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.

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

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:

National Rural Health Alliance

Contact person (name and title)

(telephone and email):

Gordon Gregory, Executive Director gg@ruralhealth.org.au; phone 02 6285 4660

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

Aboriginal health workers		**Nurses**	
Adult mental health services		**Occupational therapists**	
Aged persons mental health services		**Other medical practitioners**	
Carer advocates		**Primary care**	
Child and adolescent mental health services		**Private mental health services**	
Consumer advocates		**Psychiatrists**	
Forensic mental health services		**Psychologists**	
General Practitioners		**Public mental health services**	
Non government community mental health services		**Social Workers**	
Other (please specify)	**Consumers, communities, & workforce in regional, rural & remote Australia**		

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

OVERARCHING ALLIANCE COMMENTS

A key concern for people in regional, rural and remote Australia is to achieve equity in access and outcomes in support for mental illness. While ABS surveys indicate that the prevalence of mental health conditions in rural and remote Australia are equivalent to levels in major cities, rural Australians face greater challenges in accessing services needed for mental illness and in facing the greater visibility and stigma attached to mental health in a smaller community. This is particularly the case for males, who access mental health services at about half the rate of women.

Further, AIHW studies have shown that men in rural and remote areas were 1.3 to 2.6 times more likely to end their life by suicide than their urban counterparts. This higher risk pertains to male age groups from 15 to 64. The AIHW also reports that people in rural and remote Australia have 20-40% higher rates of risky alcohol consumption, often a co-morbid condition for people with mental illness.

In terms of available workforce, rural and remote Australia is at a significant disadvantage. Attachment A to this submission demonstrates that there is a significant mal-distribution of general practitioners and psychologists. In this context, it is a cause for concern that the background reading material for the development of a mental health workforce strategy asserts that Australia has a sufficient number of psychologists, without any discussion on their distribution or on overall levels of unmet need.

While the nursing workforce overall is relatively evenly distributed throughout Australia, in part reflecting the distribution of hospitals and aged care facilities information on the regional distribution of community nurses and social workers specially trained in mental health is not available but should be an essential element of any mental health workforce strategy and plan. Attachment A also shows that access to MBS-funded mental health services in rural and remote Australia falls substantially short of access in urban Australia (between 9% shortfall for GP mental health care plans in rural areas, down to 57% shortfall in treatment by a registered psychologist in rural areas and 88% shortfall in remote areas).

Attraction and retention of a specialised mental health workforce to rural and remote Australia is multi-faceted. As for other professions, the 'basket' of measures required to attract health professions to rural areas includes scholarships for rural people to enter tertiary education to become health professionals, high quality rural clinical training, the availability of suitable accommodation, placement in high quality well-equipped workplaces and relocation and retention allowances. Much of this basket of measures currently provided by the Commonwealth Government is focussed on GPs.

With a greater emphasis on multi-disciplinary health teams, generally and in mental health in particular, there is a strong case to extend the availability of such measures to health professions most in need in rural Australia. This requires clarification on which health professions are in shortest supply in rural and remote areas.

While the scholarship system for GPs and nurses is well established, the numbers available for allied health professions is very thinly spread across the 20-plus professions and is vastly inadequate for purpose. Undergraduate and especially postgraduate scholarships for all professions intending to provide mental health services in rural Australia could be substantially increased to address workforce needs.

The National Health and Hospitals Reform Commission recommended that the proportion of clinical training being provided in rural areas should be significantly increased. All governments have committed substantial increases in funds for such clinical training. This recommendation should be acted upon immediately, with suitable investment in clinical facilities in private, community and hospital facilities, in the support for preceptors, and in accommodation.

As with other specialists, there is also a very strong case for programs to support outreach through visiting specialists from urban and inner regional areas to rural and more remote areas.

Further, while it is vital that strategies are put in place to attract specialised mental health professionals to rural areas, it is also critical that strategies are specifically directed at building the mental health capacity within the broader primary health care team base. This approach recognises that in many smaller communities, there will simply not be the ability to attract and sustain resident mental health professionals, that many people are more likely to present to their generalist primary care provider rather than seek specialised mental health services and most importantly that mental health conditions are likely to be one of a number of co-morbidities that need to be considered and treated in a person-centred way.

