



NSW Consumer Advisory Group – Mental Health Inc.
ABN 82 549 537 349

08 January 2009

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Email: Alexandra.lewis@sigginsmiller.com.au

Dear Ms Lewis,

Re: National Mental Health Workforce Strategy and Plan

The NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) is the peak, independent, statewide organisation representing the views of mental health consumers at a policy level, working to achieve and support systemic change. Our vision is for all mental health consumers to experience fair access to quality services that reflect their needs.

NSW CAG is pleased to have the opportunity to provide a submission to the National Mental Health Workforce Strategy Project.

Please do not hesitate to contact me with any further enquiries you may have.

Yours sincerely,

Karen Oakley
Executive Officer



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 is 18th 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	✓
Other (please specify)	

Name of stakeholder / organisation making this submission:

NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG)

**Contact person (name and title)
(telephone and email):**

Karen Oakley, Executive Officer

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

Aboriginal health workers	<input type="checkbox"/>	Nurses	<input type="checkbox"/>
Adult mental health services	✓	Occupational therapists	<input type="checkbox"/>
Aged persons mental health services	✓	Other medical practitioners	<input type="checkbox"/>
Carer advocates	<input type="checkbox"/>	Primary care	<input type="checkbox"/>
Child and adolescent mental health services	✓	Private mental health services	✓
Consumer advocates	✓	Psychiatrists	<input type="checkbox"/>
Forensic mental health services	✓	Psychologists	<input type="checkbox"/>
General Practitioners	<input type="checkbox"/>	Public mental health services	✓
Non government community mental health services	✓	Social Workers	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>		<input type="checkbox"/>

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

Current challenges:

It is acknowledged to date that services are interested and wanting to integrate the philosophy of recovery into their practice, with some already referring to themselves as recovery oriented. However, it appears that there are still difficulties in conceptualising and translating what this means in everyday practice. For many, it has been a name change for existing programs and services, without the evaluation of what services and individual staff are doing differently now compared to what has been done in the past.

NSW CAG recommends that recovery be recognised as more than just a policy change - it is a social movement requiring significant cultural change. Recovery is about respecting an individual's personal journey and sits firmly in the belief structure of both consumers and service providers alike. In this regard, recovery transcends policy. Cultural change needs to occur so that service providers recognise and value the self-determination of consumers. Essentially, recovery is about coming back to good practice and good service delivery that is responsive in helping a person reclaim their lives beyond illness and disability, and towards active citizenship and participation.

The current challenge faced by services in implementing the recovery model is that the concept of recovery is frequently confused. Recovery is not only about clinically recovering *from* mental illness, but also about being "in recovery" while still having a serious mental illness. Davidson and his colleagues (2009, p.324) explain that while recovery *from* mental illness refers to the eradication of the symptoms and amelioration of the deficits caused by the illness, the notion of *being in* recovery refers to learning how to live a safe, dignified, full and self-determined life, at times in the face of the enduring symptoms of mental illness. For many consumers, recovery is also about developing individual insight into their experience of mental illness and reflecting on what is and is not useful for them in maintaining wellness.

Services can support consumers on this journey by working with them to set goals and working towards achieving them. Most importantly, it is about looking holistically at all aspects of the person's life and working in conjunction with them to ensure that a satisfying life is developed. Individual goals will be different and unique for each individual. Consumers advocate that they need

to be responsible for and have ownership over their own recovery journey. It is up to the service to examine how its service environment (one aspect of recovery) can be conducive to either promoting recovery or hindering it.

Recovery is a process rather than a destination

NSW CAG believes that there needs to be stronger recognition by services and clinicians that recovery is a process, rather than a destination. Consumers and service providers can work together to reflect on periods where the consumer has been unwell, and view this as an opportunity to reflect and learn from each experience – such as “what was different this time?” Most importantly, recovery-oriented services need to ensure that individual consumer’s wishes, goals, aspirations and entire life are the focus of service delivery.

Staff interaction with consumers

Consumers continue to express to NSW CAG that they would like to build stronger relationships with service providers. Consumers continue to indicate that staff who “hide behind the glass bowl” in inpatient settings continue the power imbalance that exists between clinicians and consumers, and are not conducive to recovery oriented practice. Some suggestions have been around staff having allocated time built into their day to interact with consumers. Consumers need to also participate in these discussions.

Service assessment framework

Recovery is about cultural change, and therefore it is important that discussions about recovery happen on a continual basis so that services which claim to be recovery oriented can be held accountable. This can be achieved if services continue to reflect on the philosophy of recovery, how this is being practiced within their service, how this is different from how they have conducted themselves in the past and how they can improve its integration.

Standards and key performance indicators need to be developed to assist services in identifying concrete ways in which they can provide recovery oriented services. A framework for services to assess how they are meeting recovery oriented service provision standards also needs to be developed to assist services in monitoring these standards. The continuing reflection on how services are operating in recovery oriented practice needs to be conducted in partnership with consumers who access their service.

