Mental Health Council of Australia's Submission to the Productivity Commission Health Workforce Study

Introduction

This submission has been prepared by the Mental Health Council of Australia (MHCA) in response to the Productivity Commission's review of the health workforce in Australia.

The MHCA is the independent, national representative network of organisations and individuals committed to achieving better mental health for everyone in Australia. The MHCA constituency includes consumers, carers, special needs groups, clinical service providers, private mental health service providers, non-government organisations, Aboriginal and Torres Strait Islander peoples, and State / Territory-based peak bodies.

The MHCA commends the Productivity Commission's issues paper released on 3 June 2005. The paper identifies a range of mechanisms for addressing health workforce deficiencies. The MHCA acknowledges that the Commission does not need further evidence of problems with the health workforce. It is disappointing however, that mental health was not identified as an area of special need in this paper.

The MHCA believes mechanisms such as improved financial incentives and professional development opportunities are necessary to address recruitment, retention and distribution problems within the mental health workforce.

Equally significant is the need for attention to the under-resourced and under-developed workforce in the community services sector. Non-government organisations providing services to mental health consumers, their family and carers are well placed to relieve pressure on the public mental health system, as envisioned when the deinstitutionalisation process was formally begun in the early 1990s. NGOs offer a broader spectrum of care through a greater variety of programs to assist with mental health consumers and their carers and families with 'recovery'. Failure to

properly resource this sector has meant deinstitutionalisation has become a recipe for isolation in the community for those living with mental illness.

The mental health sector is an area of special need within the health industry

In recent years there have been countless reviews and reports identifying the crisis in mental health care in Australia. This is a view that is strongly held by mental health consumers and carers as well as mental health workers in the mental health and community services sectors. Numerous inquiries by various parliamentary committees at the federal, state and territory levels, as well as by ombudsmen, coroners, public advocates and so on, point to the current crisis in mental health services in Australia.

In the early 1990s, the launching of the National Mental Health Strategy began the formal process of deinstitutionalisation in mental health. Unfortunately, chronic under-funding has undermined the success of this process over the last 13 years. While long term mental health institutions have closed, commensurate increases in community service and support have not occurred. Compounding this problem have been rising prevalence rates, increasing case complexity and rising drug and alcohol use. As stated in the MHCA's 2004 paper, *Investing in Australia's Future*:

> Although mental health is the third largest contributor to total health burden (13.2% of the total health burden) and the largest overall cause of disability (27.0%), it is only the seventh ranked disease area by expenditure (6.0%).[1]

In addition to those pressures afflicting the health industry in general, the mental health sector experiences particular workforce pressures not experienced by other areas. There is an increasing number of clients and a decreasing number of beds and staff (in terms of FTE hours worked). There is a paucity of community-based services and these are often not properly resourced. This leaves them ill-equipped to share the burden with acute care service providers. More patients means that health

[1] Hickie I, Groom G, Davenport T. *Investing in Australia's Future:* the personal, social and economic benefits of good mental health. Canberra: Mental Health Council of Australia, 2004.

professionals are able to spend less time per patient and this is a trend paradoxically supported by the existing system of professional remuneration.

Mental health service staff such as psychiatrists and nurses report considerable stress and burnout due to:

- client pressures (including case complexity, role of drugs and alcohol, risk of violence, community stigma, poor community support); and

- bureaucratic and administrative pressures (including paperwork, management, regulatory compliance, litigation, complaints, and other distractions from clinical role such as finding beds for patients, obtaining clinical assistance for physical health needs and caring for patients in inappropriate settings).

All jurisdictions in Australia are faced with poor interaction and disconnect between mental health services and the community sector, including areas such as:

- public mental health services;
- private mental health services;
- primary mental health care;
- allied health professionals;
- rehabilitation and recovery programs;
- housing support;
- drug and alcohol services;
- employment support; and
- family and carer support.

