

February 1999

Education and Training Partnerships in Mental Health

**Learning
together**



Education and Training Partnerships in Mental Health

Prepared by Deakin Human Services Australia
with funding from the
Commonwealth Department of Health and Aged Care under the
NATIONAL MENTAL HEALTH STRATEGY
February 1999





© Commonwealth of Australia

ISBN 0 642 39440 7

This work is copyright. It may be reproduced whole or in part for study, training, policy or curricula development purposes subject to the inclusion of an acknowledgement of the source and for no commercial usage or sale. Reproduction, for purposes other than those indicated above, requires the written permission of the Secretary, Commonwealth Department of Health and Aged Care, GPO Box 9848, Canberra, ACT, 2601.

Additional copies of the report can be obtained by calling: 1 800 066 247

Reference: Learning Together: Education and Training Partnerships in Mental Health Service. Final Report.
Prepared by Deakin Human Services Australia with funding from the Commonwealth Department of Health and Aged Care under the National Mental Health Strategy, February 1999.



The opinions expressed in this report are those of the authors and are not necessarily those of the Commonwealth Department of Health and Aged Care.
Publications Approval Number: 2570



Foreword

This report has been finalised at an important stage in the history of the National Mental Health Strategy and details a wide range of issues germane to the continuing reform of mental health services in Australia. Many of these are common across the whole health and community sectors: the education and training of the workforce, the reform of the way services are delivered, the development of intersectoral partnerships, and the increasing role that consumers and their carers play in all aspects of service delivery.

The mental health education and training workshops, details of which are documented in the report, are an example of the practical application of this consensus model of collaborative participation and consultation in health sector reform. The meetings represented a unique and valuable opportunity, over time, for many consumers, carers and mental health professionals to share ideas, values and goals.

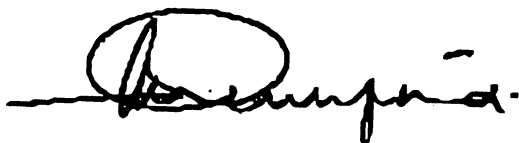
This report outlines over-arching principles developed during the course of the workshop series; it also contains a number of chapters consisting of input from consumers, carers, and representatives of the five most relevant disciplines. As such, this document will be a valuable resource which will assist in the future planning for mental health sector education, training, consumer/carer partnership, workforce supply and service delivery structure.

One of the many significant challenges still to be addressed under the National Mental Health

Strategy is to improve the attitudes of mental health service providers towards consumers and their carers. Education and training initiatives under the Second National Mental Health Plan must therefore aim to assist the workforce to be more responsive to the rapidly changing service delivery environment. This consists of more than a community care-focus for the treatment of mental illness, it is about accepting that people with these illnesses themselves have “expert” knowledge, they have individual needs and expectations. Furthermore, consumers and their carers can contribute greatly to the recovery and management of mental illness as well as to the quality of the care delivered by the professional workforce.

Fostering a culture which values the opinions of consumers and carers must be the overarching goal of continued reform in this area. Changes to curriculum and education approaches, whether at the tertiary level or as continuing training, should build upon this principle - I expect that each training regime will adapt, in their own way, to this foundation issue.

I would like to acknowledge the involvement of all participants to the workshop series as well as to commend this report to those who have a commitment to improvements to Australia’s mental health workforce. It is a valuable compendium of the results of pooled knowledge, expertise and experience.



Dr Harvey Whiteford
Commonwealth Director of Mental Health
January 1999



Contents

Foreword

Executive summary

Conclusions	1
Overview	2

Part I:

Education and training project

Chapter 1

Introducing the project	4
Introduction	4
Project method	4
Why the focus on the five disciplines?	6
Project participation	8
Reading this report	8
References	9

Chapter 2

Themes and issues	10
The priority of consumer and carer partnerships	10
The reform of the disciplines and their influence in higher education	13
The National Mental Health Strategy: the search for quality and effectiveness	17
Mental health education and training learning organisations	18
Summary	19
References	20

Chapter 3

Service users as consultants, educators and trainers	21
Why should service users be involved?	21
The statement of principles	22
Users as consumers, survivors and patients	22
Relations between professional groups	23
Service users as consultants, educators and trainers	24
What can be done?	25
References	27
Internet Sites	27

Chapter 4

Carers: their needs, rights and contributions	28
Introduction	28
State of play at beginning of the workshops	28
A carer perspective on the project	29
Where to from here?	30
Obstacles to progress	31
References	32

Chapter 5.1

Mental health nursing	33
Introduction	33
Attitudes	36
Knowledge	36
Skills	37
References	38



Chapter 5.2

Occupational therapy	39
Background	39
Consumer focused practice	39
Disciplinary curriculum	41
Interdisciplinary cooperation	42
The future	43
References	43

Chapter 5.3

Psychiatry	44
Introduction	44
Undergraduate medical education	44
Postgraduate medicine - Psychiatry	45
The education and training project	46
Psychiatry and the workshops	47
Findings from the Psychiatrists Task Group: Workshop 3	48
What was learned from the Education and Training Project?	49
Conclusions	50
References	51

Chapter 5.4

Psychology	52
Brief history	52
Present situation	52
Attitudes, knowledge and expertise framework	53
Desired situation	55
References	56

Chapter 5.5

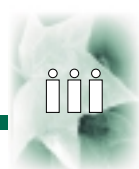
Social work	57
Introduction	57
Brief history	57
Social work and mental health service delivery	58
Present situation	59
Achievements during the project	59
Desired situation	61

Chapter 6

What the disciplines have in common	63
Introduction	63
Outcomes	64
Knowledge	65
Skills	66
Mechanisms	66
The third and final workshop	67

Chapter 7

The role of the universities	69
The complexity of education and training for mental health professionals	69
The organisation of education and training for mental health professionals	69
The content of education and training for mental health professionals	70
The challenge for education and training for mental health professionals	71



Chapter 8		Acknowledgments	85
The workplace as a learning place	73	Advisory Committee Members	86
Introduction	73	List of contributors	86
Involving consumers and carers in education and training	73		
Community expectations	74		
Concerns of employers	74		
Multi-disciplinary responses to current need	74		
Education and training of the current workforce	75		
State and Territory Governments	75		
Local health authorities	75		
Multi-disciplinary teamwork approach to in-service training	76		
The workplace as a learning place	76		
Issues in making the workplace a learning place	76		
Choosing workplace education strategies that fit the goal	77		
Discussion: towards learning organisations	78		
Conclusion	81		
References	81		
Chapter 9			
Where to from here: conclusions and recommendations	82		
Conclusions	82		
Recommendations	82		
Recommendation 1	83		
Recommendation 2	83		
		Appendix 1: A national audit of mental health education and training	A2
		Appendix 2: Attendance at workshops	A24
		Appendix 3: National Mental Health Workforce: Education and Training Consultancy: Report December 1994 KPMG Consulting	A25
		Appendix 4: The project brief	A30
		Appendix 5: Dates and places of workshops	A31
		Appendix 6: Royal Australian and New Zealand College of Psychiatrists Fellowship Curriculum 1995	A32
		Appendix 7: Specific needs for updating of the RANZCP fellowship curriculum 1995, as recommended by psychiatrist training task group workshop 3	A45
		Appendix 8: Pulling together: the future roles and training of mental health staff	A47
		Appendix 9: University of Queensland (1997) Report 1: Executive summary: professional development strategy for adult mental health services (Queensland Health) - (extract)	A48
		Appendix 10: Select bibliography: education and training of mental health professionals	A50
		Appendix 11: Contact details of five professional bodies	A56

Part 2: Appendices



Executive summary

This report provides guidelines, information and resources for universities, professional associations and employers to implement, to update mental health education and training to the requirements of meeting consumer and carer need and the benchmarks on quality and effectiveness provided by the Second Mental Health Plan. As such, it will be pertinent to the teaching of mental health educators, the training plans of workplace trainers and the day-to-day practice of practitioners in all mental health services.

The report has two major recommendations. The first positions this report as the critical document informing the development of a national education and training framework under the Second National Mental Health Plan. The second recommendation proposes a number of detailed actions for a national education and training network.

Conclusions

The conclusions of this project are as follows:

- Agreement exists between all representative participants of the five disciplines and carers and consumers at the workshops that reform of current education and training in universities, and continuing professional education in the workplace is both necessary and possible.
- All such reforms, (that is, their structures and processes) need to be assessed against the Statement of Principle, i.e.

“The relationships between consumers and service providers and carers and service providers, should be the primary focus of practice and research in mental health. Consumers and carers are therefore major players in the education, training and development of the mental health work force.”

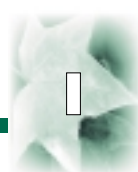
- Future education and training structures and processes must cohere around the two guiding principles:

Mental health professionals need to learn about and value the lived experience of consumers and carers

Mental health professionals should recognise and value the healing potential in the relationships between consumers and service providers and carers and service providers.

- Each discipline needs to develop a new body of knowledge around the “lived experience” of consumers and carers.
- Each discipline has developed a framework of attitudes, knowledge and skills which stem from the guiding principles ¹ which can lead to practice standards and curriculum at all levels: professional entry, senior and advanced levels of practice.
- The commonalities between each discipline are greater than the differences.
- A common interdisciplinary framework of attitudes, knowledge and skills based on the commonalities has been developed.
- The development of a leadership group (as illustrated by the members of this workshop) is a productive way of developing ‘champions’ of change.
- Experiential learning processes must parallel structural policy change.
- Basic university courses in the disciplines are under resourced with respect to mental health education.
- Complex, multi faceted workplace learning experiences through both short and longer courses should continue beyond basic disciplinary education.
- Employers should promote and fund workplace learning.
- A ‘best practice’ model of curriculum review needs to be developed in consultation with the higher education sector, professional associations, employers and Commonwealth and State Governments.

1. The exception is psychiatry: see chapter 5.3



Overview

Promoting education and training is central for the success of the *Second National Mental Health Plan*. This project was commissioned to advise on future directions for education and training. The central focus became the need for change within and between the five major disciplines working in mental health services - occupational therapy, psychiatry, psychiatric nursing, psychology and social work. The key driver was the needs and rights of consumers and carers, as they defined them around their 'lived experience'.

Part 1 of this document is the report of the workshops. In *Chapter 1*, the project is defined, scoped and outlined. In *Chapter 2*, the themes of the project are defined: how to ensure that the 'lived experience' of consumers of services, and carers, becomes central to education and training; how to advance the five major disciplines and their relationships with the universities; how to relate education and training into indicators of quality and effectiveness in service delivery through the second *National Mental Health Plan*; how to focus the matters mentioned into learning for all staff working in mental health services, through developing learning organisations by using learning strategies and learning networks.

Chapter 3 by Epstein and Rechter, acknowledges that more consumers are involved in education and training than previously, but views their involvement as sporadic and diffuse. Participation for consumers in mental health services is not an end in itself; they argue for more participation for *all*, that is carers and professionals as well as consumers. As a method to progress this, the consumers in this project advocate the practice of 'deep dialogue', that is extended workplace conversations between consumers, carers and professionals about the meaning of events, behaviours, practices and systems. The chapter discusses the importance of developing consumers' knowledge base and skills into a complementary mental health discipline through a consumer studies centre.

Involving the carers in the treatment of severe mental illness is becoming a threshold issue, argue Player and Leggatt in *Chapter 4*, pointing out that carers are sidelined or left out of most mental health decisions. This chapter points out that the general approach in both literature and practice is to assume that carers need to be socialised to the

normative assumptions of the professionals. Player and Leggatt argue the reverse: that it is professionals who need to be educated, to discover and incorporate the learning of carers about mental illness. Carers are aware that conceptualising their needs, rights and responsibilities may take time but consider their future contribution to education and training to be critical through a carers' forum.

In *Chapter 5* the five major disciplines in mental health outline separate responses to the challenges of the workshops. In the end, the disciplines involved acknowledge that their commonalties were greater than their singularities. All disciplines acknowledge the need to develop further processes and structures in education and training which place consumer and carer experiences as central to learning. All disciplines specify a framework of attitudes, knowledge and skills around the guiding principles outlined earlier already. (The exception is psychiatry which had a pre existing curriculum now needing revision).

This project posed difficulties for all disciplines and *Chapter 6* refers to these. The difficulties were most evident in the case of psychiatry. *Chapter 6* discusses a template which demonstrates what the disciplines discovered they had in common. A common framework of attitudes, knowledge and skills is specified, which can be related to curriculum, assessment and practice standards at entry level, senior and advanced levels of practice of any discipline and within interdisciplinary education and workforce based training.

Chapter 7 discusses the importance of education within the 'reflective practitioner' model and encourages reflective practice in the workplace. The complexity of assisting individuals to emerge from disciplinary based to interdisciplinary practice is acknowledged. Mental health education and training is largely about how to develop judgement for complex decision making on the part of the practitioner and team. Further education for mental health practice must be developed despite the cut backs in university funds. Effective partnerships with professional bodies and employers are essential.

Chapter 8 discusses learning in the workplace and the responsibility of employers to dedicate budget resources towards education and training as the basis of developing adequate workplace learning, both disciplinary and interdisciplinary. Every men-

tal health practitioner needs an individual learning plan. But education and training can be a potent lever for workforce change. The 'deep dialogue' process advocated by consumers and successfully utilised within the project can be expanded into a process which facilitates organisational as well as individual learning. But establishing structures and systems can achieve little change without setting up appropriate processes; 'deep dialogue' coincides with many of the approaches taking within learning organisations. The usefulness of a 'learning organisation' approach to creating innovation is outlined.

In Chapter 9 the conclusions and recommendations of the project are discussed.

Part 2 contains a number of appendices. The most important one for this project is Appendix 1 entitled a *National Audit of Mental Health Education and Training*. It assesses the current base of mental health education in undergraduate and postgraduate disciplines in universities. The inevitable move towards establishing postgraduate mental health courses (both disciplinary and interdisciplinary) is now at risk because of the abolition or reduction of HECS² based postgraduate courses. This leaves all disciplines (aside from psychiatry) with potential problems of access and participation in specialist mental health education, even if such postgraduate education becomes available.

Other appendices can be noted from the Contents list.

I. Introducing the project

Jan Carter

Introduction

How can the education and training of professionals working in the mental health field meet the needs of service users and their family carers? In the first phase of the National Mental Health Strategy in Australia, 1993 to 1998, this issue emerged as a major challenge facing governments, professional associations, educators and training providers. Ultimately, the quality and effectiveness of mental health services will be judged by their ability to achieve improved outcomes for the users of mental health services. To achieve this, education and training providers and professional bodies will face increased scrutiny, and possibly renewed accountability to the community.

This report will look at a journey of discovery taken by a group of fifty or so people³ with a common interest in the improvement of Australian mental health services through the contribution of education and training to the quality and effectiveness of services. We came from different perspectives: *as former and present users of services (called consumers throughout this report), as carers, government officials, practitioners, managers or academics in psychiatry, as mental health nurses, occupational therapists, psychologists and social workers*. Initially, our coming together was not a matter for general enthusiasm. We had been asked to revive and, if possible, to rehabilitate a subject which had been examined by a previous project, the report of which had been comprehensively rejected by most of the constituent groups mentioned above. The earlier project⁴ had upset almost all, by ignoring the roles of universities and professional associations, the experiences and views of consumers and carers and the different roles of the disciplines. So the repair job implied by the establishment of this project was not greeted with much optimism.

The original project brief⁵ was to bring together key representatives from the disciplines and bodies already outlined above. The aim was to:

- share 'best practice' developments in education, training, continuing education and staff development
- promote curriculum for each professional group
- discover and discuss successful innovations for existing education and training, continuing education and staff development.

The project objectives were refined so that they concentrated on particular targets. These targets were: improving the education and training in five major disciplines practising in mental health services (rather than improving every group in the mental health services); meeting the needs of consumers and carers exposed to severe mental illness, (rather than dealing with every type of emotional or mental condition or disability or their prevention); and outlining the enduring structures needed, that is, identifying the structural and policy 'drivers' for progress.

The extension of the project into policy and structural matters allowed thought about how consumers and carers could improve the process of the project. An early decision was that a critical mass of consumers and carers needed to be involved. The Advisory Committee to the Project⁶ agreed, so there were at least as many consumers and at least as many carers, as there were representatives of any one of the five disciplines. If consumers and carers were to be given a voice in the project, the size of their delegation needed to be adequate. So for this reason six consumers and six carers joined the six psychiatrists, six psychiatric nurses, six psychologists, six occupational therapists and six social workers invited to the initial workshop.

Project method

Essentially the method of the project was consultative and oriented to achieving a consensus through the major activity of workshops.

3. The participants in each workshop are listed at Appendix 2

4. A report by KPMG Consulting, *The National Mental Health Workforce*: was released in December 1994. Its recommendations are reproduced at Appendix 3

5. The background and aims of the project are described at Appendix 4

6. Members of the advisory Committee to the project are listed at the beginning of this report.

The project consultant, (Deakin University's Deakin Human Services Australia) worked with a representative Advisory Committee appointed by the Mental Health Branch of the Commonwealth Department of Health and Family Services. The Committee met six times (four meetings and two teleconferences). The major activities of the Project were nine workshops which consisted of the following: three plenary workshops for the project group as a whole, two for consumers and carers and four for the major disciplines. The workshops were reported separately⁷. There was an audit of all mental health education and training carried out by Australian universities which comprises Appendix 1.

At the workshops, provision of information from outside experts, conference delegates and the consultants was mixed with focus and discussion groups and feed back sessions. The development of a working agreement about the nature and direction of this project was not easy and the first two plenary workshops, the Advisory Committee and one of the consultants spent a great deal of time defining the area of approach.

The priority given to consumer and carer knowledge and opinions was unusual and took some discussion. Aside from the critical mass, the consumers and carers needed time to meet with the project staff to discuss their view of the issues. They developed a 'statement of principle'.

After some debate the following 'statement of principle' was adopted by the workshop.

"The relationships between consumers and service providers and carers and service providers, should be the primary focus in practice and research in mental health. Consumers and carers are therefore major players in the education, training and development of the mental health workforce".

This means that consumers and carers are to be:

- actively involved in policy and planning, development, decision-making, research and evaluation of all mental health services
- adequately resourced and remunerated for work, this being reflected in government policy, mental health budgets, training budgets and any tender specifications for education and training
- actively involved in all aspects of the education and training process, including curriculum development, teaching and learning programs, and accreditation

- encouraged to further develop their 'bodies of knowledge' to provide the basis for mental health disciplines.

Beyond this initial statement of principle, it was agreed by the workshop participants that consumers and carers should define the *guiding principles*, not only of this project but of future education and training in mental health. After an extended process of discovery it was decided that the future test for mental health professionals of the quality and effectiveness of any education and training process would be based on two guiding principles. These stress that mental health professionals:

- need to learn about and value the lived experience of consumers and carers
- recognise and value the healing potential in the relationships between consumers and service providers.

What were the implications of these guiding principles for the workshops? The *beginning point* of understanding mental illness needed to be learning about the experiences of people who are mentally ill and of their carers. Beyond the workshops, an appreciation of these experiences is the beginning point of the processes of assessment, treatment, rehabilitation, prevention and early intervention and needs to be understood by all mental health professionals.

The beginning point then, is not:

- knowledge about the brain and biological views about mental illness; and/or
- psychodynamic theories of causation of mental illness; and/or
- behavioural interventions in mental illness; and/or
- the social factors antecedent to or consequent on mental illness.

Important as these issues are, they are secondary to meeting a person who is or has been mentally ill face to face, in an honest, committed effort to understand this experience. It was agreed that inherent in this meeting is a potential 'healing relationship'.

7. The dates and places of the nine workshops are at Appendix 5. (Membership of the workshops was by invitation).



The two guiding principles outlined above will need to shape the future development of education and training curricula. They have the potential to challenge the current structures of imparting mental illness knowledge, (where knowledge is defined as that imparted by experts in the field). Until now, 'experts' have been defined by their university qualifications and their peers. Relationships between professionals and mentally ill people have often been reduced to summarised data or to abstract generalisations. By contrast, the guiding principles of this project imply that learning about and valuing the lived experience of consumers and carers and recognising and valuing the healing potential of relationships with professionals may reverse the conventional hierarchy of teacher and student⁸.

We looked for other projects which might assist us, or from which we might develop allied methods, but were unable to find a direct equivalent. The origins of this project in the previous KPMG report have been mentioned. We also noted a report from the UK: Pulling Together: The Future Roles and Training of Mental Health Staff, published by The Sainsbury Centre for Mental Health. No one disagreed with The Sainsbury Centre's argument for a strategic approach to the training of the mental health workforce by developing:

- *a common agenda*
- *a community focus*
- *collaborative working*
- *life long learning and sustained performance*
- *a service user and carer perspective*
- *re training for institutional staff*
- *integration of training with the service environment*
- *the skills of managers.*

The problem was how to ground these statements into policy action, organisational reform and professional commitment. The Sainsbury report, like this report, argued for the continuing development of individual disciplines, and for a set of core skills, knowledge and attitudes common to all disciplines. The Sainsbury Report acknowledges the importance of the contribution of mental health consumers and carers.

Another series of reports by the University of Queensland published in 1997 for Queensland Health aimed at developing a professional development strategy for mental health services in Queensland. The consultants produced seven reports, which, in summary, identified core competencies, reviewed training programs and needs, developed a curriculum and a training program, developed learning objectives and presented a delivery strategy.

The Sainsbury and the Queensland projects pointed to the common disciplinary nature of much mental health work. The Sainsbury report's "Core skills, knowledge and attitudes required in mental health services", (reproduced as Appendix 8) and the Queensland project's, "Core competencies for mental health professionals" (reproduced as Appendix 9) were important references. In particular the Queensland project dealt with interdisciplinary commonalities as well as distinctive professional attributes. But neither the Sainsbury nor the Queensland projects were parallel to our purposes. We had decided that consumer and carer input should be central to our process and that assisting the disciplines to map their strengths and examine their weaknesses was important. We also wished to consider the role of organisational and structural variables in professional learning. Whilst we appreciated that the individual professional can make a difference, workplace learning does not take place in a vacuum. Organisational structures and processes impinging on the professional are crucial factors to consider in individual learning and in promoting change in mental health services.

Why the focus on the five disciplines?

The disciplines of mental health: nursing, occupational therapy, psychiatry, psychology and social work, constitute the major professional grouping in mental health practice. Some may wish to dispute this choice so it is reasonable to provide the rationale for the selection of these five disciplines within this project.

The main reason is their size. The five disciplines were selected for the size of their joint representation in direct care services of the Australian mental

8. Professor John Cawte in his 1998 biography *The Last of the Lunatics* reports turning up at Hillcrest Hospital, South Australia to look for medical records from his former receiving house Enfield Hospital which had been closed. The records related to his work in the 1950s. Some indicative quotations are:

"'I've heard why you're here', greeted Dr James, shaking my hand. 'You're wondering about the fate of the medical records from Enfield Hospital.'"

'Those patients were my teachers', I replied, a little self-consciously. ... 'They were the only teachers', ... in those days' (Cawte 1998, p.14).



health workforce. Together these disciplines comprise at least three quarters of all direct care staff⁹ in the mental health workforce and about 60% of the total workforce. Second, on grounds of history and tradition, the disciplinary groups discussed in this report are assumed to have had a long term stake in mental health education and training and the subsequent practice of their members. If this assumption is correct, the national audit reported in Appendix 1 suggests that the educational, economic and professional processes which have impelled each discipline towards providing 'generic' university undergraduate education, to student nurses, occupational therapists, psychologists and social workers, may have produced unintended losses of specialist mental illness knowledge and skills. One example is nursing, where generic undergraduate education has displaced hospital based specialist training, leaving nurses who wish to undertake specialist mental health education to complete 'user pays' specialist mental health graduate courses. Similar but not identical processes have occurred in psychology and social work. The combination of user pays university education and the absence of remunerated, supervised training posts is clearly a huge handicap for development in mental health practice¹⁰.

There are other groups delivering direct care to consumers and carers in mental health whose training needs need to be considered. Some of these are smaller professional groups (such as speech pathology in child and family mental health or physiotherapy in aged mental health). In addition there are personal care staff who do not have a disciplinary affiliation, working in the disability support area who are briefly discussed at Attachment A1.

Notes:

1. As well as 539 consultant psychiatrists, there were 587 psychiatric registrars and 339 other medical officers employed in specialist mental health services in Australia.
2. In addition to 8406 registered nurses there are 1373 non registered nurses employed in mental health services.

Table 2.1 Discipline x full time equivalent professional staff x state and territory as employed in specialist mental health services, 1996-7

State Territory	Consultant Psychiatrists	Registered Nurses	Occupational Therapists	Social Workers	Psychologists	Total
NSW	185	2815	138	214	312	3664
Vic	155	2309	133	212	189	2998
Qld	97	1354	86	142	158	1837
ACT	9	114	3	23	14	163
WA	67	957	89	109	88	1310
SA	62	789	43	126	64	1084
Tas	13	244	6	29	26	318
NT	6	84	1	5	13	109
Total	594	8666	499	860	864	11,483

Source: National Mental Health Report 1997. Commonwealth Department of Health and Aged Care (1998, p147, Table A-28)

9. This figure could be regarded by some as an under estimate since it does not contain psychiatric registrars and non psychiatric qualified medical officers - see Table 2.1.

10. This report does not propose to discuss whether or not any or all of the five disciplines can be considered a 'profession'. It notes the discussion in Professional Education and Credentialism, the Higher Education Council (HEC 1996, Chapter 1) which reports the membership criteria of the Australian Council of Professions Ltd. This recognises as professions organisations which:

- represent a single body nationally
- have a specialist knowledge and service orientation
- have a code of ethics
- require life long professional development, and
- differentiated levels of membership.



The largest workforce by far is the nursing workforce. If psychiatric registrars are amalgamated with psychiatrists, psychiatry is the second largest group. Social workers and psychologists have variable employment patterns state by state but are nationally similar sized groups. Occupational therapists are the smallest group.

In discussing the position of the five disciplines, it also needs to be noted that there are two other important groups of staff in the mental health workforce, whose training needs are fundamental to quality in services delivery. These are large groups of administrative and clerical staff and domestic and related staff. Other studies (Carter, 1981) have emphasised the importance of training and support for such groups - the domestic staff are often the first and most frequent points of contact for consumers and carers, particularly in institutional or residential settings¹¹.

Overall, in 1995-6 the largest group of staff (8553) are employed in inpatient services, the second largest group (4923) in ambulatory settings, and the smallest group in residential settings (949). The expanding areas of activity are the ambulatory and residential areas, whilst over the past three years there has been a small decrease in the numbers of staff employed in inpatient units. This gives some indication of the types of work venues that must be considered in meeting education and training needs, a matter discussed in Chapter 8.

Project participation

The execution and completion of this project was only possible because of the substantial commitment of a group of people in the mental health workforce and universities who were committed to the changes of direction the report will outline. Complex changes, especially those involving disciplinary traditions and workforce culture, take a great deal of time and it is easy to forget the considerable amount of change which has taken place since the project was first mooted.

Change is a continuous process. At one point in time, the emphasis may be on the need for change in administration and structure, to assist in the reform of work practices which will in turn help to shape attitudes and behaviour. At another point in time, the starting point may be attitudes and behaviour and the need for individuals to take

responsibility in promoting change in work practices.

Because the starting point of this report was education and training and the end point was the question of how this might achieve better outcomes for service delivery for consumers and carers, both ends of the continuum needed to be considered: the structures and administration of services and the attitudes and behaviour of individuals. Chapters 2 and 8 will discuss the themes which developed during the project to encompass this range of matters.

The project participants endorsed this dual approach to consideration of the issues and as the project moved on, began to look at these issues as they applied to individual disciplines.

There was some discussion about the extent of the brief of this project, as some participants felt that the brief was too narrow and should encompass promotion, prevention and early intervention. It was decided that the remit of this project should be around education and training for people working (or intending to work) with people with severe mental illness, but that the activity of this project might provide a template to apply to a further project on prevention and early intervention.

This project proceeded concurrently with the Joint Consultative Committee research project on the education and training needs of general practitioners in primary care psychiatry. For this reason, general practice was not included as one of the key disciplines, although a general practitioner representative was present at Workshops 1 and 2.

Reading this report

Whilst some readers will wish to read this report from cover to cover most will not. Because the chapters represent contributions from a dozen or so people, there is some repetition of facts in chapters which allows chapters 3, 4, 6, 7 and 8 to be used as stand alone chapters for particular audiences. Attachment A1 will also be useful for this purpose.

Nevertheless there is a progression within the report and it is suggested that at the minimum, readers look at:

11. The inverse relationship between the length of education of a staff member and the amount and frequency of time spent with patients has been noted, with the most highly qualified staff having least frequent and fewest contacts and the least qualified staff the most frequent and most lengthy contacts. Of all disciplines in public services, medicine/psychiatry had the least contacts with patients least often. For this reason it has been termed a 'hit and run' profession (Bentovim 1974).



- Chapter 2 - about the themes of the project
- Chapter 3 - about the contribution of consumers to mental health education and training
- Chapter 4 - which outlines the issues and contributions of carers
- Chapter 6 - which discusses what all disciplines have in common
- Chapter 7 - which outlines the educational perspective of the report
- Chapter 9 - which draws the themes of the report together.

Beyond that, readers will approach the report for specialist interests, particularly in relation to the sections about individual disciplines in chapter 5, which deals with the issues brought up by the project for each of the disciplines as follows:

- 5.1 Mental Health Nursing
- 5.2 Occupational Therapy
- 5.3 Psychiatry
- 5.4 Psychology
- 5.5 Social Work.

Because we think that some readers will wish to make the material about their individual discipline more widely known, there is a certain amount of repetition of fact and details about process between each section in chapter 5 which readers of the report as a whole will need to tolerate.

Chapter 8 deals with education and training in the workplace and will be of particular interest to state governments.

Finally, a note about the use of terms. Most of the terms used in this project are defined in the glossary, but it needs to be mentioned that in this report the term 'education' is used for the learning process of the universities while 'training' is adopted for work based activity sponsored by employers, such as state governments and local health authorities.

The generic term 'mental health services' has been used to describe 'services for people with mental illness', even though some might argue that this is inexact. In general, this report discusses education and training for working with severe mental illness, but the model which has been developed has wider application.

References

- Deakin Human Services Australia 1997, *National Mental Health Education and Training workshops: Report to Commonwealth Department of Health and Family Services on Workshop One*, 11th - 12th February 1997. (unpublished report prepared for Commonwealth Department of Health and Family Services, Mental Health Branch).
- op cit *Workshop Two*, 22nd - 24th June 1997. (unpublished report prepared for Commonwealth Department of Health and Family Services, Mental Health Branch).
- op cit *Workshop Three*, 12th - 13th February 1998. (unpublished report prepared for Commonwealth Department of Health and Family Services, Mental Health Branch).
- op cit *Final Report on the discipline specific focus group workshops*, October and November 1997. (unpublished report prepared for Commonwealth Department of Health and Family Services, Mental Health Branch).
- KPMG Consulting 1994, *National Mental Health Workforce Education and Training Consultancy Report*. (unpublished report).
- The Sainsbury Centre for Mental Health 1997, *Pulling Together: The Future Roles and Training of Mental Health Staff*. The Sainsbury Centre for Mental Health UK.
- University of Queensland 1997, *Professional Development Strategy for Mental Health Services*.
- Report 1: Executive Summary*
- Report 2: Competency Standards*
- Report 3: Existing Training Programs and Training Needs Analysis*
- Report 4: Curriculum*
- Report 5: Training Programs*
- Report 6: Summary of Training Programs*
- Report 7: Delivery of Strategy*
- Produced for the Mental Health Unit, Queensland Health by The University of Queensland Department of Psychiatry and School of Psychology (unpublished reports).



2. Themes and issues

Jan Carter

The themes of this project emerged during the process and at different stages. The order in which they emerged were, as follows:

- the priority of consumer and carer partnerships
- the advancement of the disciplines and their relationship with higher education
- the search for quality and effectiveness in service delivery in the Second National Mental Health Plan
- the importance of a learning strategy and learning organisation in mental health education and training networks.

All these issues are connected and will be discussed in turn.

The priority of consumer and carer partnerships

First, who are the consumers? In this report consumers are persons suffering from severe mental illness who use services funded by revenue, whether in the public or private sector. A recent study provides us with a profile of Australian mental health services consumers. (Mental Health Classification and Service Costs Project reported in National Mental Health Report, 1996, p.91). Half are in the age groups 20-50 years, over half have never married, and two thirds receive social security pensions or allowances, which probably means that two thirds live beneath the poverty line¹². Schizophrenia and related psychoses, and mood disorders account for approximately two thirds of those treated in both community and hospital. The majority of people with a mental illness now live in the community most of their time.

Their carers may be parents, partners, children, siblings, friends or co tenants. Chapter 4 comments that the proportion of people with a mental illness living with parents is high - unrepresenta-

tive small studies suggest a range from 25 to 63 percent. Unfortunately, there is no national data base on carers of relatives with mental illness. Most epidemiological studies deal with caring as a generic issue, across a range of illnesses, disabilities and handicaps. The most recent study (Schofield et al 1998) is a survey of 26,000 Victorian households, with interviews with 1,000 carers. It found that: *“Carers as a group reported poorer health and wellbeing than non carers. Yet, most expressed satisfaction with their life and with the support and recognition they got from family and friends ... Parents and spouses tended to be more positively involved in care giving than adult offspring ... More parents than spouses or adult offspring were caring for those with predominantly mental disabilities and associated behaviour problems, which was more stressful than caring for a person who was physically disabled only”* (Schofield et al 1998, p.225).

What was the significance of the consumer and carer participation in the project? Several issues coalesced to make this matter one of central importance. As part of the reconstruction of health and community services, governments now require that service providers demonstrate value for money. Services need to achieve measurable outcomes which demonstrably assist the clients of services. Thus mental health services will be called on increasingly to demonstrate that they meet client needs and improve their status, and funding allocations will be based on achieving this outcome.

It can be demonstrated incontrovertibly that in the past, individuals with mental illness have been denied voices in the policy planning and operation of mental health services. Whilst this has applied across the board to many groups other than the mentally ill, in their case, the denial of a voice has been strengthened precisely because of the perceived nature of mental illness as a ‘master’ identity which has smothered any other individual identity. The painful and sometimes cruel history of the treatment of people with mental illness makes it clear that their exclusion has occurred precisely because of their mental illness. In far too many cases, mental illness still constitutes a stigma which serves to silence those who suffer from it.

A recent book, *A Social History of Madness* by the historian Roy Porter (1996) argues that the

¹². As this study did not collect information about housing type (eg private rental, public rental, home ownership) no assumptions can be made about housing costs which is an important factor in measuring economic poverty.



history of psychiatry is frequently written as 'good' versus 'bad' psychiatrists, but that the real protagonists are doctors and patients and the real subject "the complex range of their encounters" (p.231). He demonstrates that the system of segregation served to silence those with mental illness or to render their voices inaudible to most and unintelligible to others. Given these assumptions, whatever people with mental illness have said, in particular about their treatment and services, has been able to be discounted.

The consequence is that not only have consumers been silenced on the subject of their mental illness, but on all other subjects as well. So for all the consumers in this project, there had been the past experience of the denial of their rights to participate in treatment decisions and frequently, the denial of many other human rights (the civil, social and economic) taken for granted by the population at large. The deficits in service and the consequent gaps in meeting needs and betrayal of the human rights of individuals who are mentally ill have been documented in the report *Human Rights and Mental Illness* by the Human Rights and Equal Opportunity Commission, (HREOC 1993).

It is not only the uninformed or uninitiated with negative views of mental illness. It can be demonstrated by case study and quantitative research that the groups with the most adverse attitudes to those with mental illness are not those who are most ignorant about mental illness, but their treating staff, those who 'gatekeep' the facilities and services dealing with mental illness (Small et al 1998). Thus those professionals who work with the mentally ill and those who educate the professionals have maintained the social and psychological 'distance' between staff and patients as one of the defining features of the dominance of professionals (Conrad and Schneider 1992).

Nor can humiliating procedures and adverse stereotypes on the part of professionals dealing with mental illness be regarded as irrelevant past history (Goffman 1968). A reader searching for up to date case studies may like to read the story of 35 year old Cindy Bennett, admitted to an Australian teaching hospital with bipolar disorder in 1997. "I needed to go somewhere for a rest ... suffice it to say it was the most dehumanising experience of my life. I realised very quickly I had led a rather charmed life and comparatively I did not have a clue what discrimination was. I do now" (Bennett, 1998, p31).

At the same time it is important to note that stigma is not just restricted to consumers. The sociological literature discusses people with mental ill-

ness as stigmatised and those close to them as suffering from a 'courtesy' stigma (Goffman 1961). This could be applied to the group who are carers and to professionals in mental health who are also subjected to stigma from all other areas of the health sector and the wider community.

The carers and consumers in this project had many issues and perspectives in common: denial of access to information, blame for causation of mental illness, and relegation of their views and opinions to the periphery, or to oblivion. It cannot always be assumed however that consumers and carers will have the same or even similar standpoints; chapter 3 (by consumers) and chapter 4 (by carers) discuss some of the legitimate differences in perspective between these two groups.

All carers in this project considered that their first hand observation and experience of living with mental illness had been ignored or undervalued by professionals and educators. For carers, the reorganisation of services for mentally ill people away from institutional care and into 'community' care has brought with it extreme pressures. Deinstitutionalisation, the slow or non existent development of essential community services of rehabilitation, housing, employment and community support have required many relatives and friends of the mentally ill to volunteer to fill the service gaps.

There are other reasons for listening to consumer and carer voices. First is the measurement of equivocal satisfaction with services received, documented in Australian research in mental health services. In most general health satisfaction surveys most consumers and carers say they are satisfied most of the time, but the expression of 'satisfaction' in Australian mental health satisfaction surveys *is well below the norms for this particular type of measure*. Clearly this is unacceptable. Examples are Thomas (1996) and Quadrant Research (1997). Thomas (1996) says of consumers and carers surveyed in Victoria: "The consumers and carers have expressed the same sets of concerns about aspects of the service with which they were provided. A common theme is dissatisfaction with involvement in decision making and the scope of information about the condition, medication and prognosis for the consumer ... ratings from both consumers and carers are considerably more negative than those elicited from consumers of other health services such as acute hospital or general practitioner services. On the other hand, it can still be said that the clear majority of consumers and carers *are satisfied with their experiences outside the hospital services within the public mental health system*" (Thomas 1996, p.19).



Second, exploration of the human rights of those who are or have suffered from mental illness, makes it apparent that in the first place, people with mental illness are primarily citizens, with full citizenship and social rights (HREOC 1993). Acceptance of this tenet means that the disciplines working in mental health are now obliged to meet not only the professionally defined *needs* of a person with mental illness but also to recognise their inherent civil, political and social *rights*.

There is a conflict between the achievement of full human rights for persons who are mentally ill and their needs for special services. Certainly it is common to find that both are promoted together: the right to be treated 'normally' as well as the need for special services and special treatment. *The Declaration of the Rights of Disabled People* (1975) by the United Nations says of disabled people: "...whatever the origin, nature and seriousness of their handicap and disabilities ... have the same fundamental rights as their fellow citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible" (para 3).

The rights of disabled people to civil and political liberties, to medical care, to education and training, to a decent level of living, to a 'normal' living environment, within a family of choice, to participation in social and recreational facilities, and to protection from exploitation, abuse or degradation are specified, and disabled people are to have access to the rights - 'general' rights of every adult. Yet at the same time, the contradiction is that those who argue for 'general' rights also wish to promote 'special' rights for disabled people, such as special protection (the rights not to be abused, degraded or exploited), the claims to special services and treatment which enable them to enjoy access to the general rights listed above. The argument for 'rights' is complex because it involves the provision of special treatment and protection in order to be 'normal' and thereby to make proper use of general rights. One of the key difficulties for those who wish to promote reforms is to achieve a balance, or ratio between these two aspects of rights, the general and the special. Pursuing the general right of 'normality' offers authorities the opportunity to defer the implementation of 'special' rights to special services that require extra levels of spending. The argument then, for human rights is complex. It requires 'special' rights to go in tandem with 'general' rights. The policy issue is what balance of either is appropriate at a given time. The pursuit of general rights is likely to be at the expense of special rights and vice versa. This leads either to an over development of special services and a lack of political and civil rights, or to a

consensus about political rights, but an absence of the special services required as means to the end of achieving full citizenship (Carter, 1988, pages 141-143). But for Australian policy the key issue is that the Disability Services Act (1986) states that people with disabilities should receive the services necessary to achieve their maximum potential as members in the community.

Third, the future burden of mental illness, especially depression, suggests that the global, national and local burden of mental illness is likely to increase beyond the millennium. According to Desjarlais, Eisenberg et al:

"In Western Europe and North America, there is a downside to the remarkable improvements in the measures of daily survival and societal function. Along with the increase in life expectancy has come an increase in depression, schizophrenia, dementia, and other forms of chronic mental illness, primarily because more people are living into the age of risk. Along with economic growth and various social transformations have come a marked increase in rates of alcoholism, drug abuse, and suicide. And while there has been declining maternal mortality, the incidence of violence against women, young and old, has increased sharply. ... Mental, behavioural, and social health problems are an increasing part of the health burden on all parts of the globe (Desjarlais, Eisenberg et al 1995)".

This implies that people with mental illness, especially depression, and psychiatric disability will suffer from health morbidity. There are pragmatic arguments for governments and communities to seek to foster partnerships with people with mental illness and their carers, that aim to direct precisely targeted resources to their needs and to endorse their basic social rights to income, shelter, employment, education and health.

These three arguments for the centrality of consumer and carer contributions to mental health services are based on efficiency, equality and the pragmatics of population epidemiology. They give rise to the final argument, the political. By their very nature, established providers, both in education and services are slow to change. Universities and professional associations are by nature and history, relatively conservative institutions, inward looking, often rewarding tradition and hierarchy and resisting change and innovation. In such environments, a countervailing influence can be a useful lever by which to support change. In this project, it was clear that consumers and carers across the board had more invested in and were more supportive of major changes to mental health services than all the professional associations and all the staff of universities. Thus promoting contributions, activity and reflection from a critical mass of consumers and carers, and seeking their assistance as prime movers of change, was a policy response

indicating a desire for change. Our pacesetters were consumers and carers¹³. Our professional associations and university staff were asked to respond. At times then during the project consumers and carers became the project educators.

These observations make it clear that the project sought to move beyond mere tokenism to forms of involvement that provided a consumer and carer partnership in shared decision making. Adapting Arnstein to our task, suggested the following framework (Arnstein 1969, Carter 1981). We sought to maximise the 'degrees of power' of consumers and carers. We agreed this should be sited at level 6 on the diagram below.

be ranked on it. Thirty-four percent of providers have no form of involvement for carers and consumers. There is still a long way to go.

The reform of the disciplines and their influence in higher education

Second, as well as considering relationships between consumers and carers, the roles and relationships of two sets of bodies, the universities and professional associations need to be considered.

Figure 2.1 Ladder of participation for consumers and care

Level	Type of Participation	Meaning
8	■ Consumer/carer control	
7	■ Delegated power to consumer/carer	Degrees of power
6	■ Professional/consumer/carer partnership	
5	■ Consumer/carer placation	
4	■ Consumer/carer consultation	Degrees of participation
3	■ Consumer/carer provision	
2	■ Consumer/carer therapy groups	Degrees of non-participation
1	■ Consumer/carer manipulation	

(Adapted from Arnstein 1969 and Carter 1981)

The National Survey of Mental Health Services 1995-1996 asked local mental health providers to describe their arrangements for consumer and carer involvement in local service planning and delivery. Nearly two thirds of providers have some form of formal mechanism in place for participation. One third of organisations now have consumers and carers with formal roles: for example a position on a management committee or a specific consumer/carer group to advise on service delivery. This form of involvement ranged from all organisations surveyed in Tasmania in 1996 to fifteen percent of organisations surveyed in Victoria. From the data however, there is no way of ascertaining the strength of this representation or judging whether it is tokenistic (Commonwealth Department of Health and Family Services and Australian Institute of Health and Welfare 1998, p.90). Whilst this evidence is an advance on Cawte's description of the 1950s, when judged against Arnstein's ladder we could say that only sixty-six percent of service providers could even

These relationships are elusive and often ignored. As the KPMG report (KPMG 1994) demonstrates, employers and governments have not understood their importance and as a result there has been a tendency to fail to notice the web of relationships, structures and symbols that underpin relations between universities and the professional associations. This project sought and received the cooperation of the professional associations, but did not reach the stage of engaging the universities or their peak bodies in formal negotiations.

The five professional disciplines in mental health had a part to play in strengthening their commitment to reform. The adoption of the KPMG report (KPMG 1994) on the vocationally based Training Reform Agenda and its competency-based performance indicators had suggested to senior mental health professionals that their professional base was being discounted and that a generic mental health worker was being favoured as the basis of the future mental health workforce. The early

13. Consumer and family carers were paid for their participation in this project

parts of this project focused on dispensing with this view and involving each professional discipline in the exercise. The approach adopted was far from supplanting the disciplines by introducing a generic mental health worker. Rather it strengthened the disciplines by seeking their cooperation on the reform of education and training for professionals. The involvement of each of the professional bodies was enlisted. The focus on the five disciplines was controversial. It left gaps, such as the emerging psychiatric disability sector, which was represented but not involved in the disciplinary workshops. But the earlier KPMG report on Education and Training (1994) ignored the disciplines and their professional bodies, their central roles in accrediting education and training and the professional development of their members. For this reason a focus on the five disciplines in this project was justified and the professions were asked to consider developments in the emerging psychiatric disability sector in *Training for the Psychiatric Disability Sector: A Report to the Social and Community Industry Training Board* (November 1994) and the ANTA sponsored *Mental Health Work Competency Standards Draft* (1 May 1997) produced by the Community Services and Health Training Board.

The disciplines were asked to reconsider their roles in the fields of severe mental illness. Underlying the involvement of the five disciplines was an educa-

tional debate about learning, education and the meaning of 'competence' and 'competencies'. Figure 2.2 points to the competing paradigms of education and training discussed in the workshops.

Neither paradigm above in its pure form seemed to be entirely relevant and the task of this project became that of finding a model appropriate for mental health education and training. For example, in general the disciplines, with the possible exception of nursing, have sought to achieve 'competence' in their graduates rather than specific, measurable 'competencies'. In general, higher education (the universities) have focused on inculcating 'attitudes' and 'knowledge' ahead of 'skills' training which traditionally have been seen as the province and responsibility of the employer. But even within this general formulation, there were marked differences between disciplines within the mental health field as to whose responsibility it is to teach skills. In every case the disciplines accepted some responsibility at least for the skills (competencies) of their members.

In general, we sought to resolve the gulf implied in Figure 1.2 between the 'education and training' dichotomy or the 'knowledge and skills' dichotomy by involving the professional associations as 'mediating structures' between the universities and employers. As will be discussed all the disciplines (albeit in different modes) have an explicit interest in the performance of their members. A recent

Figure 1.2 Competing paradigms

Key Issues	Education Model	Training Model
Orientation	Knowledge	Skills
Key strengths	Thinking, problem solving	Action, doing
Key institutions	Universities	VET, TAFE
Regulatory institutions	Professional associations	Industry Training Boards
Domains	The professions (& semi professions)	Sub professional and trade occupations
Key values	Autonomy, high levels of discretion	Compliance; low or no discretion
Desired attributes	Judgement, wisdom	Best task performance
Teaching framework	Holistic and contextual	Mechanistic
Ideal output	The 'reflective practitioner'	Competency standards
Ideal outcome	Competence	Specific measurable competencies
Educational emphasis	Changing the person (beliefs, attitudes)	Changing the performance
Key institutional 'guardians'	Autonomous universities	National (Industry) Training Boards
Goals	Advancement of society	Advancement of the market
Traditional drivers	Sense of vocational mission	Industrial efficiency
Theories	Humanism, theories of Social Capital	Management, theories of Human Capital
Targets	Clients	Customers
Weak points	Status, prestige, power drives, social distance from users	Built in obsolescence

examination of the connections between the professional bodies and universities pointed to very complex and varied patterns (HEC 1996). A recent report by *The Higher Education Council, Professional Education and Credentialism* (HEC 1996) notes:

“The Council concluded that the relationships between the universities and the professional bodies are very complex and vary significantly between professional fields. The relationships over regulation and accreditation of courses is influenced by industry requirements, student demands, government policy, the regulatory environment, and globalisation.

Professional organisations are heavily involved in university course approvals and review, teaching and assessment but in spite of a history of concerns raised by universities over the intrusiveness of the professions the Council found little evidence at present of this or of unreasonable demands which might impact on institutional autonomy. The Council considers that this change may be related to the comprehensive adoption of quality assurance processes in the sector during the last three years which has resulted in a greater involvement of all stakeholders in course design and review. Nevertheless, it appears to the Council that there should be greater involvement of consumers of the educational services along with the professional bodies in the processes of approvals, accreditation and registration of graduates from professional courses.

The Council has also examined the nature of accreditation processes used in the various professions, and has concluded that the academic quality of professional education university courses is primarily secured by the internal quality assurance processes of the universities. However alignment of outputs from the courses with the requirements of professional practice both in Australia and increasingly overseas is of critical importance and can best be achieved by external accreditation processes. Such accreditors should wherever practicable recognise internal quality assurance processes and should be focussed on required outputs rather than the detailed manner in which outputs are achieved” (HEC 1996 pxi).

Within this project, the following complex patterns of relations between universities and professional bodies were noted:

- Universities have arrangements with most professional associations concerning the accreditation of courses or individuals for entry levels of practice, but no necessary responsibility for improved practice outcomes.
- Some disciplines have both professional associations and state based registration bodies.
- Professional associations accredit courses and/or individuals entering mental health practice but may have no mandated responsibility for improved practice outcomes.

- Professional associations can also act as education providers and can encourage or mandate continuing professional development through a points accrual system.

- Some former employer bodies (State Government Health Departments) have become service purchasers and have outsourced or abandoned their former state-wide training capabilities. During the project the professional associations were asked to focus on the following, using the guiding principles as driving forces:

- specifying a national curriculum for mental health education and training for that discipline (A national curriculum should encompass attitudes, knowledge and skills for practice in a multidisciplinary workforce, within mainstreamed, integrated, comprehensive, intersectoral and consumer focused services.)
- ways of developing educational preparation of the ‘competent’ and ‘reflective’ practitioner (It was agreed that improvement in mental health education would not be furthered by competency-based skills training alone.)
- achieving close contact with the mental health sector
- consideration of the roles of other stakeholders (such as universities and employers).

It was considered that a ‘safe’ practitioner (that is, one secure in his or her disciplinary identity) in each profession, must be developed before that practitioner could contribute to an interdisciplinary team. Introduction too early of interdisciplinary modes of providing care can lead to an identity confusion in a practitioner who has not formed a clear view of the science, the mores, contributions and limitations of his/her chosen discipline.

The future participation of consumers and carers in the planning, development and delivery of services will also require structures and processes for communication between consumers and carers, professional associations, universities and employers. In this project we sought to achieve a common culture and shared understanding between professionals and consumers and carers. Each discipline group had a consumer and a carer as a mentor in the latter part of the project. It was agreed that this had a great deal to do with the general agreements emerging from the project. A review of the rela-

tionship between universities and professional associations was undertaken by the Higher Education Council (1996). The terms of reference for this report were confirmed by the then Minister, the Hon. Senator Amanda Vanstone in May 1996, and were as follows.

- to examine the role of professional associations in curriculum design and content and the accreditation of graduates
- to review the relationship between higher education study and entry to the professions, including an examination of the equity between the streams of entry into the various professions and the extent of public subsidy
- to examine the issue of fees for postgraduate courses for professional entry and practice.

The report found that:

- There is a considerable amount of contact between universities and professional associations.

- Both professional associations and universities see themselves as autonomous bodies, with a sense of service to the community, (although the nature and form of this is still not highly specified).

- Professional associations either have a legislative mandate or formal practices which protect standards of entry to the profession. Whether or not graduates are required to be legally registered (as in medicine, nursing and psychology) does not affect the professions' capacity to regulate courses (as in social work). Unregulated professions can still set their own entry criteria and practice standards.

- Professional associations play a gatekeeper role to professional practice, by participating in course accreditation processes. Examples of these processes are outlined in the following table.

Table 2.1 Professional fields by registration and accreditation status¹⁴

Professional Fields	Registration and Accreditation Status
1. Medicine and Psychology	The profession is registered by law. There is an external accreditation process.
2. Nursing	The profession is registered. There is no external accreditation process.
3. Social Work ¹⁵	The profession is not registered. There is an external accreditation process.
4. Occupational Therapy	The profession is not registered. There is no external accreditation process for courses but a process of accreditation for defining membership of the association.