Currently, NSW CAG in conjunction with the Mental Health Coordinating Council (MHCC) are undertaking a joint initiative to develop a resource that provides practical support to mental health community sector organisations in incorporating the philosophy of “recovery” into service delivery practice. Once developed, this may be a valuable resource for the National Mental Health Workforce Strategy and Plan.

Consumer involvement in quality improvement and service evaluation

Genuine participation of consumers and carers is essential in ensuring quality improvement in the way services are currently delivered. Essentially, consumers are the “experts by experience” on what works in service delivery, and what needs are and are not being met. A change in culture which aims to focus on recovery-oriented practice will not occur without consumer involvement - the mental health workforce needs to work collaboratively with consumers in order for this change to occur.

Consumers can and should play a crucial role in the monitoring of service quality and ensuring that services are responsive to the needs of consumers. Consumers need to be employed as consultants and workers within these settings, as well as contributing to pre-service and in-service training for mental health professionals (Senate Select Committee on Mental Health 2006, p. 34).

The Mental Health Consumer Perceptions and Experiences of Services (MH-CoPES) Framework is an example of a process designed and driven by consumers to ensure consumer participation occurs in the evaluation of mental health services. Consumers are being involved in each step of the quality improvement cycle; from data analysis, reporting and feedback to action based on the findings. Two questionnaires were developed for evaluating services, one for an inpatient setting and one for community services. This framework and its accompanying questionnaires was developed by NSW CAG in partnership with the Mental Health and Drug and Alcohol Office, NSW Health. For more information on this project see www.nswcag.org.au .

Further development of the Mental Health Consumer Workforce

Mental Health Consumer Workers (herin referred to as consumer workers) are people with the lived experience of mental illness, employed in mental health services in various capacities to provide peer support, individual and systemic advocacy for public mental health consumers. They are seen as key workers in the support and advice they offer to Area Health Mental Health Services on a range of issues in NSW.

Currently there is no clear definition of the roles and responsibilities of consumer workers resulting in many issues currently being faced by this workforce (see outline in question 2).

NSW CAG, in conjunction with the NSW Consumer Workers’ Forum is currently conducting a project to develop a framework for the consumer workforce in NSW that clearly sets out the roles, functions and responsibilities

of consumer workers, including a set of generic position descriptions that cover the remunerated roles undertaken by the consumer workforce in NSW Area Health Services.

In our view, overcoming the problems that are embedded in the consumer workforce is a key strategy in progressing services to align with recovery-oriented practice. It is well known that exposure to working with people living with a mental illness breaks down barriers and can reduce stigma (Cheverton 2008; Corrigan 2004). By reducing stigma, services are removing one significant barrier to recovery-oriented practice.

Through the lived experience of mental illness, consumer workers represent role models not only to other consumers using the service, but also to service providers who are seeking examples of how to promote and facilitate journeys of recovery.

Currently in NSW there is also inadequate and inconsistent funding to train consumer workers to enable them to participate fully in their role. This is a fundamental and urgently needed element of workforce training and service (Senate Select Committee on Mental Health 2006, p.33).

Job Descriptions & Education Programs

NSW CAG regularly hears from consumers that staff attitudes need to change in order for services to be recovery oriented. It is recommended that value systems and ethics for professions be designed to foster respect for people who experience mental illness. These then need to be built into university and other education and training programs, so that new staff commence with a genuine respect consumers. We also hear that consumers want these values (see page 10) to be built into job descriptions so that it is an expectation during employment.

In the recent Recovery Forum 2009 conducted by NSW CAG, we heard from many service providers that they would like to have had more exposure to the lived experience of mental illness in their formal education. Consumers also are regularly promoting for this to occur. One way of doing this is for training programs to be administered by consumers in order to reduce stigma (Corrigan, 2004). NSW CAG hears regularly that in order for this to be effective it needs to take a more substantial form than ad hoc presentations by consumers.

Other training needed:

1 Workforce education around recovery orientation and principles and how to use these in practice

2 Training and education around the effects of stigma and discrimination on people who live with mental illness, their families and carers, including education around appropriate language use

3 Training around consumer participation; its value and how to incorporate it into practice

4 Continued workforce training around culturally appropriate responses, communication and treatment, focusing the needs of Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities

5 Training tailored around the consumer workforce

National Recovery Standards

NSW CAG recommends that the National Mental Health Workforce Strategy and Plan considers the National Recovery Standards when they are released for further guidance on appropriate strategies for promoting recovery in services.

