



**SIGGINS MILLER**

**National Mental Health Workforce Strategy**

Draft 6



## **Aim**

To develop and support a well led, high performing and sustainable mental health workforce delivering quality, recovery-focussed, mental health services.

## **Strategic directions**

**Objective one:** To develop, support and secure the current workforce.

**Objective two:** To build capacity for workforce innovation and reform.

**Objective three:** To build supply of the mental health workforce.

**Objective four:** To build capacity of all health and community service providers to work effectively with people living with mental illness across the lifespan and with their carers, families and communities.

**Objective five:** To collect accurate, timely and quality data on Australia's mental health workforce with well designed and integrated data collection systems.

## **Preamble**<sup>1</sup>

### ***The impact of mental illness***

Mental illness or disorder profoundly affect an individual's social, emotional, psychological, physical and cognitive wellbeing, and can have major consequences for the health and wellbeing of carers, families and communities. One in five Australians experience symptoms of a common form of mental disorder (anxiety, affective or mood disorders, substance use disorders) in any 12 month period, while about 45% of Australians will experience a mental disorder during their lifetime. Some 2.5% of the population is affected by severe and persistent mental illness, and often require many services over a long period.

Individuals experiencing mental illness, and their carers and families are at higher risk of adverse social, economic, and health outcomes. People with long-term mental health problems experience significantly higher rates of physical illness, and are likely to experience social exclusion and discrimination as a direct consequence of their difficulties.

The economic costs of mental illness to the community remain high. Approximately \$4.6 billion in services were provided in 2006-07. The annual cost to employers of reduced productivity has been estimated at 30 million working days. The value of disability and premature death among young people aged 12-25 years has been estimated at \$20.5 billion.

Mental illness has been identified as the third leading cause of the burden of disease in Australia, and projections to 2023 indicate that mental illness is expected to remain the largest contributor to the prevalence of disability until age 60. Despite growth in state and territory clinical workforces between 1993 and 2007 and improvements in access to services, only one third of those with a mental illness receive mental health services each year.

In Australia, as in comparable countries, treatment, care and support continue to evolve as society moves away from the historical focus on institutionalised care of people with a mental illness. The need for services remains high, but approaches to care are changing. Workforce development needs to support system changes, as well as meeting the needs of consumers and carers, their families and communities through existing service models.

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<sup>1</sup> Further detail of the data sources, policy documents, peer reviewed literature and other research used to inform this strategy document, together with references and full bibliography are contained in the literature and document review that accompanies this strategy document. [<insert url>](#)

### ***The workforce scope of this strategy***

The focus of this strategy and plan is the workforce whose *primary role* involves early intervention, referral, treatment, care or support to people with a mental illness, in a mental health service or other health service environment, including non-government community mental health services.

It includes mental health nurses, psychiatrists, general registered nurses, general and other medical practitioners, occupational therapists, social workers, psychologists, Aboriginal mental health workers, Aboriginal health workers, consumer workers, and carer workers. It encompasses workers in a range of settings, including hospitals, health care and community mental health agencies across metropolitan, regional and remote areas of Australia.

### ***The mental health workforce in Australia***

Growing and developing the health workforce is a priority for governments in Australia. The clinical workforce that works directly with consumers in mental health services increased by 51% between 1993 and 2007, with the largest growth reported in ambulatory services. In spite of these gains, the majority of jurisdictions are experiencing shortages in mental health workforce supply, and difficulties with mental health workforce recruitment, distribution and retention.

There is evidence that the existing mental health workforce supply cannot meet demand, and that socio-economically and geographically disadvantaged areas continue to be underserved. Unfortunately, data sources to measure and describe the public sector mental health workforce are inconsistent across jurisdictions, and in the non-government sector do not yet exist.

The World Health Organization identifies the health workforce as the most important of all health system resources. People who work in mental health services are among the major strengths of the system. They are essential both to service improvement and to mental health reform, and have a vital role in improving health outcomes for the Australian community.

### ***Working in mental health***

Working in mental health offers particular challenges and benefits.

Some of the challenges particular to the area include providing care, support and treatment to people who have severe behavioural disturbance and related safety issues. Some consumers receive involuntary treatment and care and this can raise a range of issues for workers. Job stress can be defined as the harmful physical and emotional response that occurs when the requirements of the job do not match the capabilities, resources or needs of the worker. Adequate training and support can ameliorate job stress, but may not always be available.

Workers in mental health may not always have time to deliver services in the way that they would prefer. The capacity to establish an effective therapeutic relationship, refer appropriately, or to simply spend time with a consumer, may be constrained by the realities of a busy service, limited service system, and competing demands on workers. Generic roles, such as case management positions, or excessive administration requirements, may leave workers feeling that they are not using the skills they have learnt, and are not working to their potential.

Nonetheless, working in mental health can also be exceptionally satisfying. The sector offers the opportunity to work with consumers and their families or carers and assist them in addressing the challenges they meet daily. Workers can exercise a commitment to the

promotion of independence, dignity, and self-determination for an often disadvantaged group of people. There is scope to take a wholistic approach, and to work with consumers over a long period, seeing changes over time.

Mental health services are delivered in a range of settings, and frequently utilise multidisciplinary teams. There are opportunities to work in crisis teams that intervene quickly to prevent or reduce the impact of crisis and relapse, and assertive outreach teams, that provide support, treatment and interventions for people with long-term mental health problems who have complex needs and who may find it difficult to engage directly with services. The range of work settings is diverse, and supports skill development in varying roles and environments.

Working with people from a range of disciplines is a positive aspect of employment in mental health. People bring a different range of backgrounds, experience and skills which can contribute to better treatment, care and support. Inter professional collaboration can offer benefits to consumers and workers, The interface with primary care and other areas is also an important part of the provision of effective services.

### ***The complexity of the system***

Mental-health services in Australia are delivered within a complex system of inter-related federal and state/territory government providers, private providers, Aboriginal Community Controlled Health Organisations (ACCHOs), and a substantial non-government organisation (NGO) sector<sup>2</sup> consisting of an estimated 850 organisations of varying size and service type. Services can include *hospitalisation and other residential care, hospital-based outpatient services and community mental health care services, through to consultations with both specialists and general practitioners (GPs)* (the definition adopted by the AIHW). Other mental-health related services can include mental health promotion, mental illness prevention and early intervention and referral, psychosocial support, assistance with daily living and with maintaining wellness.

Services provided to people with a mental illness and their carers and families may thus be funded from a number of sources. The individual and family journey may involve contact with a range of service providers, including departments of health, community services, housing, and employment.

### ***Background to the national mental health reform agenda in Australia***

Since 1992, Australian Health Ministers have agreed to a whole-of-government approach and have worked to a National Mental Health Strategy. The original strategy consisted of a National Mental Health Policy; the Mental Health Statement of Rights and Responsibilities; Australian Health Care Agreements (bilateral five-year agreements between the Australian Government and each state and territory); and a National Mental Health Plan to coordinate mental health care reform in Australia through national activities.

The First National Mental Health Plan (1993-98) focused on state/territory-based, public sector, specialist clinical mental health services, and advocated major structural reform, with particular emphasis on the growth of community-based services, decreased reliance on stand-alone psychiatric hospitals, and ‘mainstreaming’ acute beds into general hospitals. This plan was concerned largely with severely disabling, low prevalence mental health conditions.

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<sup>2</sup> There has been a suggestion that the NGO sector should be referred to as ‘the community-managed sector’.

The Second National Mental Health Plan (1998-2003) shifted the emphasis to more common, less acute conditions such as depression and anxiety disorders, with a focus on promoting mental health, de-stigmatising mental illness, and maximising treatment outcomes and opportunities for recovery through collaboration among public, private and NGO sector providers.

The Third National Mental Health Plan (2003-08) took a population health approach and consolidated the first two plans by emphasising the full spectrum of services required to assure the mental health of Australians. It focused on mental health promotion and mental illness prevention, improving service responsiveness, strengthening service quality, and fostering innovation.

In response to concerns about insufficient progress in some areas of reform under the National Mental Health Plans, the Council of Australian Governments (COAG) developed the *COAG National Action Plan on Mental Health 2006-2011* which committed governments to a significant injection of new funds into mental health, including expansion of the Medicare Benefits Schedule to improve access to mental health care delivered by psychologists and other allied health professionals, general practitioners and psychiatrists. It also led to increased investment by states and territories in community-based mental health services, enabling them to respond better to consumers with severe and persistent mental illnesses, and their carers and families.

The original National Mental Health Policy was updated in 2008 and identifies ten key policy directions. In relation to workforce, the policy direction calls for positive and inclusive organisational cultures; access to high quality education and training opportunities; adequately trained and sufficient numbers of clinical and non-clinical staff across public, private and non-government sectors to provide high quality services; safe environments; systemic supports; and satisfactory incentives and rewards to ensure job satisfaction (levels of remuneration, appropriate career development opportunities, prospects for promotion).

The Fourth National Mental Health Plan (2009-2014) was released in November 2009, and among other activities was the impetus for developing this National Mental Health Workforce Strategy and Plan.

