Mental
Health
Council
OF TASMANIA

COVID-19 Impacts on the community mental health workforce

Mental Health Council of Tasmania

November 2021

Contents

About us

The **Mental Health Council of Tasmania** (MHCT) is the peak body for community managed mental health services in Tasmania. We represent and promote the interests of our members and work closely with government and agencies to ensure sectoral input into public policies and programs. We advocate for reform and improvement within the Tasmanian mental health system. Our purpose is to strengthen and advocate for our communities and service providers to support the mental health and wellbeing of all Tasmanians, and our vision is that every Tasmanian has access to the resources and support needed for good mental health and wellbeing.

Executive Summary
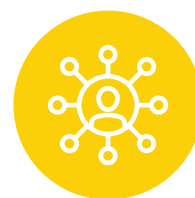
In response to the COVID-19 pandemic, MHCT implemented a strategy to monitor and report on the impacts of the pandemic on the community managed mental health sector. In July 2020, MHCT began to identify concerns from service providers related to service capacity limitations. Factors contributing to service capacity limitations included - increases in service demand, an increase in complexity of client presentations and workforce recruitment and retention challenges. The following report identifies factors impacting the workforce recruitment and retention challenges experienced by the community managed sector.

NATIONAL LEVEL

Nationally, the mental health sector saw significant increases in demand due to heightened experiences of psychological distress, placing pressure on a service system that was already hindered by workforce attraction, recruitment, and retention challenges. At the same time the sector was required to shift quickly to the provision of services predominately through telehealth with almost half of all MBS-subsidised mental health services delivered via telehealth at the peak of the pandemic. Whilst the agility for services to adapt to telehealth was positive, a number of cohorts were under-serviced due to limited access to technology and/or lower levels of digital literacy. Additionally, there were concerns raised regarding the efficacy of telehealth services for children aged 5-12 years and people experiencing more severe and complex mental illness.

STATE LEVEL

In Tasmania, findings from the report indicate further challenges impacting the community mental health workforce. For example, due to travel restrictions, international and interstate recruitment has been constrained, which has in turn highlighted the limited mental health workforce supply within Tasmania. Workforce supply is not a new challenge for the state, however, during the pandemic it has become apparent that with limited graduate opportunities in the state, many Tasmanians are choosing to move interstate to

further their career. Additionally, the impact of the pandemic has seen an increase in clients presenting with more complex needs. This requires more time with community mental health staff to assist in the coordination of other social supports placing further pressure on the already strained workforce.

INDIVIDUAL STAFF LEVEL

At the individual staff level, community mental health staff have identified an increase in workload, limited time for self-care and increase in social isolation (particularly the inability to see friends and family interstate) as contributing factors impacting on their mental health due to COVID-19. Staff have also taken much less annual leave during the pandemic in comparison to pre-COVID, senior executives and middle management in particular have taken much less annual leave than usual. Additionally, staff have noted that when looking at the next 12 months, they are concerned about ongoing and unpredictable border closures along with concerns regarding reduced work/life balance.

Whilst the community mental health workforce has been impacted by the pandemic at a national, state and individual staff level; several opportunities have been identified to support the mental health workforce in the advent of future disaster events and towards building a sustainable workforce in Tasmania. These priorities are listed on the next page.

Priorities

1 Integrated workforce planning to support recruitment and retention

2 Prevention and early intervention to address increased service demand

3 Upskill and diversify the mental health workforce

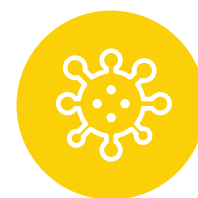**4** Foster and support mental health staff wellbeing

5 Equip mental health services to respond to ongoing COVID-19 impacts

6 Data collection and monitoring to inform an effective response

Background

COVID-19 is a new strain of coronavirus which, upon spreading globally, resulted in a worldwide pandemic. The World Health Organisation declared COVID-19 a pandemic on 12 March 2020 and as of October 2021, there have been over 4.8 million deaths from more than 239 million documented cases.[1] COVID-19 has presented a range of challenges globally, and due to the nature of the illness, these have had significant impacts on health systems world-wide.

In response to the global COVID-19 pandemic, Federal and State government responded rapidly by implementing a raft of COVID-19 restrictions and social distancing measures in mid-March 2020. In order to clearly understand the impacts on the mental health sector, consumers and their families and friends, MHCT developed a COVID-19 Response and Recovery Strategy. The Strategy incorporated extensive and ongoing consultation which allowed MHCT to map how restrictions were impacting mental health service delivery in our state. In addition, through engagement with service providers delivering psychosocial supports to the broader population in response to COVID-19, MHCT has also gained understanding around whole-of-population mental health.

As part of the Strategy, the COVID-19 Mental Health Sector Network was formed to track the impacts of COVID-19 restrictions on Tasmanian Mental Health Sector service providers during the restriction period and beyond into the recovery phase. The Network provided a platform to identify the impact of COVID-19 on service delivery, workforce and client needs along with tracking emerging issues. The network provided a mechanism to provide direct and timely information to government, agencies and other key stakeholders.

MHCT consistently heard through theCOVID-19 Mental Health Sector Network and related COVID sector surveys that service providers have been experiencing service capacity limitations since the pandemic began. This is reflected in findings reported in the *MHCT COVID-19 Impacts and Emerging Themes within the Mental Health Sector Report June/July 2021*. Upon exploring service capacity limitation further, it was identified that this was due to:

➤ increases in service demand,

➤ an increase in complexity of client presentations and

➤ workforce recruitment and retention challenges.

Based on these findings, MHCT identified a clear need to further explore impacts on the workforce and to identify opportunities to address these challenges.

Methodology

The development of this report involved two key stages:

1. LITERATURE REVIEW

A comprehensive desk-based literature review of Australian and international data was undertaken by 3P Advisory. This review explored the impact of COVID-19 on the mental health system – across service providers, the workforce, and consumers generally. It also analysed how the mental health sector has previously responded to crises and the lessons learned. A summary of findings is provided in this report, with the full literature review available on request.

2. STATE-BASED INQUIRY

A state-based inquiry to gather Tasmanian-specific data involved three key activities:

a. Consultation with CEO-level staff of Tasmanian community managed mental health services and associated stakeholders was conducted via the Tasmanian Mental Health Leaders Forum (TMHLF) in August 2021. The TMHLF convened to identify the key workforce challenges facing the mental health sector in Tasmania, discuss how these challenges had been impacted by COVID-19 and brainstorm potential solutions and opportunities (see *Acknowledgements* for a full list of contributors).

b. Following the TMHLF consultation, one on one semi-structured qualitative interviews were undertaken with three selected stakeholders to gain additional insight into their comments provided during focus groups and to inform the development of specific case studies.

c. An online survey was developed in collaboration with several TMHLF representatives to gain insight into the experiences of mental health staff during COVID-19 and associated impacts on wellbeing. The survey incorporated quantitative and qualitative data and was sent to TMHLF members to distribute amongst their staff as well as being promoted to the broader membership via MHCT member newsletters. The survey was completed by 65 participants who self-identified as mental health staff.

1 The National-level impact of COVID-19 on the mental health workforce

While there has been significant research conducted into the impact of the COVID-19 pandemic on the health workforce in general, there are limited studies available on the impact on the mental health workforce more specifically. Whilst this results in limitations when it comes to comparing data and analysing impact, it does mean there are a wide range of opportunities to begin to develop a comprehensive understanding of the impact of the COVID-19 pandemic upon the mental health workforce. A literature review was undertaken which identified key challenges experienced by the mental health workforce nationally and associated needs and priorities. A summary of these findings is provided below.

1.1. WORKFORCE SHORTAGES AND INCREASING SERVICE DEMAND

The Australian mental health workforce has been subjected to significant shortages and pressures, which have been well documented for a number of years. In 2020, the National Select Committee on Mental Health and Suicide Prevention heard from a significant number of services in need of more mental health staff to meet increasing demand. These services reported that the key barriers to attracting and retaining mental health staff, included short-term funding cycles, remuneration, workforce support, clinical supervision and a lack of professional development opportunities.[2]

The impact of the COVID-19 pandemic has required rapid adaption in respect to how mental health services are accessed and delivered, what services are available, and what is and isn't considered a priority. At the same time, the mental health sector has seen significant increases in demand as people experience heightened levels of psychological distress, isolation, and a range of other mental and social impacts due to the pandemic and the changes required in day-to-day lives.[3, 4] An increase in demand has been seen across public, private and community services and is supported by data from Medicare,[5] the Pharmaceutical Benefits Scheme (PBS)[6] and community support services and hotlines.[7] This increase in need has been felt across a system already challenged by workforce limitations.

1.2. BARRIERS AND ACCESSIBILITY TO SERVICES FOR RURAL AND REMOTE COMMUNITIES

The rural and remote mental health workforce has faced unique and significant challenges during the pandemic due to a smaller pool of available workforce, travel restrictions and an increase in service demand.[8] The Federal Government's *National Mental Health and Wellbeing Pandemic Response Plan* highlights challenges unique to rural and remote communities, including lower rates of services and limited access to specialist care, regular workforce shortages, impacts of natural disaster events and higher rates of the social determinants of mental health.[9] There is a recognised lack of qualified staff in regional areas, resulting in a lack of adequate services for people with complex mental illness. Limited public transport can also present an access barrier, alongside high costs and cultural barriers.[10, 11]

The stigma and isolation experienced by people living in rural and remote communities also contributes to barriers in seeking or receiving mental health support.[12] Additionally, the high use of locum health practitioners in remote regions creates challenges in the provision of seamless care.[13] These challenges have been further exacerbated by travel restrictions and service access barriers during the COVID-19 pandemic.