The MHCA notes comments by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) that "recruitment levels are influenced by the marginalisation of the speciality within medicine and stigma associated with the profession and mental illness"[2]. Similarly, the paper *Australian Mental Health Nurse Supply,*

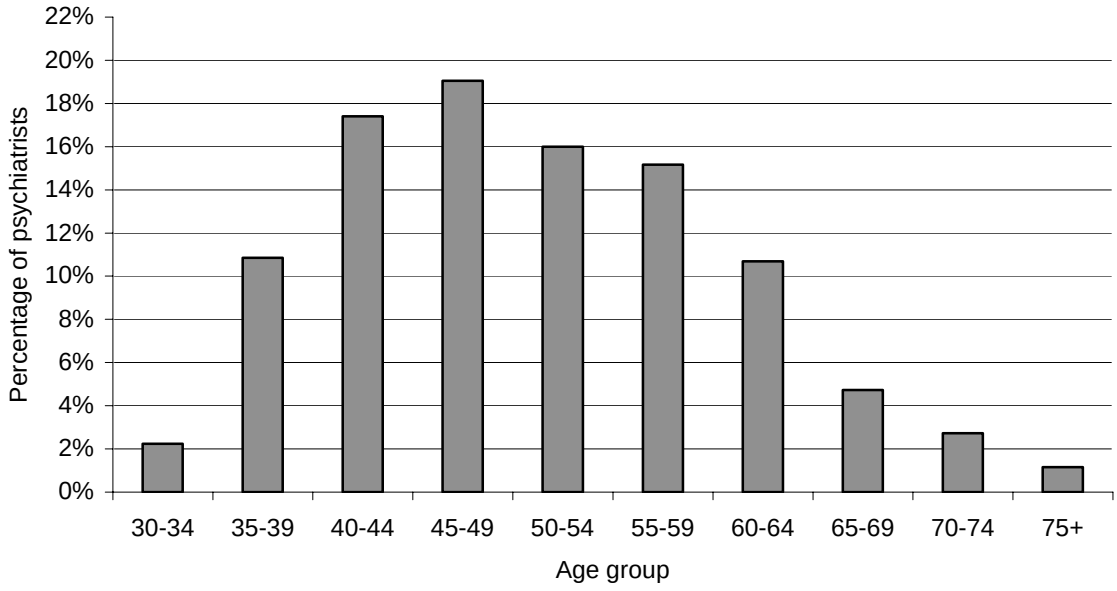
[2] Royal Australian and New Zealand College of Psychiatrists. *Submission to the Productivity Commission on Health Workforce July 2005*

Recruitment and Retention[3] identifies this problem for mental health nursing recruitment. Stigma experienced by mental health consumers and their carers and families is also a significant factor impacting on their health and wellbeing, recovery, and social engagement, overall contributing to the complexity of working with this client base.

Poor ongoing training and professional development opportunities and "the lowest average income of any medical practitioners" are cited by the RANZCP as disincentives to working in psychiatry.

The demographic profile of the psychiatry workforce reflects the RANZCP's statements regarding a lack of entrants into the psychiatry workforce.