2. Securing and developing the current workforce

The current workforce in mental health services provides the foundation on which new models of care and improved service systems rest. We are interested in your views about the key issues facing the current workforce and its managers in securing and developing the current workforce. *You may wish to comment on the organisational, system and individual factors that promote recruitment, retention and development of the current mental health workforce in your setting and make suggestions for improvements.*

Consumer identified issues facing the current workforce

NSW CAG hears about the following issues being experienced by consumers with the current mental health workforce:

- Staff shortages. The current staff shortages which are embedded in the mental health system impact on the retention of staff, staff morale and burnout. These shortages also impact on the quality of service that can be delivered to consumers, particularly services which are trying to operate within a recovery-oriented framework. There needs to be less pressure on staff by reducing case loads.

Some consumers indicate that they don't see or hear from the service for weeks at a time. NSW CAG has heard of stories where people are being put on Community Treatment Orders (CTOs) purely to ensure that they are prioritised and receive follow up by mental health staff that hold extremely high caseloads. Under the NSW Mental Health Act (2007), services are required to follow up mental health consumers on CTOs, therefore making them a priority. NSW CAG has also received feedback from consumers that a potential result of not receiving enough contact and follow up from their case managers, is that people reach a point of crisis

before receiving the support they require. This is a direct result of staff shortages and insufficient funding for community mental health staff.

- Lack of case managers. NSW CAG regularly hears from consumers about a distinct shortage of case management services available. For people who experience mental illness, the inability to gain access to case managers often results in a lack of access to support in addressing their psychosocial needs, which can include access to accommodation, income assistance, food, parenting needs, psychological support, education, employment, family and social connectedness. This shortage is detrimental to consumers' mental health and wellbeing, particularly following discharge from hospital. Without this support, many consumers are not supported to remain well in the community setting. One consumer explained:

"The first time I was released it took eight months to get a case worker and then only because I pushed for it" (Consumer, 12th May 2009)

NSW CAG also regularly hears that case manager workloads in NSW are unrealistically high. We have received information that case loads can be anywhere between 40-50 consumers, which significantly impacts on the ability of services to spend time with the consumers and provide recovery-focused support. The outcome of this type of pressure is that case management does not perform the support that it should, and becomes tokenistic, again leading to hospital based care as the option available when someone needs an increased in support.

Therefore, priority needs to be given to adequately fund and support community mental health staff.

Consumer worker identified issues facing the current workforce

NSW CAG is working with NSW Health and the Consumer Worker's Forum to conduct the NSW Consumer Worker Forum Project, which aims to address some of the current problems that are experienced by consumer workers within the mental health workforce. While the project is due for completion in June 2011, it has already begun to uncover some of the issues that are faced by consumer workers in mental health workforce in NSW:

- Lack of clear job descriptions for consumer workers. Consumer workers have indicated that they are collectively employed under varying job titles and descriptions. Some consumer workers are referred to as 'consumer advocates', 'consumer representatives', 'peer support workers', 'consumer consultants', 'consumer liaison officers' and so on. These workers often experience unclear and poor descriptions as to what is required by their role, reporting that their workloads often increase or that they are required to do additional duties once employed. This may include roles which require them to have competent computer skills or policy writing which is

often out of the scope of the advertised position. At times, they are also required to perform clinical roles such as counselling without having adequate training or support. Such issues indicate that greater clarity is needed in consumer worker job descriptions and titles to greater support consumer workers who are active within these roles.

- Absence of a general award for consumer workers. There are no set award wages for consumer workers, so many consumer workers continue to be employed on different awards and for different wages for similar roles. In NSW, consumer workers have indicated that they are employed under some of the following awards:
 - Health Education Officer Award;
 - Welfare Officer Award;
 - Hospital Employees General Administrative Award;
 - Public Hospitals (Professionals and Associated Staff) Award.Addressing this issue is a part of the scope for the NSW Consumer Worker Forum Project.
- Lack of access to on-the-job training. Consumer workers often report experiencing problems with access to training opportunities. Consumer workers have indicated that they would like access to support and training in complaint handling, communication and conflict resolution management.
- Lack of access to adequate support. At NSW CAG we have heard about instances where consumer workers are engaging in clinical and pseudo-clinical tasks in the absence of established ethics and practice standards. Support structures need to be in place where consumers are provided with adequate support and supervision to ensure that their own mental health and wellbeing is not being compromised. Services also need to ensure that consumer workers are operating within the boundaries of their job descriptions and qualifications, as non adherence with this practice also places consumers at risk.

The lack of consistency in roles and the absence of guidelines for consumer workers has occurred despite the wide acceptance of the value of consumer participation in service delivery. As a result of these issues, the following needs to occur:

- Development of national guidelines for consumer worker roles;
- Focus on building a culture of acceptance; and
- The development of a training framework and training needs assessment tool.

3. Workforce development – mental health specialists and non-specialists

The consumers of mental health services and their carers come into contact with both specialist mental health services, such as acute inpatient units and those in the broader health system, such as GPs. Building capacity for the delivery of services to people with mental

illness and their carers requires that we pay attention to workforce development in both the specialist and mainstream parts of the health system.

3a. Your suggestions about the best way to develop capacity in the **broader health workforce** to support consumers and carers would be appreciated.