1.3. INCREASED USE OF DIGITAL TECHNOLOGIES IN SERVICE PROVISION

COVID-19 fast-tracked the process of mental health services being delivered using more modern technological options, such as telehealth.[14] Data shows that at the peak of the pandemic, nearly half of all MBS-subsided mental health services were delivered via telehealth. Whilst this has increased access for some, it can also present additional challenges for under-serviced rural and remote communities, as well as certain vulnerable groups such as those aged over 65 years, who may have difficulty accessing these services due to connectivity and bandwidth issues, lower digital health literacy, limited access to appropriate technology and/or less technological support.[15, 16, 17] Impeded uptake of telehealth services may further disadvantage these vulnerable communities.[18] Additionally, the efficacy of telehealth for children 5-12 years and individuals experiencing severe and complex mental health difficulties currently lacks sufficient evidence.[19]

Alongside barriers faced by individuals, service providers have raised concerns regarding intake and assessment and building rapport when using telehealth options.[20] A study involving a survey of mental health providers in the US found that 82% of respondents felt that the pandemic had negatively impacted their ability to treat clients, and that their personal mental health was also impacted by related stressors.[21] Further, the study highlighted the detrimental effects of providing services via telehealth which included increased fatigue, frustration, dissatisfaction with work and elevated levels of empathic distress.[22]

Overall, while telehealth has a useful place in meeting the mental health needs of the community and allowing for flexibility and agility within the system, it should not be considered a substitute for in-person support.[23] Research in Australia and the US has also emphasised the need to invest in adequate training to support the mental health workforce in the delivery of online services.[24, 25]

1.4. EARLY INTERVENTION AND PREVENTION

The gaps in services across the mental healthcare system in Australia are well known. The Australian Government's 2014 *Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services* highlighted significant inefficiencies within the current Australian mental health system, highlighting the need to move towards a system based on person-centred design principles with reallocation of funding from downstream to upstream services, including prevention and early intervention supports.[26]

The Productivity Commission's *Inquiry Report into Mental Health* in 2020 identified significant gaps in low intensity services, attributing this to limited availability of low cost, low intensity and easily accessible services, as well as a lack of information and awareness amongst both individuals and referring clinicians on the existence of these services.[27] Improving community-based supports and increasing access to prevention and early intervention programs is recognised as a key way of reducing demand on the mental health system over the longer term.[28]

While work is occurring both at a state and federal level to achieve an integrated, person-centred approach to mental health, COVID-19 has highlighted the need for rapid action to achieve an integrated system that supports individuals with wraparound services for their physical, social and mental well-being, within their local communities.

1.5. DISASTER RESPONSE AND TRAINING

Whilst there is limited data on the impact of a global pandemic on mental health workforces, there is some available on the mental health workforce/ system in response to other crisis situations, which are relevant to a disaster response more generally. An evaluation of the Australian Government Mental Health response to the 2009 Victorian bushfires found that implementation of disaster response training, workforce capacity surveys, suitable supervision and peer support networks would be beneficial for responses to future disaster events.[29] Key learnings also included the need to undertake comprehensive data collection as well as clear and consistent promotion and targeting of training initiatives.[30]

1.6. DATA AND RESEARCH NEEDS

A recent review of national mental health workforce strategies in Australia identified a lack of monitoring and evaluation approaches to capture and record change.[31] This is problematic as adequately assessing the impact of the mental health workforce requires sound data. Achieving effective monitoring and evaluation of the workforce will require mixed methods approaches that involve collaboration across government departments, organisations and sectors.[32]

Australian research into the impact of COVID-19 on mental health in Australia has also indicated an urgent need for more data and research. This includes characterising current levels of mental health and wellbeing in the population and how these have been impacted by the pandemic; a specific focus on the mental health of vulnerable groups including those with pre-existing conditions; and a need for longitudinal studies that track changes in mental health both during and beyond COVID-19.[33] Collecting this data will help with real time response planning in the advent of future pandemic or disaster events, and assist in identifying a suitable skilled workforce to respond to the level of mental health need in the affected community.

2 The State-level impact of COVID-19 on the Tasmanian community mental health workforce

Whilst workforce challenges have been an ongoing issue in Tasmania, even prior to the pandemic, COVID-19 has seen many of these challenges exacerbated. Improving mental health care in Tasmania requires further investment in supporting the development of a highly skilled workforce of the right size and shape that provides services across all levels of need.[34]

2.1. THE MENTAL HEALTH WORKFORCE IN TASMANIA

The Tasmanian mental health workforce is made up of a variety of occupations that provide direct mental health services to the Tasmanian community within public, private, primary and community managed mental health settings. These occupations include Peer Workers, Psychosocial Support Workers, Aboriginal Mental Health Workers, Mental Health Nurses, medical professionals including GP's and Psychiatrists, and allied health professionals including Psychologists, Social Workers and Occupational Therapists. To a degree, the community-services sector workforce should also be considered in supporting people whose mental wellbeing has been impacted by environmental stressors.

The Australian Institute of Health and Welfare (AIHW), when discussing the mental health workforce, has stated:

> *"A variety of health and social care professionals, including psychiatrists, psychologists, nurses, general practitioners and social workers, provide a range of mental health-related services to Australians."*[35]

In identifying the breadth of the mental health workforce in Tasmania, data related to Peer Workers, Aboriginal Mental Health Workers and Psychosocial Support Workers is lacking. Collecting such data would enable a better understanding of the complete picture of the Tasmanian mental health workforce. However, data from the *Tasmanian Health Workforce Strategy 2040* provides a snapshot of several occupations who provide mental health services to the Tasmanian community.[36]

This includes:

➤ 84 Psychiatrists providing 76.9 FTE

➤ 631 General Practitioners providing 576 FTE

➤ 504 Mental Health Nurses providing 459 FTE

➤ 469 Psychologists providing 391.9 FTE

➤ 279 Occupational Therapists providing 236.7 FTE (note this data provides an overall total and is not specific to Occupational Therapists that provide specialist mental health services).

➤ 192 Social Workers providing 154.9 FTE (note this data provides an overall total and is not specific to Occupational Therapists that provide specialist mental health services).

	MH Nurses	GPs	Psychiatrists	Psychologists	Social workers	Occupational Therapists
Australia	92.2	97.4	14.4	108.1	no data	73.8
Tasmania	95.4	119.4	15.9	88.8	29.3	52.8
South	122	139.7	22.1	116.5	29.9	62.3
North	65.5	99.3	9.7	58.6	31.5	49.6
North west	69.7	96.5	8.9	60.7	23.2	33.9
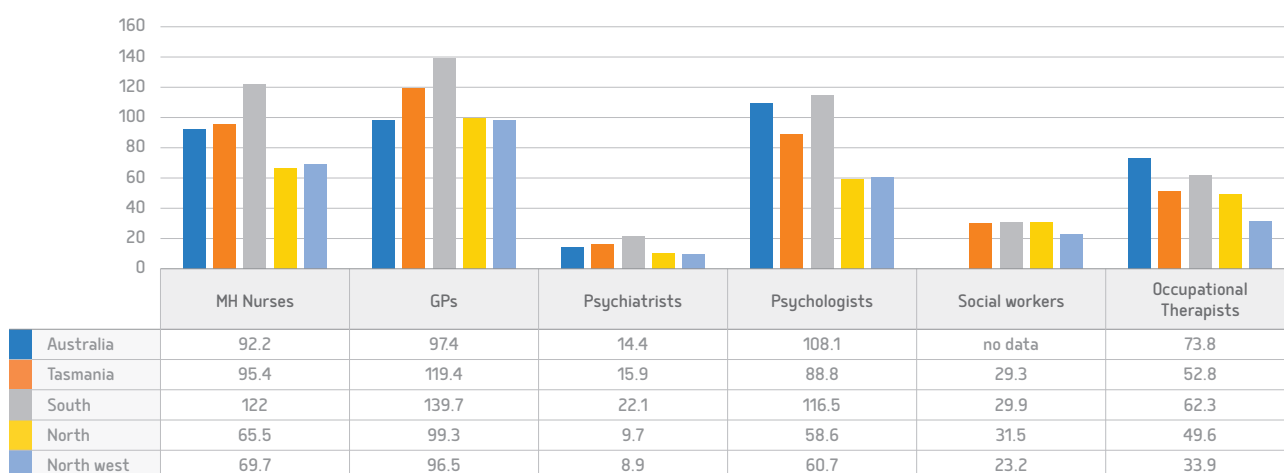
Source: Tasmanian Health Workforce 2040 strategy; (ABS population data and National Health Workforce Data Set)

In comparison to national workforce averages and within the regions in Tasmania; table 1.0 suggests that Tasmania has a high overall proportion of GPs in comparison to the national average although this is concentrated to the south of state. Psychologists and Occupational Therapists practicing in Tasmania are much lower than national averages. In addition, the proportion of Psychologists practicing in the north and northwest of Tasmania is almost half of those practicing in the south of the state.

The issue of workforce limitations is reiterated in the Productivity Commission's Inquiry into Mental Health[37], which identified a geographical mismatch in the workforce between major cities to outer regional and remote areas. In the South of Tasmania for example, there are 116 Psychologists for every 100,000 people. However, in the north and northwest of the state there is an average of 59 Psychologists per 100,000 people.

2.2. STATE-BASED INQUIRY

In August 2021, MHCT conducted consultations with senior management of community managed mental health organisations across Tasmania and other stakeholders, including Primary Health Tasmania and the Department of Health. These consultations sought to explore the pre-existing challenges for the community based mental health workforce and understand how COVID-19 had impacted on or exacerbated these (and other) challenges. The key challenges identified reflect many of those identified at a national level and include mental health staff shortages; costs of training, development and supervision; limited welfare and wrap around supports; a need for mental health literacy, prevention, early intervention and appropriate referral processes; pandemic fatigue; limited understanding of the Aboriginal mental health workforce in Tasmania; and rural and regional delivery of services.

2.2.1. MENTAL HEALTH STAFF SHORTAGES

Tasmania faces multiple challenges related to community based mental health workforce recruitment and retention. The COVID-19 pandemic has further exacerbated existing staff shortage issues. The usual practice of recruiting from interstate or overseas is currently not possible due to border restrictions and lockdowns. People may also be less likely to move to Tasmania from interstate to take up a role and may be reluctant to move away from family and friends. In addition to this, while housing affordability has always been an issue, increasing prices appear to be deterring potential staff from taking positions in Tasmania. Working remotely is also not possible or preferable for all mental health workers, which may negatively impact on recruitment and retention.

Consultations with service providers have identified that the workforce is not only too small, but it is also ageing and there is a need to recruit new staff across the sector. In Tasmania, however, there is a lack of University and TAFE level qualifications available to generate a local mental health workforce. In the allied health space this is particularly the case for occupational therapists and there is also limited face-to-face training available for social work students. Meanwhile, COVID has seen the demand for experienced allied health professionals growing due to an increase in complexity of presentations and dual diagnosis.

With respect to psychology, year 5 of the Bachelor of Psychology is only available in Hobart, limiting its accessibility and reach. Furthermore, there are ongoing reports of psychology graduates in Tasmania choosing to move interstate, or moving into private practice as it is considered more lucrative. For graduates who choose to stay in Tasmania there is limited placement support available, particularly in rural and remote locations. Community mental health organisations have reported instances of supporting graduate placements, only for those graduates to then shift to the public or private sector once fully trained.

