

Chapter 5

Mental health workforce

5.1 The previous chapters of this report have outlined the service settings for rural and remote mental health, considered the various service models used, and have discussed the key barriers to individuals seeking and receiving mental health services in rural and remote Australia.

5.2 For mental health service providers, many of the key barriers to delivering an effective service stem from workforce issues. The committee heard there is a fundamental lack of appropriately trained and supported staff to deliver mental health services in rural and remote communities in Australia. Chapter 4 noted the particular needs of Aboriginal and Torres Strait Islander peoples, which raise additional workforce challenges in delivering culturally competent services.

5.3 Evidence to the inquiry indicates that it can be difficult to attract appropriately trained clinical staff to remote areas and to then provide the professional support and ongoing professional development they require as part of their registration requirements. The tyranny of distance also poses challenges to providing training and other development opportunities when a local person has been identified as a potential mental health worker.

5.4 This chapter will examine the issues involved in maintaining an effective and sustainable mental health workforce and how these issues are exacerbated in remote communities. It will first consider some of the personal and professional challenges that face mental health professionals considering whether they and their families will move to a rural or remote community and which influence whether such professionals stay in a rural or remote community over the longer term. The second part of this chapter will examine how changes to training may help to build a sustainable and culturally competent mental health workforce for rural and remote Australia.

Challenges in attracting and retaining mental health professionals

5.5 Mental health service providers told the committee that, in order to provide appropriate levels of service, there is a pressing need for more mental health staff in rural and remote communities, but that service providers find it difficult to attract the staff they need.¹ The breadth of difficulties was outlined by the Victorian Council of Social Service:

1 See for example: Dr Roland Main, Area Director for Mental Health, Adults and Older Adults, Western Australia Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 2; Mr Jake Hay, Regional Program Manager Youth, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12; Dr Renee Bauer, Clinical Director, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 25; Mr David O'Sign, Chief Executive Officer, Cornerstone Youth Services, *Committee Hansard*, Devonport, 5 September 2018, p. 23; MindSpot, *Submission 5*, p. 2; National Aboriginal Community Controlled Health Organisation (NACCHO), *Submission 128*, p. 6.

Isolation, limited access to professional development, inadequate management and professional support and family challenges, including access to high quality education for children, spousal employment and housing all contribute to difficulties recruiting and retaining workers.²

5.6 These barriers are explored in greater detail below.

Personal factors

5.7 Of particular relevance to service delivery in remote communities is the challenge of attracting sufficiently qualified and experienced staff who are prepared to live and work in a remote community. As the Executive Officer of the Mental Health Fellowship of Australia (NT) told the committee:

There are very few trained people willing to work in remote settings due to the tyranny of distance from friends and family and the lack of infrastructure and services.³

5.8 Some of the personal factors which make it difficult to attract and retain staff and which were raised with the committee include the lack of housing and quality schooling for children and family members, as well as general lifestyle differences between rural and urban locations. These are discussed below.

Housing

5.9 The Central Australian Rural Practitioners Association noted that secure housing is essential to attract skilled and qualified practitioners:

...workers everywhere—and I think community people, too—demand things like safety and reasonable housing...There are reasons why people work in remote communities, but you have to have safe housing. You have to have housing where the locks actually work. There are a lot of dongas out there. They're old buildings on stilts, which need a lot of maintenance. People say, 'We don't...have to work like this. There are other opportunities—other work.'⁴

5.10 In the Northern Territory (NT), the committee heard that there were potentially hundreds of communities across the territory that had inadequate housing to support skilled workers.⁵

5.11 In some cases, service providers have been able to rent accommodation in order to provide stable and appropriate housing for trained staff, but for others

2 Victorian Council of Social Service, *Submission 107*, p. 8.

3 Ms Lorraine Davies, Executive Officer, Mental Illness Fellowship Australia (NT), *Committee Hansard*, Darwin, 9 July 2018, p. 16.

4 Mrs Lyn Byers, Secretary, Central Australian Rural Practitioners Association, *Committee Hansard*, Alice Springs, 10 July 2018, p. 29.

5 Ms Vanessa Harris, Executive Officer, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 19.

securing housing is more complicated.⁶ TeamHEALTH, a provider in the NT, shared its experience trying to obtain secure housing for its staff in remote communities:

From our experience, the services in Gunbalanya and Maningrida—it took us years to get appropriate housing so that we could have trained staff who were able to stay in community. We now rent one of the houses that we use so that we can provide that stability. Other times you rely on the teacher's partner, the childcare worker's partner, the policeman's wife—those sorts of people who have housing provided as part of their thing. They disappear because so-and-so gets transferred, and that really impedes. So housing for skilled workers that you want to bring in so that you can skill and pass on the culture and the mental health expertise into the community and help them build their capacity is one element.⁷

Education

5.12 Some witnesses expressed concern that the quality of schooling, especially in some remote communities, would deter prospective health professionals considering moving to a remote community if they had children.⁸

5.13 In other cases, the committee heard that it can be a challenge, even in regional locations like Whyalla, to retain health professionals who may consider moving away to more metropolitan centres to support their children's education.⁹

5.14 In Halls Creek, the Chairperson of the Jungarni-Jutiya Indigenous Corporation told the committee about the state of schooling in the community:

The quality of schooling here is way behind the eight ball. Kids coming out of school in high school still can't read and write. We've been talking about these types of things for a number of years, and very little seems to change.¹⁰

Lifestyle

5.15 One rural social worker suggested to the committee that rural communities are not able to provide the lifestyle opportunities that city practitioners, their children and families may be used to.¹¹

6 Mr David O'Sign, Cornerstone Youth Services, *Committee Hansard*, Devonport, 5 September 2018, p. 22.

7 Ms Helen Egan, Chief Executive Officer, TeamHEALTH, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 19.

8 Mrs Sharon Bambling, Acting Chief Executive Officer, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 6; Dr Stephanie Trust, Principal GP, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 16; Australian Rural Health Education Network (ARHEN) Mental Health Academic Network, *Submission 76*, p. 3.

9 Ms Andrea Triggs, Operations Manager, Country and Outback Health, *Committee Hansard*, Whyalla, 20 July 2018, p. 9.

10 Ms Robyn Long, Chairperson, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 6.

11 Name withheld, *Submission 115*, [p. 4].

5.16 The Central Australian Rural Practitioners Association explained some of the challenges associated with living in a remote community:

Very remote communities are inherently unhealthy places to live. It doesn't matter whether you grew up there or didn't. There are basic things that you need. Food is expensive. I've got resources to get good food—I've got credit cards and the ability to transport stuff—but other people don't. So food is expensive. The water won't taste as good and you'll have to dilute it with stuff—it's bore water. The air might not be as good because of the dust and so forth. It will be difficult to find places to exercise, because of dogs and so forth. It's inherently an unhealthy place to live.¹²

5.17 Another witness explained part of the challenge in living in a remote community in Western Australia is that common services, such as shops, may be limited:

The problem is retaining staff that can live in that remote circumstance. There is one shop in Mulan; it's open six hours a day. Prices are very expensive. Besides that there's nothing to do except shopping.¹³

Mental health and stress

5.18 Some submitters told the committee that there was also a need to consider the mental health of the workforce living and working in rural and remote communities.

5.19 A midwife working for a regional health service explained that healthcare professionals need to manage their mental health to protect themselves from multiple sources of stress:

It's a very stressful environment, not just for patients. It is hard to avoid mental health issues just from the work alone; add to this any other stresses or risk factors and you're a sitting duck.¹⁴

5.20 In many small communities, a health practitioner can be a high profile member of a local community. This means that the practitioner and/or their family could be subject to threats or harassment because of treatment they provide or decisions they are required to make.¹⁵ The committee heard that this can be stressful for practitioners who may not have access to the supports that they require to maintain their own mental health or who may not be able to place emotional safety or professional distance between themselves and their patients.¹⁶

12 Mrs Lyn Byers, Central Australian Rural Practitioners Association, *Committee Hansard*, Alice Springs, 10 July 2018, p. 28.

13 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 15.

14 beyondblue, *Submission 85*, p. 9.

15 Australian College of Rural and Remote Medicine, *Submission 43*, p. 6; Outback Futures, *Submission 60*, p. 5; ARHEN Mental Health Academic Network, *Submission 76*, p. 3.