## **The current policy context for this strategy**

This workforce strategy is set within a policy context of the health workforce in general as well as in mental health. Some recent developments of note in this broader context are:

### ***Reforms and developments***

A number of significant national reforms, projects, policy and governance initiatives that will affect the mental health workforce are under way, or soon to begin. These projects include:

- Forthcoming national service system guidelines/models of care for mental health
- A forthcoming National Rural and Remote Strategic Framework which has a focus on mental health and alcohol and other drugs alongside other identified service priorities (2010-2015)
- Signing of the National Health and Hospitals Network Agreement (20 April 2010, with the exception of Western Australia)
- The non-government organisation mental health workforce study (due for completion in mid-2010)
- Review of the National Standards for Mental Health Services (due for release July 2010)
- Forthcoming national service system framework development for drug and alcohol services planning
- The work of the Australian Commission on Quality and Safety in Health Care and its links with the work of the National Indigenous Health Equality Council (NIHEC) Safety and Quality Partnership Subcommittee of the Mental Health Standing Committee
- Indigenous health workforce development initiatives (e.g. the work of the Aboriginal and Torres Strait Islander Health Registered Training Organisation Network (ATSIHRTON) and; National Indigenous Health Equality Council (NIHEC) and OTASIH process to renew the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being)
- Initiatives to support the mental health of people from culturally and linguistically diverse backgrounds (such as Transcultural Mental Health Centres)
- Developments arising from the National e-health strategy
- The Mental Health in Tertiary Curricula measure

## **The National Health Workforce Agency – Health Workforce Australia**

Health Workforce Australia (HWA) is an initiative of the Council of Australian Governments, and has been established to meet the future challenges of providing a health workforce that meets the needs of the Australian community. Its initial roles will be to oversee financial support for pre-professional clinical training, to facilitate locally based mechanisms for placing students in suitable training places, to establish a health workforce statistical register to enable longer term planning initiatives, and to give advice about workforce directions. COAG has announced the following major reforms the agency will manage and oversee:

- Improving the capacity and productivity of the health sector to provide clinical education for increased university and vocational education and training places.
- Facilitating immigration of overseas trained health professionals and continuing to develop recruitment and retention strategies.
- System, funding and payment mechanisms to support new models of care and new and expanded roles.
- Redesigning roles and creating evidence based alternative scopes of practice.
- Developing strategies for aligned incentives surrounding productivity and performance of health professionals and multi-disciplinary teams.

## National Registration and Accreditation Scheme

The new National Registration and Accreditation Scheme is due to commence on 1 July 2010. The new scheme is being established to deliver a range of benefits to the Australian community, including:

- providing for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- facilitating workforce mobility across Australia and reducing red tape for practitioners
- facilitating the provision of high-quality education and training and rigorous and responsive assessment of overseas-trained practitioners
- having regard to the public interest in promoting access to health services, and
- having regard to the need to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and enable innovation in education and service delivery

The new system creates a single national registration and accreditation system for ten health professions: chiropractors; dentists (including dental hygienists, dental prosthetists and dental therapists); medical practitioners; nurses and midwives; optometrists; osteopaths; pharmacists; physiotherapists; podiatrists; and psychologists (Australian Health Workforce Online 2009). The system will be delivered through the Australian Health Practitioner Regulation Agency (AHPRA) and the new national registration boards established for each of the professions.

## The Fourth National Mental Health Plan

On 4 September 2009 the Australian Health Ministers Conference (AHMC) endorsed the Fourth National Mental Health Plan: an agenda for collaborative government action in mental health for 2009-2014. The Plan was released on 13 November 2009 and is underpinned by the National Mental Health Policy 2008.

The Plan is a Health Ministers Plan, developed in the context of a whole of government approach, and building on the three previous National Mental Health Plans that span 1993-2008. The development of this workforce strategy and workforce plan will support implementation of the 2009-2014 Plan.

The Plan outlines five areas for national action in mental health, including social inclusion and recovery. It retains the definition of recovery outlined in The National Standards for Mental Health Services (1997), which define recovery as: *'A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and / or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability'*.

The Standards have subsequently been reviewed and updated and a consultation process, auspiced by the National Standards Implementation Steering Committee, has resulted in development of the National Recovery Principles (see below).

The Plan notes that good mental health *'is a critical component of good general health'* and is determined by a complex set of interrelated factors in the individual, the family, or the community. The Plan adopts a population health framework, acknowledging that the result of mental health and illness is based on a complex interplay of social, psychological, biological, environmental and economic factors. The framework requires a whole-of-government approach to achieve effective change, and emphasises that services must meet the specific needs of different cultural groups, backgrounds and experiences. Indeed, the plan highlights that specific groups (eg Indigenous Australians, youth, and the elderly) may be more vulnerable to mental illness and issues must be assessed in a culturally sensitive manner and targeted across the lifespan.

Eight principles underlie the Plan:

- Respect for the rights and needs of consumers, carers, families and communities – engagement, support, information, choice of services, and privacy.
- Services dedicated to the recovery approach – both as process and result.
- Social inclusion – recognition of the importance of social, economic and cultural factors in mental health, and of barriers that lead to social exclusion.
- Acknowledgment of social, cultural and geographic diversity and experience – recognition of the need for cultural competency in planning mental health services, and specific issues faced by some groups, such as women, indigenous, linguistically diverse, and rural and remote communities.
- Recognition that the focus of care may be different over the lifespan – mental health services tailored to different age groups.
- Services that support continuity and coordination of care – collaboration among services and integrated models of service delivery so there is less chance that people will fall through the gaps.
- Service equity across communities, areas and age groups – services that are accessible, responsive, equitable in quality, and evidence-based, with levels and outcomes of care that are transparent to consumers.
- Attention to the spectrum of mental health, mental health problems and mental illness – the range of services spans the spectrum of mental health from wellness through to mental illness, from primary care to greater involvement, and responsive to the different demographic sectors of Australian society.

The recovery approach and the development of services that are community needs based, based on the eight principles, have implications for developing the mental health workforce in Australia, including continued development of services across sectors and community settings, to maximise treatment options and outcomes.

### ***Five key areas for national action within the Plan***

Despite the achievements of previous Australian mental health reforms and action plans, the Fourth Mental Health Plan highlights that much can still be achieved at state and national levels, and that greater emphasis on improving accountability for both mental health reform and service delivery is vital. Both the Fourth Mental Health Plan and the COAG National Action Plan on Mental Health (2006-2011) state the necessity for developing the workforce and increasing its capacity. Recruiting and retaining a workforce that is supported to maintain skills and knowledge, and is responsive, culturally competent and sustainable remains a continuing challenge. The Plan has five key areas for national action, of which priority 4: *Quality Improvement and Innovation* is most directly relevant to workforce. There are some workforce implications, however, from each priority.

#### *1. Social inclusion and recovery*

The twin aims of increasing understanding of mental health and wellbeing in the community, and recognising that delivery of services must be coordinated across health and social domains, include the following workforce implications:

- Re-focused workforce development that supports the recovery approach
- Further expansion and development of a peer support workforce

#### *2. Prevention and early intervention*

To achieve outcomes where people have a better understanding of mental health problems, and are thus more able to seek help or support others early; where there is greater recognition and response to mental health issues, including to co-occurring alcohol and drug problems, physical health issues and suicide; and where generalist services have specialist support when necessary, the workforce implications would include:

- Education for front-line workers that come into contact with people with mental health issues, including police, ambulance, child protection and other services
- Increased training of front-line workers in co-existing mental health and alcohol and substance abuse issues, and risks of suicidal behaviour

### *3. Service access, coordination and continuity of care*

The outcomes for this priority include improved access to appropriate care, continuity of care, and an adequate mix of services. Workforce implications include:

- A national service planning framework (models of care) will be developed and workforce components will be required to support it

### *4. Quality improvement and innovation*

Making information available to the community on services and outcomes by region; reporting against standards of care; using enabling legislation that supports the transfer of civil and forensic patients across jurisdictions; supporting emerging models of care and providing leadership for implementation have a number of workforce implications, including:

- Development and the initial implementation of a National Mental Health Workforce Strategy to inform a national approach to define standardised workforce competencies and roles in clinical, community and peer support areas
- Increased consumer and carer employment in clinical and community support settings
- Expanded and better used innovative approaches to service delivery, including telephone and e-mental health services.

### *5. Accountability – measuring and reporting progress*

Ensuring that the public can make informed judgments about mental health reform and the implementation of the Plan, and that there is adequate reliable information available about services to compare to national benchmarks, would have implications for:

- Improving and standardising across jurisdictions, sectors, and service providers the type and level of data collected to map and measure the mental health workforce, its attributes and trends in workforce.
- Developing effective monitoring and evaluation of the implementation of workforce strategies.

### ***Governance of the Fourth National Mental Health Plan***

The Mental Health Standing Committee (MHSC) is progressing the Plan's implementation and monitoring process on behalf of the Australian Health Ministers Conference (AHMC). All jurisdictions have been involved in developing a draft Implementation Strategy that details the process for implementation that will achieve the Plan's aims and objectives. AHMC will report on progress against this Implementation Strategy every year to the Council of Australian Governments (COAG).

