



**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:

Dietitians Association of Australia

Contact person (name and title)

(telephone and email):

Tiffany Peddle APD

Practice and Professional Development Dietitian

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

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

1. Implementing the recovery model

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

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

The Dietitians Association of Australia (DAA) believes that recovery from mental illness requires a holistic approach that includes attention to physical health through appropriate lifestyle interventions. It is essential that people with mental illness are informed of the benefits of improved physical health and supported with strategies to empower them to manage their own health and contribute to their recovery.

The relationship between mental illness, nutrition and physical health is diverse and complex. Various symptoms of mental illness have effects on dietary intake, which in turn influences nutritional status and physical health. Additionally, many of the nutritional consequences of mental illness also contribute to the symptoms of the mental illness and can potentially exacerbate them.¹ Individuals with severe mental illness who reside within the community have significant increased risk of morbidity and require continued rehabilitation and support to carry out tasks of daily living such as shopping and preparation of food.²

The key physical health issues that can impact on the quality of life of people with mental illness are:

1. Poor physical health compared to the general population. People with mental illness are three times more likely to smoke and consume a poor diet, and are less likely to engage in physical activity
2. Increased risk of chronic disease. For example, people diagnosed with schizophrenia have up to five times the risk of cardiometabolic disease, are almost two times more likely to be obese, are five times more likely to have dyslipidaemia and two times more likely to have diabetes than the general population³
3. Life expectancy is akin to the indigenous population. Mortality rates in people with schizophrenia are 10 to 25 years earlier than the general population and 60% of these premature deaths are due to physical co-morbidities related to smoking, poor diet and lack of exercise³.

In addition, there is a lack of coordinated physical care and treatment for people with mental health issues. Nutrition interventions that address physical health issues and promote recovery should include:

1. Improved nutrition care for people with mental illness
2. Lifestyle interventions, including diet and exercise, to minimise and treat the side effects of psychotropic medications and lifestyle risk factors and to reduce the risk of co-morbidities. Lifestyle interventions should occur through a multi-disciplinary team approach that includes an Accredited Practising Dietitian
3. Identification (screening and monitoring) and management of physical health issues and conditions such as dental hygiene, constipation, reflux, joint and bone problems, dysphagia, unintentional weight changes and metabolic syndrome (in particular diabetes and cardiovascular disease risk). Many of these conditions relate to both lifestyle factors as well as psychotropic medications.

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

Physical health and nutrition issues are relevant across the age spectrum and dietetic input, as part of a multi disciplinary team, is essential for consumers of mental health services across the life cycle (children and adolescents, adult and elderly).

References:

1. Webster-Gandy J, Madden A, Holdsworth M. Oxford Handbook of Nutrition and Dietetics. New York: Oxford University Press. 2006; 600-1.
2. McDougall S. The effect of nutritional information on the shopping and eating habits of a small group of chronic schizophrenic patients living in the community. Br J Occup Ther 1992; 55:62-68).
3. Lambert T, Newcomer J, Are the cardiometabolic complications of schizophrenia still neglected? Barriers to care.MJA 2009: 190 (4): S39-S42

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.*

One of the key issues for the current dietetic workforce in mental health is under resourcing. There are:

1. Very few dietitians employed in the mental health sector, and working in mental health is not necessarily attractive to dietitians
2. Many dietitians working in community health and private practice see clients with mental illness
3. Limited opportunities for mentoring, student placement and student supervision to support dietitians working with clients with mental illness
4. Limited Professional Development opportunities or courses for dietitians and other allied health professionals in the management of clients with mental illness
5. Limited nutrition and healthy lifestyle programs and resources available those working with clients with mental illness
6. Limited available evidence to guide dietetic practice in the area of working with people with mental illness.

The Mental Health Interest Group (MHIG) of Dietitians Association of Australia (DAA) conducted a workforce survey in 2009 among members across Australia. The results indicated that two thirds of respondents believed there were not enough hours to provide a quality dietetic service for clients with mental illness. On average respondents spent approximately 16 hours per week working in mental health and estimated they needed double those hours to meet the demand. The respondents indicated that additional staff would improve consumer access to dietitians and enable dietitians to also focus on prevention and early intervention resulting in better health outcomes and improved quality of life for consumers. The survey highlighted the need for a significant increase in dietetic services within the mental health sector.

The nature of mental illness adds a very different dimension to the dietetic assessment, consultation and management plan. In general, more consultation time is required to assess and consult with mental health clients and more frequent contact and is required to achieve similar outcomes.