Building the mental health skills base should be addressed through mental health training of the existing primary health care service professionals; through the use of visiting specialists who are enabled to spend some of their visiting time in professional development and support for resident primary health care professionals and through more general efforts to increase the numbers of the overall primary care workforce in rural areas.

Recommendation

Development of a National Mental Health Workforce Strategy and Plan should include, as a key objective, equity in access as well as in outcomes, for all Australians, including those in rural and remote Australia.

In this context, the Plan should:

- as a matter of urgency include an assessment of the regional distribution of key mental health professionals and levels of need;
- develop strategies to improve the distribution of these health professions through attraction and retention strategies, including provision of rural scholarships to a wide range of mental health professions and substantially increasing the share of clinical training undertaken in rural areas;
- develop compensatory plans, providing for resource flexibility and innovation at the regional level, where there are continuing shortages of the key professions;
- take a needs-based planning approach, especially to acute services, recognising the higher suicide rates in rural areas;
- support regional capacity for workforce planning;
- ensure that there is capacity for enhancing the mental health skills of the generalist primary health care workforce;
- take a strong person-centered and therefore multidisciplinary approach to delivery of mental health and related conditions; and
- develop workforce strategies specifically to make mental health service provision and support more accessible to men.

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

Alliance Comments: The recovery model or recovery principle requires, inter alia, the existence of a well-organised support system for each individual to manage and address acute episodes of care and longer term management and support. For those consumers without the necessary security of home and supportive relationships, the recovery model will require considerable cross-sectoral collaboration, eg for housing, employment and social support, as well as ongoing health profession support.

There are clear and substantial health workforce resourcing implications that must be addressed if the strategic objective of moving to a recovery model is to have any meaning.

Without commensurate resourcing, emphasis on a recovery model could well result in system pressure to provide access and treatment for 'easier cases' i.e. those people with the support systems to achieve recovery; and conversely to discriminate against those of higher need for both health profession and social support requirements.

The 'recovery model' is not without its critics, as the following extract from Wikipedia indicates;

"*Some concerns have been raised about recovery models, including that recovery is an old concept, that a focus on recovery adds to the burden of already stretched providers, that recovery must involve cure, that recovery happens to very few people, that recovery represents an irresponsible fad, that recovery happens only after and as a result of active treatment, that recovery-oriented care can only be implemented through the addition of new resources, that recovery-oriented care is neither reimbursable nor evidence based, that recovery-oriented care devalues the role of professional intervention, and that recovery-oriented care increases providers' exposure to risk and liability. ……. Other criticisms include that the recovery model can be manipulated by officials to serve various political and financial interests including withdrawing services and pushing people out before they're ready; that it is becoming a new bandwagon that neglects the empowerment aspects and structural problems of societies and primarily represents a middle class experience; that it hides the continued dominance of a medical model; and that it potentially increases social exclusion and marginalizes those who don't fit into a recovery narrative.*"

There will always tradeoffs to be made: between acute care and ongoing primary supports, between adequate and optimal levels of support, and between tackling the most challenging and resource-intensive consumers and those with lower levels of need for support and better prospects of "recovery". Given ABS data indicate that only 35 per cent of people experiencing a mental illness were receiving care in the previous 12 months, this resourcing issue cannot be ignored. Resourcing would need to consider both the absolute level of service to be provided as well and the split between more community-centred and acute hospital facilities, given the costs of acute care and its structural lack of ability to coordinate services with community health, community housing employment and other needed services..

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

Recommendation

- Ensure that the Plan identifies the resourcing implications of 'the recovery model';
- Put in place data collection and analysis processes to identify the impact of pursuit of a recovery model, especially in relation to the outcomes for people in most need of support.

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*.

Alliance Comments: In addition to attracting new health professions to rural areas, as discussed above, the Alliance agrees that support and development for the current workforce is critical.

For rural and remote Australia , there are significant work environment pressures facing both longer-term and professionals and new entrants in general.