Responsibility for monitoring and coordination of the implementation, evaluation and reporting effort vests with the MHSC. The AHMC has agreed to establish a Cross Sectoral National Mental Health Plan Implementation Working Group (the Working Group) to progress the whole of government aspects of the Plan. The Working Group will provide the opportunity to establish ongoing relationships with other sectors to promote further adoption of mental health reform across portfolios. The first Working Group meeting was held on 14 April 2010.

## National Recovery Principles

The National Standards for Mental Health Services have recently been reviewed by the National Standards Implementation Steering Committee and are due for release in July 2010.

*From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.*

The Fourth Plan notes that recovery is not synonymous with a cure; rather, those with a mental illness may have recurring or persistent problems. Consequently, recovery must be viewed as both a process and outcome. Adopting a recovery philosophy is important across severity levels and diagnosis, and is likely to be different for everyone. Maximising individual potential and coping skills is important, and services must provide support and appropriate treatment to all Australians with a mental illness a sense of identity, purpose, self-determination, and the empowerment to participate fully and competently in the community.

The National Recovery Principles identify six principles to ensure recovery-oriented mental health practice. These are:

- uniqueness of the individual (including empowering the individual to be at the centre of care);
- real choices (including achieving a balance between duty of care and support for an individual to take positive risks);
- attitudes and rights (including listening to, learning from and acting upon communications from the individual and their carers);
- dignity and respect; partnership and communication (including acknowledging each individual is an expert on their own life and that recovery involves working in partnership with individuals and their carers); and
- evaluating recovery (including measuring outcomes on a range of indicators in addition to health and wellness, such as housing, employment, social relationships).

For some services and their staff, adopting recovery principles in service is a major change in their way of working with people with mental health conditions. There are consequent implications for education and training curricula, professional development, and the mix of skills and roles in service teams.

## **Developing this strategy**

### *The process to develop the strategy*

In October 2009, the Mental Health Workforce Advisory Committee (MHWAC) engaged Siggins Miller to conduct national consultations and review peer reviewed literature and national and jurisdictional documents (including available mental health workforce data) to provide evidence and advice to the MHWAC for developing the national mental health workforce strategy and plan. On this basis background papers and a draft architecture and content for further consultation were developed.

Between October 2009 and February 2010, 368 stakeholders attended one of 17 workshops; 53 key informants were interviewed, and 34 written submissions were received.

An extensive literature and document review was prepared and is publicly available as a resource for policy development and planning and further study of mental health workforce issues [<insert url>](#).

Finally, all the information from workshops, informant interviews, written submissions and the literature were considered together to suggest priority national objectives and strategies. The choice of suggested strategies was guided by criteria including:

- Initiatives where all jurisdictions have agreed to common policy goals and coordinated national action.
- Initiatives where the Federal Government holds the policy or funding levers.
- Initiatives at State and Territory level that can be taken up and further developed to be a national approach, if appropriate and more cost effective.
- Initiatives of national significance that could be trialled in one State or Territory and then rolled out if successful.
- Initiatives that build on common current state and territory activities where national coordination, support and evaluation of that effort would reduce duplication, increase synergies, increase return investment and speed change.

### *System-wide issues raised by stakeholders*

The federal system of government in Australia has produced a complex division of funding, accountability and service delivery among different levels of government. Workforce issues cross areas of Commonwealth and state/territory responsibility, and also include matters at the organisational level, such as workplace culture and practices. Some of the issues raised in the consultations significantly affect the mental health workforce, but may be health system wide in nature.

This strategy suggests actions that will add value to the work already under way in each jurisdiction. Development of the strategy has involved mapping the current activity in mental health workforce development in all jurisdictions. The mapping demonstrates a high level of existing local activity in all parts of the country, and is documented in the supporting technical paper that accompanies this strategy.

Industrial issues in the public and NGO health workforces remain largely the responsibility of the states and territories. Many participants in the consultation process said remuneration levels (differences in remuneration among jurisdictions, and between the public and non-government (NGO) sectors) were important barriers to the attraction, retention, mobility and sustainability of the mental health workforce.

These industrial issues apply to the whole health and human services workforce, and are not unique to the mental health workforce. Housing and physical infrastructure for Indigenous and non-Indigenous rural and remote health workers was another health system issue raised in consultations. This is of particular concern in regions where the cost of housing in the private market is exorbitant.

In consultations and submissions, participants expressed concern that the mental health sector was not well connected to mainstream efforts to support and develop the health workforce in general, and in underserved areas and populations. There are significant national and state and territory strategies and funding programs and plans to support rural and remote workforce, Aboriginal and Torres Strait Islander health workers and services, overseas trained doctors, efforts to develop clinical leadership and improve clinical governance and workplace supervision and support and continuing professional development. The new agency, Health Workforce Australia, will play a significant role in the support of clinical supervisors and trainees and students in the health sector broadly and will provide considerable investment in workforce innovation and reform.

The mental health sector needs to ensure that its committee structures and plans and strategies are well connected with the opportunities provided by the new structures and investments. Strategies for the mental health workforce cannot develop in isolation from the rest of the health and human services workforce. At the same time, national reforms involving major change are still in progress at the time of preparing this strategy. Accordingly, while the importance of these issues is acknowledged, the following strategy focuses on mental health-specific workforce strategies and actions.

### **Areas of work**

Taken together, the literature, data, and consultations propose the following areas of work as the focus of this strategy:

1. Developing, supporting and securing the current workforce
2. Building capacity for workforce innovation and reform
3. Building the supply of the mental health workforce.
4. Building the capacity of all health and community service providers to work effectively with people living with mental illness across the lifespan and with their carers, families and communities
5. Collecting accurate, timely and quality data on Australia's mental health workforce with well designed and integrated data collection systems.<sup>34</sup>

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<sup>3</sup> Prioritisation of strategies suggested by the PSC need further work as well as reduction in the number of strategies and will be reflected in the implementation plan that will be developed once the strategy is agreed.

<sup>4</sup> The PSC has suggested that the rural and remote workforce, and the Aboriginal and Torres Strait Islander workforce need separate sections. This has been considered, however Mental Health Standing Committee did not support this approach, preferring an integrated model.

## **1: Developing, supporting and securing the current workforce<sup>5</sup>**

The mental health care system relies on the dedication, energy and efforts of the current workforce to maintain essential services, and to train, supervise and mentor new staff. At the same time, those who manage and work in the service system face considerable challenges in developing and adapting to new structures, new demands, and new ways of working.

Developing, supporting and securing the current workforce require attention to areas including training and development, clinical leadership, and role definition.

### **Developing the current workforce**

All jurisdictions have mental health services plans which include workforce development initiatives. Most jurisdictions have committee or advisory council structures to support workforce development, and three jurisdictions - Queensland, Victoria and Western Australia - have specific mental health workforce development plans or strategies and work plans. A number of jurisdictions have considerable investment in centres, institutes and programs that provide CPD and postgraduate training in mental health - for example, the Institute of Psychiatry in NSW, the Centre for Mental Health Learning in Queensland and the planned Victorian Mental Health Workforce Development and Innovation Institute.

### ***Implementing change***

The Fourth National Mental Health Plan implies considerable change in the way people will work in mental health care. It calls for changes in structure, philosophy and approach; changes in the place of treatment; a growing emphasis on early intervention; and the need to emphasise the broad social determinants of mental illness and relapse. The literature and the stakeholder consultations confirm that such changes have stretched existing training programs and those who teach in them, and tested the way services are configured and governed. Assisting people with these new ways of thinking and working is a key focus of this part of the strategy.

Changing the practices of people who work in or manage and lead the system, and changing the structure or resourcing of the system are only part of the change management picture. The attitudes and values of the existing workforce powerfully shape those of successive generations of health professionals as they undertake clinical placements in training programs, or as graduates in their early years. The work done in vocational, undergraduate or postgraduate programs can be nourished or extinguished by the power of peers and deep organisational culture. Investing heavily in support and development of the existing workforce, including those who teach the next generation, is therefore an investment both in the present and also in the future supply of the next generation of workers, and the capacity to attract and retain them.

More work is required to achieve a shared understanding of what is meant by the *recovery approach*. The values and attitudes it implies need to be understood and adopted consistently by the current workforce, if they are to support new ways of working effectively.

Moreover, the literature emphasises the importance of fostering workplaces where consumer-focused approaches are modelled by senior staff, and where trainees and new recruits are able to practise the skills, values and attitudes they have acquired in their training. Informants thought many people were aware of the new approaches and guidelines, but they were implemented inconsistently.

Few jurisdictions have sustained programs aimed at directly teaching the skills and knowledge necessary to implement the recovery approach and translating that knowledge into practice. This is clearly an area where national action could accelerate change.

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<sup>5</sup> Further editing of all preambles will occur.

### *Key areas of need*

The national consultations noted some key groups and settings where the current specialist and generalist workforces needed more support and training. Studies report that some members of the current mental health workforce feel they need more knowledge and training to work effectively. Some lack confidence in their ability to identify and treat co-occurring alcohol and other drug problems; to deal with aggressive or potentially aggressive situations; to treat consumers with complex needs, such as prison populations; or to meet the demands of their role, despite several years' clinical experience. Most jurisdictions' plans include attention to these areas of skill development.

