remote Member Community)

Appendix 2. Rural, regional and remote workforce training needs to improve mental health care, services and health outcomes survey questions

1. What's your age? *

   18-24 25-34 35-44 45-54 55-64 65+

2. What's your gender? *

   Female Male Other

3. Which group/ discipline best describes you? *
   - Mental health consumer
   - Carer
   - Nurse
   - Midwife
   - Aboriginal health worker/ practitioner
   - Allied health
   - GP
   - Medical specialist
   - Dentist / oral health professional
   - Researcher
   - Policy maker
   - Medical specialist
   - Other (please specify)

4. Where do you live?
   - In rural community
   - in a regional community
   - in a remote community
   - in a major city
   - Other (please specify)

5. Where do you work?*
   - In rural community
   - in a regional community
   - in a remote community
   - in a major city
   - Other (please specify)

6. What is your role with mental health issues in rural, regional and remote communities? Please provide a brief summary.

* Question must be answered
* Question must be answered
* Question must be answered

7. How would you rate your own knowledge level for mental health issues*
   - no knowledge
   - little knowledge
   - good knowledge
   - a lot of knowledge
   - extensive knowledge
   - Other (please specify)

8. Overall, how would you rate your own confidence with dealing with mental health issues?*
   - not confident
   - a little confident
   - moderately confident
   - very confident
   - extremely confident

9. Have you had formal training in mental health?*
   - Yes
   - No (Go to question 12)

10. What type of training / qualification and what institution?

11. If you were to estimate a cost to you for undertaking this training how much do you think did the training cost you taking into account travel, time off work, study time, participating in course
   - Under $500
   - $500-1000
   - $1000-2000
   - $Over 2000

12. What are your challenges in meeting your mental health training needs? Select all that apply*
   - Time off work to study
   - Cost of training
   - Cost of travel
   - Poor internet connection
   - Difficult to access/ participate in online training
   - Getting to the location of face to face training
   - Limited organisational support to attend mental health training
   - Other (please specify)

13. Do you need additional training and skills to work more effectively with particular groups of people with mental health issues or at risk of mental health issues? Select from the list the groups you need more training and skill development in. Select your top 5. *

   - Children
   - Adolescents
   - The elderly

- Carers
- Aboriginal or Torres Strait Islander people
- Cultural and linguistically diverse groups
- LGBTQI
- People with disability
- People with chronic conditions (e.g. Multiple sclerosis, HIV, dementia, cancer)
- End of life care
- People at risk of suicide and self-harm
- People with weight and body image issues
- Severe mental illness
- Other (please specify)

14. Are there other areas of mental health training that you feel you need to develop knowledge, skills and confidence in? Select your top 5*.

- Communicating with mental health clients
- Suicide
- Depression
- Anxiety disorders
- Alcohol and Substance abuse
- Smoking cessation
- Co-morbidities
- Mental health medication management
- Mental health promotion
- Providing culturally safe care
- Dealing with child abuse
- Developing counselling skills
- Providing telehealth services
- Dealing with physical health needs of mental health clients
- Other (please specify)

15. How could training and continuing professional development be improved for health professionals and peer workers caring for people with a mental illness in rural, regional and remote areas?

16. Are there other comments you would like to make about mental health training?