Psychiatrists by age group

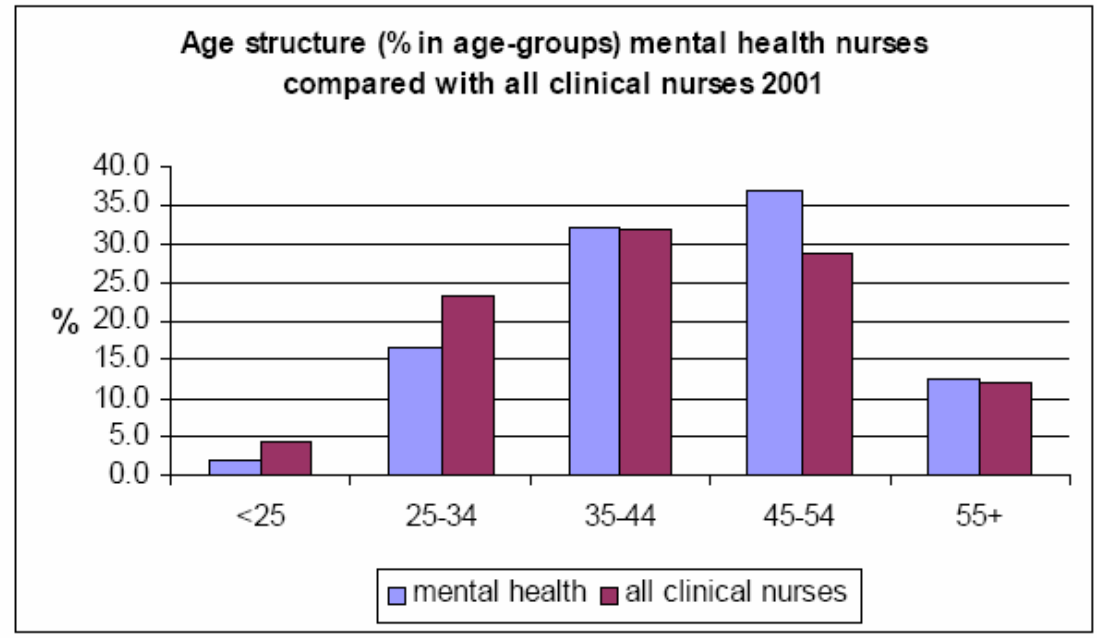


Source: RANZCP Workforce Survey 2004

Of 2,129 psychiatrists in Australia, only 13% are below the age of 40, over 20% are 60 years or older and 14% plan to retire in the next 5 years[4].

[3] Australian Health Workforce Advisory Committee (2003), *Australian Mental Health Nurse Supply, Recruitment and Retention*, AHWAC Report 2003.2, Sydney
[4] Royal Australian and New Zealand College of Psychiatrists, op cit

A similar problem can be seen in mental health nursing.



Source: AIHW, 2003 (2001 data)

Approximately 18% of mental health nurses are below the age of 35, compared with approximately 27% of all clinical nurses. These figures can be contrasted with the 35 to 44 age group where mental health nursing numbers (32%) are equivalent to all clinical nurses (31%), indicating recruitment problems over the last 20 years.[5]

The community services sector is a key avenue to relieve pressure on the (clinical) mental health workforce

The MHCA believes a fully funded and functional community services sector would be able to play a significant role in relieving pressure on Australia's stressed mental health system. In short, many of the difficulties faced by mental health services are a direct result of the diversion of funding away from mental health following the closure of most mental health institutions during the early 1990s and the failure to build the community sector to cover the withdrawal of the services provided by these institutions.

[5] Australian Health Workforce Advisory Committee, op cit

Community services need to be properly funded to play a key role in a 'whole of life' approach to care required by mental health consumers (and their families and carers), including areas such as recovery (as encompassing health promotion, illness prevention and relapse prevention), housing, social engagement and employment. An American study recently revealed that a day in hospital is estimated to cost $US280 while a day in supported accommodation is $US20.54[6]. Clearly, even when employing a suite of interventions and support, it pays to keep people out of hospital. However, the delivery of better health care than currently available is required to achieve this aim.

Formalised and functional relationships between mental health and community services are needed to close gaps and ensure continuity of care. The MHCA envisions a functioning 3-tiered mental health system of 'step up, step down' levels of care, with guided and supported diversion to community services and allied health as required. The tiers would consist of:

- Primary (e.g. GPs, allied health)
- Secondary (e.g. community mental health services, NGO community services, halfway facilities)
- Tertiary (e.g. acute care)

What's required to achieve this vision?

A number of solutions are necessary to achieve a functioning, integrated mental health system. The first step is a better understanding of the current capacity of the mental health workforce. Consideration should be given to where improved role definition (and redefinition) can make better use of the current workforce across both the mental health and community sectors. Further research is required to understand the current capacity of the various professions and workers to expand their roles to relieve key pressure points such as those faced by psychiatrists, mental health nurses and general practitioners.

[6] Campaign for Mental Health Reform (2005). *Emergency Response: A Roadmap for Federal Action on America's Mental Health Crisis*. USA

As demonstrated by the failures of deinstitutionalisation, the community services sector cannot adequately support mental health services without appropriate funding. To elaborate on the somewhat simplistic solution of 'more money', there is a need to address the training and workforce requirements of the community sector. Accountability and governance measures are also required to ensure quality mental health care is delivered and a continuous quality improvement agenda is pursued.

A recent paper by the Mental Health Coordinating Council (MHCC) of New South Wales provides a very useful examination of issues relating to the training and workforce development needs of mental health non-government organisations[7]. Issues identified included:

- ensuring the availability of courses and training providers;
- cost implications for NGOs and their staff;
- the need to address specific areas such as dual diagnosis, indigenous mental health, rural and remote, culturally and linguistically diverse (CALD) groups;
- ensuring appropriate supervision and management of staff;
- access to clinical advice and support as required; and
- achieving consistency across Australian jurisdictions.