#### *Young people and adolescents*

An area in need of urgent attention was the needs of young people and their carers as they transition from child and adolescent services to adult services at arbitrary, age-determined points. Increased capacity in the present workforce for early diagnosis and appropriate treatment and support for young people could significantly reduce the damage done by a mental illness to educational, employment and social inclusion outcomes.

#### *Aged care*

The ageing of the population is expected to increase demands on the mental health service system. The existing workforce needs to work effectively with people with multiple age or medication related comorbidities such as diabetes, cancer, and dementia.

There is a clear need for investment in training specialist mental health workers and aged care professionals to meet the needs of people with a mental illness as they age, and the aged who may develop mental illness. This growing need, the recent release of the national report into aged care, and the apparent lack of coordinated effort nationally strongly suggest that work at the national level is necessary. Only one jurisdiction, NSW, currently mounts workforce initiatives to address this part of the population: a review and development of relevant older peoples mental health education and training programs; a benchmarking project for older peoples' mental health services; and ensuring that specialist mental health clinicians delivering services for older people are equipped with core competencies from the outset.

#### *Aboriginal and Torres Strait Islander people and CALD*

Access to culturally appropriate services for Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds needs a workforce that is technically *and* culturally competent. Aboriginal and Torres Strait Islander mental health workers themselves are in need of support owing to their dual roles at work, and in their own family groups and communities. These workers face particular pressures and are often on call 24 hours a day, seven days a week. To compound the pressure they work under in many rural and remote areas of Australia, often indigenous workers are not eligible for housing and other supports made available to non-indigenous staff and visiting specialists.

#### *Rural and remote areas*

Research and consultation indicates that mental health workers in rural and remote areas face particular challenges. Problems may include a lack of career opportunities; fewer options for referral; unsafe environmental conditions in the workplace; lack of safe and suitable accommodation; and a perception that the quality and availability of clinical supervision is less than in major urban settings.

In some jurisdictions efforts are under way to reduce disparities in outcomes for consumers and carers and to better support, attract and retain staff in all disciplines where distance and remoteness is a challenge. In NSW there are rural mental health training scholarship schemes; incentives and opportunities are provided for nurses to undertake work rotations in rural MHSs. Victoria has developed a Rural Medical Partnership Project to provide professional support to psychiatric registrars working in rural areas and has funded additional rural

psychiatric registrar positions. As many stakeholders have pointed out, cross-border issues workforce such as differences in levels and types of support often mean that staff developed in one jurisdiction are lost to another. Coordinated national effort could promote more positive outcomes for the current and future workforce.

Stakeholders believe that compulsory and practical field placements for exposure to different cultural perspectives of mental illness and settings are essential. Continuous cultural awareness in-service training, rather than one-off 40 minute sessions, was the favoured strategy for building workforce capacity. A continuous approach allows training to target people in particular settings – grassroots NGOs, for example, or emergency personnel, or managers developing service for CALD communities. It also targets career path development, with cultural competency training aligned to career stage/level. As well as increasing professionalism, this long term recruitment and retention strategy has the capacity to raise the 'flag' for cultural competency at all workforce levels, and the potential to increase retention.

## **Supporting the current workforce**

### ***Stress, workload and expectations***

The factors affecting the retention of mental health workers have been well documented. Research has found that the main problems for community mental health workers are high expectations and demands with no prospect of relief, lack of clarity of their mission and roles, and workers' perceptions of being the scapegoats for shortcomings in the mental health system.

Research also reveals that feelings of helplessness, stresses associated with increasing and new demands, an ageing workforce, and high expectations from the public are major issues for the occupational health and safety of mental health nurses. Intensified work demands reduce time for training, and leaves workers too tired to undertake training outside working hours. Workers who are motivated to undertake training report that the principal barriers are workplace constraints (excessive workload) rather than family or financial constraints.

In the consultations for developing this strategy, service providers across Australia consistently described the pressure and intensity of work. They often expressed concern about the risks of burnout, and loss of experienced staff from the specialist mental health sector to the general health sector owing to burnout. Some feared that generic case coordination roles that ignored the application of specialist clinical skills could reduce those skills. There was a clear need to strengthen management and governance capacity in mental health services.

These concerns suggest the need to look not only at supply issues in workforce development, but also at the best ways to support, develop and upskill those who have chosen to stay in the dedicated mental health workforce, and how best to attract those who have left to return to mental health. The need to ensure adequate supervision and leadership for all mental health roles was raised consistently in consultations.

### ***Clinical leadership***

A review of the literature and the national consultations with stakeholders confirms that clinical leadership across all disciplines, and the leadership provided to the sector by consumers and carers and families of those with a mental illness, needs to be strengthened and supported if cultures of continuous improvement and consumer and carer and family focus are to strengthen and be sustained.

All jurisdictions have programs focussed on developing and strengthening clinical leadership in the health system as a whole, and some jurisdictions have mental health specific clinical leadership and governance improvement initiatives. One jurisdiction, Queensland, has a specific clinical reform project that aims to support public sector service providers to develop, implement and evaluate targeted change management plans that incorporate changes to organisational structures, processes and clinical practices.

Around Australia, mental health professionals and service managers consulted said that work on career pathways, access to Continuing Professional Development (CPD), clinical supervision, and development of supervision skills were needed. In every jurisdiction, some actions are being taken on most aspects of supervision, support and CPD and career structures, but there is no one jurisdiction where all these types of initiatives are in place. This situation argues for the detailed mapping and assessment of current efforts to identify, develop, and support initiatives that could be disseminated nationally to reduce current levels of duplicated effort.

### ***Use of technology***

Access to enabling technologies for support of shared care between nurses, nurse practitioners, general practitioners, psychiatrists, psychologists and other members of the multidisciplinary team, for e-health and for supervision, mentoring and support does more than increase access to services. Where it is skilfully used, and where staff are trained and supported to use the technology effectively and efficiently, it provides a powerful retention tool in isolated settings away from major teaching health services. It also acts as a tool to encourage redistribution of the workforce, as people are more likely to go to work in underserved areas if they feel that it will not be a one-way ticket professionally and that they will be well supported.

An ongoing investment in e-learning, training and system use would support clinicians and managers to maximise benefits from e-health developments. Some service providers said they had access to a reasonable standard of e-health technology, but were not using it owing to lack of competence and confidence. Others, such as the West Australian Country Health Service (WACHS), have focussed on enabling technologies.

WACHS has developed the State-wide Clinical Service Enhancement Program (SCSEP) that delivers both clinical services and education and training to consumers and staff across WACHS. This has recently been enhanced by the purchase of a multipoint conferencing bridge. Education programs delivered include mental state assessment, risk assessment, CBT, working with personality disorders, older adult psychiatry, child and adolescent psychiatry. It is also used for supervision, meetings and case conferencing. Consultant Child and Adolescent Psychiatrists deliver a clinical service to regions that would otherwise have no such service. It is hoped to develop this program further in the future. A number of ongoing training opportunities are being developed for the WACHS workforce in partnership with other organisations (eg Drug and Alcohol Office, Perinatal Mental Health Unit). WACHS are also currently as part of a state-wide process on a Generic Core Competency Training Framework. Where possible, successful local initiatives should be shared and embedded across the mental health service system.

Nationally, the Mental Health Professional Online Development (MHPOD) project will provide a seventy-hour core curriculum aimed at workers in mental health. The content is linked to the *National Practice Standards for the Mental Health Workforce*, and is about to be piloted at eleven services nationally, including WACHS. To date MHPOD has been well received—five topics are currently available for preview—and is an example of what can be achieved by pooling resources nationally to support the workforce.

### **Securing the current workforce**

#### ***Existing initiatives to support and retain the current workforce***

All jurisdictions have made some efforts to increase the attractiveness of the mental health working environment, and providing incentives to support or retain the mental health workforce.

They include family-friendly initiatives such as childcare or eldercare; implementing work/life balance policies; investigating public/private sector options for allied health professionals; looking at occupational health and safety policies for preventing and managing violence and aggression; providing flexible working environments; offering good access and support to information and communication technology (ICT); promoting attractive roster options, promoting mental health as a vocation of choice to health professionals and to

undergraduates; appointment of workforce officers to facilitate outcomes; negotiating improved conditions and increased salaries under EBA agreements, and so on.

Collection, collation and sharing of resources, policies and programs nationally could reduce duplication of effort, speed change and increase synergies of effort. In recent years, the role of consumers and carers as members of the paid workforce has increased steadily.

The literature and national consultations suggest that there are a number of ways this part of the workforce could be better supported through policy development, clear role delineation and position descriptions, and access to better mentoring, supervision and support. Mental health workers would also benefit from training in how to work well with consumer and carer colleagues, and provide them with the necessary supervision and support as part of the multi-disciplinary team.

