3.5 Clinicians

Throughout this Review, clinicians consistently expressed a desire to provide the best possible care for patients, and to work to continuously improve quality of care and service provision. Clinicians expressed a repeated theme of dismay at resource shortfalls, management and governance issues, workforce shortages, increasing demand and prevalence of mental conditions. All intertwined to effectively prevent mental health workers from achieving their aims.

This Review acknowledges the mental health clinicians for their dedication and commitment for work performed in sometimes thankless scenarios of complex issues and volatile environments, observing that, while imperatives of professional skill and knowledge are important, a crucial ingredient is a strong desire to work within the public mental health system.

Clinicians described their colleagues as committed and patient centred and their teams as cohesive. Supporting the mental health workforce is an imperative that should be continually addressed, particularly if sustainable improvement in the delivery of mental health services is to be achieved.

A community visitor described the staff as having a ‘heart for psychiatric care’ although she said that staff are under pressure with staff shortages and there are not enough clinical psychologists and allied health staff to deliver recovery programs. These ‘shortfalls are about lack of resources, not lack of will’ (personal communication Community Visitor 2012).

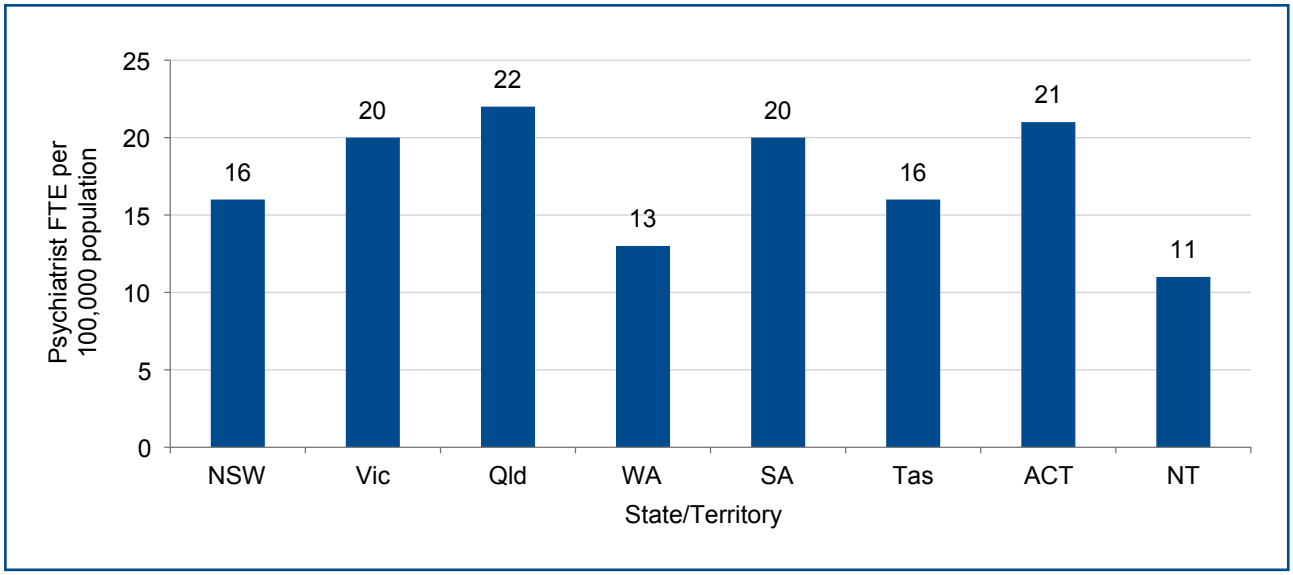
Adequate staffing and health professionals with sound knowledge and experience about mental illness are critical success factors to providing care in a safe environment within public mental health services. Clinicians describe their team members as competent and emphasised their ability to work well within a supportive model of practice. To keep up to date, clinicians attend regular peer review meetings and journal clubs and some participate in general hospital grand rounds.

A significant proportion of psychiatrists, particularly in the rural and remote setting, are overseas trained doctors working under the registration category of ‘in the Public Interest’ or in ‘Area of Need’. Under the national law of registration (AHPRA or Australian Health Practitioner Regulation Agency), only a limited number of medical practitioners can be registered in these categories, which in the next two years may pose very serious workforce issues.

Clinicians are acutely aware of the shortage of psychiatrists and nurses in the system. Compared to other Australian states, WA has the least number of mental health nurses and the second lowest number of psychiatrists per 100,000 population (AIHW 2012).

After Northern Territory, WA has the second lowest FTE per 100,000 population of employed psychiatrists and psychiatrists in training with 13.