16 Outback Futures, *Submission 60*, p. 5.

5.21 The Australian College of Rural and Remote Medicine noted that potential threats and a lack of anonymity were especially concerning in rural and remote settings as:

Many of these workplaces are very isolated, limiting access to personal and professional support for health professionals. Workforce shortages can make obtaining locum relief difficult. Lack of anonymity which makes it difficult to be 'off duty', and can increase pressure to meet community expectations and pressures. This makes them more susceptible to workplace violence and increases the likelihood that this violence might be serious.¹⁷

Professional factors

5.22 Some of the personal factors which make attracting and retaining staff difficult may also be either compounded or alleviated by the professional working environment.

Uncertainty regarding short-term funding cycles

5.23 As discussed in Chapter 2, many service providers in rural and remote Australia are facing uncertainty in funding. Submitters advised the committee that short-term funding cycles have posed a significant challenge to attracting and retaining staff.¹⁸

5.24 The Rural Doctors Association of Australia explained that it is hard to attract practitioners if their job is insecure:

People will not relocate for a temporary job for one or two years. It is a huge upset to their own families and to their own professional lives if they're moving out to a community and there's no job security.¹⁹

5.25 Youth, Family and Community Connections Inc in Tasmania told the committee that short-term contracts were not conducive to providing staff with job security and made it harder to attract staff to the region:

Short funding periods are not conducive to long-term employment, so that's a major issue. Also, as you'd be aware, it's not—if I can use this language—'sexy'. It's not attractive to deliver services in some of these regions.²⁰

5.26 Short-term contracts affect the ability of staff to have the certainty that would allow them to organise their families and personal affairs in a way that would allow them to make a longer term commitment to the community and the region.²¹

17 Australian College of Rural and Remote Medicine, *Submission 43*, p. 8.

18 Dr Andrew Wenzel, Manager, headspace Albany, Youth Focus, *Committee Hansard*, 5 June 2018, p. 20; Mr Colin Penter, Projects Lead and Policy Officer, Western Australian Association for Mental Health, *Committee Hansard*, Albany, 5 June 2018, p. 47; Mr David O'Sign, Cornerstone Youth Services, *Committee Hansard*, Devonport, 5 September 2018, p. 23.

19 Mrs Peta Rutherford, Chief Executive Officer, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 2.

20 Ms Roslyn Atkinson, Chief Executive Officer, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 33.

5.27 Youth, Family and Community Connections Inc explained that having staff on year-to-year funding cycles made it harder for them to have a mortgage or a personal loan and that the service was experiencing much higher staff turnover than when it had funding periods of three years or longer and could offer longer contracts.²²

5.28 Mission Australia told the committee that the same issues arise for staff who are on funding cycles of three years or less:

The issue with three-year funding cycles, or fewer-than-three-year funding cycles, is that as you get to the end of the funding cycle people have mortgages and ask, 'Can I stay in this community? Can I afford my rent or do I need to go back home?' which is particularly challenging. Longer-term funding is something that our organisation advocates for quite strongly.²³

5.29 Service providers identified that providing longer-term funding arrangements, even by a few years, would assist them to provide services and to recruit staff to work in rural and remote communities:

We're not sharing the knowledge of that good work. So, for me, some of the solutions to this would be around longer term funding agreements. If we look to moving towards a five-year agreement, for example, I think this would really enable outreach services and those that are place based to invest in these communities. When you know you're going to be there for five years, it makes it easier to recruit staff and you can truly invest in some place based options for those communities. I think there needs to be acknowledgement that this type of service delivery will be more expensive than delivering in a capital city, for example, and that numbers might be lower but the outcomes can be tremendous.²⁴

5.30 A number of submitters agreed that minimum five-year funding would be preferable to provide staff with certainty that would allow them to plan for the future.²⁵ Mr Chris Cowley, the Chief Executive Officer of the Whyalla City Council,

21 Mr Malcolm Darling, Acting Chief Executive Officer, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 24; Associate Professor John Boffa, Chief Medical Officer Public Health, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 1; Cr Clare McLaughlin, Deputy Mayor, Whyalla City Council, *Committee Hansard*, Whyalla, 20 July 2018, p. 5.

22 Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 34.

23 Mr Luke Butcher, Area Manager, Western New South Wales and Special Projects, Mission Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 70.

24 Ms Roslyn Atkinson, Youth, Family and Community Connections Inc, *Committee Hansard*, Devonport, 5 September 2018, p. 33.

25 Dr Martin Laverty, Chief Executive Officer, Royal Flying Doctor Service (RFDS), *Committee Hansard*, Townsville, 30 August 2018, p. 2; Ms Evelyn Edwards, Chief Executive Officer, North West Remote Health, Northern Queensland Primary Health Network, *Committee Hansard*, Townsville, 30 August 2018, p. 10; MindSpot, *Submission 5*, p. 5; Wesley Mission, *Submission 38*, p. 12.

explained why he considered that the difference between two-year funding and five-year funding was so important:

I know in my experience, certainly in my role, the provision of a five-year contract gives you a good three to four years before you start turning your mind to what is the future opportunity or am I going to be awarded a further contract. Whereas if you give out a two-year contract you're only going to be 12 months into the role and you're already creating uncertainty. It's not even particularly based on funding, but I know in the human psyche a five-year contract gives you certainty: do I relocate my family, do I invest, do I take the time to embed myself in this community or am I just a mercenary? That's the difference between a two and a five.²⁶

5.31 Service providers such as the Royal Flying Doctor Service (RFDS) acknowledged that five-year funding would provide certainty for both staff and service providers and give both the best opportunity to succeed:

As a result of our arrangements with the Commonwealth, this is funded for an initial five years, and we have every expectation of that becoming a permanent program. Five years is so terribly important because some of the existing programs of the Royal Flying Doctor Service and other community organisations have short contract lives—one year, two years or perhaps three years. That creates great uncertainty for the staff who work in them. It also creates more uncertainty for those in communities who are reliant on those services. The fact that we've got five years guaranteed resourcing to roll out this national program across underserved remote areas gives us great optimism that this service will be established and given the certainty that it needs to succeed.²⁷

5.32 Longer funding cycles may also lead to better outcomes for patients in rural and remote communities if they mean that the practitioner can live and build relationships in the community for a period of time.

Professional reputation and rapport

5.33 Some service providers explained to the committee that the problem with only having staff stay for a short period of time is that it takes time for the practitioner to develop relationships with patients.²⁸ It is also problematic for patients who are required to re-tell their story to each new practitioner:

...in regard to the turnover of staff, it takes a while for rural, regional and remote people because they're not that trusting of outside services and people they don't know. So when we have the turnover of staff which we have in our sector, then people just get to trust someone, and I hear time

26 Mr Chris Cowley, Chief Executive Officer, Whyalla City Council, *Committee Hansard*, Whyalla, 20 July 2018, p. 5.

27 Dr Martin Laverty, RFDS, *Committee Hansard*, Townsville, 30 August 2018, p. 2.

28 Mr Luke Butcher, Mission Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 70; Ms Sharon Jones, Executive Officer, CORES Australia, *Committee Hansard*, Devonport, 5 September 2018, p. 2.

and time again, 'I've got to retell my story, and I'd rather kill myself than tell my story again.' That's a real issue.²⁹

5.34 If there is a suggestion that the practitioner will not be there for a reasonable length of time, such as on a 'fly-in, fly-out' basis, there is the very real risk that community members will not engage with that service.³⁰

5.35 Currently, some communities believe that younger, less experienced practitioners are coming to regional or remote locations for a short period of time to further their own careers.³¹ The Regional Youth Program Manager for the Shire of Halls Creek explained that some practitioners only ever planned to stay in the town for a short period of time:

...the first thing people say when they arrive here to work is, 'How long are you here for?' They don't see Halls Creek as their home; they see Halls Creek as a transitioning point for greater things.³²

5.36 Service providers indicated to the committee that when practitioners are prepared to make a commitment to a community, then the members of the community are more willing to engage:

If they're supporting a person who's going to be permanently based here in town and they can put a face to a name and know that that person is going to be here for good, I think it will encourage them to come out and really speak about our story and talk about what issues they might be facing.³³

5.37 A GP working in Kununurra discussed the turnover of mental health support services in her region as being a cause of youth disengagement with the services they critically need:

I saw a 14-year-old this morning who has been to two different organisations and seen five different counsellors about what happened to her when she was younger. She has now given up and is refusing to go to anymore because she's sick of seeing different people. She is not going to school and is now starting to drink, take drugs and have antisocial behaviour. If we don't stop that, she will end up in juvenile detention.³⁴

5.38 The GP explained that in her area there were 10 different organisations with responsibility for a small portion of juvenile justice and health:

29 Ms Sharon Jones, CORES Australia, *Committee Hansard*, Devonport, 5 September 20187, p. 2.

30 Mr Brendan Morrison, Social and Emotional Wellbeing, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 4.

31 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12; Mrs Nicola Herriot, Chief Executive Officer, Northern Territory PHN, *Committee Hansard*, Darwin, 9 July 2018, p. 6; Queensland Alliance for Mental Health and Northern Territory Mental Health Coalition, *Submission 26*, p. 9.