## 1. By developing, supporting and securing the current workforce, we aim to contribute to -

- Increased quality and safety and clarity of services for consumers, families and carers and for staff
- Increased retention of staff
- Service cultures that support hope and optimism
- Increased opportunities for effective supervision, lifelong learning and Continuing Professional Development
- Improved workforce capacity to contribute to reducing inequalities in health outcomes for Aboriginal and Torres Strait Islanders living with a mental illness
- Improved capacity to retain and support the mental health workforce in rural and regional and remote locations
- Increased cultural appropriateness of service delivery<sup>6</sup>

### Strategies to achieve these objectives may include –

1. Working with the *Australian Health Practitioner Regulation Agency, Health Workforce Australia* and the jurisdictions in promoting and supporting access for the mental health workforce to investments in and resources for the development of clinical leadership, management development, clinical supervision, models of workload management and other areas across all clinical disciplines and including the NGO sector
2. Auditing existing resources and developing guidelines and templates (linked to the National Practice Standards for the Mental Health Workforce) for recruitment, induction and orientation programs for new entrants into the workforce; for clinical supervision; and for developing and customising training and professional development resources at the local level.
3. Developing clear national guidelines, consistent with National Practice Standards and the Fourth National Mental Health Plan, for roles (including consumer and carer roles and rehabilitation support roles), skill mix and competencies for a capable workforce, to improve consistency of care and to increase the effective and efficient use of the available workforce.
4. Working with the relevant professional bodies and the Directors of Mental Health to define roles that will maximise the use of clinical skills of mental health professionals, and therefore freeing up clinicians to make full use of their specialist clinical skills, by reviewing and better defining case coordination roles, and developing options for clinicians to move through a clinical stream rather than a management stream for career progression.
5. Working with NACCHO and affiliates, NIHEC and other relevant bodies to provide better career pathways for Aboriginal Mental Health Workers, develop consistent national articulation pathways for Aboriginal Health Worker and Aboriginal Mental Health Worker training programs; provide better supervision, mentoring and locum support programs, particularly for sole mental health workers located in Aboriginal

<sup>6</sup> A specific strategy in this area is under consideration

Medical Services.

6. Building on current initiatives, such as MHPOD, to develop a national mental health e-learning portal where service providers can access a one stop shop to link their workforce to current and credible sources of information regarding evidence-based approaches to treatment and service development; and continuing to develop and implement on line discussion groups where mental health professionals and service managers can engage with colleagues to share innovation and discuss solutions to challenging issues.
7. Developing targeted communication and recruitment strategies for each of the major professions that promote pride in work and showcases achievement of the sector nationally.
8. Maximising opportunities for isolated practitioners to work with mental health teams face to face and at a distance; and for mental health specialists to provide secondary consultation and education to remote and isolated workers.

## **2: Building capacity for workforce innovation and reform**

This strategy foresees reforms to the mental health workforce to better meet the needs of consumers, carers and communities, and to better define and apply the skills of mental health professionals. Consultations to help develop this strategy and the research literature together outline a substantial short and long term agenda for innovation and reform.

The newly established Health Workforce Agency promotes innovation and reform, and most states and territories and many non-government organisations now fund or provide workforce development units, functions, or capacity, and they do workforce-related evaluation research. Evidence for what works to promote sustained change in the workforce is thin but growing, though the research and evaluation effort is currently fragmented and uncoordinated.

The changing policy and planning context poses significant challenges for workforce planning and development. Some reforms in the traditional mental health workforce have been under way for some years, such as the Commonwealth funded reform of the curriculum for psychiatry training; expanding the provision of specialist psychiatric clinical training to settings other than acute public hospitals; and the exploration by IMET in NSW of a new role and career path for hospitalists in mental health.

The development of Mental Health Nurse Practitioners (MHNPs) is a contemporary initiative promoted throughout mental health services in Victoria and elsewhere. This approach, along with the establishment of a MHNP Collaborative, has seen the endorsement of MHNPs and many mental health nurses are undertaking MHNP candidature. Establishment of these roles with an advanced scope of practice makes these nurses the most advanced clinical practitioners within the discipline of nursing. They will have prescribing rights in the future, but their scope of practice is far more extensive, allowing them to refer and receive referrals to and from medical staff and order pathology tests and investigations.

There is also support for nurses to be authorised to prescribe and administer medication or to issue an order for involuntary detention and assessment in the absence of medically trained professionals. Further possible role expansions are to conduct physical health screenings, chronic disease prevention and management, smoking cessation interventions, drug and alcohol interventions, health lifestyle management and health promotion. It is suggested that formal evaluation of the outcomes of the Mental Health Nurse Incentive Program be considered.

There is a significant gap between what consumers and carers and communities value and need, and the ways services are currently delivered (that is, to whom, by whom and where). In particular, under the recovery approach, the skills required for any team are defined by the needs of the local communities and service users, rather than by the needs of the professions, the organisations in which they work, and the health system. This is a quantum shift occurring not only in Australia, but in comparable countries (and not just in mental health).

The move towards community-based recovery approaches to care creates an opportunity to engage a broader range of skills and service providers, and thus a larger pool of potential mental health workers. It also creates a responsibility to ensure that changes to ways of working achieve what it is hoped they will do - enhance outcomes for consumers and carers, improve quality and safety of processes, and better support the workforce. Harnessing and building on the current commitments to workforce innovation and reform nationally will build momentum for change, make best use of and increase research and capacity around workforce development.

Informants in consultation recommended a nationally consistent package of training and education for entry to the recovery support, psychosocial, and peer support workforce, as well as entry to the growing workforce of consumer and carer advocates. Other emerging workforce groups include mental health first aid instructors, and suicide prevention and postvention practitioners. While many have formal mental health qualifications and are employed by a mental health service, others do not, and come from varied walks of life. This latter group could

be usefully deployed in mental health promotion, community awareness and mental health literacy roles within mental health services. Consultations also stressed the need for broadening the composition of child and adolescent mental health teams.

National consultations and the literature review suggest that a focus on developing a paid carer and consumer workforce as peer support workers, recovery support workers, and as paid educators and advisors is well supported in principle. The key factors suggested in building a workforce based on the needs of consumers, carers, families and communities are:

- a clear understanding of what is meant by a 'recovery approach'.
- a clear understanding that the outcomes that consumers, families, carers and communities value are important; and extend to quality of life and capacity to manage activities of daily living and social inclusion.
- identifying at the local level the outcomes that consumers, carers, families and communities value; and a comprehensive analysis of what the work is, where it needs to happen and who/what sort of worker is best placed to do the work.
- developing workers who can improve outcomes for consumers and reduce the avoidable adverse consequences of the social, educational and employment impact of long term mental illness. This approach would aim to increase capacity for assessment, diagnosis and early intervention early in the lifespan or early in the illness.
- People with severe mental illness require access to a workforce with the appropriate expertise, skills and training. This is an essential part of service quality, and is consistent with services and workforces focused on other types of severe illness.
- developing education and training programs where the structure and emphasis is broadened to include the understanding of the broad set of social determinants of the life course of people with a severe mental illness.
- developing expanded and new roles in the workforce that respond to the needs of people with severe mental illness.

Significant work is already under way across Australia to design and implement new and innovative ways of working.

The NSW Consumer Advisory Group has received substantial funding to examine the role of consumer workers, including their role in mental health and drug and alcohol services, and how these roles can be expanded and developed. This project is due for completion in June 2011.

In Victoria, carer consultants and peer support workers are employed. These staff bring invaluable lived experience to services. It is suggested that these positions should be reviewed and introduced as an integral part of the mental health workforce in both clinical and PDRS services. However, people who undertake these roles need training, mentoring and support. The Victorian Mental Health Carers Network is currently piloting a carer consultant training program which is proving highly successful. Part of this training includes preparation of carer consultants to train mental health professionals in involvement with and support of carers.

Carer participation in system, policy and service development is also an important area of training. There are many jurisdictional policies and frameworks around carer participation, but for carers to use their lived experience effectively, they need training. For example, carers need resourcing to understand current policy and processes, training in meeting process and procedure, systemic advocacy, public speaking and assertiveness.

Programs funded under the COAG National Mental Health Action Plan including PHAMS, Day to Day Living, Community-based programs and Mental Health Respite have led to an expansion of positions for people to provide psychosocial rehabilitation, recovery support, family and carer support and peer support. During consultation and in submissions, many such examples of innovation and reform were noted, and more detailed accounts are noted in the literature and document review produced as part of the strategy development.

A number of well established and newly established centres and Institutes and units at state and territory level are designed to support workforce development and innovation and reform:

- The Queensland Centre for Mental Health Learning (QCMHL) has been established to provide strategic direction and coordination in mental health education and training and to auspice a Mental health educator development network – to facilitate sharing of information, up-skilling and consistency, and broader sharing of education resources and experiences within the current group of designated district educators in MHSs in that State. Queensland also has a major Clinical reform project which aims to support District Mental Health Services to reform service delivery to align more effectively with the priorities, principles and policies associated with the Queensland Plan for Mental Health 2007-2017.
- Victoria is establishing a Victorian Mental Health Workforce Development and Innovation Institute.
- In NSW the Institute of Psychiatry has become a major provider of continuing professional education in mental health in Australia, established by an Act of Parliament in 1964. The Institute plays an active role in initiating and encouraging research into all aspects of mental health. The Institute has agreements of affiliation with several Australian universities. The Institute has been granted approval under the provisions of the Higher Education Act, 1988 to offer a number of courses at Graduate Certificate, Graduate Diploma and Masters levels. Many of the programs offered by the Institute attract continuing education recognition from relevant professional associations. A Research Fellowship Scheme, funded by NSW Health, is administered by the Institute.
- The ACT has a dedicated education unit which facilitates experience of clinical learning for undergraduate nursing students, it has dedicated liaison nursing positions to interact between students and clinicians; Enrolled nurses with MH in MH ACT and Calvary Hospital are provided with postgraduate training in mental health in collaboration with the University of Canberra.