(Adapted from HEC 1996)

14. Where there are course accreditation processes (as in medicine and social work) the professional body gives universities guidelines. In medicine these include knowledge and skills which need to be acquired. In social work these are specifications about curriculum inputs and practicum length and status.

15. The HEC report (1996) makes an error about social work accreditation of courses. The Australian Association of Social Workers accredits courses by appointing panels to review courses every five years according to specified criteria.

■ The professional bodies also play a part in many university course reviews and approvals, on Advisory Committees and in curriculum design. Table 2.2 outlines these activities as represented by the HEC report (1996).

ness education in undergraduate courses because of overcrowded curricula and resource shortages. If such education and professional development is to be conducted at the postgraduate level, this raises major 'who pays' problems.

Table 2.2 Nature of involvement of professional organisations in academic activities for selected professions by type of activity ¹⁶

Profession	Adv. Cttee	Approvals	Course Review	Curric Design	Tchg Lect, Tute, Prac	Tchg Place-ments	Assessment	Exam boards	Influence on quotas
Medicine	✓	✓	✓	✓	✓		✓	✓	✓
Nursing	✓		✓	✓		✓		✓	✓
Psychology	✓	✓	✓	✓		✓*			✓
Social Work	✓		✓	✓	✓	✓	✓	✓	✓

Source: Adapted from HEC 1996, p.22, Table 3.2

Relationships between universities and professional associations can be linear, (that is exclusive to the professional associations and university); triangular (including employers); or *strategic* (where all stakeholders - government, employers, unions and professional associations - join with universities in discussion about curriculum and standards of education and training). It was not the purpose of this project to study industry models of collaboration between the universities and professional bodies, but in the case of mental health education no strategic relations (where all stakeholders discuss educational curriculum issues) exist. This is an important issue which will be discussed in chapter 7.

"Who pays" for professional education and professional development is also an issue of considerable importance to this report. Commonwealth support for course work (although not research) degrees at postgraduate level is being phased out. If postgraduate study by coursework is 'user pays', it remains to be seen whether this may reduce rather than expand postgraduate enrolments. It is also likely to impact adversely on the accessibility of postgraduate courses to persons of financial or other disadvantage (such as many consumers and carers). At present psychology is the only discipline which mandates a postgraduate course as a qualification. However, as will be shown, basic (undergraduate) courses in nursing, social work and occupational therapy insufficiently prepare entrants for mental health practice, so the future cost of postgraduate education is of interest to all disciplines.

It is evident from the discussion in Chapter 7 that universities face difficulties in providing mental ill-

The National Mental Health Strategy: the search for quality and effectiveness

The third theme of the report relates to the outcome of education and training - practitioners who practise with quality and effectiveness. This project straddled the First (1992) and Second National Mental Health Plans (1998) and was intersected by the release of National Standards for Mental Health Services (1996). It is evident in the Second National Mental Health Plan (1998) and the National Standards for Mental Health Services (1996) that the role of educators and trainers in mental health will need to be central to future reform. As discussed, the three key institutions which affect practice in mental health - the universities, the professional associations and the major employers and/or purchasers - needed to be involved. As already outlined, these bodies in different ways for different disciplines have shaped, influenced or even controlled the entry to and continuation of practice.

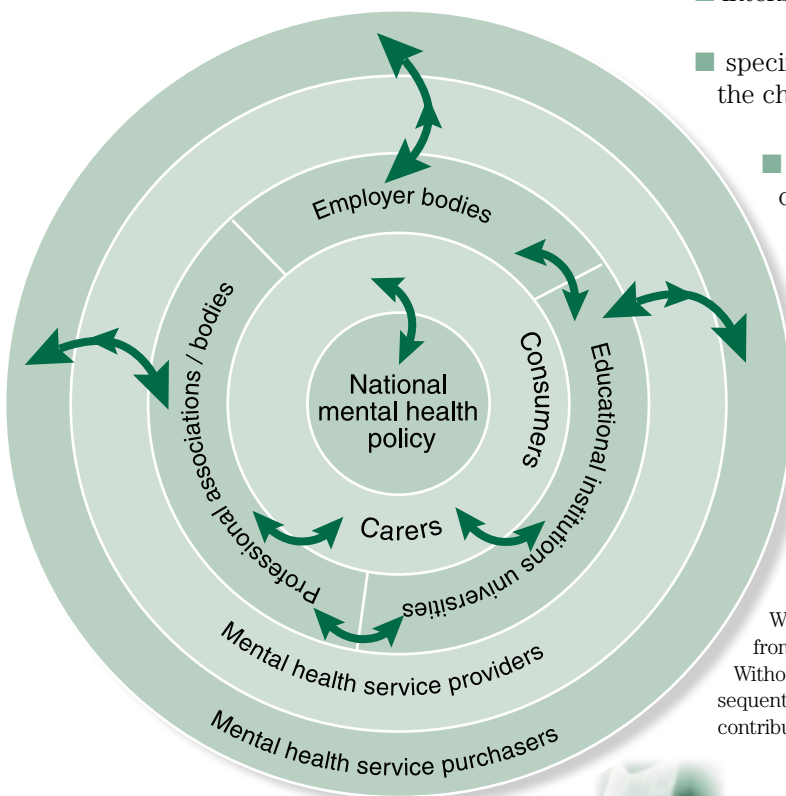
The Second Mental Health Plan identifies *quality and effectiveness* as priority areas in achieving improved consumer outcomes in mental health services. Attention to quality and effectiveness means focussing on education and training. Strategies for achieving quality in mental health services will include the following matters, all of which need to be reflected in the curricula of all professional disciplines:

¹⁶ The HEC study omits occupational therapy.

- the accreditation of mental health services according to their implementation of national service standards
- the preparation of clinical standards through clinical practice guidelines
- the benchmarking of services by the identification of models of best practice, including for people with special needs and indigenous people
- the use of evidence-based practice techniques
- the development of measures of effectiveness. (Australian Health Ministers 1998).

If these matters are 'inputs' to be reflected in all disciplinary curricula at all levels, under guidance from consumers and carers, what processes and structures are needed to bring stakeholders together? Traditionally there has been little contact between universities, professional associations, service providers, government and consumers and carers. Yet all these parties are essential to considering the future of education and training. Throughout this report the parties involved in influencing mental health will be considered as a network. Figure 2.3 outlines the relationships between these parties.

Figure 2.3 Education and training in mental health services



Mental health education and training learning organisations

In commercial organisations, a learning organisation is being recommended as a way of fostering innovation. Learning organisations not only respond to change, but also through reflection on current processes, actively seek change and innovation. It has been long noted that people in organisations tend to interpret events in a way which justifies or supports their own ideas, or promotes their own interests and success (Brewer 1995, p.88). People react differently for the following reasons to organisational change:

- fundamental predisposed feelings about change of any kind
- ambiguity of goals
- feelings of personal insecurity
- prevailing cultural beliefs and behavioural norms that might conflict with a change
- the extent of trust in management, union or work group
- historical events relevant to the change
- intensity of threat inherent in the change
- specific apprehensions and expectations about the change
- the manner in which the change is introduced and implemented. (Brewer 1995, pp.87-8).

The idea of the learning organisation illuminates the experiences of this project. Learning organisations emphasise the importance of joint reflection on activities or events, and developing a shared understanding and interpretation of impacts and significance of events and behaviour. Brewer expresses this as follows:

Without a process of joint reflection, insights gained from the action and reflection are not fully realised. Without joint reflection, management and employees consequently repeat mistakes and fail to perceive the factors contributing to the changing context (Brewer 1995, p.88).

The question arises: can partnerships between the parties to mental health education and training be built and sustained around learning?

Traditionally, as discussed, universities and professional associations have developed working relationships, but people with mental illness have had little to do with government policy until recently and even less to do with the universities and professional associations. We noted earlier that education and training projects generally ignored the universities and professional associations; both sets of bodies have exhibited a well understood aversion to interference in their affairs. Then again, the professional associations and employers have over the years often had fractious relationships. During the project, we needed a way to bring all the participants together. The method which evolved was that of 'learning groups' which combined together to become a learning organisation.

Although members of the project had been selected for their capacity to contribute to the project, the reverse was also true; all contributors became learners. We became a recognisable group, bound by a common goal. The 'symbolic cement' (Strauss 1966, p.109) which metaphorically held us together was, vaguely, 'reform' and 'change', framed as a common desire to see improvements in mental health service delivery. On that point at least we all agreed. Naturally, this goal disguised a great deal of disagreement and difference of purpose, so it was surprising that all were able to agree to the basic tenet: if consumer and carer needs were to become central, all disciplines needed to 'learn' how to implement this in their action plans. Some of the learnings of the project were painful for particular disciplines. All disciplines were aware of the encroachment of others on their territory. At other times, consumers and carers felt undervalued or ignored. But the common bond created by the workshops generated reciprocal learning.

As Senge (1992) says:

"Real learning gets to the heart of what it means to be human. Through learning we re-create ourselves. Through learning we become able to do something we never were able to do. Through learning we re-perceive the world and our relationship to it. Through learning we extend our capacity to create, to be part of the generative process of life. There is within each of us a deep hunger for this type of learning" (Senge 1992, p.10).

The various learning groups of this project combined together eventually to be a learning organisation, albeit a temporary one.

One question to be discussed by this report is how all parties to the mental health education and training can become learning organisations. John Cawte's autobiographical comment: "Those patients were my teachers" (Cawte 1998, p14) is admirable, but an earlier generation of mental health practitioners did not (or could not) reform their organisations by changing the culture. (John Cawte describes the 'madhouse' for 'lunatics' he managed in Adelaide in the 1950s, where he treated individuals in a kindly fashion but never overcame the inadequacies of 'the system'. As he says "As a psychiatrist, I had also to be a jailer" (Cawte 1998, p.16). Recently improved understanding of organisations and systems and their interlocking nature gives us an advantage over these early reformers. First, organisation, systems and action theory together with 'reflective practitioner' models (see chapter 7) offer tools to affect system change. Secondly, this project was not in a void, as it was supported by a clear policy framework. But the policy framework was not sufficient to improve the education and training of mental health professionals. This will require the creation and maintenance of learning organisations by all parties.

Summary

Quality and effectiveness in the future mental health service providers will be obtained by responsiveness to consumer and carer needs and rights. Responsiveness by professionals in the five disciplines in mental health service delivery to improved consumer and carer outcomes will only be achieved with the cooperation of a range of parties: universities, professional associations and employers. The changes required in professional practice are legitimised by the second national mental health plan. To bring the parties together is the subject of this report, but it is apparent that individuals are learners as well as contributors and that learning groups are the basis of learning organisations.



References

- Argyris, C., 1990, *Overcoming Organisational Defences*, Prentice Hall.
- Argyris, C. and Schon, D. 1978, *Organisational Learning: A Theory of Action Perspective*, Addison Wesley.
- Australian Health Ministers Advisory Councils National Mental Health Working Group 1997, *National Standards for Mental Health Services*, AGPS.
- Australian Health Ministers 1998, *Second National Mental Health Plan, Mental Health Branch*, Commonwealth Department Health and Family Services.
- Australian Health Ministers 1992, *National Mental Health Policy* AGPS.
- Australian Health Ministers 1992, *National Mental Health Plan* AGPS.
- Bennett, C. 1998, 'Shame', *Island Magazine*, Issue No.76, Spring, pp.31-43
- Brewer, A. 1995, *Change Management: Strategies for Australian Organisations*, Allen and Unwin.
- Carter, J. 1981, *Day Services for Adults: Somewhere To Go*, Allen & Unwin, National Institute Social Services Library No.40.
- Carter, J. 1988, *Creative Day Care for Mentally Handicapped People*, Basil Blackwell.
- Cawte, J. 1998, *The Last of the Lunatics*, Melbourne University Press.
- Community Services and Health Industry Training Board 1994, *Training for the Psychiatric Disability Sector*, CS&HITB.
- Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1998 *National Mental Health Report 1997*, AGPS.
- Commonwealth Department of Health and Human Services 1992, *Mental Health Statement of Rights and Responsibilities*, AGPS.
- Commonwealth Department of Health and Human Services 1995, *National Mental Health Policy*, Australian Health Ministers AGPS.
- Community Services and Health Training Australia 1997, *Mental Health Work: National Competency Standards, Draft, May 1997* (unpublished)
- Conrad, P. and Schneider, J. 1992, *Deviance and Medicalisation: from badness to sickness*, Temple University Press.
- Desjarlais, R., Eisenberg, L., Good, B., Kleinmann, A. 1995, *World Mental Health: Problems and Priorities in Low Income Countries*, Oxford University Press.
- Emery, C. and Davidson, J. 1996, *Advanced Case Management: Volume 2*. Deakin University.
- Field, L. and Ford, B. 1995, *Managing Organisational Learning: From Rhetoric to Reality*. Longman.
- Goffman, G. 1968, *Stigma: Notes on the Management of Spoiled Identity*. Penguin.
- Higher Education Council 1996, *Professional Education and Credentialism*, National Board of Employment, Education and Training.
- Human Rights and Equal Opportunity Commission 1995, *Human Rights and Mental Illness*. AGPS.
- KPMG Consulting 1994 *National Mental Health Workforce; Education and training Consultancy*. Department of Human Services and Health, Canberra.
- Mugford S et al 1998 *Attitudes of Health Professionals Project – Final Report*. F.Small and associates for Commonwealth Department of Health and Aged Care.
- Murray, C.J.L. and Lopez, A.D. 1996, *The Global Burden of Disease: Summary*. World Health Organisation.
- Porter, R. 1996, *A Social History of Madness: Stories of the Insane*. Phoenix.
- Quadrant Research Services 1997, *Consumer and Carer Satisfaction with Public Mental Health Services*. unpublished report prepared for The Department of Human Services Mental Health Branch Victoria.
- Queensland Community Services and Health Industries Training Council Inc 1997, *Professional Development Strategy for Child and Youth Mental Health Services: Competency Standards Report for Queensland Health*, (unpublished report).
- Senge, P. 1992, *The Fifth Discipline: The Art and Practice of The Learning Organisation*. Random House.
- Schofield, H. (ed) 1998, with Bloch, S., Herrman, H., Murphy, B., Nankervis, J. and Singh, B. *Family Caregivers: Disability, Illness and Ageing*. Allen and Unwin.
- Strauss, A., Schatzman, L., Erlich, D., Bucher, R., Sabshin, M. 1963, *The Hospital and its Negotiated Order in Castles*, F.G., Murray, D.J., and Potter, D.C. (ed) *Decisions, Organisations and Society*. Penguin Books.
- The Melbourne Consumer Consultant Group 1997, *The Ultimate Exit Survey: Survivors of Psychiatric Services Speak Out*. T.M.C.C.G.
- Thomas and Associates Pty Ltd 1996, *Field Trial for the Measurement of Customer Satisfaction with Public Mental Health Services*. Summary Report for Aged Community and Mental Health Division, Department of Human Services, Victoria. Unpublished.
- Victorian Mental Illness Awareness Council 1997, *Developing Effective Consumer Participation in Mental Health Services: The Report of the Lemon Tree Learning Project*. V.M.I.A.C.

3. Service users as consultants, educators and trainers

**Merinda Epstein
and Daniel Rechter¹⁷**

Why should service users be involved?

The founding principle of service user involvement in all aspects of mental health services is the notion of participation - the right of people to be agents within the services which affect their lives. This is an ideal for society in general and as such this process represents the democratisation of human services provision.

The principle of participation can be seen to encompass not only the service users but also family carers and service providers-groups with conflicting notions of what is to be done. How should these various rights of participation be balanced? Are they equal? Different but equal? Or is one to be privileged? In this chapter we argue firstly for an overall increase in participation of *all* groups. The subjective (but collective) experiences of each of these groups are marginalised within the present mental health system, but in differing ways. Service providers are seen to possess expert objective (professional) knowledge which somehow precludes subjective experience. Carers' concerns are dismissed as either irrelevant since they are not the patients, or as a consequence of over involvement with those they care for. Each of these examples contains some truth, but taken as a whole they represent a system seeking refuge in extremes. As users our experiences are interpreted as part of the 'illness' for which we are being 'treated'. This is done to silence us. Systemically, the distinction between our 'true experience' and our 'illness experience' is irrelevant.

The ideal to which we subscribe is a system which can accommodate our experiences whatever 'cause' is ascribed to them. Otherwise what justification is there for the mental health system, as dis-

tinct from society in general, in claiming itself to be therapeutic (rather than purely coercive)? A *therapeutic* system must in the first instance be more open to the experiences of each group of which it comprised than the broader social system against which it is contrasted. While our voices may be opposed, in all cases the ideal we hope for is a system which is more open to hearing them. To this end, how should we view the practices which constitute our shared system?

Empirically and democratically all voices should be equal. We would need a greater representation of user voices throughout the system for this to be a functional reality. And yet, some individuals inevitably speak louder than others. Perhaps with a greater total number of voices included such differences would collectively average out between the opposing groups. But there are also systemic reasons as to why some voices are *heard* more than others. Often we speak of power imbalances between the different groups but it is not always clear how this might be pictured. We would like to use the image of two people balancing on a seesaw. Most people do this intuitively. How is this achieved? While the other person's weight is the most obvious factor, this is an individual difference akin to some speaking more loudly than others. Systemically we must ask why some voices 'carry less weight' than others. On a seesaw this is because the closer you are to the pivot point, the harder it is to balance the other person.

Conceptually, users occupy the central or pivotal location within the mental health system. We are its focus. *In order for the voices of users to be balanced with those of others who make up the system, the thoughts, feelings, and actions of all must be viewed through a lens which privileges users' understandings of these practices.* If this is a hierarchy, it is less a ladder with users on the highest rung (an image which is the inverse of the standard picture), than concentric circles with users (and perhaps in a different way carers) at the centre. Nor is it an exclusive privilege. The metaphor of a lens allows for dialogue in the determination of meaning via the overlay of different lenses.

¹⁷This chapter has been written by us as the consumer members of the project Advisory Committee. It represents our vision of a process constituted by many people. We would like to acknowledge the contribution of all consumers who participated in the workshops from where these ideas are drawn - Simon Champ, Helen Glover, Trish Goddard, Phil Iker, Heather Moore, Julie Shaw and Meg Smith. Thanks also to all those who participated as carers. Any omissions and representations are ours alone.

Dialogue also requires that the practices of the system be viewed as relationships between people. A personal justification for this is that they are felt to be this way by users. Furthermore, systemically, you cannot *not* relate. Those practices often viewed as not involving a relationship, such as the giving of medication, become one end of a continuum within which the human (or felt) part of the relationship may vary from relatively insignificant to absolutely crucial. Either way, this is made explicit, and therefore can be the subject of a dialogue as to just which practices are insignificant or crucial, and why.

The statement of principles

Consumers and carers often have an intuitive grasp of the ideas expressed above precisely because of our centrality within the system. We have been balancing on the seesaw to the best of our ability all along. During the life of this project, consumers met with carers separately from other professional groups for a two day workshop. We collectively developed the following statement of principles:

The relationships between consumers and service providers and carers and service providers, should be the primary focus in practice and research in mental health. Consumers and carers are therefore major players in the education, training and development of the mental health workforce.

This means that consumers and carers are to be:

- actively involved in policy and planning, development, decision-making, research and evaluation of all mental health services
- adequately resourced and remunerated for work which should be reflected in government policy, mental health budgets and any tender specifications for education and training
- actively involved in all aspects of the education and training process, including curriculum development, teaching and learning programs, and accreditation
- encouraged to further develop their 'bodies of knowledge' to provide the basis for mental health workforce curricula.

Users as consumers, survivors and patients

The statement of principle's emphasis upon relationships attempts to bring user experiences into view. There are three main frames within which to understand these experiences, those of consumer, survivor or (ex)patient (often abbreviated C/S/X). The language we use to describe ourselves reflects our speaking from one of these positions (and often a mixture). These experiences sit within the context of a dominant model of relationship between user and provider. In the past this was the doctor / patient relationship (for psychiatry, one model was the psychotherapeutic one). More recently a market model of consumer / provider / purchaser has partially supplanted this model. These two professional models produce two of the dominant frames for understanding user experiences, those of 'patient' and 'consumer'. The only frame which is user driven is that of the 'survivor', which emerged from the liberation movements of the 1960's, in Western societies. The social context of mental illness and of the mental health system is crucial here to understanding the nesting of experiences within relationships, whether one posits such relationships as causal of illness or not. Hence at one end of the continuum, even dispensing medication to someone 'suffering' from a 'biological illness' remains a 'felt' relationship - especially for the user. Even (or especially) if we see such medication as the sole therapeutic agent here, we would want this relationship at worst to be felt by the user to be 'neutral', allowing the medications their full efficacy.

Disciplines such as sociology and anthropology produce critiques of existing models of social relationships (including the two dominant within mental health services) as well as providing new models through their own research practices (broadly, the use of qualitative research). They can help us to question our taken for granted assumptions. The systemic issues which need to be considered include: *What services are available and who pays?* and *Who is eligible to be a user of such (public) services?* Within any service provision, the seeking of consent for treatment and disclosure of information to family carers (or any third party) are primary day-to-day concerns for users.

The model of service user as *patient* relies on the professional skill and humanity of the service provider to resolve these issues. To this end, the doctor is given considerable autonomy. Although

this leaves the power with the service provider and not the user, it allows the provider to make assessments on the basis of individual patients rather than patient populations. This is appropriate to situations where users do not know what they want. In fact, it potentially allows great space for the user to work this out within the relationship (especially psychotherapy). But the power imbalance means that a key concern for patients on an individual basis is their rights while being treated according to a regime of the doctor's devising. The systemic issue is the incorporation of service user understandings into the notions of professional skill and humanity which guide the model.

The user as *survivor* is the only user-driven identity. It emphasises the coercive nature of mental health services (especially the use of civil mental health legislation). It seeks user controlled alternatives such as self-help groups, for people 'on a journey'. This allows space for non-medical understandings of this journey (especially spiritual understandings), which in turn form the base from which to get a clear perspective on medical approaches. This perspective is an oppositional one not only because of the injustices it perceives in the system but also because it feels itself as a distinct space to be under threat from this system. The medicalisation of self-help groups is a common example of this distinct space being threatened. Conversely the threat comes via lack of institutional support. While a charity set up to help service users qualifies for tax exemption status, a self-help group organised by those same service users would be ineligible for this status.

The user as *consumer* is the model which posits the service user as having clear knowledge of what they want. While this nominally transfers power from the provider to the user, in practice it is problematic if mental illness is viewed in part as not knowing what you want (whether as cause or effect). Within this model users have not become genuine consumers with purchasing power. Purchasing is done in our name. Our needs are represented for us and the issue of who is a legitimate consumer then becomes crucial. That is, the right of access to the care we feel we need, and the provision of a diverse range of services in the first place would be required for a genuine consumerism. In the major restructuring of the mental health system, this frame is the dominant one. We have found ourselves lapsing into its use while writing this chapter, even when we were actually thinking of a more generic notion such as that of 'user'.

Relations between professional groups

How do service providers view their own position within the system? While some are also users or carers, we will focus on their experience as professionals. There is a traditional picture of distinct professions arranged in a hierarchy with psychiatry at the top. Foregrounded is the expert knowledge one wields as a result of professional education and training. To some extent this picture has been disrupted 'from the outside' by the introduction of management expertise into the system. In the collective workshops held for this project, we became aware of a separate change coming from within mental health practice. In this view, a notion of commonality overlays each professions' expert knowledge. This is not to render expert knowledge as generally less important, or as interchangeable between specific professional groups. Nor is it to suggest that they work with users in identical ways. It seeks to make explicit a body of common sense knowledge which is the province of the professions collectively. (See Chapter 2)

Such a view sits well with the image of concentric circles suggested earlier from a user perspective. Mental health practices, viewed as relationships between providers and users, are placed in the centre. To some extent the notion of common sense knowledge makes professional groups more functionally equal. But there is a danger of creating a space into which a generic mental health worker could be 'poured'. This would background expert knowledge not because it can be taken for granted as a shared vision of knowledge and skills, but because it is cheaper to employ staff who have less extensive training. The commonality that grounds this vision for each of the disciplines is an empirical one. It is actual *users* that the disparate professional disciplines have in common. The impetus to develop a generic worker is the result of a conflation of this empirical commonality with the conceptual lenses through which we view shared practices. The expert bodies of knowledge of each profession are a concrete representation of that profession's perspective and should remain distinct. Only if these are reified as having a *fixed* and *static* content can they be taught to a generic worker. What should be made generic is *not* the disparate lenses themselves, but the way in which they are overlaid to give a common (but continually developing) vision for mental health practice.

In the traditional model, change to services uses only the expert knowledge of the professions. The

consumer body of knowledge is not considered expert, although we may individually be consulted and involved via focus groups and so on. This is also true of carers, and indeed of service providers themselves, who may be representatives of their profession's expert knowledge, but whose individual experiences of service provision are often undervalued. We have argued earlier for the increased participation of all groups. Users create a practical space we call common sense (filled with knowledge common to all professionals) as well as providing a perspective on its content. This perspective should be valued as expert. Then the real ground for change becomes the mixing via dialogue of the various perspectives. Such change is a cyclical process. We are always between twin horizons of *how services are now* and *how we want them to be*. It is the horizons themselves which shift. This is perhaps analogous to a process of continuous quality improvement.

Service users as consultants, educators and trainers

If we can guarantee the valuing of consumer perspectives, then we can begin to differentiate various roles users might have as representatives of our body of expert knowledge: as consultants, educators and trainers. It is the former which has been most clearly articulated in Victoria (where the authors live). As consultant to services our role is one of change agent. Where individual users are unable to articulate what they want, either because such services cannot be imagined in the present, or more commonly because they are not being listened to, consumer consultants can function as a kind of 'litmus test' for systems change. The work of the *Understanding and Involvement* project in Melbourne represented the first rigorous attempt to follow such a model. (Wadsworth and Epstein 1996). Some of the material it produced is listed in the references at the end of the chapter. A flow on from this work was the employment of consumer consultants to all regions within our State.

But on the whole the involvement of consumers in these other roles has been accomplished in an ad hoc way. Most commonly consumers or consumer organisations have been invited to give one-off presentations for students. The quality of these inter-

actions varies according to the experience and skill of the particular consumers and the commitment to participation of the academics or service providers involved. There can be particular problems when the professionals involved do not personally have an interest in, or knowledge of, consumer issues and their political ramifications. It has been the case that the group discussion after the consumers have left is used to discount the consumer position and undermine the authority of the consumer presenters. Often a 'consumer session' would be timetabled in the last week of a many week course with the implication that it occurred as an afterthought and is less important than other content areas. In such situations there has often been lack of understanding around the different speaking positions of 'carer' and 'consumer' with members of either group being asked to represent both perspectives.

There has been no formal training in most parts of Australia for consumers in basic skills of presentation¹⁸ or facilitation of workshops. Mostly consumers are simply invited to 'talk' to students. Often this has involved them 'telling their story'. This has tended to cast the consumer into the role of a performer with staff or students as a passive audience. Although this represents a change in role for providers from instructing consumers to learning from them, there is no evidence that one-off presentations impact on their attitudes and values in the longer term. The systematic evaluation of consumer education initiatives remains undeveloped.

Consumers are starting to insist that their expertise be recognised and remunerated accordingly. As the budgets of academic departments and other training bodies are being made more flexible by the increased use of sessional staff it should be easier for such institutions to pay consumers in this way. But difficulties continue with academics often inadequately understanding either the bureaucratic process required or the urgency of payment. It is very difficult for people living on minimal incomes to cover the expenses necessary in preparing for such sessions, even though they will be reimbursed via payment at a later date. This goes unrecognised because it poses less difficulty for professionals who more often work in this way, and individual consumers are often loathe to press for special consideration. A similar problem arises from requests for consumer contributions to academic

18. Note the exception of the National Mental Health Strategy funded Community Development Project which resulted in the production of 'the kit. A Guide To The Advocacy We Choose To Do'. This project also culminated in a one week residential course in Melbourne where 32 consumers and carers from around Australia qualified as Work Place Trainer Category 1. The course was developed by Swinburne University of Technology (TAFE Division) Department of Family and Community Studies.

texts. There is an assumption by publishers that contributors will hold academic positions from which they are in a position to write. Payment is solely via royalties.

Examples of explorative, interactive workshops run by consumers have been rare in an Australian context.¹⁹ But every Australian mental health professional needs the opportunity to be part of one. These educational packages are seen as expensive because they need and insist on a paid critical mass of consumers being involved. In a culture where the payment of consumers is a novel concept and where there are no salaried consumers within academic institutions such costs appear prohibitive. This is especially likely to be the explanation of managers who have only a rhetorical commitment to consumer participation.

Throughout the education and training workshops of this project there was a constant theme of the need to focus on the attitudes, beliefs and values of staff. It was suggested that these form a web of practices which become encrusted as they are passed down through the generations within each professional group. Consumer-driven projects which are informed by the literature on organisational change and reflective practice can help professionals to think differently about the meaning of their traditional beliefs. An example of this is the *Deep Dialogue Project* which was designed in partnership with the Western Healthcare Network and the Victorian Mental Illness Awareness Council, in Melbourne. This pilot project identified the need for an interactive process, occurring over time (resourced and structured to give consumers a voice equal with that of staff), if change to this web of practices is to occur.

Consumer initiatives tend to be isolated. It is particularly difficult to get information to or from those in other States. There are several reasons why this persists despite the information 'revolution'. There is at this time no formal network through which educational ideas, resources and literature can be shared. The embryonic Australian Consumer Network is not yet able or sufficiently well resourced to provide support, funding or flow-on resources for more specialised networks. There are no sponsored consumer positions within Australian academic institutions as exists in Great Britain. Those few consumer educators in Australia are on the whole not salaried. Therefore

there is greater pressure upon individuals to provide themselves with the resources needed to critique projects, programs and literature from a consumer perspective. We are asked to take part in lengthy collaborative exercises, writing, editing, peer review etc. without the necessary institutional support of libraries, computer technology and administrative support. Although consumers around Australia have contributed because they are politically committed, the pressure on those who have now obtained reputations is significant and stressful.

At the present stage there is little involvement of consumers in curriculum review boards, course approval committees or ethics committees. Similarly, consumer expertise in student assessment has not been widely used or well documented²⁰. Consumers must begin to articulate and document what we think is 'competence' in professional practice. There is also a need for formal support for consumers wishing to undertake postgraduate study in mental health or education related disciplines.

What can be done?

There is a need for an Australian network for all consumers working as consultants, educators and trainers. This needs to be coordinated at a national level by a national consumer studies centre (NCSC) which could be based within an academic institution (but not restricted to it), with the long term goal of growing into a clearing house for consumer produced material on education and training from here and overseas. The centre would be consumer run and would focus its activities around education and learning, research and services to the consumer community.

Central to the operating of this centre would be the development of a consumer body of knowledge and the pursuit of activities around learning, research and community services. Thus encouragement and financial support for consumers to undertake postgraduate education would be essential. Second, consumer based research which attempts to evaluate the effects of evidence based practice from a consumer perspective would be another goal. Third, there would also need to be available services to the Australian consumer community.

19. Examples of these are the interactive board game 'Lemon Looing' which was devised by the peak consumer organisation in Victoria, the Victorian Mental Illness Awareness Council, and the 'Voices' workshop which was developed by Patricia Deegan and the National Empowerment Centre in Boston, U.S.A.

20. The known exception being Swinburne University of Technology (TAFE Sector) Department of Family & Community Studies' Psychiatric Disability course, where assessment of student presentations by consumers is now established.

This would include:

- disseminating information to State and regional consumer organisations responsible for supporting consumer educators, trainers and consultants at a local level
- enhancing the capacity for networking between educational initiatives in different States and Territories
- linking up with overseas education and training projects and programs via the Internet
- developing model consumer curricula for universities nationally
- reviewing courses for their implementation of the guiding principles
- working with professional bodies on preparing competency and practice standards
- resources to enable the dissemination of consumer-driven materials which are considered best (or for the moment, good enough) practice in the area of staff education²¹
- creating resources to facilitate individual consumers and consumer organisations in applying for government and other grants to fund consumer driven presentations, research projects and to produce consumer literature
- liaising with academic institutions to provide accredited courses²² to this end
- facilitating individual consumers and consumer organisations in gaining skills as presenters and educators
- giving technical and financial support to consumers working as consultants, educators or trainers

- auditing and evaluating Australian education and training initiatives in an ongoing way.

Academic institutions and professional bodies should be given every encouragement to invite consumers to sit on academic boards, course accreditation committees and curriculum development committees. A definite statement about the desirability of consumer input into both graduate and undergraduate courses in the five key professions should be distributed to the coordinator of every relevant course within Australia.

The Mental Health Education and Training Network should undertake a regular audit of academic institutions collecting figures on the numbers of consumers involved as sessional staff, the frequency of this involvement, the consumer component of the course structure, as well as consumer involvement in the evaluation of student progress, accreditation committees, course development committees, academic boards and other such bodies.²³

Resources need to be allocated to pilot, document and evaluate projects designed to bring about work place culture change and reflective practice so that all mental health practitioners have the opportunity to work and learn over an extended period with consumers - in roles of consultant, educator or trainer. Local examples²⁴ need to be further trialled and disseminated and all such initiatives should be informed by the consumer body of knowledge. Some emphasis should be given to trialling innovative student work placements in consumer organisations or to the use of consumers as joint supervisors²⁵.

All professional bodies representing the five key professional groups working in the area of mental health should be encouraged to develop on-going liaison structures with the Network of Australian Community Advisory Groups (NOAC²⁶) and the proposed National Consumer Studies Centre.

21. For example the \$50,000 obtained by the Victorian Mental Illness Awareness Council to promote the Lemon Looing board game and to educate consumers in every capital city to work with the game and to educate others in how to use it as an educational tool.

22. See the Swinburne University of Technology accredited Train the Trainer (Category 1) course as part of the Community Development Project funded by the First National Mental Health Strategy.

23. This, of course needs to be adequately resourced. Also suggested are accommodation bursaries to enable comprehensive consumer presentations of staff education initiatives at national and international conferences including The Mental Health Services Conference (THEMHS) and the National Mental Health Education Conference

24. Such as the Deep Dialogue Project sponsored by the Western Healthcare Network in Melbourne

25. See the Report of the Deep Dialogue Project where a third year social work student was jointly supervised by a consumer from the participating consumer organisation and a social worker from the sponsoring Healthcare network.

26. The NOAC will replace NCAG (National Community Advisory Group) from November 1998.

References

- Breggin, Peter 1991, *Toxic Psychiatry*, St Martin's Press New York²⁷.
- Epstein M and Shaw J. 1997, *Developing Effective Consumer Participation in Mental Health Services: the Report of the Lemon Tree Learning Project*, VMIAC, Melbourne.
- Farber, Seth 1993, *Madness, Heresy and the Rumor of Angels*, Open Court, Chicago²⁸.
- Littlewood, Roland 1991, 'Against Pathology', *British Journal of Psychiatry* 159: 696-702.
- Melbourne Consumer Consultants' Group 1997, *Do you Mind? The Ultimate Exit Survey: Survivors of Psychiatric Services Speak Out*. (available from the Richmond Fellowship of Victoria).
- Read, J. and Reynolds, J. (eds) 1996, *Speaking Our Minds: an anthology*, The Open University Press Milton Keynes.
- Sedgwick, Peter 1982, *Psychopolitics*, Pluto Press.
- Spink J. 1998, *Helping the Service Listen To You: Narrative Report of the Royal Children's Hospital Mental Health Service Consumer Participation Project*, MH Sky, Travancore Campus.
- Wadsworth Y and Epstein M. 1996, *Understanding and Involvement (U&I) Consumer Evaluation of Acute Psychiatric Hospital Practice - A Project Unfolds* VMIAC, Melbourne, August 1996²⁹.
- Wadsworth Y and Epstein M. 1996, *Orientation and Job Manual: Staff-Consumer Consultants in Mental Health Services*, VMIAC, Melbourne³⁰.
- Internet Sites
- <http://www.madnation.org>³¹
- <http://www.users.bigpond.com/saraclarke/>³²

27. Includes extensive guide to anti-psychiatry and related literature.

28. Interviews with founders of the American Consumer/Survivor/Ex-patient movement.

29. See pp. 52-56, 'The Concept of Consultancy'.

30. See pp. 72-76, 'working as a consumer, with a consumer perspective'.

31. International site with links to others around the world.

32. This Australian site offers information and links useful to consumers of mental health services and to others interested in consumer perspective.

4. Carers: their needs, rights and contributions

Judith Player and Margaret Leggatt

Introduction

Although not all carers are family members, those involved in this project were close relatives who tended or who had tended on a daily basis a relative with a severe mental illness. Recent research findings from 'family intervention' studies show many positive results for consumers when their families are involved in their treatment and care (Falloon 1998). There is now a substantial research base for the efficacy of these interventions, making it clear that there are no valid reasons for not involving families in the treatment and care process. 'Best practice' based on existing research evidence can only happen when families of people with major mental illnesses are included. Mental health professionals must now be educated and trained to work with families, who are usually carers. This chapter describes how this can be tackled in future policies for the education and training of the disciplines.

The role of families as carers for people with a mental illness has altered over the last three decades, with the rate of change accelerating over the last ten years. Periods of inpatient hospitalisation have been decreasing as medication has become more effective and service providers have developed an awareness of the negative effects of extended periods of hospitalisation as well as the cost of hospitalisation. Increases in the co-location of acute psychiatric beds within general hospitals and the provision of ambulatory services (CDHFS and AIHW 1998) means that people experiencing acute episodes of mental illness are being treated in their home and those who live with them or care for them will be involved.

Most people with a mental illness live in the community most of the time. Their informal carers may be parents, partners, children, siblings, friends or

co-tenants. A survey of public and non-government psychiatric services clients in the Inner East of metropolitan Melbourne in 1989-90 showed around 25 percent to be living at home with parents (Gallois 1990). The Association of Relatives and Friends of the Emotionally and Mentally Ill (ARAFEMI) minimum data statistics showed that 63 percent of consumers attending a self help group were living with family - either partners, parents or their own children. Family members may be the major and continuing social and emotional support for some consumers, even if they are not residing together. "The movement towards deinstitutionalization has in general imposed on families a caregiving role for which they are unprepared, untrained and from which they have been systematically excluded in the past" (Lefley 1997).

The National Mental Health Policy 1992 recognised that many people with mental disorders are cared for by 'unpaid' carers and included objectives to develop and expand assistance to carers and to expand community based support for carers. *The National Mental Health Report 1996* (CDHFS and AIHW 1998) indicates an increase in consumer and carer participation in public sector mental health service organisations but does not separate carers from consumers. Carer and consumer interests do not always coincide and carers have needs in their own right. Further, anecdotal evidence suggests that many carers of people with mental illness have health problems of their own.

State of play at beginning of the workshops

The literature relating to carers of the mentally ill emphasises *their need* for education, rather than the needs of mental health service providers to be educated and trained to work with families (Lefley and Wasow, 1994). A few mental health services directed towards carers aim to improve carers' knowledge and skills. Mutual support groups allow carers to share their experiences and learn from

each other, while some non-government organisations offer courses directed at meeting the carers' own needs. Generally speaking though, carer representatives have been more adept and practiced in advocating for better services for *consumers* than for services for themselves as carers.

Family carers have long considered that mental health professionals were under-informed about carers and their needs but have had difficulty conveying this message to the professionals delivering services to their family member. That professional may be pressed for time, and at best may have concerns about the professional/consumer relationship being disrupted by any involvement with the family. At worst the professional may be antagonistic to the family.

A carer perspective on the project

Initially the program supported consumer and carer contributions to the discussion. It was apparent that attitude changes were necessary if education and training of mental health professionals were to include elements considered essential by consumers and carers. The new paradigm of mental health services had to include recognition of the lived experience of consumers and carers and an acceptance of measures of consumer and carer participation in and satisfaction with the service.

How could we convey this message to the very senior academics and mental health bureaucrats at the workshops? How much did those people know about the realities of life at the local community mental health centre and in the home? Were we to contribute actively to the discussion or to maintain an observer role? How were we to communicate with professionals in a way that would allow them to recognise that *they* needed to learn from *us*?

The initial statement of principle 'that consumers and carers are to be central to mental health services' articulated the legitimacy of consumers and carers in the process. This statement was further developed at the consumer and carer two-day workshop³³. This workshop marked a turning point for carers in the workshop process. A small number of consumers and carers were able to confront their differences openly away from the whole project group. Carers acknowledged that their needs did not necessarily coincide with those of consumers and that they had a right to acknowledge their own needs for service. Carers spoke of the range of

responses to the caring role, from that of willing participant to unwilling conscript. The group agreed that, for some, the large 'institution on the hill' had been replaced by the 'domestic institution' where both consumer and carer were locked into conflict which was not healthy for either.

A number of ideas which had been developed by the consumer representatives were reviewed and began to be incorporated by the carer representatives. The thinking and capacity of the consumer representatives to articulate and conceptualise their issues was significantly more advanced than that of the carers. Perhaps reflecting their own realities, carers listened to the consumers and contributed to the discussion rather than initiating their own points of difference and of need.

Carers were introduced by the consumers to the concept of 'deep dialogue', where practitioners could reflect on any relevant issues that arise with consumers and carers. We explored the notion that psychiatry, as a branch of medicine, has permeated the whole mental health system, leading to a medical model of practice. While many carers may be comfortable with and comforted by a medical approach to mental illness, we had all experienced a lack of respect on the part of the professionals, for the knowledge of mental illness held by our family member and by ourselves. We recognised that consumers were now concerned to explore issues which underlie practice such as the language used between mental health professionals and consumers, whereas carers to this point had seen their role as advocacy for access to and improvement of services for consumers. As well, carers stressed the point that they were often speaking for and on behalf of mentally ill relatives who were less able to publicly articulate their needs. We found agreement with consumers when we explored notions of what is considered a mental illness at a particular point in time, since this will influence access to services.

During the workshops the group reviewed competencies, including those of the consumer and the carer as well as of the professional. We agreed on the need to identify and challenge bad practice which had become locked into the mental health service delivery system. Attitudes and values were at the heart of change. The vision of the 'new mental health worker' and the 'traditional' mental health practitioner were deftly illustrated, bringing together much of the discussion. Values and attitudes which the practitioner should bring to the task were outlined. Recognising that some already possessed the attitudes and values seen as desir-

33. This workshop was held in Melbourne on 15th and 16th June 1997

able, we questioned how these were developed and how these could be imparted to co-practitioners. When new graduates entered the mental health system with desirable values and attitudes, could they be nurtured to retain the values rather than adopt a workplace culture which might be rejecting of such values? Skills and knowledge should incorporate consumer and carer perspectives but could be learned. These were the province of the academics within the education institutions and supervising professionals in the workplace so these groups should be targets for change.

The original statement of principle was changed to: *'the relationships between consumers and service providers and carers and service providers should be the primary focus in practice and research in mental health. Consumers and carers are therefore major players in the education, training and development of the mental health workforce'*. The accompanying process issues, content issues and teaching techniques which had been agreed at the consumer-carer workshop were discussed with all the disciplines.

Whilst the onus was on the disciplines to change, consumers and carers were reminded that their involvement at all levels of education and training would only continue if positive outcomes for consumers and carers were able to be clearly demonstrated. These notes of caution were accepted but the concepts sustained the remainder of the process, as did the solidarity amongst the consumers and carers.

Attitudes, knowledge and skills were explored further in the discipline specific focus group workshops for occupational therapy, psychiatric nursing, psychology and social work. Initially three guiding principles were included in a template to explore factors which enable and hinder the development of these principles. These statements were:

1. *Mental health professionals need to learn about and value the lived experience of consumers and carers.*
2. *Mental health professionals should recognise and value the healing potential in the relationships between consumers and service providers and carers and service providers.*
3. *Mental health professionals should recognise and value the ongoing potential for recovery of people within the mental health system.*

The four disciplines then explored attitudes, knowledge, skills and performance indicators for these three principles in a second template. Across the board, the discipline workshops came to agreement on the first two statements of principle, with less consensus regarding the third. The templates ensured that each discipline had to consider the attitudes and values which the consumer and carer representatives had put forward as most important.

The review of the standards of practice and competencies for each of the five disciplines and other professional documentation presented at the focus group workshops reinforced carers' perception that there was no formal awareness of their existence and roles, let alone of their needs³⁴.

By the end of the process, it seemed that there was agreement on the attitudes which should underpin the practice of mental health professionals. The disciplines developed profiles of sets of knowledge and skills which showed that the principles put forward by the consumers and carers had been absorbed and were being utilised. The professions appeared ready to acknowledge the consumers as legitimate partners in mental health services. Carer needs for service in their own right were not considered but their involvement in the care of the consumer was sanctioned.

Where to from here?

The framework of attitudes, knowledge and skills presented at the final workshop reflected the direction which would meet the expressed beliefs of carer representatives. The Second National Mental Health Plan identifies priority areas for reform within three key themes:

- promotion/prevention
- the development of partnerships in service reform
- the quality and effectiveness of service delivery.

The second and third themes fit with the future direction of education and training. By developing partnerships with consumers and carers, as well as with other health practitioners, mental health services will be able to confront many of the attitude changes which consumers and carers seek. By evaluating the quality and effectiveness of their services against consumer and carer benchmarks

34. The exception is the NMHS National Standards for Mental Health Services (1996, AGPS, Canberra)



of service, providers will learn more effective ways to ensure that their service meets the needs of the consumers and their carers.

There is an increasing body of research studies relating to the effects of living with mental illness. Most of the work is from the USA and research in the 1980s has mainly relied on families affiliated with the National Alliance for the Mentally Ill. We do not have reliable Australian data on the number of people living with or caring for a family member with a mental illness³⁵.

While appreciating the ponderous nature of change at the level of tertiary institutions, their graduates will have to operate in the community and attitudinal and value changes should permeate all facets of all courses and not necessarily require additional classroom hours. The introduction of consumer and carer consultants to curriculum committees is already occurring in some institutions. Costs of payment for consumer and carer consultants were seen as creating a barrier to their participation in course presentation.

In Victoria there has been a significantly increased awareness of carers over the last 12 months, as the impact of the Victorian Government's Carers' Strategy filters through. Area mental health services have appointed and paid carer representatives to assist in their administration of Carer Crisis Support Funds. Carers and consumers attended the Get Together FaST (Family Sensitive Training) program with clinical and psychiatric disability support service providers and were included in the process of the training, rather than being onlookers. ARAFEMI has had an increase in requests from service providers to locate carers to join curriculum and consultation committees.

Carers now need to develop their specific 'body of knowledge' so that professionals hear about and learn from the carers' 'lived experiences.' Once mental health professionals have a true appreciation of the experiences of family members, they will better understand what families need to enable them to become effective caregivers.

Carers then need to define what it is that they want from professional workers. The attitudinal changes were well defined and described in the carer and consumer workshop, but how these attitudes are to be translated into relevant and appropriate knowledge and skills, needs substantial development.

There needs to be a recommendation for a national process which enables carers to work closely with a national body representative of all disciplines. This would be a way of ensuring that the attitudinal change of professionals was implemented and maintained. It could also be the means for carers to be able to develop the knowledge and skills base that they believe professional workers should have in order to be able to work in collaboration with them. A National Mental Health Carers' Education and Training Forum which reviews carer issues, prepares model curriculum, and trains carers to take part in education and training would be a major step forward.

Obstacles to progress

It was salutary that towards the end of the project everybody realised (as a result of one exercise in the final workshop) that the gains were perhaps more shallow than we had hoped. Professionals had been exposed to significant consumer and carer knowledge and had appeared to be sympathetic to the guiding principles. If they could revert so quickly to the stereotypes of the old paradigm, the task of re-orienting the existing mental health workforce and ensuring that students learned and practiced these principles from the outset was daunting.

The old paradigm of professional dominance is entrenched and many professionals have considerable investment in persisting with existing practices. The dyad of health professional and patient does not readily become a triad of professional, consumer and carer. As people spend significantly less time in hospital in all treatment areas including mental health the triad will become the significant treating group in years to come.

Consumer opposition to the inclusion of carers in the partnership with mental health practitioners may be an issue for some. When mental health professionals are able to begin with a presumption of inclusion and recognise that boundaries of confidentiality should be set by the consumer, not by the professional, many of the present fraught confidentiality issues will disappear. Mental health practitioners must begin to realise that, when they enter the consumer's home, they are often entering the *family* home. Extramural ambulatory care will assist to drive change in practice.

35. Although it is possible that information will be derived from the 'low prevalence disorder' study, an Australian national study which took place in 1997 in Brisbane, Melbourne and Perth as yet unpublished. The published report of the ABS Mental Health and Wellbeing Profile of Adults does not include information relating to carers (ABS 1997).

When mental health practitioners are working with large case loads, it is unrealistic to expect that they will find additional time to work with the family, and families will not be assertive about their needs for service. Their focus will remain on obtaining the best service for the consumer. When there is little or no opportunity to choose the mental health service provider, the family will be reluctant to antagonise that service. But as already noted, unless the families of people with mental illness are included, there will be no 'best practice'.

By the nature of their roles, most carers are task focused and at present lack the structures to contribute to education and training more broadly. Thus it is important to develop a way for carers to contribute to education and training on a broad level. The establishment of regional, state and national workshops which meet annually to assess the major issues for carers, and thence to plan for the incorporation of these issues into curricula and practice standards would be worthwhile. In addition carers need to be represented on interdisciplinary and disciplinary structures set up following this project.

Carers are some distance from regarding themselves as a discipline, with a unique body of knowledge. During this project they have begun to articulate their needs and requirements for the demands made on them by the person with mental illness, the professional workforce and the community as a whole. Articulating their needs and requirements is the beginning of their contribution to higher education, the disciplines and the workforce.

References

- Association of Relatives and Friends of the Emotionally and Mentally Ill, 1998, Victoria, internal data, unpublished.
- Australian Bureau of Statistics 1997, *National Mental Health and Wellbeing: Profile of Adults*, Australia 1997, A.B.S.
- Commonwealth Department of Health and Family Services and Australian Institute of Health and Welfare, 1998, *National Mental Health Report 1996*, Mental Health Branch Commonwealth Department of Health and Family Services.
- Falloon, I. 1998, *Cognitive-behavioural Interventions for Patients with Functional Psychoses and Their Caregivers*. (An annotated bibliography prepared for the World Schizophrenia Fellowship's document: *Families as Partners in Care* -unpublished).
- Gallois, L. 1990, *Inner East Community Residential and Support Services Survey Report 1989-1990*, unpublished report.
- Lefley, H. 1997, *An Alliance of Care*, Keynote address to ARAFMI Brisbane 20th Anniversary National Conference 7-9 August 1997, unpublished.
- Lefley, H.P. and Wasow, M. (ed) 1994, *Helping Families Cope with Mental Illness*, Harwood.

5.1 Mental health nursing

Mike Hazelton

Introduction

Mental health nursing (sometimes referred to as psychiatric nursing or mental health-psychiatric nursing) can be thought of as a specialised branch of nursing which focuses on meeting the mental health needs of the consumer, in partnership with family, significant others and the community, in any setting. While there are many definitions of mental health nursing, most are based on some notion of helping consumers to manage mental health problems within the reality of their life situation. Once closely linked to the custodial mindsets and practices of the asylums, mental health nursing is now more concerned with encouraging consumers to make decisions about their health care; to involve family and/or significant others and communities in the care and support of consumers; and to assist consumers to exercise the rights and responsibilities expected of fully participating citizens. This, at least, is the theory. The extent to which the theory is carried over in to practice through educational preparation for mental health nursing (and the other mental health disciplines) was a key theme of the *National Mental Health Education and Training Project*.

While mental health nurses certainly employ a range of performance capabilities that would be considered basic to any branch of nursing, it is important to note that these are augmented by a range of skills, attitudes and forms of knowledge that are specific to the mental health area. In Australia (and New Zealand), it is the Australian & New Zealand College of Mental Health Nurses which has taken the leading role in developing standards of practice, incorporating the specialised skills, attitudes and forms of knowledge required for mental health nursing.

Prior to considering the outcomes of the project workshops in respect of mental health nursing, it is necessary to provide some outline of the educational, professional, workforce, and policy contexts within which the profession currently finds itself. At the outset it is important to acknowledge that the majority of mental health nurses would cer-

tainly see the discipline as being at somewhat of a cross-roads at present, with multiple challenges being posed both from within and outside the profession.

