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Public Consultation on an Emerging Mental Health Curriculum Framework for Undergraduate Health Degrees

Submitted Online Via the Department of Health and Aged Care Consultation Hub

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Introduction

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 11,000 people with lived experience of mental health concerns across Australia. This includes lived experiences with all parts of the mental health care system, NDIS, psychosocial disability support outside the NDIS, PHN commissioned services, public and private service options, and service provision across urban, regional, rural and remote Australia. All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care and psychosocial disability support services and support across the lifespan, across the whole Australian health and social care system, including within State and Territory jurisdictions.

We welcome the opportunity to provide our feedback to this consultation.

Background & Purpose of this Consultation

The Department of Health and Aged Care has commissioned Deloitte to provide *recommendations* to support the development and implementation of a mental health curriculum framework for undergraduate health degrees.

The focus of this work is on health and allied health professions who do not usually or primarily work in specialised mental health roles, and who have an expected or required level of undergraduate training. The health professions in scope include - nursing, midwifery, occupational therapy, paramedicine, pharmacy, oral health, optometry, physiotherapy, Aboriginal and Torres Strait Island health practitioners, nutrition and dietetics, social work, exercise physiology, speech pathology.

Deloitte's review of published and grey literature and preliminary key stakeholder consultations have determined that:

- There is limited evidence of specific mental health related curriculum or competency requirements across existing accreditation and professional standards for each health profession.

- Most references to mental health relate to practitioners managing their own mental health to ensure fitness to practice. Student access to resources and support is also commonly stated.

- Where available, references to mental health are often vague and framed as promoting 'wellbeing' or working with those with 'mental health challenges' without further specification. In contrast, the majority of accreditation and professional standards provide more detail on related constructs such as cultural competence and safety, and interprofessional collaboration and practice.

- There is a recognition that education and training need to respond to increased health service pressure, increased mental health presentations in non-mental health settings, and increased prevalence of mental health concerns across the population.

- There is general agreement that the current level and focus of training is not sufficient to meet consumer needs.

- There is some disagreement as to whether content should be integrated across the curriculum or delivered as a dedicated unit.

- There are concerns that differences across health professions in their terminology, approach to care (e.g., medical models versus social models), and conceptualisation of mental health risk becoming diluted in any move to standardised content were expressed.

Our Responses to the Consultation

1. What activities would be needed to support the development of any mental health curriculum framework?

We would hope that inclusion of Lived Experience perspectives and experiences of contact with and receipt of services and support from these professional groups are central to any mental health curriculum framework.

Lived Experience Australia has undertaken many projects from a Lived Experience perspective asking people about their experiences at the interface of contact with health services and health professionals. Our most recent example is a national survey, with the questions co-designed with people with personal and family/carer Lived Experience of mental health challenges and oral health, and the analysis also informed by them. You can download the report and infographic from https://www.livedexperienceaustralia.com.au/oral-health.

Among its many findings, this survey completed with 234 people across Australia found a number of concerning issues that would clearly inform curriculum competencies for oral health, as an example group in scope for this current consultation:

- Half of consumers said anxiety and past trauma prevented them from visiting the dentist. One-third avoided dentists due to self-stigma and shame.
- Felt oral health concerns were not taken seriously by dental staff.
- 30% of consumers reported experiencing stigma or discrimination from dental staff.

Likewise, our national survey on Loneliness and Mental Health offers many insights for curriculum development for many groups across the workforce in scope for this current consultation. You can download the report and infographic from https://www.livedexperienceaustralia.com.au/loneliness

2. What types of mental health-related competencies should be included in any mental health curriculum framework (noting these should apply to all health professions in scope)?

'Person-centred care' and 'putting the person at the centre of health care' are commonly used terms with many documents, including curriculum frameworks. However, translating this rhetoric to practice is the challenge. It is likely more helpful to unpack competencies that underpin such terms. We believe that Human Rights is a useful framing, and 'everyday' Human Rights are crucial competencies because it is the many micro-aggressions that play out for people with mental health challenges during their interactions with services and health professionals that are important, regardless of the rhetoric of person-centredness. These micro-aggressions can be seen in implicit (and disappointingly explicit) assumptions about people's capacity, literacy, ability to provide consent, stigmatising behaviours towards the person, infantizing the person in the presence of family/carers/kin and paid support workers, and so forth.

