Submission on the Draft National Practice Standards for the Mental Health Workforce

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Executive Summary

- The National Practice Standards (NPS) draft document is seriously flawed as it potentially leads to the perception of devaluation of the skills and knowledge base already extant in the disciplines described.

- Enshrining such attitudes about eg psychiatry in such a document will lead to the dangerous potential for this to be interpreted as a blueprint for the introduction of the concept of "the generic mental health worker" - this has the potential to be used as a "training module" for the politically inspired introduction of a supposedly cheaper workforce.

- The omission in this draft of the role of government in facilitating service delivery by appropriate legislation and policy is of serious concern.

- Mental health standards are primarily the responsibility of governments (in consultation with the profession) to provide the resources and systemic potential for mental health professionals to practice in an ethical and competent manner in co-operation with patients, families, and carers. The draft seems to omit this.

- Alternative recommendations are made to address the issues which most affect the practise of clinical and ethical psychiatry.

- It is suggested that this draft be more widely circulated for more thorough reconsideration.

Foreword

The draft National Practice Standards for the Mental Health Workforce (NPS) is being circulated for feedback by 22 February 2002. It was developed by the National Mental Health Education and Training Advisory Group (NMHETAG) which was to review international trends in the area. The NMHETAG is an offshoot of the Australian Health Ministers Advisory Council (AHMAC) National Mental Health Working Group.

Although the NPS document is intended to be aspirational, this draft together with the concept of National Standards, is severely flawed and problematic. While attempting to set standards this document arguably devalues the skills and knowledge base already extant in the disciplines described, and in psychiatry in particular, in that its standards seem to fall short of those existing in psychiatry training for example. Whilst advocating for the attainment of reasonable attitudes is laudable, the prescription of this in bureaucratically inspired ways which ignore current political reality makes its contents appear divorced from clinical practice. This together with advocating for a lower standard than already exists, limits its value.

Further, enshrining the perception of devaluation of the role of individual workers in psychiatry in such a document will lead to the dangerous potential for this to be interpreted as a blueprint for the introduction of the concept of "the generic mental health worker". The potential misuse of such reports/draft documents is not new, as evidenced by the denigration of psychiatry contained in such reports as the Solomon, Buckingham, Epstein Report, the MacKay Report etc.

We cannot overstate our concern that the NPS has the potential to be used as a "training module" for the politically inspired introduction of a supposedly cheaper and workforce – whose lack of expertise and skill will lead to poorer quality care and outcomes. This of necessity will eventually lead to an explosion in other health costs.

Specific Critique

Important omission in NPS

The NPS draft document is seriously flawed because it seemingly ignores /omits other current policy recommendations that aim at devolving clinical responsibility away from psychiatrists. The perception of collusion with a managerially inspired agenda is evidenced by an arguably undue emphasis on "managing" and "teams" across a number of inter-related disciplines, but which ignores the individual expertise of each. That this will facilitate the introduction of generic mental health workers is a critical issue.

For example, the NPS fails to reference recommendations already in existence for moves towards generic mental health workers. In NSW, Northern Sydney Health is considering the following recommendations (underline added):

> *"Closely review the current staffing mix throughout the Area and Sub Area services. Identify ways to most effectively use professional expertise, to reduce single-discipline dependency, and to increase the number of technical level staff."*[1]
>
> *"Examine closely the current roles and utilization* (sic) *of psychiatrists and registrars through out the service system and identify areas in which greater efficiencies could be achieved without sacrificing consumer outcomes."*[2]
>
> *"Wherever possible, shift to hiring for position, rather than discipline."*[3]

In the current political climate, the promulgation of draft documents that seemingly support the prescription of managerialism, and thereby reduce the scope for clinical judgement and autonomy, must give pause for serious and thorough consideration.

NPS Foreword

Lack of evidence

The primary thrust of the NPS Foreword is to make the case that Practice Standards for the mental health workforce are needed and desired – but no evidence is given for such a need. Its only assertion is that

> *"Few countries take a high level strategic approach to the problems of developing and sustaining a mental health workforce but some common trends were identified."* [4]

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[1] Curtis, LC. *Psychiatric Rehabilitation in Northern Sydney Area mental Health Services: A Review and Analysis of Systems Performance*. North Ryde, NSW, Australia: Northern Sydney Health, Area Mental Health Services. 2001. pg 31.
[2] *ibid*. pg 31.
[3] *ibid*. pg 31.
[4] National Mental Health Education and Training Advisory Group (NMHETAG). *Draft National Practice Standards for the Mental Health Workforce*. August 2001. pg 3.