Further, staff shortages in acute care, exacerbated by the pandemic, has reportedly led to more people seeking complex supports in the community sector. There is also a recognised shortage of NDIS support workers to support persons with psychosocial disability. The lack of skills mix within the mental health workforce means that service providers are often trying to address issues outside of their skillset, which may negatively impact on client outcomes and contribute to lengthy waitlists for Tasmanians in accessing appropriate mental health care.
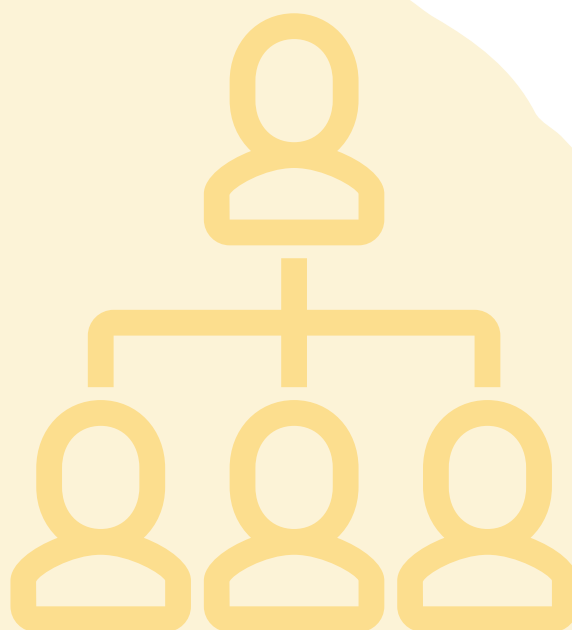
→ A Tasmanian Lifeline

"For a workforce in crisis, partnerships are vital"

Debbie Evans, CEO, Lifeline Tasmania

As the COVID-19 pandemic unfolded in early 2020, Lifeline Tasmania began to experience an unprecedented increase in calls from community members needing support. In response, a partnership was formed between Lifeline Tasmania and the Tasmanian Government in March 2020 to develop a dedicated psychosocial phone line, 'A Tasmanian Lifeline', that would allow Tasmanians to receive specific support that acknowledged the current impact of COVID-19 on their community.

Establishing the phone line rapidly (within a six week period) required a reliance on collaboration. This included seeking advice and input from the mental health sector and support from both the Department of Health and the Department of Treasury and Finance, who provided a physical venue and phone line for the service.

Given that the mental health workforce was already understaffed, and many staff were already being redeployed, the phone line required an innovative approach to staffing. A partnership was established between Lifeline Tasmania and the University of Tasmania that involved final year social work and psychology students being offered paid casual positions to staff the phone line. The selected students were provided with a fast-tracked, abridged version of the standard Lifeline training as well as training in suicide prevention and referral pathways. Experienced volunteers and counsellors provided mentorship, support and supervision. The student's role was to listen to callers, give them space to share, and then refer them on to appropriate professionals. Employing students not only allowed the phone line to be staffed quickly, but it also gave students first-hand practical experience that improved their future job prospects.

"The A Tasmanian Lifeline initiative reflects our commitment to providing rich learning opportunities to support future service delivery and a sustainable workforce"

Debbie Evans, CEO, Lifeline Tasmania

A Tasmanian Lifeline is an innovative model which is unique in Australia and internationally. Rather than simply being a call-in service, the phone line also offers call backs to check in, call outs to socially isolated older Tasmanians (identified through services, concerned loved ones or health professionals), as well as reaching out to people working within industries that have been significantly impacted by the pandemic through support, counselling or employee assistance programs.[38]

A TASMANIAN LIFELINE

While it was set up in crisis, the phone line is now moving towards becoming a critical part of Tasmania's mental health service. Initially only a one-year project, funding has now been extended for a further three years and Lifeline Tasmania is currently working with the Department of Health and Primary Health Tasmania to shift the focus of the phone line to a centralised assessment and referral service. As concerns regarding the pandemic ease, the phone line is consistently receiving calls related to mental health queries, demonstrating that it is fulfilling a gap and can provide a much-needed gateway to mental health access and navigation over the longer term. An Initial Assessment and Referral (IAR) framework will also be implemented as part of this change and will enable assessments to be made that take into account clinical symptoms as well as their context and identify appropriate supports and services based on the needs and level of care required. To support this change in focus, staffing of the phone-line is moving towards a permanent part-time model to provide increased job security.

In reflecting on the development of the service, Lifeline Tasmania CEO Debbie Evans believes that a key to its success was the collaboration and partnerships involved. In a system where there is increased pressure on services and a limited capacity to employ new staff, looking at innovative models and opportunities to share staff is vital. Collaboration between the mental health sector and education enables a shared understanding of workforce needs and supports a better system in terms of placements. As demonstrated by the Tasmanian Lifeline initiative, partnerships in this space enable the sector to get the best value they can out of the current workforce while also continuing to support training of students and graduates.

2.2.2. RURAL AND REGIONAL DELIVERY OF SERVICES

Rural and regional locations are particularly impacted by staff shortages (see Table 1.0). In the North West of Tasmania, for example, there are extensive waiting lists for services, with many extending into 2022. There are also reports of staff being required to work significant additional hours to meet demands, leaving many feeling over-worked and fatigued.

Rural clinicians may also be particularly likely to experience social isolation, which may be exacerbated by a shift to remote working and other COVID-19 impacts, indicating a need for effective team-based models that ensure clinicians are connected to community.

→ Group-based mental health support

Supporting community wellbeing and reducing pressure on services

Mental health education focused on prevention aims to build individual and community capacity in managing mental health and wellbeing, freeing up service providers for those who need additional support.

Psychology Caffe in regional North West Tasmania has experienced success delivering group-based community mental health education sessions. These 'psychoeducation' sessions equip community members with skills and knowledge regarding wellbeing, which they can then pass on to their families and peers. Recognising that it can be difficult to engage people in group-based work, sessions are delivered through existing institutions such as schools, or other groups such as Rotary. A recent series of sessions for parents delivered at a local school was considered helpful in equipping parents to deal with upcoming lockdowns and associated stressors. The sessions received very positive feedback from schools, not only in relation to the information provided, but also in how they had fostered connection between families. Similar programs can also be provided to health professionals to increase mental health literacy. For example, sessions have been provided to General Practitioners during their lunch breaks.

Psychology Caffe also runs up to eight parent groups a year as part of their ongoing services. Recognising the importance of engaging the whole family in addressing behavioural problems amongst young people early, these groups offer parents an opportunity to learn new information and skills and share challenges with fellow participants.[39]

Making funding grants available specific to providing group-based community mental health education would enable service providers to develop and deliver proposals in collaboration with other community organisations, such as schools. This investment in group-based prevention and early intervention sessions could have a direct impact on service demand and reduce the pressure placed on more high intensity mental health services.

2.2.3. COST OF TRAINING, DEVELOPMENT, AND SUPERVISION

Prohibitive costs of training, development and supervision is another identified mental health workforce issue, this is particularly prevalent within the community managed mental health sector. Meeting quality and safety standards requires training and professional development, as well as clinical supervision. This can reportedly equate to approximately 30% of costs, which is significant and can be prohibitive.

Ensuring cultural competency of the workforce has also been highlighted as a need. Whilst this is not a new issue, the pandemic has impacted some population groups more than others, therefore there is a need to upskill workers who may experience an increase in clients from disproportionately impacted groups. This includes Tasmanian Aboriginal people, culturally and linguistically diverse communities, people who identify as LGBTIQA+, younger people and older people.

2.2.4. LIMITED WELFARE AND WRAP AROUND SUPPORTS

A significant challenge reported to MHCT is a lack of youth mental health services that support the whole family, particularly families with children aged 6-15 years. This is important given youth may be carers or may have parents who are experiencing mental ill-health. MHCT has also received reports of organisations refusing to see young clients due to violent or traumatic episodes, however these clients are not being put in touch with someone who can help them find the right supports. Service providers are reporting that they are spending significant time trying to coordinate wrap around services for young people, leading to inefficiencies and impacting on capacity.

The COVID-19 pandemic has exacerbated these issues as there is increased pressure on families due to lockdowns and other measures. MHCT has heard that during the pandemic, mental health service providers have reported an increase in clients presenting with complex needs, which puts pressure on workers to coordinate wrap around supports (a task that is outside of many service provider's primary role). This in turn requires more time with the client (more episodes of care) and places further strain on the workforce. MHCT has heard that in the past, Youth Workers were positioned in local councils and provided a point of contact for young people to assist in the coordination of these wrap around support services, however funding for these programs has ceased, leaving community based mental health services to provide this type of support.

→ The 'Lead Support Coordination Services' model

Providing client-focused navigation support to free up capacity

There is an identified need to develop a model of support for provision of wrap around services to young people and their families that ensures their needs are being met, while also freeing up mental health workforce capacity. This is an ongoing issue that is increasingly urgent as the COVID-19 pandemic puts further strain on mental health workforce capacity.

Young people are often managing multiple providers, receiving conflicting information and suffer a lack of coordinated service goals and client goals. Recognising this, in 2017-2019 Department of Communities Tasmania trialled the 'Lead Support Coordination Services (LSCS)' model to support Tasmanians with complex needs to navigate government and community services.[40] The trial was delivered by Mission Australia, Australian Red Cross and Baptcare, who supported a total of 30 clients through a full 9 month trial.

The LSCS model took a holistic and client centred approach to case management and involved clients working with a Lead Coordinator to identify their needs and match these with the services available. Lead Coordinators acted as advocates for their clients, building relationships and assisting them to take a client-led journey that realised their own goals and outcomes. In this way, the model supported self-advocacy and self-agency, along with streamlining the number of services clients engaged with and subsequently freeing up these services to take on new clients.

"It was the shift of power in favour of positive outcomes for clients that was a key point of difference in the LSCS model. Importantly, power was not only exercised through LSCS workers' interactions with partner organisations, it was made available directly to the client"[41]

The process involved assessing client needs, developing a common case plan, sharing this plan with all service providers and measuring outcomes within a standard framework. Lead Coordinators could then work collaboratively with relevant services to move towards positive client outcomes, based on their identified priorities. Flexibility on brokerage use, allowed funding to pay for a range of identified needs, including food, home repairs, and health appointments. Services were able to be escalated when needed and then removed from the plan when no longer required, resulting in a more cost-effective approach that avoided unnecessary service use.

The trial resulted in positive outcomes in relation to mental health along with wrap around services that support the mental wellbeing of young people including; parenting, food security, engagement with services, housing, safety, personal relationships, alcohol and drug dependence and school engagement.[42] Lead Coordinators also reported positive changes to client's attitudes, confidence and commitment to change. The trial also measured client's self-reported quality of life before and after their participation. Before the trial, results were lower than Australians with chronic conditions such as cancer and severe disability. After the trial, however, results "exceeded (and were almost double) the minimal clinically important difference for service or intervention evaluation… driven by statistically significant improvements in psychosocial health". This was a significant achievement in a 9 month timeframe.