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

Strategic planning is required around:

1. The current adequacy of dietetic services available to people with mental illness
2. Optimal use of the current (limited) dietetic workforce in mental health
3. Supporting and mentoring new graduate dietitians or dietitians new to mental health
4. The most effective utilisation of a dietitian's time and skills, and most the appropriate mix of individual interventions, group programs and workplace training for health professionals.

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

Dietitians are uniquely placed to take a leadership role, within the multidisciplinary team in mental health services, to identify and deliver best practice physical health care for people with mental illness. Physical health measurements are a key part of the criteria upon which dietitians base their nutritional assessments and care, and poor dietary practices are a key contributor to poor physical health. Dietetics intervention is required to improve physical health and minimise health risks. Development of capacity in the broader health workforce would include:

Increased dietetic workforce in mental health services

To provide quality nutrition interventions in mental health services there is a need for adequate dietetic services throughout the mental health system to both improve service delivery and enhance recovery.

Training and Professional Development for all health professionals

Training for health professionals would address diet and the relationship to mental health and chronic disease. It would highlight the importance of nutrition in the mental health setting, the role of a dietitian in the mental health team and their scope of practice. Training would also enhance the health professional's knowledge, commitment and support for physical health care for people with mental illness and the importance of communication between health professionals. It is crucial that an Accredited Practising Dietitian is involved in the development and implementation of this training.

Resources

Providing evidence based resources to support programs in nutrition and healthy lifestyle habits for people with mental illness. It is crucial that an Accredited Practising Dietitian is also involved in the development and implementation of such resources and to train other health professionals on their use. This will ensure that evidence based information is available to health professionals and clients.

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

Over the past two years DAA has taken the first steps to build capacity in the new graduate dietetic workforce. Dietitians have the qualifications and skills to provide expert nutrition and dietary advice; however they require more knowledge and skills in working with clients with mental illness. The

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

DAA Mental Health in Tertiary Curricula for Dietitians project, funded by the Department of Health and Ageing (DoHA) under the Council of Australian Government's National Action Plan on Mental Health, was developed to identify the competencies required by newly graduating dietitians for interacting with clients with mental illness. In a follow-on project funded by DoHA, the same project team developed tools and resources to assist nutrition and dietetics training in Australian universities operating DAA accredited programs. The resources were demonstrated in a national roadshow attended by 500 dietitians across Australia. While roadshow participants were enthusiastic about what they saw – they also asked for more!

Dietitians now have continuing access to the materials developed in the project through the DAA website and resources distributed to the University nutrition training units. These are tangible outcomes of the projects, but others have included the active engagement of consumers and mental health experts in the project steering committee, a greater awareness of mental health issues in everyday dietetic practice, continuing professional development opportunities in mental health and the formation of a Mental Health Interest Group (MHIG) for DAA members. The MHIG is currently developing a role statement for dietitians working in mental health to provide guidance on the role of the dietitian in the mental health setting. Further capacity can be built through the development of resources and guidelines for dietitians to use when working with people with mental illness.

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 3a)

Health care services, resources and interventions in the mental health sector should be appropriate and, wherever possible, evidence based. It is essential that an Accredited Practising Dietitian is involved in the development, implementation and training of other health professionals in the mental health setting to implement nutrition and healthy lifestyle interventions to address physical health issues.

Communication and establishment of links between non-government organisations and health service providers is essential to ensure a continuum of care across settings to make certain that appropriate care and support for people with mental illness is provided.

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:

(See 2 and 3a)

Education and training for dietitians and allied health professionals working in mental health should include:

1. University undergraduate training programs and post graduate courses
2. Continuing Professional Development and workplace training
3. Student placement and supervision
4. Mentoring, clinical supervision and coaching opportunities.

Education and training may be implemented in a multidisciplinary capacity on general mental health issues, conditions, practices, clinical guidelines and services. In addition, training of health professionals in

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

correct methodology anthropometric measurements (height, waist circumference etc) and in physical health monitoring (weight charts, Blood Glucose monitoring etc) would be beneficial.

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

Successful management of physical health and comorbidities of people with mental health issues requires the knowledge and skills of appropriately trained health professionals working in a multidisciplinary health care team. Health professionals within the mental health sector require education on scope of practice, areas of expertise and contribution to the multidisciplinary team. Many health professions frequently engage in nutrition and healthy lifestyle interventions without any prior training in nutrition which may place clients at risk. Therefore the development of scope of practice guidelines, referral guidelines and practice recommendations around the management of nutrition and physical health in clients with mental illness is required to ensure that appropriate and evidence based interventions are implemented.