It might be argued that these countries are acutely aware of the potential pitfalls in duplicating standards already contained within the core competency standards of mental health disciplines, and of attempting to generalise across a range of professions.

Assumed expectation of uptake of Standards

The NPS Foreword makes much of the "expectation" that these Standards will be used by educators. Firstly, this devalues what specific disciplines like psychiatry already do in this area. Secondly, it promotes a "big brother" mentality in an area already struggling to attract trainees and retain expertise. Thirdly, it potentially implies that anything not meeting expectations might not be acceptable - a kind of "thought police" concept.

Consumers not Patients to educate mental health workforce

The terms "consumer" and "patient" are not the same. The use of such language colludes with a managerialist view that medical services can be treated as a commodity, which in turn ignores the centrality of the doctor-patient relationship and fosters poor quality care.

The NPS document states

> *"It is also expected that all members of the mental health workforce and undergraduate and postgraduate students will have opportunities to be educated by mental health consumers, their family members and carers about their 'lived' experiences of mental illness…"*[5]

That emphasis should be put on being "educated" by consumers as opposed to patients regarding their "lived experience" is extraordinary given the psychiatric profession's continued protest at current government policies that deliver rationed access, inequity and a significant amount of emotional suffering to patients so affected.

For example, feedback from "consumers" (patients) and their families in the private and public systems regarding their experience of deficiencies in care delivery have repeatedly been ignored. Specific examples include a lack of access to public sector treatment via public hospital beds and outpatient clinics; difficulties in follow-up care in public systems; and lack of continuity.

Restrictions to intensive psychiatric outpatient treatment due to government restrictions to Medicare rebates has also added to the increased burden being shouldered by the private system in response to policies seemingly aimed at running down the availability of expertise in the public arena. This particular lived experience and its implications is not addressed in the NPS document.

[5] *ibid.* pg 3.

Government role

That the NPS document ignores the need to redress the larger political framework in order to promote ethical standards of practise is of grave concern.

This issue implies that it needs to be made explicit in any document that government has a role to play in facilitating an environment in which standards can be met, clinical autonomy maintained, and the primacy of the doctor-patient relationship safeguarded.

Dismissing the role governments play in facilitating service delivery colludes with the notion that such services are not the true responsibility of elected governments.

Introduction

Reform agenda

When the draft NPS states

> *"The* Standards *provide a benchmark for the levels of practice recommended for the mental health workforce in the 21st century."*[6]

there is uncritical promotion of the view that this will improve outcomes for patients. No supporting evidence is given other than the assertion that the NPS continues the thrust of the National Mental Health Strategy (NMHS).

In fact, the NMHS was criticised for not addressing the needs of people with the whole range of debilitating and pervasive disorders. There is little evidence that the NMHS has improved outcomes across the board to the degree once expected, and the existence of rationing mechanisms and funding shortfalls now compounds this failure.

Generic mental health worker

When one general set of standards of practice is aimed at a variety of different professional groups, we question on what basis, and for what purpose, these standards have been devised considering that each group's needs differ, in many cases to a large degree.

Throughout the draft, the term "mental health practitioner" is used. Clearly the NPS document is referring at all times to workers in several disciplines (psychiatry, nursing, social work, psychology and occupational therapy).

The language, however, betrays the existence of the concept of the "***generic mental health worker***", with its potential for political manipulation and the downgrading of expertise. NAPP has documented[7] elsewhere the evidence from national and international research that shows the positive cost savings achieved by providing access to the full range of psychiatric services.

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[6] *ibid*. pg 6.
[7] Submission to Medicare Benefits Consultative Committee.

NAPP finds it difficult to avoid the conclusion that the agenda for reform, as proposed in the draft NPS, is an attempt to reduce the mental health workforce to a common denominator, which can only lead to the demoralisation of the professional groups and to an environment of de-skilling.

The NPS claim that

> *"The* Standards *focus on the knowledge, skills and attitudes required by all members of the mental health team, regardless of their profession."*[8]

Psychiatry educators (at least) might be very curious about the proposition that these issues are supposedly not addressed in current curricula, and of the proposition that *"benchmarks for levels of practice"*[9] are needed.

Certainly, the NPS's references to the need by some workers to "*upskill*"[10] to meet the Standards does little to allay fears that the political agenda here might be to downskill expertise in favour of generic mental health workers.