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

- Mental Health First Aid Training is a 12-hour course developed in 2000 by Betty Kitchener and Professor Tony Jorm with the aim to improve the mental health literacy of members of the Australian community (MHFA 2007). NSW CAG believes that Mental Health First Aid Training needs to be made available to all people working in a health setting, to ensure that staff have the skills to assist consumers who may be experiencing a mental health crisis. Such training will help improve the mental health literacy among the broader health workforce, and contribute to breaking down the stigma associated with mental illness. For more information on Mental Health First Aid Training, visit www.mhfa.com.au.
- The broader health workforce also needs to be supported in attaining skills and training which focuses on how to de-escalate potentially violent situations involving people who experience mental illness. At NSW CAG we understand that it is crucial that the methods used to respond to people who experience mental illness are different to a typical criminal emergency situation, and that training in de-escalation is important to ensure that staff do not further contribute to the crises already being experienced by this vulnerable population group. Consumers have particularly identified the need for ambulance workers to receive this training.
- Demystifying mental illness with a national public education campaign.

3b. Your suggestions about the best way to develop capacity in the **specialist workforce** to support consumers and carers would be appreciated.

See previous comments regarding recovery oriented service provision.

3c. Your suggestions about the best way to develop capacity in **the non-government community mental health workforce** to support consumers and carers would be appreciated

See previous comments regarding recovery oriented service provision.

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:

Consumers have indicated that they would like to see the following knowledge, values and attitudes embedded in the mental health workforce:

- Knowledge of
 - i. Recovery principles and how they are operationalised in service delivery;
 - ii. Holistic treatment options, and the importance of considering a person's mental and physical health in diagnosis and treatment. This includes knowledge of the impact of medications on a person's lifestyle and health;
 - iii. Stigma and discrimination issues that face people living with mental illness, their families and carers, and strategies which challenge this in services and the broader community;
 - iv. Promotion, prevention and early intervention and how to effectively treat those with early warning signs of mental illness.
 - v. Referral pathways and procedures for discharge planning and follow up care, including knowledge of community mental health services and their specialisation areas;
 - vi. Culturally appropriate communication and treatment; and
 - vii. How to maximise consumer participation in treatment and choice, and the provision of information to consumers about how to participate in the community, service improvement and policy development.

- Skills in:
 - i. Providing respectful treatment where consumers are encouraged to actively participate in their treatment and community where desired;
 - ii. Being able to provide culturally responsive treatment when required;
 - iii. Being able to establish a rapport and a relationship based on trust with consumers;
 - iv. Providing flexible treatment that recognises that every person has their own response to mental illness, and therefore treatment requirements at different stages of their illness. This involves encouraging self-determination and working in partnership with consumers to provide treatment where they lead their own recovery;
 - v. De-escalating situations which involve people who experience mental illness;
 - vi. Strong communication skills, including listening and verbal communication, to ensure that consumers, families and carers have complete understanding of diagnosis, rights and responsibilities, treatment and medication options, and services that exist in the community setting; and

- vii. Being able to take a holistic approach to treatment and care, and not defining a person by their illness.
- Attitudes which:
 - i. Focus on the whole individual – seeing the whole person and not only their illness;
 - ii. Are non-judgmental. Members of the workforce should not demonstrate discriminatory or stigmatising attitudes;
 - iii. Are positive, encouraging and empathetic that empower consumers to live life to their fullest with the belief that recovery is possible;
 - iv. Are patient and tolerant;
 - v. Value, understand and encourage consumer participation and self-determination. The mental health workforce must value the importance of a consumer’s participation in their treatment; and
 - vi. Reflect a genuine desire to improve the life of another person.

Education, training, CPD and supervision, mentoring and coaching which builds on these principles will significantly enhance the delivery of recovery practices and greatly improve the ability of the mental health workforce in meeting the needs of people who experience mental illness.

Mental Health training at the undergraduate level

A number of studies have suggested that undergraduate nursing students are not specifically prepared for work within the mental health field (Clark et al 2005; Armitage et al 2000; Wynaden et al 2000), and universities need to be encouraged to include components of training in mental health and exposure to mental illness to enhance the development of the this workforce. In the Senate Inquiry into Nursing (2002) it was recommended that undergraduate courses provide additional theory and clinical experience in mental health. The Bachelor of Nursing undergraduate degree at the University of Newcastle is an example of where this is occurring. The degree offers Mental Health Literacy and Mental Health First Aid, which involves looking at the knowledge and beliefs about mental health problems and disorders which aid in the recognition, management and prevention of mental illness. The degree also offers Mental Health Nursing Therapeutics, which outlines nursing approaches to the assessment and collaborative management of people with a mental illness. NSW CAG recommends that all nursing degrees incorporate similar components about mental illness in their curriculum.