The mental health policy reforms of the last decade have seen a shift in the locus of care from an institutional focus to a community focus. Moreover, *The National Mental Health Policy* (Australian Health Ministers, 1992) has also concentrated on bringing mental health services into mainstream health services, and on safeguarding and enhancing the citizenship and human rights of persons with mental health disorders and problems. Henceforth mental health professionals, including mental health nurses, can undoubtedly expect much more assertive consumer and carer involvement at all levels of mental health service planning and provision (Hazelton, 1995). A particular concern raised within the context of the recent reforms has been the need to ensure the development and maintenance of a highly skilled specialist mental health workforce, capable of delivering high quality outcomes in terms of both treatment and consumer satisfaction outcomes (Andrews, Peters and Teesson, 1994). Mental health nursing is obviously fundamental to the skill mix of any mental health professional workforce, with mental health nurses comprising up to 70 per cent of the mental health workforce.

There is no doubt that the recent reforms imply significant changes for the mental health professions, and none more so than in the case of mental health nursing. While the development of mental health nursing has been closely linked to the history of asylums (later renamed psychiatric hospitals), the reforms of recent decades have seen more and more nurses working in a variety of smaller scale settings, in the community, with consumers who are more knowledgeable and assertive regarding their rights, and who are supported by increasingly assertive consumer and carer representative organisations. These changes deserve the full support of mental health nurses, and have certainly been fully endorsed by the Australian and New Zealand College of Mental Health Nurses and other peak nursing organisations in Australia.

Without doubt these developments pose significant challenges for mental health nurses specifically, and for the nursing profession in general. A signif-

ificant number of mental health nurses face substantial retraining in making the shift from the working culture of the old institutional settings to that found in community based services. New skills and knowledge and different therapeutic attitudes are required at a time in which the field of mental health care is opening up to new service delivery approaches, improved forms of treatment, and greater levels of professional accountability. Moreover, there is a concern among many mental health nurses that changes to nurse education over the last few decades, especially the discontinuance of direct entry mental health nursing courses, have resulted in a significant reduction of interest in mental health nursing as a career option for new graduate nurses. Many mental health nurses feel the learning content specific to mental health nursing has been significantly reduced and devalued in comprehensive (i.e. 'generalist') undergraduate nursing curricula throughout the country (Farrell and Carr, 1996; Happell, 1998). Concern has also been expressed that the statutory regulation of mental health nursing in Australia has effectively dissolved under the Mutual Recognition Act, 1992, and the Trans-Tasman Mutual Recognition Act, 1997 (Australian & New Zealand College of Mental Health Nurses, 1997). Nurse registration boards throughout Australia are moving increasingly to establish single registers for nursing, while professional nursing organisations, such as the Australian & New Zealand College of Mental Health Nurses are beginning to explore options for self-regulation, accreditation and credentialling (Hazelton and Farrell, 1998).

The changing nature of the health workforce in the face of public sector funding difficulties, technological developments and population health trends has also been central to recent debates surrounding the need to rethink the education and training of the mental health professions. On one hand, these changes have seen the acceleration of professionalisation and a proliferation of specialisations in nursing. On the other hand, the occupational space being vacated by nursing is being filled by new categories of health worker. The organisation and skill mix of the current nursing workforce in Australia varies greatly from that of twenty years ago, and will be very different again twenty years from now.

These same developments in the nature of health care service delivery have also contributed substantially to changes in the educational preparation for work as a health professional, including nursing. Indeed, it is probably in the area of nurse education - with the recent transfer from hospital-

based to university-based nurse education - that we see the greatest change of the last few decades. While the shift to a broad comprehensive preparation for beginning level practice as a registered nurse had many opponents (and some of these remain), it is nevertheless now well established throughout Australia. However, it is important to recognise that undergraduate nursing courses in Australia prepare a graduate for beginning level practice and are thus focused on what are considered to be the minimal performance capabilities required to achieve this purpose. What is still being worked out is the means of educating and credentialling nurses for advanced and specialised work in areas such as mental health nursing. While it can be argued that the transfer of nurse education is now complete at the undergraduate level, this is by no means the case at the postgraduate level. Indeed, the recent introduction of fees for postgraduate coursework programs such as graduate diplomas, has further compounded recruitment difficulties by imposing an up-front financial burden on nurses wishing to undertake further studies leading to a qualification in mental health nursing. Many of these are recent graduates who are still paying off a HECS debt from their undergraduate studies

The question of who should credential nurses for advanced and specialist practice (such as mental health nursing) is another key issue at present. Should this be the responsibility of the nursing boards, or should the professional nursing organisations now move into this area? There is certainly a feeling among many mental health nurses that mental health nursing, which had long been regulated through the nursing boards in Australia, has been left vulnerable and at risk of dissolution by the recent changes in nurse education, especially the cessation of direct entry mental health nursing education courses (Australian & New Zealand College of Mental Health Nurses, 1997). The urgency of finding a way through these issues has been further intensified recently, by a number of recent Administrative Appeals Tribunal decisions which in summary, found that it is no longer valid under Mutual Recognition legislation, to regulate nursing beyond the point of initial registration. Put another way, these outcomes imply that a registered nurse has the legal authority to practise nursing in any area of practice, including mental health. The only exception to this seems to be midwifery. These decisions clearly have serious implications for integrity and viability of mental health nursing as a specialist branch of the nursing profession (Australian & New Zealand College of Mental Health Nurses, 1997).

The preceding discussion was intended to provide a broad contextualising overview of the recent history and cultural traditions of mental health nursing in Australia, as these have implications for the outcomes of the *National Mental Health Education and Training Project*. In particular, these implications need to be read in respect of current and future directions for education and training for mental health nursing, and ongoing developments in the scope of practice of the discipline.

As indicated above, mental health nursing is currently at somewhat of a cross-roads. Many mental health nurses feel the very integrity of the discipline is threatened by recent developments in nurse education, and especially by changes to the statutory regulation of mental health nursing. There is probably no clear consensus on how mental health nurses should be educated at present, and arrangements for regulating mental health nursing now differ between various states and territories. On the other hand, the discipline continues to professionalise, and there is little doubt that the Australian & New Zealand College of Mental Health Nurses has emerged as one of the more effective, energetic and influential of the various professional nursing colleges in Australia.

Given the aforementioned developments and challenges facing mental health nursing, the *National Mental Health Education and Training Project* should undoubtedly be seen as a most timely initiative. While a process which brought mental health professionals, consumers and carers together in roughly equal numbers, and asked them to work collectively towards developing a national curriculum for mental health education and training, will no doubt attract some scepticism, the workshops nevertheless provided both an opportunity and (increasingly) a climate in which old assumptions could be challenged and new approaches could be tested. If participants (including the author) approached the initial workshops with an attitude of attempted (but cautious) open-mindedness, the realisation that this was a serious attempt to build a cooperative project around identifying key principles that might inform mental health education and training came as somewhat of a relief. That the workshops also included much stronger (and more numerous) representation by consumers and carers than most health professionals would previously have experienced was challenging, insight-producing, and very welcome.

The details regarding the skills, attitudes and knowledge considered to be common to all the dis-

ciplines are outlined elsewhere in this report, and will not be repeated here. What is surprising, and can be expected to result in ongoing debate, is the extent to which the workshops produced a (fragile) consensus regarding the differentiation of common (across all disciplines) and specific (to certain disciplines) attitudes, skills and knowledge. We are discussing the division of labor in what in recent decades has been one of the more strifetorn segments of the Australian workforce - health care. Achieving agreement that all the disciplines have a legitimate stake in a broad range of attitudes, skills and forms of knowledge was an important outcome of the workshops, which will require sensitive negotiations within and between the professional organisations.

Agreement that the future test of any education and training process should be that mental health professionals: *need to learn about and value the lived experience of consumers and carers; and need to recognise and value the healing potential in the relationships between consumers and service providers and carers and service providers*, if carried over into course content would very likely revolutionise education and training in the mental health professions, eventually flowing on into improved outcomes for consumers and carers. While most undergraduate comprehensive nursing courses and postgraduate mental health nursing courses in Australia currently include learning content which addresses the intention of these principles, it has to be acknowledged that these often take the form of a session, or sessions given by consumers and/or carers within the context of a course structure which remains heavily focused on the clinical knowledge and skills considered important for mental health nursing. It is valid to suspect that in many instances, viewpoints and experiences of consumers and carers remain an after-thought, or worse, a token within a curriculum typically overloaded with procedural, pharmacological, psychodynamic and diagnostic information.

In its most insidious form this kind of learning within mental health nursing education is very much geared towards the needs of the nurse who must deal constantly with the 'difficult' patient, rather than the needs of the consumer who must contend with a frightening, inflexible, and indifferent 'therapeutic' environment, while experiencing a mental disorder. Indeed, a recurring theme throughout the workshops was the extent to which relationships between providers and consumers and providers and carers continued to be characterised largely in terms of 'doing for', rather than

‘doing with’. Consumers and carers participating in the workshops argued strongly that collaborative approaches often referred to in policy documents and text books, even when they were translated into practice, rarely amounted to equal collaboration; an ongoing structural inequality remains painfully evident to even the most assertive of consumers and carers. In the experience of consumers and carers the human rights aspects of recent mental health policy have had little impact at the level of everyday relationships between providers and consumers, remaining little more than empty rhetoric. If the aforementioned principles could be placed at the core of nursing undergraduate comprehensive and mental health nursing postgraduate curricula, it seems likely that a fundamental paradigm shift would eventuate.

The experience of the workshops certainly suggested that discussions regarding the rights and responsibilities of consumers, carers and providers certainly take a much harder edge when the consumer and carer voices are strongly represented in the discussions. Indeed, the strong presence of consumers and carers in the workshops certainly served to ensure that the principles referred to throughout this report remained a constant reference point within discussions during the workshops.

As with the other disciplinary groups, the nursing group was asked to identify the attitudes, skills and forms of knowledge required for effective mental health nursing, and in doing so generated the following:

Attitudes

Mental health nurses, along with all other health professionals, should:

Value the lived experience of consumers and carers

In demonstrating this they will:

- have respect for the dignity of the individual
- be willing to listen to consumers and carers and examine their professional practices in the light of the experiences of consumers and carers
- acknowledge the importance of the stories, worlds and knowledge of consumers and carers, and be prepared to use these in collaborative planning of treatments and support

- work to achieve ‘deep dialogue’ with consumers, and learn by reflection on this
- be non-judgmental of consumers and carers and avoid attributing blame
- consider the social, cultural and spiritual needs of consumers and carers in the planning for non-discriminatory treatment and support strategies

Value the healing potential in the relationships between consumers and service providers and carers and service providers

In demonstrating this they will:

- uphold the rights of consumers and carers as stated in relevant legislation, regulations and charters
- maintain commitment to their relationships with consumers and with carers
- be open, honest and ‘fair dinkum’
- accept and learn from criticism and acknowledge when a relationship is not maintaining healing potential
- recognise the capacity of people to develop and change
- give information to consumers and carers about treatment options
- allow consumers and carers to make choices
- acknowledge their own fallibility and be willing to change and learn

These statements of value and attitude were identified as being common to each discipline.

Knowledge

Mental health nurses should have knowledge of:

- the lived experience of consumers and carers
- self (models of, theoretical perspectives on)
- models of clinical supervision (e.g. reflective practice)

- the requirements of practice (treatment and care and evaluation of outcomes of care)
- therapeutic relationships (and effects of changing contexts on this)
- historical, cultural and political contexts of nursing
- legal and ethical frameworks for practice
- professional context of practice (accountability)

These statements were generated by the nursing group (which included consumers and carers).

Skills

Mental health nurses need to be able to:

- create a welcoming and safe environment
- promote and maintain physical well-being
- listen to, and use the experience of consumers and carers as a key focus in care
- establish and sustain therapeutic partnerships
- engage in reflective practice
- evaluate the outcomes of care, in partnership with others
- network
- plan and manage care
- use knowledge bases to inform practice
- work effectively in teams
- practise within an ethical framework
- practise within a legal framework
- assess risk
- use skills of observation and assessment to identify needs
- teach and facilitate groups

- communicate effectively in a wide variety of situations

These statements were generated by the nursing group (which included consumers and carers).

These statements regarding the knowledge, skills and attitudes required for nursing are offered as a possible template against which courses of education and training for mental health nursing (undergraduate, postgraduate and professional continuing), might be evaluated. As such they warrant careful consideration by university schools of nursing and other education and training providers, nurse regulatory bodies and the Australian & New Zealand College of Mental Health Nurses.

In conclusion, it is appropriate to comment on the process of the workshops. It was certainly noteworthy, and possibly remarkable, that the scepticism and rivalry of the early workshops, had by the end of the process given way to a cooperative and optimistic attitude in which it was felt that workforce reform, and education and training initiatives designed to improve the outcomes of mental health care, are entirely feasible.

Nevertheless, it is realistic to anticipate the recommendations of the project (e.g. identifying attitudes, skills and forms of knowledge common to all disciplines; identifying attitudes, skills and forms of knowledge that are specific to certain disciplines; developing a national curriculum, or at least national curriculum principles) will be controversial. We are, it must be remembered, considering a workforce in which occupational boundaries have been jealously defended for decades. Nevertheless, if the spirit of good will and cooperation which characterised the workshops is any kind of indicator, the recommendations of the project are achievable. What will be required for this to happen will be an open-mindedness on the part of all stakeholders, an unqualified acknowledgement of the legitimacy of consumer and carer experiences and viewpoints, and a willingness by all parties to view mental health education and training as a shared responsibility of considerable importance. The recommendations of the *National Mental Health Education and Training Project* deserve the complete support of stakeholders within mental health nursing.

References

- Andrews, G., Peters, I. & Teesson, M. 1994, *The Measurement of Consumer Outcome in Mental Health: A Report to the National Mental Health Information Strategy Committee*, Clinical Research Unit for Anxiety Disorders, Sydney.
- Australian Health Ministers 1992, *National Mental Health Policy*, Australian Government Publishing Service, Canberra.
- Australian & New Zealand College of Mental Health Nurses 1995, *Standards of Practice for Mental Health Nursing in Australia and New Zealand*. ANZCMHN Inc. PO Box 126, Greenacres, SA, 5086.
- Australian & New Zealand College of Mental Health Nurses, 1997, *Self-Regulation and Credentialling*, Discussion Paper. ANZCMHN Inc, P.O. Box 126, Greenacres SA, 5086.
- Farrell, G. A. & Carr, J. M. 1996, 'Who Cares for the Mentally Ill? Theory and Practice Hours with a Mental Health Focus in Nursing Curricula in Australian Universities', *Australian & New Zealand Journal of Mental Health Nursing*, 5, 77-83.
- Happell, B. 1998, The Implication of Legislative Changes to the Future of Psychiatric Nursing in Victoria, *Australian & New Zealand Journal of Psychiatry*, 32, 2, 229-234.
- Hazelton, M. J. 1995, 'Mental Health, De-institutionalisation and the Problem of Citizenship', *Australian and New Zealand Journal of Mental Health Nursing*, 4, 101-112.
- Hazelton, M. J. & Farrell, G. A. 1998, *Self-Regulation and Credentialling in Mental Health Nursing: Preliminary Report to the Nursing Board of Tasmania*, School of Nursing, University of Tasmania.

5.2 Occupational therapy

Dagmar Ciolek

Background

Broad guidelines for entry level education and training of occupational therapists are set by the World Federation of Occupational Therapists (WFOT). Each member country (Australia included) has the opportunity to contribute to the establishment and review of these guidelines. Although WFOT guidelines state “approximately the same time should be given to experience with psychiatric patients and patients receiving treatment for physical conditions”³⁶ in education and training of undergraduates, the prevailing economic climate and other political issues have led to loose interpretation of these guidelines by the Australian universities. As a result, there are as many different undergraduate curricula for education and training in mental health as there are universities.

For OT Australia, the Australian Association of Occupational Therapists, the national audit of education and training outlined in Appendix 1, confirmed the number of undergraduate courses in Australia. Compared with the education available to other mental health professionals, occupational therapy has the fewest undergraduate and post graduate courses available. It also confirmed that each undergraduate course followed a different curriculum.

In view of the WFOT requirements, the audit’s claim that “Mental health practice was not, however, included in all ... occupational therapy courses.”³⁷ is alarming. This reiterates the issue of non-uniformity in curriculum and consequent varying entry level competencies of therapists. In NSW alone, two new courses in occupational therapy have commenced in the last five years. Practically, this means that in order to honour the WFOT minimum standards guidelines, a greatly increased number of mental health placements are required. However, as alluded to in the audit, the reality is that there are fewer occupational therapists working in mental health, hence fewer placements are available. “Universities are being cut for money.

Any proposal for a curriculum has got to address funding issues and not demand great additional resources.”³⁸ Universities need to take more students, they need them to graduate, hence WFOT minimum graduation requirements are in some cases being distorted, to the detriment of the quality of undergraduate education and training, and ultimately, the detriment of service provision by the profession and service delivery to the consumer.

This chapter emphasises the expectations that developed for occupational therapists throughout this process. First there is the expectation that it is the attitude with which each staff member conducts his or her business that the consumer and carer thought to be most important. That is, it is consumer focused practice that counts. Second, there is the expectation that each discipline needs its own national curriculum. Third, there is the expectation that each discipline will come to a better understanding of each other and their roles.

Consumer focused practice

In these workshops, participants agreed that it was *the way* in which the various disciplines went about their business that made the difference; the method was the glue which held a mental health team together. David Prideaux asked whether we needed a ‘social work glue’, or an ‘OT glue’, or whether a universal adhesive would do the job³⁹. And this was an appropriate question since each discipline found only a handful of unique activities which they could call their own; and the *attitude* with which each staff member conducted his or her business was what the consumer and carer thought to be most important.

Working together in workshop format with the consumers and carers was a rich and rewarding experience. “Accepting the lived experience of the consumer or carer” took on renewed meaning. For example, much was shared about different cultures and their expectations and limitations of the mental health team; how their communities support their sick relatives, and the respect that was required of the professional to the community elders. The richness of the extended family was apparent.

36. Extract from WFOT minimum standards booklet, 1991, Chapter B5, p.57.

37. Appendix 1.

38. David Prideaux, National Mental Health Education and Training Workshops, Report to Commonwealth Department of Health and Family Services, Workshop 2, Canberra, June 1997, p 32. See also Chapter 7.

39. David Prideaux, National Mental Health Education and Training Workshops, Report to Commonwealth Department of Health and Family Services, Workshop 2, Canberra, June 1998, p 28

It seemed that the workshops were raising a dilemma that could make or break future mental health service delivery. Dr Harvey Whiteford defined it for us: "Put aside personal idiosyncrasies, put aside discipline specific ideologies ... and think about the patient and the consumer. Think about the systems in which you work and how they can be better. Think about what sort of ways, if the workforce was better trained, ... we could actually do better."⁴⁰ Is this the same as a 'universal adhesive'? Will the medical model continue to meet the changing need of the future? The challenge was to don a more narrative approach, one which embraces the guiding principles. Naturally, any change can be seen as a threat, but the opportunity is there, and the rewards are great.

Thankfully, the practice of occupational therapy in mental health is not steeped in jargon or complicated testing procedures. Rather, as one consumer put it, occupational therapists 'talk our language' and are task oriented. Central to occupational therapy practice and philosophy is that we work with people, at their level of ability to achieve their maximum functional potential in the areas of their choice. This need for change was specified at the consumers' and carers' focus group⁴¹, in this way: "The language [of current documents] is patriarchal in tone, and couched in terms of 'doing to' rather than 'doing with'."

Occupational therapists (as did participants from the other disciplines) believed they were already demonstrating the attitudes identified by the consumers and carers as being essential to good practice; but consumer and carer representatives could not support this from OT or from any of the disciplines⁴². Nor were these attitudes reflected in current OT professional guidelines. To have obviated this discrepancy between what we *think* we're doing and what consumers would *like* us to be doing reflected success from the workshop process. I believe that every occupational therapist was challenged by this.

The OT participants were left thinking seriously about their skills and knowledge. Some were familiar with a narrative approach to their work, valuing the lived experience of consumers and carers;

some *thought* they were doing this, yet expressed threat to their professional power and traditional models of working; whilst others admitted to not knowing a different way to practise. How reflective is this of the general practising population? What tough road lies ahead?

Whilst it was heartening to see the commitment and enthusiasm of Australian OTs in mental health, it was disappointing that our current documentation did not reflect the *attitude* recognised as being essential to customer focused practice. Occupational therapists were challenged by the power shifts which would be necessary if they adopted consumers and carers as equal partners in both practice and in education and training. To truly accept and work with the lived experience of the consumers and carers demands a paradigm shift from the medical model in which so many have been trained.

To reflect occupational therapy philosophy, the OT's core attitude to service provision needs to be one of respect and genuine recognition of the person's perceived need, not what the therapist thinks is best for that person. Newer guidelines for practice such as the Canadian Occupational Performance Measure (COPM)⁴³, hospital accreditation standards⁴⁴, and the standards for mental health services⁴⁵ recognise the need for partnerships between service provider and consumer. For many therapists, this will require an attitudinal change and may be perceived as a threat. But if it is addressed in undergraduate education and training, eventually any such threat will become non-existent.

These are the principles upon which our future education, training and practice need to be built. In order to practically and genuinely recognise that a person has knowledge about their own life and has goals that they want and need to achieve, it will require a paradigm shift for some more traditionally trained occupational therapists. The profession has already started to make this change⁴⁶, but much more work is needed.

Our practice as a whole will lend itself easily to these attitudinal changes, providing our educators and trainers are given sufficient support and

40. Dr Harvey Whiteford, Commonwealth Director of Mental Health, "The Future of Australia's Mental Health Services", opening address to Workshop 2, Canberra, June 1997

41. November 1997

42. Professor Jan Carter, Final report on the discipline specific focus group workshops, November 1997, Deakin Human Services, Australia, p 4

43. Law, M., Baptiste, S., et al., Canadian Occupational Performance Measure, Canadian Association of Occupational Therapists, 2nd ed., 1994

44. The Australian Council on Healthcare Standards, The Evaluation and Quality Improvement Program (EQulP), Sydney, 1996

45. National Standards for Mental Health Services, National Mental Health Strategy, Commonwealth Department of Health and Family Services, 1996

46. From the findings of a report by Frank Small and Associates, "Attitudes of Health Professionals Towards People With a Mental Illness", The National Mental Health Strategy, March 1998



encouragement to do so. (Who will train *them* into thinking differently?) And our consumers and carers will be the best judge of how we are going, and in many instances will also be the best trainers.

Of greatest benefit was meeting and learning a different way of working with consumers and carers who were articulate in their experiences of 'the system' and their own personal stories, and were good advocates for others. Consumers and carers raised some thought provoking and challenging issues, and were a constant sentinel, ensuring that the language used in the workshops was consistent with the concepts being endorsed. In this way, they were excellent teachers whilst fostering breadth of understanding of their experiences.

Disciplinary curriculum

The variation in entry-level competencies and skills within and across disciplines was expressed by consumers and carers at the workshops as confusion about which professional will best meet their need. It was generally clear that their general practitioner or psychiatrist prescribed medication regardless of the consumer's geographical location, but it was often unclear to consumers and carers which profession would best meet their other needs. A national curriculum for each discipline would, in part, overcome this problem.

The Commonwealth Government has requested a strong commitment to and ownership of the national curriculum concept by the disciplines,⁴⁷ and OT Australia has embarked on this process. Already the national association has been actively working on the first steps of developing national standards for undergraduate curricula. It has received funding (July 1998) from the Commonwealth Department of Health and Family Services, Mental Health Branch, to develop entry-level mental health competency standards for occupational therapists. This will provide a baseline standard for occupational therapy curriculum designers nationally to ensure uniformity in knowledge and skill base for entry-level therapists. The series of workshops and in particular the discipline-specific focus groups held in November 1997 have laid the foundations required for developing consistency across curricula nationally, within each discipline.

The fact that OT Australia has already commenced a subsequent project documenting entry-level mental health competencies for occupational therapists indicates the profession's practical commitment to change. At completion, the competency standards document can be used by curriculum designers in the arduous task of creating national uniformity in under-graduate courses which will include consumer and carer participation at all levels of education, training, assessment, and practice. Clearly though, competencies do not automatically create competence. Monitoring must occur. OT Australia is currently improving the process of accreditation of individuals and the school curricula.

Further evidence of OT Australia's active commitment to change in service delivery is their development of a method of accreditation⁴⁸ for occupational therapists. To be accredited practitioners, therapists will have to demonstrate their involvement in ongoing relevant professional education and training. In the future to maintain consistency with the statement of principle, a component of this accreditation for mental health workers could be conducted by consumers and carers through a workplace-based performance appraisal process.

From the second workshop⁴⁹, it was determined that attitudes, knowledge and skills were the essential elements of practice. Psychiatrists' learning objectives⁵⁰ are already written against this framework, which was broadly adopted by the workshops; and occupational therapy accreditation may well incorporate the same framework.

For occupational therapy, attitudinal attributes relating to the principles espoused by consumers and carers were acknowledged as being:

- openness to new ideas and different perspectives
- willingness to seek out information about the lived experience of consumers and carers
- acceptance and respect for information about lived experience
- non-blaming, non-judgmental
- willingness to engage in dialogue (sharing experience)

47. Unpublished letter to Professor Jan Carter from Dr Harvey Whiteford.

48. Accreditation for Occupational Therapists, The Australian Association of Occupational Therapists, 1998, in progress

49. University House, ANU, Canberra. June 1997

50. Fellowship Curriculum, the Royal Australian and New Zealand College of Psychiatrists, Melbourne, September 1995

- willingness to relinquish power in relationships
- willingness to see the consumer as a whole person (not as a category)
- willingness to change self
- optimistic, acceptance of hope
- willingness to inform consumers and carers of their rights, treatment options, how to access information (e.g. case notes)
- courtesy (as it applies in all other social contexts).

The final workshop⁵¹ allowed significant time for each discipline to identify and refine what they thought were knowledges and skills required for entry-level mental health work. When these were pooled, the diffuse boundaries of mental health work became evident in that each discipline could identify only a small handful of skills and knowledges which were distinctively theirs.

Knowledge distinctive to occupational therapy was:

- knowledge of human occupation⁵²
- knowledge of creative problem-solving
- knowledge of program development through to activity analysis
- knowledge of specific resources for OT.

The occupational therapy emphasis was on creativity, tasks, and task analysis and the model of human occupation; the *ways* in which occupational therapists do things through a practical approach were seen to be unique.

The distinctive occupational therapy skills required in mental health work were seen as being:

- the ability to share occupational therapy resources in a mutual educational process with consumers and carers and other disciplines
- the ability to implement assessment and treatment skills - activity analysis (living skills, pre-vocational training, application of the model of human occupation)

- the ability to provide occupational therapy service plans and implementation at the levels of individuals (leisure, self-care and work) and of service systems
- the ability to modify the social and physical environment
- the ability to facilitate creativity.

The mental health knowledges and skills common to the disciplines will be covered in Chapter 6.

These attitudes, knowledges and skills for occupational therapists in mental health practice need to be taught in education and training and incorporated into the entry-level competencies project currently in progress by OT Australia. They are to be assumed as being fundamental to all levels of practice, from undergraduate through to continuing professional development, and specified in the national accreditation process of practising occupational therapists.

The process of the workshops constituting the *National Mental Health Education and Training Project* has had a positive outcome for occupational therapy. It has recognised the profession as an integral discipline in the delivery of mental health care, raising its profile amongst other workers through their exposure to our unique contribution in the area. Learning what each discipline does, their philosophies, how they go about their business and the strengths and weaknesses of each has also been rewarding.

Interdisciplinary cooperation

Working closely with the five disciplines over the two year period of the project fostered another expectation: that each discipline would come to a better understanding of other disciplines and of consumers and carers and their various roles in mental health service delivery teams. As Chapter 6 points out there is significant sharing of roles between the various mental health professionals. Each discipline has few uniquely discipline-specific skills.

51. University House, ANU, Canberra. February 1998

52. Kielhofner, G. (ed.) 1985, *A Model of Human Occupation: Theory and Application*, William & Wilkins, Baltimore



Networking with individuals across a variety of work areas has been invaluable. Because of the structure of the OT Australia National Advisory Group on Mental Health, this networking has enriched the profession's resource bank.

The reverse side of working more closely with other disciplines is of course coming to agreement on points of contention when each discipline believes strongly in their own mission, with good reason. Another disbenefit was that of excess information coming from so many 'experts' in a confined area. It was however imperative to recognise and actively acknowledge that the consumers and carers were the true experts among us, and essential that their voice be heard and the essence of their experiences embraced and worked with. Some disciplines found this notion more difficult to grasp than others.

The future

Although only a handful of OTs were actually able to attend the discipline specific focus groups, therapists from across Australia contributed local knowledge and experience. This involvement of all levels of workers is seen to be critical to the acceptance, both in principal *and* in practice of the type of behaviours and attitudes we need to engender.

The task remains to progress the attitude of a profession, nationally. The workshops and their outcomes, the guiding principles, the networking and energy expended will lie dormant until a national approach is adopted to breath life into this framework. The way ahead is clear; the opportunity lies before us to change the face of mental health practice for occupational therapists towards better outcomes for our consumers. This is a challenge to do things differently to effect a change towards best practice. It's a challenge to *think* differently, to *practise* differently, to *relate* differently to our consumers, and reap the rewards of richer and more effective outcomes of therapeutic relationships.

OT Australia, the Australian Association of Occupational Therapists endorses the principles agreed to by the workshop process. As a national organisation, it has been proactive in embarking upon the first stage in the development of a national curriculum which could be used for uniform education and training of occupational therapists in the field of mental health. There is opportunity for the national accreditation project to ensure that the

guiding principles are incorporated into courses which are submitted for accreditation by the Association. Both the accreditation process and workplace performance appraisal have the potential to require the practising professional to demonstrate change in the areas of attitudes, knowledge and skills honed through further education and training. In this way, the essence of the workshops will pervade the present and future workforce.

Universities and education and training bodies will need to allocate adequate funding to allow for the guiding principles to become active in their curriculum. There is also a need for these bodies to negotiate with industrial unions to allow consumers and carers to take an active role in education and training.

All three projects currently being undertaken by the National Advisory Group on Mental Health⁵³ for OT Australia have the capacity to influence change in the practice of occupational therapists in mental health by incorporating the guiding principles and the outcomes of the workshop process.

To change the practice of a discipline is a difficult but not impossible task and OT Australia is actively assisting its members in the process. Therapists attending the workshops, those involved across Australia in the projects and discussions, and the state and territory representatives of the OT Australia National Advisory Group on Mental Health will champion the change into the future.

References

- From the findings of a report Frank Small and Associates, Attitudes of Health Professionals Towards People With a Mental Illness, The National Mental Health Strategy, March 1998.
- Keilhofner, G. (ed.) 1985, *A Model of Human Occupation: Theory and Application*, Williams and Wilkins, Baltimore.
- Law, M., Baptiste, S., et al., Canadian Occupational Performance Measure, Canadian Association of Occupational Therapists, 2nd ed., 1994.
- National Standards for Mental Health Services, National Mental Health Strategy, Commonwealth Department of Health and Family Services, 1996.
- The Australian Council on Healthcare Standards, The Evaluation and Quality Improvement Program, Sydney, 1996.

53. OT Australia Position Paper on Mental Health Fieldwork Placements; Outcome Measures and Indicators for Intervention; and a Support Network for Rural and Remote Mental Health Workers (unpublished)

5.3 Psychiatry

**Robert Kosky,
Alan Rosen and
Jonathon Phillips**

Undergraduate medical education

Introduction

Although this chapter discusses both undergraduate medical and postgraduate psychiatric education and training for mental health and psychiatry, the main focus will be postgraduate psychiatry. Mental health in undergraduate and postgraduate curriculum will be discussed and followed by a discussion of those aspects of the process of the education and training project which posed challenges for psychiatrists. The specific learning - formal and informal - from the project will be outlined and recommendations are addressed to the National Mental Health Strategy and the Royal Australian and New Zealand College of Psychiatrists.

In particular, discussion will centre around the future of the present Royal Australian and New Zealand College of Psychiatrists' curriculum, for education and training (1995). In 1995 the Royal Australian and New Zealand College of Psychiatrists completed a major revision of its curriculum⁵⁴, which was based on principles rather than on detail. It was a progressive document for the time. But psychiatrists now have to recognise that the world in 2005 will be vastly different from the world today. It will be a world in keeping with the vision of the renewed National Mental Health Strategy, with consumers at the centre of it all. The curriculum will need to embrace the requirements of consumers and carers and best science.

In addition, a curriculum will need to break down the barriers between undergraduate medical education, the postgraduate training of psychiatrists and the continuing professional education of experienced psychiatrist practitioners. It will need to enable the collaboration of psychiatrists with other mental health disciplines.

Issues of mental health and illness now run through the whole of Australian undergraduate medical syllabi. The binary mind-body split is giving way again to the ancient tradition that has held a unitary view of mind and body. As a result, in medicine, increasingly, the way people think about and construct their experience of the world, is again being considered to influence their health. How this holistic view has been expressed in academic teaching programs for undergraduates has varied from time to time, and from place to place. It is fair to say that the degree of emphasis on mental health issues has varied, also.

In most modern medical schools in Australia and New Zealand, there is now a focus on mental health issues. Teachers see these to be of importance in the contemporary world in which the graduates will practise. Modern medical schools generally integrate mental health issues into the various strands of the teaching programs. Thus at Newcastle University these aspects of health are intimately involved in the clinical problem-solving teaching method that characterises that medical course. In a more traditional school like Adelaide, mental health issues are emphasised in preclinical years in the teaching stream that is devoted to the relations between the doctor, the patient and society. There are clinicians, anthropologists, psychologists, philosophers, and others teaching in this stream - the aim being to give a well-rounded medical educational experience.

Medical courses are generally of six years duration. In the new post-graduate schools, such as Flinders and Sydney, medicine follows a first degree and may be shorter. Clinical education is still primarily a hands-on learning experience and the most important source of knowledge - albeit knowledge for diagnostic classification - is the person who is seeking help. It is from such people that the budding doctor learns lessons that will stick. Consequently, most medical schools try to facilitate comfortable interactions between the student and the patient, and this is a matter of ongoing concern and interest to teachers who plan the clinical courses.

54. The curriculum is included at Appendix 6.



One of the challenges facing medical schools is to keep pace with consumers' increasing sense of rights, needs and responsibilities. These require reflecting in teaching and practice. Several medical schools now encourage consumer input at various levels - in classes, in curriculum planning and in the selection of medical students.

In most modern medical schools, students are offered electives as they move towards their final year. They are encouraged to choose to work in areas where they can broaden their own personal experience. Many students work in deprived areas of Australasia or overseas. Some take on scientific projects, including in areas of mental health. (For instance, a recent student at Adelaide investigated the health conditions of children in a remote north-west Aboriginal community).

The formal teaching of mental illnesses - their nature, aetiology, course, treatment, diagnosis, prognosis, etc. usually occurs as a separate teaching program in the clinical years. This subject, psychiatry, is taught as a specialty of clinical medicine, like surgery or obstetrics. In this sense, the main focus of this clinical study is psychopathology and the main object of study is the individual experience of mental illness. About a quarter of the clinical experience in the under-graduate medical course at our medical school, is devoted to the study of psychiatry. One of the issues for teachers is how to integrate this study with the more general one of mental health. The danger is that if this integration is not successful, transfer of knowledge between the fields will not occur. Each medical school tackles this issue in its own way.

Efforts are made to place psychiatry within the context of the earlier studies of mental health issues. In some medical schools, clear distinctions between clinical psychiatry and mental health are not made. In these schools, aspects of mental illness are inter-twined with studies of problems of general health, mental health and patient care. Nevertheless, it is expected that all graduating doctors, from any medical school in Australia and New Zealand, will be able to care adequately for someone suffering from a mental illness.

The role of medical schools in affecting change in how doctors think about mental illnesses and about those who suffer from them, was largely overlooked (except in Workshop 3, see Table 5.4.1, Column 1) in the education and training project because of the focus on severe mental illness. In the long run, the way medical students are taught about mental health and illness may be of more sig-

nificance to the community than an updated curriculum for specialists in psychiatry. The attitudes of all doctors of the future will be shaped by this undergraduate teaching experience. Input to the development of medical school curricula is something that consumer and carer groups may need to consider more seriously in the action that results from this project, particularly as the second national mental health plan stresses prevention and intervention.

Postgraduate medicine - Psychiatry

Psychiatry is the study of mental illnesses - their origin, their nature, their treatment and their prognosis. Although this aspect of medicine has an ancient history, psychiatry as a specific specialty has only existed for about 200 years, since Phillippe Pinel's textbook appeared. Even so, most psychiatrists regard themselves as physicians first.

In Australia and New Zealand, standards of practice in psychiatry are set by the Royal Australian and New Zealand College of Psychiatrists. Entry to the College as a Fellow determines the right to be registered as a specialist in psychiatry with the Medical Boards and the Federal Government. In order to regulate standards, the College conducts an entrance examination for the Fellowship. The Royal Australian and New Zealand College of Psychiatrists has branches in New Zealand, the Australian states and the ACT. The branches supervise postgraduate training in psychiatry. They determine who enters the training programs, the clinical placements available to training psychiatrists, and maintains scrutiny of training programs via a system of accreditation of the programs. The minimum training period is five years, following medical training and hospital rotational house jobs.

In 1995, General Council of the College, for the first time, approved a formal curriculum, setting out the objectives of the training (Appendix 6). This curriculum was the result of consultation with a wide range of people who had a stake in the training of psychiatrists. Those consulted in the process included representatives of consumers and carers. As already mentioned, this document was not meant to be definitive. It was a formal expression of what was intended to be an on-going discussion with interested parties. The curriculum is complemented by other documents of Council, such as the RANZCP Code of Ethics.

The objectives of training are defined in the curriculum in three domains. The first of these domains relates to attitudes and expresses the ethical basis that the College expects for the practice of psychiatry. The second domain relates to knowledge and defines the boundaries of the subject. The third domain indicates the skills that the College expects psychiatrists to possess in order that they can practise effectively. Each domain has sub-sections which contain statements about the standards expected by the College (see Appendix 6).

The advantage of the curriculum is that it outlines what intending psychiatrists need to know and how they are expected to behave. In doing this, the curriculum makes this information available to the public as well. The disadvantage of the curriculum is that there will always be those who disagree with it. Indeed, the curriculum specifically invites disagreement, by its claim to be a first attempt to define training and the implication contained in it that further, modified, editions will follow. How to keep the curriculum as a living document and how to channel dissenting views usefully, will be challenges for the College in the future.

Another challenge for the College is to determine its relationship with the universities with respect to postgraduate training. The Dougherty Report (1988) recommended that most post-graduate training in medicine be devolved to universities as higher degrees. This has not occurred, not least because no substitute is obvious for the important ethical functions of the medical colleges.

However, the role of the Australian and New Zealand College of Psychiatrists in training psychiatrists is a unique one. In North America and in Continental Europe, universities play a much more prominent role. All other professions in the mental health area, such as psychology and nursing, have developed their tertiary education bases in universities. In this environment, psychiatry training in Australia and New Zealand is in danger of being seen as unusual. Some arrangements with universities about post-graduate education will certainly be necessary in the future.

The education and training project

The psychiatrists present could not recall any previous meetings like those held at the workshops. First, it was of great value for the psychiatrists to

meet with other professionals in other disciplines. Second, from the point of view of psychiatry, it was a most timely test of how others responded to the RANZCP curriculum and whether they found that it conveyed useful information to them. It was seen as a useful model and a point of departure for the other disciplines. Third, at the discussions of the Advisory Committee of the project, some major bridges were made between senior representatives of consumers, educationists and practitioners which will bear fruit in time. Fourth, the workshops confirmed the formal principle, (which the RANZCP pioneered), that consumers should be involved in the development of education and training curricula. The workshops illustrated, once more, how useful it is to discuss training issues with representatives of consumers and carers.

For psychiatrists, the process of the workshops presented them with some considerable challenges. Since the 1960s at least, psychiatry has been in the forefront of the reforms that have swept through mental health services. In Europe, for instance, there was the powerful influence of Professor Franco Basaglia and the movement called Democratic Psychiatry. In the United Kingdom, change began in the late 1950s with the actions of successive brave superintendents, who opened the closed wards of the old asylums to develop a more humane, community-based approach. Their work was underpinned by the writings of several psychiatrists, such as Russell Barton and R.D. Laing, who tried to re-think the approach to the challenges of mental illness from the point of view of the person with mental illness. In Australia, a similar history could be written.

The process of this project exposed psychiatrists to the realities of the consequences of the 'democratic' approach which some had for so long advocated. The workshops meant having to defend the basis of the profession to colleagues from other disciplines and to the consumer representatives. Psychiatrists were asked to explain what psychiatry could offer and to signal its limitations. This meant that the psychiatrists who attended the workshops had to define those aspects of their profession on which they agreed among themselves and to identify other aspects where they held significantly different opinions. This was an uncomfortable process, especially as the psychiatrists who were at the workshops were aware that they were far from a representative group of the profession.

This discourse among the psychiatrists was an extension of a wider debate going on in psychiatry about the profession's changing role in contempo-

rary mental health. It is clear that these issues will take some time to work through. This is not only a challenge for psychiatry; the role of all the disciplines and the way they are structured to meet the needs of the future in mental health, is an issue that will, in due course, face the wider group of professions with an interest in mental health.

Psychiatry and the workshops

Aside from the National Audit, the main common activity within the project involving psychiatrists was the series of plenary workshops. Process issues existed between psychiatrists and other mental health professionals, consumer and carer groups. Understanding the reasons for these are important. It may have been a matter of needing to acknowledge as a profession that psychiatry has different and complementary (rather than superior) areas of expertise and knowledge, as well as areas of inexperience and ignorance. Additionally to some extent psychiatrists may need to improve skills in working cooperatively and democratically with fellow professionals, or with consumer and carer groups. The issues that emerged and outlined here are an attempt to learn from the process.

Some issues that arose in the first two workshops were not resolved and appeared to pose obstacles both to further participation of psychiatrists and their collaboration with other groups. These factors required some attention at the beginning of the third workshop. Such factors appeared to include the following:

First, the RANZCP representative on the Advisory Committee changed several times during the education and training project and the lack of continuity was unfortunate.

Second, psychiatrists were less willing to engage in workshop exercises than other groups. [For example, the psychiatrists did not feel that a disciplinary based workshop on a new curriculum was required. In the second workshop the psychiatrists' group were reluctant to do a SWOT analysis of their profession in the context of developing a national curriculum, on the basis that the College had already produced a curriculum, which should be used by other professions as a benchmark. There is an evaluative issue here, as to whether the workshop organisers could have used more appropriate methods to engage the psychiatrists. A prob-

lem in facilitation could partially explain why the psychiatrists were not well engaged in the workshop tasks].

Third, even though the psychiatrists had strong feelings about the subject matter of the workshops, there was the appearance that they kept their feelings to themselves regarding their interactions with other professions and interest groups, which left the public impression amongst the other disciplines that psychiatrists were unwilling to participate. This was not the case but psychiatrists were unable to share their sense of vulnerability with the other professions and consumers and carers or perhaps felt that it was unsafe to do so within the wider workshop process. This may have left the perception among psychiatrists that the wider group were not particularly responsive to the psychiatrists' dilemmas.

Fourth, another problem was a fluctuating and decreasing number of psychiatrists at the workshops, which posed problems of continuity and connection with the other disciplines. This plus the absence of a mini discipline specific workshop for psychiatry evoked a general impression that they had "left themselves out of the loop"⁵⁵, as one workshop member described it. The mini workshop was apparently a positive experience for other disciplines. This means that many of the contentious issues raised by psychiatrists initially and some of which required extended discussion had no opportunity to be reflected on or worked into a framework.

Fifth, a number of content issues were raised in plenary sessions by speakers who were psychiatrists. At times members of other disciplines were not particularly responsive to adopting their recommendations. In fact, these content issues were useful in generating debate and reflection even if they were not acceptable to the workshop members generally. Because speakers who were psychiatrists often came, spoke and left there was little opportunity for working through these issues in a more informal and extended fashion. This compared to the increased investment by others in time in the workshop by other disciplines. Some of the issues raised in the workshop concerned with psychiatry were the following propositions:

- Mental health services require expert clinicians (psychiatrists) and a few other core professionals, but most mental health professionals could be replaced by more generic mental health workers who acted as patient advocates.

55. The workshop organisers were made aware of some difficult timetable clashes with overseas conferences after the workshop dates were set.

- For the non psychiatry disciplines, competency-based training was required.
- Psychiatrists' training is more comprehensive and longer than the other disciplines⁵⁶.
- The psychiatrists' work in producing (in 1995) a curriculum, (through the Royal Australian and New Zealand College of Psychiatrists) suggested it was for other professions to catch up.

All these issues meant that when it came to the final workshop, the new framework developed by the disciplines stemming from the guiding principles did not exist for psychiatry. The task for this workshop became to review and make recommendations concerning the 1995 RANZCP Fellowship Curriculum, from the viewpoint of consumer, carer and other professional stakeholders needs of psychiatrists. As already stated (RANZCP 1995) the curriculum was developed as a document which would invite ongoing discussion and development. (The curriculum was viewed by its authors as a pilot, contained a three year sunset clause, and was due for extensive revision). Thus, the advice of the workshop was seen as timely. As already discussed, the psychiatrists' initiative in constructing and applying such a curriculum had been generally admired by other participants in the previous workshops. However, it was widely felt that it was far from perfect, and that it did not relieve psychiatrists of the responsibility to keep working with others towards improvement of their curriculum and progress towards an interdisciplinary framework. (As one consumer stated "Much of the curriculum is *good*. I just wish it was *true*"⁵⁷).

Findings from the Psychiatrists Task Group: Workshop 3

The task group had consumer and carer representatives. It considered the RANZCP Fellowship Curriculum 1995, which is reproduced as Appendix 6. The participants agreed that the curriculum was:

- well organised, consistent with established principles of setting palpable educational objectives
- ahead of its field in its recognition of the need for some consultation with consumers
- worthy of its time incorporating more humane objectives and making them explicit
- a set of learning objectives, rather than a curriculum, (as it offers no plan, no time sequence, no 'chunking' of modules, no term by term or year by year separation of tasks, no criteria, and no evaluation mechanism)
- lacking in differentiation of core attitudes, knowledge and skills common to all mental health professionals and those specific to this profession
- lacking in guidance of 'level of detail' of the knowledge, skills and experience required. (For example, it was felt that the organic knowledge and skills of trainees were fairly thorough; that psycho-cultural knowledge covered a lot of territory superficially; but that practical skills - both range and depth - were patchy or shallow.)
- requiring revision as its 3 year trial expired in September 98. The RANZCP should now be working on a version which fits with the national curriculum.

This task group made specific and detailed comments and recommendations for updating of many sections of the 1995 RANZCP curriculum. These recommendations are specified in Appendix 7. The general conclusions regarding the 1995 curriculum, as specified by consumers and carers were:

- The curriculum should express more clearly its ethical and human rights basis by grounding these in the internationally occupied articles of human rights and the national policies regarding consumer rights and responsibilities. (For example, the curriculum needs to support a consumer right to choose registrar or case manager; and the right to question doctor and negotiate treatment even (or especially) if unwell.)
- More emphasis should be placed on psychiatrists' understanding of ethical and legal responsibilities both to consumers and carers and the community as a whole. The curriculum appeared to support the training of psychiatrists to become 'monomodal gurus'. The curriculum did not teach limits of psychiatrists' legal powers and skills. Also, it was questioned whether it imposed a sole psychiatric ideology, one which dismissed other viewpoints and approaches).
- Recognition should be provided of the role of others in the care of those with mental disorders. (It

56. See Rosen, A. (1998).

57. As mentioned in Chapter 1 work of the University of Queensland Department of Psychiatry on Professional Competencies for Queensland was also acknowledged. However, the development of such competencies required national participation and consumer and carer participation was crucial. Access to these reports was made available to all workshop participants once the reports were released.

was considered that there is insufficient emphasis in the curriculum on collaboration, on knowing when to seek advice, when to refer, when it would be appropriate to bring someone else in, recognising the contribution of others, including all other health disciplines, consumers, families and support groups, welfare and emergency services.)

- Theoretical models of mental illness need more articulation. (There was thought to be insufficient emphasis on multimodal approaches, with bio/psycho/socio-cultural models being insufficiently developed and specified).

A major issue was the question of what was specific to psychiatry and what attitudes, knowledge and skills were held in common with other disciplines. These points were noted:

- Psychiatrists and other doctors in training share many competencies in common with other professions (see chapter 6). But specific competencies for doctors and medicine are discrete and these discrete competencies are very important and essential to interdisciplinary teams, and amount to more than the sum of their parts.
- The distinction between psychiatry-specific and common skills is mostly blurred but often is a matter of emphasis and detail. The biophysical knowledge of a psychiatrist is very important, that is, it is necessary but not sufficient. It was also contended that the bio/psycho/social/cultural perspectives of psychiatry should be substantive not just gestural. Psychiatrists need to acquire attitudes, knowledge, skills and real experience of psychological, social and cultural interventions at a sufficient academic level to make a well informed, appropriate referral, or to make a basic level appropriate intervention. Doctors particularly need to know when not to work alone, and how to work in teams.
- Both 'top down' and 'bottom up' approaches to updating the present curriculum should be employed. The bottom up approach should include a survey of what all stakeholders, including consumers and carers, require of doctors in relation to psychiatric assessments and interventions. A pilot example of such an approach - asking consumers and carers what they require of doctors at different levels regarding their psychiatric training - is appended in Table 5.4.1.
- Learning objectives of the RANZCP Curriculum need to be linked to: the *National Mental Health Standards*; the *National Disability*

Standards; internationally accepted WHO classification distinguishing disease, impairment, disability, handicap and knowing appropriate interventions for each; and the *United Nations Principles on the Protection (and Rights) of People with Mental Illness* (1991).

- It was considered that psychiatrists-in-training and their supervisors should receive more explicit training in how to sustain themselves sensibly regarding their professional lives and workloads.

Other issues nominated for consideration for a future RANZCP curriculum were: a greater and more explicit emphasis upon, concepts of therapeutic optimism; resilience enhancing strategies; strengths-based interventions; power sharing in working partnerships with consumers and carers; the potential for recovery; 'quality of life' as well as clinical variables; and qualitative as well as quantitative research paradigms. A rigorous examination of the available evidence on these issues would better inform their inclusion and emphasis in the curriculum.

What was learned from the Education and Training Project?

There are valuable lessons for psychiatrists. First, while attendance by academics was substantial, the workshops would have benefited from the presence of more clinicians. This would have provided a firmer footing to deliberations about the skills required from each profession in everyday practice. This would also have provided greater awareness and experience of the possible high standards of interdisciplinary practice and relations with consumers and carers, including their participation in service provision.

Second, as noted, the workshops could be viewed as a crucible for the psychiatrists, in which we could become aware, under closely observed conditions, of the type of reactions which our stances evoked. It could be argued that for whatever reason there is a question of a 'problem of image' for the psychiatric profession, with a gap of perceptions and priorities between the psychiatric profession, other mental health professionals and major stakeholders⁵⁸.

One important question for psychiatrists to consider is whether psychiatrists evoke negative responses

58. A recent study of Frank Small and Associates. (Mugford et al 1998, Walter, 1998) regarding attitudes of mental health professionals showed that psychiatrists and other doctors, among other professional groups were perceived as being the group most distant from consumers in the role they play, as having the lowest identification with consumer perspectives and values, (and possibly by consequence) as generating the lowest consumer and carer satisfaction with treatment.

es *stereotypically* from other professions and stakeholders, that is, responses which may be quite independent of psychiatrists' actual interactions and real behaviours. If this is the case, are psychiatrists helpless to prevent these? Alternatively, do psychiatrists contribute directly to such responses? If so, how can we act constructively to prevent them? This issue needs further consideration. It is well worth acknowledging and trying to resolve such issues between psychiatrists and other disciplines, consumers and carers, if psychiatrists are to contribute constructively to inter-disciplinary workforce education and training, and if such collaboration is to be a fundamental plank of mental health services delivery.

Conclusions

First, the education and training project needs to propose to the RANZCP that it rebuild its training curriculum around consumer and carer needs and rights and takes into account the common disciplinary attitudes, knowledge and skills outlined in Chapter 6. Updating of the curriculum should support the training needs and requirements of trainee psychiatrists with specified elective interests and those of established psychiatrists. All graduate medical practitioners should be able to participate. Additionally psychiatrist participation should be encouraged and supported by the RANZCP and university departments of psychiatry, in collaboration with the other professions, in the development of some common or shared training modules in any interdisciplinary curriculum. Such participation should include many more practitioners, as well as academics from all the mental health professions, who would have greater experience of optimal standards of interdisciplinary practice and of consumer and carer participation in service provision.