For longer term professionals, there is the risk of burn-out with longer hours, on-call and emergency responsibilities and lesser access to work replacements for essential family and recreational requirements. There are also issues of lesser levels of peer support and higher cost, time and access barriers for professional development.

For new starters in rural areas, the availability of mental health clinical leadership, personal mentoring and management and career structure and development can be hindered by barriers of time, distance and opportunity within a given health service structure in a given location.

To the extent that the recovery model represents change in the approach to mental health service, it would be crucial to ensure that the existing scarce mental health workforce, especially in rural and remote Australia, is enabled to be active participants in mapping and pursuing improvement rather than disempowered and devalued through top-down impositions. Such enabling will include adequate time, resourcing and inter-disciplinary training as well as clinical leadership and workplace participatory processes.

More generally, the concept of "mental health services" needs to be broadly inclusive.

General practitioners are often the first health professionals to be consulted about mental health concerns, either directly on a mental health issue or as part of more general primary care. An August 2009 AIHW report shows that GPs have never been more prominent in the delivery of primary care services, with an estimated 12 million GP-patient encounters in 2007-08 involving management of a mental health problem. While GP services for mental health are increasing, paradoxically there is also a serious access problem.

This means about 65 per cent of people with a mental illness are not receiving care – a startling statistic when compared to the rates of treatment for other chronic illnesses.

The fact that the majority of GP visits were not claimed as Medicare mental health-specific items suggests that people may be seeing their GP for other health matters but raising mental health concerns during their consultation.

For those who do seek treatment and support, a general practitioner may be their first or only local medical contact in a rural or remote community. This is particularly the case for men, who are only 50% as likely as women to seek support for a mental health condition, but who may be likely to visit a general practitioner for other reasons.

However, even accessing a GP can be difficult in some localities and GPs may vary in their level of experience with treatment of psychological distress or mental illness. A national study (Caldwell et al 2004) found lower rates of GP encounters for psychological problems in rural areas and found that GPs in remote areas prescribed mental health medications at half the rate of their counterparts in capital cities.

Especially where general practice is in short supply, nurse practitioners and remote areas nurses may be the entry to and/or frontline of primary care, including for mental health issues.

Thus, support and ongoing training for, GPs, general practice nurses, remote area nurses and nurse practitioners in mental health management is therefore a key part of the required workforce capacity building and development response for rural areas.

Recognising the multiple needs of patients, the scopes of practice of nurses and allied health professions and ongoing shortages of all professions with mental health training, multi-disciplinary teams are fundamental to providing coordinated and comprehensive mental health care in rural areas and in being inclusive of patients and carers in care planning and support.

Development of such teams requires investment in health services facilities eg in comprehensive primary care facilities, in general practices, in multi-purpose services in smaller rural towns to enable and foster multi-disciplinary interaction. Working in collaborative teams is also regarded by allied health professionals as an attractive working condition that provides clinical and peer support and assists in retention, especially where other conditions may be more challenging. Inter-disciplinary training of these teams would be valuable in promoting the desired level of teamwork.

The coordinated provision of visiting specialists such as psychiatrists can also be valuable in supporting the local workforce. An evaluation of the Mental Health Integration Project in the Far West (Lyle and Perkins, 2003) showed that with flexible funding arrangements (cashing up of MBS and state-provided funding to national/state averages), visiting psychiatrists provided strong support to GPs, Community Mental Health Teams (CMHTs), Aboriginal Health Services and NGOs in terms of education and training, clinical advice, case review and peer support, as well as in providing direct services and reducing the need for patients to travel outside the region for essential specialist care.

This support will undoubtedly be all the more welcome in rural areas where health professionals are young and relatively inexperienced and where clinical directors are under significant workload and other resource constraints.

Key features of this project were breaking down Commonwealth/State responsibility and funding boundaries, integration of mental health services across private and public services, detailed planning and coordination of specialist visits to optimize their access to patients, and paid time for specialists to collaborate with and support local professions in general practice, state public and NGO services. Local services were also structured in hub and spoke fashion.