Doctor-patient relationship

It is curious that the NPS feels the need to espouse the importance of "*The relationship between consumers and service providers…"*[11] and *"…lived experience of consumers…"*[12] reiterating principles of workshops emphasising the need to change mental health workers' attitudes.

These concepts, once taken for granted, are core values which lie are at the heart of the doctor-patient relationship, integral to the practice of medicine and more particularly psychiatry, but which have now fallen into disrepute under persistent governmental and third party attack and managerialism.

Target groups and Development

Consultation

It is difficult to reconcile our view of the general lack of awareness amongst Fellows in the Royal Australian & New Zealand College of Psychiatrists (RANZCP) of the existence of this draft, with the document's stated assertions that it was compiled in consultation with professional associations.

> *"…the* Practice Standards *have been drafted in consultation with representatives of each of the five national professional associations or*

[8] NMHETAG. *op cit.* August 2001. pg 6.
[9] *ibid*. pg 6.
[10] *ibid*. pg 6.
[11] *ibid*. pg 6.
[12] *ibid*. pg 7.

> *colleges of social work, psychiatry, psychology, mental health nursing and occupational therapy."*[13]

NAPP is of the view that RANZCP Fellows have not been made aware of the work of NMHETAG, let alone the production and political ramifications of the draft NPS document.

It is extremely worrying that the NPS draft, given the current political focus on deskilling, de-professionalisation, outsourcing, and reduced government funding, should be promulgated ***as if it has*** been endorsed by RANZCP Fellows. We question whether the seemingly limited consultative process is sufficient at such critical times. We would argue that wider consultation should be mandatory.

Implementation

The potential for political misuse, for increased bureaucratisation and control, and for the further restriction of training and practise is evident in the section on Implementation, with its anticipation that the NPS will used to:

- *guide clinical supervision, mentoring and continuing education;*
- *accredit services;*
- *develop undergraduate and postgraduate curriculum;*
- *credential mental health practitioners.*[14]

Where the NPS draft refers to "developing standards of practice" in order to

> *"…offer a tool for service providers and managers in relation to organizational management, supervision, business planning and performance management."*[15]

NAPP is concerned that this will facilitate the introduction of increasing bureaucratic control over the clinical responsibilities and autonomy of psychiatrists, and other mental health professionals.

NAPP finds the omission of any reference to the role of government in supporting ethical practice and standards worrying in the light of current policy.

The potential for service providers to feel impelled to collude with bureaucratic agendas if their accreditation hangs in the balance is of grave concern.

[13] *ibid*. pg 7.
[14] *ibid*. pg 8.
[15] *ibid*. pg 8.

Practice Standard 1

Privacy and Confidentiality

NAPP wonders as to the need for a standard on Privacy, when this is part of standard medical training and practice, and when this has further been enshrined in recent privacy legislation under the Privacy Amendment (Private Sector) Act. Suffice to say that the public sector already had a similar legislative framework for privacy in place.

> *"People with mental disorders and/or mental health problems have the right to … have their privacy protected and their documentation treated in a confidential manner."*[16]

It can readily be argued that the assumption which Practice Standard 1 makes, with no evidence, is that psychiatrists and other mental health professionals do not protect the privacy of their patients.

In practice, this Standard ignores that in reality it is impossible to "*ensure*"[17] privacy and confidentiality of those patients who, for example, receive funding via Medicare Item 319. To achieve a higher probability of privacy and confidentiality requires removal of stigmatising and exposing criteria.

Similarly, the special authority PBS system requires that a patient's diagnosis be given to an unknown third party via telephone. This is clearly a breach of privacy and confidentiality.

Further, this Standard does not consider the issue of confidentiality in regard to the special case of the child or adolescent. Experience shows us, when adolescents are being dealt with confidentially in the public sector, that their parents are not notified about what is going on. However, what becomes of the patient when it is patently obvious that the adolescent is out of control and needs family containment? The inclusion of this Standard might well lead to poor outcomes in these cases.

Evidence based

The NPS document asserts that mental health practitioners understand the

> *"Appropriate use of evidence-based interventions and treatments."*[18]

This assertion leaves the way open for managerialist definitions of what constitutes appropriate evidence. As with all open ended systems, this can arguably be open to abuse and the promotion of a devaluation of clinical judgement and autonomy. This in turn will lead to deskilling and make for poorer outcomes from an increasingly disillusioned workforce.