THE 'LEAD SUPPORT COORDINATION SERVICES' MODEL

"The LSCS model was a game-changer for many young people we were supporting. We encountered young people across the state who were engaging with 20+ services, yet despite the best intentions of service providers, young people often felt more overwhelmed than before reaching out for support. The LSCS approach assisted in improving access to the supports young people needed while dropping the ones they didn't, which in-turn led to a greater sense of control over their lives and significant improvements in physical and psychological wellness"

– Jurek Stopczynski, Regional Leader – TAS, Mission Australia.

Importantly, the LSCS model can reduce inefficiency in an overburdened community health system. By supporting clients to recognise the services they require (or no longer require), capacity is freed up for providers to focus on those most in need of their services.

There may be potential for a model similar to LSCS to also involve youth peer workers. Lived experience could enhance the Lead Coordinator role and see it become both a support and mentorship role.

While there are recognised issues involving challenges in sharing client information, the LSCS model demonstrates the benefit of a coordinated, innovative approach to providing wrap around services that reduces inefficiencies, frees up workforce capacity and results in positive client outcomes.

2.2.5. MENTAL HEALTH LITERACY, PREVENTION AND EARLY INTERVENTION

MHCT has received reports that people are regularly being referred to clinicians (often resulting in ending up on waiting lists) when they don't currently require that level of care. For example, data collected across 10 community mental health organisations in April – May 2021 found that of 551 young people referred on, 47 were not accepted as they didn't meet criteria for the service.[43] This highlights the importance of mental health literacy, prevention and early intervention to improve understanding of suitable mental health services based on level of need. It also demonstrates the importance of having effective referral processes in place. Referral issues are reportedly exacerbated by the high use of locum GPs in some areas who are not aware of all referral options. A lack of communication between services on the ground is an ongoing issue, which has reportedly become increasingly problematic for workplaces already under strain due to COVID-19. Community mental health services, particularly those in remote and regional areas, have reported complex referral processes and problematic pathways between community and public mental health services. This not only impedes on client care, but the complexity of the high-level processes has also resulted in organisations needing to recruit triage clinicians to help navigate them.

2.2.6. PANDEMIC FATIGUE

The pandemic has also brought its own set of additional challenges related to workforce. There are increasing reports of fatigue amongst staff who are over-worked and stressed, including carers and volunteers. Staff are choosing to not take leave due to lockdowns and limited travel options. Staff who have moved to the state recently are experiencing isolation, impacting on their wellbeing. Furthermore, team-building and other wellbeing initiatives can be neglected when organisations are busy responding to a crisis. There is a need to explore ways to maintain staff wellbeing and understand how ready the workforce is to face potential future lockdowns.

2.2.7. LIMITED UNDERSTANDING OF ABORIGINAL MENTAL HEALTH WORKFORCE IN TASMANIA

A recognised gap in the workforce consultation process in Tasmania is a limited understanding of impacts within the Tasmanian Aboriginal community. There is a need to strengthen relationships in order to develop an increased understanding of COVID-19 impacts on this cohort specifically.

3 The individual-level impact of COVID-19 on the community mental health workforce

Whilst a number of papers and reports exist that discuss the impact of COVID-19 on the health workforce more generally, data and discussion around the impact on the mental health workforce specifically is limited. Australian research indicates that the additional pressure on an already under-resourced sector, particularly in rural and remote regions, creates further challenges for mental health staff and their own support and mental health needs. This can lead to anxiety, burnout, depression and an increase in personal and sick leave.[44]

In September 2021, MHCT distributed a survey to staff of community mental health organisations in Tasmania. The survey aimed to understand community mental health staff's individual experience of COVID-19 and how it has impacted on their wellbeing and their work. In particular, the questionnaire aimed to gain an understanding of:

> ▸ The impact of COVID-19 on staff wellbeing and work practices

> ▸ What the community mental health workforce may need in the event of future lockdowns and/or the continued impacts of the pandemic.

65 people participated in the survey. Of these, 38 were direct service providers, 11 were senior executive staff, nine administrative support staff and seven middle management. 38 respondents worked full time, 25 part time, one was a causal worker and one a volunteer.

3.1 IMPACT ON WELLBEING

The findings of the survey highlight the significant impact that COVID-19 has had on the wellbeing of the mental health workforce. While there have been positive and beneficial outcomes, the majority of the impact appears to be negative. When asked about the impact that the pandemic had on their wellbeing, of 54 responses, 19 reported positive effects (35%), while 36 reported negative effects (67%).

The most commonly reported positive effect (20.1%) was the impact of working from home. This was considered to have enabled greater work/life balance, allowed staff to spend more time with family, reduced travel time and reduced work-related stress. One participant noted that working from home also allowed more time for case management, resulting in improved client outcomes. Other positive effects included fast-tracking of IT upgrades and system improvements, a sense of being of assistance to others and a greater sense of connection with team members and other service providers.

"During lockdown, being able to work from home made my life a little easier – I didn't feel as stressed about work/life pressures"

– survey respondent

The most commonly reported negative impact (29.6%) was a significantly increased workload, which led to increased stress and fatigue and less time for self-care. A sense of unease and uncertainty about the future and a need to adapt to a changing environment was also commonly reported (22.2%). This included feeling overwhelmed and having reduced hope. Increased social isolation and loneliness was also commonly reported (18.5%), particularly in relation to working from home or undertaking quarantine.

Others reported negative impacts on wellbeing included anxiety for the health of loved ones, inability to visit and spend time with family and friends abroad or interstate, increased pre-existing anxiety and depression, and stress associated with financial implications.

"Impacts of a significantly increased workload, constant changes to what is being asked due to the nature of the pandemic, and the impacts of COVID on my children have impacted my mental health more negatively than positively"
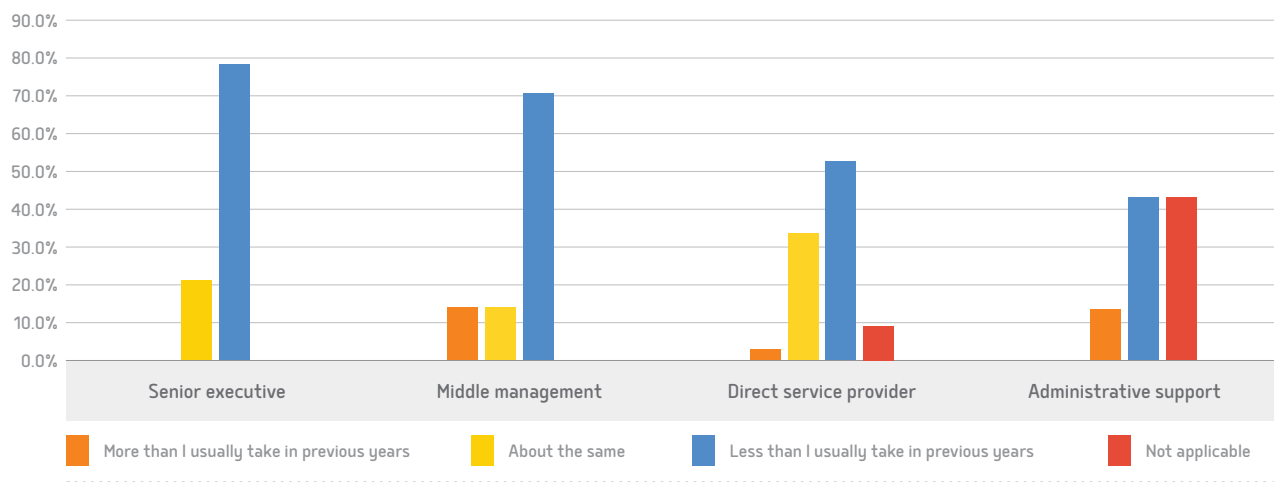
– survey respondent

"I think the biggest impact on my wellbeing is a sense of unease and uncertainty about whether there will be another lockdown and I worry about how I will cope juggling all those factors from home"

– survey respondent

CHART 1: ANNUAL LEAVE TAKEN IN THE PAST 15 MONTHS

HOW MUCH ANNUAL LEAVE HAVE YOU TAKEN IN THE PAST 15 MONTHS?

Legend:
- More than I usually take in previous years
- About the same
- Less than I usually take in previous years
- Not applicable

When asked about annual leave, the majority of 55 respondents (58.18%) had taken less than they would usually have taken in previous years. This was particularly the case for senior executives (77.8%). Reasons for this included a lack of ability to travel interstate as well as an inability to take leave due to an increased workload. A breakdown across different roles is provided in Chart 1 above, demonstrating that less leave has particularly impacted middle management, senior executives and to a lesser extent direct service providers and administrative support.

"This lack of leave is a huge stressor and negative impact on my general wellbeing"