The relationship between the RANZCP and the universities needs to be resolved around the common needs of postgraduate psychiatry. The knowledge needed by psychiatrists lies in several domains: biological, psychological, social and cultural and political. Psychiatrists need to be in contact with the academic disciplines generating knowledge and research in these areas. Thus partnerships between the College and universities need to be considered. For the Fellowship of the RANZCP, a two part training program should be considered. The new Fellowship would consist of basic training in psychiatry leading to a primary examination. The second part would be a series of learning units (some compulsory and others elective). While all practising psychiatrists would have certain knowledge of skills in common, they may specialise in different areas. The curriculum must allow for some degree of individuality and specialisation.

Additionally, and importantly, the learning modules could be made available to experienced practitioners. Experienced practitioners using them for purposes of professional development would use the material differently compared with the younger peers seeking postgraduate qualification. The assessment of experienced practitioners might differ accordingly.

In addition to providing learning modules for experienced practitioners, other disciplines may also access learning modules through the universities or the Colleges. It is envisaged that the range of knowledge and the educational expertise of the universities could also be accessed by the College for postgraduate training. This might offer the added value of increasing the number of psychiatric researches.

Second, the Commonwealth Department of Health, via the National Mental Health Strategy should promote and support, as soon as possible, a study of:

- the roles and tasks of psychiatrists, whether in the private or public sectors, in a mental health service, in the health and the wider communities
- the elements required of a training curriculum in psychiatry for graduate doctors, trainee psychiatrists, established psychiatrists, and accredited trainer psychiatrist/supervisors
- the reasonable needs, requirements and expectations of a psychiatrist by psychiatric consumers and carers, by other doctors, by other mental health professionals, other stakeholders and agencies, and representatives of both urban and rural communities
- the implications of the compatibility of such roles and elements of training with the National Mental Health Strategy and Standards (1997, 1998), with National Disability Standards, the WHO International Classification of Disease, Impairment, Disability and Handicap, and the UN Principles on the Protection (and Rights) of People with Mental Illness (1991).

This study design should take the opportunity to build the process of collaboration and involvement commenced in the education and training project and thus contain a significant qualitative and action research dimension.

Finally, there is an urgent need to bring issues relevant to the historical, social, political, health and mental health position of indigenous Australians into the curriculum at all levels. This certainly applies to psychiatry and needs to be considered by the other disciplines as well. Whilst individuals have written on this matter⁵⁹, the College and the universities have yet to act. In New Zealand there is now a Professor of Psychiatry in the School of Maori Studies, Massey University and this provides a benchmark for Australian psychiatry⁶⁰.

59. For example, Ernest Hunter.

60. Professor Mason Dury.

Table 5.4.1 Knowledge specific to doctors and psychiatrists: consumer and carer perspectives⁶¹

	Entry level doctors	Psychiatric Registrar in Training	Postgraduate continuing education
Bio	<ul style="list-style-type: none"> ❖ Interactions between all bodily systems. ❖ Pharmacology: Drug Interactions and side effects; working knowledge of contemporary range of psychiatric drugs. ❖ Accurate Mental State Exam and Physical Exam of all psychiatric presentations - both are equally important. 	<ul style="list-style-type: none"> ❖ Detailed up-to-date open minded non-doctrinaire understanding of clinical psychiatric conditions and their contemporary treatments. ❖ Detailed understanding of multifactorial etiology and Multi-modal approaches. 	<ul style="list-style-type: none"> ■ Relativistic viewpoint of psychiatric knowledge and how it is constructed, and relativist view of psychiatric history. ❖ Elective refresher modules.
Psycho	<ul style="list-style-type: none"> ❖ Understanding psychology of presc and misuse of compliance; impa having to medication and h to live with side effects. 	<ul style="list-style-type: none"> ■ Broad knowledge of psycho-social interventions for individuals, groups and families. ■ Deepening understanding of practitioner's own needs, the impact of practice on the patient, the practitioner, the practitioner's family. 	<ul style="list-style-type: none"> ■ Elective refresher modules.
Socio	<ul style="list-style-type: none"> ❖ Uses and misuse of medical power. ❖ Lived experience of being subject to external power of the Mental Health Act. 	<ul style="list-style-type: none"> ■ Understanding and promoting use of positive and negative feedback mechanisms particularly complaints process. ❖ Understanding least restrictive treatment and balance with least intrusive care. 	<ul style="list-style-type: none"> ■ Elective refresher modules.
Cultural	<ul style="list-style-type: none"> ■ Learning how and when to work with interpreters and bilingual/bicultural counsellors. 	<ul style="list-style-type: none"> ■ Learning how to work with consumer and family self-help groups. ■ Approaches to Indigenous and Transcultural mental health services. 	<ul style="list-style-type: none"> ■ Elective refresher modules.

Notes:

- ❖ Interdisciplinary knowledge
- Doctor specific knowledge

References

- Cox, J.L. 1997, 'Whole Person Psychiatry: Educational Implications', Plenary paper *World Psychiatric Association Thematic Conference*, Jerusalem, November, 16-21.
- Dougherty Report 1988, *Australian medical education and workforce into the 21st century*, April 1988 / Committee of Inquiry into Medical Education and Medical Workforce. Canberra: AGPS, 1988.
- Kozłowska, K., Nunn, K., Cousen, P. 1997, 'Adverse experiences in Psychiatric Training, Part 2', *ANZ. Journal of Psychiatry*, 31:5:641-652.
- Mugford S et al 1998 *Attitudes of Health Professionals Project – Final Report*. F. Small and Associates for Commonwealth Department of Health
- Rosen, A. 1998, Comment: 'Divining' the role of the consultant psychiatrist in a public mental health service, *ANZ Journal of Psychiatry*, 32:5:612-615.
- Royal Australian and New Zealand College of Psychiatrists Fellowships Board 1995, *A Curriculum of the RANZCP Fellowship Training Program*, RANZCP Melbourne.
- Walter, G. 1998, 'The attitude of health professionals towards carers and individuals with mental illness', *Australasian Psychiatry*, 6:2:70-72.

61. Derived from Workshop 3.

5.4 Psychology

Alison Garton

Brief history

Psychologists invited to attend the National Mental Health Education and Training Workshops were drawn from universities and academia, private practice, the professional association and a private education provider. Each invitee had also had extensive experience in working in public service mental health services as well as experience teaching on postgraduate programs. Thus a wealth of experience was represented and while not all psychologists attended every workshop, there was sufficient knowledge available for considerable progress to be made throughout the workshops. There were also psychologists amongst the consumers and carers, so the profession was well represented.

It was established during the first workshop that psychologists' specialised professional training, particularly for working in mental health services, was at the postgraduate level. Psychologists firstly complete an undergraduate degree, which provides the scientific and research underpinnings to professional practice. An Honours degree is the typical route towards postgraduate study, and in the fourth year, a substantial piece of independent research must be completed by students. Entry to postgraduate coursework degrees is extremely competitive, despite the introduction of fees in recent years. These degrees are currently mainly at Masters level but increasingly universities are offering DPsychs as doctoral level training programs.

The psychologist participants needed to focus attention on postgraduate psychological training programs and to acknowledge that undergraduate degrees, while providing useful entry-level education and training, did not provide adequate training in skills relevant for a mental health workforce. In psychology three year degrees, education in abnormal psychology is required, and occasionally there are units (often optional) on psychopathology and counselling. Ethics and professional practice issues are also required components of the curriculum and are taught at 3rd or 4th year level, usually without any practical component.

Once it was agreed that the primary focus for psychology would be on postgraduate training programs for psychologists, it was then necessary to justify the further focus on clinical psychology. Psychology has a number of specialisations and each is catered for by university training programs. Clinical psychology has by far the largest number of training programs and possibly the longest heritage as a separate area of advanced specialisation and study. Clinical psychology was selected because of its explicit emphasis on training psychologists to work in the mental health sector, specifically with people with mental health problems and with mental disorders. As well as providing education in working with people with serious mental illness, clinical psychology programs typically require that at least one placement (out of three or four) be completed in an institutional setting. Furthermore, clinical psychologists are trained in assessment, diagnosis, and treatment of people with mental illness, as well as in research and evaluation of the efficacy of the interventions.

Psychologists are proponents of the scientist-practitioner model which emphasises the value of the scientific basis to professional work. This is most clearly seen in the 1990s by the trend towards evidence-based (medical) practice, which psychologists have been advocating for many years. All clinical psychology training programs must demonstrate that this model underpins the teaching of applied psychology, and that all approaches taught and demonstrated are grounded in scientific research. This does not prevent critical appraisal of other approaches, often those preferred by consumers, but psychologists must understand both how and why a particular approach or technique achieves results and change.

Present situation

The audit of postgraduate clinical psychology training programs revealed 31 such courses distributed across Australia (Appendix 1). This is actually an underestimate as new courses developed since the audit are already running and some more are anticipated. It is expected that most if not all Australian universities will offer a clinical psychology training program. These training programs all have to be accredited by the Australian

Psychological Society (APS) as meeting the requirements for membership of the Society by demonstrating they meet the guidelines for 5th and 6th year training programs. Furthermore, they have to meet the Course Approval Guidelines for the APS College of Clinical Psychologists, eligibility for associate membership of which is obtained by psychologists who complete an approved course. Accreditation and approval are rigorous and involve both the submission of extensive documentation plus the undertaking of a site visit (usually of a minimum of two days' duration) from an appointed site visit team composed of psychologist peers. Full accreditation and approval is granted only when both sets of guidelines have been met; conditional accreditation is granted when there are areas of deficiency that require improvement, for example, extra resources are required or additional areas of psychological content need to be covered in the curriculum. Accreditation can of course be withheld or even withdrawn. Accreditation and approval are conducted on a five year review cycle. The psychologists were very pleased with the compliments about the way the accreditation system operates and how we were able to assist with the audit in a comprehensive manner.

The inclusion of consumers and carers in the training programs for psychologists is not, and has not been, extensive. Informally, the experiences of those who had involved consumers and carers in teaching classes varied from the exultant "Yes, this is incredibly valuable for everyone concerned", to the "No, there is no way I'd ever do this again. The consumer was so anxious that he got drunk before the class and unfortunately fulfilled all the negative stereotypes about people with mental illness". It was noted that curriculum and financial constraints prevented greater opportunities for external involvement in clinical psychology teaching (this is true also for outside experts as well as consumers and carers). Furthermore, although all clinical training programs are required to have Advisory Committees, few if any, have consumers or carers on these. Again, university regulations and financial constraints limited who is eligible for invitation onto such Committees in many cases. External representation is mainly confined to other psychologists working in the field. This restriction is also true for those involved in the selection of students for entry to the programs (if and where external participants are involved) and also for selection of staff to teach and train psychologists.

Thus we aimed at developing strategies for the inclusion of consumers and carers in mental health

education and training. This enabled the psychologists to begin to discuss some of these issues and identify the barriers to the involvement of consumers and carers. This aspect, along with the need to identify core competencies as well as common interdisciplinary competencies, permitted psychologists to think about what it is we are trying to teach and how we are achieving this. Inevitably, this resulted in the development of some broad overarching themes, rather than specific competencies. Indeed, psychologists have already developed competencies, both for entry into the profession, and for entry into the different areas of specialisation, including clinical psychology. It became apparent that what we were being required to do was to characterise the curriculum (be it national or profession specific) so that it reflects the needs and expectations of the consumers and carers as well as fulfilling university and professional association requirements. These include, for psychologists, APS accreditation and approval requirements and competencies (which themselves were linked during their development so that they reflect one another, the former representing inputs or resources, the latter outcomes or skills derived from training).

Attitudes, knowledge and expertise framework

The workshop held specifically for psychologists enabled the development of some core attitudes in relation to practising as a mental health professional. The sorts of attitudes identified had considerable overlap with those identified by the other professional groups. Examples included the following, that mental health professionals:

- treat consumers and carers with respect and dignity
- recognise consumers as individuals, apart from their illness
- understand the value systems of their own culture and those of consumers and carers
- expect consumers to get well, that is, have hope
- know their own limitations.

Attitudes that were identified as essential and unique to psychologists were that mental health professionals:

- treat consumers, carers and others with due humility
- understand the issues and tensions related to confidentiality and exercise judgement in sharing information
- engage in participatory decision-making in regard to intervention and service provision
- are willing to acknowledge their own fears, ambitions, dependencies, attractions, aversions, prejudices, inadequacies and inexperience (sic)
- are willing to keep learning and to remain open to ideas
- have patience and perseverance
- demonstrate empathy
- are open to recreate
- acknowledge the immediacy of the 'I/thou' relationship.

These attitudes reflect the psychologist's training in the scientist-practitioner model while acknowledging the importance of the client, patient or consumer and his or her feelings, reactions and emotions. They also reflect the respect for the consumer and his or her support network while recognising the sensitivities associated with dealing with fragile emotional and behavioural states. It was noted that many of these attitudes cannot be 'taught' in the traditional sense but are essential to the establishment of empathy, understanding and rapport in a therapeutic relationship.

The psychologists were then asked to develop competencies in relation to the attitudes identified by the consumers and carers. The resultant lists are not of competencies as traditionally defined; rather they reflect how the psychologists interpreted each guiding principle and translated them into actions that would demonstrate their commitment and adherence to them. In many cases it was felt that these represented good professional practice as they were fundamental to working with people.⁶²

As discussed earlier, the guiding principles governing the knowledge and skills to be taught in education and training programs are:

- *Mental health professionals need to learn about and value the lived experience of consumers and carers.*
- *Mental health professionals should recognise and value the healing potential in relationships between consumers and service providers and carers and service providers.*

At a general level the workshops highlighted the many ways in which these principles are not currently expressed through the work of mental health professionals, and explored mechanisms for change.

In demonstrating *behaviour* for the first guiding principle, psychologists identified the following:

- respect for the individual
- willingness to listen
- acknowledgment of the importance of the stories, worlds and knowledge of consumers and carers
- preparedness to acknowledge their own experience, including personal resistance to the lived experience of consumers and carers
- willingness to achieve 'deep dialogue' with consumers and to learn by reflection on this
- avoidance of laying blame (on self or on others).

In demonstrating the second principle, psychologists identified the following:

- acknowledgment of the immediacy in relationships
- maintenance of commitment to relationships with consumers and carers
- acknowledgment of when a relationship is not maintaining healing potential

62. It is a matter of record that psychologists were not happy about this process because (i) it was felt it duplicated a similar exercise of the previous workshop and (ii) the overarching attitudinal principles that we were asked to work on were not derived from the profession but from an equivalent workshop with consumers and carers. Psychologists thus took issue with the wording of these principles and consequently only worked on two of three. It was not so much the content of the principles that was the point of dispute, rather the perceived duplication of the process and the failure to take into account the considerable time and effort that had so far gone into the development of a set of attitudes.

- openness and honesty, being ‘fair dinkum’
- valuing gentleness, compassion, humour
- acceptance of criticism and learning from it
- recognition of the capacity of people to develop and change.

Again, these sets of attitudes reflect both psychologists’ training and experience as well as personal characteristics that are valued in the establishment and maintenance of any therapeutic relationship.

Psychologists also identified a further over-arching guiding principle that was not worked on by the workshop generally, namely: *Mental health professionals should have a commitment to the extension of knowledge and to innovative practice.* The core knowledge for practice as clinical psychologists was identified as being specified previously in the APS College of Clinical Psychologists competency document. Nonetheless, some 100 areas of knowledge were identified at the third workshop; these included knowledge originating from other disciplines as well as knowledge common to all disciplines. These were in addition to the specific areas of psychological knowledge essential to professional mental health work. Among the areas of psychological knowledge identified were:

- theories of human development and behaviour
- psychological theories and models, and the major methods of psychological inquiry
- theories and data that underlie the main areas of psychological intervention
- theories of the bases of behaviour, cognition and emotion
- major methods of psychological investigation and techniques of measurement
- application of psychological knowledge through understanding of the interplay between science and practice.

It was concluded however, that with reference to the two guiding principles, there was no specific knowledge base. It must be recognised that advanced knowledge is often the domain of psychology, the teaching, research and practice of which requires extensive knowledge and skills.

Furthermore, much psychological knowledge has been absorbed into the knowledge base of other disciplines and professions. The fundamental importance of the scientific and research base to the practice of psychology was reaffirmed in this workshop.

Finally, the skills required to meet the guiding principles were identified. The list is too long to reproduce here in its entirety, but includes:

- negotiation and advocacy
- effective communication
- a variety of problem solving techniques
- evaluations
- assessment of needs
- assessment of risk
- effective working in terms of using the knowledge and skills of others
- establishing partnership for providing care
- reflection on own practice
- establishing and sustaining therapeutic relationships
- practising within an ethical and legal framework
- working effectively with culturally diverse groups
- establishing and maintaining networks.⁶³

Desired situation

The strategies identified by psychologists for achieving and maintaining the guiding principles include:

- the provision of programs and funding to enable participation of consumers and carers in education and training
- assurance that any proposed curriculum requires professionals to provide evidence of engagement in the lived experience of consumers and carers

63. These were the views of the psychologists involved in this project and broader consultation with other clinical psychologists will be necessary to confirm (or disconfirm) the content of any of the lists.

- the establishment of networks of consumers and carers by practitioners and educators
- inclusion of structured ways during education, training and supervision of encouraging professionals to secure insights into their own experiences
- planned exposure to a range of bodies of knowledge, including first person accounts, in the education and training of mental health professionals.

It is vital that, in meeting the needs of consumers and carers for involvement in the education and training of mental health professionals, government support is provided. For the training of psychologists, for example, there are competing demands on the training programs at the masters and doctoral levels and if any serious attempt is to be made to involve consumers and carers, then there must be some incentive. For example, the programs are being pressured to include a far greater component of education, training and working with indigenous people. An extension of this may be to include specific training for working with migrant populations. At present, there is insufficient time and space in the curriculum to incorporate anything but fundamental training in evidence-based approaches to clinical work.

The psychologists expressed a preference for a targeted approach whereby only *certain* training programs, in clinical psychology say, are funded to train psychologists to work with people with mental illness. Consumer and carer involvement would be a central component in all aspects of these particular training programs, from student selection to teaching and assessment. Such a proposal would not exclude consumers and carers from other training programs which may have a different focus (for example, on training to work with people with intellectual or physical disabilities). Given the plethora of clinical training programs across Australia, such an approach would not in any way limit the potential involvement of consumers and carers; instead it would be more focused, with a better outcome in terms of training and satisfaction for the trainees and for the consumers and carers.

For both of the above arguments, government funding would assist in accommodating the training for psychologists to work with people with mental illness and in involving consumers and carers in such training. A targeted approach would allow for psychology programs to provide both general and specialised training which the trend to doctoral training would permit. It would make sense to capitalise on the current moves to doctoral level training and identify mental illness as one

of the areas of specialisation. Furthermore, those involved in the implementation and monitoring of the APS Accreditation Guidelines are already considering how best to deal with the doctoral programs and increasing professional specialisation. This proposal is in line with current professional expectations and trends.

The aforementioned strategies are also mirrored in the more general proposal for the implementation of a national framework for the education and training of mental health professionals, including the development of a national curriculum, approved university courses, participation by carers and consumers in education and training (as teachers, expert advisers, student learners, as appropriate), and continuation of high standard clinical psychology training programs (with suitably qualified and experienced staff) that encourage working with people with mental disorders and mental health problems. It goes without saying that all the above need to be adequately resourced.

While this project focused on the postgraduate training programs, it is essential that for our profession, equal attention is given to practitioners requiring on-going professional development or to those wishing to commence or move from other fields into working with people with serious mental illness. The APS has a system of mandatory professional development (PD) for College members and ways need to be found to build the guiding principles into this on-going aspect of education and training.

The practical outcomes sought by these workshops all rely upon greater involvement of consumers and carers in planning and delivery of professional training and continuing education. It is essential that the innovative directions of the workshops are followed up by a commitment by government to funds that will enable participation of consumers and carers in education and training. The professions also require funding to develop further the knowledge and skills in relation to the attitudes and values espoused at the workshops. Such processes are likely to be both challenging and rewarding for psychologists.

References

- Australian Psychological Society 1996, 'Competencies for Psychologists: A Discussion Paper', *Supplement to The Bulletin of the Australian Psychological Society*, 18. ISSN 0157-9517
- Australian Psychological Society 1997, *Competencies of the APS College of Clinical Psychologists* (available on request from the APS).

5.5 Social work

Maria Harries

Brief history

Introduction

The Australian Association of Social Workers (AASW) welcomed the opportunity to contribute to The National Mental Health Education and Training Project⁶⁴. The consumer and carer focus for the project was a significant reason for the project achieving unqualified support. As well, the instigation of the project was timely for the Association because it coincided with our recognition of the need to develop a formal system for developing and monitoring standards of practice in a range of specialist areas including mental health⁶⁵.

However, none of us could have predicted the significance of the impact of this project on the way we came to revisit the core of the mental health social work. The powerful consumer and carer input at every step of the project plus the often provocative information sessions and the opportunity to continually debate issues with other discipline members, provided challenges that have permanently altered the way we will conceptualise the practice of social work in mental health service delivery. Testimony to the impact of the education and training project has been the fact that the momentum to review practices and to develop a clear framework of competencies for social work did not dissipate when the project finished⁶⁶. Earlier this year⁶⁷, the Board of the AASW endorsed with enthusiasm the proposal to establish a Steering Committee to build on the outcomes of the project to develop a national framework for standards in mental health social work and signed off on a national consultancy project, funded under the National Mental Health Strategy to achieve this objective⁶⁸.

The need for the education and training project had become apparent in the very persuasive evidence from consumers and carers to the National Mental Health Strategy. These people identified consistent negative experiences and poor outcomes for people with a mental health problem and their carers who entered the mental health network of care. As well as this, it had become clear that there was a need to engage social work at a grassroots level if the changes required by consumers and carers were to be incorporated in what was evidently required, that is, a fundamental reorientation of education and training which could achieve satisfactory outcomes for people with a mental illness or mental health problem and for their carers.

The Advisory Committee, representing consumers, carers, and representatives from each discipline provided a thoughtful and progressive forum for the project. The task of the social work representative was to bring perspectives from mental health service delivery, from education, policy development, research, clinical practice and management roles as well as representing the AASW. The Committee met regularly. Consumer and carer members gave a rich depth to the planning for, and conducting of, the consultative process in social work. The consumer and carer workshops ensured that subsequent multi-disciplinary and discipline specific workshops were informed by strong consumer and carer perspectives. An audit established the baseline of the current educational structures for social work in Australia (Appendix 1).

As already discussed, the guiding principles represented a new paradigm for generating a framework for competencies in social work. This means that the following principles, rephrased for social work, must at all times be at the forefront of thinking and practice:

64. The AASW placed its full support behind it by nominating an Association member to the Advisory Committee for the project and facilitating the attendance at workshops of the Chief Executive Officer.

65. The debate about implementing Boards of Practice had been going for some time and resulted in a discussion paper – Quality Practice Options: Discussion Paper being circulated in Feb 98. As well as this, the Continuing Professional Education policy (CPE) had been finalised and had started focusing the minds of members on the opportunities for continued education in specialist areas including mental health.

66. The last workshop was held in Canberra on 12th and 13th February 1998

67. This was finalised at the AASW Board of Directors meeting in June 1998

68. The Project is due to report to the AASW Board of Directors in March 1999.

- Social workers need to learn about and value the lived experience of consumers and carers.
- Social workers should recognise and value the healing potential in the relationship between consumers and service providers and carers and service providers.
- Social workers should recognise and value the ongoing potential for recovery of people within the mental health system.

Whilst these affirmations appear pivotal intuitively to good social work practice, the challenge they present is an ability to work constantly at the interface between the lived experience of the people social workers serve and knowledge that is informed by multiple lived experiences as well as research. This in turn requires a humility on the part of social workers to be constantly vigilant about their values and attitudes. Consumers and carers advised us that, in their experience, this vigilance was often absent.

Social work and mental health service delivery

There were a number of serious questions posed for the discipline of social work at the project workshops. The first multi-disciplinary workshop⁶⁹ raised the key question: how does social work identify its core contribution to the delivery of services to people with a mental illness or a mental health problem and their carers? A second, and equally important question emerged: how do we educate social workers to prepare them for this complex domain of mental health service delivery? And thirdly, how do we foster the development of competencies in mental health service delivery for social work practitioners who are working in a broad range of organisations, only some of which are dedicated mental health services?

The challenges and opportunities confronting social work in this project were evident at the outset and were expanded upon in the first workshop⁷⁰ at which seven social workers from across Australia were present alongside an equivalent number of colleagues from other disciplines and a large number of consumers and carers. Social workers have a tradition of assuming that practice is grounded in the needs of the people it serves; they purport to have an empowering role with peo-

ple who experience disadvantage in society; they argue that they have an important role in the development of services to meet emerging community and individual needs. As well as this, social workers have a long history of involvement with people with mental illness and with their carers. This project offered us the opportunity to reflect on and operationalise core principles on which social work is based and review their meaning for practice.

Social work education in Australian universities is generic. Its aim is to produce graduates with a broad range of skills in a considerable range of practice settings. Social work is self regulating and it is not a registered profession (see Appendix 1). It requires that its practitioners are self-motivated to continue learning and to achieve outcomes rather than being driven by legal requirements and sanctions. Although Social Work Schools in universities have to meet certain standards to achieve 'approval' by the Australian Association of Social Workers (AASW), these standards have, until recently, been focused on input requirements (e.g. information and learning) rather than outputs or outcomes (e.g. performance and demonstrable skill). Although competency standards for entry level social workers in general - not for mental health - have been developed by the AASW, these are not necessarily incorporated into teaching in each of the Schools of Social Work⁷¹. Also, the competency standards for social work in general were not developed with consumers or carers as pivotal to the process of standards development.

In the light of this brief description, the challenges provided for social workers by this project were considerable. Social workers work with people who experience a range of mental health problems in practice settings that do not fall within the narrow definition of specialist mental health services. Many work in non government agencies with broad mandates. Some work with the severely mentally ill under other labels, such as homelessness, substance abusers or social security. How could we conceptualise social work to be inclusive enough to encompass the generic nature of the tasks and roles that are undertaken, and at the same time, honour the specialised nature of the roles and tasks in dedicated mental health services?

Social workers develop their expertise in mental health by working 'in the job', undertaking in-service training and self-initiated postgraduate studies. There are no paid training posts, as there are in psychiatry. There are no baselines for skills required in different settings. How could social

69. February 11th and 12th 1997, Canberra

70. February 11th and 12th 1997, Canberra

71. Although The Australian Social Work Competency Standards for Entry Level Social Work, AASW were finalised in September 1994, these have never received the full endorsement of the AASW Board of Directors.

work competencies be conceptualised in a way that would foster a recognition of the specific role of social work? And as social workers have not incorporated the views of consumers and carers in any formal way in the development of competency standards, how could we understand and integrate the consumer and carer perspectives before assuming that any 'practice wisdom' within the profession about its core competencies was the point at which to start?

A number of principles, in addition to the consumer and carer focus, were adopted during the course of the workshops. One of the critical ones was that *discipline strands should remain intact*, in order to enable us to value and build on the traditions and expertise of each discipline. The acceptance of a discipline base to the development of competencies enabled all professional groups to avoid the time consuming distraction of dealing with the threat of the 'generic mental health worker'. For social work this was an important starting point because of the perception that the threat of not being able to capitalise on a significant history, commitment and tradition in mental health was very real to us.

A significant factor that made the project an exciting one for social workers involved in it was the range of practice knowledge amongst the social work representatives in the project. Clinical, research, education, policy and management positions were held by social work participants. Whilst this created a robust environment for debate, numerous practice arenas were not represented. Debate would need to be even more robust before the final standards were developed.

Present situation

The national education and training audit conducted as part of the project provided concrete evidence to support some of the observations made by social workers in the workshops. Most social work courses in Australia are four year undergraduate degrees. Some universities run postgraduate two year degrees alongside of, or instead of, a dedicated four year degree. All courses assume some considerable overlap between generic social work competencies and specific mental health ones. Very few courses have a dedicated mental health unit. Postgraduate courses in social work may, in some instances, address the needs for competency development in mental health, however, the number of these has reduced as HECS fees for postgraduate study have reduced the financial viability

of applied courses. All courses are struggling with 'crowded pre-qualification curricula' and demands for more input in specialist areas. Some students undertake their fieldwork in mental health agencies. Some courses include input from carers and consumers but this input is not central to course structure and design. Most courses provide knowledge, information and skills in preparing graduates for working with people with a mental health problem. To meet these challenges, there is a strong sense that the specialised area of knowledge and skills in social work and mental health needs to be undertaken at a postgraduate level, and that at least some of this should be studied through multi-disciplinary training modules.

As already mentioned, there have been no national mental health competency standards for social workers in Australia⁷². On a more positive note, in 1996, two state branches of the Australian Association of Social Workers (NSW & Victoria) developed models for standards of practice and roles and responsibilities for social workers in mental health care. Additionally, there is now a hearty enthusiasm on the part of the AASW to develop national competencies in a range of specialist areas. There is little doubt that social work practitioners in mental health are committed to: improving their practice in the light of the input of consumers and carers; critical reflection of their practice; new research evidence; and organisational recognition of the need for quality improvement through in-service training and postgraduate education.

One further element of the current situation of which account needed to be taken was that the AASW, the professional association for social workers in Australia, is a not-for-profit organisation which relies entirely on membership funds and an honorary board of directors to address a very complex set of needs for social workers in diverse fields of practice. It does not have the funds to conduct the type of comprehensive national consultations required to effect the type of changes signalled by this project.

Achievements during the project

It is not easy to define all of the outputs for social work during the course of the workshops because much of the value emerged in an organic way from the networking, exchange of ideas and the encouraging confrontation of values and attitudes

72. As earlier discussed there are national generic competency standards that have not achieved total endorsement by the AASW or professionals.

amongst the participants. A personal challenge for the writer was how to utilise the learning from the workshops to carry the momentum for change from the workshops to the profession across Australia. This challenge became clear in the opening address at the first workshop by The Hon. Michael Wooldridge, Minister for Health and Family Services, when he stated that all participants carried a responsibility for generating a new work-force culture that values the contribution of consumers and carers. The Director of the Mental Health Branch in the Department of Health and Family Services, Dr Harvey Whiteford said that “there was no going back”, nor was there an option of retaining the status quo. The advice of consumers and carers about their troubled experiences at the receiving end of mental health service delivery was too persuasive to counter any option other than a new direction driven by evidence of effectiveness in interventions and quality of outcomes for consumers and carers.

The following describes briefly some of the key outputs for social work from the workshop process.

In the first workshop⁷³, social work representatives:

- validated the vital role of consumers and carers in education, service planning and delivery and argued for award rates for any such work
- recognised the limited scope for extending mental health input into graduate courses and acknowledged the need to vigorously pursue postgraduate educational options at a uni-disciplinary and inter-disciplinary level
- asserted the important role of this project in enabling the professional association to support good practice and practitioners by developing standards for social work practice in mental health settings
- acknowledged the contribution that consumers and carers could make to the maintenance of such standards by being involved in supervision, evaluation and review of workers and programs
- requested that an audit of social work programs in Australia be undertaken to establish a baseline for our knowledge about current courses
- presented a number of initiatives that would facilitate the implementation of changes beyond the workshop.

One of the important outcomes of this workshop was the realisation of the need for an ongoing formal dialogue with the AASW and the formal acknowledgment that the commitment we had already made would require ongoing work by the AASW as well as the discipline group. From this time the Executive Officer of the AASW became a member of the social work disciplinary group on the project.

At the second workshop⁷⁴, social workers focused on core competencies for mental health in relation to a national curriculum for the postgraduate education of social workers and other mental health disciplines. At this workshop, anxieties were expressed about whether there were many discrete competencies for disciplines in general and for social work in particular. Consumers and carers were pivotal to the ensuing discussions; they kept us all grounded in a basic reality for them, that is, that while the specialist nature of each discipline was important and evident to them, at the same time consumer and carer outcomes were predicated on disciplines working effectively together (holistic care). Consumers and carers in the discipline specific group during this workshop assisted social workers to start to build on their strengths, identify their weaknesses, engage with some opportunities and address the threats to social work in mental health service delivery.

The primary outcome from this session was the reminder to social workers that one contribution to mental health services could reside in assisting to interpret the social world of consumers and carers for other disciplines and to value and assist consumers and carers to validate and strengthen their ‘lived reality’ outside the mental health service system. Social workers were encouraged to acknowledge the central place in their competencies of their knowledge of resources, their role in developing resources and of their skill in thinking systemically about the consumer and carer in their social environment.

During this workshop, social workers acknowledged the importance of contributing to the development of a national interdisciplinary curriculum to foster postgraduate competencies in social work mental health practice. However, it was also acknowledged that some of this continuing education needed to be discipline-based.

In the social work disciplinary workshop⁷⁵ the social workers, informed by consumers and carers, utilised the principles for the workshops and the draft standards of the AASW Branches in NSW and

73. 11th and 12th February 1997

74. 22nd - 24th June 1997, Canberra

75. 13th and 14th November 1997, Melbourne



Attitudes	Knowledge	Skills
■ Openness to the experience of others	■ Of self	■ Ability to enter a meaningful dialogue
■ Willingness to tolerate 'not yet knowing' and to suspend judgment	■ Consumer and carer experiences and wisdom	■ Interpreting and promoting the importance of the social world of the consumer
■ Valuing difference in people	■ Person in environment	■ Ability to balance carer and consumer needs
■ Willingness to learn, to explore, be curious	■ The uniqueness of every experience	■ Community development
■ Respect for the stories of consumers and carers	■ Organisational resources	■ Resource development
■ Willingness to enter relationships on an equal basis	■ Sociology of oppression and alienation	■ Research and evaluation
■ Willingness to contribute to the healing process, and be willing to make changes	■ Organisational theories such as power and influence, structures	■ Advocacy
■ Willingness to negotiate an outcome	■ Social research	■ Empowerment
■ A focus on strengths	■ Philosophy	■ Application of social justice principles at all times
■ Acceptance of 'connectedness' in relationships	■ Economic and sociopolitical theory	■ Relationship building
■ Acknowledgment of the boundaries in relationships	■ Social justice principles	■ Networking
■ Management of own authority	■ The history of mental illness and institutional care	■ Counselling
■ Optimism and the belief in recovery	■ The impact of disadvantage on people	■ Ethical thinking and practice
	■ Mental health research	■ Priority setting
	■ Community and family systems	■ Resource identification and development
	■ Mental illness - classification, causes, epidemiology and personal meaning	■ Self evaluation

Victoria, plus a curriculum model from the University of Queensland (see Chapter 1) and started the process of developing a framework for national social work mental health standards.

An extensive list of values, attitudes, knowledge and skills was developed during the course of the project. It was developed with consumers and carers who started the process by drawing up with us a list of core competencies for all professionals⁷⁶. The following picks out the essential items that were then listed for social workers:

Desired situation

The desired situation for social work is that it has a recognised and valued place in the delivery of services to people with a mental illness and their carers and that it can make a difference to the lives of these people in a way that they report to be beneficial. Most importantly, the process to date has been one that has simultaneously validated the social work role and confronted the need for the profession to be more explicit about its contribu-

76. Consumers are treated with respect and dignity; recognition of the rights of consumers and carers; active listening; a non patronising approach; taking responsibility for own behaviours and agendas; acknowledgement of what is not known; collaborative working relationships with consumers and carers; accountability for decision making; responsibility for maintaining knowledge and skill base; justice in dealing with consumers, carers and other professionals; honest dealings with consumers; a sense of privilege to be working in the field.

tion and to advocate for itself as it claims to advocate for others. The goals set for the profession at the end of this project were that social work:

- develops a set of core 'entry level' competency standards for graduating social workers entering mental health practice that:
 - is driven by the strong involvement of consumers and carers
 - makes attitudes and values central
 - involves a comprehensive national consultation that takes account of different models of, and locations for, service delivery
 - is supported by educators
 - obtains the full endorsement of the Australian Association of Social Workers
 - develops a set of secondary level competency standards for specialist social work areas
 - assists in the development of opportunities for practitioners to maintain and increase their skills in providing services for people with a mental health problem and their carers
 - achieves recognition for the contribution that social workers can make to the development of the highest quality of mental health services in Australia.

Following the completion of the project, it was agreed that social work would commit itself to the advancement of the principles that were enunciated in the workshops, capitalise on the framework developed to date, and seek a national opportunity to build on the work undertaken in the workshops to develop entry level and secondary level competency standards for social workers in consultation with all branches of the AASW, and with consumers, carers and university social work schools and departments.

It was agreed that the framework to be used to develop the competency standards and post quali-

fying curriculum design for social work will be modelled on that developed by the Royal Australian and New Zealand College of Psychiatrists⁷⁷ which involves the identification of core values, attitudes, knowledge and skills - the framework that was endorsed by consumers and carers and discipline representatives in the workshops and that was utilised in the social work discipline-based discussions. There was a consensus that *attitudes and values* had to be the pivot for the effective application of any knowledge and skills.

Crucial to the development of any standards will be the direction and wisdom to be provided by consumers and carers. Also a strategy is needed that will lead to the 'ownership' of the standards by all mental health social workers in Australia. Funding for a national consultation was sought to advance the progress made during the project. The AASW is conducting a national consultation, funded by the Commonwealth Government which is being undertaken by the University of Tasmania School of Social Work⁷⁸.

These national consultations have been welcomed by social workers in mental health with enthusiasm. This is the first time that social workers in mental health have had a potent opportunity to contribute to the development of improved standards of care in mental health. It is certainly the first time that they have done so in a collegial effort with consumers, carers and other disciplines. The questions asked by social workers in the first stages of the project are all being answered. The specific role of social work does honour its generic base, consumers' and carers' perspectives must be at the core of the practice wisdom, competencies can honour the diverse practice base of social work outside of formal mental health services. And social work will have a valued place in mental health, as long as it keeps its focus on what consumers and carers have identified as its most valued contributions. The challenge is to develop our framework in a way that continues to honour the integrity of the process to date with the continuing contribution of consumers and carers as the ultimate beneficiaries of refined, articulated and tested social work standards.

77. Appendix 6.

78. Professor Robert Bland, an active participant throughout the Project is leader of this project.



6. What the disciplines have in common

**Lesley Hardcastle
and Jan Carter**

Introduction

Throughout the project, the interplay between disciplinary and interdisciplinary issues ebbed and flowed. As the project progressed and the disciplines became more confident about their identity and their mission, it became possible to contemplate interdisciplinary collaboration.

We noted that many mental health staff have worked together productively in teams, developed new service frameworks, and have a common mission. Developments to postgraduate education were apparent through the recent interdisciplinary postgraduate courses established at Wollongong University, the University of Queensland, the University of Melbourne and Monash University and Flinders University of South Australia⁷⁹.

However, it was not interdisciplinary collaboration which was to the fore at the commencement of the project. The atmosphere of the first and second workshops was tense (and sometimes angry). What kept the disciplines apart was more evident than what brought them together. But as the process developed, the question was raised of the

possibility of a common national curriculum and it was decided that at the very least a framework for a national curriculum should be developed. Thus this chapter attempts to see first, what the disciplines had in common, and second, what educational and training outcomes this might presage.

As has been discussed in chapter 5 the disciplines have very different histories, outlooks, of education and training paradigms and practices, and separate organisation and accreditation procedures. At the beginning of the workshops, all groups wished to stress their differences and this led to tensions. *By the end, all disciplinary participants were prepared to acknowledge that the similarities between them were more marked than the differences.* This chapter will discuss this process.

In addition this chapter suggests that the outcome achieved by this process, offers a paradigm which has relevance for the future education and training needs not only of the five disciplines, but for members of the mental health workforce who are not members of the five disciplines. Some of these may be the staff who will seek specialist mental health education in interdisciplinary postgraduate mental health university courses. Thus this chapter raises issues for the five disciplines, for members of the mental health workforce who belong to smaller disciplinary groups, such as speech pathology, physiotherapy, teaching and for those personal care staff in mental health services who have no disciplinary membership at all.

79. Wollongong University (NSW) is a multi-disciplinary postgraduate course work program commenced in 1992 which equips graduates with clinical and research skills for comprehensive, community-based treatment and rehabilitation. Graduates' satisfaction has been tempered by reports of frustration at their inability to put this learning into practice because of inflexible management structures and a lack of support from colleagues.

The University of Queensland offers a postgraduate Diploma in Community Mental Health using the Wollongong curricula with some different emphases and consumer and carer participation. This course had initial support from Queensland Health.

The University of Melbourne and Monash University. A Graduate Diploma in Community Mental Health is a joint venture between the two universities and involves medicine, social work and nursing staff. This was initially assisted by the Department of Human Services, Victoria.

The Flinders University of South Australia. A Graduate Certificate in Community Mental Health commenced in 1994, at masters level. This course focuses on best practice in mental health promotion, prevention and early intervention within contextual, community-based, community and consumer responsive services. It provides training in brief, effective therapies. It is available nationally and internationally.

Outcomes

One of the goals of the workshop had become the exploration of the possibility of a common curriculum. At the same time, the disciplines were unclear about their own curriculum. Could a common curriculum be achieved?

By the end of the second workshop it was apparent that the disciplines needed more time to discuss and reflect on the principles of the project as defined by the consumers and carers and to examine the implication of these for their own curriculum⁸⁰.

The mini workshops⁸¹ identified those attitudes, knowledge and skills, governed by the principles, which each of the disciplines groups could embrace. As viewed from the perspective of Arnstein's ladder of participation (see chapter 2) these small group meetings moved the relationship between the professional groups and the consumers and carers from 'degrees of participation' to the beginnings of 'degrees of power'. Because the mini workshops were held consecutively and the timing of the workshops staggered, this encouraged acceptance and take-up of the views of other groups. Recognition of other disciplines' perspectives by each discipline noticeably moved from antagonism to acknowledgment and then to acceptance.

The general principles have been fully discussed in the earlier chapters. But it needs to be noted that a third was proposed but was not acceptable to all:

Mental health professionals should recognise and value the ongoing potential for recovery of people within the mental health system⁸².

It had been pointed out clearly by the consumers that attitudes were of key interest to them in the conduct of mental health professionals (see Chapter 3). The project successfully expressed common attitudes of mental health professionals. For practical purposes these have been reduced to three statements, sufficiently general to allow performance to be further identified and described, regardless of discipline.

80. Chapters 1 - 4 discuss the principles underpinning the common attitudes, knowledge and skills that were established early in the process, were articulated by the consumers and by the carers at all stages of the project, and were accepted as the basis for further work in identifying common attitudes, knowledge and skills. These principles are consistent with the guiding principles of the *National Standards for Mental Health Services* (Commonwealth of Australia, 1997).

81. At workshop 2 the psychiatry members suggested that other disciplines needed to catch up and define their learning objectives through a similar process adopted by the RANZCP (see chapter 5.3) and were thus not part of the mini workshop process, a matter discussed in chapter 5.3.

82. This principle was controversial; there were just as many strongly supporting it as were troubled by it. The problem was the assumption that recovery was desired (or even desirable). The connotation of the word 'recovery' suggested to some that people who did not recover were less acceptable. In a future process, replacing the word 'recovery' with 'healing' may assist further discussion.

Attitude 1. Treat consumers and carers with respect and dignity.

In demonstrating this attitude, all mental health professionals will:

- 1.1 Acknowledge the knowledge and the lived experience that consumers have about their own mental health and the mental health system.
- 1.2 Acknowledge the knowledge and the lived experience that carers have of [the consumer's] mental illness and the mental health system.
- 1.3 Be willing to use the knowledge of consumers and carers in collaborative planning of treatments and support.
- 1.4 Pay attention to the priorities, wishes, social and spiritual cultures of consumers and carers.

Attitude 2. Recognise the rights of consumers and carers.

In demonstrating this attitude, all mental health professionals will:

- 2.1 Comply with the relevant regulations and legislation protecting the rights of people affected by mental health problems, including:
 - *United Nations Principles on the Protection of People with Mental Illness and the Improvement of Mental Health Care* (Geneva, 1992)
 - *Australian Health Ministers' Mental Health Statement of Rights and Responsibilities* (1991).
- 2.2 Demonstrate respect for the dignity of the individual.
- 2.3 Recognise and treat consumers as individuals apart from their illness and carers apart from their role as carer.
- 2.4 Be non-judgmental of consumers and carers and not attribute blame.
- 2.5 Maintain optimism in their work and allow consumers and carers to have hope.

Attitude 3. Take responsibility for their own attitudes and behaviour.

In demonstrating this attitude, all mental health professionals will:

- 3.1 Acknowledge their prejudices, their difficulties, their mistakes, their limitations and their lack of knowledge.
- 3.2 Value the maintenance of their professional knowledge and skills, be open to new ideas and committed to keeping abreast of research in their own and related fields.
- 3.3 Apply reflective learning practices.
- 3.4 Examine their professional practices in the light of the knowledge and experiences of consumers and carers.

Knowledge

The work on knowledge began in the mini workshops where groups familiarised themselves with documentation from the professional associations, including standards of practice, competencies and curriculum statements, and was concluded in the final workshop. In the synthesis of the core knowledge identified by each group, it became obvious that the distinction between specialist core knowledge and common knowledge was a matter of emphasis and detail. Thus Social Work might put the history and effects of social justice policies high on its list of core knowledge areas, while another discipline might reflect that area of knowledge as part of the study of the effects of mental illness on the individual and the family. All disciplines agreed that the attitudes and knowledge that they shared were more important than those that they did not share. The recognition of common areas of *knowledge* is an important confirmation of the principles. It allows the disciplines to bring their own pattern of attitudes and knowledge to their work. Each profession affirms its specific knowledge in its curriculum and its standards of practice. The common attitudes and knowledge will help to ensure that the common elements are addressed in the curriculum at all levels, undergraduate, graduate, postgraduate and in continuing professional education.

There was one particular area of 'knowledge' reiterated by all groups, although it may be described as attitudinal rather than knowledge as such. All

groups acknowledged the importance of *knowing what they do not know*. This suggests a respect for and acknowledgement of another person's knowledge and lived experience, an acceptance of a range of theoretical positions and humility in the face of their own lack of the lived experience.

The professionals synthesis of core knowledge identified that all working in mental health will have, and demonstrate, *knowledge* of:

- the lived experience of consumers and carers
- mental illness: its causes, epidemiology, approaches to treatment
- historical, cultural, social and political contexts for mental health and the treatment of mental illness, and attitudes of groups to mental illness, to family relationships, and to the nature of interventions
- qualitative and quantitative research methodologies
- evaluation methodologies
- relevant regulations and legislation protecting the rights of people affected by mental health problems, including:
 - *United Nations Principles on the Protection of People with Mental Illness and the Improvement of Mental Health Care* (Geneva, 1992)
 - *The National Standards for Mental Health Services* (Commonwealth of Australia 1997)
 - *Australian Health Ministers' Mental Health Statement of Rights and Responsibilities* (Commonwealth of Australia 1991)
 - *Model Mental Health Legislation: Volume 1*, (Mental Health Branch, Department of Health and Family Services, 1995)
- policies affecting the assessment, treatment and welfare of people with mental health problems
- strategies for integrating health care services.

Skills

The distinction between knowledge and skills is blurred, moving as it does from knowledge *of* or *about*, to knowledge *how to*. Knowing *how to* does not ensure skill. Here the eventual development of competencies will help to describe the manner in which the skills are demonstrated and in what conditions. Again, identification of common skills and performance outcomes will help to ensure that the common elements are addressed in all curricula at all levels.

The skills listed below are dependent on the principles, their related attitudes and a knowledge base. They require specific attention in education and training because they cannot be learned or practiced in isolation or without reflection (see Chapter 5). Furthermore the skills are complex and multifaceted and single performance measures will be insufficient to measure them. It was agreed that all mental health professions in all disciplines, must be able to:

- actively listen to consumers and carers
- establish and maintain therapeutic partnerships with consumers and carers
- reflect on their own practice and use knowledge of self
- communicate effectively with individuals, groups and organisations, and in educational contexts
- demonstrate negotiation skills
- demonstrate advocacy skills
- plan, manage and evaluate care programs, with individuals and within the mental health system
- manage resources, human and material
- use a variety of problem-solving strategies
- use a variety of decision-making strategies
- evaluate outcomes of care and services within the system
- establish and maintain networks

- recognise the skills of other professionals and apply the principles of team work in working with colleagues, with consumers and with carers
- specify outcomes which focus on consumers and carers
- take measures to give power to consumers in the management of their treatment and care
- take account of the culture and belief systems of consumers and carers and ensure that attitudes of groups to mental illness, to family relationships, and to the nature of interventions are considered
- prioritise actions according to immediate needs and special circumstances
- assess needs
- assess risk
- practise within an ethical framework
- practise within a legal framework.

Mechanisms

The mechanisms involved were thought to be essential in producing the common frameworks of attitudes, knowledge and skills. There were two stages, although of course the ground for this had been prepared much earlier in the project. The two stages which produced common attitudes, knowledge and skills as outcomes were the discipline specific workshops (the mini workshops) and the third and final workshop⁸³. These have already been discussed from the perspective of disciplinary groups in chapter 5. This section outlines the process for those who wish to have a succinct overview of the method.

- Workshops of a day and a half were held for the consumers and carers, followed by similar workshops for each of the professional groups, (excluding the psychiatrists).
- The workshop for consumers and carers identified a number of principles and established the agenda for the subsequent discipline workshops. In this way the consumers and carers formed the front end of the process, and ensured that the long term intention of the recommendations were met.

83. Although the psychiatrists did not participate in a mini workshop, they worked with consumers and carers in the third and final workshop. This work is reported in chapter 5.3



- At each discipline workshop there were two carers and/or consumers present. Thus the 'lived experience' of consumers and carers was kept to the forefront of the deliberations and there was some consistency in the ways these were interpreted.
- The findings from each mini workshop were presented to each subsequent workshop. The facilitator and those who had been part of the project from the beginning observed the willingness of each group to listen and learn from the other groups. A powerful narrative about consumers' and carers' experiences of mental health services developed through the mini workshops.
- Each mini workshop included the following activities:
 - The playing of the game *Lemon Looning*, facilitated by a consumer or a carer⁸⁴.
 - The use of a focus group technique to identify the attitudes and values consumers and carers expect from mental health professionals.
 - A review of the statements of standards of practice and competencies of each of the disciplines, and other available documentation of principles and practice was reviewed.
 - The use of a template developed by consumers and carers to begin the process of developing core values and attitudes and related skills and bodies of knowledge.
 - The values each profession believed were core to their profession were thus identified. They were then synthesised and those common to all groups were identified.

The third and final workshop

At the final workshop a similar process to the above was used to identify the areas of *knowledge* and *skills* that were seen as core to each discipline. As each discipline group reported on its core knowledge and skills to the plenary meeting, common areas of knowledge and skills were synthesised and fed back to a plenary session of all professionals, consumers and carers and state government observers for endorsement.

The significance of this process is that there now exists a common framework of principles, attitudes, knowledge and skills for mental health education and training in Australia. This can be endorsed:

- by all five disciplines as their own minimal framework for disciplinary curriculum development, delivery and assessment and accreditation
- by interdisciplinary education and training programs as a common template for curriculum development, delivery, assessment and course accreditation
- by training programs aimed at members of the mental health workforce not included in this process, such as general practitioners, speech pathologists.

Should the project have developed a national curriculum? Several examples of ready made curricula which had the potential to be translated into a national curriculum were discussed at the workshops but not widely supported. Certainly a national curriculum would provide a benchmark against which all disciplines could be rated. Alternatively, could the project have developed a set of core components for inclusion into curriculum for all disciplines? The answer is probably not. A national curriculum is unlikely to be well received by all the disciplines or the universities for reasons to do with both the mental health and educational viewpoints.

It would be difficult to implement from a mental health point of view for the following reasons:

- The universities as corporate entities may well ignore the curriculum if they had no part in developing it.
- University teachers of mental health are opposed to taking instructions from outsiders; at least some would ignore a national curriculum.
- Overall the rights of any professional association specifying 'input' into any curriculum is weak and not to be relied on (although this may be changing).
- The principle reform interests of the consumers and carers, lies in changing the *values and attitudes* of professionals and building a stronger relationship between practice which is evidence based, and professional performance.

84. See Chapter 3. This activity is a game designed by consumers for use in education and training, which highlights for players some of the positive and negative experiences of consumers in the mental health care system. The involvement of consumers and carers allowed commentary, explanation and reflection on the negative and positive aspects for consumers and carers within the mental health system.