32 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 15.

33 Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 4.

34 Dr Stephanie Trust, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 15.

It's so confusing for me sitting around the table after all my experience. You can imagine what it's like for parents and for kids.³⁵

5.39 Miss Nawoola Newry told the committee that the high turnover can exacerbate a lack of cultural awareness and lead to communities having to deal with the consequences of service gaps:

They come here and we have such a high turnover of staff up here, but it takes people at least two to three years to build relationships in town. They don't come to our community and do cultural awareness training. They sit in their offices from eight to four, they go home at four o'clock and they shut their door—their job is done. It's our community that is dealing with it. It's our community that is trying to stop our family from hanging themselves in the trees.³⁶

Remuneration and team support

5.40 As noted above, the cost of living in regional, rural and remote communities can be higher than in cities. However, remuneration packages may not be commensurate with the increased cost of living. Witnesses reported that some experienced mental health professionals had expectations of high remuneration which organisations described as being 'difficult to meet within funding levels'.³⁷

5.41 In Tasmania, the committee received evidence that offering lower amounts of remuneration increased the difficulties in attracting qualified staff. The Mental Health Council of Tasmania told the committee that attracting qualified staff was an ongoing issue:

We're well below the national average for access to psychiatrists and GPs. A lot of people are receiving care from fly-in, fly-out locums. We don't have that continuity of care or those important relationships being built between patients, clients and clinicians. It is an ongoing challenge for Tasmania because, yes, we don't offer more—in fact, we'd be on the lower end of the pay scale for attracting those staff. Then we've got the additional isolation of being surrounded by a ring of water. You choose to come to a place like this and to work here. There are some difficulties in being able to attract people and keep them here.³⁸

35 Dr Stephanie Trust, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 15.

36 Miss Nawoola Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 25.

37 Mr Malcolm Darling, Danila Dilba Health Service, *Committee Hansard*, Darwin, 9 July 2018, p. 24; Dr Jennifer Cleary, Chief Executive Officer, Centacare Catholic Country SA, *Committee Hansard*, Whyalla, 20 July 2018, p. 43.

38 Mrs Connie Digolis, Chief Executive Officer, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 38.

5.42 This issue is compounded by the fact that service providers feel that they are not receiving sufficient funding for certain programs to employ staff with the qualifications actually required to deliver the service.³⁹

5.43 Some witnesses in remote locations, such as Derby, expressed concern about attracting staff because they could not offer the same level of remuneration or other benefits as other regional organisations.⁴⁰

5.44 The Central Australian Aboriginal Congress, which has developed a successful and self-sustaining practice, stressed that paying health professionals good salaries and supporting them with a collegiate team was key to attracting and retaining good staff to stay in rural and remote communities:

I think the salaries that are offered are attractive. Psychologists are highly urbanised. This is an issue in rural Victoria. Most psychologists remain in the cities. To be able to get them to come out to a remote area you have to give them the right salary. It does not compete. If a psychologist wants to stay in private practice, they can make a lot more money. You do need to have a decent salary offered. I think also we have that reputation. We have other psychologists here, so psychologists feel supported.⁴¹

5.45 Associate Professor John Boffa, Chief Medical Officer Public Health at the Central Australian Aboriginal Congress, told the committee that psychologists should be remunerated by a form of blended payment, comprised of part salary and part Medicare Benefits Schedule payments.⁴²

5.46 Associate Professor Boffa explained that the blended model was needed to ensure that psychologists could afford to stay in the community even if not all of their patients attended all of their appointments:

The other challenge in remote areas is that people don't just turn up to appointments in the way they might in the city where people are motivated in that they might be paying a big gap fee to see their psychologist and they might want to turn up for six appointments. Here, people have major issues but the challenge is to keep people coming and to engage them. You might do that and people might come to their appointment and then not come to the next appointment and then maybe come to the third appointment. When you've got a salary you can cope with people not attending at times but it is

39 See, for example: Mrs Connie Digolis, Mental Health Council of Tasmania, *Committee Hansard*, Devonport, 5 September 2018, p. 41; Ms Helen Egan, TeamHEALTH, *Committee Hansard*, Darwin, 9 July 2018, p. 25.

40 Dr Lynette Henderson-Yates, Chief Executive Officer, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 8.

41 Dr Jon-Paul Cacioli, Social and Emotional Wellbeing Manager, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 4.

42 Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 2 and 5.

difficult when you're trying to fund it all through Medicare and through Medicare plus a gap fee.⁴³

5.47 Associate Professor Boffa also noted that building a supportive team was critical to supporting practitioners and that it was also helpful in attempting to recruit practitioners because the prospective practitioner would know that they would be supported:

The report of someone in the recruitment process is really important as well. If a psychologist rings up, it is important that they are able to talk to someone who is in their field and is already working there. That really helps. That person helps develop the JD. They can provide support. So there is external supervision and support. You have got to have a network.⁴⁴

5.48 That view was supported by the Western Queensland Primary Health Network, which told the committee that it believes that having a network of professionals in a regional area creates a much more sustainable workforce:

Another thing that is really important is creating those clinical hubs and networks and having professional advocacy within communities. Clinical leadership comes from a team. So it's about building those teams and supporting them. People can come into the country areas and really work to their scope and experience opportunities they don't experience in regional and metropolitan areas. They can get stretched and exposed to a whole range of different cultural, personal and professional experiences. I think that's often the hidden success, because it's more sustainable, you're working as a team, you're supported and you thrive professionally. Also you're in a network that has an interest in your family, your children and your own wellbeing.⁴⁵

Clinical supervision

5.49 One of the key concerns expressed by practitioners and their representatives is that they may not receive adequate clinical supervision in a rural or remote community.⁴⁶

5.50 However, the committee heard that providing clinical supervision for a trainee practitioner can place great stress on clinical practitioners who are already in high demand and have a high workload.⁴⁷

43 Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 2.

44 Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 4.

45 Mr Stuart Gordon, Chief Executive Officer, Western Queensland Primary Health Network, *Committee Hansard*, Mount Isa, 29 August 2018, p. 2.

46 Occupational Therapy Australia, *Submission 65*, p. 12; Australian College of Mental Health Nurses, *Submission 82*, p. 5; Australian Psychological Society, *Submission 103*, p. 15.

47 Royal Australian and New Zealand College of Psychiatrists, *Submission 95*, p. 4.

5.51 The medical colleges said they have identified that they have an obligation to assist practitioners who wish to work in these areas to obtain adequate supervision from metropolitan based practitioners if there is no supervisor in the non-metropolitan location. The Royal Australian and New Zealand College of Psychiatrists noted:

...you may also have a limited number of psychiatrists who can supervise a psychiatric trainee, because there's only one regional psychiatrist. And that's where our college is trying to look at: 'How can metropolitan based supervisors perhaps fill in some of that gap?' until you get to a critical mass where you're then able to take on more positions.⁴⁸

5.52 The Chairs of the Nursing and Midwifery Board of Australia, Medical Board of Australia, Psychology Board of Australia and the Aboriginal and Torres Strait Islander Health Practice Board (Chairs of the National Boards) told the committee that they were flexible about how clinical supervision was provided.⁴⁹ In some cases, supervision may be able to be provided via either videoconference or telephone.

5.53 For trainee psychologists, the committee was advised that off-site supervision was available, videoconference could be used for supervision sessions, and that teleconference supervision could be requested from the Psychology Board of Australia.⁵⁰ However, the coordinator of the clinical psychology program at James Cook University noted that external supervision requires greater input from supervisors:

...the appropriate professional supervision or mentoring of people who go to the west is a massive issue. I can speak mostly about psychology: I've supervised many people who are working in Mt Isa. But it's a long way. You can't hold a person's hand from Townsville very easily, so those kinds of things are difficult. It's very challenging to work in mental health in Mt Isa.⁵¹

5.54 Some submitters advised the committee that incentives or additional remuneration may need to be provided to supervisors, including specialist psychologists, to ensure that they remain committed to supervising the student and to ensure that supervision does not impede their own clinical work.