The key challenge is to harness those efforts, evaluate them and ensure support for the timely dissemination of good practice. This outcome area of the strategy seeks to provide advice on how to achieve synergies of effort nationally and reduce duplication of effort.

**2. By building capacity for workforce innovation and reform we aim to –**

- Understand better what the work is, where it happens and where it needs to happen to close gaps and improve continuity of care and support
- Build capacity to adapt to new structures and new ways of working that better meet consumer and carer and family needs and promote early intervention
- Contribute to an improvement in access to early intervention across the life course of mental illness and in relapse episodes

**Strategies to achieve these outcomes may include –**

1. Developing a shared understanding of the recovery approach and the implications for workforce development.
2. Commissioning a mapping of consumer, family and carer needs across the life course to support continuous improvement in workforce planning and development and to inform development of models of care and resource allocation.
3. Developing and supporting a virtual network, building on the existing Centres, Institutes and Units that support the mental health workforce and its development, to promote research and development in innovation and reform; and working with existing mental health academic and research organisations to develop a strategy to build capacity in the academic and teaching workforce and conjoint clinical and academic appointments in services in mental health
4. Using expert panels to review the skills and capabilities of the existing workforce, including clinical roles and community-based rehabilitation support roles, and the implications for education and training and CPD, address the gaps, develop a workforce profile and trial and evaluate innovative approaches to recovery-based workforce development.
5. Commissioning work to consider the expansion of team profiles to include consumers, carers, support workers, and assistants in agreed professions, delineate the roles different workers play in the teams, the support mechanisms they can expect, and their accountabilities; and exploring suitable training, supervision, roles and career pathways for consumer and carer involvement in service delivery, possibly including competency-based training modules.
6. Facilitating discussion between jurisdictions, professional associations and unions to arrive at nationally agreed scopes of practice, classifications, clinical supervision standards and career progression for mental health professions.
7. Developing national core competencies and roles in clinical, community and peer support areas, linked to the National Practice Standards for the Mental Health Workforce.
8. Developing or adapting on-line courses around recovery (including case studies of lived experience) that could be offered through registered training organisations and higher education providers
9. Developing strategies and resources for leadership development and change management to assist providers to build organisational readiness for new ways of thinking about the structure, roles and responsibilities in an expanded mental health workforce, including the industrial implications of change.

10. Ensuring that professionals and managers receive training and organisational support in applying the values, skills and attitudes consistent with reforms that call for partnership with consumers and carers; evidence-based practice; cultural competence in service delivery; comprehensive cross-agency interventions; individualised care and home and community based approaches.
11. Developing and disseminating national guidelines and resources for the training, mentoring and support of Consumer and Carer Consultants that will help them support the system to give better support to consumers and carers.

### **3: Workforce supply**

Australia's mental health workforce faces challenges with limited supply, significant shortages, and maldistribution. There is a pressing need to attract and develop more workers, as well as using the skills and capacities of the current workforce to best advantage. A number of factors have contributed to health and mental health workforce shortages, despite the growing number of health workers in recent years. These factors include the reduction in work hours; a growing and an ageing population; increasing cultural and linguistic diversity; increased community expectations of health services; increased demand for health services as a result of economic prosperity; and limited training and support capacity.

#### ***Nurses***

There is a shortage of nurses providing mental health care owing to the higher than average age of the profession, increased services, and recruiting difficulties. The number of nurses providing mental health care has remained relatively static, with nurses working longer hours. The existing workforce has inadequate capacity to provide supervision and mentoring and undertake professional development. While the majority of nurses providing mental health care serve in metropolitan areas, in general they are distributed more evenly than other mental health professionals. The majority of these nurses are employed in the public sector, especially in psychiatric hospitals or mental health facilities.

#### ***Psychiatrists***

Available data also point to a critical shortage in the supply of psychiatrists to meet demands in the next decade. Representing approximately 85% of the psychiatrist workforce in Australia, RANZCP has 2,622 fellows (as at November 2009), of whom 14.6% are over the age of 65 years, and 39% will reach retirement age in the next decade. Shortages in the psychiatrist workforce in Australia are likely to worsen: two thirds of psychiatrists practising in 2000 expect to retire by 2025. Increasing demand, and the challenges of filling psychiatry training positions, recruiting psychiatrists to work in rural and remote areas, and the changing nature of the workforce (notably the increasing proportion of female psychiatrists and reduction in working hours among older male psychiatrists) mean that replacing one retiring psychiatrist is likely to require more than one younger psychiatrist.

#### ***Psychologists***

While there appears to be no immediate threat to the availability of the psychologist workforce in the public or non-government sector, increasing uptake of psychological services through the Better Access Program may lead to increased demand for psychologists in the future. As Medicare rebates for psychologists continue, it is also possible that an increasing number of psychologists may opt to work in the private sector. The majority of psychologists currently work in the public sector and in metropolitan areas. Psychologists in the private sector may also undertake visiting services in the public setting.

In a member survey conducted by the APS in 2009, about 22% of survey respondents indicated an intention to cease or reduce work in the public sector in preference for work in the private sector. However, it is important to note that workforce data on psychologists are currently based on the agreed levels and types of qualifications for psychologists to be registered to gain access to the Medical Benefits Scheme, and changes to current registration and accreditation requirements for psychologists are likely to adversely affect the availability of the psychology workforce in the future.

#### ***Social workers and occupational therapists***

While available data suggest that a growing number of social workers and occupational therapists are working with people with mental health conditions, there are limited data relating to the supply of social workers and occupational therapists relative to their demand in mental health settings.

## ***Recruitment***

Based on the State and Territory Skill Shortage List, registered mental health nurses are identified as an occupational group with statewide shortage in all States and Territories, with WA noted as having statewide recruiting difficulties. Clinical psychologists were considered to be in statewide shortage in NSW, Victoria, Queensland, SA, NT, and Tasmania, with WA noted as having recruiting difficulties in rural and remote areas. For social workers, statewide shortages were recorded in NSW (particularly for specialised areas such as child abuse, drug and alcohol and mental health), Queensland (especially in rural and remote areas and the community sector), Victoria, WA, and NT and ACT, with Tasmania experiencing shortage in rural and remote areas.

For occupational therapists, statewide shortage was recorded for NSW (particularly in specialised areas such as aged care and mental health), Victoria, Queensland, Tasmania and NT, with WA noted as having recruiting difficulties. Taken together, available data suggest particular workforce shortages in psychiatrists and nurses providing mental health services, and that there remains a disproportionate distribution of mental health professionals Australia, with greater shortages in rural and remote than in metropolitan areas.

In developing this national mental health workforce strategy, the MHWAC does not propose strategies to solve workforce shortages by recruiting overseas professionals. The recruitment and credentialing of international medical graduates and overseas trained health professionals is and will continue to be an ongoing activity of jurisdictions and professional accrediting bodies, and of the newly established Health Workforce Australia at least in the short term. There is strong evidence that the same workforce shortages and trends are experienced globally, and that international recruitment is not the solution to Australia's mental health workforce shortages in the longer term. Nonetheless, it is acknowledged that now and for the foreseeable future, overseas trained health professionals make an essential contribution to mental health services, especially in rural and remote areas.

The Bradley Report on Higher Education (2008) and the subsequent reforms announced by the Commonwealth government in 2009 changed the mechanisms for government to influence the number of university (and eventually VET) places in teaching institutions. While the system has changed, incentives remain for students to choose nursing study (in the form of reduced study loan repayments). These incentives are not accessible unless graduates work in nursing for a prescribed period of time after graduation, thus entailing a retention mechanism. Allied health education will not have similar incentives, and the number of places will be demand driven. The impact of the reforms will be monitored by Skills Australia, which will also advise government on the effectiveness of the system in meeting workforce needs.

The current and forecast continuing shortages in psychiatry and nursing call for broader strategies to help those professions function at an optimal level, maximising the use of their clinical skills. The research and consultation process suggested a need for changes to career paths for clinicians, in order to offer clinical career pathways that keep people in clinical roles rather than diverting them into management roles. The process also suggested a need to re-think notions of and training for leadership in interdisciplinary teams, so that clinical leadership roles can cross disciplinary boundaries and so that professions in short supply are not automatically expected to take on leadership roles.

## ***Role redesign***

There is a need for significant role redesign for psychiatry, mental health nursing, and possibly also psychology.

Supply data and retirement projections in psychiatry and mental health nursing over the next 10 years, taken together with demand data, suggest significant supply shortfalls. Such role redesign would need to provide clinical career pathways that keep clinicians in clinical roles, the capacity for teaching the next generation and for research capacity into the future.