There are also arguments against a national curriculum from an educational viewpoint:

- Curriculums go out of date very quickly. Any national curriculum set now would be out of date by the end of the Second National Mental Health Strategy.
- It would be a massive cost exercise to keep updating a national curriculum every three years or so.
- The universities may be uncomfortable with the concept of a national curriculum without major consultation. Some may interpret a national curriculum as interference in their core activity.
- There is an argument in favour of more diversity (not less) in the higher education sector, i.e. that there should be *many* curricula, offering choice to intending students.
- The universities (and university teachers) are divided about the role of competency standards. At one extreme, they are rejected totally, as having no role in the research university, but being more appropriate for the TAFE sector. In the recent past, the imposition of competency standards on the universities has been an invitation to educational battle.

Hence this chapter concludes that the Government should support a set of processes which 'buy in' the future involvement of the higher education sector in curriculum change. The policy question is: under what circumstances will the universities welcome this report? This can be achieved if the recommendations of the report concentrate on setting up the *processes* for collaboration between higher education sector, the Commonwealth and State Governments and the professional associations.

Chapter 2 referred to a model of curriculum development proposed by the Higher Education Council (1996). The strategic model was seen to be a model where all stakeholders - government, employer, unions and professional associations - join with universities in discussion about curriculum and standards of education and training. Bearing the *strategic* model in mind, The Higher Education Council (1996) suggested a 'model of good practice' in course review and accreditation processes which can apply to the individual disciplines and to the development of interdisciplinary education. This model:

- includes all stakeholders (including consumers)
- is open, consultative and consensus building about future developments
- is transparent to all parties
- meshes the external registration requirements and public safety issues with internal academic requirements
- monitors implementation of changes after accreditation of the course is approved
- involves an ongoing cycle of review
- focuses on the achievement of objectives, maintenance of academic standards, public safety requirements, good outputs and outcomes rather than detailed specifications of curriculum.

The frameworks involved in this chapter then provide a basis for a continuing process about which all present and future stakeholders might be in agreement. It assumes that a national curriculum may impose a burden on universal acceptance of the report. Therefore implementation of the framework presented in this chapter will need 'drivers' who will also champion its implementation.

7. The role of the universities

**David Prideaux
and Jan Carter**

The complexity of education and training for mental health professionals

The provision of education and training for mental health professionals is a complex task. There are at least four elements that define this complexity.

The first and most important element of complexity arises from the commitment in this project to ensure that the needs and interests of consumers and carers form the very basis of education and training and are represented throughout all aspects of the process. This is a task of some significance.

The second element concerns the characteristics and context of those who participate in education and training. Mental health professionals are adult learners in busy work environments. Resources are limited and potential sources of stress are high. Education and training programs must accommodate this context. Similarly they must be available all over Australia. Mental health professionals are not restricted to capital cities. Their work also takes place in regional centres and in smaller rural hospitals and communities.

The third element derives from the diversity of existing provisions as demonstrated in the national audit conducted as a part of this project. The initial training of mental health professionals differs. Psychiatrists have an extensive apprenticeship based program with a comprehensive examination. Social workers, on the other hand, require an undergraduate degree only although few work in mental health care immediately upon graduation. If these examples were to be regarded as two ends of a spectrum then, in between, there is a variety of

graduate certificate, diploma and masters courses as well as provisions for mental health studies in undergraduate courses. In addition there are short non-award courses and workshops offered by employers, agencies and other groups. The approach undertaken within each of the five disciplines is quite different. Bringing the five groups together for common provisions in education and training is not an easy task.

The fourth element is associated with the ongoing debate about common and discipline specific knowledge, skills and understandings in mental health education and training. This is clearly a central issue in this project. Each group has its own particular skills and knowledge to bring to the mental health context. This provides for a strong professional identity. However, if there are to be significant reforms in education and training for mental health, the disciplinary groups will need to continue to work very closely together and to identify the shared and common knowledge and skills that all mental health professionals require. Chapter 6 has provided a framework for this and a model of good practice for the universities, the basis of which is a strategic relationship between universities, professional associations and Commonwealth and State Governments.

Responding to these four elements demands a different type of curriculum organisation and educational approach than currently exists. Defining, developing and implementing such a program is a challenging task but one that is worthwhile.

The organisation of education and training for mental health professionals

The second and third elements outlined in the previous section have clear implications for the organisation of education and training for mental health professionals. Programs must be flexible and soundly based in the principles of adult learning and then take into account the work environments

of practitioners and their diversity. In achieving the latter the programs should:

- be based on participants' needs and interests
- be relevant to the goals, aspirations and actions of learners
- enable self-learning and self-direction in learning
- enable learners to actively participate in the learning process.

As the next chapter will make clear, in developing education and training programs for mental health professionals there must be concerted attempts to seek, define and clarify the needs of the learners. In addition courses must relate to professional practice and learners should be able to determine and direct their own learning within established guidelines and frameworks. Most importantly, learning tasks must be designed so that mental health professionals can engage in practical problem-solving and considered reflection on their practice.

The geographic spread of mental health professionals provides a further organisational challenge. Universities and other training programs must be available to all mental health professionals irrespective of where they live or work. Contemporary approaches to flexible delivery of learning are needed. A combination of print, audio-visual and information technology media should be used. This will not only provide for learning at a distance, but will have the added advantage of enabling health professionals to organise their own learning, within their own time and around their essential work commitments.

The structure of education and training must also be flexible so that any new programs can readily be articulated with undergraduate and initial education and the diversity of existing provisions in mental health education and training. Programs need to be developed within an overall framework for a learning strategy covering the whole spectrum of education and training and which incorporates guidelines for both initial and continuing education and training. Such a framework needs to be adaptable and responsive to the changes in the mental health workforce and its changing education and training requirements. Just as a variety of teaching and learning methods are essential, so too are a variety of forms of organisation. These may range from university graduate certificate, diploma and

degree courses to short courses, intensives and workshops which may be provided by employers and service providers. Partnerships between higher education institutions, governments and employers are necessary so that recognition of prior learning and credit provisions are put into place for the articulation of the various forms of education and training provision.

The content of education and training for mental health professionals

The first and fourth elements introduced in the first section of this chapter have implications for the content of education and training for mental health professionals. This is particularly the case for the contested and problematic issue of common and disciplinary specific knowledge and skills. As Chapter 5 makes clear mental health professionals should continue to derive a strong foundation for practice from studies within their disciplines and the importance of this should not be diminished. Nevertheless, Chapter 6 identifies some common knowledge and skills for contemporary practice. Some of the more important common knowledge and skills so identified are:

- decision-making, exercising judgement and problem solving
- cooperation and team work
- inter-disciplinary practice
- case management
- accommodating social, cultural and ethnic differences in mental health care.

Above all, the major outcome of this project is the commitment to the inclusion of the consumer and carer needs and interests throughout all facets of the education and training of mental health professionals. This inclusion is to go beyond tokenism to pervade all aspects of programs in education and training.

Thus university education and work based training for mental health professionals should proceed from preparation as a competent professional in a specific discipline but with additional 'value' gained

through the acquisition of common and complex knowledge and skills. This is further to a clear understanding of and commitment to the needs and interests of the consumers of mental health services and their carers. The 'value adding' will come through the concept of a mental health professional as a 'reflective practitioner'. Such a practitioner will have a firm grounding in his or her own disciplinary area but with the ability to reflect critically on practice, to act on the reflections, to further reflect and further act on practice. The practitioner will have decision-making and team work skills, a clear awareness of the complexities of the context in which he or she works and, above all, the ability to address and advocate for the needs and interests of his/her clients to agree with the practitioner.

The development of the knowledge, skills and abilities for reflective practice should provide the central concept for the *content* of education and training for mental health professionals. There are precedents and models for this approach within disciplines such as nursing and education, for example, and these may well be able to be adapted for mental health professionals.

It is recognised that other forms of organisation of the content of education and training for mental health professionals exist. In the TAFE sector, for example, courses are organised around basic competencies or minimum standards and this was the thrust of the Queensland project. These may be appropriate for some of the basic and fundamental knowledge and skills but are less applicable to the complex decision-making and inter-disciplinary team work knowledge and skills suggested here. These attributes require the development of judgement, judgement which can be gained only through action and reflection on practice.

The challenge for education and training for mental health professionals

It is worth reiterating that the development of a comprehensive approach to education and training across all the health professions provides real challenges. Flexibly organised and delivered programs using adult learning principles, promoting reflec-

tive practice, based around common knowledge and skills and addressing consumer and carer needs and interests will not be achieved without considerable effort and action at all levels.

The principles of effective curriculum change will need to be firmly applied to achieve this challenge. In particular, the major stakeholders in the process must be enabled to develop ownership of programs through realistic and meaningful participation in their development. There are at least four major stakeholders who each face specific and unique challenges.

First, consumers and carers must find a means to obtain and maintain an effective voice in the initial and ongoing development of the education and training programs. This will involve finding committed consumers and carers who can participate in educational decision-making at all levels all over Australia. Clearly this will involve greater access to resources, greater access to decision-making forums and greater organisational assistance for consumers and carers than has existed to date. A National Mental Health Consumer Studies Centre (see Chapter 3), and a National Mental Health Carers' Education and Training Forum (Chapter 4) would play central roles.

The second players, universities, also face significant challenges. Non-research based postgraduate programs are increasingly being designated as full-fee paying courses⁸⁵. Courses must 'pay their way' to be included in the profile of institutions. Viability must be demonstrated through enrolment numbers. Given the increasing loads in teaching and research carried by academics, many may be less than willing to engage in informal curriculum reform processes which may not gain the acceptance of university management. Progress must be made at a 'macro' and a 'micro' level. As well as the strategic curriculum reform referred to in the previous chapter, means must be found to increase the profile of mental health teaching within universities. The formation of an association for teachers of mental health to promote excellence in teaching and learning through conferences, awards and publications is needed. It is likely that a partnership between universities and the national mental health strategy is required for a time.

Employers and health agencies, as the third group, also need to develop different structures and processes to incorporate the new directions in education and training. This will have to be

⁸⁵ According to the Australian Vice Chancellors Committee, net federal outlays on university funding will have dropped between 1993 and 2000. Net funding per student will drop from close to \$12,000 per annum in 1993 to close to \$8,600 per annum in 2000. Staff-student ratios have increased between 1993 and 1997: a percentage increase of 10% in social sciences and health courses. Library expenditure per student has reduced 7.6% over the same period.

achieved against a background of reorganisation of mental health services and reduced levels of funding across health systems, as well as less capacity within the university to respond to employers' requests. The service demands of mental health are pressing. Finding time to devote to both planning and implementation of new education and training programs will not be able to be accomplished overnight. It will be further complicated by the complexity of the reforms proposed here. This issue is dealt with in more detail in Chapter 8. The fostering of special interest groups to discuss new developments in mental health and the development of joint research projects are matters for employers to consider.

Finally, professional associations must ensure that the needs of mental health professionals and educators are recognised and communicated to employers and government. While the associations are diverse in nature they will need to come together for regular discussions, particularly around the issue of defining common knowledge and skills. This will require some new ways of working together.

The way forward lies in effective partnerships and networks between the four stakeholders with

resource support from government. As indicated previously, a combination of short and long term courses based around the work experiences of mental health professionals which can be articulated or recognised in university awards, is necessary. This requires not only cooperation between universities and health authorities, but cooperation amongst universities themselves. Increasingly universities compete with each other for enrolments yet the interests of mental health education and training will be best served by flexible credit arrangements across a number of universities and through local consortia of agencies, educational institutions and consumers and carers.

As indicated previously this new approach to education and training will not be easy to achieve but significant educational reform rarely is. Nevertheless an opportunity now exists to bring the mental health professions together with consumers and carers to change education and training and subsequently the practice of mental health professionals. Consumer and carer based flexible programs which are aimed at producing reflective practitioners and which are properly supported and recognised are a form of educational 'best practice'. The case for their development is strong.

8. The workplace as a learning place

**Wendy Weir,
John Farhall
and Jan Carter**

Introduction

Emphasis has been placed on the role of universities and professional associations to provide undergraduate, postgraduate and continuing education in mental health to the five professions of psychiatry, social work, nursing, occupational therapy and psychology. However the process of change in the higher education sector and in professional organisations is complex and may take many years. In addition to their roles in preparing the future workforce, the workshops acknowledged that Australia has an urgent need now to skill the current workforce to provide an evidence-based, high quality mental health service, which meets consumer and carer needs. Arguably the universities and professional associations have been divorced from the 'real' world, which now begins with employment in a multi-disciplinary team of highly-skilled people of varying clinical and other backgrounds, and in a variety of settings including integrated hospital and community-based services.

The current problem facing employers is that the knowledge base and skill level of practitioners varies enormously. Many graduates are not adequately prepared for the complexities of working in newly-evolving specialised mental health services. The current workforce may not have had access to realistic staff development programs which change attitudes and values and update them in service delivery. We need to make the mental health system more effective through creating a better trained, better educated and better organised workforce.

There has been a past assumption that education and training is not the responsibility of the departments of health but of universities. Whilst this is so at undergraduate and postgraduate levels, in-service development and training is a different matter. This relates to national and state frameworks, delivered locally and meeting the requirements of

employers for short-term skills specific courses, which will have an immediate impact on service delivery. Further closer contact between employers, universities and professional associations will be needed if universities are to make study more relevant to workforce demands and to deal with their shrinking educational dollar.

This chapter will discuss the provision of in-service education and training for the current workforce as being the responsibility of a number of organisations, but particularly the state and territory health authorities. There are a number of roles that might be envisaged. There is a need to identify training and development funds, and to release staff to attend specific activities for changing attitudes, increasing knowledge, clinical and management skills. The workforce requires on-going education in order to meet improved outcomes for consumers and carers. If employers were in a position to make professional development a requirement for all staff and to make consumer and carer partnerships at all levels fundamental, this would be a helpful development. Key issues in the provision of training and education are discussed below.

Involving consumers and carers in education and training

This project highlighted the importance of involving consumers and carers in the education and training process to change attitudes and values of the mental health workforce. A recent national consultancy on attitudes of health professionals confirms this requirement (Small and Associates, 1998). Consumers and carers have a wealth of experience and knowledge, which practitioners must acknowledge and accept. Their contribution to the education and training of the workforce cannot be underestimated. They can be involved in policy development, planning and decision-making processes at national, state, territory and local levels. They need to have opportunities to attend education and training activities with other people. Employers can support these principles, to enable a better understanding of the needs of people living with mental illness and how service providers can provide for their needs.

Community expectations

During the workshops it was apparent that the community at large is now placing greater demands on government and private authorities to meet local needs. The community experiencing mental health problems or mental disorders has become more vocal in the last decade and will no longer accept sub-standard service delivery. The community as well as governments expect the following:

- quality and effective services, which meet consumer, carer and community mental health needs
- services which demonstrate value for money
- services which achieve measurable outcomes
- a workforce which is multi-skilled, caring and responsive and which involves consumers and carers in the policy development and planning processes
- a workforce that seeks alternatives to hospital admission wherever possible, whilst not placing an added burden on carers
- services and a workforce that provide a safe and secure environment for consumers, carers and the general community
- services which are innovative, integrated into mainstream health and welfare services and which create partnerships with a range of organisations and people
- services which are well managed and have appropriate leadership.

Concerns of employers

Whilst there is pressure on employers to provide the above, employers have concerns. Staff are often enthusiastic to enter mental health services but not all are prepared for mental health work by

university courses. Many individuals may be expected to work in what are for them stressful situations, often alone, or without close supervision. This applies to both urban and rural settings as chapter 4 indicates. The workshops made it clear that the workforce in general is not knowledgeable about national and state directives and the need to update skills. It is difficult for many staff to accept change. Hospital-based staff, particularly those working in the old institutions have difficulty conceptualising community-based care and institutional practices are also slow to change. Many members of the disciplines are concerned that they will become 'generic mental health workers' so they hold on to their discipline-specific roles and traditional professional boundaries. Workforce practice does not always reflect the new paradigm in mental health, and workforce training has little connection with the programs of universities and professional associations. Consumers, carers and other organisations complain about poor work practices. There is a need for a mix of the right expertise to build a shared vision in partnership with a number of organisations and people.

Multi-disciplinary responses to current need

As already mentioned in this report, the five identified disciplines in mental health provide undergraduate and in some states postgraduate courses at universities. Australian states and territories in general have been slow to establish innovative long-term professional development structures to cater for the enormous and changed needs of the mental health workforce. New South Wales has three main education and training organisations, which now work together as a consortium with multidisciplinary team approaches. These organisations are the NSW Institute of Psychiatry, the Hunter Institute of Mental Health and Wollongong University, all of which provide education services to all parts of the state, including rural and outlying areas. A brief description of initiatives in the NSW consortium is provided below⁸⁶.

86. NSW Institute of Psychiatry was established by a 1964 Act and through its board, responsible to the NSW Minister; it is independent of any teaching institution. The Institute initiates research into all aspects of mental health, educates professionals and fosters the advancement of mental health education. Short-term (one week) and longer-term courses (part-time over one year) are conducted on campus, off-campus and in distance mode.

Hunter Institute of Mental Health (NSW) commenced in 1992 through establishment grants provided by the Hunter Area Health Service and the University of Newcastle. The Institute's charter is to foster research in mental health; offer education and training in mental health related areas to specific interest groups (such as teachers, police officers), to health professionals and to the community at large; and to offer community education in preventative mental health.

Wollongong University (NSW) is a multi-disciplinary postgraduate course work program commenced in 1992 which equips graduates with clinical and research skills for comprehensive, community-based treatment and rehabilitation. Graduates' satisfaction has been tempered by reports of frustration at their inability to put this learning into practice because of inflexible management structures and a lack of support from colleagues.

Education and training of the current workforce

Some of the issues raised in the workshops follow:

- Employers are acutely aware of the costs, both in time and money, associated with the education and training of their staff. It is often feasible to release staff for a few days or even for one week but in some circumstances staff need to be replaced. This places a budget pressure on those who remain, or leaves service gaps. So allocation for training and development could helpfully incorporate replacement costs when necessary.
- Professional support strategies are needed for clinical supervision, professional development, retention of the skilled workforce and career progression.
- Mental health managers and team leaders need broader management courses provided to the wider health and administrative sector so that mental health staff obtain a better understanding of management and financial issues.
- In addition staff working in generalist health services need education in identifying mental illness and promoting mental health.
- It is appropriate for employers to support both disciplinary-based as well as interdisciplinary-based higher education for staff as each discipline needs to maintain individual professional identity and build on current knowledge and skills. (The consensus of the workshop was that it was not possible to be an expert multidisciplinary team member without becoming expert in one's own discipline first. - This is reinforced in Chapter 3 by the user perspective provided by M. Epstein and D. Rechter).

Some of these difficulties could be overcome if a percentage of the mental health budget at state, territory and local levels were allocated annually and specifically for planning, promoting, initiating, providing, monitoring and evaluating professional development activities. It is suggested that this level be 2 per cent⁸⁷.

In addition an individual training and development plan for *each staff member* would be a helpful requirement in meeting the National Mental Health Strategy quality and effectiveness standards. This plan could be reviewed annually as part of staff appraisal.

The long-term benefits of having skilled employees include: a greater range of cost-effective, quality services being offered to meet consumer and carer needs; high satisfaction of staff in providing services and of consumers receiving them; high morale; low staff turnover; and greater productivity. Costs of constantly training new staff are reduced, high standards of care and continuity of service provision are achieved (Weir, 1989).

State and Territory Health Governments

The role of state and territory governments in education and training is crucial and if each state and territory health authority had a comprehensive policy on staff education and training this would provide clear guidelines and signals for staff on its importance. Standardisation throughout Australia could be considered. Incentives including scholarships, travel grants and recognition of prior learning would assist individual members of the workforce to make a commitment.

As already mentioned, a framework for implementation and monitoring would include workforce opportunities to participate in postgraduate education, as well as professional development and in-service training related to newly developing, integrated mental health services. Health authorities at state level could consider the establishment of an educational body, which will be responsible for developing material (content/modules) and be a 'clearing house' for distribution of material and information. (Chapter 9 discusses a Chief Learning Officer). These bodies can be appointed or selected through a tender process. In addition a state education and training committee, with representation from consumers and carers could be established to develop a plan to oversee the implementation of a structured program and to monitor and evaluate activities to determine outcomes and effectiveness. Funding could be allocated for both state-wide activities and for local health authorities to implement programs to meet local needs. Linkages and collaboration would occur between all states and at national level.

Local health authorities

Local health authorities could develop plans to meet the specific needs of their mental health workforce. A coordinator of staff education and

87. The Training Guarantee, 1990-1994 was set at 1.5 per cent.

training could be appointed, assisted by a local education and training committee to 'drive' the process identifying needs, overseeing the plan, allocating funds for specific purposes and monitoring effectiveness and outcomes. Coordinator positions may be the key to driving the change process and those appointed need a comprehensive background and expertise in mental health (not generic health). These could be senior positions with a certain degree of autonomy. As mental health services will continue to evolve following more intensive research and evaluations, coordinator positions need to be ongoing to provide a long-term approach for both ensuring an up-to-date skilled workforce and for developing plans for individuals. Committees at local level could have links to the state and national education and training committees, and to other networks including early intervention, early psychosis and suicide prevention, to ensure cross-fertilisation of information and ideas. Workplace supported courses seem to be the most successful and enduring allowing students flexibility in employment, shifts, hours, study time and funding (see Attachment A1).

Multi-disciplinary teamwork approach to in-service training

This project has highlighted the enormous overlap of professional attitudes, knowledge and skills required to successfully work in Australian mental health services. Whilst individual professions bring specific knowledge and skills to the services and need to continue refining and developing discipline based knowledge, it is through teamwork, breaking down professional boundaries and learning together that successful models have evolved. It is therefore proposed that the overarching model of education and training of the current and future workforce should emphasise the importance of *learning together* in multi-disciplinary teams of health professionals, consumers, carers, support staff, managers and where appropriate general practitioners, staff of other government departments and non-government organisations. Participants need to include those working in a variety of urban and rural settings including hospital and community-based services. This model promotes cross-fertilisation of knowledge, skills and experiences, partnerships in education and training. The model also supports short-term and long-term structures which would ensure an ongoing commitment to continuing education and skills-specific training, and maintain initiatives established. There is an

issue therefore in establishing when disciplinary and interdisciplinary education and training is appropriate and for whom.

The workplace as a learning place

Even when university education is the issue, post-graduate education and training, both disciplinary and interdisciplinary can be far more work-based than at present and delivered in a number of sites across Australia as current technologies offer greater flexibility in styles of delivery. Resources can be shared to avoid re-inventing the wheel. Staff need initiation and induction into the culture (attitudes and values) in which they are going to work (see Chapter 7). This applies to newly-appointed staff as well as those who have been working in the system for several years.

Whilst the workplace is often the most effective venue for learning new skills, the success of this may depend upon the relationship which exists between the people and the goals in the organisation. The goals for mental health service delivery need to be matched by a commitment from the workforce in meeting these goals. Building shared visions involves developing genuinely shared images of the future, which fosters commitment and engagement.

Issues in making the workplace a learning place

During the workshops, the limitations and possibilities of workplace learning were thoroughly discussed. These are summarised below.

Meaningful needs assessments may take time and effort. Organisations and their staff sometimes have difficulty in deciding relevant and effective programs for staff development. Training needs surveys of staff are sometimes little more than superficial popularity contests amongst perennial topics. More effective training needs assessment strategies may include bringing staff, managers, consumers and carers together to discuss gaps between policy and practice, to identify areas of work that staff are struggling with, and to anticipate changes in the mental health service that staff will need to respond to in the future. They must be 'grounded' in the life and work of the organisation as Chapter 9 will discuss.

Voluntary attendance at external or internal training limits possibilities for change. Few people volunteer for training programs which they expect will challenge their values or professional framework. Thus, staff development for the purpose of change may therefore need to be arranged around automatic attendance of entire work teams or professional groups.

Changing of work practices may be dependent on psychological transitions. Major changes of work location, role, model of practice or skill can have powerful psychological impacts. Staff may experience loss of familiar ways and of expertise, be hampered by uncertainty and confusion and experience threats to professional identity and confidence. These experiences are natural reactions to any major change, but are often labelled as 'resistance to change' and not addressed directly. Solutions include normalising the experience through 'managing change' workshops, involving front line staff in the planning and management of change and providing viable new roles for staff.

Limitations of private and tertiary providers. External providers may have a product to sell rather than be skilled in, or motivated to assist an organisation to identify its own needs and to create a training or other strategy. Development of education training programs in a new area of practice is very time consuming and may be avoided by both tertiary and private providers unless remunerated realistically. This is particularly the case in the university postgraduate area where the Commonwealth Government has largely withdrawn funds.

Competition versus collaboration. The increasing use of competitive tendering and comparative performance indicators may sharpen awareness of performance relative to other workplaces and be beneficial in self-assessment but there is a downside. It may be perceived as risky to expose competence deficits or to share practice insights and expertise with competitors (unless at a profit). Thus, collaborative training and sharing of expertise across mental health organisational boundaries needs encouragement.

Conformity versus plurality. The 'best practice' policies and guidelines of today will almost certainly be changed in the future. Training in current best practice is highly important, but innovation needs encouragement, and dissenting voices need space and the opportunity to demonstrate alternatives. Chapters 2, 5 and 9 discuss the value of an educational process as opposed to a narrow skills

based training. The latter has attractive short term gains but needs to be balanced against long term value.

Choosing workplace education strategies that fit the goal

A range of methods for education and training were referred to during the workshops. A workplace focused education and training system should consider a variety of components including external conference and workshop attendance, in-house training, individual and peer supervision, and participation in quality improvement projects of an action learning nature. Training is unlikely to be successful unless it is embedded within a wider organisational change strategy including a review of structures, development of policy and procedure, and transition management. The best use of two common forms of workplace training - attendance at off-site workshops, and training programs for whole work teams - deserves some comment due to the prevalence of unrealistic expectations of the former, and the considerable value of each.

■ Voluntary off-site workshops tend to attract participants through content related to their current role and interests or because they offer practical solutions to everyday work challenges such as self-harm behaviours or legalities of reporting abuse. Benefits of such courses extend beyond the course content and include networking with, and informal learning from other participants, boosts to confidence, respite from work. However such workshops or courses have predictable limitations. Off-site courses need to accommodate people from a variety of workplaces, making the content more likely to be general rather than tailored to any one organisation's specific need. It can be difficult to teach skills at anything other than a simple level, due to time constraints and the lack of follow-up and supervision. From a change management point of view, many voluntary off-site courses can have the particular limitation of rarely attracting participation by staff, whose values or model of practice is likely to be challenged. Despite these limitations, off-site courses can be cost-effective for increasing awareness of new approaches, for dissemination of new policies and information, and for the introduction of knowledge that is perceived to extend rather than challenge, the existing practice of participants.

- Tailored training for specific work teams or networks has been found to be a particularly effective way of implementing significant change within an organisation. Implementation issues can be directly addressed, the actual talents of the team can be incorporated and team vision and team processes critical to the change can be developed. The involvement of all staff means that doubters must confront the issues alongside their colleagues, and the psychological transitions of letting go of the old or resolving doubts about the new can be properly addressed. Although potentially more costly, the power to effect change makes this approach a good choice where the goal is widespread adoption amongst staff of a new element of treatment or service. Embedding this in a wider organisational change approach may not be too difficult, and the assistance of outside consultants is easy to obtain where needed. Participation of senior management in planning and program delivery highlights the importance of a program, and involvement of front-line staff and consumers in its planning raises the likelihood of realistic implementation being effectively addressed. Where possible, modelling of the new approach by the innovators should be sought as a powerful element of learning. Local ‘champions’ of the approach should be nurtured to be visible role models and providers of peer support.

There were a number of other strategies discussed during the workshops which can be implemented throughout Australia to support and encourage the current and future workforce. These include:

- Ensure that all education and training activities involve consumers and carers as participants, teachers and session leaders.
- Identify model services and support site visits to ‘centres of excellence’. Ideally visits would be for a minimum of one week, where staff from other services work along side skilled people and learn from their experiences. In addition, staff of model services should provide a consultancy service and be prepared to travel.
- Induction courses for newly appointed staff and re-orientation workshops for all staff at least once a year. These enable management to inform staff of current policy and local service delivery and provide opportunities to keep the workforce updated.
- Provide clinical supervision and peer support, particularly to inexperienced members of the workforce. This should be mandatory to ensure advancement of clinical skills and provision of high-quality services.

- Identify skilled ‘trainers’ within the local services and promote their involvement in training others. Trainers must have opportunities for updating their own skills.
- Provide training to a rural workforce with common issues of isolation, lack of educational and training resources and lack of opportunities to attend skills-based courses. This could be provided by the state educational body or contracted to a private organisation or university and needs to be flexible in delivery.
- Provide flexible work opportunities to enable staff to rotate through the range of mental health services to gain added experience and skills.
- Provide opportunities for other government departments, non-government and community organisations to access education and training programs related to mental health matters.

Discussion: towards learning organisations

I. Processes

This chapter suggests that mental health education and service providers might become learning organisations, that is “organisations which are continually expanding their capacity to create their future”, (Senge 1992, p6) because of their capacity to feedback their learning into innovation and into change of the organisation’s culture. The traditional view is that the service provider’s capacity to learn is based on the capacity of individual staff members to learn, but this is a necessary but insufficient condition for learning by organisations (Argyris and Schon 1978). During the project instances were noted where learning by individuals was undervalued or rejected by a service provider as too threatening to the status quo. So the individual learning promoted by some is not equivalent to organisational learning and does not necessarily of itself contribute to changed organisational perspectives.

How can processes be developed in organisations to absorb the lived experiences of consumers and carers into the learnings of mental health service providers? With the passing away of the mental hospital, the present and future mental health organisation needs a new symbolic mandate to replace the old symbolic mandate, “returning the patient to the world in better shape” (Strauss et al 1966). Putting the lived experiences of the consumer and carer first would mean for instance that most acad-

emic texts and most mental health curricula would need to be reconsidered, along with most organisation policies, procedures and modes of practice.

Progress will require the enrolment (or 'buy in') of mental health practitioners, educators and researchers in Australia around the guiding principles and their subsequent implementation of this commitment. Using education and training as a process to assist workplace change emphasises the importance of considering the processes required to support particular structures to promote team and organisational learnings. Achieving this will require the following:

- developing training partnerships with carers and consumers
- creating a supportive learning context for policy and practice
- carefully selecting the right staff for appropriate training
- engaging staff in organisation development issues
- directly addressing values and attitudes
- using effective learning methods
- fostering leadership by supporting 'champions'
- actively supporting implementation. (Farhall 1998)

When the above are combined with the consumers' conception of 'deep dialogue', education and training can become a means for achieving quality, effective services rather than an ineffectual and expensive 'add on'.

The type of engagement the consumers and carers advocated to the workshop participants, that is, 'deep dialogue' parallels contemporary approaches to the enhancement of learning in organisations. Learning organisations are those which establish a joint process for understanding events and for entering on a process of joint reflection (Argyris and Schon 1978). 'Double loop' learning is a type of 'deep dialogue'. Originally proposed by Argyris and Schon (1978) this particular kind of learning tries to foster innovation, responsiveness to change and to minimise the haphazard learning which takes place by default and is rarely anchored to organisational goals or strategies. 'Double loop' learning tries to take people beyond their personal beliefs to shared meanings by focusing on goals, and learning through critical questioning and reflection.

The final workshop of the project provided an example of the usefulness of 'double loop' learning.

As an exercise, the workshop was broken in interdisciplinary groups, and each was asked to prepare a brief play or tableau representing one of the disciplines at its optimum in the year 2010. At the same time, the consumers and carers were asked to prepare a scenario about their vision of the ideal discipline. Several unscripted things happened.

First, whilst most of the portrayals of disciplines of the future were funny, clever, revue material, not one discipline of the future was painted as having incorporated the guiding principles into goals, structures and processes. In other words, every discipline group 'forgot' the consumers and carers, and in their portrayal of disciplines, fell back on well worn stereotypes and caricatures. Second, some consumers and carers felt extremely distressed at being left out of the interdisciplinary and disciplinary groupings, in which they had worked throughout the workshops. In the deconstruction of the exercise which followed, some consumers and carers said they had felt discarded and excluded by being asked to leave these work groups.

This event posed an eleventh hour crisis for the workshop. With the goals of the project in mind we tried to learn through a critical reflection and questioning process. Consumers and carers explained what fears this event had generated. Members of the disciplines acknowledged their thoughtlessness and denial of the guiding principles. We discussed the event - (who did what to whom) - then moved to trying to understand the implications of the behaviour of the professionals and carers and consumers in this incident. What caused it? The result was a 'deep dialogue' which resulted in all participants being able to accept a common view of what happened. The professionals understood that the consumers and carers feared that nothing had really altered and that they (consumers and carers) could easily be discarded again. The professionals also understood the panic they had unwittingly engendered in some consumers and carers, their own propensity to revert to 'old' behaviours and their tendency to stereotype their colleagues. The consumers and carers were able to see the consequences of taking professionals out of their comfort zone and placing them in a situation of high unpredictability. The workshop became a learning organisation at this point. In reflecting on this event, the words of Argyris and Schon are relevant:

We will give the name 'double-loop learning' to those sorts of organisational inquiry which resolve incompatible organisational norms by setting new priorities and weightings of norms, or by restructuring the norms themselves together with associated strategies and assumptions".

In these cases, individual members resolve the interpersonal and intergroup conflicts which express incompatible requirements by creating new understandings of the conflicting requirements, their sources, conditions, and consequences - understandings which then become embedded in the images and maps of organisation. By doing so, they make the new, more nearly compatible requirements susceptible to effective realisation.

(Argyris and Schon 1978, p.24)

This is a small snapshot of the way that learning processes can be central to any mental health workplace. Recommendations for the future need to be of two types, structural and processual. Both are equally important to workplace competence. Getting the *processes* right - that is, fair, inclusive, consensually oriented, and conducive to 'deep dialogue' - is critical to achieving specified outcomes. Undeniably, this is a resource-intensive process. But then, getting the processes wrong is a waste of resources too. Improved consumer and carer output and outcomes will never be achieved by maintaining or introducing incompetent processes, anti-reflective, 'double loop' learning.

So far this chapter has argued that learning processes⁸⁸ are central not only to the goals of education and training, but to competent mental health service provision in an organisation. The other essential ingredient is *structure*. Without appropriate structures to build learning processes into continuing policies, procedures and systems, little will change. Organisational learning is now taken so seriously in commercial organisations that some are appointing a Chief Learning Officer.

2. Enduring structures

Mental health organisations are part of a wide service network. Cooperation with other services need 'enduring structures' for mental health education and training in universities and workplaces to achieve competent services. The 'enduring structures' to sustain the service network of the future will be required to:

- support the consumers and carers to implement the guiding principles in all mental health education and training
- encourage each professional association to work with consumers and carers to formulate a disciplinary framework which includes curriculum and practice standards for students, for professional entry level, senior and advanced levels of practice based around the guiding principles
- fund adequately mental health education and training
- support the disciplines represented within the universities to implement, and resource the implementation of the guiding principles in disciplinary and interdisciplinary curriculum, course content, teaching methods and assessment
- assist employers to develop properly resourced learning processes and structures within workplaces and to support the disciplines in upgrading disciplinary based education and training and professional development as critical to achieving service quality and effectiveness
- assist all mental health staff to develop a personal learning plan
- link all the above groups together in an education and training network, the Mental Health Education and Training Network.

Thus the 'partnerships' referred to in Chapter 8 need to be built into networks by building enduring structures to achieve each of the outcomes above.

The 'enduring structures' this report recommends will need to be both horizontal and vertical. The *horizontal* axis will need to refer to and link all the parties (Chapter 2) and the *vertical* span will need to incorporate all parties in mental health service delivery organisations.

88. Senge (1992) suggests 'competent technologies', (or personal disciplines) in achieving a learning organisation:

- Building *shared vision* - this involves the skills of unearthing shared pictures of the future mental health service that foster commitment and enrolment.
- *Mental models* are the assumptions about the mental health system or the service provider we carry that influence how we understand the world and take action on it.
- *Team (or group) learning* starts with dialogue and a genuine thinking together: "Unless teams learn, organisations cannot learn". (Senge 1992, p.10)
- *Personal mastery* - this involves deepening vision, focusing energy and seeing reality objectively. Any mental health organisation's commitment to and capacity for learning can be no greater than its members.



Conclusion

The argument of this chapter, that effective education and training can be a central 'driver' of change, will involve a reconceptualisation of policy and service delivery. So often, education has been seen as the province of universities, and training either tacked on as an afterthought or seen purely as short term skills development. We need effective vertical and horizontal partnerships built for progress. Vertical partnerships from national policy to education and training plans for teams and their members, and horizontal policies linking together all the National Mental Health Education and Training parties in networks (as discussed in Chapter 2), will be a major step forward in achieving quality, effective services. These themes are advanced in the chapter which follows.

References

- Argyris, C. and Schon, D. 1978, *Organisational Learning: A Theory of Action Perspective*, Addison Wesley, Massachusetts.
- Farhall, J. 1998, 'Factors Involved in Using Education and Training as a Strategy for Workplace Change'. (unpublished).
- Senge, P. 1992, *The Fifth Discipline: The Art and Practice of the Learning Organisation*, Random House, New York.
- Small, F. and Associates 1998, *Attitudes of health professionals: future directions under the renewed national mental health strategy*, Commonwealth Department of Health and Family Services, Canberra.
- Weir, W. R. 1989, *Education and training programmes for mental health professionals: a report to the Churchill Trust of Australia*, Winston Churchill Memorial Trust, Canberra.

9. Where to from here: conclusions and recommendations

Conclusions

The following conclusions are drawn from the project:

1. There is agreement between all five disciplines that reform of current education and training in universities, and training and continuing professional education in the workplace is both necessary and possible.
2. All such reforms, (that is, their structures and processes) need to be assessed against the Statement of Principle, that is:

The relationships between consumers and service providers and carers and service providers, should be the primary focus of practice and research in mental health. Consumers and carers are therefore major players in the education, training and development of the mental health work force.
3. Future education and training structures and processes must cohere around the two guiding principles:
 - *Mental health professionals need to learn about and value the lived experience of consumers and carers.*
 - *Mental health professionals should recognise and value the healing potential in the relationships between consumers and service providers and carers and service providers.*
4. Each discipline needs to develop a new body of knowledge around the 'lived experience' of consumers and carers.
5. Each discipline has developed a framework of attitudes, knowledge and skills which stem from the guiding principles⁸⁹ which can lead to practice standards and curriculum at all levels, professional entry, senior and advanced levels of practice.

6. The commonalties between each discipline are greater than the differences.
7. An interdisciplinary framework of attitudes, knowledge and skills based on the commonalties has been developed.
8. The development of a leadership group (as illustrated by the members of this workshop) is a productive way of developing 'champions' of change.
9. Experiential learning processes must parallel structural policy change.
10. Basic university courses in the disciplines are under resourced with respect to mental health education.
11. Complex, multi-faceted workplace learning experiences through both short and longer courses must continue beyond basic disciplinary education.
12. Employers must promote and fund workplace learning.
13. A 'best practice' model of curriculum review needs to be developed between the higher education sector, professional associations, employers and Commonwealth and State Governments.

Recommendations

This report includes two major recommendations. The first positions this report as the critical document informing the overall development of a national education and training framework under the Second National Mental Health Plan.

The second recommendation proposes a number of detailed actions for a national education and training network that have been broadly informed by the workshop series.

89. The exception is psychiatry; see Chapter 5.3.

Further education and training reform will address some of the core objectives of the Second National Mental Health Plan. This reform should also aim to ensure better outcomes for consumers and carers, more fulfilling professional careers, and a future workforce with a greater capacity to respond to the evolving models of health service delivery agreed to by all Health Ministers under the National Mental Health Strategy.

National activity in education and training for the mental health workforce under the Second Plan should be in the realms of leadership, influence and facilitation.

Recommendation 1

The final report of the education and training workshops should be considered as a valuable source document which will assist in the development of a national policy framework in mental health education and training. This policy framework, as clearly identified in the workshop series, must address attitudes, knowledge and skills amongst mental health professionals and allied service providers.

Recommendation 2

That the AHMAC Mental Health Working Group considers the development of a National Mental Health Learning Plan (NMHLP) taking account of the following:

2.1. Learning processes

In establishing these it is recommended that, during the time of the Second National Mental Health Plan, all mental health practitioners, researchers and educators participate in a reflective learning process in the workplace designed and presented by consumers, carers and educators.

2.2 Enduring structures

2.2.1 Mental Health Education and Training Network

That the parties to mental health education and training be established to become a national mental health education and training network (NMHETN) and implement the National Mental Health Learning Plan⁹⁰. The role of the NMHETN is to:

- provide curriculum support and guidance to discipline-based postgraduate programs
- endorse discipline based mental health courses which reflect the principles, attitudes, knowledge and skills outlined in this report
- encourage the development of university consortia to deliver interdisciplinary postgraduate courses
- accredit interdisciplinary postgraduate courses
- conduct an education and training workshop to review strategies and priorities for education and training in the Second National Mental Health Plan, particularly for prevention, early intervention and depression
- support a study into the roles, tasks and training of psychiatrists.

2.2.2 The National Mental Health Consumer Studies Centre

That a national mental health consumer studies centre (NMHCSC) be established by the NMHETN. The NMHCSC will develop a graduate research and course-based educational program for consumers, foster nation wide consumer 'evidence based practice' research and provide services to assist consumers to carry out their roles in education and training⁹¹.

90. The stakeholders for the NMHETN should include each professional body plus practitioner and academic members of each discipline as nominated by each professional body, a member of AHMAC, each state and territory government, the Australian Vice Chancellors Committee, the National Mental Health Council and a substantial representation of carers and consumers

91. The National Mental Health Consumer Studies Centre will

- encourage and support consumers nationally to undertake higher education at undergraduate and postgraduate levels, through providing accessible forms of educational and personal support
- undertake "evidence based practice" studies from the perspective of the lived experience of consumers
- develop model curricula for universities nationally and
- review courses (curricula, teaching, assessment methods) for consumer input
- work with professional disciplines on preparing competency and practice standards

2.2.3 The National Mental Health Carers Education and Training Forum

That a national mental health carers education and training forum be established by the NMHETN to review carer issues, prepare model curricula for higher education and train carers to participate in education and training⁹².

2.2.4 Professional Associations

That all five professional disciplines be invited to join the NMHETN and to agree to implement national learning plans for their disciplines as follows:

- Develop framework of principles, attitudes, knowledge and skills to reflect competencies at entry, senior and advanced levels of practice.
- Develop and implement accreditation for disciplinary based mental health courses.
- Accredit mental health practitioners at entry, senior and advanced levels and maintain a register.
- Review the mental health practice of their discipline in a published annual report.
- Establish jointly with at least one university, and preferably a consortia of universities, at least one national centre of excellence in mental health⁹³.

2.2.5 Royal Australian and New Zealand College of Psychiatry

That the RANZCP:

- Rebuild its present curriculum around consumer and carer rights and needs, taking into account the common disciplinary framework.
- Commence discussions with universities concerning the joint university-professional body delivery of the Fellowship program.

2.2.6 Universities

- That the Commonwealth Government through the Departments of Health and Aged Services, and Education, Training and Youth Affairs establish an inter departmental committee to investigate the financial status of postgraduate mental health degrees, on the basis that these now constitute 'basic' mental health education.

- That the Australian Vice Chancellors' Committee (AVCC) be invited to participate in the National Mental Health Learning Plan, and be represented on the National Mental Health Education and Training Network.

- That the AVCC recommend to Vice Chancellors that all universities should develop their mental health teaching programs around the guiding principles, attitudes, knowledge and skills outlined in this report.

- That the AVCC recommend to its members that all universities should adopt an accreditation and review process similar to that recommended by the Higher Education Council.

- That the National Mental Health Education and Training Network with the AVCC undertake and publish an annual audit on national mental health education and training courses and curricula and publish this.

- That the NMHET and the AVCC establish a joint working party to support the establishment of:

- a national association of mental health educators
- a national mental health educators' conference
- annual national mental health educators' awards
- university based mental health 'centres of excellence' for the disciplines in nursing, psychology, occupational therapy and social work, in conjunction with the professional disciplines
- mental health practice and policy research grants and postgraduate awards program
- a national mental health teaching and learning clearing house for mental health educators
- a mental health education and training website
- university based regional interdisciplinary mental health forums.

2.2.7 Workforce: State Government

- That all State and Territory Governments require that all mental health budgets devote two percent of their operating budget to education and training and provide hypothecated resources to achieve this.

92. The National Mental Health Carers Education and Training forum should:

- review carer issues (task, burden, responsibilities, rights) for inclusion in education and training materials
- prepare model carer curricula for higher education in conjunction with the five disciplines and universities
- train carers to contribute to education and training at all levels (curriculum development, accreditation committees, and teaching and assessment)

93. This centre of excellence will provide for undergraduate mental health education; offer a nationally available and accessible postgraduate program; outsource evidence based practice; research grants and a clearing house on mental health research and practice. This centre will be internationally benchmarked.

- That State and Territory Governments, in conjunction with professional associations and consumers and carers, facilitate and resource student units, training posts, professional supervisors and chief professional officers in mental health in each of the five disciplines, in ratios which relate to the present and future staff profiles.
- That all State and Territory Governments support the participation of staff working in mental health services in accredited disciplinary and interdisciplinary courses by bursaries, fee support, provision of study leave, work relief and back fill of positions.
- That State and Territory Governments establish a model mental health service around the guiding principles of this report as a demonstration project with action research evaluation.

2.2.8 Workforce: Service Providers

- That all mental health service providers appoint a Chief Learning Officer.
- That all members of the national mental health workforce have a personal, triennial education and training plan agreement with their employer.
- That all mental health service providers develop a plan to involve all members of the organisation in a reflective learning process led by consumers and carers.
- That service providers establish a mental health forum with staff of local universities.

2.2.9 National Mental Health Education and Training Network

That a process for development, implementation and evaluation of all the above recommendations be undertaken by the National Mental Health Education and Training Network.

2.2.10 Commonwealth Government

That the Commonwealth Government ensure that there is a research program to fund research into national mental health services on the basis that education and training must be informed by timely, relevant and critical research.

Acknowledgments

Grateful thanks are extended to those named below (and all who are not named) who contributed to the outcome of this project.

- The consumers and carers who enriched the understanding and deepened the vision of other members of the workshops.
- The Advisory Committee whose depth of knowledge, commitment and wisdom is evident in their contributions to this report.
- All contributors to this report for their enthusiastic participation and thoughtful writing.
- The speakers at each of the workshops for their challenging addresses.
- The members of the workshops whose commitment and optimism was crucial.
- Dr Harvey Whiteford and Ms Leonie Young of the Commonwealth Mental Health Branch, Department of Health and Aged Care who accepted variations of the original process with flexibility and encouragement.
- The executive and honorary directors of the professional bodies whose goodwill and interest made the project possible.
- Betty Kerr for an outstanding secretarial effort and much more.
- Margaret Leggatt and Chris Byrt who developed and organised the first two workshops and the consultative process. Margaret Leggatt read and commented on the report. Lesley Hardcastle organised and facilitated the disciplinary workshops, the final workshop and edited the report.
- Other Deakin staff who contributed were Virginia Fazio, Alan Oppy and Julie Shaw.

Advisory committee members

Ms Merinda Epstein
Ms Dagmar Ciolek
Mr John Farhall
Associate Professor Christine Grant (resigned June 1997)
Ms Maria Harries
Associate Professor Michael Hazelton (appointed July 1997)
Professor Robert Kosky
Mr John McGrath (resigned December 1996)
Dr Jonathon Phillips (appointed February 1997)
Ms Judith Player (appointed February 1997)
Professor Beverley Raphael
Mr Daniel Rechter
Professor Bruce Singh (resigned February 1997)
Professor Sue Spence
Ms Wendy Weir
Commonwealth Government
Ms Joan Lipscombe (to March 1997)
Dr Harvey Whiteford (from April 1997)
Ms Leonie Young (from April 1997)
Deakin University
Professor Jan Carter
Dr Margaret Leggatt

List of contributors

Jan Carter is a Professorial Fellow at Deakin University and Executive Director of Deakin Human Services Australia and its National Mental Health Services Centre. She has been Director of the Education and Training Project.

Dagmar Ciolek is Convenor, National Advisory Group on Mental Health and Director of Occupational Therapy, Calvary Hospital ACT.

Merinda Epstein has been a mental health consumer and is author of a number of consumer based publications.

John Farhall is a Senior Lecturer in the School of Psychological Science at LaTrobe University and Consultant Clinical Psychologist for the North Western Health Care Network, Melbourne.

Alison Garton is Executive Director of the Australian Psychological Society Ltd.

Lesley Hardcastle is an education consultant and Associate Director of Deakin Human Services Australia.

Maria Harries is Senior Lecturer in Social Work at the University of Western Australia.

Brenda Harrison is a former senior lecturer in nursing at Deakin University and undertaking a PhD on carers' needs.

Michael Hazelton is Associate Professor and Head of the School of Nursing at Curtin University of Technology. He is a past Councillor of the Australian & New Zealand College of Mental Health Nurses and is currently editor of the Australian & New Zealand Journal of Mental Health Nursing.

Robert Kosky is Professor of Child Psychiatry at the University of Adelaide and former Chair of the Committee of Training in Child Psychiatry of the RANZCP.

Margaret Leggatt is President of the World Schizophrenia Fellowship and was a consultant to this project.

Jonathon Phillips is a psychiatrist in private practice in Sydney NSW and President Elect of the Royal Australian and New Zealand College of Psychiatrists.

Judith Player, is Executive Director of the Association of Relatives and Friends of the Emotionally and Mentally III (ARAFEMII) Victoria and a registered psychologist.

David Prideaux is an Associate Professor in Medical Education at Flinders University of South Australia's School of Medicine.

Daniel Rechter has worked over recent years as a consultant in consumer-perspective policy and practice in the mental health field.

Alan Rosen is Director, Royal North Shore Hospital and Community Mental Health Services, Sydney, Associate Professor in Public Health, University of Wollongong and Clinical Senior Lecturer in Psychological Medicine, University of Sydney.

Sue Spence Head of School of Psychology, University of Queensland.

Wendy Weir is a Mental Health Consultant, and Occupational Therapist and was formerly Senior Manager with NSW Department of Health, Mental Health Services.

Harvey Whiteford formerly Commonwealth Director of Mental Health, Commonwealth Department of Health and Aged Care, now on secondment to the World Bank in Washington, USA.





Appendices

Learning together

Education and Training Partnerships
in Mental Health

Part 2



Appendix I

A national audit of mental health education and training

Brenda Harrison

Introduction

This appendix describes an analysis of educational programs for mental health education offered by universities and other bodies in Australia in early 1998, the detailed results of which are in Attachment A1. It shows that there is a paucity of mental health specific education at undergraduate level and that the trend towards establishing discipline specific postgraduate education is jeopardised by the removal of HECS rated courses. No education could be described as consumer/carer focused. Workforce training where it exists is generally short and skills based.

Participants at the first and second National Mental Health Education and Training Workshops identified a need for an audit of current education and training available in Australia for mental health professionals. An audit of mental health education had already been undertaken in Queensland and one was planned in New South Wales. Knowledge of currently available materials and courses was seen as relevant to future planning for mental health education and training in medicine, nursing, occupational therapy, psychology and social work¹. A census of all mental health courses in all Australian universities was undertaken.

Method

The following information was sought about each higher education course in each of the disciplines.

- Location of campus
- Title of award
- Level of award
 - under/post graduate
 - pre/post registration (if applicable)

- Mode of presentation
 - on/off campus
 - full/part time
 - length of course in years
- Student payment
 - Higher Education Contribution Scheme
 - cost if fee paying
- Mental health theory content
 - amount
 - general topic areas covered
 - compulsory/elective
- Mental health practice
 - amount
 - compulsory/elective
- Consumer and carer input
 - type
 - amount
 - payment offered
- External accreditation/standards for the course.

More detail about the method is included at Attachment A1.

Higher education courses – general comments

None of the courses surveyed base their curriculum, assessment or teaching around the guiding principles as established in the workshops. Courses surveyed were those at undergraduate and postgraduate levels that prepare practitioners for general/basic practice in their discipline, including mental health practice. As well as these, many courses offering preparation for more advanced mental health practice were focal. Tables

¹ The emerging group of generic workers in the area of mental health was acknowledged but not included in this audit. Similarly, other professionals working with individuals with mental illness, for example, general practitioners, welfare officers and nutritionists, were not included.



Table A.1: Distribution of identified tertiary courses in Australia with specific mental health content.