5.55 This approach was supported by the Central Australian Aboriginal Congress, the Australian Psychological Society and the Centre for You.⁵² The Centre for You

48 Dr Matthew Coleman, Committee Member, Section of Rural Psychiatry, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, Canberra, 19 July 2018, p. 8.

49 Australian Health Practitioner Regulation Agency, answers to written questions on notice, pp. 1–2 (received 31 August 2018).

50 Australian Health Practitioner Regulation Agency, answers to written questions on notice, p. 2 (received 31 August 2018).

51 Dr Beryl Buckby, Coordinator Clinical Psychology Program (Acting), James Cook University, *Committee Hansard*, Townsville, 30 August 2018, p. 39.

52 Central Australian Aboriginal Congress, *Submission 55*, p. 13; Australian Psychological Society, *Submission 103*, p. 15; Centre for You, *Submission 57*, [p. 2].

currently trains Provisional Psychologists undertaking Masters Degrees in Clinical Psychology to provide clinical services in rural Victoria. However, the Centre for You noted that its current psychologist training pipeline may not be able to continue without some form of incentive payment because it is having trouble attracting qualified supervisors.⁵³

5.56 Ms Brenda King, a sexual assault counsellor working for Anglicare WA in Kununurra, also told the committee that additional resources for expert clinical supervision were needed for Anglicare WA's service to continue in the area.⁵⁴

Continuing Professional Development

5.57 Some submitters told the committee that it was difficult for practitioners based in rural and remote areas to access continuing professional development.⁵⁵

5.58 The Chairs of the National Boards⁵⁶ advised the committee that the National Boards adopted a very flexible approach to continuing professional development to ensure that rural and remote practitioners were supported:

Learning activities can be broad and varied. Health practitioners are able to use multimedia and multiple learning opportunities including simulation, interactive e-learning and self-directed learning. It is therefore possible for rural and remote practitioners to access CPD to support their practice and in some instances, may access CPD arranged for other professions if that CPD relates to their chosen scope of practice.⁵⁷

5.59 The National Rural Health Alliance told the committee that multimedia and e-learning may not be possible because telecommunications, including for the transmission of teaching and learning materials, were poorer in non-metropolitan areas. This meant that to keep their professional registration and maintain and increase their skills there is a need for practitioners working in rural and remote locations to travel to access professional development opportunities.⁵⁸

5.60 While the Australian Government has a Rural Locum Assistance Program to provide funding which should enable a locum to backfill positions to allow practitioners to attend professional development sessions, travelling to larger centres

53 Centre for You, *Submission 57*, [p. 2].

54 Ms Brenda King, Sexual Assault Counsellor, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 20.

55 Queensland Nursing and Midwifery Union, *Submission 36*, p. 4; Australian Psychological Society, *Submission 103*, p. 15.

56 The Chairs of the National Boards are the Chairs of the Aboriginal and Torres Strait Islander Health Practice Board of Australia, the Medical Board of Australia, the Nursing and Midwifery Board of Australia and the Psychology Board of Australia.

57 Australian Health Practitioner Regulation Agency, answers to written questions on notice, [p. 1] (received 31 August 2018).

58 National Rural Health Alliance, *Submission 37*, p. 18.

to access the professional development can be expensive for the healthcare professional or their organisation.⁵⁹

5.61 The Australian Nursing and Midwifery Federation told the committee that it was difficult for nurses and midwives in rural and remote practice areas to access continuing professional development in mental health because a scholarship program for rural and remote nurses and midwives had been discontinued.⁶⁰ The Australian Nursing and Midwifery Federation noted that reinstating the funding would allow nurses and midwives working in rural and remote areas to maintain their skills in the mental health area:

There needs to be attention to continuing professional development and postgraduate mental health program funding so that nurses in rural and remote areas can be upskilled, can continue the education that they received in their undergraduate programs and can remain relevant to the environment in which we're working today.⁶¹

5.62 There may also be a role for some of the medical colleges to upskill the general health workforce to provide them with greater skills to recognise and deal with mental health issues. The Australian College of Rural and Remote Medicine told the committee that it was currently reviewing its curriculum to ensure that its Fellows were properly equipped to meet the needs of the communities they serve:

Rural and remote GPs have significant needs in terms of training and upskilling and many struggle to meet these needs. Mental health is a key component of the College's primary curriculum for GP registrars, and advanced skills training (AST) training option in mental health is available.

The College is currently reviewing its primary curriculum and the upskilling and professional development courses it provides for its Fellows to ensure that these continue to meet the needs of rural and remote communities.⁶²

5.63 Some potential proposals to address these concerns are discussed later in this chapter.

Committee view

5.64 The committee acknowledges that it is difficult for service providers to attract and retain a skilled mental health workforce in rural and remote communities. While the committee understands that practicing in a rural or remote community can be incredibly rewarding and provide interesting professional challenges, the committee

59 Department of Health, *Submission 30*, p. 33; National Rural Health Alliance, *Submission 37*, p. 18.

60 Ms Elizabeth Foley, Federal Professional Officer, Australian Nursing and Midwifery Federation, *Committee Hansard*, Canberra, 19 July 2018, p. 18.

61 Ms Elizabeth Foley, Australian Nursing and Midwifery Federation, *Committee Hansard*, Canberra, 19 July 2018, p. 18.

62 Australian College of Rural and Remote Medicine, *Submission 43*, p. 7.

understands that there may be both personal and professional reasons practitioners do not move to and stay in rural and remote communities.

5.65 The committee notes that short funding cycles mean that service providers cannot offer mental health professionals the job security that is needed for them and their families to commit to living and working in a rural or remote community in the longer term. The committee notes that the length of the funding cycles is closely linked to staff turnover and that there is a connection between staff turnover and community engagement with mental health services. Some submitters consider that five-year funding would be preferable for service providers and practitioners. The committee considers that longer funding cycles would provide greater certainty for mental health service providers and their staff.

5.66 The committee understands that clinical supervision is problematic for some professionals to obtain in rural and remote areas. The committee welcomes the Chairs of the National Boards' flexibility towards supervision and considers that the colleges have a responsibility to match trainees in non-metropolitan areas with a metropolitan based supervisor if there is no supervisor on-site in the trainee's location.

5.67 The committee accepts that some form of incentive payment may need to be considered for supervisors to encourage a commitment to supervision and recognise the additional workload clinical supervision entails, over and above their own clinical work.

5.68 The committee considers that the colleges and other training providers should consider the professional development needs of practitioners working in rural and remote communities when they develop training materials. The committee understands that the withdrawal of some scholarship funding has made it harder for practitioners, such as nurses, to undertake additional professional development.

Training the workforce

5.69 Throughout the inquiry the committee received evidence that changes to what training is provided, who is provided with mental health training and where the mental health workforce is trained may help to build a more sustainable mental health workforce in rural and remote communities.

5.70 As discussed in Chapter 3, one of the issues affecting service delivery in rural and remote locations is the number of clinicians that practice in these areas. This section will consider the location of clinicians training and how that affects whether they elect to practice in a rural or remote area.

5.71 Improving mental health in rural and remote Australia requires a variety of skills and levels of training. In Chapter 3, the role of a peer workforce was discussed in supporting members of the community and breaking down stigma. This section will also consider the role that a peer workforce may play in both Aboriginal and non-Aboriginal communities.

5.72 Finally, this section of the chapter will consider the workforce training aspects of developing a culturally competent workforce. As discussed in detail in Chapter 4, mental health service delivery for Aboriginal and Torres Strait Islander peoples has a very different service context. The committee heard evidence that a culturally

competent workforce is essential to effective service delivery for Aboriginal and Torres Strait Islander peoples.

Training a workforce in rural and remote areas

5.73 Throughout the inquiry, submitters and witnesses identified the location of training as being important to the development of a mental health workforce that is likely to practice long term in a rural or remote area.