The concept of evidence-based medicine (EBM) is itself problematic in our current health system. The links between the health financing system and health care delivery

[16] *ibid*. pg 11.
[17] *ibid*. pg 11.
[18] *ibid*. pg 11.

make unavoidable the ever-present risk of political manipulation based on claimed economic imperatives (real or imagined).

EBM arguably puts clinicians in ethical dilemmas because in some areas, the sort of evidence demanded is difficult to obtain if limited to the results of double blind randomised clinical trials – even if we could be certain that all these trials are truly objective and scientifically valid, which we cannot.

The selection of outcomes may not give adequate weight to other factors that patients, or the public generally, regard as important. This is particularly relevant for conditions that lead to chronic ill health rather than early death, where the full experiences of sufferers, over long periods, is difficult to capture in a simple outcome measure.

This view cannot be seen as anything other than realistic in the light of the current EBM debate[19], and how the concept was used to arguably influence the introduction of Medicare Item 319 and associated restrictions in order to ration access to treatment.

Safety

Unfortunately, it is impossible to "*ensure*"[20] the safety of patients, their relatives or their carers.

Inclusion of this aspect of Practice Standard 1 may result in unrealistic expectations of the mental health professional and thus lead to a potentially significant increase in litigation when there has been patient assault, murder or suicide or some other safety related incident. Medical litigation is already a huge financial burden on medical practitioners, as reflected in current debate over rising premiums.

It is possible, however, to increase the probability of patient safety if there are significant changes to the mental health system. Such changes may include:

- Removal of barriers to hospital admission of patients when recommended by a doctor, eg CAT team assessment. (This will also increase the probability of patient safety.)
- Architecturally separate and secure bedrooms for male and female patients to reduce risk of rapes, murders and other assaults in hospital.
- Adequate funding of positions for hospital staff, commensurate with responsibility.
- Appropriate non-stressful workloads on staff to increase morale, decrease burnout and reduce risk to patient safety.

Expertise needs to be explicitly valued and recognised. Models of health care which allow a deskilling of the workforce only lead to high staff turnover due to

[19] Simon R Tomlinson. Kerry J Breen. Malcolm H Parker, Chris B Del Mar. Paul P Glasziou Lucie Rychetnik. Stephen R Leeder. Ethics and evidence-based medicine**.** *Medical Journal of Australia*. 2002; 176: 137-139.
[20] NMHETAG. *op cit*. August 2001. pg 11.

dissatisfaction. This in turn compromises safety for staff and patients and leads to poor outcomes, poor care, and increased costs.

Practice Standard 2

Consumerism

This Practice Standard reads as follows:

> *"Mental health practitioners encourage and support the participation of consumers in determining their individual treatment and care. They also actively promote, encourage and support the participation of consumers, family members and/or carers in the planning, implementation and evaluation of mental health service delivery."*[21]

Whilst the importance of consumer and carer participation is acknowledged, we cannot ignore that this Practice Standard seemingly puts the entire burden and responsibility for planning and implementing service delivery on the shoulders of psychiatrists and consumers / patients. No mention is made of the critical role governments play in facilitating these by appropriate policy decisions.

For example, the NPS draft states that practitioners/workers should

> *"Value the role of consumers, family members and carers in educating mental health practitioners about their disorder, their requirements for adequate services and support, and their ability to work in partnership with practitioners."*[22]

This standard colludes with current political trends that absolve governments of their responsibilities to their constituents. Medical care does not take place in a political vacuum.

The reality is that in many cases patients do not seek active participation in determining their individual treatment and care. Similarly they may decline that others, family and carers, be made aware of such treatment. What legal issues does this raise for the clinician? What legal obligation has a doctor to third parties not involved in the doctor-patient relationship? These questions remain unanswered in the draft.

Further, practitioners seem to be impelled to

> *"Participate in implementing government policies on consumer and carer participation."*[23]

[21] *ibid.* pg 13.
[22] *ibid.* pg 13.
[23] *ibid.* pg 14.

It might appear that practising psychiatry becomes compromised by becoming an agent of government policy directives. It is clear that many dilemmas would face those practitioners who refused to comply with government directives which were not, on their assessment, in the best interest of patients. Whether this in turn would lead to credentialling being threatened remains a worrying possibility.