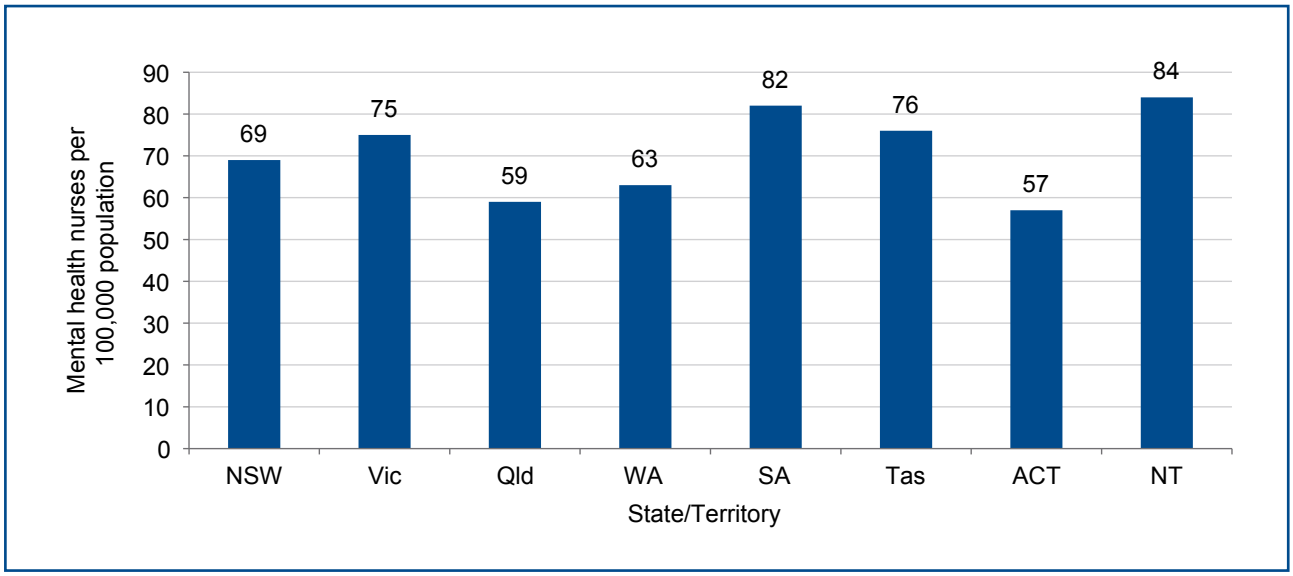
Figure 9 **FTE employed psychiatrists and psychiatrists in training in WA compared to other states and territories, 2009**



Source: AIHW Table 13.3 Medical Labour Force Survey (2009).

The nursing hours worked in mental health in WA was FTE 63 hours per 100,000. This is less than the national average of 69 FTE per 100,000 population.

Figure 10 **FTE employed nurses in WA compared to other states and territories, 2009**



Source: AIHW Table 13.12 Nursing and Midwifery Labour Force Survey (2009).

There is also an inadequate number of pharmacists. A pharmacist informed the Review that the standard national ratio of pharmacists to beds is 1:20. In mental health services, the allocation of pharmacists varies. For example, one 35-bed unit has three hours of clinical pharmacy per day, that is a 1:80 ratio. This limits opportunities for pharmacy medication reviews and education to patients about their medication regimes.

3.5.1 Workload and attrition

Clinicians informed the Review that inpatient beds are limited to patients requiring intensive care, such as those that are at risk of harm to self or others and those with symptoms that cannot be managed in the community.

Caring for patients with very high risk is stressful for psychiatrists and nurses; and patient throughput has increased. Additionally, adequate staffing requires the capacity to provide appropriate leave cover to enable staff to take leave when required. Currently, in many community mental health services psychiatrists do not have leave cover and there are also difficulties providing weekend cover because of low staff numbers.

These factors are likely to act to deter those who may otherwise seek employment within the public mental health services.

Maintaining a workforce capable of meeting the intense needs of acute mental health care requires concerted effort. High attrition rates and an ageing workforce require careful management along with effective succession planning. Twenty-five per cent of the nursing workforce and one-third of psychiatrists are aged 55 and over (AIHW 2012).

Sustaining safe mental health care with an appropriately trained and experienced staff in the remote areas of WA is currently addressed by a fly-in, fly-out or drive-in, drive-out model. In some regions, a community emergency response and after-hours face-to-face consultation cannot be offered. At times, staffing needs are met by clinicians in temporary positions and there is great concern in these areas that services are unable to meet the needs of all patients.

A fly-in, fly-out model provides experienced staff. However, the number of clinicians required for this model to succeed results in the patients meeting different psychiatrists at their appointments. Patients may be retelling their histories and it can be difficult for the clinicians to build trust. The mental health workers in most rural and remote areas engage the patient in therapeutic relationships, provide the after-hours care and use on-call consultant psychiatrists to provide advice and support.

Recruitment difficulties are also a significant problem affecting capacity of restorative services within the public mental health services in WA.

3.5.2 Staff training and professional development

The National Standards for Mental Health Services (2010) describe the requirement to recruit staff with the skills and capabilities to perform their duties. However, there are also requirements for the staff and the mental health service to ensure ongoing professional supervision, training and education (see Standard 8). This Review was referred to Queensland Health's work developing guidelines for clinical supervision (Queensland Health 2009).