– survey respondent

While 39.3% of 56 respondents had taken about the same sick leave as in previous years, 32.14% reported that they had taken more sick leave than usual, with reasons for this including a need to stay at home when exhibiting any COVID symptoms and the time required to undertake testing.
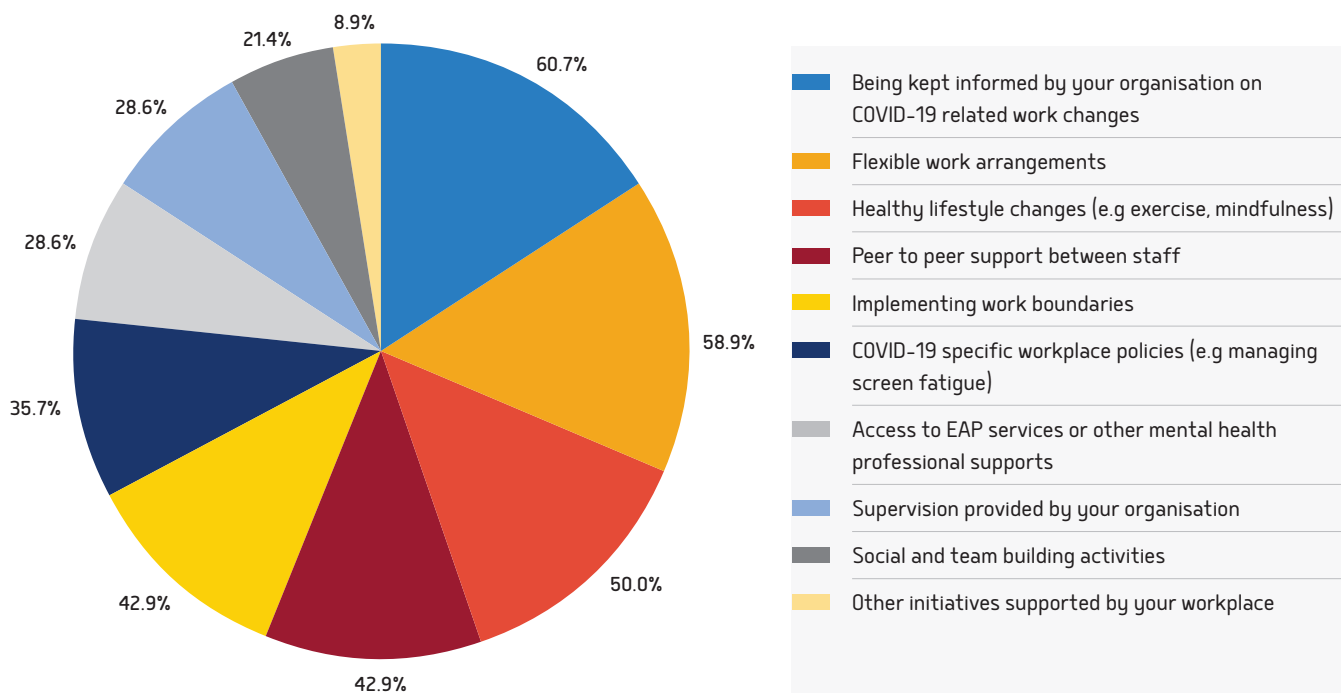
3.2 WHAT HAS HELPED?

Recognising the impact of COVID-19, many organisations have implemented strategies to support the wellbeing of staff, with varying impact. As illustrated in Chart 2, when asked what strategies have supported their mental wellbeing in the workplace over the past 15 months, 60.7% of 56 participants selected 'Being kept informed by your organisation on COVID-19 related work changes'. This demonstrates the importance of ensuring clear internal communication in relation to COVID impacts and responses. This was closely followed by flexible work arrangements (58.9%), healthy lifestyle changes (50%), implementing work boundaries (42.9%) and peer to peer staff support (42.9%). One respondent reported that their workplace had provided an additional 2 weeks of sick leave for all front-line workers (to support testing, isolating etc), which was well received, although not made available outside of front-line staff.

CHART 2: STRATEGIES THAT HAVE SUPPORTED STAFF WELLBEING OVER THE PAST 15 MONTHS

WHAT STRATEGIES HAVE SUPPORTED YOUR MENTAL WELLBEING IN THE WORKPLACE DURING THE PAST 15 MONTHS?

- Being kept informed by your organisation on COVID-19 related work changes
- Flexible work arrangements
- Healthy lifestyle changes (e.g exercise, mindfulness)
- Peer to peer support between staff
- Implementing work boundaries
- COVID-19 specific workplace policies (e.g managing screen fatigue)
- Access to EAP services or other mental health professional supports
- Supervision provided by your organisation
- Social and team building activities
- Other initiatives supported by your workplace

Flexible working arrangements was the most popular strategy amongst direct service providers (63.6%), indicating the importance of this to staff wellbeing amongst this cohort. Meanwhile for senior executives, implementing work boundaries, COVID specific workplace policies, healthy lifestyle changes, being kept informed by your organisation on COVID related work changes, peer to peer support between staff and flexible work arrangements were all equally commonly reported by 55.6% of respondents.

3.3 IMPACT ON STAFF WORK PRACTICES

It appears the majority of community mental health workers have experienced a shift to a hybrid approach to working arrangements and service delivery. When asked about how work has changed over the past 15 months, the majority of survey respondents (59.2%) reported a shift to hybrid supports (e.g. face to face and telehealth) and/or a shift to working remotely and in the workplace (49%). Further, 32.7% reported a shift in team-work dynamics, 30.6% a shift to working remotely, 24.5% a shift to telehealth reports and only 12.2% reported no change. It was also noted that COVID had resulted in significant additional requirements for many workplaces, including regular sanitisation, checking in, wearing masks and undertaking COVID testing.

There were numerous concerns expressed around these changes to work practices. Of 38 responses, 7 (18%) referred to concerns around working remotely having a negative impact on working relationships and connections with colleagues and other service providers. For example, staff were unable to meet and debrief following a challenging client engagement. Concerns were also raised around clients being unable to or less willing to engage with telehealth services, often due to cost or technology related issues (10.5%). Respondents also reported that remote working arrangements could lead to less work/life balance and limited managerial support or supervision. Screen and zoom fatigue were also a recognised concern, as was the effect of wearing masks on the ability to engage with clients.

On the other hand, 25 of 45 respondents (56%) considered the increased flexibility around working arrangements to be a positive outcome for reasons including reduced travel time, increased time to focus, enhanced productivity and reduced fatigue. Respondents also noted that the hybrid supports resulted in less no-shows for appointments and also allowed clients to engage in a range of different ways, increasing accessibility.

3.4 IMPACT ON WORKLOAD

When asked to compare their current workload with pre-COVID-19 workload, the majority of 51 respondents indicated that it had increased. On a scale of 0 to 100 (where 0 is decreased, and 100 is increased), the overall mean was 69. For senior executives, the mean was much higher at 79.9.

When asked to describe how workload changes have impacted them, 37% of the 43 responses indicated increased client complexity and 23% indicated increase in intensity/level of distress amongst clients. Other common responses included feeling stressed and overwhelmed, an increase in referrals, an increase in daily duties (including COVID screening questions, cleaning/sanitising), anxiety around COVID restrictions and requirements, shorter timeframes to adapt to change and a lack of referral options, particularly for complex or intense mental health presentations. Interestingly, 3 respondents indicated a reduced workload, which may have been specific to the services provided by their organisation. For example, one survey respondent noted a dramatic drop in referrals to Quitline, the smoking cessation resource.

3.5 STAFF WELLBEING NOW AND INTO THE FUTURE

When asked to rate their wellbeing against a number of different factors, sleep, exercise and social engagement received the lowest ratings with 37.3% of 51 respondents indicating poor or moderate disruption to wellbeing in relation to exercise, 37.3% in relation to social engagement and 17.6% in relation to sleep. In terms of positive wellbeing, 45.1% rated very good or excellent wellbeing for engagement with family, 44% for appetite and 43% for engagement with work.

CHART 3: STAFF WELLBEING RATED AGAINST DIFFERENT FACTORS

HOW WOULD YOU RATE YOUR CURRENT WELLBEING AGAINST THE FOLLOWING FACTORS?

Legend: Poor — Moderate disruption — Mild disruption — Good — Very good — Excellent
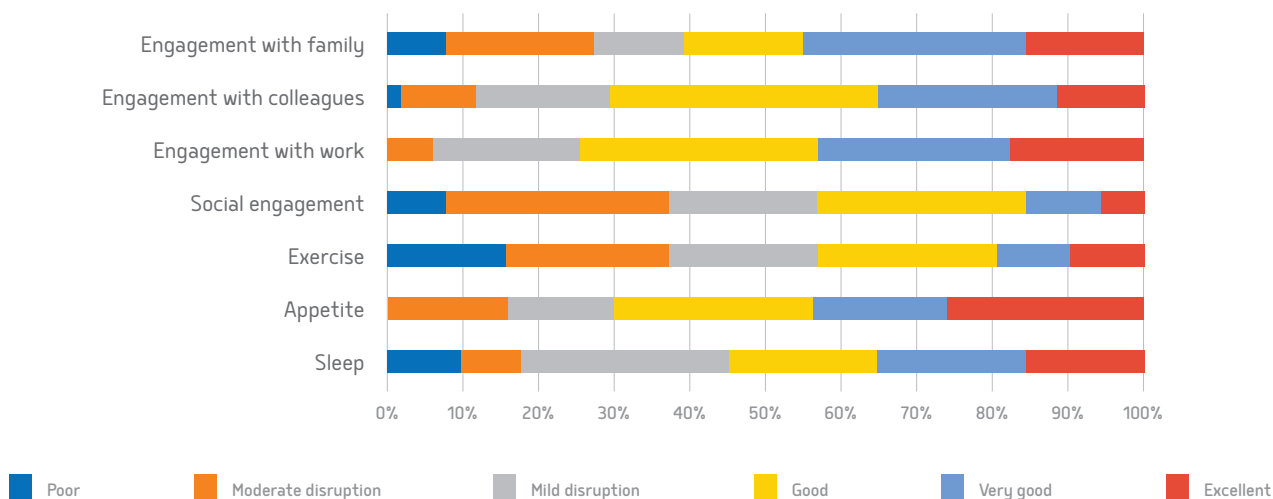
There were high COVID-19 vaccination rates reported with 77.1% of 48 respondents having received both doses and 14.6% having received the first dose as at September 2021. One of these respondents reported difficulties accessing vaccinations early in the pandemic as they received conflicting information about eligibility. Three respondents (6.3%) indicated that they had concerns or barriers to being vaccinated, which included being put-off by side effects and beliefs that the vaccine was not fully tested yet. One participant (2.1%) declined to answer.
(Note: since completion of the survey, the Tasmanian Government has announced the requirement for all Tasmanian health care workers to be vaccinated against COVID-19).

When looking towards the next 12 months, the most commonly reported issues that concern community mental health staff about their ability to maintain wellbeing were:

➤ Isolation from work colleagues, friends and family

➤ Lack of work/life balance and limited ability to practice self-care

➤ Ongoing and unpredictable border closures

➤ Inability to maintain personal physical health (including lack of energy to exercise, lack of ability to exercise if in lockdown, poor sleep hygiene)

➤ Anxiety for the wellbeing of family members

➤ Increased demand on mental health services and challenges to meet these needs (financial and workforce issue)

➤ Inability to take leave/travel

➤ Fear around future outbreaks and/or lockdowns.

"I worry about being able to juggle work and study from home, whilst caring for two young children, if there were another lockdown. I also worry that the government cannot support people financially through further lockdowns"

– survey respondent

"The likelihood of further outbreaks is a given, and so there is worry that we are a long way from a 'rest' and that this will further impact the health and mental wellbeing of health professionals"

– survey respondent

Finally, when asked what resources would support them if there were further changes to the way they worked due to the pandemic, 59.2% of 42 respondents selected 'flexibility in work arrangements to manage work and family demands', again emphasising the significant value staff place on flexible working arrangements. This was followed by access to reputable research on staff and client impacts (40.8%), access to technology grants to enable telehealth support (38.8%) and collaborative initiatives to share information and support between organisations on successes and challenges (34.7%). Strategies to support mental wellbeing and professional capacity (32.7%) and training in telehealth services delivery

(28.6%) and crisis support (26.5%) were also popular. Other strategies suggested by respondents included more opportunities for peer support, continuation of Employee Assistance Programs for health professionals, business support for fatigued managers and special leave for those who are having difficulty connecting with loved ones interstate.