Team Work

The NPS states that mental health practitioners are able to

> *"Work as a team member in conjunction with other specialist mental health practitioners."*[24]

NAPP acknowledges the need for this in certain settings (eg child psychiatry & public hospital psychiatry) as dictated by clinical need, but we cannot agree that this should be enshrined in the draft given its potential to be used to reduce clinical autonomy. The potential is for this directive to undermine the importance of the doctor-patient relationship, rather than enhance it, by virtue of the implication that case management by teams might come to be seen as best practice in all settings.

Practice Standard 4

Although a broad education is clearly desirable across disciplines, NAPP cannot identify the rationale for this Standard, with its objectives to have all workers be able to identify signs and symptoms, understand pharmacology, understand medical issues and comorbidity. This Standard invites the concept of generic mental health workers, with all the attendant concerns it evokes.

Each discipline might emphasise differing aspects of medical education that impinge on their core competencies and practice – but this already happens in current curricula, and the potential for political misuse remains high if everyone is going to supposedly be able to do everything (and do it well?).

Also, it is not possible to "apply" knowledge to patient care in the absence of adequate resources eg hospital staff, funded psychiatric beds, direct access to psychiatric beds, funded intensive psychiatric treatment.

Practice Standard 5

Prevention requires changes to corporate and government policies. Corporations and governments are not mentioned in this Standard. The applicability of such a Standard without such assessment is of little value.

[24] *ibid.* pg 14.

Practice Standard 6

This Standard replicates the errors of the previously mentioned NMHS in seemingly focussing mainly on the serious mental illness end of the spectrum of disorders, and saying little about the equally large burden placed on the community by debilitating and pervasive disorders such as personality disorders, and comorbidity issues.

The concern is evidenced by an overemphasis on "evidence based strategies", an overreliance on "clinical practice guidelines" (whose usefulness and pitfalls are a matter of recent debate), and "risk reduction programmes". To be sure, the latter have their rightful place - the former are cause for serious concern due to their intrusion into the way psychiatry is being practiced.

Professor Richard Smallwood, an advocate of guidelines, says of guidelines:

> *"Guidelines must never supplant clinical judgements; "even good evidence can lead to bad practice if applied in an unthinking or unfeeling way". Rather, they should provide the base from which expert clinicians will obtain helpful guidance for their clinical interventions."*[25]

NAPP is aware of recent moves by the RANZCP, currently being implemented, to move away from the use of prescriptive guidelines and move toward accumulating evidence as information only. That the NPS draft makes no mention of this development leads us to question the credibility of consultative processes in formulating this document.

Practice Standard 7

The notions present in this Standard that mental health practitioners

> *"…provide or ensure that consumers have access to a high standard of evidence based assessment, treatment, rehabilitation and support services which prevent relapse and promote recovery. They monitor the appropriateness and effectiveness of interventions."*[26]

are inherently open to manipulation. Those seeking to justify economic adjustment to mental health funding can potentially alter the level of "evidence", "appropriateness", and "effectiveness" to suit their purpose. This is simply unacceptable as it provides no safeguard for patients.

The NPS does not acknowledge that "*Assessment, Treatment, Relapse Prevention and Support*"[27] are already catered for in professional development and the practise of ethical psychiatry. To suggest otherwise is a devaluation of current training, which will not improve patient outcomes, one of the purported aims of the NPS draft.

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[25] Smallwood, R. A. & Lapsley, H. M. Clinical Practice Guidelines: To What End? *The Medical Journal of Australia*. 166:11. 592-595.
[26] *ibid*. pg 26.
[27] *ibid*. pg 26.

Practice Standard 8 - 9

These standards emphasise a perceived need to "promote integration" and "develop partnerships" and "ensure the delivery of coordinated and integrated care". NAPP cannot support this.

Whilst we can see that these notions might be superficially appealing, nevertheless our view is that previous attempts have been made to introduce differing versions of "coordinated care" - and that this is antithetical to the practise of ethical psychiatry.

Co-ordinated care strategies have been criticised elsewhere[28] by NAPP, due to the over reliance on third party funding models, reduced clinical autonomy, and an overemphasis on (the more costly) case-management by teams who are not directly responsible for patient care.

Practice Standard 11

Quality assurance

NAPP cannot support the notion that every practitioner monitor and evaluate practice in the seemingly bureaucratic way described under "rationale" for this Standard. This may be performed by researchers, trials, surveys etc but the business of clinical psychiatry is difficult enough without a compulsion to evaluate, at scientific research levels, at the same time as one is treating.

