SIGGINS MILLER

Development of a

National Mental Health Workforce

Strategy and Plan

Mental
Health
Workforce
Advisory
Committee

Template for written submissions

Thank you for requesting the template to make a written submission. As the covering email suggests, please save this document on your system with a title that includes your own name. This document is set up as a Word document with boxes that will expand to fit your content. When you have completed your submission, please attach it to an email addressed to alexandra.lewis@sigginsmiller.com.au. Alternatively, you can print it and post it, attention Alexandra Lewis, PO Box 1143, Kenmore Queensland, 4069.

The due date for written submissions is18th December 2009

The objectives of the project:

- Review Australian and international literature on mental health workforce that identifies key strengths and challenges, and notes current workforce innovations and reforms.
- Scope possible changes in treatment and technology that could affect the capacity and capability of the workforce.
- Identify major workforce capacity building requirements to ensure a sustainable, high quality response to the treatment and prevention of mental illness.
- Develop a nationally agreed strategy and related set of priority actions for the short, medium and longer term.
- Support a cross-jurisdictional approach to workforce development for those providing health & community mental health services to people with a mental illness.

The scope of this project:

The focus is health and community mental health service professionals whose primary role involves treatment, care or support for people with a mental illness in a mental health service or other health service environment. The scope includes mental health nurses, general registered nurses, medical practitioners, occupational therapists, social workers, psychologists, mental health workers, Aboriginal mental health workers, Aboriginal health workers, consumer workers and carer workers working in hospitals, healthcare and community mental health agencies across metropolitan, regional and remote areas of Australia.

It includes health and community mental health service professionals working across the range of service types—for example, mental health services for adults, children and adolescents, and aged persons. It also includes staff working in non-government community mental health services; nurses working in the Mental Health Nurse Incentive Program, and psychologists, occupational therapists and social workers providing services under the MBS Better Access to Mental Health Care program. The forensic mental health workforce is within the scope of the project. People working in the housing and employment sectors are outside the scope of the project.

We need to ensure that in the development phase of the plan we work backwards from outcomes for consumers and carers and their needs to what sort of workforce can meet those needs. On this basis, we seek your views and advice on the following key issues that arise from an analysis of the workforce development literature and experience in Australia and other countries.

We also welcome your comments on any other issues and any other suggestions you wish to register.

Please note that we do not expect that everyone will want to make a comment on all aspects of workforce development; so please feel free to comment only on those issues that are of interest to you or for which you have particular observations or suggestions.

To help us understand the views expressed through this survey, we need to gather some basic information about you (or your organisation, if you are responding as a representative). This will allow summary information to be presented to the Project Steering Committee about who has responded to the survey.

If you are responding as an individual, none of the information requested will allow you to be identified. If you are responding on behalf of an organisation, we do invite you to provide us with details of your organisation so that summary information can be prepared on the range of stakeholder organizations involved in mental health that have responded to this survey. This is same process that will be followed in the face-to-face consultations for the development of the strategy.

On what basis are you responding to this survey? (please tick or cross)

As an individual	
On behalf of your organisation	**x**
Other (please specify)	

Name of stakeholder / organisation making this submission:

Private Mental Health Consumer Carer Network (Australia)

Contact person (name and title) **Ms Janne McMahon OAM, Chair**

(telephone and email): 08 8336 2378 email: jmcmahon@senet.com.au

My comments or interests particularly concern (please tick or cross those that apply):

Aboriginal health workers		**Nurses**	
Adult mental health services	**x**	**Occupational therapists**	
Aged persons mental health services		**Other medical practitioners**	
Carer advocates	**x**	**Primary care**	
Child and adolescent mental health services		**Private mental health services**	
Consumer advocates	**x**	**Psychiatrists**	
Forensic mental health services		**Psychologists**	
General Practitioners		**Public mental health services**	
Non government community mental health services		**Social Workers**	
Other (please specify)	**x**		

We are a national mental health consumer and carer advocacy peak body.

Please insert your responses in the answer boxes. You can choose to answer some questions only.

1. Implementing the recovery model

The Fourth National Mental Health Plan (2009 to 2014) has a strong emphasis on the implementation of the recovery model in individual practice and in changing organisational cultures and the way service systems work. Recovery models are more than just a change in language or jargon. Mental Health Services will be required to incorporate recovery principles into every day practice. In your view, what are the major challenges facing us in the way we all think about and/or behave in relation to recovery from mental illness? What strategies do you suggest might help consumers and carers, individual practitioners, organisations and services to align better with the recovery model?