3.6 DISCUSSION

The results of the survey demonstrate that the COVID-19 pandemic has had a negative impact on the wellbeing of many community mental health staff in Tasmania. This appears to be primarily associated with stress and fatigue caused by an increased workload and compounded by reduced leave and limited time for self-care. On top of this, social isolation (particularly an inability to see friends and family on the mainland), and a sense of fear and uncertainty around the future also appear to be negatively impacting the wellbeing of mental health staff. These findings are consistent with national and international research that has indicated that mental health practitioners have reported higher levels of workplace stress during the COVID-19 pandemic, which has had a negative impact on their physical and mental health.[45, 46, 47]

With respect to the changes to working conditions, a shift to hybrid working arrangements and service delivery has been a common experience and has also impacted on team dynamics. Interestingly, while flexible working arrangements introduced in response to the pandemic were reported to be supportive of mental wellbeing by many, working remotely also seems to have had some negative impacts on wellbeing. Namely, some staff feel more isolated and less supported when working remotely. Other research has similarly found remote working can increase feelings of isolation and providing services via telehealth can be more tiring and potentially reduce efficacy.[48] These findings indicate a need to work closely with staff to determine how 'flexible' working arrangements can best support wellbeing and to recognise that this may look different for different staff. It should be noted that the small size of the survey sample limits generalisability and findings should be interpreted with caution.
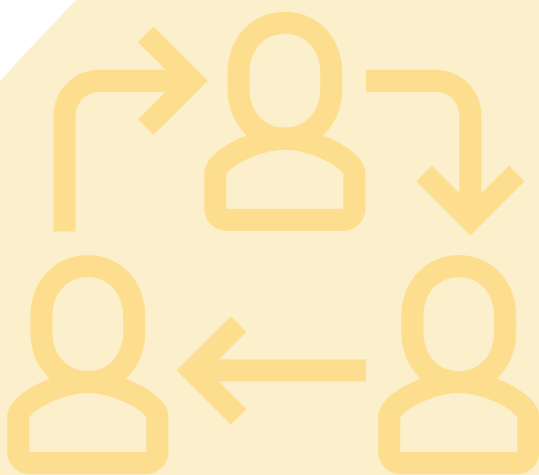
4 Key priorities

The COVID-19 pandemic has significantly increased the strain on the Tasmanian mental health system, including the community mental health sector. With service demand expected to continue to rise, immediate action is required to address workforce gaps and shortages and foster staff wellbeing.

In ensuring a robust mental health workforce to serve the future needs of Tasmanians, all workforce development strategies should look to align and complement one another. This includes consideration of the yet to be released National Mental Health Workforce Strategy and National Agreement on Mental Health and Suicide Prevention.[49]

For the community managed mental health sector, a coordinated and integrated response is required that responds to the key priorities identified below.

■ PRIORITY 1:
INTEGRATED WORKFORCE PLANNING TO SUPPORT RECRUITMENT AND RETENTION

To ensure a sustainable Tasmanian mental health workforce, further focus should be placed on supporting and resourcing recruitment and retention strategies. Joint approaches across public, private and community workforces will be important to ensure integration and establish the right workforce mix across all levels of mental healthcare.

The impact of COVID-19 on the mental health workforce in Tasmania, particularly in rural and remote areas, has been significant as previous reliance on international and interstate recruitment and locum staff has been hampered by travel restrictions. This makes the current lack of Tasmanian-based training problematic and highlights the need to support additional mental health training packages in the state and improve training pathways for the rural and remote workforce. Establishing strategic partnerships between the mental health sector and educational training institutions and providers will be an important element in establishing this and securing a more stable local workforce.[50] This collaboration could also support the provision of appropriate placements across the sector, particularly in regional areas. The benefits of such partnerships was demonstrated in the aforementioned 'A Tasmanian Lifeline' case study.

Supporting graduates to stay on in Tasmania and to ensure there is appropriate incentive and professional development available to achieve that is also important. This should include creating incentives for a skilled workforce to live and work in rural communities. It should also focus on resourcing the provision of adequate high-quality supervision. This is an identified challenge in the Tasmanian community mental health sector due to a lack of resourcing and funding and would benefit from further investigation into potential solutions such as supported partnerships between organisations to share supervisory resources.

Development of a training strategy for the mental health workforce should prioritise integrated health workforce planning that involves all settings, including community, public, primary, NDIS and private. The state plan for mental health in Tasmania, *Rethink 2020*, prioritises the development of the mental health workforce with a key action to develop a joint workforce strategy.[51] The joint workforce strategy should include improved linkages between the mental health sector and educational and training institutions, along with consideration to supporting graduate programs within community managed mental health organisations, particularly in rural and remote areas of the state. Further, the National Mental Health Workforce Strategy (due for release in late 2021) will identify key objectives to address mental health workforce challenges. MHCT's response to the draft national MH workforce strategy suggests alignment should be made between the national and state-based mental health workforce strategies.

PRIORITY 2:
PREVENTION AND EARLY INTERVENTION TO ADDRESS INCREASED SERVICE DEMAND

The COVID-19 pandemic has seen an increased demand for mental health services across the state, placing significant burden on an already strained workforce. Investment in promotion, prevention and early intervention (PPEI) is recognised as a key factor in reducing the burden on the mental health workforce. This will help to ensure that people can access supports early before becoming acutely unwell and potentially requiring higher intensity (and limited) mental health services provided by mental health nurses, psychiatrists and clinical psychologists. This priority has been supported by work within the Tasmanian health system both during and post COVID-19. The shift to preventative support options available at a community level, a stepped model of care, early intervention and more effective "upstream" services are all priorities being developed and implemented as part of *Rethink 2020* in an attempt to shift the focus away from hospital-based care and into care at a community level.[52]

Additionally, a mental health literacy approach should be adopted to support this shift. An investment in a mental health literacy approach aims to see more Tasmanians know how to recognise and take care of their mental health and get help as early as possible if they need it. This will have a direct impact on service demand and will reduce the pressure placed on more high intensity mental health services within the mental health system. Building mental health literacy in the community also has the added benefit of reducing stigma which in turn may support a greater interest and uptake into mental health professions in the future, thus supporting workforce recruitment and retention initiatives.

In building mental health literacy across the whole of population, a coordinated system must be in place to respond effectively to individuals who require further information and access to mental health supports and services. The #checkin campaign was developed

as a response to raising concern regarding mental wellbeing in the community given the impacts of the COVID-19 pandemic. The #checkin website provides education and information to assist Tasmanians in accessing relevant information based on their mental health needs. In addition to this, A Tasmanian Lifeline provides a central phone number to support Tasmanians with information, advice and referrals to mental health supports. A high number of callers to this service are provided with information to self-manage their mental health concerns, further supporting a focus on early interventions.

In building on these components further, MHCT suggests that a state-wide mental health literacy program is implemented, this should support upskilling individual community members along with health practitioners, school communities and community service workers (see Priority 3). The State election promises and subsequent 2021-2022 state budget announcements have committed to resourcing mental health literacy through the expansion of MHCT's Check In website along with building the capacity of communities to look after their mental wellbeing by training and supporting Regional Coordinators and Community Engagers. Further details on the mental health literacy program can be found in the *MHCT Budget Priority Submission 2021-2022*.

In addition, the establishment of a centralised information and intake service should be developed alongside a mental health literacy program so that people receive the right information and support based on their level of mental health need. The Initial Assessment and Referral (IAR) framework provides a tool to assess the level of mental health need for an individual.[53] Appropriate supports and services can then be identified based on the level of need. A trial of the IAR framework is a key action in the Rethink 2020 plan. Outcomes of this trial will be used to inform future implementation of the framework across the mental health care system.

■ PRIORITY 3:
UPSKILL AND DIVERSIFY THE MENTAL HEALTH WORKFORCE

A well-developed mental health PPEI approach will require a focus on upskilling the community services sector, people with lived experience (peer workforce) and other health professionals to increase mental health awareness and early intervention support throughout the community.

The limited capacity of the current mental health workforce to meet the varying levels of need in the community indicates a need to consider the inclusion of psychosocial supports and increased access to low intensity supports. This is particularly relevant in the current climate as the COVID-19 pandemic has led to a significant increase in people experiencing situational distress.[54] This form of distress requires wrap around supports to address the situation/s impacting on a person's mental wellbeing, combined with lower intensity mental health supports. To address this, focus should be placed on reorientating services so that individuals can meet their mental health and wellbeing needs through not only addressing their mental ill-health but by also rebuilding mental wellbeing through assistance with psychosocial supports and appropriate wrap around services.

Such an approach would involve upskilling the community service sector workforce in mental health education and awareness to enable provision of early intervention supports that can address the situational components of a person's distress. Additionally, this approach requires consultation with the sector to redefine the skills and qualifications needed to provide lower intensity mental health supports and how these 'new' roles may be recognised.

The recent budget commitments to support mental health literacy across the state would benefit from additional resourcing to provide an opportunity to explore structured upskilling programs for the mental health workforce. This could be further expanded to provide specific early intervention training for the indirect mental health workforce, including the community service sector.

The LSCS model discussed in section 2.2 is an example of an innovative approach to meeting both the mental health and wrap around support needs of young Tasmanians. Such an approach could be further enhanced with adoption of the IAR framework, shared client information and structured referral pathways informed by current service mapping work that is already underway in Tasmania.

Furthermore, developing a professional peer workforce through Tasmania's Peer Workforce Development Strategy will help to address current workforce supply shortages while harnessing the unique skills and experience of people with lived experience of mental illness.[55] The implementation of the Peer Workforce Strategy and recent recruitment of the Peer Workforce Coordinator will provide opportunity for people to build skills in peer work to support the diversification of the mental health workforce. The implementation of the Peer Workforce Strategy should additionally explore opportunities for peer workers to support people in the coordination of psychosocial supports and wrap around services.