		Medicine	Nursing	OT	Psychol	SW	Other
ACT	UG ²		1		2	1	
	PG ³		* ⁴		2		
NSW	UG	3	15	4	7	5	1
	PG	1	9	1	8	1	3
NT	UG		1			1	1
	PG						
QLD	UG	1	8	2	7	3	1
	PG	1	3		7	2	2
SA	UG	2	2	1	3	2	
	PG	1	6		3		3
TAS	UG	1	1		1	1	
	PG	1	1		1		
VIC	UG	2	9	1	8	6	1
	PG	1 ^{#5}	7		6	2	6
WA	UG	1	2	1	4	3	2
	PG	1	2		4	1	

Table A.2: Total number of identified tertiary award courses in Australia with specific mental health content.

Discipline	Level	Number
Medicine	UG	10
	PG	6
Nursing	UG	38
	PG	28
Occupational Therapy	UG	9
	PG	1
Psychology	UG	32
	PG	31
Social Work	UG	22
	PG	6
Other disciplines	UG	6
	PG	14
		Total = 189 ⁶

A.1 and A.2 show distribution of courses across disciplines and geographically throughout Australia. There are probably more courses that have single units focusing on mental health or mental illness, and on other areas of study and therapy including music and other arts areas. The difficulty in providing a finite list of courses and units is acknowledged. Attachment A2 shows the higher education courses by institution and profession.

Courses are generally offered either at a single campus or across campuses in one university, and most are discipline-specific. However, there are some variations to this. Some courses were offered at more than one site, for example, the undergraduate social work course at La Trobe University is available at Bundoora, Albury-Wodonga and Bendigo campuses. There are also some courses run jointly by more than one institution, for example, the Graduate Diploma of Mental Health Nursing is a tripartite offering by University of

Adelaide, Flinders University and University of South Australia. Other arrangements include a multi-institution and cross-disciplinary Graduate Diploma in Community Mental Health, a joint venture between University of Melbourne and Monash University and involving medicine, nursing and social work staff. Courses where content was obviously tailored to workplace needs and with liaison between area health authorities and universities, were identified in several states and are generally confined to the discipline of nursing.

In the university departments contacted, there was considerable difference in both mental health content in curriculum and commitment to mental health teaching for professionals. The variation seemed to be determined by the approach and input of individual teachers. Across disciplines, mental health was acknowledged as an important component of generalist practitioner preparation, but even within disciplines this is approached differently. There appears to be no requirement in

2. UG = undergraduate

3. PG = postgraduate

4. * = University is in NSW, students work in ACT

5. # = Masters qualification as well as FRANZCP available at two universities

6. 20 courses (6 undergraduate and 14 postgraduate) not belonging to any one discipline were noted, but not included.

any discipline for mental health education at undergraduate level based on a specified curriculum or for a specific length of time.

Preparation for practice varies between disciplines, with respondents viewing undergraduate preparation as insufficient for specialist mental health practitioners. The result of this is a postgraduate focus on education for mental health professionals, but with variance in offerings and courses spanning the range between graduate certificate and professional doctorate levels. Medicine differs from the other professions in that their specialist qualification is wholly organised and controlled by the psychiatrists' professional college, even though it is taught through university medical schools. Membership of the Royal Australian New Zealand College of Psychiatry is achieved in this way, rather than by graduates obtaining an academic tertiary qualification (See Part 1, Chapter 5.3).

The practice-focus of medicine, nursing, occupational therapy and social work was defined clearly as being fundamental to each of these disciplines. For these disciplines, the basic undergraduate preparation is for practice in the generic field. Undergraduate courses offered reflect this, with practice or field components being compulsory at this level. Mental health practice is not, however, included in all social work or occupational therapy courses. In psychology teaching at universities, undergraduate preparation of students is academic, and the clinical masters/clinical doctorate courses are intended for the preparation of practising psychologists.

At undergraduate levels, all disciplines - apart from psychology - prepare practitioners for general practice. In psychology, students with a four-year degree are eligible to enter practice. In each discipline there is a large number of individual subject areas to be covered in the theory portion of undergraduate courses so that students are introduced to a wide spectrum of knowledge on which to base future practice.

Postgraduate courses prepare students for specialist mental health practice. The length, level and content of these courses varies remarkably between disciplines and institutions. Some nursing and occupational therapy courses are at postgraduate certificate level, whereas preparation for practice in some psychology courses is offered at professional doctorate level.

All disciplines offer higher degrees by research. The mental health focus of such studies are cir-

cumscribed by student interests as well as suitability and availability of supervisors. These research courses were not considered as part of this audit, as they do not prepare graduates specifically for any particular level of practice.

There are a small number of other postgraduate courses focusing on specific aspects of mental health practice, for example, child and adolescent, and transcultural psychiatric practice. Although there are courses in gerontological care, there is no one course focusing on aged-care psychiatry even as the age of the Australian population is increasing. There is however, a gerontology stream in the clinical psychology masters course at Edith Cowan University in Western Australia.

Other education and training – general comments

The differences in the availability of non-award courses for mental health professionals were noticeable at both the state/territory level and between metropolitan and rural areas and this will be discussed later. Also, organisation and focus of funding for mental health education and training is different in each state/territory. In some there is focus on support of university award courses, whereas in others, there seems to be focus on in-service education. Decentralisation of funding has caused a drop in the number of mental health courses available for professionals in some states.

Budgets and responsibilities for education and training are, in many instances, at least partially regionalised and localised. Details of such training are not necessarily available at state level. Generally this education and training is related to immediate practice needs and available only to service employees.

Although much of the localised training in mental health services is multi-disciplinary, some services, especially those in rural areas, focus the educational proportion of their budgets creatively to suit their specific needs. For example, a rural mental health service may employ four-year undergraduate-prepared psychologists and host video-linked metropolitan-based supervision for these staff members until they achieve their full practice registration. This is one way of coping with the dearth of masters-prepared psychologists in rural areas.

Private providers offer other non-award courses. In some instances these relate to specific therapies, for example, family therapy. Other courses focus around mental health/illness topics. It is very difficult to audit such courses as many are ephemeral, and may be dependent on infrequent visits from overseas specialist practitioners and teachers.

The place of professional conferences and workshops, such as The Mental Health Services Conference, and the individual disciplinary and other mental health practice conferences should not be ignored when considering mental health education. The value of such gatherings cannot be measured, nor can their facility for inspiring interest and a desire to undertake further education and training be ignored.

Often when discussing education and training for mental health professionals, it is formal courses that are focal. It was mentioned earlier that no course was based around the lived experience of consumers and carers. There is, however, an ever-growing collection of consumer and carer prepared literature and other materials available through many non-government organisations. Many mental health professionals have undertaken their own education through use of this material; booklets and pamphlets are read at home, a video or television program scanned during a meal break. Much of this material is based on the lived experiences of consumers and carers. Many publications are the result of creative collaborative efforts between consumers, carers and health professionals. It is information many mental health professionals give out to other carers and consumers during the course of a day's work. It is not regularly included as either teaching materials in a formal course, nor recognised as having particular academic value or credibility. It is, however, a flexible learning resource available to mental health professionals that could be more fully utilised.

Although this audit did not include generic mental health workers, courses offered at Technical and Further Education (TAFE) institutions were noted, especially in the area of psychiatric disability support and Aboriginal mental health. Psychiatric disability support is an area emerging as a speciality in mental health practice. Some mental health professionals from the five identified disciplines are undertaking tertiary courses in these specialist areas as a means of obtaining the post-basic disciplinary education they see as most relevant in speciality-practice areas. Some of these courses are sponsored by state/territory governments. The lived experience of consumers and of

other involved community members (for example, family carers) is seen as important in the preparation and teaching of these courses. In the audit, these courses are grouped under the heading of 'non-specific', even though some courses are only open to individuals with Aboriginal or Torres Strait Islander heritage.

Disciplines

This section summarises the findings of the audit in relation to the disciplines.

Medicine/Psychiatry (Refer to Part I, Chapter 5.3)

Medicine is a registered profession, and registration is required for practice in all states and territories of Australia. Recognition of specialist medical qualifications is facilitated through professional colleges. For psychiatry this is through the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

Basic medical education is via an undergraduate course, either as a first or second degree. The course length varies between four and six years. Psychiatry is a compulsory speciality within the undergraduate course and is based around a clinical placement with theoretical input. Total teaching time varies between programs, but there is no less than 279 hours and possibly over 440 hours of psychiatry education in a medical degree course (O'Connor, Clarke & Presnell, 1996).

Postgraduate credentialling in psychiatric medicine is the province of the RANZCP. The college prescribes four years of clinical training followed by a final elective year where the individual has some choice of area or speciality. The final year may consist of, for example, consolidation of clinical skills, advanced specialist practice, or research. During the total five year period of specialist training the doctor works as a senior house officer/registrar at a recognised mental health facility. The training is organised at branch level in each state and skills are learnt through an apprentice-type training undertaken with different consultant psychiatrists in different clinical areas and psychiatric specialties. Candidates are required to pass written and clinical examinations and present a final year dissertation. Depending on the location of the RANZCP training, students may be able to enrol in a postgraduate university-based course in psychological medicine concurrently with their college

training, utilising the same theoretical input for a dual purpose (see Chapter 5.3).

Carers and consumers were consulted for the Fellowship curriculum 1995 (RANZCP 1995). Input from carers and consumers resulted in attitudinal objectives being at the forefront of the psychiatrist set of curriculum objectives. Occasionally carers and consumers are invited to provide presentations to undergraduate students and psychiatrists-in-training. The informal feedback from consumers who have participated in clinical examinations for candidates receives little or no formal recognition as part of medical education.

As medical education is at undergraduate level, the Higher Education Contribution is payable throughout a student's undergraduate course. This is regardless of whether the incoming student is taking medicine as a first degree or second degree course. Specialist training as a psychiatrist is full-fee paying. RANZCP members pay a substantial annual membership fee that facilitates provision of services to their profession, including aspects of psychiatry training. However, unlike the other disciplines, paid training posts are available to trainee psychiatrists.

Continuing professional education is a requirement for practising medical practitioners. It is also a requirement of psychiatrists through RANZCP.

Mental Health Nursing (Refer to Part I, Chapter 5.1)

Nurses are required to register in a state or territory prior to practise in that location. Specialist qualification as a psychiatric nurse is recognised in all states/territories, other than New South Wales. As already mentioned credentialling of nurses in specialist areas of practice was addressed recently in the National Review of Specialist Nursing Education (Russell, Gething & Convery, 1997).

Preparation for nursing practice is a three year undergraduate program (3.5 years in two universities). Graduates from these courses are eligible for registration as a general or comprehensive nurse, depending on their course and where they register.

Within undergraduate nursing courses, psychosocial, mental health and/or psychiatric aspects of nursing are taught in on-campus lectures and laboratory sessions. Students may undertake between two (2) and six (6) weeks of practice in a mental health facility or community mental health service

during their course. In some courses, mental illness is not a specific focus of study, but is integrated into the general course 'problem-based' teaching. For this reason it is difficult to assess exactly how much time is spent in teaching about mental health and mental illness.

Generally, undergraduate nursing students are not prepared specifically for work in the mental health field. During their course students are influenced to the extent that they see mental health/psychiatric nursing as having a lower status than general nursing and not being an attractive area of practice. Anecdotal surveys from several nursing departments concur that only 5 percent of nurses graduating choose psychiatric nursing as their first option for practice. Psychiatric nurse-academics see several reasons for this: there is a large general nurse-academic presence in undergraduate teaching compared with the small psychiatric nurse-academic presence; students are encouraged to become general nurses; students are uninspired by their undergraduate mental health placement; psychiatric facilities are not welcoming new graduates in their first year; preparation in undergraduate nursing courses for working in the mental health field lacks a skills base; and the general stigma of mental illness. This is supported by recent research (Stevens & Crouch, 1998). One psychiatric nurse-academic said: "Unfortunately many new graduates are more interested in machines that go 'beep' than in the humanistic aspects of caring".

The change in the delivery of mental health services, particularly deinstitutionalisation and the focus on community mental health care, has resulted in a limited availability of placements for undergraduate nurses in the psychiatric area. The problem relates to the sheer number of undergraduate nursing students requiring brief placements. This is problematic for both academic staff trying to place all the students and mental health workers who take these students into their workplace. This is a factor in both rural and metropolitan areas.

The quality of mental health theoretical input as well as clinical placements available to undergraduate nursing students varies enormously. The numbers of psychiatric nurses in academic positions has decreased in the last two to three years. In many mental health facilities that accept nursing students, staff are often asked to support cohorts of students throughout the year. As students so rarely go back to the same placement again, and so few go to the mental health field, staff get little feedback on their own performance as support

personnel, or on the continuing performance of students.

Specific preparation for psychiatric nursing practice is now undertaken at post-graduate level. This is where development of specific skills in mental health practice takes place. Students may gain graduate certificates, graduate diplomas, masters degrees in mental health nursing practice offered at or through tertiary institutions. In many areas universities have established postgraduate courses in psychiatric/mental health nursing co-operatively with mental health service employers. Courses meet employer needs as well as university course requirements. The nature and extent of support for students who are studying varies between state and locality. Students may be supported through a variety of means including: on-going salary reductions rather than having to pay up-front course fees; adjustment of rosters to fit in with lectures; part-time employment for the duration of a course to facilitate study as well as current practice; provision of supervised practice for the duration of the course. This has been useful in making such courses available and viable to nurses.

Consumers and carers may present some sessions in undergraduate courses, but are not usually involved in other aspects of course preparation or delivery. At postgraduate level, there may be more involvement by consumers and carers in other aspects of course preparation and delivery, for example on advisory committees and in aspects of student assessment, but this is sporadic rather than routine.

There are few career incentives to undertake post-graduate courses in psychiatric nursing. Within nursing, there is no formal requirement for senior-grade staff to have even an undergraduate degree, and no formal recognition within their career structure for psychiatric nurses who undertake doctoral studies. Also there is no generalised requirement for formal supervision within psychiatric nursing. Within nursing generally, and including psychiatric nursing, the only requirement for mandatory continuing education is that nurses must have practised nursing within the past five years to retain their registration (except in NSW where there is no such requirement).

The Australian and New Zealand College of Mental Health Nurses (ANZCMHN) is the professional body for psychiatric nurses, but it is not representative of all practitioners or psychiatric nurse-academics. It has no mandating power and does not at present offer a national program of continuing edu-

cation. Some respondents see the ANZCMHN as leading mental health nurses in the future.

Occupational Therapy (Refer to Part I, Chapter 5.2)

Occupational therapists are registered for practice in Queensland, Western Australia and South Australia, but not in other states/territories. Preparation for practice is through a four year undergraduate degree course.

In their undergraduate courses, occupational therapy students focus on physical and psychological aspects of care. Working with individuals with a mental illness is an integral part of courses, and many students have an option of one fieldwork placement working in a mental health facility or with a mental health team.

Occupational therapists respondents say they include consumers and carers as an integral part of course presentation. This is limited by funding availability, and the involvement does not generally extend beyond formal classroom presentation and some informal input to student assessment.

Postgraduate courses focusing on occupational therapy practice, rather than research are available, but not in each state; and the number of courses is limited. These can be focused on various specialist areas, including mental health.

OT Australia is the professional organisation for occupational therapists. The organisation does not currently have any formal mandating, accrediting or approval role with the courses preparing occupational therapy practitioners. OT Australia has an active mental health special interest group that is currently considering curriculum issues in mental health for the profession. The group is committed to consumer and carer involvement in mental health education and training.

Whilst as a profession occupational therapists are conscious of the importance of mental health education and practice, it is occupational therapists themselves who say that only a small number of practitioners and academics promote a positive image of mental illness. This results in many students avoiding mental health practice or limiting their practice to areas where social acceptance is greater. There are also some students who seek out work in the mental health field because of encouragement received during training.

Psychology (Refer to Part I, Chapter 5.4)

Psychology is a registered profession, with registration boards in each state and territory of Australia. Minimum requirements for registration are a four year degree with a major in psychology and two years supervised practice as a psychologist. It is required that the undergraduate degree is accredited by the Australian Psychological Society (APS) and that supervision is undertaken by a qualified psychologist.

Currently psychology at undergraduate level is studied through a three year bachelor degree, or a four year bachelor degree with honours, or a three year bachelor degree with a fourth year being an honours year or a postgraduate diploma. Entry to an honours year is usually by invitation and dependent on performance and grades. Undergraduate psychology is a scientific-academic rather than practice-based discipline.

Mental health studies are present in most undergraduate courses as either core or elective units in abnormal psychology or psychopathology. Interpersonal studies are not specifically taught at this level, and fieldwork is not a requirement in APS undergraduate course accreditation. In some postgraduate diploma courses there may be minimal exposure to fieldwork, and some practice-based content.

Masters degrees are offered in the various psychology specialties. Clinical psychology focuses specifically on preparing practitioners to work with individuals with a mental illness. Clinical psychology masters degree courses include a minimum of 1000 hours practicum, and most students spend the majority of this supervised practicum in mental health facilities or other health care facilities. Course content is based on scientific, evidence-based practice and includes theory and practice-focused units. In all courses ethical and professional issues are addressed as well as psychology practice with adults and children. Teaching about psychological testing is included in all masters courses.

Consumers and carers are rarely involved in psychology course preparation or any other aspect of curriculum. In departmental psychology clinics, clients may be asked to evaluate the services received, but most often consumers are the subjects of, rather than partners in, mental health care.

The Australian Psychological Society (APS) is the professional organisation for psychologists. It has levels of membership that relate to levels and type of academic qualification and practice, and also a number of associated professional colleges focusing on specialist areas of psychology practice. The APS offers accreditation for university courses in psychology at both undergraduate and postgraduate levels. This accreditation has become one accepted way of the profession regulating itself, and of universities demonstrating how they meet APS standards. Students who graduate from APS accredited courses are eligible for APS membership. The APS is generally held in high regard by psychologists. Although its course requirements for undergraduate study are questioned, especially the lack of client exposure, membership of APS is high. Respondents indicated that there was respect for APS accreditation of courses. The work APS does in maintaining professional standards is recognised.

The APS stipulates four years of undergraduate psychology study as the basic requirement to enter a two year postgraduate masters degree preparing psychologists for professional practice. Both APS and universities emphasise that undergraduate academic achievement is of paramount importance for prospective masters students. An honours degree level 2A is a minimum entry requirement for many masters courses. With competition for places, many universities are able to select students with higher qualifications than this for entry to masters courses.

The APS is clear that a four year undergraduate course in psychology is not appropriate preparation for professional psychology practice. This is at variance with all the state registration boards who do see this, together with two years of supervised practice as appropriate preparation for professional practice as a psychologist. After the year 2000, APS will grant full membership only to psychologists who have undertaken masters level preparation for practice.

Psychology academics make a cogent case for requiring at least a masters degree for professional practice. Some say preparation for practice should now be through a professional clinical doctorate (Toyuz, 1995). Some psychologists regard anything less than face-to-face supervision as a compromise.

Some mental health service employers, especially those in rural areas, are unable to secure the services of a masters-prepared psychologist. Although



in three or four years it is anticipated that there will be quite a number of six year prepared qualified clinical psychologists, it remains to be seen whether they will be available to work in rural areas. This would depend on whether there were public service jobs available. (One respondent commented that the lack of availability of a psychology service to a local Aboriginal community was “appalling”.)

Participation in continuing professional education is now a requirement for continued membership of APS. This is aligned with membership of a professional college of APS and thus to a particular area of specialisation.

Increasingly respondents said that psychologists are moving to private practice. Salaries and career structures in the public sector are said to be disadvantageous. Respondent psychologists observe that they have minimum opportunities to focus on primary prevention, spending most of their public practice focusing on tertiary care and maintenance. Another point of concern aired by respondents is the dwindling number of supervised places available for student psychologists as public services continually downsize and more psychologists enter private practice.

Social Work (Refer to Part I, Chapter 5.5)

Social workers are not required to register prior to entering social work practice within any state or territory of Australia. Entry to social work practice is via an undergraduate degree of four years, or, for students with a diploma or other degree, after completing a further two year undergraduate degree course. The recognised qualification is Bachelor of Social Work, and university course curricula are submitted for review to the professional organisation, Australian Association of Social Work Ltd. (AASW), for approval regularly. Students graduating from an AASW approved course are eligible for AASW membership.

Undergraduate courses prepare social workers for practice in many different work areas. For this reason the basic social work course is generic, with mental health being only one of many areas competing for space in a full curriculum. Mental health social work is addressed in all undergraduate courses. As with nursing, some of the courses are problem-based, and the actual focus or amount of mental health content is not clear in all cases. Student social workers undertake fieldwork place-

ments during their course, but not all students undertake mental health placements. Most students do encounter individuals with a mental illness during their placements, but often this is incidental and in many instances, clients’ mental health needs are not addressed specifically. Concern was expressed by some social work academics about the progressive falling-off of mental health content in undergraduate courses during the past few years. Just what should be included and what should be excluded in courses preparing social workers for practice is an issue for many social workers in both academic and practice positions.

Postgraduate practice-based education for social workers is also available at graduate diploma and masters levels. It is said by some practitioners and some academics that, whilst the basic undergraduate course is a beginning, qualification for specialist social work practice should be at a postgraduate level. Mental health social work is accepted generally and recognised by the AASW as a specialist area of social work practice. There is no specific social work masters degree in mental health.

Consumers and carers are not involved with social work courses beyond the level of guest class presentations in most instances. Funding cutbacks and other considerations, including the amount of mental health content particularly in undergraduate programs, appear to have a marked influence on involvement of consumers and carers.

Although there are often jobs available for social workers in the mental health field, social work respondents observed that very few are for new graduates. The majority of social workers in mental health work in community settings, and an increasing number are working in the area of psychiatric disability support (Association of Mental Health Social Workers, 1997). Some social work academics see the medicalisation of mental health as being problematic to social workers. The skills social workers and some other mental health professionals are taught during their training, are not used to the full.

The AASW is developing its profile professionally. It has several special interest groups among its members. Groups focusing on mental health social work practice exist in several state branches. The AASW has also endorsed a policy for continuing professional education for its members. This program began in 1997 and includes various educational activities and professional supervision and is administered at branch level. This policy is rele-

vant only to AASW members; not all practising social workers or social work academics are members of their professional organisation.

Other issues

Location of education and training

Most mental health education and training courses are based in metropolitan centres. Although most Australians live in and around the capital cities, there is a significant proportion of the population - and of the mental health workforce - in regional, rural and remote areas. When education is not available locally, mental health professionals have to travel out of their areas to upgrade their education and skills. The exceptions are a few distance education courses. Although telepsychiatry is available in many non-metropolitan areas, programs offered are not as widespread or comprehensive as the telemedicine offerings. Enhancement of telepsychiatry and other rural mental health training initiatives, and inclusion of material for the non-medicine disciplines, would allow non-metropolitan mental health professionals to link in with their city colleagues and benefit from the professional interactions.

Some tertiary institutions are opening professional programs at their rural campuses; for example, there is a new clinical psychology course at Ballarat University, Victoria University of Technology and a new undergraduate social work course at Edith Cowan University's Bunbury Campus, South Western Australia. These courses may help to encourage professionals to work in rural areas. The lack of local educational opportunity contributes to country students leaving their homes and moving to the cities to study. The absence of professional support outside the capital cities is one of the reasons mental health professionals give for not going to work outside the main cities after qualifying.

Disciplines - general comments

Nurses are the largest workforce among the five main mental health disciplines. This is a reflection of the past institution-based services now being phased out in favour of community-based mental health services. Although it is nurses who generally staff and manage the remaining in-patient mental health services, community teams are comprised of personnel from other disciplines in increasing proportions. As discussed, psychiatric

nursing courses have ceased to exist and the number of nurses training for psychiatric/mental health specialty nursing practice has also decreased over the past decade. The psychiatric/mental health proportion of comprehensive courses has not increased either (Happell, 1997).

The next most numerous courses being offered are in psychology. There is an increase in clinical psychology courses. With their scientific approach, psychologists readily offer measurement of outcomes of therapy. This is eminently desirable in the current climate of outcome-based models of mental health service delivery.

Social workers and occupational therapists are constantly in demand to add dimension and balance to mental health teams. In many instances, because of the structure of their undergraduate courses, these professionals have had little or no preparation or fieldwork experience in mental health work. They work in crisis, treatment and support teams and individually with mental health clients, often with performance and resilience expectations which are unrealistic, given their lack of preparation. The turn-over of staff in mental health teams and generally, is something team managers note. Staff are often enthusiastic about, but not prepared for, mental health work. Many of these individuals may be expected to work in what are, for them, stressful situations, often alone or without close supervision for periods at a time. This can be the case in both urban and rural settings.

Cost of education

As has been noted, currently there is a change in funding options for postgraduate courses at tertiary institutions. Higher Education Contribution Scheme (HECS) funding to postgraduate courses is being progressively decreased. There will be no HECS funding for postgraduate courses in a few years. This is a situation that is already felt keenly by psychology, nursing, occupational therapy, and social work. Even though some universities offer their basic medical degree as a second degree course, it still attracts HECS funding for the whole course.

Students preparing for psychology practice at masters level may no longer automatically qualify for HECS funding, if the university determines that HECS funding does not apply. This means psychology students could be paying \$10,000-\$12,000 per annum for a masters degree course in the future. There are concerns that this will limit the students



who seek available places to those who can afford the up-front fees. This has not been fully tested to date, but is a major concern for psychology, for both academics and practitioners.

The cost of a one year full-time multi-disciplinary graduate diploma is quoted at \$16,500 by one university. Even though students may receive a \$10,000 bursary towards costs, it would be expected that students who are attracted to further education in mental health are deterred by this.

Although preparation for practice in nursing, occupational therapy and social work is through undergraduate courses, mental health practice is not addressed specifically. Without financial support, postgraduate courses offering discipline-specific preparation for psychiatric/mental health nursing practice, and multi-disciplinary courses in mental health practice areas may not survive on the local market. Workforce-supported courses appear to be successful and enduring. Not only are they designed to meet at least some service needs, but students can often obtain workforce support with funding and other arrangements for study. The future viability of such courses may be tied in with benchmarking and service standards for an appropriately prepared and accountable mental health workforce.

Carer and consumer input to mental health education and training

Generally, mental health professionals recognise the wealth of experience both consumers and carers possess. However, only a small number of mental health teachers demonstrated any intention or ability to harness this vast body of knowledge. There seems to be some distancing of the consumer and carer bodies of knowledge from the knowledge of paid workers, as if these are two distinct entities, never to meet. The tokenistic presence of consumers and/or carers as guest lecturers/speakers in some undergraduate and postgraduate courses has to be an important first step in involving carers and consumers as partners in mental health education and training. But moving from this to a true partnership model of mental health education may not be uniformly easy for all institutions or all disciplines.

There are exceptions to this general trend. There are instances where mental health teachers have also been mental health consumers. This adds an important extra dimension to their teaching. In the TAFE psychiatric disability support sector there

are some situations where consumers are employed as lecturers. The encouragement and support of consumers and carers to become students in courses preparing them for professional mental health practice is also a recent innovation by some academics. The existence of a self-help chat-line for consumer-students via the Internet has also become an important support for many of these students.

At this time, most consumers and carers are not prepared to undertake or provide professional mental health education (see Chapters 3 and 4). Similarly, many course teachers do not recognise that consumers and/or carers can take on roles as either students or lecturers. Even with a cohort of consumers and carers prepared and ready to participate in mental health education and training, a change in values and attitudes will be vital in academia. The ethical difficulties many highlighted during collecting this data were especially relevant in small communities. For example a student therapist was working with a patient who then became a consumer-educator, in this role providing professional education to the student and to other professionals. Without an accepted partnership model of care this reversal of role is very difficult for students.

Opening up some professional (postgraduate) mental health education and training courses to consumers and carers, is a step in recognising that consumers and carers can contribute to mental health services. However, it loses its potential if the special consumer and carer bodies of knowledge are simply subsumed into traditional professional framework and practice perspectives.

Conclusions

Undertaking this audit has highlighted some features of concern about current professional mental health education and training. The major issues are:

- the minimal input of consumers and carers to formal professional mental health education and the absence of any reflection of the 'guiding principles' of education and training in academic or workforce activity
- the gaps in specific mental illness education at undergraduate level
- the potential effects of cuts to HECS funding for postgraduate courses for each discipline (except psychiatry)

- the different levels of organisation and emphasis on professional pathways, credentialing and focus on continuing education of the professional associations for each of the five disciplines.

In addition a series of observations can be made about present issues in education and training. These are:

- the marked difference between psychology and other mental health disciplines (except psychiatry) in that the profession does not recognise preparation for a general psychology practitioner at undergraduate level
- the increased practice of the blurring of professional roles in many areas of mental health service delivery, especially in community mental health teams
- the growing presence of psychiatric disability support as a specialty area of mental health practice
- the growing number of interdisciplinary postgraduate courses
- the apparent need for finance support for postgraduate mental health courses
- the resources produced by consumers and carers that are not wholly legitimised for inclusion in mental health professional education and training
- the difficulty many professionals have with mental health consumers providing professional education that is relevant to the mental health workforce
- the variation in 'indirect' expenditure on mental health education and training varies considerably between the states (Mental Health Branch 1998, p.132). (This is difficult to compare because state education and training structures vary. At the time of this audit only the Victorian and Tasmanian Governments appear to fund academic chairs, and in selective disciplines. If the policy objectives of the national mental health strategy are to be met, a more equitable distribution of state mental health education and training funds needs to be achieved across the disciplines).

Recommendations

In order to communicate information relating to and consumer and carer involvement in education and training in mental health, the following recommendations are put:

1. An Internet site detailing accredited programs should be established. Setting up such a site incurs cost, and on-going hosting of such a site by a web-server might also involve cost. The site should be up-dated once or twice a year.
2. A regular audit of mental health education and training should be held. This will be particularly important in measuring progress in consumer and carer involvement.
3. An annual conference would be an important way of capturing and maintaining the considerable enthusiasm and commitment of many mental health educators and continuing the development work with consumers and carers.

References

- Association of Mental Health Social Workers 1997, *Social Work in Victoria's Mental Health Services*, Association of Mental Health Social Workers, Melbourne.
- Happell, B. 1997, 'Psychiatric nursing in Victoria, Australia: a profession in crisis', *Journal of Psychiatric and Mental Health Nursing*, Vol 4, pp. 417-422.
- Mental Health Branch 1998, *National Mental Health Report 1996, Fourth Annual Report: Changes in Australia's mental health strategy under the National Mental Health Strategy 1995-1996*. Commonwealth Department of Health and Family Services, Canberra.
- National Board of Employment, Education and Training, Higher Education Council 1996, *Professional Education and Credentialism*, Australian Government Publishing Service, Canberra.
- O'Connor, D.W., Clarke, D. & Presnell, I. 1995, 'How is psychiatry taught to Australian and New Zealand medical students?' Monash University, Department of Psychological Medicine, Clayton, Victoria.
- Russell, R.L., Gething, L. & Convery, P. 1997, *National Review of Specialist Nurse Education*, Department of Employment, Education, Training and Youth Affairs: Evaluations and Investigation Program (Higher Education Division), Canberra.
- Stevens, J. & Crouch, M. 1998, 'Frankenstein's nurse! What are nursing schools creating?' *Collegian*, 5(1), pp. 10-15.
- Touyz, S.W. 1995, 'Clinical psychology in dissent: the challenge ahead', *Australian Psychologist*, 30(3), pp. 191-195.
- Yardley, T., Munns, C. & Lord, M. 1996, *The directory of Higher education courses 1997*, New Hobsons Press, North Sydney

Attachment A I

Methodology of a national audit of mental health education and training in mental health

As the audit was to find out what mental health education and training was available, a census of all available and accessible relevant programs in Australia was undertaken. Even with this approach, it was realised that the audit would only yield an approximate rather than finite list of materials and courses in some areas. This is because there are always changes being made to offerings, including program innovations and revisions, and course deletions. Such variables are subject to available funding as well as workforce requirements, and the viability of marketing and offering courses at specific geographic locations.

Tertiary courses

Through generally available publications (for example, Yardley, Munns & Lord, 1996), awards offered in the five (5) specified mental health disciplines were identified. In an associated project, a recent request for information from university departments on consumer and carer involvement in tertiary courses in mental health resulted in a postal response rate of approximately 15 percent. It was therefore decided that telephone contact with course coordinators would be a more effective way of collecting the required spread of both relevant and current data.

Introductory letters were sent to the heads of all university departments of medicine, nursing, occupational therapy, psychology and social work in Australia. In the letter, the project being undertaken was introduced and contextualised, and the heads of schools invited to nominate who would be the most appropriate person to be contacted for a telephone survey on course and unit content related to mental health. When specific information on appropriate contacts was received this advice was followed. In other cases, course coordinators were targeted.

Telephone interviews were undertaken at a time that was identified as convenient to respondents, and a maximum of thirty minutes was planned for

each interview. Questions asked of respondents were uniform. Topics included course and unit mental health content and practice, availability of course offers, course costs, and carer/consumer input in mental health areas. Standards and competencies for courses were also clarified, and other relevant information recorded. Each interviewee was invited to share his/her values and attitudes with regard to mental health education and training. Assurances were given that neither individuals sharing this material, nor their institutions, would be identified. The intention to collect this qualitative information into discipline groupings and then identify themes to be used in a report to accompany the audit was clearly stated.

State government mental health branches

Letters introducing the project and requesting relevant information, were sent to state government mental health branches. Specific information was sought about in-service education programs and other mental health education and training offered, funded or supported in any way. Initial letters were followed up by telephone contact to clarify information required when necessary, and to seek further information if required. Carer/consumer involvement in courses was not a focus in this part of the data collection, as much of the information made available was not actually organised or offered by the state mental health branches themselves. Follow-up telephone calls to main providers of sponsored courses was more detailed, and focused on the topics outlined in the above section.

Non-government agencies

National and statewide non-government organisations, those in the mental health area and those involved in mental health education or training, were contacted by telephone and invited to share information on their input to the education of mental health professionals. These contacts included both private and government-sponsored groups

and self-help groups. Carer/consumer involvement in preparation of educational materials, as well as in other education and training pursuits, was canvassed.

Other education and training resources

Workshop participants - mental health workers and consumers and carers - were also invited to share any information about available non-award education and training for mental health professionals in which they were either involved or which they knew were being conducted. The high probability of overlap of such material with other data collection was acknowledged but, even so, this avenue was utilised to ensure valuable resources were not missed.

Data already gathered by Queensland Health was used in the construction of the audit. Liaison was also maintained with the Institute of Psychiatry in New South Wales regarding their pending audit.

Database construction

A decision was made to collate award course material gathered into a relational database; MS Access® was utilised. Through use of the database, data input time and duplication of material could be minimised and output options maximised.

The parameters for the information to be gathered were based on comments from the first two National Mental Health Education and Training Workshops. One important focus was the type and level of involvement of consumers and carers in education and training programs. Another issue was the amount of practice/fieldwork students undertook in the mental health area in courses preparing them for practice. Specifically, information on the mental health content of courses was sought, with the other general course information only included to contextualise the mental health content as and when necessary.

Data analysis

As the requirement of this project was to audit, that is identify, examine and verify available courses, the main operation performed on the material gathered was its organisation into an accessible format. The qualitative data received from tertiary course teachers and others was separated into the

disciplines of contributors. Reading and re-reading responses, elicited themes that emerged from the data. These were used as a basis for the discussion section in this chapter.

Award courses

The award course material was organised by state/territory and discipline, then grouped by institution of offering, and finally separated into undergraduate and postgraduate level courses. From the data gathered, the number of tertiary award courses available in each state and discipline was totalled (see Table A.1). (Attachment A2 summarises the award courses by institution and discipline).

Non-tertiary award courses

The material received from a myriad of different sources about non-tertiary award courses varied greatly in detail and complexity. State mental health branches were particularly helpful. Much of the information received from the different sources did not pertain directly to this audit, but was rich in its diversity, and included such things as first aid courses and computer skills training for staff. Only mental health material was extracted for use in the audit. Other contemporaneous and extraneous, yet often fascinating, information was excluded. Some of the data already recorded in the tertiary award section of the audit was repeated. Although this was not duplicated in the audit, any additional relevant details gleaned were added as appropriate.

Data collection

The audit commenced in June 1997, with most of the tertiary award course data being collected over the three (3) month period from October 1997. The focus of the audit was on award and non-award education courses and other education and training for the identified groups. The audit was completed in its present form in February 1998.

Respondents in all areas were generally helpful with course data, providing information they had to hand and backing that up with more detailed information as requested. Most people contacted were also willing to share their values and attitudes with regard to mental health education and training. When the general focus of the interview was introduced prior to the actual interview, the information shared by informants was pertinent and readily available.

Table I

National audit of mental health education and training, 1998¹

1. Excludes preparation for psychiatry through the RANZCP, but includes undergraduate medicine.

Table I Institution	State	Discipline	Award
Australian Catholic University	NSW	Nursing	Bachelor of Nursing
Australian Catholic University	Qld	Nursing	Bachelor of Nursing
Australian Catholic University	Vic	Nursing	Bachelor of Nursing
Australian Catholic University	Vic	Nursing	Bachelor of Nursing
Australian Catholic University	ACT	Social work	Bachelor of Social Work
Australian National University	ACT	Psychology	Bachelor of Arts (Honours)/ Bachelor of Science (Honours)
Avondale College	NSW	Nursing	Bachelor of Nursing
Batchelor College	NT	ATSI Health	Certificate in Social and Behavioural Health
Bond University	Qld	Psychology	Bachelor of Social Science (Psychology) (Honours)
Bond University	Qld	Psychology	Post Grad Dip of Professional Psychology
Bond University	Qld	Psychology	Master of Psychology (Clinical)
Central Queensland University	Qld	Multidisciplinary	Indigenous Therapies Certificate
Central Queensland University	Qld	Nursing	Bachelor of Health Science (Nursing)
Central Queensland University	Qld	Nursing	Bachelor of Health Science (Nursing)
Central Queensland University	Qld	Psychology	Bachelor of Arts (Honours)
Central Queensland University	Qld	Social work	Bachelor of Social Work
Charles Sturt University	NSW	ATSI Health	Diploma of Health Science (Mental Health).
Charles Sturt University	NSW	Multidisciplinary	Master of Mental Health
Charles Sturt University	NSW	Nursing	Bachelor of Nursing
Charles Sturt University	NSW	Nursing	Bachelor of Health Sci (Mental Health) for RNs
Charles Sturt University	NSW	Nursing	Master of Health Science (Nursing)
Charles Sturt University	NSW	Nursing	Post Graduate Diploma in Mental Health Nursing
Charles Sturt University	NSW	OT	Bachelor of Occupational Therapy
Charles Sturt University	NSW	Psychology	Bachelor of Social Science (Psychology) (Honours)
Charles Sturt University	NSW	Psychology	Master of Psychology (Clinical)
Charles Sturt University	NSW	Social work	Graduate Certificate in Community Mental Health
Charles Sturt University	NSW	Social work	BSW/Bachelor of Arts (BSW)
Curtin University of Technology	WA	Multidisciplinary	Assoc Degree in Aboriginal Health/B App Sci (Indig Comm Health)
Curtin University of Technology	WA	Nursing	Bachelor of Science (Nursing)
Curtin University of Technology	WA	Nursing	Master of Nursing - (specialty mental health).
Curtin University of Technology	WA	OT	Bachelor of Science (Occupational therapy)
Curtin University of Technology	WA	Psychology	Bachelor of Arts (Honours)/ Bachelor of Science (Honours)
Curtin University of Technology	WA	Psychology	Master of Psychology (Clinical)
Curtin University of Technology	WA	Social work	Bachelor of Social Work

Table Institution	State	Discipline	Award
Deakin University	Vic	Nursing	Bachelor of Nursing
Deakin University	Vic	Nursing	Grad Cert/Dip/Master of Nursing (Psychiatric) for RNs
Deakin University	Vic	Psychology	Master of Psychology (Clinical)
Deakin University	Vic	Psychology	BA (Hons)/B Sc (Hons)
Deakin University	Vic	Social work	Bachelor of Social Work
Edith Cowan University	WA	Nursing	BN - undergrad & BN - for RNs
Edith Cowan University	WA	Nursing	Graduate Diploma in Mental Health Nursing
Edith Cowan University	WA	Psychology	BA (Hons)/ B Sc (Hons)/ B Psychol
Edith Cowan University	WA	Psychology	Master of Psychology (Clinical)
Edith Cowan University	WA	Social work	Bachelor of Social Work
Flinders University of South Australia	SA	Medicine	Bachelor of Medicine and Bachelor of Surgery
Flinders University of South Australia	SA	Multidisciplinary	Graduate Certificate of Community Mental Health.
Flinders University of South Australia	SA	Multidisciplinary	Master of Primary Health Care/ Master of Science (Primary H/Care)
Flinders University of South Australia	SA	Nursing	Bachelor of Nursing
Flinders University of South Australia	SA	Nursing	Graduate Diploma of Mental Health Nursing.
Flinders University of South Australia	SA	Psychology	BA (Hons)/ B Sc (Hons)/ B Psychol(Hons)
Flinders University of South Australia	SA	Psychology	Master of Clinical Psychology
Flinders University of South Australia	SA	Social work	Bachelor of Social Work
Griffith University	Qld	Nursing	Bachelor of Nursing
Griffith University	Qld	Nursing	Graduate Diploma/Masters of Mental Health Nursing
Griffith University	Qld	Nursing	Bachelor of Nursing
Griffith University	Qld	Psychology	BA (Psychol) (Hons)/B Health Sci (Hons)/B Behav Science (Hons)
Griffith University of Nth Qld	Qld	Psychology	Master of Clinical Psychology
James Cook University of Nth Qld	Qld	Nursing	Bachelor of Health Science
James Cook University of Nth Qld	Qld	Nursing	Post Graduate Diploma in Mental Health Nursing
James Cook University of Nth Qld	Qld	OT	Bachelor of Occupational Therapy
James Cook University of Nth Qld	Qld	Psychology	BA (Hons)/ BSocSci (Hons)/ B Psychol (Hons)
James Cook University of Nth Qld	Qld	Psychology	Master of Psychology (Clinical)
James Cook University of Nth Qld	Qld	Social work	Bachelor of Social Work
La Trobe University	Vic	Multidisciplinary	Post Grad Cert Family Therapy and Fam Sensitive Prac
La Trobe University	Vic	Nursing	Bachelor of Nursing
La Trobe University	Vic	Nursing	Graduate Diploma In Community Psychiatric Nursing.
La Trobe University	Vic	Nursing	Bachelor of Nursing
La Trobe University	Vic	OT	Bachelor of Occupational Therapy
La Trobe University	Vic	Psychology	BA (Hons)/ BSc (Hons)/ B Behav Sci (Hons)
La Trobe University	Vic	Psychology	Master of Psychology
La Trobe University	Vic	Social work	Bachelor of Social Work
La Trobe University	Vic	Multidisciplinary	Graduate Diploma/Masters/Doctorate in Family Therapy
Macquarie University	NSW	Psychology	BA (Hons)/BSc (Hons)/B Psychol (Hons)
Macquarie University	NSW	Psychology	Master of Clinical Psychology
Monash University	Vic	Medicine	Bachelor of Medicine and Bachelor of Surgery
Monash University	Vic	Medicine	Master of Psychological Medicine
Monash University	Vic	Nursing	Bachelor of Nursing
Monash University	Vic	Nursing	Graduate Certif./Diploma of Nursing (Psychiatric Nursing).
Monash University	Vic	Psychology	Bachelor of Arts (Honours)/ Bachelor of Science (Hon)
Monash University	Vic	Psychology	Doctor of Psychology
Monash University	Vic	Social work	Bachelor of Social Work
Monash University	Vic	Social work	Master of Social Work
Monash University/Uni of Melb.	Vic	Multidisciplinary	Grad Dip in Mental Health Science (Comm Health)
Murdoch University	WA	Psychology	Bachelor of Arts (Honours)/ Bachelor of Psychology
Murdoch University	WA	Psychology	Master of Psychology (Clinical)/ Doctor of Psychology (Clinical)
Northern Territory University	NT	Nursing	Bachelor of Nursing and Bachelor of Nursing for RNs
Northern Territory University	NT	Social work	Bachelor of Social Work
Queensland University of Technology	Qld	Nursing	Bachelor of Nursing
Queensland University of Technology	Qld	Nursing	Graduate Certificate/Diploma in Psychiatric/ Mental Health Nursing

Table Institution	State	Discipline	Award
Qld University of Technology	Qld	Psychology	B SocSci (Hons) and Grad Dip SocSci (Psychol)
Qld University of Technology	Qld	Psychology	Graduate Diploma of Social Science (Psychology)
Royal Melb. Institute of Technology	Vic	Nursing	Bachelor of Nursing
Royal Melb. Institute of Technology	Vic	Nursing	Bachelor of Psychiatric Nursing
Royal Melb. Institute of Technology	Vic	Nursing	Grad Cert/Dip/Master in Advanced Psych Nursing Prac
Royal Melb. Institute of Technology	Vic	Nursing	Bachelor of Applied Science and Grad. Dip. in Psychology
Royal Melb. Institute of Technology	Vic	Social work	Bachelor of Social Work
Southern Cross University	NSW	Nursing	Bachelor of Nursing
Southern Cross University	NSW	Nursing	Graduate Certificate/Diploma/ Master of Health Science
Swinburne University of Technology	Vic	Multidisciplinary	Dip Comm Services (Psych Disability Support)
Swinburne University of Technology	Vic	Psychology	Bachelor of Arts (Hon.)/ Bachelor of Applied Science (Hon.)
University of Adelaide	SA	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Adelaide	SA	Multidisciplinary	Post Graduate Diploma of Psychotherapy
University of Adelaide	SA	Nursing	Graduate Diploma of Mental Health Nursing.
University of Adelaide	SA	Psychology	BA (Hons)/ BSc (Hons)
University of Adelaide	SA	Psychology	Master of Psychology (Clinical and Health)
University of Ballarat	Vic	Nursing	Bachelor of Nursing
University of Ballarat	Vic	Nursing	Graduate Certificate/ Diploma in Mental Health Nursing
University of Ballarat	Vic	Psychology	BA(Hons) Psychol
University of Ballarat	Vic	Psychology	GradDip AppSci in Prof Psych/ PostGradDip ProfPsych
University of Ballarat	Vic	Psychology	Doctor of Psychology
University of Canberra	ACT	Nursing	Bachelor of Nursing
University of Canberra	ACT	Psychology	Bachelor of Applied Psychology (Honours)
University of Melbourne	Vic	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Melbourne	Vic	Medicine	Master of Medicine (Psychiatry)
University of Melbourne	Vic	Multidisciplinary	Grad Dip of M/Health Sci (Transcultural M/ Health)
University of Melbourne	Vic	Multidisciplinary	Grad Dip M/Health Sci (Young Persons' Mental Health)
University of Melbourne	Vic	Multidisciplinary	Graduate Diploma in Case Management
University of Melbourne	Vic	Nursing	Post Graduate Diploma in Advanced Clinical Nursing (Psychiatric)
University of Melbourne	Vic	Psychology	Masters/Doctorate of Psychology (Clinical)
University of Melbourne	Vic	Social work	Bachelor of Social Work
University of Melbourne	Vic	Social work	Master of Social Work
University of New England	NSW	Nursing	Bachelor of Nursing Studies (EN conversion)
University of New England	NSW	Nursing	Bachelor of Nursing
University of New England	NSW	Psychology	BA(Hons)/BSocSci(Hons)/BSc(Hons)/ BPsych(Hons)
University of New England	NSW	Psychology	Master of Psychology (Clinical)
University of New South Wales	NSW	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of New South Wales	NSW	Psychology	BA(Hons)/BSocSci(Hons)/BSc(Hons)/ BScPsych(Hons)
University of New South Wales	NSW	Psychology	Master of Psychology (Applied Clinical)
University of New South Wales	NSW	Social work	Bachelor of Social Work
University of Newcastle	NSW	Psychology	Master of Psychology (Clinical)
University of Newcastle	NSW	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Newcastle	NSW	Nursing	Bachelor of Nursing
University of Newcastle	NSW	Nursing	Grad Cert in Advanced Practice (Mental Health)
University of Newcastle	NSW	OT	Bachelor of Health Science (Occupational therapy)
University of Newcastle	NSW	Psychology	Bachelor of Arts (Honours) (Psychology); Bachelor of Science (Honours) (Psychology); Bachelor of Social Science
University of Newcastle	NSW	Social work	Bachelor of Social Work
University of Queensland	Qld	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Queensland	Qld	Multidisciplinary	Grad Cert/Post Grad Dip/Masters of Comm M/Health
University of Queensland	Qld	Multidisciplinary	GradCert/PostGradDip in M/Health Sci (Therapies)

Table Institution	State	Discipline	Award
University of Queensland	Qld	OT	Bachelor of Occupational Therapy
University of Queensland	Qld	Psychology	BA(Hons)/BSc(Hons)/BSocSci(Psychol)
University of Queensland	Qld	Psychology	Master of Clinical Psychology
University of Queensland	Qld	Social work	Bachelor of Social Work
University of Queensland	Qld	Social work	Post Grad Dip/Masters of Advanced SW Prac (M/Health)
University of South Australia	SA	Nursing	Graduate Diploma in Mental Health Nursing
University of South Australia	SA	Nursing	Graduate Diploma in Community Mental Health
University of South Australia	SA	Nursing	Grad Dip in Rural/Remote M/Health Nursing
University of South Australia	SA	Nursing	Master of Mental Health Nursing
University of South Australia	SA	Nursing	Bachelor of Nursing
University of South Australia	SA	OT	Bachelor of Science (Occupational therapy)
University of South Australia	SA	Psychology	Bachelor of Arts (Honours) Psychology
University of South Australia	SA	Psychology	Master of Psychology (Clinical)
University of South Australia	SA	Social work	Bachelor of Social Work
University of Southern Queensland	Qld	Nursing	Bachelor of Nursing
University of Southern Queensland	Qld	Psychology	BA (Hons)/ BA (Behav Sci)/ BSc (Hons)
University of Southern Queensland	Qld	Psychology	Master of Psychology (Health and Community)
University of Sydney	NSW	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Sydney	NSW	Nursing	Bachelor of Nursing
University of Sydney	NSW	Nursing	Graduate Diploma/Master of Nursing (Mental Health).
University of Sydney	NSW	Nursing	Bachelor of Nursing for registered nurses
University of Sydney	NSW	Nursing	Bachelor of Arts (Honours)/ Bachelor of Science (Honours)
University of Sydney	NSW	OT	Bachelor of Occupational Therapy
University of Sydney	NSW	OT	Grad. Certif. in Occupational Therapy (Mental Health)
University of Sydney	NSW	Psychology	Master of Psychology/PhD
University of Sydney	NSW	Social work	Bachelor of Social Work
University of Tasmania	Tas	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Tasmania	Tas	Nursing	Grad Dip in Advanced Nursing - for BN or RPN
University of Tasmania	Tas	Nursing	Bachelor of Nursing
University of Tasmania	Tas	Psychology	BA (Hons)/ BSc(Hons)
University of Tasmania	Tas	Psychology	Master of Psychology (Clinical)
University of Tasmania	Tas	Social work	Bachelor of Social Work
University of Technology, Sydney	NSW	Nursing	Bachelor of Nursing
University of Technology, Sydney	NSW	Nursing	Graduate Diploma in Clinical Nursing (Mental Health)
University of Technology, Sydney	NSW	Nursing	Master of Clinical Practice
University of Western Australia	WA	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Western Australia	WA	Psychology	Master of Clin Psych/ Master of Clin Psych and PhD
University of Western Australia	WA	Psychology	BA (Hons)/BSc(Hons)
University of Western Australia	WA	Social work	Bachelor of Social Work
University of Western Australia	WA	Social work	Post graduate Diploma in Advanced Social Work
University of Western Sydney	NSW	Multidisciplinary	Graduate Diploma in Mental Health Studies
University of Western Sydney	NSW	Nursing	Bachelor of Nursing
University of Western Sydney	NSW	Nursing	GradCert/GradDip/Masters of Nursing (Mental Health)
University of Western Sydney	NSW	Nursing	Bachelor of Nursing
University of Western Sydney	NSW	Nursing	Grad Dip of Nursing (Advanced Clin Prac - M/Health)
University of Western Sydney	NSW	Nursing	Bachelor of Nursing
University of Western Sydney	NSW	OT	Bachelor of Applied Science (Occupational Therapy)
University of Western Sydney	NSW	Psychology	BA(Hons)/BSc(Hons)
University of Western Sydney	NSW	Psychology	Master of Clinical Psychology