Models are provided by the UK Better Ways of Working for psychiatrists, such as the potential for developing a new category of psychology assistant and the further development of nurse practitioners. The issues of role redesign, task delegation or substitution, and the creation of new roles need considered attention nationally.

There may also be a need to reconsider the definition of what constitutes the mental health workforce, as there is evidence that involvement of other professional groups such as dieticians, speech pathologists and pharmacists has grown in response to need, but not in any coordinated or consistent manner.

Informants support existing national initiatives to improve access in rural and remote areas. There is a need not only to attract more staff, but also to consider how to use the skills and talents of the current workforce to best advantage. That may mean re-considering the role of psychiatrists in private practice, greater use of nurse practitioners or mental health nurses in primary care settings.

### ***Curricula and training***

In written submissions received by the MHWAC and through the national consultations, consumers, carers and service providers were critical of current curricula and training in most disciplines and occupation groups involved in mental health care. Curricula were reported to lack adequate opportunity to learn from the lived experience of consumers, carers and families; to be too 'siloed' and therefore perpetuate the lack of understanding of what other disciplines and professions can contribute in mental health care. They offered insufficient early exposure to commonly occurring mental health conditions and to experiences of recovery, and insufficient exposure to service settings other than acute hospital settings. Commonwealth funded programs to review the curriculum for psychiatry training and to provide trainees with greater learning opportunities in community settings are showing some early success and the model could be extended to other training programs.

Several submissions called for the consistent inclusion of mandatory mental health modules in the training programs for all health-related professions; for mandatory or incentive-based training placements in rural and remote settings; for consistent and more streamlined processes for expanding scopes of practice; and for simpler, more attractive options for trained health professionals to update skills and return to or transfer into mental health care.

The Commonwealth has done significant work on the place of mental health in curricula through the Mental Health in Tertiary Curricula measure. MHWAC has continued to follow up implementation of the recommendations of the Mental Health Nurse Education Taskforce (MHNET). Curriculum change, however, can be slow and difficult to embed. An ongoing effort will be need to ensure that skills and knowledge in mental health are seen as a foundation area for all health practitioners.

The mental health sector was an early adopter of a multidisciplinary workforce. However, a flexible, multi-disciplinary approach to education and training needs further development. Further development of competency-based training, linked to the *National Practice Standards for the Mental Health Workforce*, is also required. The states and territories report activity in some or all of these areas.

### ***Initiatives to increase supply***

The extensive list of current jurisdictional initiatives to increase the supply of mental health professionals is included in the literature and document review that accompanies this strategy development. The list also indicates the considerable duplication of effort and resources to find solutions to nationally-shared workforce supply issues. The stage of development and evaluation of jurisdictional initiatives varies, but a national role in facilitating the expansion of successful initiatives beyond jurisdictional boundaries would be a logical approach in a national workforce strategy. Such proven local initiatives would need to have the potential to

develop and sustain the supply of mental health workers without negative impact on other mental health workforces.

The exploration of new roles in mental health care emerges as a commonly proposed strategy both overseas and in national research and consultations. Roles such as psychologist assistants and community support or recovery support workers are suggested in the Australian context. Psychologist assistant roles would tap into the estimated 4000+ graduates per annum who have psychology majors or honours degrees but who currently do not progress to higher degrees necessary for full registration. Community support worker roles could be tailored to local needs and would draw on the potential consumer and carer workforce, members of culturally and linguistically diverse communities (including refugee groups) and on local people with local knowledge and relationships. Essential to the successful development and sustainability of any new roles are clear role definitions and job descriptions, articulated training routes leading to accredited qualifications, the availability of appropriately trained supervisors, and consistent career pathways across sectors and jurisdictions.

### ***Perceptions of mental health work***

The attraction of people to train to work in mental health continues to be a major challenge owing to poor public perception of mental health work. Again, considerable work is under way at the state and territory level to develop local strategies to promote mental health as an attractive career choice. Participants in workshops and written submissions saw an important role here at the national level for educating the media and the public. This education would be about the role of the workforce in promoting wellness, and acknowledge the achievements of mental health workers in a range of settings in working with consumers, carers, families and communities in prevention and early intervention, and supporting recovery and social inclusion.

There is evidence of successful ‘grow your own’ strategies for developing the mental health workforce in Aboriginal and Torres Strait Islander communities (such as Wuchopperen in Queensland, and Greater Western Area Health Service in NSW) that could be used as models for national implementation. Sometimes these service providers successfully ‘grow their own’ and then lose their graduates to government-funded positions as Aboriginal and Torres Strait Islander Mental Health Workers. These services’ success in training providers should be acknowledged and funded as a valued contribution to workforce development.

Some services have less difficulty with recruitment than others. There is anecdotal evidence of successful recruitment into new approaches and service models, such as the Brain and Mind Research Institute, beyondblue, e-Hub ANU, Black Dog Institute, Orygen Youth Mental Health Services, headspace, Inspire Foundation and Reach Out, and Crufad, St Vincent’s Hospital Sydney. Through the consultation process, however, many employers reported concerns about workforce sustainability due to the lack of career paths for staff working in these programs and the insecure tenure of many of the positions.

A range of strategies is needed to build the supply of the mental health workforce now and into the future. It is important that the strategies align with and maximise opportunities to work within the broad national programs of the new agency Health Workforce Australia and the recently released National Workforce Development Strategy *Australian Workforce Futures*.

### 3. By building supply of the mental health workforce we aim to:

- Contribute to providing access to a range of appropriate services by providing the workforce to meet projected population growth and need
- Contribute to capacity to provide effective and appropriate services
- Improve the distribution of and access to the workforce across all geographic regions, to better serve people in rural and regional and remote and other underserved areas

**strategy**

#### Strategies to achieve these outcomes may include -

1. Undertaking supply modelling to determine the roles, skill mix and workforce architecture required in mental health to meet future service care needs.
2. Supporting and coordinating a national communication strategy about the positives of working in mental health, wellness and recovery.
3. Supporting the training of people of Aboriginal and Torres Strait Islander background to become mental health workers by ensuring the continuation and support of successful programs, piloting new programs, widely promoting existing scholarships and supporting the evaluation and governance of programs through existing bodies such as the Aboriginal and Torres Strait Islander Health Registered Training Organisation Network.
4. Coordinating nationally agreed frameworks for the development of roles, training, accreditation and career pathways for people with lived experience as consumers and carers (building on existing work of States and Territories).
5. Ongoing development and implementation of a national approach to agreed role definitions for the full range of disciplines involved in mental health.
6. Facilitating and supporting a national approach to the development of career paths for clinicians who choose to remain clinicians; and for professionals from a range of disciplines and in a range of settings who choose to become managers and leaders in mental health.
7. Supporting and coordinating the creation of new roles including consideration of career paths and training requirements at both VET and tertiary levels.
8. Developing dual VET training programs in Alcohol and Drugs and Mental Health with comparable career entry requirements.
9. Ongoing development and implementation of national mental health curricula and competency architecture in health and human services-related education and training programs.
10. Working with Health Workforce Australia to ensure that clinical placements, expanded settings, and supervisor training across all the disciplines involved in mental health are included in resource allocation considerations.
11. Working with the DEEWR and other relevant bodies, such as Skills Australia, to continually monitor and review the impact of the reforms arising from the Bradley Report on the number and type of undergraduate and postgraduate enrolments in relevant health courses; and working with the States and Territories to complement local targeted scholarship schemes.

#### **4: Building the capacity of the general health and wellbeing workforce to work effectively with people living with mental illness across the lifespan and with their carers, families and communities**

The general health and wellbeing workforce includes General Practitioners, practice and other primary care nurses, Aboriginal Health Workers, social workers, occupational therapists, speech pathologists, pharmacists and psychosocial support workers. Generalist providers treat and support people with a wide range of health conditions, and are usually based in community settings. They may:

- provide a first point of contact with the health system and operate as a gateway to other parts of the health system through referrals;
- provide holistic and continuing care to people and their families/carers over time and across episodes of care; and
- coordinate care for patients receiving care from several different providers.

Mental illness is common, and generalist providers need knowledge and skills in recognising and assisting people with mental illness. This is particularly so in rural and remote areas where specialist services are difficult to access.

Types of mental health care provided may include patient education, pharmacotherapy, psychological treatment, and ongoing management and support. Mental health consumers also require physical care, and are more likely than the general population to smoke, have a poor diet, have high alcohol consumption and undertake less exercise with consequent increased morbidity; and have increased rates of ischaemic heart disease, stroke, high blood pressure, bowel cancer, breast cancer and diabetes than the general population and develop illnesses at a younger age and are dying from them earlier. Most people with mental disorders are seen by GPs, however, data indicates that consultation with a GP for any reason was far more common than consultation with a GP for mental health problems.

##### ***Training and education***

Training can support the general health and wellbeing workforce in achieving improved health outcomes for consumers. Effective referral requires consideration of the interaction of the general health and wellbeing workforce and specialist mental health services. There is evidence of the effectiveness of skilling the generalist health workforce in Mental Health First Aid, and indeed of providing Mental Health First Aid training to other front-line workers who come into contact with at risk population groups (eg correctional staff, police) to facilitate prompt referral to appropriately skilled mental health workers.