Health professionals involved in the delivery of nutrition and healthy lifestyle interventions and programs should:

1. Receive training in healthy eating from an Accredited Practising Dietitian
2. Clearly understand their scope of practice and professional limitations
3. Understand and identify when to seek advice and refer clients on to a specialised health professional such as an Accredited Practising Dietitian.

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

(See 1)

Dietitians are an integral part of the mental health team and are appropriately qualified and uniquely placed to be advocates for improved physical health of consumers with mental health issues. This role also includes collaboration with mental health workers, carers, representatives and support workers. This ensures a continuum of care across settings in the health sector and improved outcomes for the consumer.

Increased employment of dietitians in the broader mental health service and increased consumer access to dietitians across the mental health sector are required to address physical health issues.

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?

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

(See 1)

Screening of all mental health clients for physical health issues, particularly those prescribed psychotropic medications (atypical antipsychotics and others), is an essential part of health care. Appropriate and timely assessment of mental health clients would allow interventions to be commenced at the most opportune time and prevent the risk of physical health issues. Clients would be educated at this time on the benefits of the assessment to their own self care and recovery. The implementation of screening protocols and tools would need to be developed and equitable access to health services, including dietetics services, would be required.

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

Physical health screening at initial assessment of mental health clients would increase the profile of physical health across the mental health sector and increase the workload on the mental health workforce. Therefore employment of appropriately skilled and trained staff to manage physical health issues and comorbidities would be required. In addition, there would be increased referrals to services outside the mental health sector to ensure continuum of care. This may increase the prevalence of mental health clients for non mental health services and would present a need for more mental health training for these health workers.

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

Provision of a 'one stop shop' for the holistic care of people with mental health issues would provide services where mental health and physical care needs could be treated and managed by a multidisciplinary health care team that includes Accredited Practising Dietitians.

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

Access to specialist allied health services and other specialist services relating to physical health is essential across the mental health sector. Adequate access to affordable dietetic services and other health services through Medicare (Better Access, ECP) and other health care initiatives is essential for the effective management of physical health conditions.

It is important to note that a significant amount of time must be spent in building trust and rapport in working on lifestyle interventions with mental health clients and that is likely to be increased in mental health clients of an ATSI or CALD background.

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.

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

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

Inclusion of mental health training in ALL health professional training is crucial to maintain adequate numbers of health professionals in the mental health workforce. It would also assist in reducing stigma associated with mental health and promote it as an attractive area of the health sector in which to work.

A multidisciplinary team approach to mental health training may improve the understanding and appreciation of the knowledge, skills and scope of practice that each discipline brings to the health care team.

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:

Inclusion of physical health interventions into transfer and discharge planning with appropriate referral pathways to ensure that all relevant treatment and interventions are included across the continuum of care to enhance recovery.

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:

Identification and management of physical health issues is an integral part of the mental health care plan. Physical health management requires an integrated holistic treatment plan through a multidisciplinary team approach. Accredited Practising Dietitians have the expertise and skills to provide leadership in the area of physical health management within a multidisciplinary team.

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?

The establishment of mentoring programs, clinical supervision and debriefing opportunities to support all health professionals (across the multidisciplinary team) working in mental health, especially those who are new to mental health.

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?

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

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

Service managers or managers from other health professions, especially traditional mental health professions, may benefit from increased understanding of the role of different health professionals including dietitians. This may also foster a greater understanding, mutual support and enhanced communication between the health professions working in the multidisciplinary team.

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:

The use of technology will improve the management of health care for mental health clients and would include:

1. Electronic management of assessment and treatment plan to be shared by all members of the mental health care team (medical, nursing and allied health).
2. Electronic management of appointments with appointment reminders for consumers
3. Electronic management of measurements and outcomes, which can be collated for quality improvement activities and research purposes
4. Accurate assessment tools for physical health screening including anthropometric tools (scales, height measures, tape measures)

Clinical supervision:

To provide review summaries on the health care plan of clients for debriefing with clinical supervisor.

Secondary consultations:

Electronic management would provide information on the clients' condition, treatment and care plan to assist with specialists assessments and follow-up reviews.

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?

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

Electronic patient data may be used for assessing client progress reports, developing management reports and for research purposes.

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

Electronic data management and reporting with clear concise summaries (with access by all health care providers) would enhance the health care management of consumers.

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

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?

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:

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

Secondary symptoms of mental illness and the effects of medications prescribed for treatment include amotivation, sedation, lethargy, poor concentration, distraction and poor memory and are barriers to effective lifestyle changes. These symptoms can be challenging for people with mental illness and can impact their ability to consume a well-balanced diet and maintain physical health. Increased dietetics staff and hours are required across the health care sector to address these issues for people with mental illness to achieve optimal health outcomes.

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