5.74 Training for medical practitioners is largely based in large metropolitan and regional hospitals which, as the Rural Doctors Association of Australia noted, does little to influence a practitioner to select a career in a regional or remote location:

I think one of the big challenges for rural [areas] is that a lot of the training still happens in the metropolitan and large regional hospitals, and they are filled with the specialists of all the other colleges other than the RACGP or the Australian College of Rural and Remote Medicine. You've got your psychiatrists. You've got your surgeons. You've got your anaesthetists. The fellows of those colleges are doing constant recruitment to pick and choose the brightest to go into their college training pathways. Rural or general practice do not have that influence in the training hospitals.⁶³

5.75 The committee heard that there is a growing evidence base that it is easier to recruit and retain staff if they are from, or undertake study in, a rural or remote area.⁶⁴ The Royal Australian and New Zealand College of Psychiatrists explained that there was evidence demonstrating that practitioners who began their careers in a rural area were more likely to become part of that community and to practice there long-term:

It's part of the specialist training program. I can commend it to the committee. I think that this is a strategic way for both the college and state and federal stakeholders who fund these positions to get people from the beginning of their medical career into rural and remote communities so that they become part of a rural community. Hopefully they partner, get themselves a mortgage and have children in that community to become part of that community and then stay. It's a strategic way to train, recruit and retain both GPs and specialists. The evidence has been demonstrated over the past 10 to 15 years with rural clinical schools. The universities training medical students have been giving them longer term rural placements. I see in the Riverina that you'll be able to go from school into university and do

63 Mrs Peta Rutherford, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 8.

64 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12; Marcella M S Kwan et al, 'The rural pipeline to longer-term rural practice: General practitioners and specialists', *PLoS ONE*, vol. 12, no. 4, 2017, <https://doi.org/10.1371/journal.pone.0180394>, in Australian Psychological Society, *Submission 103*, p. 12. See also: Therese Zink et al, 'Efforts to graduate more primary care physicians and physicians who will practice in rural areas: examining outcome from the University of Minnesota-Duluth and the Rural Physician Associate Program', *Academic Medicine*, vol. 85, no. 4, 2010, pp. 599–604; James TB Rourke, 'Relationship between practice location of Ontario family physicians and their rural background or amount of rural medical education', *Canadian Journal of Rural Medicine*, vol. 10, no. 4, 2005, pp. 231–240.

your medical undergraduate training in a rural location. The college's aim is that you can then remain as an intern and a junior medical officer and start your specialist training in a rural location. If you can start and complete your training in a rural location, you're more likely to stay there as a consultant specialist.⁶⁵

5.76 The Chief Executive Officer of the RFDS also stressed the importance of requiring practitioners to complete their training in rural or remote areas:

The placement of mental health training facilities in remote or country areas is absolutely essential. The evidence is that you're more likely to have a doctor stay and work in a country community if (a) they grew up there or (b) they spent their medical training in a country area. We don't see too many schools of psychology or mental health nursing that are situated in the bush or in remote areas. They're certainly in regional centres, but the opportunity to place more training in remote Australia is an absolutely essential component of attracting your staff, just as it is to rethink the professional skill set of your individual staff.⁶⁶

5.77 The committee received evidence from Dr Prue Plowright, a Senior Medical Officer with the Derby Aboriginal Health Service, who confirmed that doing her initial medical training in Derby was a significant contributing factor to why she decided to stay in the community.⁶⁷

5.78 During the inquiry the committee heard about the development of a new National Rural Generalist Pathway. The National Rural Generalist Pathway will equip General Practitioners with advanced skills to also provide secondary and tertiary level care in a rural setting if needed.⁶⁸ These advanced skills will include mental health and alcohol and other drug services.⁶⁹ The Rural Doctors Association of Australia indicated that Queensland and New South Wales' experience in developing rural generalist pathways provided useful evidence that training in a rural location could lead to practitioners staying in those locations:

I think the early lessons learned from the Queensland and the New South Wales pathway will hold the national pathway in good stead, and they are about early recruitment, having positions at intern level, and the second year of the doctors' training, the third-year, and then their rural training all

65 Dr Matthew Coleman, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, Canberra, 19 July 2018, p. 3. See also: Royal Australian and New Zealand College of Psychiatrists, *Submission 95.1*, [p. 2].

66 Dr Martin Laverty, RFDS, *Committee Hansard*, Townsville, 30 August 2018, p. 6.

67 Dr Prue Plowright, Senior Medical Officer, Derby Aboriginal Health Service, *Committee Hansard*, Derby, 6 July 2018, p. 8.

68 Professor Paul Worley, National Rural Mental Health Commissioner, Department of Health, *Committee Hansard*, Canberra, 19 July 2018, p. 79.

69 Mrs Peta Rutherford, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 8; Professor Paul Worley, Department of Health, *Committee Hansard*, Canberra, 19 July 2018, p. 79.

happening in rural and regional areas. The reality is: if you train them in the bush, they're more likely to stay in the bush.⁷⁰

5.79 The Department of Health advised the committee that some steps were already being taken in this area to train more health professionals in rural and regional areas, including the establishment of five rural medical schools in the Murray-Darling region:

There are a number of things that we are addressing through the Stronger Rural Health Strategy announced as part of the recent budget in terms of ensuring that we have training in rural and regional locations to ensure that people who fundamentally would like to work in rural and remote locations are able to train and then continue their employment in rural and regional Australia. There is a whole raft of things coming through out of that around training and retention in terms of trying to keep people training and working within those locations.⁷¹

Developing a peer workforce

5.80 Clinical mental health workers are not the only people who have the ability to assist members of the community who may be suffering with a mental illness; members of the community, including those with life experience of a mental illness, can be empowered to provide assistance.

5.81 The issue of empowering existing community members to become stronger supports in their community was discussed by many submitters and witnesses.⁷² The issue was seen as complex, as while it is beneficial to include people with local knowledge and trust, if not properly resourced it can lead to burn-out of community leaders.

5.82 The Kununurra Waringarri Aboriginal Corporation outlined a training program it provides, where individuals 'get taught Aboriginal mental health first aid, youth mental health first aid, and techniques and tools to help people who might be in a crisis, especially if they're in a community, and have them as the go-to person'.⁷³

5.83 A medical practitioner from Kununurra flagged some issues with this approach that need addressing when improving and supporting peer and community supports:

If you talk to any of the big families in the Kimberley, there's always one or two people that stand out from those families. Those people especially need support because often they're the strong ones in the family. And I guess

70 Mrs Peta Rutherford, Rural Doctors Association of Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 8.

71 Ms Chris Jeacle, Assistant Secretary, Rural Access Branch, Health Workforce Division, Department of Health, *Committee Hansard*, Canberra, 16 October 2018, p. 8.

72 See, for example: Roses in the Ocean, *Submission 7*, p. 2.

73 Mr Brendan Morrison, Kununurra Waringarri Aboriginal Corporation, *Committee Hansard*, Kununurra, 5 July 2018, p. 6.

there's a fine line between empowering them but also not setting those people up to then be the person that takes everything on.⁷⁴

5.84 The Kimberley Mental Health and Drug Service pointed out that expecting Aboriginal and Torres Strait Islander peoples to volunteer to provide unpaid health and wellbeing support in their communities would be 'systemic institutionalised racism, by saying, "This service is essential, yet we're not going to place the same socioeconomic value on that essential service"'.⁷⁵

5.85 Mental health first aid and a workforce of peers and community members is not just important for Aboriginal and Torres Strait Islander peoples, but for rural and remote communities as a whole.

5.86 In many communities there are already people who have established peer-based support networks. Where those networks exist, some organisations told the committee that they wanted to work with local practitioners to build local capacity, leadership and referral pathways.

5.87 ConnectGroups Support Groups Association WA (ConnectGroups) noted that transient service provision is rarely effective because of a lack of community context.⁷⁶ Instead, ConnectGroups advocated for building local capacity and to develop a peer workforce to provide social and emotional wellbeing support based on lived experience.⁷⁷ As noted in Chapter 3, these groups can be vital to breaking down stigma in a community.