NSW CAG also advocates for this training to be balanced by incorporating study around the personal view of recovery. At NSW CAG, we understand that the stigma associated with mental illness has often inhibited positive stories about recovery from being heard, which often reinforces the prejudice that currently exists around mental illness (Frese & Davis 1997, p.245). The

absence of these stories has often resulted in the impression that there is no hope for people who experience mental illness to move forward with their lives. However, through the philosophy of recovery we understand that people can go on to lead happy and meaningful lives in the presence and/or absence of mental illness. NSW CAG strongly believes that this message needs to be filtered through training, particularly at the undergraduate and postgraduate levels. The Bachelor of Nursing at the University of Newcastle provides students with exposure to people who have the lived experience of mental illness, which enables students to understand that the diagnosis of having a mental illness does not prevent an individual from living a happy and fulfilling life. NSW CAG strongly believes that the inclusion of consumers as educators is a key strategy for educating the current and future workforce about the personal view of recovery.

Consumer workers

Training options for consumer workers are considerably limited. There is currently no standard training for consumer workers or for those consumers who supervise and manage other consumer workers within the mental health system in NSW (Stewart et al 2008, p.349). The NSW Institute of Psychiatry, located in Sydney, is one of the few providers of training that is available to consumer workers, which provides introductory training about advocacy, social justice, human rights, and representation. NSW CAG also runs Kit Training for consumers who want to learn more about advocacy. However, these training opportunities are limited in scope by offering training at an introductory level and are less accessible for consumer workers who live in regional and remote areas.

5. Scope of practice

Broadening the scope of practice of some health professionals is being considered in the health workforce overall and in mental health. For example, allowing people other than medical practitioners prescribing rights once properly trained.

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

If the extension of prescribing rights beyond medical practitioners were to go ahead, NSW CAG strongly advocates for policies and protocols to be developed which ensure the health and safety of consumers. Staff allocated the right to prescribe medication would need to take into consideration the other medications an individual may be on (and how these may interact), and a strong understanding in anatomy, physical illness, drug interactions and other related aspects. It is also essential that consumers be consulted regarding the broadening of scope in relation to prescribing rights.

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

NSW CAG advocates strongly for the development and expansion of new roles in relation to consumer workers, advocates and representatives in NSW. This is currently being reviewed by NSW CAG in the NSW Consumer Worker Forum Project, which will be conducting consultations with consumer workers and other key stakeholders including Area Health Service Directors and other staff and NSW Health Mental Health Drug and Alcohol Programs (MHDAO), looking at the current roles of consumer workers and how these positions can be expanded and developed. This project is due for completion in June 2011. The expansion of this workforce would need to be developed with clear position descriptions, training, and support standards set in place.

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?

Historically, the dominance of the traditional medical model in service delivery has resulted in a poor mix of pharmacological vs. non-pharmacological treatments which are available to consumers. NSW CAG constantly hears from consumers that they would like more choices in treatment, and that an over-reliance on medication is not always conducive to their ability to live with and manage their mental illness. What needs to occur is a shift in dependence on the clinical and medical models of care, to one which incorporates the personal views of recovery and choices in treatment. Most importantly, clinicians need to take on a multi-faceted approach to treatment where medication is considered only one element of a person's care. As noted, a broad cultural change towards recovery-oriented service provision is required.

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

Culture change in the way care is provided to people who experience mental illness, which would require a greater understanding of and commitment to principles of recovery. Clinicians would also need an understanding of different treatments and support that are available as alternative options for consumers.

How might the skill mix or professional mix of teams change in the future, and still work to provide safe and quality care?

Mental illness is only one aspect of a person's identity, and therefore should only be one aspect of their care. Alternative options including lifestyle programs such as Yoga, meditation and Thai Chi need to be made accessible to low income populations and incorporated as options for people's plans for wellbeing. NSW CAG also regularly hears a need for more social programs and increased accessibility to these programs through transport provision (particularly in rural and regional areas). There also needs to be an increase in the mental health consumer workforce to provide peer advocacy support to consumers, once a framework for this workforce is fully developed.

Full consideration of the workforce composition to deliver recovery-oriented service provision in different settings has not been undertaken and is required. Consumers must be involved in such a review.

8. Access to services

The accessibility and appropriateness of services is an issue for all consumers of mental health services and their carers. There are however, particular groups for whom access is particularly difficult eg Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds and people in rural and remote and other underserved settings. What workforce developments could improve access for such groups?

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

People from Culturally and Linguistically Diverse (CALD) communities

Consumers from CALD communities continue to experience problems with accessing mental health services. These difficulties extend beyond just language barriers, and can include cultural interpretations of mental illness. For many people from these communities, mental illness is a taboo subject which creates significant barriers to the desire to access services. However, many people from CALD backgrounds believe that their difficulties in access largely stem from the system's inability to cope with diversity.