Comments and suggestions; examples of good practice; case studies where things have not worked and lessons learned

The *Private Mental Health Consumer Carer Network (Australia)* represents Australians who have private health insurance and/or who receive their treatment and care, and those that care for them, from private sector settings for their *mental illnesses or disorders.* As our title implies, the Network is the authoritative voice for consumers and carers of private mental health settings.

The whole concept of 'recovery' is a difficult one for consumers and carers especially when struggling with chronic mental illness often on a day by day basis.

We think it is important to define what 'recovery' really means in terms of appropriation to mental health services. There are now a number of definitions including one within the 4th Plan, but what do they mean exactly for service delivery and to the health professionals working in the mental health system?

The employment of consumer and carer advocates is consistent with and even essential to a recovery focused model – that is consumers and carers are able to see examples of and get support from people who are in the process of recovery.

The Network believes that a recovery focus will assist somewhat with workforce recruitment and retention issues – it may be a more attractive option for people to work with mental health consumers where the assumption is that consumers can and will recover, that there is real hope and a chance to make a difference, rather that the current belief that we have a system that assumes consumers will always be very unwell. The belief currently that no matter what interventions are put in place, some consumers will never lead anywhere near a reasonable quality of life.

4 Education and Training; CPD; Supervision ; Mentoring and Coaching

The education and training and continuing professional development of the current and potential future workforce is a key component of all workforce development strategies. In recent times there has been considerable debate about the need for inter-disciplinary training, and for developing articulated programs and courses from the VET sector to the tertiary sector. Your comments and suggestions about the education, training, CPD and supervision, mentoring and coaching of the workforce are invited:

Our Network strongly believes that consumers and carers have a great potential to train and educate mental health professionals in the first instance and also within their continuing professional development.

The barriers currently existing to this initiative relate to the acceptance by clinical colleges, clinical organisations, universities and other training institutions as to what consumers and carers can offer. How

many times have we heard passionate stories of consumers and carers experiences, yet these are not carried forward into training and ongoing education of health professionals.

We strongly believe that the implementation of the *National Practice Standards for the Mental Health Workforce* (Standards) which cover the specific areas of knowledge, skills and attitudes would go some way to addressing the attitudinal aspects which are current barriers. Indeed we are dismayed and frustrated that the Standards, endorsed by AHMAC NMHWG in **September 2002** still have not been implemented.

Within this document, it states that the Standards provide a guide for **education and training curricula** with the aim for students to achieve most of the Standards including continuing education in the workplace. It discusses the need to ensure all mental health professionals, graduates and current workforce, are aware of the core knowledge, skills and attitudes required in the current and future mental health service delivery.

It also talks of the key importance for any health professional either entering or within the current mental health workforce, to have the opportunity **to be educated by mental health consumers, their family members and carers** about their:

Lived experiences of mental illness;

Requirements for adequate services and supports; and

Ability to work in partnership with mental health professionals.

We are aware that the RANZCP conducted an Implementation Project for 3 of the 12 standards and we understand that this was a very difficult task for a number of reasons.

Given that this was endorsed in September, 2002, now some 7 years ago, as consumers and carers we continue to be frustrated by this ongoing dialogue yet still without action.

6 Composition of mental health teams

Broadening the composition of mental health teams, including involvement of consumers and carers through the recovery model of service delivery has been broadly canvassed in Australia and internationally. This implies the need to develop or expand new roles, eg peer support workers, consumer advocates, consumer representatives, consumer mentors, carer advocates, carer representatives, carer support workers.

Comments and suggestions, examples of good practice, case studies where things have not worked and lessons learned

Our Network strongly recommends the acknowledgement, acceptance and engagement of consumers and carers as paid and employed members of the mental health workforce.

With the issues facing the mental health workforce particularly around dwindling numbers of university enrolments, increasing retirements, recruitment, retention and other factors, greater use of mental health consumers and carers must now be considered.

We are in a position as 'experts by experience' and whilst not perhaps trained in the health disciplines, are nonetheless able to provide, with appropriate training and education, meaningful and critically needed services that would complement those provided by health professionals.

Consumers who have received their treatment and care from mental health services and who have gone on to meaningful engagement with family, friends, employers and the community could play a unique role in service delivery. Carers could be engaged in a similar way, offering a significant, if different perspective.