3. What are some effective ways to teach mental health-related competencies in undergraduate education and training settings?

From my own experience of delivering post-graduate and undergraduate education to medicine, nursing and the multitude of allied health professional disciplines, and similar professional development to the existing workforce across all of these disciplines for 15 years within a university environment, it is clear that teaching them about mental health-related competencies must include Lived Experience educators. This has powerful positive impacts on learners because it challenges their potential negative assumptions, it helps to address potential stigma and discrimination, and it provides them with practical ways to translate the rhetoric of curriculum concepts into real world practice.

4. Do you have any considerations in relation to interdisciplinary training or practice that could have implications for this piece of work?

There is significant evidence already for the benefits of Interprofessional Education (IPE) and Interprofessional Practice (IPP). This includes their role in building team cohesion versus professional hierarchies, misunderstanding and 'culture wars' between the various disciplines, often played out in the field of practice. Health care systems are significantly impacted by poor interprofessional working relationships, with fragmented care, gaps, differences in assessing what the person needs, and many other issues played out, to the detriment of the person who is attempting to seek help and navigating these services. For people who experience mental health challenges, these impacts can be compounded by low mental health literacy of the workforce, stigma and discrimination, and so forth.

5. What activities would be needed to support the implementation of any mental health curriculum framework?

Leadership from universities across their teaching and learning would be important. These environments already have policies and practices that focus on supporting students with disability. They also have a focus on establishing Reconciliation Action Plans (RAPs) to sustainably and strategically take meaningful action to advance reconciliation for First Nations communities. They could take a similar approach, potentially, to focus on mental health which would then strategically impact all of their education programs, rather than leaving this to be variously taken up, championed or ignores across a multitude of individual programs, universities/education environments, and systems.

6. What else might be happening in your sector/area of expertise that could have implications for this piece of work?

The growing influence and uptake of the Lived Experience (peer) workforce is an important consideration that may impact and be important for this group of health professionals to understand better. LE peer workers are likely to interface with many of these disciplines in their day-to-day roles in the community walking alongside people with mental health challenges as they navigate their holistic health care needs, including those beyond mental health specialist services.

There is a growing body of evidence and literature on this important workforce, including our own literature review undertaken for the Department of Health and Aged Care in 2024 to inform the 'Unleashing Workforce' work being undertaken by them. You can download the report here https://www.livedexperienceaustralia.com.au/_files/ugd/907260_285b20e189694d0488735e2d39970914.pdf

7. **(Re- lived and living experience / carers and families)** Are there any things that you think need to be considered for this work, based on your own lived or living experience in the health and care and support system?

There are many things that need to be considered:

Ironically and sadly, many people with mental health challenges experience more stigma and discrimination, coercion and trauma as a consequence of their contact with mental health specialist services. Experiences of interactions with health professionals who sit outside these services and make up those in scope for this current consultation can actually be less stigmatising and discriminatory, seeing people as people first. There are likely many reasons for this. Care in developing the curriculum framework must therefore be careful not to take on the negative and narrow views that can pervade mental health services. Please ensure that you do not rely solely on the voice of mental health clinical expertise which can be dominated by deficits language and illness-driven understandings. Please include the expertise of Lived Experience.

It is also important that the competencies have a strong focus on understanding the impacts of trauma, stigma experiences and anticipatory stigma on help-seeking and interactions when people are in contact with the professions in scope here. Past experiences of services can very much impact a person's sense of trust in systems of support, especially if their dominant experiences have been of being let down or traumatised within services. Trauma can express itself as distress, anger, fear, shame, disengagement and not turning up for planned appointments. These are valid LE responses that need to be understood with humanity, respect, tolerance and compassion.

Many people with LE of mental health challenges have and continue to experience disempowerment in their interactions with services and health professionals. These experiences can reinforce trauma. Therefore, inclusion and inclusion of the person's family/carers (where they want this), consent, autonomy and self-determination, access to information and knowledge, supported decision-making (where relevant), and many other fundamental human rights of any person are even more important to them.

Contact

We thank you for the opportunity to put our views forward. We wish you well with the next steps and would be pleased to contribute our Lived Experience perspectives to any future discussions about this important topic.

Your sincerely

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