From the consultations conducted by NSW CAG, consumers from CALD backgrounds have raised concern about the following issues:

- Language barriers. Many consumers report experiencing difficulties in accessing mental health services due to the lack of translation and multilingual services that are available. The inability to communicate with providers often means that consumers from CALD backgrounds become considerably unwell before they receive the appropriate care needed for their mental health.

NSW CAG has also heard that consumers who have been involuntarily admitted to inpatient facilities are experiencing difficulties in gaining access to written statements of their rights in a language that they can

understand. NSW CAG is aware that a written statement of a person's rights needs to be provided to involuntary patients within 12 hours of their admission to a facility – as per the Mental Health Act 2007. However, currently there is no written statement of rights available to consumers in different languages.

- Accessible and appropriate interpreters. Understanding the English language or having an interpreter is a necessary pre-condition for a consumer's participation in their own care. Consumers have indicated that some interpreters are not well educated about mental health issues which can result in the translation of inaccurate or confusing information. The lack of provision of these services, particularly in rural and remote areas are a major barrier to access for people from CALD communities, and usually results in them presenting at a later stage when they have become acutely unwell. In this regard, the access to appropriate interpreter services needs to be greatly enhanced to improve the experience of the mental health system by people from CALD backgrounds.

Auslan interpreters also need to be provided for consumers who are deaf. People living in rural and regional areas particularly experience limited access to Auslan interpreter services.

- Stigma. The stigma, including different understandings and meanings associated with mental illness across different cultures often acts as a barrier to service participation.
- Lack of culturally appropriate services. Consumers identify that there is a lack of culturally appropriate services that take into consideration cultural issues, such as gender, age and life experiences. The lack of these services, particularly in rural and remote areas is a major barrier to accessing services for people from CALD communities, and usually results in them presenting at a later stage when they have become acutely unwell.
- Systemic and organisational barriers. This includes a lack of cultural competency by some health care providers. Often, poor English skills is perceived as too hard for service providers, due to a lack of confidence in how to engage with people from CALD communities.

Workforce developments which could improve access for people from CALD communities include:

- Consideration of the language, cultural and communication needs of consumers;
- Cultural competency training for staff where there are high levels of people from CALD communities using services. It may be beneficial for the Mental Health Workforce Advisory Committee to review the

National Cultural Competency Tool which is being developed for the mental health workforce, when it is completed in mid-2010 (see Multicultural Mental Health Australia 2009, p. 12);

- Consideration of gender barriers which may exist in some communities – eg. same-sex clinicians may be more appropriate for some cultural backgrounds;
- Professionally trained bilingual and bicultural community workers in mental health is essential for breaking down the language barriers experienced by CALD communities;
- Increase in interpreter workforce;
- Increased employment for consumer workers from a CALD or Aboriginal and Torres Strait Islander background; and
- The representation of people from CALD communities who experience mental illness in both policy and service development to ensure that the integration of cultural views are integrated into politics, policies and systems.

Rural and Remote Areas

Many problems that exist for consumers in rural and remote areas are centred on the limited availability of services and clinicians. Many small towns have limited or no access to psychiatrists, and lengthy waiting periods increase access limitations. When psychiatric services are not available in these areas, although consumers have access to practitioners who travel from outside the area, visits are infrequent and cannot offer the contact needed for ongoing support. This often results in many going without access to support or respite services. It also limits people's choice of who they work with in relation to their mental health. If an individual is not able to build rapport with a particular professional, they may not have any other options available to them. Shortages of services that are available in the community have made it difficult for many consumers to access services before the onset of acute illness. NSW CAG advocates for incentives to be developed that encourage people to work in rural and remote areas in mental health. This may be in the form of offering scholarships that provide people with training and require them to spend time working in rural and regional areas.

Transport to and from such facilities and services are also a major barrier for access in rural and remote areas. Many consumers are not fortunate enough to have their own means of private transport and the lack of available community transport makes it difficult for them to travel to medical appointments and social activities that are important to their mental health and wellbeing. This is also of particular concern for consumers when they are discharged from inpatient facilities, and have no means of travel home from hospitals. This is often a vulnerable time when consumers are in the process of recovering from their hospital admissions.

Please refer to question 12 for innovative services that are attempting to overcome the service limitations faced by consumers in rural and remote areas.

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 negative views and stigma in the community about mental illness act as a barrier to the recruitment and retention of the mental health workforce.

The mental health sector has a reputation for being particularly under-funded with chronic workforce shortages and system dysfunction. Staff currently employed within the public mental health system are working in stressful environments with a focus on treating acute mental health problems only, with high workloads. Such workloads lead to further attrition of the workforce and discourage new graduates from entering the public mental health workforce. The announcement of a National anti-stigma campaign in the Fourth National Mental Health Plan is a key strategy for improving the status of mental health workers within this sector.