These characteristics would appear to be effective in increasing equity in access for local residents and in providing supportive working environments and service models for existing health professionals in those regions.

With increasing emphasis on early intervention, the mental needs of children and the roles played by paediatricians is also important while the increasing proportion of aged people also points to the importance of gerontologists or to others specialising in the needs of the aged. . While such specialisations are not common in rural and remote areas, their availability in inner regional areas and/or through visiting specialist schemes also warrants their being included as essential members of the mental health workforce.

In relation to health services generally in rural and remote Australia, the National Health and Hospitals Reform Commission has suggested a range of measures to boost capacity and support the workforce. Its proposals include telehealth services (practitioner to practitioner; practitioner to specialist); referral and advice networks for remote and rural practitioners that support and improve the quality of care; on-call, 24 hour telephone and internet consultations and advice for urgent services, staffed by remote practitioners; and expansion of specialist outreach. All these measures would be relevant to support for the existing mental health workforce in rural and remote Australia.

Recommendations

- In rural Australia, support for the mental health workforce should encompass all health professions, dedicated or general, who provide services.
- This support should include ongoing CPD and mentorship by resident or visiting specialists, or through peer support including provision through telehealth systems.
- Effective and adequately resourced change management principles are adopted with ownership by the existing health workforce in the determination and implementation of change and improvement.

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

Alliance Comments: See 2 above.

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

Alliance Comments: There is a major challenge in attracting specialists such as psychiatrists and psychologists to reside and practise in rural areas. In 2000, only 7.5% of psychiatrists were located in rural or remote locations with more than 90% of those in non-metropolitan areas being in major regional centres like Toowoomba.

Recommendations:

In addition to well-planned, -funded and -coordinated visiting specialist services, other possible measures should include:

- preference in access to specialty Colleges for practitioners intending to practise at least on a part-time basis in rural and remote areas; this would require agreement with the relevant Colleges and funding support for preceptors in rural areas;
- special funding arrangements, such as along the lines of the 'cashing up to national average' model used in the Far West Mental Health Integration project, along with accommodation and relocation retention allowances to address the financial risks of fee for service practice in rural areas with low density populations; and
- as noted above, telehealth services with clinical advice and support being provided by mental health specialists, possibly as a part of an emergency service; these sorts of services would require special funding, again possibly along the lines of the cashing up to national average model.
- There is a need – not just in mental health but all areas of health – to be able have access to infrastructure and training to support effective use of technology. There could also be Simulated Learning Environment (training without patients) available at regional and rural universities as part of core curriculum in coursework.

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

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:

Alliance Comments: Access to CPD, supervision, peer support and career pathways is crucial to retaining health professions in rural Australia. Even when these are available, distance, work pressure and the lack of back up to allow time for CPD can all conspire to work against a positive outcome.

Recommendation

- Strategies such as on-line CPD, locum services and funding to meet the additional costs of attending CPD and to provide back-up support are all required to support rural professions.
- Mentoring and coaching are also crucial for new and inexperienced professionals. Investment in academic/research and clinical leadership positions, for example in University Departments of Rural Health that have well-established multi-disciplinary programs, and in Rural Clinical Schools, should be pursued as one effective way of attracting and retaining professional and clinical leadership and support for mentors and other professionals.

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

Alliance Comments: Current policies to enable nurse practitioners, working in collaborative teams, to provide MBS-eligible funded services for patients, provide a relevant model for utilising scarce health profession skills to the full extent of their accredited training, while seeking to avoid fragmentation of services.

Recommendation

- Measures to expand or better utilise scope of practice of health professions should be based on collaborative models of service to promote coordinated care for the patient, to ensure quality and safety of care and to provide the supportive working environment especially necessary in rural and remote areas to attract, retain and support health professionals.

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

Alliance Comments: Given the shortages of health professionals in rural Australia, measures to broaden the workforce base would be a welcome means of increasing access and support for consumers. Rural Australia is innovative in building new models of service and would be a ready test-bed for trialling new models.

There would, however, appear to be a number of challenges. At the outset, given scarce resources, it would be important to establish the cost-effectiveness of broadening of the mental health workforce.