5.88 Throughout the inquiry the committee heard from a number of organisations that were working to support their communities and educate them about mental health. Mr Dylan Lewis, the founder of Katherine Mental Mates, told the committee that his group was providing free training for anyone in the Katherine community that wanted to do it:

The training is in mental health crisis support through nationally recognised training such as Mental Health First Aid and safeTALK. Through the hard work of volunteer trainers, we have seen around 350 people trained in Mental Health First Aid in the last 2½ years, and it's all been for free when this course normally costs about \$160 per person.⁷⁸

5.89 Mr Lewis explained to the committee that a survey of the program run by Mental Mates demonstrated that, on average, each participant had helped five people struggling with depression, anxiety or another mental illness.⁷⁹

74 Dr Stephanie Trust, Kununurra Medical, *Committee Hansard*, Kununurra, 5 July 2018, p. 13.

75 Dr Huu Duy Tran, Consultant Psychiatrist, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 25.

76 ConnectGroups Support Groups Association WA (ConnectGroups), *Submission 3*, [p. 8].

77 ConnectGroups, *Submission 3*, [p. 3].

78 Mr Dylan Lewis, *Committee Hansard*, Katherine, 9 July 2018, p. 18.

79 Mr Dylan Lewis, *Committee Hansard*, Katherine, 9 July 2018, p. 19.

5.90 Another example of a group helping to develop a peer workforce was the Depression Support Network Albany. The Depression Support Network Albany explained to the committee that it had been running a peer support network to support social activities that connected members of the community with resources and organised meals and activities to support mental health in the community.⁸⁰ The Depression Support Network Albany also raises awareness and works to break down stigma around mental illness.⁸¹

5.91 The committee received evidence throughout the inquiry that these groups of individuals were helping others who were experiencing a mental illness to find the help and support they needed.⁸²

5.92 It is clear that people really value the support that can be provided by a peer workforce. Mr John Harper, a Lived Experience Member of Suicide Prevention Australia, told the committee that he frequently receives calls because he is a non-clinical person with a lived experience of working through an episode of mental illness that included a suicide attempt:

I'm like a peer support worker. I get people ringing me up. This is what gets me: most people know what to do, but I get people ringing me up from North Queensland, Mount Morgan, Weipa or wherever, because I'm an ordinary joker. All I've got to talk about is my lived experience and what worked for me—that I went to the doctor, I did this, I did that. It seems to give people the confidence to take the next step. That's how important it is.⁸³

Cultural competency

5.93 The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) explained the importance of a culturally appropriate workforce in stark terms: if a service is not culturally safe, Aboriginal and Torres Strait Islander peoples will not use it, even if their life is in danger.⁸⁴

5.94 CATSINaM submitted that the presence of both an Aboriginal and Torres Strait Islander workforce and a non-Indigenous workforce are central to meeting the Closing the Gap targets for health outcomes and employment. CATSINaM contended that increasing the Aboriginal and Torres Strait Islander health workforce is important

80 Ms Jo Brown, President /Coordinator, Depression Support Network Albany Inc, *Committee Hansard*, Albany, 5 June 2018, pp. 30–31.

81 Ms Jo Brown, Depression Support Network Albany Inc, *Committee Hansard*, Albany, 5 June 2018, p. 31.

82 Mrs Joanne Cooke, Lived Experience Advocate and Board Member, The Butterfly Foundation, *Committee Hansard*, Canberra, 19 July 2018, p. 49.

83 Mr John Harper, Member, Lived Experience, Suicide Prevention Australia, *Committee Hansard*, Canberra, 19 July 2018, p. 48.

84 Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), *Submission 74*, p. 5.

in providing cultural safety training to support the capability of the non-Indigenous workforce.⁸⁵

5.95 CATSINaM stressed in its submission that the non-Indigenous workforce must be culturally safe and responsive, must be interdisciplinary and must include and value Aboriginal and Torres Strait Islander health professionals.⁸⁶ Aboriginal Medical Services Alliance Northern Territory (AMSANT) also pointed to the need to provide culturally appropriate training from entry level to post graduate training, with entry level training to be available within communities and to be designed with Aboriginal input.⁸⁷

5.96 The Director of Mental Health Services for Northern Australia Primary Health Limited discussed the difficulties mainstream health providers face in trying to develop a culturally competent workforce across multiple specialities, when clinicians often move away from rural areas:

The workforce issue needs to be a coordinated regional approach with the PHN, the universities, government services and NGOs to come up with a plan to change that. This has been happening since I started, and nothing has changed. It is likely to get more difficult because more clinicians are moving down south, going away.⁸⁸

5.97 AMSANT told the committee that a local workforce is well-placed to support incoming clinical specialists:

A well supported local workforce is able to address these psychosocial and cultural aspects of care and can also support the mental health professional to provide therapeutic care.⁸⁹

5.98 Associate Professor John Boffa of the Central Australian Aboriginal Congress supported this view, and told the committee that an Aboriginal Health Worker can provide a range of services that support therapy, but the therapy itself needs to be delivered by a highly skilled therapist. Associate Professor Boffa went on to say that where people experience poor treatment from low-level counsellors, they will not return as they think the treatment does not work.⁹⁰

5.99 The RFDS pointed to the Aboriginal Health Worker model as a successful model of developing the skills of the allied health professional at a subclinical level and suggested the model should be adopted by mainstream care providers. The RFDS

85 CATSINaM, *Submission 74*, p. 3.

86 CATSINaM, *Submission 74*, p. 2.

87 Aboriginal Medical Services Alliance Northern Territory (AMSANT), *Submission 129*, p. 6.

88 Mr Phil Ihme, Senior Director Mental Health Services, Northern Australia Primary Health Limited, *Committee Hansard*, Townsville, 30 August 2018, pp. 21–22.

89 Mrs Danielle Dyall, Team Leader Trauma Informed Care and Social Emotional Wellbeing, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

90 Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 3.

went further to state that the model has been successful beyond training and has been successful in attracting and retaining health professionals in rural and remote locations:

We will always need psychiatrist, [sic] psychologists, mental health nurses and allied health workers, but I think, in modelling the success of the Aboriginal health worker, which has been so successful not just in Alice Springs but across Australia, we've got to learn from that in the mental health sector. It's not out of necessity because we don't have enough staff but out of the opportunity because the Aboriginal health work has been so successful.⁹¹

Nature of cultural training

5.100 The committee heard examples from several service providers demonstrating that non-Aboriginal staff are not receiving culturally appropriate training to equip them to work in rural and remote communities. The Mental Illness Fellowship of Australia (NT) told the committee that in some cases non-Aboriginal staff are ill-prepared for their roles and to engage with the community when they arrive because their training has been poor and too generic:

Most community services staff receive a generic, politically correct cultural-training course and then find the reality of living in remote communities is very different from the cultural training they have received.⁹²

5.101 The Regional Youth Program Manager for the Shire of Halls Creek told the committee that, in some cases, staff did not have an adequate understanding of the geographic or cultural concerns of the people they were coming to serve:

Staff do not have an adequate understanding of geographical and cultural concerns for Kimberley clientele. This has resulted in the township of Halls Creek going through extended periods of time without any Child and Adolescent Mental Health Service workers. This issue is even more problematic in our remote communities, mainly for Balgo, Mulan, Billiluna and Ringer Soak. Service delivery needs to be malleable towards Aboriginal cultural concerns; staff members need to learn the right language and the right approach to sensitive to cultural practice.⁹³

5.102 Furthermore, cultural competence is dependent on the local community because Aboriginal culture and tradition is not homogenous—what is culturally appropriate varies between communities. It is therefore necessary for non-Aboriginal people to undertake cultural training specific to the area they are going to.

91 Dr Martin Laverty, RFDS, *Committee Hansard*, Townsville, 30 August 2018, p. 6.

92 Ms Lorraine Davies, Mental Illness Fellowship of Australia (NT), *Committee Hansard*, Darwin, 9 July 2018, p. 16.

93 Mr Jake Hay, Shire of Halls Creek, *Committee Hansard*, Halls Creek, 5 July 2018, p. 12.

5.103 The Central Australian Aboriginal Congress considered that all mental health staff ought to be equipped to understand and deliver programs specifically for Aboriginal communities and have knowledge of the available resources:

...there is a need to ensure that all mental health staff (especially non-Aboriginal staff) working for Aboriginal people and communities are able to address the specific health and wellbeing needs of Aboriginal people. This means equipping health professionals with the knowledge, skills, attributes and cultural understanding to competently design and deliver health services and programs and policies for Aboriginal communities. It is particularly important for those service providers in remote areas (i.e. nurses/Aboriginal Health Workers and GPs) undertaking risk assessments to have the competency to manage and work with clients, and to have the knowledge of available resources.⁹⁴

5.104 The Wurli-Wurlinjang Health Service told the committee that training should include practical advice on how to appropriately be in or visit a community:

...within the delivery of services training, cultural training is crucial for non-Indigenous staff. It should include history, as well as practical tips on how to actually be in a community—things like visiting the elders to pay respect, asking if it's okay to be in community at this time and if there is anything that it may be helpful for me to know.⁹⁵

5.105 Miss Nawoola Newry, a local advocate from the Kimberley, recommended that the Public Service Commission organise cultural awareness training for all services in the Kimberley region and that this training should be mandatory for every staff member who works in remote communities.⁹⁶

5.106 CATSINaM recommended a practical contribution that Health Ministers could make would be to ensure that cultural safety is a legislated requirement for health professionals. CATSINaM suggested this could be achieved by amending the *Health Practitioner Regulation National Law Act 2009* to embed requirements for cultural safety into clinical practice, and further recommended that all health practitioners working in rural and remote Australia have access to cultural safety training and are also supported to undertake this continuing professional development.⁹⁷

5.107 However, providing cultural awareness or cultural safety training can only extend so far. Some service providers, such as the Consultant Psychiatrist with the Kimberley Mental Health and Drug Service, told the committee that no amount of mental health training would provide the skills necessary to connect with Aboriginal

94 Central Australian Aboriginal Congress, *Submission 55*, pp. 12–13.

95 Miss Mary Moloney, Wellbeing Manager and Registered Mental Health Nurse, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 8.