Strategies for overcoming the barriers to recruitment and retention of the workforce could include:

- Greater provision of awareness and training in both nursing and other medical undergraduate and postgraduate degrees to increase the exposure to and understanding of mental illness for people who are looking to enter the workforce. As indicated previously, research has ascertained that the most successful strategies to overcome stigma are multi-faceted and include those which increase people's contact with people living with mental illness (Cheverton 2008; Corrigan 2004);
- Programs where mental health consumers spend time educating people in schools, universities, workplaces, including health and mental health workplaces, the media and other key institutions need to be funded;
- Public figures who are well known in the community who are willing to discuss their experience of mental illness and they recovered; and
- Use of the media as a tool in educating the wider community around the issues of stigma and discrimination. Stronger monitoring of media representations of mental illness and suicide and lobbying for accurate representations of people with a mental illness is also needed.

A program which has incorporated these strategies is the “Like Minds, Like Mine” which is currently operating in New Zealand. This program has increased public awareness surrounding mental illness, reduced the prevalence of stigma and discrimination from family, mental health services, the public and employers, and has made progress in building infrastructure for the delivery of high quality training and education (NZ Ministry of Health, 2007; Vaughan & Hansen, 2004, p.117). The range of strategies used to achieve these outcomes include a nationwide television and radio advertising campaign, public speaking engagements by people with the experience of mental illness, and local awareness raising events such as art exhibitions. There has also been support through the media with complaints about discriminatory reporting through letters to the editor, the production of guidelines for working journalists and training for journalism students (NZ Ministry of Health, 2007, p.19). NSW CAG strongly recommends that the ‘Like Minds, Like Mine’ campaign be used as a model for addressing the stigma associated with mental illness.

10. Managing the places where consumers and carers fall through the gaps between providers

In many parts of the health system, capacity is being built and access and quality improved by efforts to build networks between the government and non government sector, between primary care and hospital based services, between GPs and specialist mental health workers, between community and home based providers of nursing and personal support services and others. Your comments and suggestions for how we could enhance access by better knitting existing resources together would be useful

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

Entering the mental health system

NSW CAG has frequently heard consumers indicate that service gaps are particularly evident when a consumer is first diagnosed with a mental illness and trying to navigate the mental health system. The difficulty experienced when trying to find out knowledge about what services are available is compounded when health professionals too are unaware of how the system works or the types of services that are available locally. NSW CAG believes that all service providers in health have a responsibility to ensure that consumers are informed and assisted in this transitory stage, and systems need to be developed to ensure that the workforce has access to information that can assist consumers on this journey.

Poor clinical handover between inpatient facilities and the community

Consumers have also raised concern about service gaps following discharge from an inpatient facility. They have reported the lack of discharge summary paperwork that is forwarded to clinicians which provide detailed notes about their medication and treatment, and what services may be needed. NSW CAG has heard of consumers being handed their discharge papers without any referral to support services within the community, which is detrimental to

ensuring the continuity of care for consumers in their transitional period back into the community.

What is needed is a holistic approach to making sure that people know what services exist, and that these links are made prior to or shortly after discharge. Clinicians need to have knowledge about the local services which are available for consumers within their areas, or make referrals to community mental health teams that can provide this information.

Co-morbid mental health, drug and alcohol

NSW CAG was pleased to see the inclusion of the “no wrong door” policy within the *NSW Clinical Guidelines for the Care of Persons with Co-morbid Mental Illness and Substance Use Disorders* (2009), as it is essential to addressing the problem of people not having access to coordinated service delivery between mental health and drug and alcohol services. However, some consumers with co-morbid mental illness and substance use disorders have continued to experience refusal of some specialist services which creates significant service gaps. As a result, these consumers have continued to shift between mental health services and other specialist services without receiving effective treatment from either. The Mental Health Workforce Strategy and Plan needs to address this issue.

Need for multi-disciplinary community based mental health centres

General Practitioners (GPs) are usually the sole point of entry into mental health care, but this is dependent on accessing a GP with sufficient training and knowledge in the identification and treatment of mental health problems. The current reliance on GPs to conduct the majority of this primary mental health care, including prevention and early intervention, has been ineffective. The provision of multi-disciplinary community based mental health centres would aid the shift away from the current acute care focus towards a stronger emphasis on community based care, a key focus of the National Mental Health Strategy (Senate Select Committee on Mental Health 2006, p.148).

11. Culture and management and leadership of services and the service system

Many researchers, commentators and advocates in the sector note that efforts to attract more people into the mental health workforce and retain them can be hampered by traditional professional cultures, rivalries and boundaries. Do the culture of the professions and services need to change, and how could positive change be supported?

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

NSW CAG believes that positive change can be supported by:

- Multi-disciplinary training to foster understanding of and respect for all professions within mental health, with the intention to reduce competitive practice; and
- Commitment to changing the culture to one which is recovery focused.

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Mental health services can be stressful places to work. Do you have any ideas, solutions or examples of actions that better support workers and managers in services?