Ongoing professional self improvement aims to ensure that psychiatrists are constantly evaluating their work against their peers, research, and patient response. To suggest otherwise, is simply to ignore the ethical principles of the profession *viz*: Principle 7 of the RANZCP Code of Ethics

> *"Psychiatrists shall continue to develop their professional knowledge and skills and share these with colleagues."*[29]

This Standard leaves the way open for the introduction of third party interference which will then dictate what constitutes "excellence" or "benchmarks to be funded" or "best outcome".

Matters such as what constitutes "best outcome" or "best treatment" are matters of clinical practice and judgement, able to be modified as part of ongoing professional development if need be. The dangers of such bureaucratising of the idea of evaluation would seem to be self-evident given the expressed political stance by some funding bodies that managed care strategies are highly desirable.

[28] Submission on Integrated Mental Health Trials.
[29] http://www.ranzcp.org/fellows/code3.htm#7

Conclusion

There is seemingly an implicit belief in health bureaucracy that high standards of clinical practice can be achieved by issuing top down directives to medical practitioners ie quality by edict.

Demming[30], in discussing the issue of quality assurance, claims that innovation and excellence emanate from the bottom up – by people who are enthused and encouraged to achieve high standards.

The draft NPS fails in this regard because of the assumption that clinicians are the barrier to developing a greater range of mental health services. This assumption needs to be made explicit. Furthermore, the document would have consumer groups, not patients, as a focus of response by clinicians when clinician training is clearly to respond to the needs of the patient population within the bounds of the doctor-patient relationship.

The authors of the NPS draft arguably add only to a growing confusion, which inevitably will bring with it a legal confusion, over what exactly will be defined to be the extent of a duty of care, and who will be responsible for it.

In order that our comments might be seen in the light of broader community and professional concerns, we can note the view expressed by Zeev E Neuwirth, MD, Attending Physician; and Clinical Associate Professor of Medicine, New York University School of Medicine, that

> *"Patient-care surveys reveal a steady decline in public satisfaction with medical care."*[31]
>
> *"The personal care that a doctor, nurse, social worker and every other healthcare professional offers to his or her patients on these multiple levels cannot be scripted, packaged, or coded."*[32]

Whilst the author of this article describes how compassionate behaviour in practice is extinguished by the rewarding of "academic acumen, technical knowledge and business savvy", similar concerns have been voiced by members of NAPP elsewhere.[33]

In other words, we need to acknowledge that we live in a policy culture where it is increasingly difficult to have the importance of humanistic relating valued as an integral part of medical/psychiatric practice. Indeed it is that part that is vital in psychiatric treatment and evaluation, and it is that part which is increasingly ignored by policy makers. It cannot be prescribed or "packaged" but the appreciation of it must be facilitated by teachers steeped in their discipline, and governments in formulating overarching policy direction.

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[30] The father of quality assurance.
[31] Neuwirth, Zeev E, MD. Reclaiming the lost meanings of medicine. *Medical Journal of Australia*. 2002; 176: 77-79.
[32] *ibid*. pg 78.
[33] Psychiatrists Working Group (Ed). *She STILL Won't Be Right, Mate!* Psychiatrists Working Group, Camberwell Victoria, Australia. 1999.

NAPP views with increasing concern the quiet promulgation of documents such as the NPS draft, given its emphasis on bureaucratising of practice, seeming devaluation of professionalism, and the obvious danger inherent in the concept of the "generic mental health worker". The latter has already become problematic given anecdotal evidence, from Sydney, which describes the introduction of generic workers at Coral Tree House child psychiatric unit, and the consequent staff dissatisfaction and resignations.

Mental health practitioners, patients and their relatives are powerless to influence treatment if there is no access to appropriate treatment because of lack of funding for assessment/treatment and appropriate staffing.

Recommendations

NAPP makes the following suggestions, related to both the public and private mental health sectors, in view of our stated aim in advocating for equity and access to the whole range of clinical treatments and strategies.

1. Realistic mental health standards cannot be developed in isolation of the political environment and government. This provides the majority of resources and systemic potential for mental health professionals to practice in an ethical and competent manner in co-operation with patients, families, and carers. Acknowledgement of this role and how it may impact on any Practice Standards for mental health practitioners needs to be included.

2. Explicit acknowledgement is required to state that differing levels of seniority, expertise and training, all combine to make up the complexity of good quality medical care. Diversity should be encouraged rather than diminished.

3. That there be a thorough reconsideration of this document in the light of the considerable misgivings expressed above, and that it be widely circulated amongst the medical and allied health professions for further comment and debate.