96 Miss Nawoola Newry, *Committee Hansard*, Kununurra, 5 July 2018, p. 25 and 26.

97 CATSINaM, *Submission 74*, p. 6.

and Torres Strait Islander persons on the same level that a person from the same community is able to do:

No matter how hard I try, I won't be able to engage with someone sitting in front of me as well as someone who is local. No matter how kind, how compassionate or how skilled I am, I won't get the level of engagement with someone who is in distress that a local person will get.⁹⁸

5.108 For that reason, it is vital to upskill the local Aboriginal and Torres Strait Islander workforce.

Aboriginal and Torres Strait Islander workforce

5.109 The Aboriginal and Torres Strait Islander mental health workforce is diverse: it includes clinicians, nurses, Aboriginal Health Workers, support staff for social and emotional wellbeing programs and volunteers. Aboriginal and Torres Strait Islander staff can be local to the area in which they are working, or can be from a culturally distinct different region.

5.110 CATSINaM submitted that a lack of Aboriginal and Torres Strait Islander peoples in the workforce was one of the factors that contributed to the lower rates of Aboriginal and Torres Strait Islander peoples accessing health services, compared to non-Indigenous Australians.⁹⁹ AMSANT agreed with this view and submitted that services which are governed, designed, delivered and staffed by a local Aboriginal workforce are more accessible and effective for Aboriginal people living in rural and remote areas.¹⁰⁰ The Chief Executive Officer of the Northern Territory PHN also agreed with this view, telling the committee that a 'well trained, well supported and well resourced Aboriginal mental health workforce is critical to the delivery of culturally engaged mental health care for Aboriginal people'.¹⁰¹

5.111 CATSINaM pointed to the current Australian Government benchmark to achieve representation in the Aboriginal and Torres Strait Islander workforce equivalent to population parity, which is 2.8 per cent. CATSINaM submitted that because the burden of disease experienced by Aboriginal and Torres Strait Islander peoples is 2–3 times higher than non-Indigenous Australians that goal should be higher, but as of 2016 only 1.03 per cent of all registered nurses and midwives identified as Aboriginal and Torres Strait Islander peoples.

5.112 CATSINaM stressed that the *National Aboriginal and Torres Strait Islander Health Plan 2013–2023* recommended focus on building the workforce including increasing the proportion of Aboriginal and Torres Strait Islander peoples working in mental health and wellbeing related fields. CATSINaM recommended this should be a

98 Dr Huu Duy Tran, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 21.

99 CATSINaM, *Submission 74*, p. 3.

100 AMSANT, *Submission 129*, p. 6.

101 Dr Denise Riordan, Chief Psychiatrist, Northern Territory Department of Health, *Committee Hansard*, Darwin, 9 July 2018, p. 6.

priority in strategies to build cultural capacity and safety within Australia's mental health workforce.¹⁰²

5.113 The National Aboriginal Community Controlled Health Organisation (NACCHO) submitted that the importance of Aboriginal Mental Health Workers is recognised in the inclusion of rights of consumers to access culturally competent services, including an Aboriginal Mental Health Worker in the mental health legislation in a number of Australian jurisdictions.¹⁰³

5.114 NACCHO submitted that Aboriginal Health Workers and Health Practitioners acting as 'cultural brokers' between mainstream health services and Aboriginal and Torres Strait Islander peoples is a vital tool to bridging the cultural gap between those services and the consumers' access to mental health care, treatment and support.¹⁰⁴

5.115 The Aboriginal and Torres Strait Islander Healing Foundation acknowledged that there is difficulty in attracting and training qualified Aboriginal and Torres Strait Islander staff in remote communities and recommended that the sector should develop a targeted staff retention strategy to reduce the issue of high staff turnover, which burdens clients with disrupted clinical relationships.¹⁰⁵

5.116 Professor Sabina Knight from the Centre for Rural and Remote Health pointed out that the full capacity for Aboriginal Health Workers to act as referral pathways for mental health is limited by the fact that clinical psychologists cannot receive a Medicare rebate for services provided to people who are referred by an Aboriginal Health Worker or remote area nurse instead of a General Practitioner doctor.¹⁰⁶

5.117 Associate Professor John Boffa told the committee there are other avenues for potential Medicare improvement, which could include expanding Medicare funding beyond Aboriginal Health Workers to other workers delivering social and emotional wellbeing programs.¹⁰⁷

5.118 The Wurli-Wurlinjang Health Service pointed to the lower remuneration of Aboriginal Health Workers as a key barrier to workforce development:

So we pay these people in our system—even in our ACCHO system, which is supposed to value culture—the least and give them the least in our organisation, and we expect the most. That's the dilemma that we face every day, even in our own structure. Why are we paying health workers, whether they're Aboriginal health workers, registered health workers or mental

102 CATSINaM, *Submission 74*, p. 3.

103 NACCHO, *Submission 128*, p. 2.

104 NACCHO, *Submission 128*, p. 2.

105 Aboriginal and Torres Strait Islander Healing Foundation, *Submission 39*, p. 8.

106 Professor Sabina Knight, Director, Centre for Rural and Remote Health, James Cook University, *Committee Hansard*, Mount Isa, 29 August 2018, p. 30.

107 Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 7.

health workers, the wages of kids leaving school and expecting huge amounts from them?¹⁰⁸

5.119 The North Queensland Combined Women's Services said the difficulties in establishing a qualified Aboriginal Health workforce in mental health included the many specialities of the sector and that some roles also had a gender component, requiring only a female or male health professional.¹⁰⁹ The Sexual Assault Counsellor for Anglicare WA raised similar concerns regarding culturally appropriate gender roles, stating that a lack of a male sexual assault worker hinders the work of that organisation:

[b]ecause of the cultural limitations—women's business and men's business—it's not comfortable or appropriate to talk about sexual things in mixed company, and probably uncomfortable for people to speak out about it. It limits my ability to really address the secrecy around child sexual abuse and sexual abuse in the hope of increasing reporting and empowering, and making links with, victims.¹¹⁰

5.120 The Central Australian Aboriginal Congress also pointed out that even Aboriginal clinical psychologists, if they were not from the community they are servicing, may not have the local cultural knowledge required for culturally competent service delivery.¹¹¹

Challenges in building the Aboriginal workforce

5.121 Some communities indicated that they wanted to build and sustain their own capacity within the community to allow them to manage their own mental health issues.¹¹²

5.122 The Wurli-Wurlinjang Health Service told the committee that for a sustainable and culturally competent workforce to be developed, more needs to be done within communities to develop an Aboriginal and Torres Strait Islander mental health workforce:

The greatest resource in Indigenous health is Indigenous people. But we just ignore that and bring in a psychiatrist or an ophthalmic surgeon or something like that to solve the eye problems. We keep missing the point

108 Dr Peter Fitzpatrick, Executive Director, Medical Services, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 11.

109 Ms Catherine Crawford, Coordinator, North Queensland Combined Women's Services, *Committee Hansard*, Townsville, 30 August 2018, p. 27.