Assuming cost-effectiveness is demonstrated, a further challenge will be to develop the education, training and support systems to provide entry for local people into these roles, and to build their skill base to required levels. People in regional, rural and remote Australia currently have less access to tertiary education and training than people in urban Australia. It will be crucial that any new education and training have clear rural pathways to entry and to ongoing professional development.

Another challenge will be to introduce new types of health workers in a way that manages the difficulties that can arise in bringing workforce of different workplace environments together. Teamwork should be the key.

Recommendation

- Broadening the composition of the mental health workforce should be based on cost-effectiveness and the capacity to form effective teams.
- It will be crucial that any new education and training have clear rural pathways to entry and to ongoing professional development.

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?

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

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

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

Alliance Comments: As noted in our introductory comments, the key to equity and service access in rural and remote Australia must begin with needs-based planning of the workforce on a regional basis. Workforce development without this underlying discipline is only likely to skew distribution further in favour of those areas with greater resources and perceived more attractive working conditions. This is especially the case for private fee-for-service professions who will make location decisions on business viability, career development and family grounds, rather than on considerations of population needs.

A needs-based development of services is also essential. However, rural towns and communities are unlikely to have specialised acute mental health services and other dedicated mental health services. Reliance will be far more on forms of out-reach for specialists and for mental health services imbedded within more general services such as general practice, comprehensive primary care services and multi-purpose services.

The AIHW report also shows an increase in the number of beds in specialised psychiatric wards of public hospitals. This highlights the propensity of the system to invest in acute over community care and early intervention and support services designed to keep people living well in the community.

Recommendation

Equitable access to services will depend on both needs-based planning of services and of workforce development and distribution.

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

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:

Alliance Comments:

Successful models in rural Australia include multi-purpose services in rural towns, bringing together some flexibility in funding for acute services, for aged care and for community services and providing services developed in consultation with the community and under the umbrella of an integrated service.

While primary care is the backbone of the mental health system in rural areas, the Commonwealth-State split of responsibilities does not assist in seamless care. Most States and Territories have some initiatives in place to build bridges across these boundaries eg HealthPlus in South Australia, HealthOne in NSW, but a national integrated system for the whole of primary care is required to eliminate this artificial barrier. Building comprehensive primary care centres and networks of services to provide holistic care including capacity for mental health would also provide a systemic response and not rely on innovation and initiative on a case by case basis.

Other approaches include the development of 'area specific' pathways of care, built to recognise the particular services and resources available in a region, and how and when a patient might be referred to other parts of the health system, taking into account their needs and issues of safety and quality.

Recommendation

Systemic responses to reducing the risk of consumers falling through gaps should include:

.one level of government being responsible for primary care;

.development of comprehensive primary care centres and networks of services;

.extension of successful models of care such as flexibly funded multi-purpose services;

.funding for the development of area-specific pathways of care, taking into account the services available in the community, patient need and safety and quality.

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:

Alliance Comments:

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?

Alliance Comments: 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:

Alliance Comments:

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

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:

Alliance Recommendations:

The use of e-health technologies to provide clinical consultations, clinical supervision and support for secondary consultations is supported. The issue to be addressed is how such services would be funded.

Apart from the establishments costs of setting up such services, funding models need to be put in place for ongoing service. Direct consultations could be covered under MBS, and a case could also be made that subject to gatekeeper control such as through a GP or other professional within scope of practice,, secondary consultations (ie with the carer) might also be subject to MBS eligibility.

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 will provide a better indication of and in being trialled?

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

How can and planning, monitoring and evaluation methods for workforce strategies be improved?

Alliance Comments: The National Registration and Accreditation Scheme, due to start for ten health disciplines by July 2010 with a further three health disciplines due for July 2012, will provide a better indication of workforce size and composition than at present.

This information should be made publically available and broken down by region, so that there is better understanding at the regional level and better accountability for the system as a whole.

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?

Alliance Recommendation:

From an equity perspective, one key evaluation measure of workforce development should be that of mental health workforce distribution. Also bearing in mind the reliance on the general health workforce to provide mental health services in rural areas, the extent of uptake of mental health CPD by all professions would also be a useful measure.