NSW CAG makes the following recommendations:

- Appropriate resourcing for the mental health workforce. Resourcing needs to be provided to decrease staff workloads. This will also assist in working under a recovery philosophy where staff have more time to build relationships with consumers, rather than work being crisis driven; and
- Regular supervision of clinicians needs to be provided. NSW CAG advocates that this supervision be oriented around the philosophy of recovery and how this is being delivered in practice.

In some countries it has been found that asking service managers to become career mentors for clinicians helps to build bridges of understanding and support both ways. How can we build better mutually supportive working relationships between those who deliver clinical services, those who manage them and those who work at the policy and funding levels in the system?

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

The building of mutually supportive working relationships can only begin when there is specifically delegated funding to support this framework.

12. Technology

The use of distance communication technologies for clinical consultations, providing support for other people in the workforce or volunteers (secondary consultation) and clinical supervision is increasingly possible as technology, broadband access and computer literacy and access to computers improves. Your views on the use of technologies such as this to support and build workforce capacity would be welcomed.

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

Clinical consultations:

NSW CAG continues to hear that consumers from rural and remote areas have considerable difficulty in gaining access to mental health services, particularly in gaining access to GPs. The lengthy waiting periods in country towns often mean that consumer's needs are not being attended to in a timely manner. For those communities that have clinicians flying in from out of town, the consistency in care and relationship building is also a challenge.

The Mental Health Emergency Care Rural Access Program (MHEC-RAP), developed by the Greater Western Area Health Service (GWAHS) in New South Wales is a good example of where clinical assessments via technology have been successful. The program provided a video-link system which was

available 24/7 by mental health nursing staff who have been specifically trained and supported by psychiatrists. Prior to the program the large distances and staff shortages in rural hospitals often meant that hospitals were unable to provide skilled mental health assessments and management of consumers who were experiencing mental health emergencies. As a result, many consumers were being transported to distant inpatient psychiatric units, often quite costly and in some cases dangerous. This also meant that consumers were moved to hospitals further away from family and friends. After 12 months of the service, it was found that there was very high stakeholder satisfaction (which included consumers, nurses, GPs, Police and Ambulance), increased nurses skills and confidence, and a dramatic reduction in unnecessary transports. NSW CAG recommends that this program be explored by the MHWAC project.

While NSW CAG supports the idea of the further use of technology by the mental health workforce, the relevant protocols, guidelines and strategies need to be developed to ensure that consumers still receive an interpersonal connection with their clinicians. NSW CAG also advocates for consumer and community consultation around how the use of technology will be operationalised before full implementation. NSW CAG strongly believes that an evaluation of the consumer's experience of the use of technology to deliver services needs to be conducted, before this is streamlined.

Clinical supervision:

An example of good practice in the use of technology is the Children and Adolescent Psychological Telemedicine Outreach Service (CAPTOS), which provides clinical support via video conferencing to geographically isolated child and adolescent mental health workers. The service recognises that clinicians working in these communities frequently manage children and adolescents with complex mental health needs, but are often isolated from the workforce and inexperienced. With limited access to senior staff and specialist assistance, clinical supervision had previously been difficult. The CAPTOS service provides an urban rural partnership for ongoing specialist mental health care, providing support and training to assist rural and remote areas build a sustainable mental health service. At any one time, there are roughly 80 clinicians receiving supervision in the form of one-on-one and group supervision depending on the needs of the particular area. Evaluations of the service found that "100% of rural respondents indicated that tele-supervision was very or generally useful in improving their clinical and case management work with children and adolescents, their own professional development and increasing their confidence working in child & adolescent mental health" (ARCHI, n.d).

NSW CAG believes that any support which is given to the mental health workforce which improves staff access to clinical supervision will greatly improve the access issues experienced by isolated communities. In this

regard, NSW CAG supports the idea of increasing technology use in clinical supervision.

Secondary consultations:

N/A

13. Data collection

Successful and cost effective workforce development rests on a foundation of good data and information about the current workforce, and the monitoring and evaluation of workforce strategies once in place. How best can current data collections be improved?

Do you have any examples of successful strategies already in place or being trialled? How can and planning, monitoring and evaluation methods for workforce strategies be improved?
Comments and suggestions; examples of good practice; case studies where things have not worked and lessons learned:

N/A

14. Evaluation of workforce development

Evaluation of mental health workforce initiatives internationally is at an early stage. A preliminary scan of the literature suggests a number of research and evaluation questions in relation to workforce development, for example, what are the most cost effective strategies to develop and deepen the capacity of the workforce? What impact will role redesign and redefinition have on outcomes for consumers?

Any other key evaluation questions relevant to workforce development?

NSW CAG strongly recommends that consumers be involved in this evaluation process.

15. Cross-sectoral links

Building better links among the government, non government and private sectors is noted by some as a key way to improve capacity and access and return on investment in the current and future workforce.

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

N/A

16. Any other issues/comments/ suggestions for the national workforce strategy you would like to make?

N/A

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

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