Mental health consumers and carers also provide a largely untapped resource as experienced mental health workers. A recent paper developed for the Australian Health Ministers' Advisory Council National Mental Health Working Group explored the issue of Consumer Operated Services[8]. As described above, consideration would need to be given to training and support needs as well as evaluation and

[7] Fisher J, Freeman H. *Options Paper: Training and Workforce Development for the Mental Health NGO Sector*. Mental Health Coordinating Council, New South Wales, June 2005.
[8] Conner H (2005). *Consumer Operated Services Discussion Paper, March 2005*. Australian Health Ministers' Advisory Council National Mental Health Working Group, Australia.

quality assurance measures. The MHCA believes this concept has great merit and calls for funding of a pilot Consumer Operated Service in Australia.

However, more needs to be done than just improving the capacity of the community sector to support mental health services. Long-term strategies to boost mental health workforce numbers through improved training and retention are also required:

- incentives to specialise in psychiatry and mental health nursing (scholarships, research, placements);

- incentives to recruit more private sector psychiatrists to work in the public sector (restructuring of the Medicare Benefits Schedule to promote ongoing care, salaries commensurate with other medical specialities, professional development opportunities);

- incentives to increase access for mental health consumers to GPs and other providers of primary mental health care (restructuring of the Medicare Benefits Schedule to promote mental health care by GPs, promote longer consultations, and funding of psychological sessions); and

- incentives to address mal-distribution of the mental health workforce (i.e. increased distribution rural and remote, outer suburban and regional areas).

The MHCA supports calls by the Australian Psychological Society (APS)[9] for substantially increased MBS funding of psychological therapies. Currently the only avenues for such therapies that are publicly funded are the Australian Government-funded *Better Outcomes in Mental Health Care* initiative and via referral by GPs under the MBS Access to Allied Health Professionals item numbers. Both avenues are severely limited by caps on both rebates and number of sessions that are funded, especially the Access to Allied Health Professionals item numbers. That such caps do not exist for other areas of health suggests a discriminatory attitude towards mental health.

[9] Crook A, Stokes D, Fazande M. *Submission to Productivity Commission Health Workforce Study*. Australian Psychological Society, 2005.

The MHCA also acknowledges the APS' call for "restructuring in public sector mental health units to utilise postgraduate trained clinically expert psychologists who are as competent as psychiatrists to diagnose and treat mental health disorders". This MHCA believes this idea has some merit and should be more fully explored with key stakeholders such as the Royal Australian and New Zealand College of Psychiatrists, Australian Psychological Society, Australian and New Zealand College of Mental Health Nurses, consumer and carer groups and the Australian Health Ministers' Advisory Council National Mental Health Working Group.

Key recommendations:

- Improved data collection on mental health and community services workforces.

- Further research involving all major stakeholders into role definition and redefinition of the mental health and community services workforces.

- Substantially increased allocation of mental health funding in each jurisdiction to community services supporting mental health consumers and their carers and families.

- MBS funding of psychological therapies.

References

Australian Health Workforce Advisory Committee (2003), *Australian Mental Health Nurse Supply, Recruitment and Retention*, AHWAC Report 2003.2, Sydney.

Campaign for Mental Health Reform (2005). *Emergency Response: A Roadmap for Federal Action on America's Mental Health Crisis*. USA.

Conner H (2005). *Consumer Operated Services Discussion Paper, March 2005*. Australian Health Ministers' Advisory Council National Mental Health Working Group, Australia.

Crook A, Stokes D, Fazande M. *Submission to Productivity Commission Health Workforce Study*. Australian Psychological Society, 2005.

Fisher J, Freeman H. *Options Paper: Training and Workforce Development for the Mental Health NGO Sector*. Mental Health Coordinating Council, New South Wales, June 2005.

Hickie I, Groom G, Davenport T. *Investing in Australia's Future:* the personal, social and economic benefits of good mental health. Canberra: Mental Health Council of Australia, 2004.

Royal Australian and New Zealand College of Psychiatrists. *Submission to the Productivity Commission on Health Workforce July 2005*.