Nursing workforce

There are 15,000 nurses working in Australian mental health services. However, specialties are not recorded by the Australian Health Practitioner Regulation Agency and no records are kept by AHPRA about post-graduate qualifications (CEO, Australian College of Mental Health Nurses; Assistant for Registration, AHPRA). The result is that the number of specialised practitioners in mental health services is unknown.

Enrolled nurses undertake TAFE certificate courses and graduate as comprehensively trained Division 2 nurses.

Division 1 Registered Nurses are university graduates with comprehensive qualifications enabling employment in the mental or general health services (personal communication CEO Australian College of Mental Health Nurses 2012). These nurses undertake a minimum three-year university course, including mental health theory and clinical placements. Nurses who choose to work in mental health are supported with a graduate program hosted at Graylands. Rather than obtaining experience in a range of mental health environments, the post-graduate course provides a six-month rotation within three specialties, for example, mental, surgical and medical health.

The Mental Health Nurse Education Taskforce aim to ensure that all nurses attain the knowledge and skills to recognise, understand and respond to the needs of patients with mental illness (Mental Health Nurse Education Taskforce 2008). Their report (2008) identified the need to strengthen the mental health content and clinical placements within pre-registration courses of Australian universities. The content has increased by 33 hours since 1999 and universities now provide an average of 254 hours of compulsory clinical placement and 149 hours of compulsory theory in mental health. Students can also select to major in mental health during their bachelor course. Post-graduate training for nurses varies in length, intensity and the type of qualification attained. These include the acute mental health courses and psychosocial intervention and recovery courses.

While Australian mental health nurses are comprehensively trained with a post-graduate qualification in mental health, nurses trained in the US, Canada or the UK have usually undertaken an undergraduate course focusing specifically on mental health care. In Australia, the practice of overseas-trained mental health nurses is restricted to mental health settings and they cannot practice in general medical or surgical care (CEO, Australian College of Mental Health Nurses; AHPRA, WA).

Clinicians expressed concern that student nurses on clinical placement often see the patient at their worst, rather than recovering, and few are attracted to a career in mental health nursing.

Clinicians commented that mental health nurses have little exposure to further education and there were few courses available. Further, attendance at professional education is hampered by lack of staff backfill, support and resources. Staff are concerned that when they attend educational sessions additional workload and stress is placed on their colleagues.

Mental health employees identified that it was difficult to find a supervisor who understands the complexities of their specialist roles and who is not a line manager to provide professional supervision and professional development.

Psychiatrists

Psychiatry training takes five years to complete with The Royal Australian and New Zealand College of Psychiatrists. Clinicians commented that services have difficulty retaining psychiatrists once they graduate and there is an influx of interns. Reasons provided include the high level of responsibility without clinical line management and supervision and the requirement to be on-call frequently.

As indicated, there is an increasing number of overseas-trained personnel who may not be recognised as psychiatrists until they obtain Australian qualifications. These doctors may also benefit from cultural training to better enable them to respond to questioning of their practice by carers and other health staff.

Training about legal matters, such as obtaining consents, assessing capacity, enduring power of guardianship, and advance-care planning with advance-care directives, are valuable skills in addition to knowledge of the Mental Health Act (personal communication S. Boulter, Mental Health Law Centre 2012).

Psychiatrists in rural and remote areas have clinical responsibility and are clinically isolated because there is no clinical leadership position or clinical line management. There is no clear single line of communication and it is difficult for the clinicians to find someone to provide supervision. They often need to use clinicians in the metropolitan area who are not familiar with the limitations of working in rural and remote areas.

A supervisory system should be encouraged that supports staff to manage and monitor the delivery of high-quality services and effective outcomes for patients. Clinical supervision as a formal process of support and reflection separate from individual performance appraisals is required for all mental health professionals. Such supervision needs to focus on the issues relating to and affecting clinical practice.

Regular protected time and confidential supervision can ensure clinicians are trained and supported in their practice within mental health. Novices may require one hour a fortnight while more experienced (more than five years) clinicians may need one hour a month (Queensland Health 2009).

3.5.3 Staff management

Unlike general hospital clinicians, mental health staff are not managed on the health campus in which they practice. Instead, they are governed by the Mental Health Area operational offices off-campus. The Review heard this disempowers the mental health clinicians and creates complex layers to obtain permission for any change and improvements. Clinicians are accountable to their discipline clinical lead concerning clinical matters and to the external operational division for line management.

Clinical mental health staff said they rely on their personality and personal relations with management staff in order to ‘get things done’. Lacking a clear model of management, the onsite mental health facility managers said they ‘were unable to communicate local resource needs and the scarcity of resources has depleted provision of restorative and preventative mental health care’.

The multilayered management presents onerous processes for clinicians who want to create improvements or to resolve a concern, the result of which is clinicians expressing a sense of administrative powerlessness—‘a throwing of the hands into the air’.

For example, to obtain access to PSOLIS, authorisations are required, and then the application is progressed up the bureaucracy to the data custodian of the Area Health Service for approval and this process can take over a month.

See Recommendation 1: Governance (1.1.5; 1.1.6; 1.1.7); Recommendation 4: Clinicians and professional development; and Recommendation 8: Children and youth (8.6.4; 8.6.5).