Table 1 Institution	State	Discipline	Award
University of Western Sydney	NSW	Social work	Bachelor of Social Work
University of Wollongong	NSW	Nursing	Bachelor of Nursing
University of Wollongong	NSW	Psychology	BA(Hons)/BAPsychol/Sociol)(Honours)/BSc(Hons)
University of Wollongong	NSW	Multidisciplinary	GradCert M/Health/GradDiplomaSci(M/Health)/MSc(M/Health)
University of Wollongong	NSW	Psychology	Master of Psychology (Clinical)
University of Melbourne	Vic	Psychology	BA (Hons)/BSc (Hons)
Victoria University of Technology	Vic	Nursing	Bachelor of Health Science (Nursing)
Victoria University of Technology	Vic	Nursing	Graduate Diploma/Master of Nursing (Psychiatric)
Victoria University of Technology	Vic	Psychology	Bachelor of Arts (Honours)/ Bachelor of Science (Hon.)
Victoria University of Technology	Vic	Psychology	Master Psych (ClinPsych)/ Doctor of Psych(Clin Psych)
Victoria University of Technology	Vic	Social work	Bachelor of Social Work

Table 2

National audit of mental health education and training, 1998 by discipline

Table 2 Institution	State	Discipline	Award
Batchelor College	NT	ATSI Health	Certificate in Social and Behavioural Health
Charles Sturt University	NSW	ATSI Health	Diploma of Health Science (Mental Health).
Flinders University of South Australia	SA	Medicine	Bachelor of Medicine and Bachelor of Surgery
Monash University	Vic	Medicine	Bachelor of Medicine and Bachelor of Surgery
Monash University	Vic	Medicine	Master of Psychological Medicine
University of Adelaide	SA	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Melbourne	Vic	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Melbourne	Vic	Medicine	Master of Medicine (Psychiatry)
University of New South Wales	NSW	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Newcastle	NSW	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Queensland	Qld	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Sydney	NSW	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Tasmania	Tas	Medicine	Bachelor of Medicine and Bachelor of Surgery
University of Western Australia	WA	Medicine	Bachelor of Medicine and Bachelor of Surgery
Central Queensland University	Qld	Multidisciplinary	Indigenous Therapies Certificate
Charles Sturt University	NSW	Multidisciplinary	Master of Mental Health
Curtin University of Technology	WA	Multidisciplinary	Assoc Degree in Aboriginal Health/B App Sci (Indig Comm Health)
Flinders University of South Australia	SA	Multidisciplinary	Graduate Certificate of Community Mental Health.
Flinders University of South Australia	SA	Multidisciplinary	Master of Primary Health Care/ Master of Science (Primary H/Care)
La Trobe University	Vic	Multidisciplinary	Post Grad Cert Family Therapy and Fam Sensitive Prac
La Trobe University	Vic	Multidisciplinary	Graduate Diploma/Masters/Doctorate in Family Therapy
Monash University/University of Melb.	Vic	Multidisciplinary	Grad Dip in Mental Health Science (Comm Health)
Swinburne University	Vic	Multidisciplinary	Dip Comm Services (Psych Disability Support)
University of Adelaide	SA	Multidisciplinary	Post Graduate Diploma of Psychotherapy
University of Melbourne	Vic	Multidisciplinary	Grad Dip of M/Health Sci (Transcultural M/ Health)
University of Melbourne	Vic	Multidisciplinary	Grad Dip M/Health Sci (Young Persons' Mental Health)
University of Melbourne	Vic	Multidisciplinary	Graduate Diploma in Case Management
University of Queensland	Qld	Multidisciplinary	Grad Cert/Post Grad Dip/Masters of Comm M/Health

Table 2 Institution	State	Discipline	Award
University of Queensland	Qld	Multidisciplinary	GradCert/PostGradDip in M/Health Sci (Therapies)
University of Western Sydney	NSW	Multidisciplinary	Graduate Diploma in Mental Health Studies
University of Wollongong	NSW	Multidisciplinary	GradCert M/Health/GradDiplomaSci(M/Health)/MSc(M/Health)
Australian Catholic University	NSW	Nursing	Bachelor of Nursing
Australian Catholic University	Qld	Nursing	Bachelor of Nursing
Australian Catholic University	Vic	Nursing	Bachelor of Nursing
Australian Catholic University	Vic	Nursing	Bachelor of Nursing
Avondale College	NSW	Nursing	Bachelor of Nursing
Central Queensland University	Qld	Nursing	Bachelor of Health Science (Nursing)
Central Queensland University	Qld	Nursing	Bachelor of Health Science (Nursing)
Charles Sturt University	NSW	Nursing	Bachelor of Nursing
Charles Sturt University	NSW	Nursing	Bachelor of Health Sci (Mental Health) for RNs
Charles Sturt University	NSW	Nursing	Master of Health Science (Nursing)
Charles Sturt University	NSW	Nursing	Post Graduate Diploma in Mental Health Nursing
Curtin University of Technology	WA	Nursing	Bachelor of Science (Nursing)
Curtin University of Technology	WA	Nursing	Master of Nursing - specialty mental health.
Deakin University	Vic	Nursing	Bachelor of Nursing
Deakin University	Vic	Nursing	Grad Cert/Dip/Master of Nursing (Psychiatric) for RNs
Edith Cowan University	WA	Nursing	BN - undergrad & BN - for RNs
Edith Cowan University	WA	Nursing	Graduate Diploma in Mental Health Nursing
Flinders University of South Australia	SA	Nursing	Bachelor of Nursing
Flinders University of South Australia	SA	Nursing	Graduate Diploma of Mental Health Nursing.
Griffith University	Qld	Nursing	Bachelor of Nursing
Griffith University	Qld	Nursing	Graduate Diploma/Masters of Mental Health Nursing
Griffith University	Qld	Nursing	Bachelor of Nursing
James Cook University	Qld	Nursing	Bachelor of Health Science
James Cook University	Qld	Nursing	Post Graduate Diploma in Mental Health Nursing
La Trobe University	Vic	Nursing	Bachelor of Nursing
La Trobe University	Vic	Nursing	Graduate Diploma In Community Psychiatric Nursing.
La Trobe University	Vic	Nursing	Bachelor of Nursing
Monash University	Vic	Nursing	Bachelor of Nursing
Monash University	Vic	Nursing	Graduate Certificate/Diploma of Nursing (Psychiatric Nursing).
Northern Territory University	NT	Nursing	Bachelor of Nursing and Bachelor of Nursing for RNs
Queensland University of Technology	Qld	Nursing	Bachelor of Nursing
Queensland University of Technology	Qld	Nursing	Graduate Certificate/Diploma in Psychiatric/ Mental Health Nursing
Royal Melbourne Institute of Technology	Vic	Nursing	Bachelor of Nursing
Royal Melbourne Institute of Technology	Vic	Nursing	Bachelor of Psychiatric Nursing.
Royal Melbourne Institute of Technology	Vic	Nursing	Grad Cert/Dip/Master in Advanced Psych Nursing Prac
Royal Melbourne Institute of Technology	Vic	Nursing	Bachelor of Applied Science and Grad. Dip. in Psychology
Southern Cross University	NSW	Nursing	Bachelor of Nursing
Southern Cross University	NSW	Nursing	Graduate Certificate/Diploma/Master of Health Science
University of Adelaide	SA	Nursing	Graduate Diploma of Mental Health Nursing.
University of Ballarat	Vic	Nursing	Bachelor of Nursing
University of Ballarat	Vic	Nursing	Graduate Certificate/Diploma in Mental Health Nursing
University of Canberra	ACT	Nursing	Bachelor of Nursing
University of Melbourne	Vic	Nursing	Post Graduate Diploma in Advanced Clinical Nursing (Psychiatric)
University of New England	NSW	Nursing	Bachelor of Nursing Studies (EN conversion)
University of New England	NSW	Nursing	Bachelor of Nursing
University of Newcastle	NSW	Nursing	Bachelor of Nursing
University of Newcastle	NSW	Nursing	Grad Cert in Advanced Practice (Mental Health)

Table 2 Institution	State	Discipline	Award
University of South Australia	SA	Nursing	Graduate Diploma in Mental Health Nursing
University of South Australia	SA	Nursing	Graduate Diploma in Community Mental Health
University of South Australia	SA	Nursing	Grad Dip in Rural/Remote M/Health Nursing
University of South Australia	SA	Nursing	Master of Mental Health Nursing
University of South Australia	SA	Nursing	Bachelor of Nursing
University of Southern Queensland	Qld	Nursing	Bachelor of Nursing
University of Sydney	NSW	Nursing	Bachelor of Nursing
University of Sydney	NSW	Nursing	Graduate Diploma/Master of Nursing (Mental Health).
University of Sydney	NSW	Nursing	Bachelor of Nursing for registered nurses
University of Sydney	NSW	Nursing	Bachelor of Arts (Honours)/Bachelor of Science (Honours)
University of Tasmania	Tas	Nursing	Grad Dip in Advanced Nursing - for BN or RPN
University of Tasmania	Tas	Nursing	Bachelor of Nursing
University of Technology, Sydney	NSW	Nursing	Bachelor of Nursing
University of Technology, Sydney	NSW	Nursing	Graduate Diploma in Clinical Nursing (Mental Health)
University of Technology, Sydney	NSW	Nursing	Master of Clinical Practice
University of Western Sydney	NSW	Nursing	Bachelor of Nursing
University of Western Sydney	NSW	Nursing	GradCert/GradDip/Masters of Nursing (Mental Health)
University of Western Sydney	NSW	Nursing	Bachelor of Nursing
University of Western Sydney	NSW	Nursing	Grad Dip of Nursing (Advanced Clin Prac - M/Health)
University of Western Sydney	NSW	Nursing	Bachelor of Nursing
University of Wollongong	NSW	Nursing	Bachelor of Nursing
Victoria University of Technology	Vic	Nursing	Bachelor of Health Science (Nursing)
Victoria University of Technology	Vic	Nursing	Graduate Diploma/Master of Nursing (Psychiatric)
Charles Sturt University	NSW	OT	Bachelor of Occupational Therapy
Curtin University of Technology	WA	OT	Bachelor of Science (Occupational therapy)
James Cook University of Nth Qld	Qld	OT	Bachelor of Occupational Therapy
La Trobe University	Vic	OT	Bachelor of Occupational Therapy
University of Newcastle	NSW	OT	Bachelor of Health Science (Occupational therapy)
University of Queensland	Qld	OT	Bachelor of Occupational Therapy
University of South Australia	SA	OT	Bachelor of Science (Occupational therapy)
University of Sydney	NSW	OT	Bachelor of Occupational Therapy
University of Sydney	NSW	OT	Graduate Certificate in Occupational Therapy (Mental Health)
University of Western Sydney	NSW	OT	Bachelor of Applied Science (Occupational Therapy)
Edith Cowan University	WA	Psychology	BA (Hons)/ B Sc (Hons)/ B Psychol
Griffith University	Qld	Psychology	BA (Psychol) (Hons)/B Health Sci (Hons)/B Behav Sci (Hons)
La Trobe University	Vic	Psychology	BA (Hons)/ BSc (Hons)/ B Behav Sci (Hons)
Swinburne University of Technology	Vic	Psychology	Bachelor of Arts (Hons)/ Bachelor of Applied Science (Hons)
University of Newcastle	NSW	Psychology	Master of Psychology (Clinical)
University of Southern Queensland	Qld	Psychology	BA (Hons)/ BA (Behav Sci)/ BSc (Hons)
University of Western Australia	WA	Psychology	Master of Clin Psych/ Master of Clin Psych and PhD
University of Wollongong	NSW	Psychology	BA(Hons)/BAPsychol/Sociol)(Honours)/BSc(Hons)
Victoria University of Technology	Vic	Psychology	Bachelor of Arts (Hons)/ Bachelor of Science (Hons)
Australian National University	ACT	Psychology	Bachelor of Arts (Honours)/Bachelor of Science (Honours)
Bond University	Qld	Psychology	Bachelor of Social Science (Psychology) (Honours)
Bond University	Qld	Psychology	Post Grad Dip of Professional Psychology
Bond University	Qld	Psychology	Master of Psychology (Clinical)
Central Queensland University	Qld	Psychology	Bachelor of Arts (Honours)
Charles Sturt University	NSW	Psychology	Bachelor of Social Science (Psychology) (Honours)
Charles Sturt University	NSW	Psychology	Master of Psychology (Clinical)
Curtin University of Technology	WA	Psychology	Bachelor of Arts (Hons)/ Bachelor of Science (Hons)
Curtin University of Technology	WA	Psychology	Master of Psychology (Clinical)
Deakin University	Vic	Psychology	Master of Psychology (Clinical)

Table 2 Institution	State	Discipline	Award
Deakin University	Vic	Psychology	BA (Hons)/B Sc (Hons)
Edith Cowan University	WA	Psychology	Master of Psychology (Clinical)
Flinders University of South Australia	SA	Psychology	BA (Hons)/ B Sc (Hons)/ B Psychol(Hons)
Flinders University of South Australia	SA	Psychology	Master of Clinical Psychology
Griffith University	Qld	Psychology	Master of Clinical Psychology
James Cook University of Nth Qld	Qld	Psychology	BA (Hons)/ BSocSci (Hons)/ B Psychol (Hons)
James Cook University of Nth Qld	Qld	Psychology	Master of Psychology (Clinical)
La Trobe University	Vic	Psychology	Master of Psychology
Macquarie University	NSW	Psychology	BA (Hons)/BSc (Hons)/B Psychol (Hons)
Macquarie University	NSW	Psychology	Master of Clinical Psychology
Monash University	Vic	Psychology	Bachelor of Arts (Hons)/ Bachelor of Science (Hons)
Monash University	Vic	Psychology	Doctor of Psychology
Murdoch University	WA	Psychology	Bachelor of Arts (Honours)/ Bachelor of Psychology
Murdoch University	WA	Psychology	Master of Psychology (Clinical)/Dr of Psychology (Clinical)
Queensland University of Technology	Qld	Psychology	B SocSci (Hons) and Grad Dip SocSci (Psychol)
Queensland University of Technology	Qld	Psychology	Graduate Diploma of Social Science (Psychology)
University of Adelaide	SA	Psychology	BA (Hons)/ BSc (Hons)
University of Adelaide	SA	Psychology	Master of Psychology (Clinical and Health)
University of Ballarat	Vic	Psychology	BA(Hons) Psychol
University of Ballarat	Vic	Psychology	GradDip AppSci in Prof Psych/PostGradDip ProfPsych
University of Ballarat	Vic	Psychology	Doctor of Psychology
University of Canberra	ACT	Psychology	Bachelor of Applied Psychology (Honours)
University of Melbourne	Vic	Psychology	Masters/Doctorate of Psychology (Clinical)
University of Melbourne	Vic	Psychology	BA (Hons)/BSc (Hons)
University of New England	NSW	Psychology	BA(Hons)/BSocSci(Hons)/BSc(Hons)/ BPsych(Hons)
University of New England	NSW	Psychology	Master of Psychology (Clinical)
University of New South Wales	NSW	Psychology	BA(Hons)/BSocSci(Hons)/BSc(Hons)/ BScPsych(Hons)
University of New South Wales	NSW	Psychology	Master of Psychology (Applied Clinical)
University of Newcastle	NSW	Psychology	Bachelor of Arts (Honours) (Psychology); Bachelor of Science (Hons) (Psychology); Bachelor of Social Science
University of Queensland	Qld	Psychology	BA(Hons)/BSc(Hons)/BSocSci(Psychol)
University of Queensland	Qld	Psychology	Master of Clinical Psychology
University of South Australia	SA	Psychology	Bachelor of Arts (Honours) Psychology
University of South Australia	SA	Psychology	Master of Psychology (Clinical)
University of Southern Queensland	Qld	Psychology	Master of Psychology (Health and Community)
University of Sydney	NSW	Psychology	Master of Psychology/PhD
University of Tasmania	Tas	Psychology	BA (Hons)/ BSc(Hons)
University of Tasmania	Tas	Psychology	Master of Psychology (Clinical)
University of Western Australia	WA	Psychology	BA (Hons)/BSc(Hons)
University of Western Sydney	NSW	Psychology	BA(Hons)/BSc(Hons)
University of Western Sydney	NSW	Psychology	Master of Clinical Psychology
University of Wollongong	NSW	Psychology	Master of Psychology (Clinical)
Victoria University of Technology	Vic	Psychology	Master Psych (ClinPsych)/ Doctor of Psych(Clin Psych)
Australian Catholic University	ACT	Social work	Bachelor of Social Work
Central Queensland University	Qld	Social work	Bachelor of Social Work
Charles Sturt University	NSW	Social work	Graduate Certificate in Community Mental Health
Charles Sturt University	NSW	Social work	BSW/Bachelor of Arts (BSW)
Curtin University of Technology	WA	Social work	Bachelor of Social Work
Deakin University	Vic	Social work	Bachelor of Social Work
Edith Cowan University	WA	Social work	Bachelor of Social Work
Flinders University of South Australia	SA	Social work	Bachelor of Social Work
James Cook University of Nth Qld	Qld	Social work	Bachelor of Social Work
La Trobe University	Vic	Social work	Bachelor of Social Work

Table 2 Institution	State	Discipline	Award
Monash University	Vic	Social work	Bachelor of Social Work
Monash University	Vic	Social work	Master of Social Work
Northern Territory University	NT	Social work	Bachelor of Social Work
Royal Melbourne Institute of Technology	Vic	Social work	Bachelor of Social Work
University of Melbourne	Vic	Social work	Bachelor of Social Work
University of Melbourne	Vic	Social work	Master of Social Work
University of New South Wales	NSW	Social work	Bachelor of Social Work
University of Newcastle	NSW	Social work	Bachelor of Social Work
University of Queensland	Qld	Social work	Bachelor of Social Work
University of Queensland	Qld	Social work	Post Grad Dip/Masters of Advanced SW Prac (M/Health)
University of South Australia	SA	Social work	Bachelor of Social Work
University of Sydney	NSW	Social work	Bachelor of Social Work
University of Tasmania	Tas	Social work	Bachelor of Social Work
University of Western Australia	WA	Social work	Bachelor of Social Work
University of Western Australia	WA	Social work	Post graduate Diploma in Advanced Social Work
University of Western Sydney	NSW	Social work	Bachelor of Social Work
Victoria University of Technology	Vic	Social work	Bachelor of Social Work

Appendix 2

Attendance at workshops

Name	Discipline	State
Bland, Robert	Social Work	Qld
Brand, Stephen	Social Work	ACT
Champ, Simon	Consumer	NSW
Chipp, Jennifer	Govt	NSW
Ciolek, Dagmar	Occupational Therapy	ACT
Cotton, Peter	Psychology	Qld
Clinton, Michael	Nursing	SA
Davies, Wendy	Other	NSW
Epstein, Merinda	Consumer	Vic
Fanning, Paul	Nursing	NSW
Farhall, John	Psychology	Vic
Fox, Wayne	Govt	Tas
Garton, Alison	Psychology	Vic
Gerrand, Val	Govt (SW)	Vic
Gilbert, Jillian	Occupational Therapy	Qld
Glover, Helen	Consumer	Qld
Goddard, Trish	Consumer	NSW
Grant, Christine	Nursing	Vic
Gray, Jill	Occupational Therapy	Vic
Handley, Christine	Govt	Tas
Hanich, Adolph	Carer	Vic
Happell, Brenda	Nursing	Vic
Hargreaves, Sally	Occupational Therapy	SA
Harries, Maria	Social Work	WA
Harris, Ross	Psychology	NSW
Harrison, Brenda	Nursing	Vic
Hayes, Robyn	Occupational Therapy	Qld
Hazelton, Michael	Nursing	Tas
Henderson, Scott	Psychiatry	ACT
Horgan, Kay	Govt (Nursing)	Vic
Iker, Phil	Consumer	Qld
Jablensky, Assen	Psychiatry	WA
Kelk, Norman	Social Work	NSW
King, Robert	Psychology	Qld
Kinnear, Judith	Other	NSW
Kosky, Robert	Psychiatry	SA
Lambert, Gordon	Nursing	NSW
Learmont, Jenny	Consumer	NSW
Lloyd, Chris	Occupational Therapy	Qld
Martin, Graham	Psychiatry	SA
McGrath, Barry	General Practice	Qld
Miller, Viv	Occupational Therapy	NSW
Minkov, Christine	Govt (Nursing)	NSW
Mitchell-Dawson, Bea	Nursing	Vic
Moore, Heather	Consumer	Vic

Name	Discipline	State
Mullavey-O'Byrne, Colleen	Occupational Therapy	NSW
O'Halloran, Paul	Psychology	London Sainsbury Centre
Parker, Gordon	Psychiatry	NSW
Paxinos, Kali	Carer	Vic
Pennock, Joy	Occupational Therapy	NSW
Phillips, Jonathon	Psychiatry	NSW
Plant, Rowena	Carer	Qld
Player, Judith	Carer	Vic
Prideaux, David	Education	SA
Raphael, Beverley	Govt	NSW
Rea, Carol	Occupational Therapy	Tas
Rechter, Daniel	Consumer	Vic
Renouf, Noel	Social Work	Vic
Rentsch, Ian	Social Work	ACT
Rosen, Alan	Psychiatry	NSW
Shaw, Julie	Consumer	Vic
Singh, Bruce	Psychiatry	Vic
Smith, Meg	Consumer	NSW
Speedy, Sandra	Nursing	NSW
Spence, Sue	Psychology	Qld
Thorburn, Chris	Social Work	Qld
Towler, Irene	Carer	SA
Upton, Judith	Govt	ACT
Waring, Trevor	Psychology	NSW
Weir, Wendy	Occupational Therapy	NSW
Whiteford, Harvey	Govt (Psychiatry)	ACT
Wieland, Barbara	Govt	SA
Williams, A.T. (Tony)	Psychiatry	NSW
Wilson, Ian	Other	SA
Wilton, Noel	Psychiatry	NSW
Yellowlees, Peter	Psychiatry	Qld
Young, Leonie	Govt	ACT

Deakin Human Services staff

Byrt, Chris
Carter, Jan
Fazio, Virginia
Hardcastle, Lesley
Kerr, Betty
Leggatt, Margaret
Oppy, Alan

Appendix 3

National Mental Health Workforce: Education and Training Consultancy: Report December 1994 KPMG Consulting

Executive summary

Introduction

Each year in Australia, approximately 2.9 percent of the population or approximately 500,000 people experience serious mental illness. Of this percentage, however, only 45 - 54 percent receive treatment. Since the 1950s the locus of delivery of this treatment has shifted from psychiatric hospital settings to a more community oriented approach, with a 70 percent decrease in institution-based care since the mid 1960s.

In April 1992 a National Mental Health Policy was developed to address the key issues in Australia's mental health service. While this policy acknowledges the needs of all people with mental health problems, its main focus is on those with severe mental health problems. A National Mental Health Plan was then devised which outlined strategies for implementation of the policy. The Australian Health Ministers' Advisory Council (AHMAC) National Working Group on Mental Health Policy is responsible for overseeing the implementation of the National Mental Health Strategy (NMHS) and comprises representatives from the Commonwealth as well as from each State and Territory.

Objectives

The consultancy primarily considered the education and training needs of those staff who provide care for persons with serious mental illness in an integrated mental health system. It also aimed to assist the development of a national approach to education and training of these mental health professionals.

Training needs of hospital-based staff were considered in relation to the transition from institution-based care to a comprehensive, client-centred,

integrated service. Ongoing education and training needs of staff currently working in community-based settings were addressed. The need for active involvement of the post-secondary sector was also considered.

Methodology

In addressing these three major components the consultancy drew on a variety of sources including the views of practitioners, key stakeholders within the sector, education and training providers, and relevant literature.

A qualitative research methodology was employed using a structured interview format so that issues critical to the development of a national approach encompassing the five specialist mental health professions were identified. A six stage process was developed which included: literature review/research, determining the focus, the consultation phase, development of an options paper, a Workshop and the final report.

Project findings

Literature review and research

The literature review and research stage had three foci: a review of the literature from Australia and overseas that examined approaches to case management and training programs for multi-disciplinary teams; a scan of pre-service courses available to the five specialist mental health professions to determine the mental health specific and case management focussed units of study; and a review of courses and training programs provided to current mental health staff operating in an integrated service model.

The literature pointed to some directions in training for work in community-based settings. These included a time commitment of between two and four weeks, a combination of team skill develop-

ment and discipline specific training and a commitment to ongoing training to constantly upgrade skills of staff. The literature on case management indicates that the issue of defining case management is an ongoing one that has been taking place for more than a decade.

Consultation phase findings

(i) Stakeholder Survey

The consultation phase comprised two sections. The first covered stakeholders within the mental health field including peak professional bodies, unions, senior government representatives, education and training providers, and consumer and carer groups. Their views were sought via a series of face-to-face consultations known as the stakeholder survey, where a structured questionnaire was used. The interviews were designed to establish the current skills of mental health practitioners, the skills required for the delivery of care according to the NMHS, attitude to change, and the perceived role of consumers and carers in training mental health professionals.

The major findings from the stakeholder survey are outlined below.

There was general consensus that entrenched attitudes within the sector and the community are major barriers to successful implementation of the NMHS, and that a fundamental cultural and attitudinal change is needed in the mental health workforce. The culture of the system was seen as focussed on staff and custodial care, on individual professions; characterised by low status and morale, lacking clear goals, directions and identity, and resistant to change.

Additional barriers identified inadequate funding, community backlash and stigmatisation of mental health services, differing ideologies and work practices among workers, and high case loads that lead to a crisis intervention mode of service. Stakeholders also pointed to a variety of current models of service delivery in existence in both the private and public systems. However it was evident from the consultations and the submissions received that a significant shift towards an integrated service has already occurred.

Three models of care were referred to during the consultations. These were the medical model which was in some cases presented as the dominant model, a psycho-social model which tended to

be addressed more by non-government organisations, and a bio-psycho-social model to which it was often claimed that the system is moving.

The importance of establishing benchmarks for effective service provision emerged throughout the consultation. There was general consensus that this required a combined effort from professional bodies, support services, consumers and carers and mental health professionals.

(ii) Staff Survey

Current staff employed in both community and hospital-based settings were covered by section two of the consultation phase. Again, a structured questionnaire approach was adopted. In this case each group used a different questionnaire, with hospital-based staff responding to a more structured set of questions. In each case the interviews were designed to establish the current skills of staff, skills required for future service delivery, priority areas for training, factors that enhance staff involvement in ongoing education and training, and the perceived role for consumers and carers in the education and training of mental health workers.

The major findings from the practitioner survey are outlined below.

Hospital-based practitioners indicated that the greatest confidence gaps existed in the areas of team functioning, maintaining and expanding consumers' social networks, linking with community resources and crisis intervention. They also indicated that the biggest changes they would face related to knowledge of community resources and linking with other service sectors.

A set of common professional skills required by mental health staff working in an integrated service system was identified. However, most groups were also quick to point out that they were not in favour of a generic mental health worker, and that discipline specific skills were still critical in ensuring quality care for consumers.

Underpinning the skill mix was a change in attitudes and values that would be required in implementing the NMHS. These included the need to work from a 'client first' rather than from an 'ownership of the client' perspective, understanding the importance of consumer empowerment and accepting a more equal consumer to professional relationship.

Staff currently working in community-based settings saw education and training as a way of both deepening and broadening their skill base. Involvement in education and training activities would build their skills and competencies in the areas of working in the new model, consumer orientation, clinical skills, community and social issues and working within a team framework. In addition knowledge of non-English speaking and Aboriginal mental health issues also emerged as needs to be addressed.

Strong support was expressed for training that was delivered on the job by other practitioners with a strong interactive rather than didactic focus. The view was also put that this training should occur both within and across professional disciplines. Training which was accredited by educational bodies and employer groups would also encourage maximum involvement.

All groups consulted expressed support for an enhanced role for consumers and carers in the education and training of practitioners. They saw their role encompassing all stages in the education and training cycle from needs analysis, through course and curriculum planning, training delivery, to course evaluation.

Implications and recommendations

In responding to the challenge of developing a national approach within the sector a broad framework was developed within which a plan for national mental health education and training can be developed. This plan should comprise a series of strategic initiatives closely related to the recommendations of this report, with an order of priority among them. The framework for the plan comprises a set of principles, priority areas for attention, a set of education and training planning elements, a framework of roles and accountabilities and a list of target groups. These are outlined below.

Principles

The principles are that the plan should:

- (i) support a broader change management process;
- (ii) build a capacity for knowledge within the sector as a whole and within each of its participants;
- (iii) be shaped and driven by the imperative of meeting consumer outcome standards within the context of the NMHS;

(iv) promote and enhance the involvement of consumers and carers in all aspects of the plan;

(v) ensure that education and training of the workforce are continuously improved by the constant exchange of high quality, high status information between policy makers, education and training providers, consumers and carers and practitioners;

(vi) ensure flexibility in all components of the plan so that it is able to respond to changes in government policy, consumer needs and innovations in learning design and delivery;

(vii) clearly articulate the complementary roles of national and State/Territory authorities in the progression of the plan;

(viii) involve diversity and innovation on one hand, and co-ordination and quality assurance on the other; and

(ix) involve the continued existence of high quality discipline-specific education as well as education and training for all mental health workers in the required core attitudes, skills and knowledge.

Priority areas

The consultancy findings and the outcomes from the Workshop clarified a number of priorities to be addressed. These priorities are to:

(i) maximise the national impact of positive initiatives being undertaken within the sector;

(ii) foster dialogue across organisational and professional boundaries;

(iii) assist staff make the move from traditional hospital-based services into integrated community-based services;

(iv) build an enhanced role for consumers and carers;

(v) raise the status of Mental Health in the higher education sector; and

(vi) establish a responsive coordinated, quality learning system.

Plan elements

The normative elements around which a national education and training plan needs to be built are:

(i) a competency and service standards framework linked to consumer needs, practice standards and government policy;

(ii) needs analyses involving the identifica-

tion/auditing of the capacities of the workforce and identifying the gap between expectations and capacities;

(iii) meeting the needs identified through the needs analysis process;

(iv) establishing flexible educational pathways;

(v) keeping abreast of national and international developments; and

(vi) networking and information dissemination.

Organisational framework

A clear organisational framework of roles and accountabilities is required in a national education and training plan. This must take into account the contributions of national state and local/regional agencies, as well as the relationships between government, employers, consumer and carer organisations, practitioner representative bodies, the higher education sector, training providers and peak professional bodies.

Target groups

A national plan needs to take account of all service providers as well as people with mental health problems or mental disorders. These include:

- the five specialist mental health professions;
- other professions operating mainly in the mental health sector;
- consumers and carers;
- primary health workers;
- people working in allied sectors; and
- mental health educators and trainers.

Working within this framework for the plan a set of recommendations was developed which is outlined below.

Recommendations

Overarching Recommendation

That the AHMAC Working Group on National Mental Health Policy sponsor the creation of a network for mental health education and training to:

- *promote innovative approaches in mental health education and training in relation to the objectives of the National Mental Health Strategy; and*
- *promote co-operation on education and training initiatives where national or co-ordinated action would have substantial benefits.*

Recommendation One:

That the AHMAC Working Group on Mental Health Policy establish by tender a National Network Co-ordination Group whose major role is to further develop and co-ordinate the implementation of national initiatives to foster mental health education and training to underpin the directions of the NMHS; and promote a national network for all parties with an interest in mental health education and training

Recommendation Two:

That the National Network Co-ordination Group initiate a project to produce a detailed plan for State/Territory implementation that is targeted at maximising consumer and carer participation in decision-making about mental health education and training, and providing training and support for their involvement in the delivery of education and training.

Recommendation Three:

That the National Network Co-ordination Group develop a detailed draft policy of payment for consumer and carer involvement in education and training of mental health workers for consideration by relevant Commonwealth, State and Territory government agencies.

Recommendation Four:

That the AHMAC Working Group on Mental Health Policy modify the terms of reference of projects established to examine standards and consumer outcomes to incorporate, with reference to this report, the relationship between education and training and practice and outcome standards.

Recommendation Five:

That the terms of reference of the National Service Standards Project to be shortly undertaken also be modified by the AHMAC Working Group on Mental Health Policy to incorporate consideration of a strategy for developing education and training practice standards; and that staff with education and training skills be appointed to the Standards Committee.

Recommendation Six:

That a project be developed by the National Network Co-ordination Group to develop a series of case studies that examine best practice application in an integrated community-based mental health system

Recommendation Seven:

That the National Network Co-ordination Group develop a coordinated strategy to raise the status of integrated mental health care in the higher education sector and to increase its focus on preparing people to work in an integrated mental health service. This strategy should include funding and processes to:

- (i) identify, recognise and support centres of excellence in the education and training of mental health practitioners;
- (ii) support additional joint appointments being made within the higher education sector; and
- (iii) support the publication of a journal of mental health studies.

Recommendation Eight:

That the National Network Co-ordination Group sponsor or develop a model for integrated change management based on Australian and overseas experience of best practice in managing the change to community-based mental health services; that the model include education and training designed to address staff concerns and generate support from staff, consumers and carers, and the community; and that it be trialed, evaluated, and implemented by the States and Territories, with co-ordination of the process by the National Network Co-ordination Group.

Recommendation Nine:

That the National Network Co-ordination Group sponsor or develop a model for integrated human resource planning based on Australian and overseas experience of best practice in integrated mental health services; that the model address workforce planning, team and job roles, staff selection, consumer and carer involvement and community relations, in addition to staff development and training; and that it be trialed, evaluated, and implemented by the States and Territories, with co-ordination of the process by the National Network Co-ordination Group.

Recommendation Ten:

That the National Network Co-ordination Group sponsor or develop a model transition training programme based on Australian and overseas experience of best practice in moving to community-based mental health services; that the programme be trialed, evaluated, and implemented by the States and Territories, with co-ordination of the process by the National Network Co-ordination Group; and that the programme target two major areas:

- (i) the common professional skills identified for community-based case managed care delivered by multi-disciplinary teams; and
- (ii) the skills and competencies required for effective self-managing team functioning.

Recommendation Eleven:

That the National Network Co-ordination Group auspice or develop a model for continuing education and training of mental health practitioners, based on Australian and overseas best practice; that the model be trialed, evaluated, and implemented by the States and Territories, with co-ordination of the process by the National Network Co-ordination Group; and that the programme target the following priority areas: comprehensive assessment; case management and case planning; consumer orientation; clinical skills; community and social issues; and working within a team framework.

Recommendation Twelve:

That the National Network Co-ordination Group explore with the relevant bodies, and in collaboration with the Standards Consultancy team, the inclusion of education and training standards and criteria into the current and emerging quality accreditation processes for mental health services.

Recommendation Thirteen:

That the National Network Co-ordination Group facilitate discussion between bodies currently responsible for accreditation processes with a view to developing an integrated approach to accreditation of education and training courses.

Recommendation Fourteen:

That the National Network Co-ordination Group and the National Community Services and Health Industry Training Advisory Board be jointly responsible for the development and validation of a description of the common body of values, attitudes, skills and knowledge required for the delivery of acceptable and high standard mental health services; and that these form a basis of preservice, transition and continuing education and training initiatives.

Recommendation Fifteen:

That the national mental health education and training initiatives encompass the mental health competency and training requirements of human services workers in occupations with significant levels of service to people with mental disorders; and that the National Network Co-ordination Group sponsor projects to develop mental health competency standards and training for these groups, focusing on recognition, management, referral criteria and processes, and elimination of discrimination.

Appendix 4

The project brief

Background to the workshops

This project is about the development of a series of national workshops to explore and exchange ideas on innovation in education and training for the specialised professional mental health workforce, with input from consumers and carers.

These workshops are to be framed around exploring the education and training implications for the general model of service delivery defined under the National Mental Health Strategy. The Strategy proposes integrated mental health services, mainstreamed with general health and community services, and recommends that a multidisciplinary mental health workforce is the most appropriate for delivering these integrated services. The responsiveness of mental health services to the needs of consumers and family carers is viewed as a priority.

The Australian Health Ministers' Advisory Council (AHMAC) National Mental Health Working Group proposed a series of workshops as preferable to the recommendation from the earlier KPMG report which suggested a process of extensive national 'networking'. The workshops are designed to determine common as well as discipline specific areas of need in relation to education and training.

Deakin Human Services Australia (Deakin Human Services Australia), Deakin University was appointed to organise these workshops in conjunction with the Mental Health Branch, Commonwealth Department of Health and Family Services.

Aims of the workshops

The aims of the workshops as described in the tender brief, are to:

- bring together key representatives from the professions, educational bodies, consumers, carers, clinical and psychiatric disability support staff, managers of mental health services, governments, unions and industry training authorities;
- provide a regular avenue for sharing information and experience regarding innovative approaches to, and best practice in, mental health education, training, continuing education and staff development; and
- promote the inclusion of any agreed skills, knowledge, values and attitudes for each professional group in the specialised mental health workforce and any successful innovations identified during the workshops into existing entry level education and training, continuing education and training and staff development;
- provide a forum for identifying emerging education, training and staff development issues and proposing approaches to deal with them.

The tender brief cited several models of service provision that should form the basis of discussion about relevant education and training for professional mental health workers, vis:

- case management;
- team leadership
- involvement of consumers and carers;
- problems of rural and remote areas; and
- the need for cross-cultural training.

Appendix 5

Dates and places of workshops

Workshop One: 11th - 12th February, 1997
University House
Australian National University
Canberra

Workshop Two: 22nd - 24th June, 1997
University House
Australian National University
Canberra

Discipline Specific: *Consumers and Carers*
15th - 16th June, 1997
247 Flinders Lane
Melbourne

30th - 31st October, 1997
Ross House
Deakin University
Melbourne

Occupational Therapy
6th - 7th November, 1997
Deakin University
Melbourne

Nursing
10th - 11th November, 1997
Deakin University
Melbourne

Social Work
13th - 14th November, 1997
Deakin University
Melbourne

Psychology
27th - 28th November, 1997
Deakin University
Melbourne

Workshop Three: 12th - 13th February, 1998
University House
Australian National University
Canberra

Appendix 6

Royal Australian and New Zealand
College of Psychiatrists
Fellowship Curriculum 1995

A Curriculum for the RANZCP

FELLOWSHIP TRAINING PROGRAM

September 1995

Prepared by the Fellowships Board

The Royal Australian and New Zealand College of Psychiatrists

Contents

■ PREFACE	A34
■ ATTITUDES OBJECTIVES	A35
■ KNOWLEDGE OBJECTIVES	A38
■ SKILLS OBJECTIVES	A41

- The Australian and New Zealand College of Psychiatrists was incorporated on 28 October 1963.
- Its incorporation was procured by The Australasian Association of Psychiatrists (founded in October 1946) with a view to its continuing the work of the Association.
- The College was granted the prefix Royal on 9 May 1977.
- This is the first formal curriculum statement of The Royal Australian and New Zealand College of Psychiatrists Fellowship Training Program.

It was prepared by the Fellowships Board and approved by the RANZCP General Council on 6 May 1995.

Published by the RANZCP
309 La Trobe Street
Melbourne Victoria 3000
Printed by Capitol Press Pty Ltd (Melbourne)

Preface

Over the past decade, there has been increasing pressure from trainees, the fellowship and the wider community for the College to be more specific in identifying the special skills of a psychiatrist, and in particular, to develop a curriculum for training. This document is the result of a two-year process in which a subcommittee of the Fellowships Board achieved this task.

The curriculum has been approved by General Council for implementation in relation to trainees who are commencing their first year of training on or after 1 December 1995.

The curriculum is divided into three sections: objectives in regard to knowledge; those in regard to skills; and those covering attitudes. In many of these areas, trainees will be building on knowledge, skills and attitudes that they have developed during their medical training and refining those which relate specifically to psychiatry. This is particularly true in the section on attitudes. When medical graduates begin psychiatric training, they should already be committed to those attitudes and codes of practice derived from the study of ethical principles as they apply to medical practice. Attitudes to psychiatric practice build on those ethical principles underlying all medical practice. These principles are enunciated in the RANZCP *Code of Ethics* and trainees are expected to behave in accordance with these principles.

In regard to knowledge, it is stressed that whilst all objectives are important, it is not the intention that all need to be achieved to the same level, and trainees should seek guidance from their supervisors as well as from their academic teachers as to the amount of detail required. Similarly with the skills objectives, the Fellowships Board is not implying that all will have been fully mastered by the end of training—rather, some should be seen as skills which require continuing development over

the psychiatrist's professional life. On the other hand, the attitudes objectives should have been achieved by the end of training in that they represent approaches to the practice of psychiatry which should inform the work of each and every psychiatrist.

In educational terms, the curriculum is expressed in mid-level objectives. From time to time, more specific objectives will be issued by the Committee for Training in areas which are seen to be appropriate. In many areas, the College will have issued position papers, practice guidelines and ethics guidelines. It is expected that trainees will use these documents as guides.

It is acknowledged that the nature of psychiatric practice is rapidly changing and the curriculum should reflect this dynamic development. Consequently, the curriculum will be fully reviewed by the Fellowships Board after its first three years of implementation and reissued in revised, updated form during 1999.

This document is the first formal attempt to draw together the educational objectives for the training of psychiatrists in Australia and New Zealand. Its publication occurs as the College approaches the 50th anniversary of its predecessor body, the Australasian Association of Psychiatrists, which set as a principal objective the professional education and training of psychiatrists in Australasia. I am pleased to see the publication of the curriculum as one of my legacies to the College and to record my thanks to the colleagues who assisted me in the process. As well, I express my appreciation to all those who read and commented on various drafts, including consumer groups, particularly the Australian National Consumer Advisory Group on Mental Health and other community groups in Australia and New Zealand.

Professor Bruce Singh
Chair, Fellowships Board

on behalf of:
Associate Professor John Condon
Dr Elizabeth O'Brien, Dr Paul Schneider
Dr Jonathan Phillips, Professor Peter Ellis

With the assistance of:
Dr Robert Broadbent, Ms Sheena Mathieson

Attitudes objectives

A Curriculum for the RANZCP Fellowship Training program

A1 Attitudes to patients

Trainees should develop an attitude of respect for the humanity and dignity of their patients.

Trainees will demonstrate this attitude by:

- A1.1 Endeavouring to form partnerships with their patients as appropriate in regard to treatment, including a willingness to consult with appropriate cultural advisers as necessary.
- A1.2 Neither discriminating against nor exploiting their patients on any grounds particularly of age, gender, race, ethnicity, sexual orientation, creed, religion, or political affiliation or values.
- A1.3 Never exploiting their patients or former patients.
- A1.4 Taking particular care where patients are detained against their will to balance respect for the patient's autonomy with duty of care and responsibility to the wider community.
- A1.5 Recognising that there is a differential power relationship between psychiatrists and patients and being particularly aware of the implications of this for patients.
- A1.6 Recognising that sexual relationships between psychiatrists and their patients are always unethical.
- A1.7 Recognising that the involvement of patients in teaching exercises and clinical examinations requires respect for the patient's dignity and privacy, that participation is voluntary and unwillingness to participate will not affect their treatment.

A2 Attitudes to patient care

Trainees should develop an attitude whereby they seek the best possible care for their patients.

Trainees will demonstrate this attitude by:

- A2.1 Endeavouring to serve the best interests of their patients by engendering mutual trust, avoiding intentional or foreseeable harm and endeavouring to deliver their treatment under the best possible conditions.
- A2.2 Endeavouring to facilitate the continuity of care of their patients, recognising however that trainees need to rotate through their various required work experiences.
- A2.3 Recognising the limitations of their expertise and practising within these limitations, thus seeking and utilising appropriate supervision within the apprenticeship model.
- A2.4 Developing an awareness of the impact of illness on patients, families or carers and the wider community, and striving to balance the needs of the patients with those of the family or carers.

A3 Attitudes to patient confidentiality

Trainees should develop an attitude of respect for the confidentiality of patient information.

Trainees will demonstrate this attitude by:

- A3.1 Maintaining patient confidentiality, except in those instances involving legal compulsion or risk of serious harm to the patient or other parties.
- A3.2 Striving to develop an understanding of the complexities of the issue of confidentiality as it applies in psychiatric practice: mindful of the appropriate balance between the patient's rights to confidentiality and the carer's need for information relevant to the care of the patient.
- A3.3 Being aware of statutory considerations as they apply to patient confidentiality, e.g. Freedom of Information/privacy legislation.

A4 Attitudes to patient consent

Trainees should develop an attitude whereby they recognise the right of a patient for adequate information in order to give consent to any proposed procedure or treatment.

Trainees will demonstrate this attitude by:

- A4.1 Striving to develop knowledge and skills to allow them to present patients with appropriate information on the nature, purpose, benefits and risks of proposed and alternative treatments.
- A4.2 Conveying information in a way which can be understood by the patient, and their families or carers (when necessary).
- A4.3 Taking particular care where the patient's capacity to understand may be impaired.
- A4.4 Ensuring consent is given freely without pressure or coercion, taking particular care with involuntary patients or those in a forensic setting.

A5 Attitudes to the practice of psychiatry

The practice of psychiatry is based on both scientific principles and a long history of clinical precedent, both of which need to be constantly reviewed by the psychiatrist in the light of new knowledge.

Trainees should develop an attitude whereby they demonstrate their acceptance of this need for constant critical review by:

- A5.1 Developing an awareness of the relative benefits, costs and risks of different procedures and treatments.
- A5.2 Openness to change in their own practice in the light of demonstrated advances in knowledge.
- A5.3 Striving to contribute to the knowledge base of psychiatry by scientific endeavours and considered reflection on the nature of practice.

A6 Attitudes to research in psychiatry

The practice of psychiatry needs to be continually updated as new knowledge accumulates; research to advance knowledge needs to be conducted according to established ethical and scientific principles.

Trainees should develop an attitude whereby they demonstrate this approach by:

- A6.1 Adhering to the relevant ethical principles when involved in clinical research.
- A6.2 Striving to contribute to the development of knowledge whereby any research they perform will conform to generally accepted scientific principles, be based on a thorough knowledge of the scientific literature, and be planned and executed according to the highest standards.
- A6.3 Recognising and accepting the role of an independent ethics committee to evaluate relevant research proposals to ensure that research studies in which they are involved conform to accepted standards of ethical research.

A7 Attitudes to the professional role of psychiatrists

Trainees share the responsibility of upholding the integrity of the medical profession and should develop an attitude whereby they recognise the privileges accorded them because of their calling and tradition.

Trainees will demonstrate this attitude by:

- A7.1 Recognising the obligation to maintain appropriate personal moral standards in their professional practice, and in those aspects of their personal life which may reflect upon the integrity of the medical profession.
- A7.2 Knowing and adhering to the Codes of Conduct for Trainees as issued from time to time by the RANZCP.
- A7.3 Always using their professional knowledge or skills in the patient's interests. Trainees will never diagnose or treat a mentally ill person on the basis solely of their political, religious, ideological, moral or philosophical beliefs, or of race, ethnicity or sexual

preference. They will not use non-conformity with society's prevailing moral, political, religious or any other value system as the determining factor in diagnosing mental disorder.

- A7.4 Never unjustifiably refusing to assess and when necessary treat a patient.
- A7.5 Refusing to participate in situations where psychiatric knowledge is being misused or abused.
- A7.6 Recognising that their own physical and mental health is necessary to enable them to undertake their professional responsibilities competently. This attitude is also demonstrated by seeking appropriate assistance in the event of their own ill health which interferes with their professional duty, ceasing to treat patients until such time as their health is satisfactorily restored, and informing the appropriate clinical authorities to allow for alternative care for their patients.

A8 Attitudes to colleagues and other professionals

Trainees should develop an attitude of respect for the knowledge and skills of their own psychiatric colleagues, other medical colleagues and other health professionals.

Trainees will demonstrate this attitude by:

- A8.1 Seeking to develop constructive and cooperative working relationships with colleagues and other mental health professionals involved in the provision of care to patients.
- A8.2 Expressing viewpoints with candour and respect in the event of differences of opinion.

- A8.3 Taking appropriate action in regard to unprofessional conduct by or ill health in a colleague or other health professional, including consulting, when appropriate, with a respected senior colleague.

A9 Attitudes to the role of the psychiatrist in society

Trainees in their societal role should strive to improve the quality of psychiatric services.

Trainees will demonstrate this attitude by:

- A9.1 Preparing themselves to promote the just allocation of services and contribute to the education of society regarding mental health, including the issue of stigma, when advocating in this role trainees should avoid being overly critical of colleagues and promoting self-interest.
- A9.2 Preparing themselves by virtue of their knowledge and experience to advise those responsible for the provision of health services, to act as advocates on behalf of psychiatric patients, to work with advisory, statutory and voluntary bodies that have a role in the provision of psychiatric services, and to take action if services, by reason of fiscal restriction or otherwise, fall below minimal standards.
- A9.3 Preparing themselves to interpret and disseminate relevant scientific information in relation to public debate on psychosocial issues and, in doing so, differentiating their role as educators based on professional knowledge as distinct from their personal views.

Knowledge objectives

K1 Normal development

By the completion of training, trainees should be knowledgeable about normal biological, psychological and social development from infancy to old age.

In particular, trainees should be able to demonstrate knowledge of:

- K1.1 The stages of normal development so as to determine whether an individual's style of thinking, feeling or behaving is appropriate for that stage or may be indicative of illness.
- K1.2 How the stage of cognitive and emotional development may influence the aetiology and presentation of psychiatric disorder and its management.
- K1.3 Age-appropriate coping and defence mechanisms utilised in the face of physical or psychological trauma and illness.
- K1.4 Factors which may be associated with vulnerability to psychiatric disorder and protective factors associated with resiliency.
- K1.5 Social and cultural factors, including family issues, which influence the development, presentation and management of psychiatric disorder at various points in the life-cycle.
- K1.6 Developmental issues specific to indigenous peoples, including relevant historical and political factors which have influenced their development, individually and as a group.
- K1.7 The way in which the developmental stage of the patient may affect the therapeutic alliance.
- K1.8 The particular issues facing dying patients (and their relatives) including the significance of religious and cultural factors

K2 Basic sciences

By the completion of training, trainees should be knowledgeable about aspects of those biomedical, social and psychological sciences which underpin the practice of clinical psychiatry.

In particular, trainees should be able to demonstrate knowledge of:

- K2.1 Those aspects of neuroanatomy, neurophysiology, neurochemistry, neuropharmacology and other biological sciences which are relevant to understanding psychiatric disorders.
- K2.2 Those aspects of psychology, sociology, anthropology and other social sciences which are relevant to psychiatric disorder.
- K2.3 Those aspects of pathological disturbances in the biological or psychological spheres which are relevant to psychiatric disorders.
- K2.4 The various biological, psychological, social and cultural models of the aetiology of psychiatric disorders.
- K2.5 The theoretical underpinnings of the major treatment modalities for psychiatric disorders, including biological, psychotherapeutic and social interventions

K3 Psychiatric disorders

By the completion of training, trainees should be knowledgeable about the epidemiology, aetiology, psychopathology, clinical features (including complications), and natural history of psychiatric disorders and psychological reactions in both the individual and the carer, including concepts of impairment, disability and handicap. A sound knowledge of the assessment and care of these conditions is also expected.

In particular, trainees should be able to demonstrate knowledge of:

- K3.1 The incidence and prevalence of illnesses at different ages and in various populations.

- K3.2 The history of the evolution of concepts of psychiatric disorders and principles of treatment.
- K3.3 The phenomenology of psychiatric disorders, including the definitions of psychiatric symptoms and their significance.
- K3.4 Psychiatric diagnoses and the criteria on which these are based, within the framework of one of the widely accepted classification systems.
- K3.5 Possible causative or exacerbating factors in psychiatric disorders.
- K3.6 The natural history of the disease process in psychiatric disorders which enables identification of:
- the severity of the disease
 - the urgency of the need for treatment
 - the stage of the illness
 - the prognosis.
- K3.7 Appropriate management plans for psychiatric disorders including:
- physical and psychological investigations and assessments
 - psychotherapeutic techniques
 - psychopharmacological and other physical therapies
 - situations in which referral to, or consultation with, colleagues in psychiatry and other disciplines is appropriate
 - programs involving changes in lifestyle
 - rehabilitation programs.
- K3.8 The influence of specific factors on assessment and care of psychiatric disorders, including:
- age
 - intellectual capacity
 - medical illness
 - gender
 - culture
 - spiritual beliefs
 - socio-economic status.
- K3.9 The influence of factors which affect treatment outcome.
- K3.10 The principles underlying the choice and integration of interventions in psychiatric disorders, including relative cost effectiveness.
- K3.11 The principles of legislation which relates to the practice of psychiatry, with particular emphasis on mental health legislation, including its local application.

K4 Impact of psychiatric disorders

By the completion of training, trainees should be knowledgeable about the impact of psychiatric disorders on patients, their families, carers and significant others.