110 Ms Brenda King, Anglicare WA, *Committee Hansard*, Kununurra, 5 July 2018, p. 19.

111 Associate Professor John Boffa, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 8.

112 Ms Helen Egan, TeamHEALTH, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 17.

that the greatest resource is sitting in front of us, largely underemployed and very available to help—and their own systems work against that.¹¹³

5.123 The Chairperson of the Jungarni-Jutiya Indigenous Corporation told the committee that one of the barriers to the development of this workforce is that training is not being offered to locals and this means that knowledge was not retained by the community when external workers left:

There are a lot of outsiders who get employment here and they get all the incentives and everything to go with it, but they don't actually leave a lot behind. They take a lot of knowledge with them, and our people are not getting the training, even if it's only basic training. They talk about these crisis lines. While the crisis line is good sometimes, when you've got someone in your household going off, if you know there is someone in the community who might be able to settle that person, maybe they should be looking up those people.¹¹⁴

5.124 The Jungarni-Jutiya Indigenous Corporation told the committee that this capacity building may include providing members of the Aboriginal community with the opportunity to make a difference in their own community:

If they're going to just put one coordinator in, and you've got so many people out of at [sic] Balgo, and none of those other people are going to be employed or going to take part in actually trying to make a difference, you're pretty much wasting your time, because those people need to be given jobs as well, if they want jobs, I guess. They should be encouraged to be the ones who make the difference.¹¹⁵

5.125 Some service providers are already working to increase community capacity by employing local Aboriginal staff.¹¹⁶ For example, the committee received evidence that the Kimberley Mental Health and Drug Service was prioritising upskilling the local Aboriginal workforce in Broome:

For us, in our service, our priorities are really about strengthening our Aboriginal workforce. Currently about 22 per cent of our workforce is Aboriginal, and we really want to try and provide leadership opportunities and further enhancement of the workforce. As Duy has mentioned, I think

113 Dr Peter Fitzpatrick, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, pp. 14–15.

114 Ms Robyn Long, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 4.

115 Ms Robyn Long, Jungarni-Jutiya Indigenous Corporation, *Committee Hansard*, Halls Creek, 5 July 2018, p. 4.

116 Dr Renee Bauer, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 25; Dr Roland Main, Western Australia Country Health Service, *Committee Hansard*, Albany, 5 June 2018, p. 2.

that's where we find that local knowledge and that local expertise, and the trust that people have in them is exceedingly important for our service.¹¹⁷

5.126 The Chief Executive Officer of TeamHEALTH, a mainstream mental health service provider, considered that non-Indigenous and Aboriginal and Torres Strait Islander organisations should collaborate on training and workforce development to upskill some of the smaller community-based organisations.¹¹⁸

5.127 AMSANT considered that one option to develop a low intensity Aboriginal workforce could be to deliver entry-level training on country with Aboriginal input.¹¹⁹ beyondblue explained that a 'low intensity' workforce was one that was trained to apply cognitive behavioural therapy techniques. beyondblue explained that it is currently developing supervising and training a low-intensity workforce to apply cognitive behavioural therapy techniques after 12 weeks and become fully qualified after 12 months.¹²⁰ beyondblue explained that the program is currently being trialled using local people in 11 metropolitan and regional Primary Health Networks.¹²¹

5.128 The Executive Director of Community Services for the Wurli-Wurlinjang Health Service told the committee that if programs are going to be run to upskill the local workforce, it is essential for the training programs to be adapted to the needs and educational background of the individual, to ensure that people identified with good potential are not set up to fail by training programs beyond their means.¹²²

5.129 Currently, there is also some mental health first aid training that is being provided by the government. The Department of Prime Minister and Cabinet indicated that Aboriginal Mental Health First Aid training is available to provide community members with the ability to recognise mental health symptoms and that 112 communities so far have received one or both streams of the course.¹²³ The Department of Prime Minister and Cabinet advised that 41 local instructors had also been trained as part of the program.¹²⁴

117 Dr Renee Bauer, Kimberley Mental Health and Drug Service, *Committee Hansard*, Broome, 6 July 2018, p. 25.

118 Ms Helen Egan, TeamHEALTH, Northern Territory Mental Health Coalition, *Committee Hansard*, Darwin, 9 July 2018, p. 18.

119 AMSANT, *Submission 129*, p. 6.

120 Ms Georgina Harman, Chief Executive Officer, beyondblue, *Committee Hansard*, Canberra, 19 July 2018, p. 49.

121 Ms Georgina Harman, beyondblue, *Committee Hansard*, Canberra, 19 July 2018, p. 49.

122 Mr Darrell Brock, Executive Director, Community Services, Wurli-Wurlinjang Health Service, *Committee Hansard*, Katherine, 9 July 2018, p. 8.

123 Department of Prime Minister and Cabinet, answers to written questions on notice, pp. 3–4 (received 2 November 2018).

124 Department of Prime Minister and Cabinet, answers to written questions on notice, p. 4 (received 2 November 2018).

Supporting a clinical Aboriginal workforce

5.130 Some submitters told the committee that there are a number of barriers to training a workforce of Aboriginal clinical psychologists.

5.131 AMSANT noted that for some Aboriginal and Torres Strait Islander peoples considering undertaking clinical training, there was cultural and family pressure for the young person not to leave country.¹²⁵ Even if Aboriginal and Torres Strait Islander peoples do leave country to train, the Townsville Aboriginal and Islanders Health Services pointed to the high cost of training qualifications as a major barrier to developing an Aboriginal and Torres Strait Islander health workforce:

If you go and do even just a counselling course, that's \$10,000-plus. I don't have \$10,000 to pay for that myself. So that's what I'd like to see: when we do get new staff, being able to send them through and have the formal education side of it done so they get the qualifications that we actually need.¹²⁶

5.132 AMSANT suggested that the high cost of training could be defrayed by providing scholarships to support Aboriginal people to study psychology and social work.¹²⁷ AMSANT told the committee that there were often language barriers that Aboriginal people needed to overcome to undertake clinical training.¹²⁸

5.133 The Central Australian Aboriginal Congress noted that there are limited courses to become a clinical psychologist in the NT and that often people who become clinical psychologists do not come back to the NT.¹²⁹ The Central Australian Aboriginal Congress reiterated that this was another reason that it is vital to establish clinical training centres in rural and remote communities.¹³⁰

Concluding committee view

5.134 The evidence the committee received demonstrates that if practitioners are trained in a non-metropolitan area or are from a non-metropolitan area, they are more likely to stay in those areas. The committee considers that creating five medical schools in regional locations represents a good initial investment in training the future rural and remote workforce, but notes that further development of training centres in rural and remote communities may help to develop a professional clinical workforce pipeline for rural and remote Australia.

125 Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 10.

126 Mrs Erica Buttigieg, Social and Emotional Wellbeing Program Manager, Townsville Aboriginal and Islanders Health Services, *Committee Hansard*, Townsville, 30 August 2018, p. 29.

127 Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 7.

128 Mrs Danielle Dyall, AMSANT, *Committee Hansard*, Darwin, 9 July 2018, p. 10.

129 Dr Jon-Paul Cacioli, Australian Central Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, pp. 7–8.

130 Dr Jon-Paul Cacioli, Central Australian Aboriginal Congress, *Committee Hansard*, Alice Springs, 10 July 2018, p. 8.

5.135 The committee acknowledges that a peer workforce can be a powerful and useful support for people who are experiencing a mental illness and plays a role in reducing stigma. The committee considers that these groups should be supported to continue their work supporting members of the community experiencing mental illness.

5.136 A culturally competent workforce is vital to deliver services to Aboriginal and Torres Strait Islander clients in rural and remote Australia. The committee considers that this requires a non-Aboriginal and Aboriginal workforce working together to promote understanding and to develop culturally safe services.

5.137 The committee was concerned by evidence that the non-Aboriginal workforce does not appear to be receiving adequate training to deliver culturally competent services to Aboriginal and Torres Strait Islander clients. The committee considers that all service providers who are moving into or working in a rural or remote community should engage with cultural training that is specific to the locality to ensure that they are able to provide culturally competent services.

5.138 The committee considers that it is essential to train and upskill the local Aboriginal workforce to allow them to play a part in the mental health of their own communities and to develop a sustainable capacity that will endure beyond the term of the next funding cycle. For that to happen, there is a need to support a clinical Aboriginal pathway and a need for non-Aboriginal organisations to partner with communities to train a low intensity workforce.

5.139 The committee understands that attracting and training a capable, sufficient and sustainable mental health workforce to serve rural and remote Australia will be challenging. There is a lot of work to be done to ensure that Aboriginal communities in particular are able to manage their own mental health challenges. The committee considers this requires a coordinated approach to ensure that the mental health workforce is developed as quickly as possible.

5.140 Mental health and wellbeing services are dependent on the quality of the workforce delivering those therapeutic services. Without a concerted effort by all stakeholders involved, the lack of cultural competency of the workforce will continue to cause these services to fail, which in turn has devastating effects on the health of individual Aboriginal and Torres Strait Islander persons, and more broadly on the entire communities in which they live.