Ensuring cultural competency of the workforce has also been highlighted as a need. Whilst this is not a new issue, the pandemic has impacted some population groups more than others, therefore there is a need to upskill workers who may experience an increase in clients from disproportionately impacted groups. This includes Tasmanian Aboriginal people, culturally and linguistically diverse communities, people who identify as LGBTQIA+, younger people and older people. Cultural training programs should be co-designed with priority populations and seek direction from them on what is needed and suitable in this space. This work is supported through Rethink 2020, Reform Direction 7 which focuses on responding to the needs of specific population groups, however it is yet to be resourced.[56]

■ PRIORITY 4:
FOSTER AND SUPPORT MENTAL HEALTH STAFF WELLBEING

As outlined in this report, community mental health staff have reported higher levels of workplace stress during the COVID-19 pandemic, which has had a negative impact on their physical and mental health.[57] This has implications for workforce retention and highlights the need to promote and fund appropriate staff training and wellbeing initiatives. MHCT's recent survey of the community mental health sector identified several protective factors to support staff wellbeing including; being kept informed on COVID-19 related work changes, flexible work arrangements, healthy lifestyle changes, implementing work boundaries and peer to peer staff support. Given the varied impact of working remotely on staff wellbeing, flexible working arrangements may vary across organisations and may require a person-centred approach. There is a need to further explore innovative and effective ways to maintain staff wellbeing and support the workforce through potential future lockdowns and COVID-19 restrictions. MHCT is currently in the process of establishing a workforce wellbeing Community of Practice (CoP) to explore and share successful strategies and initiatives. Further resourcing may also be necessary to support additional Employment Assistance Program (EAP) sessions and supervision for staff in the advent of future pandemics and disaster events.

■ PRIORITY 5:
EQUIP MENTAL HEALTH SERVICES TO RESPOND TO ONGOING COVID-19 IMPACTS

The impact of COVID-19 will have long-lasting effects on the delivery of mental health services and requires a focus on ensuring the sector is well equipped to respond to these ongoing impacts. As recognised at a national level, professional development on the use of digital technology in providing services, particularly the use of telehealth, should be integrated into mental health training and professional development moving forward.[58] This should be accompanied by development of best-practice guidelines and resources for mental health practitioners using telehealth, recognising that telehealth is useful but should not be considered a substitute for in-person support. Further, training and resources should be supported by ensuring access to technology grants to enable provision of telehealth support.

As part of the 'Our Healthcare Future' immediate actions, the Tasmanian government has committed to developing a Telehealth Strategy for the state to provide high quality, integrated patient care across acute, subacute, primary and community care, as well as commencing consultations on the development of a State-wide Digital Health Strategy.[59] In the development of these strategies it will be important to consider best practice in telehealth for mental health consumers, including the suitability for particular cohorts, such as CALD, Tasmanian Aboriginal people and young people. Digital literacy and digital access should also be addressed alongside the implementation of a telehealth strategy.[60]

Providing training in pandemic-specific crisis support would equip the mental health workforce to respond more effectively to the ongoing impacts of COVID-19 and also to develop and deliver effective pandemic response programs.[61] Further, there is a recognised need to foster collaborative initiatives to share information and support between organisations on successes and challenges related to COVID-19. This would generate shared learnings from the response to the pandemic and help the sector to identify opportunities and needs that will support the future mental health workforce and its sustainability. The COVID-19 Mental Health Sector Network demonstrated an effective approach to sector collaboration during the pandemic, with consideration to similar networks re-instated in the advent of further COVID-19 impacts or potential future disaster events.

■ **PRIORITY 6:**
DATA COLLECTION AND MONITORING TO INFORM AN EFFECTIVE RESPONSE

Responding to the challenges faced by the mental health workforce requires a clear understanding of the impact of COVID-19, supported by high quality data and evidence. There is a recognised lack of coordinated monitoring and evaluation occurring across the mental health sector in Australia, negatively impacting on available data and research and the ability to fully understand COVID-19-related changes.[62] Timely access to workforce data would also help to inform responses to future pandemics. Given the complexity of the mental health workforce, transdisciplinary and mixed methods research, combined with cross-organisation and cross-sector data sharing is required to gain a full picture of COVID-19's impact and related needs and gaps.[63] It is anticipated that the National Mental Health Workforce Strategy, scheduled to be released in late 2021, will also highlight the necessity of access to timely workforce data and look to develop a National Mental Health Workforce Data Strategy.[64]

A lack of data availability to inform workforce planning is a particular challenge for the community mental health sector in Tasmania. Actions outlined in the Rethink 2020 Implementation plan include the development of a suite of key performance indicators to measure service efficiency and effectiveness and desired outcomes relevant to the mental health and wellbeing of Tasmanians and establishment of a comprehensive evidence base to support real-time monitoring and data collection for the mental health system.[65] As part of this, further data related to Peer Workers, Aboriginal Mental Health Workers, Psychosocial Support Workers and the Community Service Workforce should be routinely collected to gain a better understanding of the complete picture of the Tasmanian mental health workforce. To achieve this, collection and reporting of workforce data could be made a reporting requirement across the community sector. Further, data for occupations who work across multiple sectors (e.g. nurses, speech pathologists etc) should be disaggregated to identify work undertaken within the mental health sector specifically.

Supporting and funding further research into the impact of COVID-19 on the mental health workforce would also allow organisations to access reputable information on staff and client impacts to inform their ongoing response. As part of this, regular capacity surveys would enable a clearer understanding of workforce capacity to inform future planning.

5 Next steps

This report demonstrates the significant impact of the COVID-19 pandemic on the community mental health workforce at both a national and state level. While the challenges faced by the mental health workforce in Tasmania are not new, COVID-19 has significantly exacerbated many of these, while at the same time introducing additional urgent priorities.

Moving forward, it is important that workforce reform acknowledges and considers the permanent systemic influence of COVID-19 over the mental health system and implements strategies that cater for an uncertain future.

The recent mental health budget commitments from the Tasmanian government represent a positive initial step towards supporting the uptake of a coordinated and integrated response, however, further resourcing should be considered to support the community mental health workforce in light of the COVID-19 pandemic.

The findings and identified priorities included in this report should be used to further inform actions and resourcing requirements in the implementation of Rethink 2020. In particular, further resourcing should be considered to support identified actions in reform direction 9 of Rethink 2020 – 'Supporting and Developing our Workforce'. Actions and resourcing under this reform direction should include:

- ➤ Consideration of strategies to collate community mental health workforce data in order to gain an understanding of workforce size, gaps and service capacity.

- ➤ Establishment of a training, professional development and supervision fund for the community mental health workforce along with training to upskill the broader health and community-services sector in understanding mental health (this is particularly important in rural and remote communities).

- ➤ Understand psychosocial and wrap around support needs required to meet the growing complexity and situational distress experienced as an outcome of the pandemic – and establish specific roles in the community mental health sector to meet this need.

- ➤ Improve linkages between the mental health sector and educational and training institutions as part of the development and implementation of a joint mental health workforce strategy.

References

[1] World Health Organisation (2021) *WHO Coronavirus (COVID-19) Dashboard With Vaccination Data*, accessed 20 October 2021, https://COVID-19.who.int/

[2] Parliament of Australia (2021) *Submissions - Inquiry into Mental Health and Suicide*, accessed 20 October 2021, https://www.aph.gov.au/Parliamentary_Business/Committees/House/Mental_Health_and_Suicide_Prevention/MHSP/Submissions

[3] Aknin L, De Neve J, Dunn E, Fancourt D, Goldberg E, & Helliwell J et al (2021). 'Mental Health During the First Year of the COVID-19 Pandemic: A Review and Recommendations for Moving Forward', *The Lancet,* doi:10.31234/osf.io/zw93g

[4] Australian Institute of Health and Welfare (2021) *Mental health services in Australia*, accessed 18 October 2021, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia

[5] Australian Institute of Health and Welfare (2021) *Mental health services in Australia: COVID-19 impact on mental health*, accessed 18 October 2021, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/covid-19-impact-on-mental-health

[6] ibid

[7] Australian Institute of Health and Welfare (2021) *Mental health services in Australia*, accessed 18 October 2021, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia

[8] Gardiner FW, Bishop L, Churilov L, Collins N, O'Donnell J, & Coleman M (2020) 'Mental Health Care for Rural and Remote Australians During the Coronavirus Disease 2019 Pandemic,' *Air Medical Journal*, 39(6), 516–519, doi:10.1016/j.amj.2020.08.008

[9] National Mental Health Commission (2020) *National Mental Health and Wellbeing Pandemic Response Plan*, accessed 10 October 2021, https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce-5d1a-44fc-b1e9-c00204614cb5/National-Mental-Health-and-Wellbeing-Pandemic-Response-Plan

[10] Bishop L, Ransom A, Laverty M, Gale L (2017) Mental Health in Remote and Rural Communities, Royal Flying Doctor Service, accessed 1 October 2021, https://nacchocommunique.com/wp-content/uploads/2017/06/rn031_mental_health_d5.pdf

[11] Mental Health Carers Tasmania (2018) *Submission to the Inquiry into the Accessibility and quality of mental health services in rural and remote* Australia, accessed 10 October 2021, https://www.aph.gov.au/DocumentStore.ashx?id=be4a39c6-28e4-4398-91b1-ddb13bc68899&subId=566108

[12] Bishop L, Ransom A, Laverty M, Gale L (2017) Mental Health in Remote and Rural Communities, Royal Flying Doctor Service, accessed 1 October 2021, https://nacchocommunique.com/wp-content/uploads/2017/06/rn031_mental_health_d5.pdf

[13] Mental Health Carers Tasmania (2018) *Submission to the Inquiry into the Accessibility and quality of mental health services in rural and remote* Australia, accessed 10 October 2021, https://www.aph.gov.au/DocumentStore.ashx?id=be4a39c6-28e4-4398-91b1-ddb13bc68899&subId=566108

[14] Australian Institute of Health and Welfare (AIHW) 2021, *Mental health services in Australia*, accessed 18 October 2021, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia

[15] Gardiner FW, Bishop L, Churilov L, Collins N, O'Donnell J, & Coleman M (2020) 'Mental Health Care for Rural and Remote Australians During the Coronavirus Disease 2019 Pandemic,' *Air Medical Journal*, 39(6), 516–519, doi:10.1016/j.amj.2020.08.008

[16] Mental health Council of Tasmania (2019) *Productivity Commission Inquiry into Mental Health 2019: Submission from Mental Health Council of Tasmania*, accessed 10 October 2021, https://mhct.org/wp-content/uploads/2019/09/2019-MHCT-Submission-to-the-PC-Commission-Inquiry-Mental-Health-050419.pdf

[17] Mental Health Council of Tasmania (2021) *Submission to Legislative Council Inquiry into Rural Health Services*, accessed 10 October 2021, http://mhct.org/wp-content/uploads/2021/05/SUB-MHCT-LegCo-Inquiry-into-Rural-Health-20211203.pdf