In particular, trainees should be able to demonstrate knowledge of:

- K4.1 The impact on patients of psychiatric disorder and its treatment, including the broader potential impact on multiple areas of a patient's life and lifestyle.
- K4.2 The particular impact on patients of psychiatric disorder and its treatment when this treatment involves hospitalisation and involuntary treatment.
- K4.3 The impact of psychiatric disorder on families and carers, including an awareness of their needs and their role in the care of the patient.
- K4.4 Community consequences of psychiatric disorder and implications for the community of policies for the care and treatment of people so affected.
- K4.5 The attitudes and responses of the community to psychiatric disorder, including the implications of stigma for patients, families and carers.

K5 Medicine in relation to psychiatry

By the completion of training, trainees should be knowledgeable about general medical and surgical conditions. Higher levels of knowledge, tempered by maturity and experience, are expected in those areas of general medicine which particularly relate to psychiatric practice.

In particular, trainees should be able to demonstrate knowledge of:

- K5.1 The presentation, investigation, diagnosis and treatment of medical conditions, particularly in those areas which relate to psychiatric practice.
- K5.2 Further investigations which are necessary to confirm or reject diagnostic hypotheses and to aid the patient's management.
- K5.3 The basic principles involved in the management of significant medical illnesses.
- K5.4 The interaction between medical and psychiatric disorders.

K5.5 The psychosocial and cultural aspects of medical illness and the significance to patients and their families of both the illness and its treatment.

K6 Mental health promotion

By the completion of training, trainees should be knowledgeable about the principles and process of mental health promotion and psychiatric disorder prevention.

In particular trainees should be able to demonstrate knowledge of:

- K6.1 The principles of preventative medicine in relation to psychiatry.
- K6.2 The use of preventative approaches in clinical practice, particularly secondary and tertiary prevention, including their effectiveness, efficiency and acceptability.
- K6.3 The influences of lifestyle, social, cultural and environmental factors in promoting health and preventing disease.
- K6.4 Possible roles for a psychiatrist in illness prevention in both hospital and community settings.

K7 Scientific method

By the completion of training, trainees should be knowledgeable about the principles of scientific method in their practice and the use of this knowledge to evaluate developments in psychiatric research.

In particular, trainees should be able to demonstrate knowledge of:

- K7.1 The history and philosophy of science as they relate to concepts of mental disorder.
- K7.2 Scientific analysis and interpretation of psychiatric literature.
- K7.3 The application of this approach to research, including clinical trial design, basic statistical techniques and outcome assessment.

K8 Service issues

By the completion of training, trainees should be knowledgeable about the organisation and delivery of mental health care including the ethical, economic, geographical and political constraints within which it operates.

In particular, trainees should be able to demonstrate knowledge of:

- K8.1 The ethical, cultural, economic, practical and political factors which influence the health care and social welfare systems when providing services for the individual.
- K8.2 The philosophy underlying modern mental health service delivery, including the balance between hospital and community treatment and care.
- K8.3 Government and the RANZCP policies on mental health services.
- K8.4 The basic principles of health services management as they relate to the provision and management of psychiatric services.
- K8.5 Funding mechanisms for psychiatric services and the implications of these for the delivery of services.
- K8.6 The role of consumer groups and other major mental health groups in relation to the delivery of psychiatric services.

K9 Professional responsibility

By the completion of training, trainees should be knowledgeable about the principles of medical ethics, the development of professional attitudes and mechanisms for the development and maintenance of clinical competence, acknowledging the need for professional and public accountability.

In particular, trainees should be able to demonstrate knowledge of:

- K9.1 The principles of medical ethics as applied to psychiatric practice, in particular the RANZCP Code of Ethics as a guide to professional conduct.
- K9.2 The critical role of peer review in the maintenance of professional standards.
- K9.3 The principles governing the maintenance of practice standards and quality assurance, including knowledge of relevant RANZCP position statements and other guidelines for clinical practice.
- K9.4 Effective mechanisms for ensuring continuing medical education.

Skills objectives

S1 Assessment of psychiatric disorders

By the completion of training, trainees should possess the skills necessary for performing a comprehensive psychiatric assessment in patients of all ages.

In particular, trainees should be able to:

- S1.1 Demonstrate an empathic approach to the assessment of all patients which fosters the formation of a therapeutic alliance facilitating both the assessment process and compliance with treatment.
- S1.2 Elicit histories from patients suffering from psychiatric disorders, perform comprehensive mental status examinations and document these accurately.
- S1.3 Assess the seriousness of an individual patient's presentation, in particular, identify cases where the level of disturbance is severe and risk of adverse events, such as injury to self or others, may be high.
- S1.4 Assess the individual's presentation in the context of his/her personality, developmental stage, strengths and coping mechanisms.
- S1.5 Take account of the patient's indigenous or ethnic and cultural background.
- S1.6 In the process of assessment, competently utilise and integrate the contributions of other medical and non-medical professionals as well as other relevant groups in the community (including advisers from the patient's own culture).
- S1.7 Determine which further investigations are appropriate for achieving a comprehensive understanding of each patient.
- S1.8 Integrate the information obtained from patients and significant others into a formulation of the case in which relevant predisposing as well as precipitating, perpetuating and protecting factors are highlighted.
- S1.9 Utilise a widely accepted diagnostic system to assist in making the diagnosis (and differential diagnosis) in each case.

S1.10 Recognise the significance and meaning of stressful life events for individual patients.

S1.11 Recognise, and make an assessment of, relevant features of the family context in which the patient's psychiatric disorder becomes manifest.

S1.12 Recognise special issues implicit in medico-legal assessments.

S2 Care and treatment of psychiatric disorders

By the completion of training, trainees should possess the skills to care for psychiatric disorders in patients from early childhood to old age.

In particular, trainees should be able to:

- S2.1 Develop and implement a clear plan of care which integrates biological, psychological and social interventions according to the needs of each individual patient.
- S2.2 Take appropriate account of the implications of the patient's age, gender, cultural background and other factors relevant to the individual in the formulation of the care plan.
- S2.3 Take appropriate account of the implications of the patient's ethnic and cultural background in the formulation of the care plan and specific modes of treatment.
- S2.4 Take particular account of the issues relating to the care of indigenous peoples.
- S2.5 Routinely re-evaluate diagnostic and management decisions to monitor their appropriateness and thus ensure optimal care.
- S2.6 Communicate clearly, considerately and sensitively the principles of care and treatment to the patient and his/her significant others.
- S2.7 Communicate clearly the treatment options available and negotiate sensitively the most preferred option in order to enable the patient to give appropriately informed consent for the treatment, whenever possible.

- S2.8 Offer treatment in the most appropriate setting for the individual concerned, utilising the least restrictive option for that patient.
- S2.9 Use humanely the provisions for involuntary hospitalisation, mindful of the major implications of such hospitalisation for the individual and his/her family.
- S2.10 Maintain a therapeutic alliance (and enhance compliance) by utilising an understanding, empathic and supportive approach for each individual, whilst demonstrating an understanding of the meaning and consequences for the patient of receiving psychiatric treatment.
- S2.11 Recognise and apply the principles of long-term care and rehabilitation for those people with well-established psychiatric disorders.
- S2.12 Use knowledge of the implications of co-existing medical illness to modify treatment appropriately.
- S2.13 Recognise and utilise the contributions of non-medical professionals in the care of persons with psychiatric disorders, and collaborate effectively with these professionals to provide optimal care.
- S2.14 Recognise the impact of psychiatric disorder on the patient's significant relationships, and offer appropriate support and explanation for these persons.
- S2.15 Provide competent and safe care in psychiatric emergencies and the more common medical emergencies which may be encountered in the clinical practice of psychiatry.
- S2.16 Recognise the limits of their own expertise and, when appropriate, seek consultation with colleagues.

S3 Communication skills

By the completion of training, trainees should demonstrate a finely developed ability to communicate clearly, considerately and sensitively with patients, their significant others, other health professionals and members of the general public, in a wide variety of settings.

In particular, trainees should be able to:

- S3.1 Communicate clearly with referring agencies about the nature and implications of any psychiatric presentation.

- S3.2 Communicate clearly to the patient the nature of any psychiatric disorder which is present as well as the various options for treatment.
- S3.3 Communicate sensitively with patients from different cultural groups.
- S3.4 Use professional interpreters appropriately.
- S3.5 Communicate clearly with the patient's relatives and carers the nature of any psychiatric disorder which is present as well as the various options for treatment, mindful of the appropriate balance between their need to know particular information and the patient's right to confidentiality.
- S3.6 Communicate clearly and appropriately in multidisciplinary treatment teams, thus facilitating appropriate use of the expertise of other professionals.
- S3.7 Communicate clearly and appropriately with colleagues in psychiatry and other specialties or disciplines.
- S3.8 Keep adequate records of the patient's history and mental status as well as of significant interactions with patients, relatives and carers, and other professionals.
- S3.9 Prepare comprehensive written reports when required (with the patient's permission, as appropriate).
- S3.10 Communicate clearly and appropriately in broader settings, e.g. with consumer groups.
- S3.11 Communicate clearly and appropriately when providing expert testimony on psychiatric aspects of legal cases.

S4 Interpersonal skills

By the completion of training, trainees should demonstrate highly developed interpersonal skills.

In particular, trainees should be able to:

- S4.1 Approach every patient with a sensitive and empathic attitude which will foster the development of a therapeutic alliance between doctor and patient, as well as facilitate assessment and management.
- S4.2 When conflicts arise, negotiate with consideration and sensitivity with the patient, family and care givers, and other professionals.

- S4.3 Work effectively with medical colleagues and non-medical professionals in multidisciplinary teams.
- S4.4 Demonstrate leadership skills in settings where clinical direction is required
- S4.5 Demonstrate skills appropriate for taking on a supervisory role with students, junior colleagues or other professionals seeking supervision in psychiatry.

S5 Medicine in relationship to Psychiatry

By the completion of training, trainees should be able to competently assess patients for the presence of medical illnesses. Higher levels of skill, tempered by maturity and experience, are expected in those areas of general medicine which particularly relate to psychiatric practice.

In particular, trainees should be able to:

- S5.1 Elicit a thorough, accurate and organised medical history relating to all systems of the body.
- S5.2 Perform a proficient physical examination of all systems of the body and competently elicit and recognise signs indicative of the presence of illness.
- S5.3 Interpret and integrate the history and physical findings and formulate an appropriate differential diagnosis.
- S5.4 Specify and interpret laboratory, radiological and other further investigations appropriate to clarify the differential diagnosis and to aid the patient's management.
- S5.5 In both assessment and management, recognise the interrelation between physical illness and psychiatric disorder.
- S5.6 Recognise with a high level of expertise, symptoms and signs of physical illness which may arise as complications of psychiatric treatments.
- S5.7 Recognise with a high level of expertise, symptoms and signs of those physical illnesses which may be more directly associated with psychiatric disorders.
- S5.8 Demonstrate competence in the practice of consultation liaison psychiatry including:
 - (a) the psychiatric assessment of medically ill patients
 - (b) the management of psychiatric disorders in medically ill patients

- (c) effective communication with non-psychiatric medical and other health professionals
- (d) the ability to grasp, and effectively deal with, the psychological issues which often surround the referral and psychiatric management of patients in medical settings.

S6 Mental health service-related skills

By the completion of training, trainees should have skills relevant to effective delivery of mental health services in hospital, community and integrated settings, both public and private. Such skills encompass both those specific to the discipline of psychiatry as well as those required for effective team performance.

In particular, trainees should be able to:

- S6.1 Contribute effectively to the planning, organisation and evaluation of mental health services.
- S6.2 Assess the basic resources required for the efficient delivery of mental health services.
- S6.3 Appropriately negotiate responsibility and accountability within the clinical setting and in external relations with other organisations.
- S6.4 Assess realistically the potential impact of changing structural and political issues on the delivery of effective mental health services.
- S6.5 Identify and utilise peer review and other quality assurance processes, as well as continuing medical education activities, to assist in the evaluation and maintenance of quality mental health services.
- S6.6 Develop skills necessary for effective team performance including:
 - (a) conflict resolution
 - (b) problem solving
 - (c) the ability to delineate and work within role boundaries
 - (d) team goal setting
 - (e) team development
 - (f) case management and planning.
- S6.7 Develop skills necessary to elicit and assess consumer perspectives on psychiatric services delivery, including, where appropriate, skills facilitating empowerment of consumers of psychiatric services.

S7 Scientific method

By the completion of training, trainees should have the skills necessary to undertake a research or evaluation study and to critically appraise published research relevant to psychiatry.

In particular, trainees should be able to:

- S7.1 Apply the principles of scientific method to interpret new knowledge and critically analyse research reports relevant to psychiatry.
- S7.2 Critically appraise the methodology of published scientific research in psychiatry, including addressing problems in study design, measurement and statistical analysis.
- S7.3 Design an information search strategy and efficiently retrieve information from published sources.
- S7.4 Design a research or evaluative study relevant to psychiatry.
- S7.5 Apply the principles of scientific method to any basic or clinical research which may be conducted.

S8 Health promotion

By the completion of training, trainees should be able to apply specific knowledge of the principles and processes of health promotion and illness prevention.

In particular, trainees should be able to:

- S8.1 Utilise appropriately preventative approaches in clinical practice, particularly secondary and tertiary prevention, with due regard to their effectiveness, efficiency and acceptability.
- S8.2 Incorporate, as relevant, the influences of lifestyle, social, cultural and environmental factors in promoting health and preventing disease.
- S8.3 Recognise protective factors which contribute to psychological resilience in individual patients and assist patients in the continuing development of such factors.
- S8.4 Recognise and utilise appropriate opportunities for a psychiatrist to become involved in health promotion and illness prevention activities in hospital and community settings.
- S8.5 Recognise the relevance of the experience of illness by the patient's relatives and significant others and use this information effectively in treatment and health promotion activities with these individuals.

Appendix 7

Specific needs for updating of the RANZCP fellowship curriculum 1995, as recommended by psychiatrist training task group workshop 3

Attitude

A1, A2 and A5

There needs to be an appraisal of the need for *therapeutic optimism* and *strengths-based* psychiatric therapeutic alliances and interventions, amplifying the *potential for recovery*.

Psychiatrist trainees are good as ‘analytic diggers’ in pursuit of biological knowledge, but often only make superficial contact with psycho-socio-cultural knowledges and experiences

Whether with respect to bio-psycho-, socio-, or cultural knowledge, trainees should be both rigorously analytic and highly receptive.

A1.7 and A2

There is an insufficient acknowledgement of the abuse of power maintained for the convenience of clinicians, researchers or trainees. Consumers and families feel it is highly insensitive to be “wheeled in” as a live exhibit in a huge ward round, in the presence of trainees and staff not involved in the case.

A6 Research attitudes.

These include

- recognition of the value of both qualitative and quantitative methodologies, their relative differences and complementarities, their relative strengths, limitations and potential to synergise each other
- Recognition of the roles of consumers and family members as potential co-investigators.

A7 Attitudes to their professional roles

These are

- A7.5 This should require not just refusing to participate, but being prepared to actively challenge and report situations where psychiatric knowledge or *power* is being mis-

used and abused. Trainees should seek confidential advice from trusted senior *independent* colleagues about these matters before reporting where possible. They should be able to contribute constructively in assisting to dismantle closing of ranks and ‘protection rackets’.

- A7.6 Its present expression is overly negative. This attitude is at least equally demonstrated by:

- making time for self and family
- learning to value self and interests apart from being a doctor
- learning not to be a doctor 24 hours a day

(see also A9)

A8 Attitudes to colleagues and other professionals

There is no statement about willingness to being open to learn from other professionals, and how to become a constructive and useful team player.

A9 The psychiatrist in society

- A9.1 The section on stigma is convoluted. It should be divided into two sentences. It should express willingness to actively challenge stigmatising practices within our profession, with provisos only about carefully avoiding “being overly critical of colleagues” unless there is palpable justification and/or substantiation.

- A9 This should include a prominent clause regarding the role of psychiatrists as consultant to local communities (as Gerald Caplan’s work demonstrates).

Overall, regarding The Psychiatrist in Society

- Some of the required attitudes are unobtrusive *restraints* on appropriate activism by all trainees, (possibly for the sake of damage-control of the feared effects of a few activists on the profession as a whole).

- This section lacks an agenda for the development of the role of Community Consultant Psychiatrist with communal groups and organisations.

Knowledge

There is a missing link from K: *Knowledge of Consumer and Carer Movement* and how to talk with consumers and carers.

K1 Normal Development

- K1.3 This should include understanding of universal and culture-specific life transitions, rites of passage and methods of processing life crises.

K2 Basic Sciences

- K2.5 This should include “and cultural healing practices” and “cultural interventions” eg the works of Ernest Hunter, Pat Swan, Jane McKendrick, Beverley Raphael, Alan Rosen, Mason Durie and Erikana Ryan (i.e. should include Maori perspective).

K3 Psychiatric Disorders

- K3.7 should include the need to
 - monitor, progress, chase and ensure appropriate physical treatment of detected physical disorders
 - provide active intensive case management, whenever appropriate
 - unpack the essential components of specific management of functional impairments, disabilities and handicaps rather than *alluding only in one line and two words* to “rehabilitation programmes”. (The curriculum should use the WHO Classification of Impairments, Disabilities and Handicaps with appropriate interventions for each).

K4 Impact of Psychiatric Disorders:

This unsuccessfully attempts to operationalise empathy. There is no recognition that therapeutic optimism can be taught and can improve the impact of the disorder (as well as the lives of professionals and their families).

K5 Medicine in Relation to Psychiatry

K5 - as 3.7a) and b) - these interventions are missing. The differential impact of disease illness and sickness and their respective appropriate interventions (eg Pilowski’s work) needs to be encompassed.

K6 Mental Health Promotion

This should include

- knowing the difference between promotion and prevention (both should be in the heading of this section)
- 6.5 Knowledge of early prevention and early intervention programs

K7 Scientific Method

This should include:

- K7.4 Understanding of the differences and complementarities between qualitative and quantitative research paradigms and methodologies.

K8 Service Issues

This should include:

- In K8.2 “including the principles of service integration and mainstreaming with general health services”.
- K8.7 Understanding of the National Mental Health Strategies in Australia and N.Z.
- K8.8 The key findings and recommendations of pivotal inquiries and reports affecting the development and evolution of Mental Health Services in Australian and New Zealand (c.f. Britain and North America).

Skills

Missing: Skills in how to work with consumer family and community groups.

- S.2 This should include:
 - cultural interventions in 5.2.1
 - unpacked components of longterm care and rehabilitation skills in 5.2.11
 - “recognise, utilise and *learn from* the contributions of non-medical health professionals in 5.2.13

S.5 Medicine

These skills should include:

- S5.9 skills in promoting and ensuring effective management of co-existing physical conditions.

S.7 Research

As noted in *Attitudes* and *Knowledge* sections above, regarding need for constant qualitative research and how to work with consumer and carer co-investigators.

S.8 Distinguish Promotion from Prevention

This should include:

Skills involved in *Early Prevention Detection and Intervention* in Early Psychosis Depression, Suicidality and Behavioural Disorders in all age-groups.

Appendix 8

Pulling together: the future roles and training of mental health staff

The Sainsbury Centre for Mental Health: London pp. 15 and 16

The Core Skills, Knowledge and Attitudes Required in Mental Health Services

We propose the following comprehensive, core competencies for specialist staff working with adults with severe mental illness:

Management and administration

- Knowledge of current systems of care and the policy background (CPA, supervision registers, community care and care management procedures, functions and organisation of primary care).
- Understanding of mental health law and related legislation, especially in relation to users' civil rights and powers of compulsion and detention.
- Understanding of the roles of the various disciplines and agencies involved in the provision of mental health care and the range of settings within which care and treatment take place.
- Awareness of the role and contribution of non specialist and support staff, and the ability to supervise and provide support to those staff.

Assessment

- Skill in conducting a collaborative needs-based assessment.
- Ability to develop a treatment and care plan based on a thorough and comprehensive assessment of the client, family and social system.
- Apply knowledge of the issues and skill in the assessment and management of the combined problem of drug/alcohol abuse and mental illness.
- Skills in the assessment of users' needs and requirements of housing, occupation and income.
- Apply knowledge and skill in risk assessment and the management of violence and aggression.
- Apply knowledge of factors related to the development of "chronic crises" and skill in assessment and management strategies.

Treatment and care management

- Knowledge of the priority target group, their needs, characteristics and clinical symptomatology.
- Knowledge of crisis intervention, theory and practice.
- Effective understanding of current medical interventions and possible side effects.

- Knowledge of basic current cognitive-behavioural strategies to assist users, carers and family networks to contain and manage a severe and enduring mental illness.
- Understanding of the issues in the evaluation and treatment of service users at risk of self harm or suicidal behaviour.
- Knowledge and skills in effective inter-personal communication.
- Awareness of cultural and gender issues in mental illness and an awareness of the principles and practices of anti-discriminatory and anti-racist practice.
- Knowledge and skill in creating therapeutic co-operation and developing an alliance with the service user.
- Awareness of the needs, characteristics and principles of care for homeless people with mental illness.
- Knowledge and skill in the provision of assertive outreach and long term continuing care.
- Awareness of the needs, characteristics and principles of care for forensic patients.
- Awareness of user perspectives on the provision of treatment and continuing care.
- Knowledge of care management principles.

Collaborative working

- Awareness of the need to work in partnership with carers and social networks.
- Ability to work effectively as a member of a multi-disciplinary mental health team through clarity about the role and purpose of the team and its individual members.
- Understanding of sources of conflict and development of basic teamwork skills including negotiation and conflict resolution.

Comprehension of the need for and willingness to participate effectively in multi-disciplinary team supervision.

This list of core skills, knowledge and attitudes is proposed as the basis for a training framework which will guarantee "fitness for purpose" of staff working with people with severe mental illness. It is the foundation upon which the unique, specialist skills of the various disciplines should be built. We have no doubt that all staff functioning at key working or care management levels should be competent in all of the above core areas as well as in areas that are professionally distinct.

Appendix 9

University of Queensland (1997) Report 1:

Executive summary: professional development strategy for adult mental health services (Queensland Health) – (extract)

Core competencies for mental health professionals

CLINICAL CARE

Level A

- Unit CC 1 Establish and Maintain Therapeutic Relationship with Patient/Carer
- Unit CC 2 Assess Patient/Carer Needs
- Unit CC 3 Analyse Information
- Unit CC 4 Formulate Intervention Plan
- Unit CC 5 Implement Intervention Plan
- Unit CC 6 Monitor Planned Intervention/s
- Unit CC 7 Terminate Intervention/s
- Unit CC 8 Respond to Crisis/Emergency
- Unit CC 9 Undertake Medico-Legal Responsibilities

Level B

- Unit CC 10 Develop Policy and Procedures for Crisis and Emergency Situation
- Unit CC 11 Facilitate Ongoing Best Practice in Clinical Areas

Level C

- Unit CC 12 Develop Practice Standards

PROFESSIONAL PRACTICES

Level A

- Unit PP 1 Practice within Professional, Legislative and Organisational Parameters
- Unit PP 2 Maintain Professional Competency

Level B

- Unit PP 3 Support Professional Work Practices
- Unit PP 4 Provide Staff Development and Performance Enhancement

WORKING WITH OTHERS

Level A

- Unit WO 1 Communicate in a Range of Ways
- Unit WO 2 Participate in Meetings

- Unit WO 3 Participate as a Multidisciplinary Team Member

- Unit WO 4 Establish Networks with Service

- Unit WO 5 Advocate for Patients/Clients

Level B

- Unit WO 6 Develop Strategic Links with Community Organisations

- Unit WO 7 Lead Team

Level C

- Unit WO 8 Establish Strategic Working Relationships to Improve Intersectoral Links

- Unit WO 9 Provide Leadership in the Workplace

INFORMATION DISSEMINATION AND PSYCHO EDUCATION

Level A

- Unit ID 1 Provide and Use Information in a Range of Ways

- Unit ID 2 Provides Psycho-Education at Individual Level

- Unit ID 3 Utilise Group Processes/Programs to Provide Information/Psycho-Education

- Unit ID 4 Provide Community Education and Mental Health Promotion

Level B

- Unit ID 5 Identify Requirements for Training

- Unit ID 6 Manage Information Systems

Level C

- Unit ID 7 Manage Training

- Unit ID 8 Manage Information Strategically

ADMINISTRATION AND MANAGEMENT

Level A

- Unit AM 1 Undertake Administrative Work

- Unit AM 2 Documentation and Record Keeping

- Unit AM 3 Manage and Maintain Resources and Equipment

- Unit AM 4 Manage Full Range of Duties and Responsibilities

Unit AM 5 Comply with Occupational Health and Safety Policies, Procedures and Programs

Level B

Unit AM 6 Develop, Implement and Monitor Program/Project

Unit AM 7 Design and Implement Policies and Procedures

Unit AM 8 Manage Staff

Unit AM 9 Maintain Work Environment

Unit AM 10 Implement and Monitor the Organisation's Occupational Health and Safety Policies, Procedures and Programs

Level C

Unit AM 11 Manage Resources

Unit AM 12 Human Resource Management

Unit AM 13 Manage Service/organisation

Unit AM 14 Establish, Maintain and Evaluate the Organisation's Occupational Health and Safety System and Emergency Disaster Response

RESEARCH AND EVALUATION

Level A

Unit RES 1 Contribute to Research

Level B

Unit RES 2 Plan, Manage and Evaluate Research

Level C

Unit RES 3 Design and Initiate Research

Appendix 10

Select bibliography: education and training of mental health professionals

- Alexander, K. 1995, *Schizophrenia: teaching relatives the 14 principles of coping. a course and manual*. Melbourne: Schizophrenia Fellowship of Victoria.
- Anthony, W. A., Cohen, M. R., & Farkas, M. 1988, Professional pre-service training for working with the long-term mentally ill. *Community Mental Health Journal*, 24(4), 258-268.
- Arkar, H., & Eker, D. 1997, Influence of a 3-week psychiatric training programme on attitudes toward mental illness in medical students. *Social Psychiatry Psychiatr Epidemiol*, 32, 171-176.
- Backer, T. E., Liberman, R. P., & Kuehnel, T. G. 1986. Dissemination and adoption of innovative psychosocial interventions. *Journal of Consulting and Clinical Psychology*, 54, 111-118.
- Baker, B. L., Heller, T. L., Blacher, J., & Pfeiffer, S. I. 1995, Staff attitudes toward family involvement in residential treatment centers for children. *Psychiatric Services*, 46(1), 60-65.
- Barreira, P. J., & Dion, G. I. 1991, Training psychiatrists in rehabilitation principles and practice for working with people with long-term mental illness. *Psychosocial Rehabilitation Journal*, 14(3), 93-96.
- Beckwith, J. B., & Matthews, J. M. 1995, Measurement of attitudes of trainee professionals to people with disabilities. *Journal of Intellectual Disability Research*, 39(4), 255-262.
- Berman, R. I. 1994, Staff Development in Mental Health Organizations. *Administration and Policy in Mental Health*, 22(1), 49-55.
- Bernheim, K. F. 1990, Promoting Family Involvement in Community Residences for Chronic Mentally Ill Persons. *Hospital and Community Psychiatry*, 41(6), 668-670.
- Bernheim, K. F. 1994, Determining and implementing the family service plan. In H. P. Lefley & M. Wasow (Eds.), *Helping Families Cope with Mental Illness*. USA: Harwood.
- Bernheim, K. F., & Lehman, A. F. 1985, Biases, Loyalties, and Conflicts, *Working with Families of the Mentally Ill* (pp. 188-199). New York: W.W. Norton & Company.
- Bernheim, K. F., & Lehman, A. F. 1985, Developing a Family Program: Time to Begin, *Working with Families of the Mentally Ill* (pp. 200-213). New York, London: W.W. Norton & Company.
- Bernheim, K. F., & Lehman, A. F. 1985, Teaching Mental Health Work Trainees to Work With Families of the Chronic Mentally Ill. *Hospital and Community Psychiatry*, 36(10), 1109-1111.
- Bernheim, K. F., & Olewniczak, J. R. 1990, Sensitizing mental hygiene therapy aides to the needs of patients' relatives. *Hospital and Community Psychiatry*, 41(9), 1013-1015.
- Bernheim, K. F., & Switalski, T. 1988, Mental health staff and patients' relatives: how they view each other. *Hospital and Community Psychiatry*, 39(1), 63-68.
- Biegel, D. E., Song, L.-y., & Milligan, S. E. 1995, A comparative analysis of family caregivers' perceived relationships with mental health professionals. *Psychiatric Services*, 46(5), 477-482.
- Bland, R., & Harrison, C. A. 1995, Investigating discharge destinations for schizophrenic patients. *Australian and New Zealand Journal of Psychiatry*, 29, 288-292.
- Blum, S. R., Feldman, S., & Heller, K. 1991, Responsibilities and Training Needs of Mental Health Administrators. *Administration and Policy in Mental Health*, 18(4), 257-269.
- Boker, W. 1992, A call for partnership between schizophrenic patients, relatives and professionals. *British Journal of Psychiatry*, 161(18), 10-12.
- Boyd, M. A., Luetje, V., & Eckert, A. Creating Organisational Change in an Inpatient Long-Term Facility. *Psychosocial Rehabilitation*, 47-54.
- Bridges, W. 1986, Managing Organizational Transitions. *Organizational Dynamics Summer*, 24-33.

- Brooker, C., & Butterworth, T. 1992, Training in psychosocial intervention: the impact on the role of community psychiatric nurses. *Journal of Advanced Nursing*, 18, 583-590.
- Brooker, C., Falloon, I., Butterworth, A., Goldberg, D., Graham-Hole, V., & Hillier, V. 1994, The Outcome of Training Community Psychiatric Nurses to Deliver Psychosocial Intervention. *British Journal of Psychiatry*, 165, 222-230.
- Brooker, C., Tarrier, N., Barrowclough, C., Butterworth, A., & Goldberg, D. 1992, Training Community Psychiatric Nurses for Psychosocial Intervention: Report of a Pilot Study. *British Journal of Psychiatry*, 10, 836-844.
- Castaneda, D., & Sommer, R. 1989, Mental health professionals' attitudes toward the family's role in care of the mentally ill. *Hospital and Community Psychiatry*, 40(11), 1195-1197.
- Cole, S. A., & S. Cole, D. 1987, Current Status and Suggestions for Clinical Training. In H. Lefley (Ed.), *Professionals Who Work with Families of the Chronic Mentally Ill* (pp. 278-306). New York.
- Cook, J. A., Jonikas, J. A., & Razzano, L. 1995, A Randomized Evaluation of Consumer Versus Nonconsumer Training of State Mental Health Service Providers. *Community Mental Health Journal*, 31(3), 229-238.
- Corrigan, P., Holmes, E. P., Luchins, D., Basit, A., Delaney, E., Gleason, W., Buican, B., & McCracken, S. 1995, The Effects of Interactive Staff Training on Staff Programming and Patient Aggression in a Psychiatric Inpatient Ward. *Behavioural Interventions*, 10(1), 17-32.
- Corrigan, P., McCracken, S., Edwards, M., Brunner, J., Garman, A., Nelson, D., & Leary, M. 1997, Collegial support and barriers to behavioral programs for severe mental illness. *Journal of Behavioral Therapy & Experimental Psychiatry*, 28, 193-202.
- Corrigan, P.W. 1994, Differences between clinical and nursing inpatient staff: implications for training in behavioral rehabilitation. *Journal of Behavior Therapy & Experimental Psychiatry*, 25, 311-316.
- Corrigan, P.W. 1995, Wanted: Champions of Psychiatric Rehabilitation. *American Psychologist*, 50(7), 514-521.
- Corrigan, P.W., Holmes, E. P., & Luchins, D. 1993, Identifying Staff Advocates of Behavioral Treatment Innovations in State Psychiatric Hospitals. *Journal of Behaviour Therapy & Experimental Psychiatry*, 24(3), 219-225.
- Corrigan, P.W., Holmes, E. P., Luchins, D., Parks, J., Basit, A., DeLaney, E., & Kayton-Weinberg, D. 1994, Setting Up Inpatient Behavioral Treatment Programs: The Staff Needs Assessment. *Behavioral Intervention*, 9(1), 1-12.
- Corrigan, P.W., & McCracken, S. G. 1995, Psychiatric rehabilitation and staff development: educational and organizational models. *Clinical Psychology Review*, 15, 699-719.
- Corrigan, P.W., & McCracken, S. G. 1995, Refocusing the Training of Psychiatric Rehabilitation Staff. *Psychiatric Services*, 46(11), 1172-1177.
- Corrigan, P.W., & McCracken, S. G. 1995, Refocusing the Training of Psychiatric Rehabilitation Staff. *Psychiatric Services*, 46(11), 1172-1177.
- Corrigan, P.W., Wallace, C. J., Schade, M. L., & Green, M. F. 1994, Learning medication self-management skills in schizophrenia: relationships with cognitive deficits and psychiatric symptoms. *Behavior Therapy*, 25, 5.15.
- Covin, T. J., & Kilmann, R. H. 1990, Participant Perceptions of Positive and Negative Influences on Large-Scale Change. *Group & Organization Studies*, 15(2), 233-232.
- Curry, L., & Farhall, J. 1995, The Shift from Psychiatric Nurse to Manager: The design, implementation and evaluation of an Action Learning Program. *Therapeutic Communities*, 16(4), 215-228.
- Duggan, M. (1997). *Pulling Together*. London: The Sainsbury Centre for Mental Health.
- Factor, R. M., Stein, L. I., & Diamond, R. J. 1988, A Model Community Psychiatry Curriculum for Psychiatric Residents. *Community Mental Health Journal*, 24(4), 310-327.
- Falloon, I. R. H. 1986, Response to Agnes B. Hatfield. *Schizophrenia Bulletin*, 12(3), 334-336.
- Farhall, J. 1996, *Working with Family and Other Carers: Final Evaluation Report of a pilot training program for mental health professionals*. Bundoora, Victoria, Australia: La Trobe University.
- Farhall, J., Hocking, B., Leggatt, M., Reiss, C., Young, J., & Webster, B. 1995, *The Impact of a Family Work Training Intervention on an Area Mental Health Network*. Paper presented at the 5th Annual Mental Health Services Conference of Australia and New Zealand, 1995, Auckland, N.Z.

- Farhall, J., Webster, B., Hocking, B., Leggatt, M., Reiss, C., & Young, J. 1998, Training to enhance partnerships between mental health professionals and family caregivers: A comparative study. *Psychiatric Services*, 49 (In press).
- Farkas, M. D., & Anthony, W. A. 1989, *Psychiatric rehabilitation programs - putting theory into practice*. Baltimore & London: The Johns Hopkins University Press.
- Fox, J. C., & Chamberlain, J. 1988, (Nurses Education for Chronically Mentally Ill). *Community Mental Health Journal*, 24(4), 306-309.
- Furlong, M., & Cook, G. 1988, Styles of Practice: An Adult Learning Approach to Professional Development in Social Work. *Australian Social Work*, 41(4), 15-22.
- Furlong, M., & Smith, J. 1994, The broader system begins with the workplace. *ANZ Journal of Family Therapy*, 15, 197-207.
- Gilandas, A. J. 1973, The problem-oriented record in psychiatry. *Australian and New Zealand Journal of Psychiatry*, 7, 138-140.
- Glaser, E. M. 1983, *Putting knowledge to use*. San Francisco: Jossey Bass.
- Goldstein, A. P., Martens, J., Hubben, J., Belle, H. A. v., Schaaf, W., Wiersma, H., & Goedhart, A. 1973, The use of modeling to increase independent behavior. *Behaviour, Research & Therapy*, 11, 31-42.
- Grella, C. E., & Grusky, O. 1989, Families of the seriously mentally ill and their satisfaction with services. *Hospital and Community Psychiatry*, 40(8), 831-835.
- Grosser, R. C., & Vine, P. 1991, Families as advocates for the mentally ill: a survey of characteristics and service needs. *American Journal of Orthopsychiatry*, 61(2), 282-290.
- Grunebaum, H., & Friedman, H. 1988, Building collaborative relationships with families of the mentally ill. *Hospital and Community Psychiatry*, 39(11), 1183-1187.
- Gutride, M. E., & Goldstein, A. P. 1973, The use of modeling and role playing to increase social interaction among asocial psychiatric patients. *Journal of Consulting and Clinical Psychology*, 40, 408-415.
- Gutride, M. E., Hunter, G. F., Clark, L., Furia, R., Goldstein, A. P., Carrol, S., & Lower, W. Structured learning therapy with transfer training for chronic inpatients. , 277-279.
- Haddock, G., Butterworth, T., Tarrier, N., & Baguley, I. Training mental health professionals to use psychosocial interventions with people who have severe mental health problems. Manchester UK: School of Nursing Studies University of Manchester.
- Hanson, J. G. 1995, Families' perceptions of psychiatric hospitalization of relatives with a severe mental illness. *Administration and Policy in Mental Health*, 22(5), 531-541.
- Hanson, J. G., & Rapp, C. A. 1992, Families' perceptions of community mental health programs for their relatives with a severe mental illness. *Community Mental Health Journal*, 3, 181-195.
- Harchik, A. E., Sherman, J. A., Sheldon, J. B., & Strouse, M. C. 1992, Ongoing Consultation as a Method of Improving Performance of Staff Medmbers in a Group Home. *Journal of Applied Behavior Analysis*, 25(3), 599-610.
- Hargrove, D. S. 1992, Community Mental Health Center Staff Development for Service to Special Populations. In S. Cooper & T. H. Lentner (Eds.), *Innovations in Community Mental Health* (pp. 141-169): Professional Resource Press.
- Hargrove, D. S., & Spaulding, W. D. 1988, Training Psychologists for Work with the Chronically Mentally Ill. *Community Mental Health Journal*, 24(4), 283-295.
- Hatfield, A. B. 1979, Help-seeking behavior in families of schizophrenics. *American Journal of Community Psychology*, 7, 563-569.
- Hatfield, A. B. 1983, What Families want of Family Therapists. In W. R. McFarlane (Ed.), *Family Therapy in Schizophrenia* (pp. 41-65). New York: Guilford.
- Hatfield, A. B. 1986, Semantic barriers to family and professional collaboration. *Schizophrenia Bulletin*, 1(12), 325-333.
- Hatfield, A. B. 1994, Developing Collaborative Relationships with Families. *New Directions for Mental Health Services*, 62, 51-59.
- Hersen, M., Kazdin, A. E., Bellack, A. S., & Turner, S. M. 1979, Effects of live modeling, covert modeling and rehearsal on assertiveness in psychiatric patients. *Behaviour, Research & Therapy*, 17, 369-377.

- Holden, D. F., & Lewine, R. R. J. 1982, How families evaluate mental health professionals, resources, and effects of illness. *Schizophrenia Bulletin*, 8, 626-633.
- Intagliata, J., Willer, B., & Egri, G. 1988, The role of the family in delivering case management services. *New Directions for Mental Health Services*, 40, 39-52.
- John, I. 1998, The scientist-practitioner model: a critical examination. *Australian Psychologist*, 33, 24-30.
- Johnson, D. L. 1987, Professional-family collaboration. *New Directions for Mental Health Services*, 34, 73-79.
- Johnson, D. L. 1990, *Service needs of the seriously mentally ill: training implications for psychology*. Washington, DC: American Psychological Association.
- Johnston, D. L. 1994, *Psychologists Serving the Seriously Mentally Ill - Public Academic Linkages*. Washington: American Psychological Association.
- Kavanagh, D. J., Clark, D., Piatowska, O., Manicavasagar, V., & Rosen, A. 1993, Application of Cognitive-Behavioural Family Intervention for Schizophrenia in Multidisciplinary Teams: What Can the Matter Be? *Australian Psychologist*, 28(3), 181-188.
- Kazarian, S. S., & Vanderheyden, D. A. 1992, Family education of relatives of people with psychiatric disability: a review. *Psychosocial Rehabilitation Journal*, 15(3), 67-84.
- Kuehnel, T. G., & Liberman, R. P. *Competence-based training of psychiatric practitioners in the rehabilitation of the chronically mentally ill*.
- Kopelowicz, A., Liberman, R. P., Mintz, J., & Zarate, R. 1997, Comparison of efficacy of social skills training for deficit and nondeficit negative symptoms in schizophrenia. *American Journal of Psychiatry*, 154, 424-425.
- Krupa, T., Eastbrook, S., Blake, P., & Goering, P. 1992, Lessons Learned: Introducing Psychiatric Rehabilitation in a Multidisciplinary Hospital Setting. *Psychosocial Rehabilitation Journal*, 15(3), 29-36.
- Kuehnel, T. G., & Liberman, R. P. 1990, Competence-based training of psychiatric practitioners in the rehabilitation of the chronically mentally ill. Commentary to Ch 8. In H. Lefley & D. L. Johnson (Eds.), *Families as allies in treatment of the mentally ill* (pp. 241-254). Washington: American Psychiatric Press.
- Lamb, H. R. 1988, One-To-One Relationships with the Long-Term Mentally Ill: Issues in Training Professionals. *Community Mental Health Journal*, 24(4), 328-337.
- Lancashire, S., Haddock, G., Tarrier, N., Baguley, I., Butterworth, C. A., & Brooker, C. 1997, Effects of training in psychosocial interventions for community psychiatric nurses in England. *Psychiatric Services*, 48(1), 39-41.
- Lefley, H. P. 1990, Introduction: On Educating Mental Health Professionals to Work with Families of the Long-Term Mentally Ill. In L. Johnson (Ed.), *Families as Allies in Treatment of the Mentally Ill* (pp. xv-xix).
- Lefley, H., & Cutler, D. 1988, Training Professionals to Work With the Chronically Mentally Ill. *Community Mental Health Journal*, 24(4), 253-257.
- Lefley, H. P. 1987, Impact of mental illness in families of mental health professionals. *The Journal of Nervous and Mental Disease*, 175(10), 613-619.
- Lefley, H. P. 1988, Training professionals to work with families of chronic patients. *Community Mental Health Journal*, 24, 338-357.
- Lefley, H. P., & Johnson, D. L. 1990, *Families as Allies in Treatment of the Mentally Ill: New Directions for Mental Health Professionals*. Washington DC: American Psychiatric Press.
- Lesage, A., & Pollini, D. 1989, A New Schedule to Assess Relatives Satisfaction with Psychiatric Services: Preliminary Results on a Sample of Relatives Living with a Mentally Retarded Young Adult. *New Trends in Experimental and Clinical Psychiatry*, V(3), 151-159.
- Liberman, R. P., & Eckman, T. A. 1989, Dissemination of skills training modules to psychiatric facilities: overcoming obstacles to the utilisation of a rehabilitation innovation. *British Journal of Psychiatry*, 155(5), 117-122.
- Liberman, R. P., Kopelowicz, A., & Young, A. S. 1994, Biobehavioral treatment and rehabilitation of schizophrenia. *Behavior Therapy*, 25, 89-107.
- Liberman, R. P., Massel, H. K., Mosk, M. D., & Wong, S. E. 1985, Social skills training for chronic mental patients. *Hospital and Community Psychiatry*, 36, 396-403.
- Marks, I., Bird, J., & Lindley, P. 1978, Behavioural nurse therapists 1978 - developments and implications. *The Quarterly Bulletin of the British Association for Behavioural Psychotherapy*, 6, 25-36.

- Marsh, D.T. 1992, *Families and Mental Illness: New Directions in Professional Practice*. New York: Praeger.
- Marsh, D.T. 1992, A More Responsive System, *Families and Mental Illness* (pp. 220-231): Praeger.
- Marsh, D.T. 1992, The Needs of Families, *Families and Mental Illness* (pp. 157-175). New York: Praeger.
- Marsh, D.T. 1992, New Directions in Professional Practice, *Families & Mental Illness* (pp. 43-59). New York, Connecticut, London: Praeger.
- Marsh, D.T. 1994, Services for Families: New Modes, Models and Intervention Strategies. In L. Wasow (Ed.), *Helping Families cope with Mental Illness* (pp. 39-62). USA: Harwood.
- McElroy, E. M. 1987, The Beat of a Different Drummer. In A. B. Hatfield & H. P. Lefley (eds), *Families of the Mentally Ill: Coping and Adaptation* (pp. 225-243). New York: Guilford.
- Mintz, L. I., Liberman, R. P., Miklowitz, D. J., & Mintz, J. 1987, Expressed emotion: a call for partnership among relatives, patients, and professionals. *Schizophrenia Bulletin*, 13(2), 227-235.
- Morgan, S. L. 1989, Families' Experiences in Psychiatric Emergencies. *Hospital and Community Psychiatry*, 40(12), 1265-1269.
- Muijen, M. 1997, The future of training. *Journal of Mental Health*, 6, 535-538.
- Orford, J. 1987, Integration: A General Account of Families Coping with Disorder. In J. Orford (Ed.), *Treating the Disorder, Treating the Family* (pp. 266-292). Baltimore: The Johns Hopkins University Press.
- Paul, G. L., & McInnis, T. L. 1974, Attitudinal Changes Associated with Two Approaches to Training Mental Health Technicians in Milieu and Social-Learning Programs. *Journal of Consulting and Clinical Psychology*, 42(1), 21-33.
- Peternelj-Taylor, C. A., & Hartley, V. L. 1993, Living with Mental Illness: Professional/Family Collaboration. *Journal of Psychosocial Nursing*, 31(3), 23-28.
- Platt, C. 1990, An Experiment in Psychiatric Community Care in North Staffordshire: the experience of working with relatives of mentally-ill people. *Journal of Advanced Nursing*, 15, 1315-1318.
- Pulice, R. T., McCormick, L. L., & Dewees, M. 1995, A Qualitative Approach to Assessing the Effects of System Change on Consumers, Families, and Providers. *Psychiatric Services*, 46(6), 575-579.
- Rapp, C. A., & Hanson, J. 1988, Towards a Model Social Work Curriculum for Practice with the Chronically Mentally Ill. *Community Mental Health Journal*, 24(4), 278-282.
- Reppucci, N. D., & Saunders, J. T. 1974, Social psychology of behavior modification: problems of implementation in natural settings. *American Psychologist*, 649-660.
- Riesser, G. G., & Schorske, B. J. 1994, Relationships between family caregivers and mental health professionals: The American experience. In H. P. Lefley & M. Wasow (Eds.), *Helping Families Cope with Mental Illness* (pp. 3-27). U.S.A.: Harwood.
- Robey, K. L., Ramsland, S. E., & Castelbaum, L. 1991, Alignment of Agency and Personal Missions: An Evaluation. *Administration and Policy in Mental Health*, 19(1), 39-45.
- Rogers, E. S., Cohen, B. F., Danley, K. S., Hutchinson, D., & Anthony, W. A. 1986, Training mental health workers in psychiatric rehabilitation. *Schizophrenia Bulletin*, 12, 709-719.
- Ruggeri, M. 1994, Patients' and relatives' satisfaction with psychiatric services: the state of the art of its measurement. *Soc Psychiatry Psychiatr Epidemiol*, 29, 212-227.
- Ruggeri, M., & DallAgnola, R. 1993, The development and use of the Verona Expectations for Care Scale (VECS) and the Verona Service Satisfaction Scale (VSSS) for measuring expectations and satisfaction with community-based psychiatric services in patients, relatives and professionals. *Psychological Medicine*, 23, 511-523.
- Schene, A. H., & Wijngaarden, B. v. 1995, A Survey of an Organization for Families of Patients with Serious Mental Illness. *Psychiatric Services*, 46(8), 807.
- Shera, W., & Delva-Tauliili, J. 1996, Changing MSW Students' Attitudes Towards the Severely Mentally Ill. *Community Mental Health Journal*, 32(2), 159.
- Smets, A. C. 1982, Family and Staff Attitudes Toward Family Involvement in the Treatment of Hospitalized Chronic Patients. *Hospital & Community Psychiatry*, 33(7), 573-575.

- Solomon, P. 1994, Families' Views of Service Delivery: An Empirical Assessment. In H. Lefley & M. Wasow (Eds.), *Helping Families Cope with Mental Illness* (pp. 259-274). USA: Harwood.
- Solomon, P., Beck, S., & Gordon, B. 1988, Family Members' Perspectives on Psychiatric Hospitalisation and Discharge. *Community Mental Health Journal*, 24(2), 108-117.
- Spaniol, L., Jung, H., Zipple, A. M., & Fitzgerald, S. 1987, Families as a Resource in the Rehabilitation of the Severely Psychiatrically Disabled. In A. B. Hatfield & H. P. Lefley (Eds.), *Families of the Mentally Ill: Coping and Adaptation* (pp. 167-191). New York: Guilford.
- Spaniol, L., Zipple, A., & FitzGerald, S. 1984, How Professionals Can Share Power with Families: Practical Approaches to Working with Families of the Mentally Ill. *Psychosocial Rehabilitation Journal*, 8(2), 77-84.
- Spaniol, L., Zipple, A. M., & Lockwood, D. 1992, The Role of the Family in Psychiatric Rehabilitation. *Schizophrenia Bulletin*, 18(3), 341-347.
- Spivack, G., Siegel, J., Sklaver, D., Deuschle, L., & Garrett, L. 1982, The long-term patient in the community: life style patterns and treatment implications. *Hospital & Community Psychiatry*, 33, 291-295.
- Stewart, J. A., Horn, D. L., Becker, J. M., & Kline, J. S. 1993, Postdoctoral Training Severe Mental Illness: A Model for Trainee Development. *Professional Psychology: Research and Practice*, 24(3), 286-292.
- Stricker, G. 1997, Are Science and Practice Commensurable? *American Psychologist*, 52(4), 442-448.
- Sumich, H. J., Andrews, G., & Hunt, C. J. 1995, *Handbook for the Schizophrenic Disorders*. Sydney, Australia: World Health Organisation Training and Reference Centre for CID.
- Tessler, R. C., Gamache, G. M., & Fisher, G. A. 1991, Patterns of Contact of Patients' Families with Mental Health Professionals and Attitudes Toward Professionals. *Hospital and Community Psychiatry*, 42(9), 929-935.
- Thompson, R., & Weisberg, S. 1990, Families as Educational Consumers: What Do They Want? What Do They Receive? *Health and Social Work*, 15(3), 221-227.
- Vicente, B., Vielma, M., Jenner, F. A., Mezzina, R., & Lliapas, I. 1993, Users' Satisfaction with Mental Health Services. *International Journal of Social Psychiatry*, 39(2), 121-130.
- Vicente, B., Vielma, M., Jenner, F. A., Mezzina, R., & Lliapas, I. 1993, Attitudes of Professional Mental Health Workers to Psychiatry. *International Journal of Social Psychiatry*, 39(2), 131-141.
- Warren, N. J. 1994, Training psychiatry residents and psychology interns to work with families of the seriously mentally ill. In H. P. Lefley & M. Wasow (Eds.), *Helping Families Cope with Mental Illness*. USA: Harwood.
- Wasow, M. 1994, Training future clinicians to work with families. In H. P. Lefley & M. Wasow (Eds.), *Helping Families Cope with Mental Illness*. USA: Harwood.
- Williams, B. E. 1988, Parents and Patients: Members of an Interdisciplinary Team on an Adolescent Inpatient Unit. *Clinical Social Work Journal*, 16(1), 787-91.
- Wynne, L. C. 1994, The rationale for consultation with the families of schizophrenic patients. *Acta Psychiatrica Scandinavica*, 90, 125-132.
- Young, J., & Oliver, I. 1997, Should mental health professionals show their feelings? *Psychiatric Rehabilitation Journal*, 21, 23-30.
- Zipple, A., Spaniol, L., & Rogers, E. S. 1990, Training mental health practitioners to assist families of persons who have a psychiatric disability. *Rehabilitation Psychology*, 35(2), 121-129.

Appendix II

Contact details of five professional bodies

Mental health nursing

Jon Chesterson

President

Australian and New Zealand College
of Mental Health Nurses
P.O. Box 126
Greenacres SA 5086
02 9807 2602 (phone/fax)

Social work

Ian Rentsch

Chief Executive Officer

Australian Association of Social Workers (AASW)
PO Box 4956
KINGSTON ACT 2604
02 6273 0199 (phone)
02 6273 5020 (fax)

Psychology

Dr Alison Garton

Executive Director

Australian Psychological Society (APS)
PO Box 126
CARLTON SOUTH VIC 3053
03 9663 6166 (phone)
03 9663 6177 (fax)

Psychiatry

Dr Robert Broadbent

Executive Director

Royal Australian and New Zealand College
of Psychiatrists (RANZCP)
309 La Trobe Street
MELBOURNE VIC 3000
03 9640 0646 (phone)
03 9642 5652 (fax)

Occupational therapy

Lin Oke

Executive Director

OT Australia
Australian Association of Occupational Therapists
(A.A.O.T.)
6 Spring Street
FITZROY VIC 3065
03 9416 1021 (phone)
03 9416 1421 (fax)