It is envisaged that mental health services could provide the venue, information and training for these support workers. It is acknowledged that it is the re-engaging with life more broadly that encourages, assists and motivates people to recover.

There are a number of services which consumers and carers have been calling for, for a long time. These would include things like consumer run casual drop-in type services, program delivery, peer support and consumer and carer advocacy services.

Some of the **benefits** if accepted by current managers would be:

the support of peers;

re-engagement with others;

social interaction;

motivation;

less reliance on mental health services; and

better involvement in productive activities.

The **barriers** to meaningful engagement within mental health services of consumer and carer paid staff, would be:

appropriate training and education to fulfil their roles and responsibilities;

acceptance by current mental health professionals within the workforce; and

the championing by management.

7 Future developments

It is possible that changes to models of care, changes in treatment methods, drug therapies and treatment philosophies and policies could impact on the capacity and capability of the workforce. What are some likely ways things might change and what would be the impact on the way services are delivered and configured?

The Network would like to see an expansion of the types of services currently offered. We would like to see an additional model which addresses the essential components of clinical care, yet expanded to include social interaction and social inclusion.

This could encompass things such as but not limited to, assistance with managing within the home, managing finances, cooking, shopping and social interaction. Many of these activities are undertaken away from the home environment in day programs, the NGO sector etc. Social interaction and social inclusion is imperative to the recovery of individuals.

The benefits would be:

greater acceptance by consumers and carers;

improved consumer outcomes; and

more cost efficient services.

We see some of these expanded activities undertaken by consumers and carers employed within the mental health sector. There have been valuable programs which have been effective and cost

efficient, run in various jurisdictions mostly as pilots which failed to receive ongoing funding for their sustainability. It could be argued that part of the barriers to the ongoing nature of these types of services came from mental health professionals.

The Network would like to see the re-introduction of these types of consumer and carer supported models of care which would require changes to philosophies currently held by mental health professionals and the support of managers through funding and policies.

What would be the flow on effects of the changes above for workforce development?

More activities of a non clinical nature would be undertaken by employed consumers and carers. This would reduce the contact hours for **non clinical work** of mental health professionals. This would free up significant workloads and **allow prioritization for greater clinical care**.

9 Perceptions and status of work

How the community views mental health and those that work in the sector has been identified as a barrier to the recruitment and retention of workforce. Your reflections on the extent and nature of this in Australia and your suggestions for strategies to improve the status and standing of work in the mental health sector would be appreciated.

Comments and suggestions, examples of good practice, case studies where things have not worked and lessons learned

The Network is aware that stigma abounds about mental illness and this is also transferred to those health professionals who **choose** to work within the system.

Psychiatrists for example are the lowest paid of all health specialties. If you talk to mental health nurses, social workers and occupational therapists, they often tell you that friends and families question why they would **choose** to work within mental health.

It is a complex and difficult area. People can be behaviourally challenging both physically and verbally. They can be un-motivated, lack goals, have difficulties with housing, have no opportunities for employment and education. People are hospitalized sometimes for long periods. People are detained against their will and required to undergo treatment, also against their will.

Furthermore, inpatient units and community settings are often less resourced in terms of their environment including painting, floor coverings, bathroom facilities etc. The mental health workforce is not pleased in the main with working within this environment and neither they should be. In short, it is an unattractive area.

In terms of suggestions for strategies to improve the mental health sector:

increased remuneration for psychiatrists, both those that work within the public sector and those who work as private psychiatrists;

increased remuneration must also be followed through to other health professionals as an incentive for working in the area of mental health;

reinforcement to Governments, hospital administrators and managers that the environmental issues must be addressed; and

anti discrimination strategies must be continued by Government/s.

There must also be a strong mental health component incorporated within all curricula and extended work experience opportunities for all health disciplines within the private sector to ensure trainees see all sides of mental illness not just schizophrenia and psychosis.

Consumers particularly, must be engaged within the training of ALL health professionals to ensure that a balanced view of mental illness is understood including seeing that consumers DO recover.

Thank you for your time, thought and effort in preparing your written submission to this project. Please email your submission by 18th December 2009 to:

alexandra.lewis@sigginsmiller.com.au

or post to:

Ms Alexandra Lewis, Siggins Miller, PO Box 1143, Kenmore Qld 4069