[18] Gardiner FW, Bishop L, Churilov L, Collins N, O'Donnell J, & Coleman M (2020) 'Mental Health Care for Rural and Remote Australians During the Coronavirus Disease 2019 Pandemic' *Air medical journal*, 39(6), 516–519, doi:10.1016/j.amj.2020.08.008

[19] Mental Health Council of Tasmania (2021) *Submission to Legislative Council Inquiry into Rural Health Services*, accessed 10 October 2021, http://mhct.org/wp-content/uploads/2021/05/SUB-MHCT-LegCo-Inquiry-into-Rural-Health-20211203.pdf

[20] Mental Health Council of Tasmania (2021) *Submission to Legislative Council Inquiry into Rural Health Services*, accessed 10 October 2021, http://mhct.org/wp-content/uploads/2021/05/SUB-MHCT-LegCo-Inquiry-into-Rural-Health-20211203.pdf

[21] Fish JN & Mittal M (2021) 'Mental Health Providers During COVID-19 : Essential to the US Public Health Workforce and in Need of Support', *Public health reports (Washington, D.C. : 1974)*, 136(1), 14–17, https://doi.org/10.1177/0033354920965266

[22] Fish JN & Mittal M (2021) 'Mental Health Providers During COVID-19 : Essential to the US Public Health Workforce and in Need of Support', *Public health reports (Washington, D.C. : 1974)*, 136(1), 14–17, https://doi.org/10.1177/0033354920965266

[23] Mental Health Council of Tasmania (2021) *Submission to Legislative Council Inquiry into Rural Health Services*, accessed 10 October 2021, http://mhct.org/wp-content/uploads/2021/05/SUB-MHCT-LegCo-Inquiry-into-Rural-Health-20211203.pdf

[24] Berger E and Reupert A (2020) 'The COVID-19 Pandemic in Australia: Lessons Learnt,' *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(5): 494–496, doi: 10.1037/tra0000722

[25] Edwards E, Janney CA, Mancuso A, Rollings H, VanDenToorn A, DeYoung M, Halstead S and Eastburg M (2020). Preparing for the Behavioral Health Impact of COVID-19 in Michigan,' *Current Psychiatry Reports*, 22(12): 88, doi: 10.1007/s11920-020-01210-y

[26] National Mental Health Commission (2014) *The National Review of Mental Health Programmes and Services*, Sydney: NMHC, accessed 10 October 2021, https://www.mentalhealthcommission.gov.au/getmedia/6b8143f9-3841-47a9-8941-3a3cdf4d7c26/Monitoring/Contributing-Lives-Thriving-Communities-Summary.PDF.

[27] Productivity Commission (2020), *Mental Health*, Report no. 95, Canberra, accessed 1 October 2021, https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.docx

[28] Department of Health (2020) *Our Healthcare Future: Immediate actions and consultation paper*, accessed 1 October 2021, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/416845/Our_Healthcare_Future_IAaCP_vf_21_Dec20.pdf

[29] ibid

[30] ibid

[31] Cleary A, Thomas N & Boyle, F (2020) *National Mental Health Workforce Strategy - A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries*, University of Queensland, accessed 1 October 2021, https://www.health.gov.au/sites/default/files/documents/2021/08/national-mental-health-workforce-strategy-a-literature-review_0.pdf

[32] ibid

[33] Tan EJ, Meyer D, Neill E, Phillipou A, Toh WL., Van Rheenen TE & Rossell SL (2020) 'Considerations for assessing the impact of the COVID-19 pandemic on mental health in Australia' *The Australian and New Zealand Journal of Psychiatry*, 54(11): 1067–1071, doi:10.1177/0004867420947815

[34] Department of Health (2020) *Our Healthcare Future: Immediate actions and consultation paper*, accessed 1 October 2021, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/416845/Our_Healthcare_Future_IAaCP_vf_21_Dec20.pdf

[35] Australian Institute of Health and Welfare (AIHW) 2021, *Mental health services in Australia*, accessed 18 October 2021, https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia

[36] Department of Health Tasmania, *Health Workforce 2040*, accessed 1 October 2021, https://www.dhhs.tas.gov.au/ourhealthcarefuture/immediate_actions_and_consultation_paper/health_workforce_2040,_tasmanias_workforce_strategy

[37] Productivity Commission (2020), Mental Health, Report no. 95, Canberra, accessed 1 October 2021, https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.docx

[38] Lifeline Tasmania (2021) *A Tasmanian Lifeline*, accessed 22 September 2021, https://atasmanianlifeline.com.au/

[39] Psychology Caffe (2021) *Group Work, accessed 10 October 2021*, https://www.psychologycaffe.com.au/services/groups/

[40] University of Tasmania (2019) *Lead Support Coordinator Service (LSCS) Evaluation Report*, Hobart: Department of Communities, Tasmania.

[41] University of Tasmania (2019) *Lead Support Coordinator Service (LSCS) Evaluation Report*, Hobart: Department of Communities, Tasmania, p12

[42] University of Tasmania (2019) *Lead Support Coordinator Service (LSCS) Evaluation Report*, Hobart: Department of Communities, Tasmania

[43] MHCT, Youth Mental Health Response Data Collection Project (2020), available on request

[44] Gardiner FW, Bishop L, Churilov L, Collins N, O'Donnell J, & Coleman M (2020) 'Mental Health Care for Rural and Remote Australians During the Coronavirus Disease 2019 Pandemic' *Air medical journal*, 39(6), 516–519, doi:10.1016/j.amj.2020.08.008

[45] McLean SA & McIntosh JE (2021) The mental and physical health of family mental health practitioners during COVID-19: relationships with family violence and workplace practices, *Australian Journal of Psychology*, doi: 10.1080/00049530.2021.1934118

[46] Fish JN & Mittal M (2021) 'Mental Health Providers During COVID-19 : Essential to the US Public Health Workforce and in Need of Support', *Public health reports (Washington, D.C. : 1974)*, 136(1), 14–17, https://doi.org/10.1177/0033354920965266

[47] Gardiner FW, Bishop L, Churilov L, Collins N, O'Donnell J, & Coleman M (2020) 'Mental Health Care for Rural and Remote Australians During the Coronavirus Disease 2019 Pandemic' *Air medical journal*, 39(6), 516–519, doi:10.1016/j.amj.2020.08.008

[48] Fish JN & Mittal M (2021) 'Mental Health Providers During COVID-19 : Essential to the US Public Health Workforce and in Need of Support', *Public health reports (Washington, D.C. : 1974)*, 136(1), 14–17, https://doi.org/10.1177/0033354920965266

[49] Prime Minister of Australia (2020) Media Statement: 11 Dec 2020, accessed 1 October 2021, https://www.pm.gov.au/media/national-federation-reform-council-statement

[50] Department of Health Tasmania (2020) *Our Healthcare Future: Immediate actions and consultation paper*, accessed 1 October 2021, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/416845/Our_Healthcare_Future_IAaCP_vf_21_Dec20.pdf

[51] Tasmanian Government (2020) *Rethink 2020: A state plan for mental health in Tasmania 2020-2025*, accessed 1 October 2021, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/419549/Rethink_2020_A_state_plan_for_mental_health_in_Tasmania_20202025.pdf

[52] Department of Health (2020) *Our Healthcare Future: Immediate actions and consultation paper*, accessed 1 October 2021, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/416845/Our_Healthcare_Future_IAaCP_vf_21_Dec20.pdf

[53] Department of Health (2020) *National PHN Guidance: Initial assessment and referral for mental healthcare, accessed 10 October 2021*, https://www.health.gov.au/resources/publications/primary-health-networks-phn-mental-health-care-guidance-initial-assessment-and-referral-for-mental-health-care

[54] Mental Health Council of Tasmania (2021) *COVID-19 Impacts and emerging themes within the mental health sector: Monthly Report, June/July 2021*, accessed 28 October 2021, https://mhct.org/mhct-covid19-report-june-july-2021/

[55] Mental Health Council of Tasmania (2019) *Peer Workforce Development Strategy*, accessed 1 October 2021, https://mhct.org/wp-content/uploads/2019/11/MHCT_PWDS-Web.pdf

[56] Department of Health Tasmania (2021) *Rethink 2020 Implementation Plan*, accessed 15 October 2021, https://www.health.tas.gov.au/__data/assets/pdf_file/0003/439239/Rethink_2020_Implementation_Plan.pdf

[57] McLean SA & McIntosh JE (2021) The mental and physical health of family mental health practitioners during COVID-19: relationships with family violence and workplace practices, *Australian Journal of Psychology*, doi: 10.1080/00049530.2021.1934118

[58] National Mental Health Commission (2020) *National Mental Health and Wellbeing Pandemic Response Plan*, accessed 10 October 2021, https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce-5d1a-44fc-b1e9-c00204614cb5/National-Mental-Health-and-Wellbeing-Pandemic-Response-Plan

[59] Department of Health Tasmania (2020) *Our Healthcare Future: Immediate actions and consultation paper*, accessed 1 October 2021, https://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/416845/Our_Healthcare_Future_IAaCP_vf_21_Dec20.pdf

[60] Mental Health Council of Tasmania (2021) *Improving mental healthcare in Tasmanian communities: MHCT response to the Our Healthcare Future Consultation*, accessed 1 October 2021, http://mhct.org/wp-content/uploads/2021/03/MHCT-repsonse-to-Our-Healthcare-Future-Consultation-12022021.pdf

[61] National Mental Health Commission (2020) *National Mental Health and Wellbeing Pandemic Response Plan*, accessed 10 October 2021, https://www.mentalhealthcommission.gov.au/getmedia/1b7405ce-5d1a-44fc-b1e9-c00204614cb5/National-Mental-Health-and-Wellbeing-Pandemic-Response-Plan

[62] Cleary A, Thomas N & Boyle, F (2020) *National Mental Health Workforce Strategy - A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries*, University of Queensland, accessed 1 October 2021, https://www.health.gov.au/sites/default/files/documents/2021/08/national-mental-health-workforce-strategy-a-literature-review_0.pdf.

[63] ibid

[64] Acil Allen (2021) *National Mental Health Workforce Strategy: Consultation Draft*, accessed 15 October 2021, https://acilallen.com.au/uploads/media/NMHWS-ConsultationDraftStrategy-040821-1628234534.pdf

[65] Department of Health Tasmania (2021) *Rethink 2020 Implementation Plan*, accessed 15 October 2021, https://www.health.tas.gov.au/__data/assets/pdf_file/0003/439239/Rethink_2020_Implementation_Plan.pdf

Notes

www.mhct.org

Mental Health Council
OF TASMANIA