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:

Alliance Comments: For people with a mental health condition, as well as for many others with chronic health conditions, support from other sectors, including education, employment, housing, social services and the justice system, is a vital part of a comprehensive response to treatment and recovery. Health services can and should take the initiative in building these collaborations and support networks for and on behalf of their consumers.

Collaborations need to be developed and maintained at the strategic and the operational level; for example in establishing contracts or memorandums of understanding between health services and a range of state government, local government and other organisations about providing services to health consumers, and then by health practitioners, e.g. a health system case coordinator working with the consumer to organize their access to required services from other sectors.

Lessons can be learned from other countries. In England, the Primary Care Trusts (PCTS) have been required to develop Local Area Agreements and Local Strategic Partnerships. These are agreements between the PCT and local Councils on improving a community's environmental and socio-economic outcomes. Examples have included the establishment of Crime and Disorder Reduction Partnerships (CDRP) with police and related agencies, recognizing that deprived communities are most often those with the poorest health and highest crime. Experience of crime and fear of crime can lead to both physical and mental ill health. Similarly, many offenders have mental health problems.

PCTs have contributed to these partnerships through provision of information and data related to violent crime incidents, provision of a non-stigmatising access point for the reporting of criminal or disorder incidents, joining up mental health services with crime reduction programs, and cross-agency work on issues such as domestic violence, drugs and alcohol.

Recommendation

Building on the experience of other countries, promote the development of cross-sectoral agreements that support the provision of necessary social and other supports to assist people with mental illness in recovery.

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

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

In order to be most effective, the recommendations need to be prioritised.

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

ATTACHMENT A

Compared to urban Australia, rural areas of Australia suffer from significant shortages of nearly all health professions. For GPs the following table of AIHW estimates of GP workforce demonstrates that there are fewer GPs per 100,000 of population. The AIHW survey also found that hours of work by primary care clinicians were 2.6 hours more in inner regional, 6.1 hours more in outer regional and 10.3 hours more in remote/very remote, compared to their metropolitan counterparts. Thus it is clear that primary health care practitioners in rural Australia already work longer hours and have a broader range of demands for their services and will be significantly less well placed than their metropolitan colleagues to devote additional time to recovery models of care.

AREA	Total Medical Workforce per 100,000 2002 2006	Growth Rate in Employed Medical Practitioners	Employed Primary Care Clinicians FTE per 100,000 2002 2006	Employed Hospital non-specialists FTE per 100,000 2002 2006	Specialists/ in training FTE per 100,000 2002 2006
Metro	312 332	18.5%	105 98	29 39	154 170
Inner Regional	176 184	8.3%	90 87	14 18	65 71
Outer Regional	146 154	4.9%	80 86	15 15	43 45
Remote, Very Remote	140 191	31.2%	89 108	22 34	21 35
Overall Clinicians	271 290 252 272		101 97		

The availability of psychologists

The National Allied Health Workforce Report (2003) showed that 20.5 per cent of practising psychologists were reported as working in rural and remote regions. This equates to 0.83 psychologists per 10,000 head of population in very remote areas and 3.44 in Inner Regional centres, compared to 5.92 per 10,000 head of population in major capital cities. The rural sector tended to attract the youngest and hence least experienced health professionals. Although data are scarce, there would appear to be few Indigenous people working as psychologists, regardless of whether or not they are located in rural areas.

The *2nd Report on the Mental Health and the New Medicare Services* for the two years to August 2008 by the Mental Health Council of Australia (MHCA) revealed that since the introduction of the new Medicare Items for mental health services, people living in rural Australia have less access to the new MBS services, indicating a lack of appropriate health professionals and mental health specialists in rural Australia. Access ratios per 1000 population compared to urban areas for various services were:

- GP mental health plans: 0.91 for rural, 0.34 for remote;
- psychological assessment and therapy by a clinical psychologist: 0.76 for rural and 0.17 for remote; and
- treatment by a registered psychologist: 0.43 in rural and 0.12 in remote.