Through the review of literature and the national consultation, it became evident that skilling the generalist health workforce about mental health will involve an education program that focuses on the needs and experiences of people with a mental illness, and their carers and families. For instance, understanding the needs of children and young people experiencing early signs of mental health problems, and of their carers and families, would be essential for paediatricians and child health clinicians and field workers, together with confidence in early intervention and referral. Similarly, as the population ages, training of mental health and aged care professions and the generalist health workers that focuses on the needs of people ageing with a mental illness, and their elderly carers, is regarded as essential by those currently working with older people living with mental illness.

The literature and feedback from stakeholders suggest that involving consumers and carers in training the workforce should not be tokenistic—not simply a guest lecture from someone with lived experience. Rather, it should involve meaningful engagement of people with lived experience, from curriculum development, training and assessment through to evaluation of training programs for the health workforce. The literature also suggests expanding the boundaries of the secondary mental health workforce, and offers early evidence of the effectiveness of doing so. Secondary mental health workers who could be or have been

trained in mental health literacy, mental health first aid, and early intervention include teachers, correctional officers, police and inmates in correctional centres, and government workers who come into contact with farmers and rural communities.

### ***Comorbidities***

In states and territories, there are differing approaches and service delivery models for treating and supporting people with co-occurring mental health and drug and alcohol problems. In some jurisdictions, services are co-located and staff are trained in early intervention and referral for both aspects of the clients' needs. Informants working in rural and remote areas advised that the health needs of their clients are complex and commonly involve mental health, substance abuse and chronic physical health problems (and the data from rural and remote areas of Australia support this). The literature suggests that in many cases, staff confidence in assessing and treating clients with such complex needs is low. Consequently, this national strategy proposes that health workers who commonly deal with people with complex co-occurring health problems are routinely trained at least in mental health first aid, early intervention and referral.

*Linking physical and mental health... it makes sense (LPMH)* is an initiative of the NSW government to work collaboratively with other health care providers to improve the physical health of people who use a mental health service. This and other innovative State and Territory programs have the potential to be evaluated and applied nationally. The South Australian government is developing modules to assist mainstream Aboriginal health services to develop partnerships with other providers and; the Northern Territory government, is also developing a mental health shared care program for collaboration between mental health providers and other government and non-government agencies.

There is evidence of a lack of awareness between different health professions (including mental health specialists) about the potential contributions of generalist health providers to the care and support of people living with mental illness. Community pharmacy is often a forgotten resource that could be better engaged and used by Government and by other health care providers in implementing community-based health programs and providing primary health care services.

National facilitation of the development of role definitions for the contribution of different professions to mental health has been raised earlier in this document. The importance of developing 'health system literacy' - a shared understanding of the contributions of different types of providers and professions and of referral pathways and consumer-centred treatment approaches is equally relevant to building the capacity of the generalist health and support workforce.

**4. Through building the capacity of all health and community service providers to work effectively with people living with mental illness across the lifespan and with their carers, families and communities we aim to –**

- Further develop the capacity of health and community service providers to support people with complex health and social needs, wherever they present.
- Improve links and reciprocal supports between specialists and generalists
- Promote shared care and cooperation across the government, non government and private sectors
- Improve the mental health literacy and confidence to work with and support people with mental illness in generalist health and support workers

**Strategies to achieve these outcomes may include –**

1. Facilitating mental health system literacy and mental health first aid training for the generalist health workforce and for identified front-line workers in emergency, welfare and associated sectors such as ambulance officers, teachers, correctional officers and police in accordance with national action recommended in the 4th National Mental Health Plan.
2. Facilitating access to Aboriginal Mental Health first aid training to the front-line workforce of agencies working in rural, regional and remote areas.
3. Further developing the capacity for specialist mental health professionals to act as secondary consultants at key points in the health and aged care systems e.g. emergency departments, aged care assessment teams, school counselling services, general practice, psychology etc.
4. Further developing and building MHPoD as the platform for generalists to access on line self directed mental health modules, based on a nationally consistent core curriculum

## 5: Data and monitoring and evaluation

To support workforce planning and modelling and the monitoring and evaluation of workforce initiatives, it is essential to have well-designed and integrated data collections systems. However, there is an ongoing challenge in collecting accurate, timely and quality data on Australia's mental health workforce. There is no data set specifically designed or suitable for planning the Australian mental health workforce.

While there are a range of data sources that provide information about size and characteristics of Australia's mental health workforce, aggregation of existing data collections to provide a single picture of the mental health workforce is challenging, owing to variations in their quality and usefulness. These variations are the result of a number of factors, including differences in workforce coverage, data definitions, the range of data items, time periods, response rate, and State and Territory differences in workforce related legislations, registration requirements, and service design (see the Background Paper for a more detailed analysis of mental health workforce data collections).

A major gap in current workforce data collections is the absence of a national data collection on the mental health workforce in the non-government community sector. The first steps to address this data gap have been undertaken through the Non-Government Organisation Mental Health Workforce Study. If the data collection instrument developed and trialled is successful and cost-effective, there would be potential for it to be built into a comprehensive national collection.

Another key data gap is the insufficient disaggregation of data categories in existing data collections to enable a more accurate identification of the mental health workforce. In particular, the lack of information on the number of mental health nurses in Australia owing to the lack of differentiation between mental health nurses and the broader nursing workforce that provide mental health care is problematic. Nor are there data that could be used to determine the extent to which care for people with mental health problems is provided by the general health workforces. Further, the lack of regular longitudinal data in many data collections means that there is no capacity to estimate rates of attrition from the workforce over time.

Taken together, current workforce data collections cover a range of variables that are consistent with good practice in workforce planning, modelling and monitoring and evaluation. However, variables such as demography, working hours, sector of employment, qualifications, and intentions to leave or return to the workforce are not defined and collected consistently or adequately linked across data collections to enable the development of an accurate profile of the mental health workforce and effective monitoring and evaluation of workforce initiatives.

To increase the capacity to inform workforce planning and monitor and evaluate national mental health workforce initiatives, it is critical to enhance the ability of current data collections to collect data on mental health specialisation (ie to identify the mental health workforce from the general health workforce) and improve data consistency and linkages across the whole of mental health sector. Workforce planning also requires robust and well-linked service, workforce and client (or population) data collections.

### *Existing collections*

At the State and Territory level, there are some notable data collection and workforce monitoring and planning activities.

In Queensland, mental health workforce targets (number of FTE staff) for community mental health programs have been established by the Mental Health Branch (Queensland Health) and monthly telephone surveys of mental health services are conducted to ascertain staffing levels and vacancies. Progress towards meeting the staffing targets is then calculated to inform workforce planning.

In Victoria, human resource payroll data and data from a census of the public direct care mental health workforce were used in 2003 to model and forecast the workforce (total FTE) and strategies needed to meet service demand to 2011-12.

Supply and demand analyses of the allied health professional groups were conducted in Tasmania in 2001-2002.

In WA, a Workforce Requirements Model and a Workforce Supply Model are being developed to provide projections for workforce demand, supply and the gap between the two, and evidence for service planning and funding submissions.

There has also been work to profile the mental health workforce in the non-government community sector in the ACT, Queensland and Tasmania.

It is evident that states and territories vary considerably in their capacity to undertake data collection and workforce modelling and planning.

## 5. By collecting accurate, timely and quality data on Australia’s mental health workforce with well designed and integrated data collection systems, we aim to<sup>7</sup>:

- support workforce planning and modelling
- increase the capacity to inform workforce planning
- monitor and evaluate national workforce initiatives

### Strategies to achieve these objectives may include –

1. Developing and implementing a monitoring and evaluation framework for this workforce strategy.
2. Assessing the usefulness of existing data collections and their data items, identifying data gaps and needs, and making better use of existing data systems (both workforce and clinical data) to monitor, analyse and evaluate workforce activities and inform workforce planning.
3. Including consumer and carer input as part of the monitoring and evaluation of mental health workforce initiatives
4. Supporting the inclusion of specialisation as a mandatory item in key health workforce data collections to enable greater disaggregation of workforce categories and the identification of mental health professionals (eg in human resource and payroll data systems and/or the National Register)
5. Auditing workforce data definitions and improving consistency in core workforce data categories across data collections (eg in data definitions and sub-categories) across States and Territories and the public, private and not-for-profit sectors.)
6. Ensuring data such as employment sector (eg private, government, non-government community sector) workforce intentions (eg to retire or move into a different employment sector), and actual workplace transitions (eg moves within or between workforces or out of the labour force) are collected for all mental health professional groups and in a consistent way across data collections
7. Exploring cost effective ways for collecting data, wherever possible, longitudinally and continuing to follow respondents once they leave the workforce either short or long term. Understanding both those who leave (eg through exit interviews) and those who stay in the mental health workforce is equally important for workforce planning.
8. Ensuring that the work begun through the “Non-Government Organisation Mental Health Workforce Study” to develop an agreed methodology for collecting mental health workforce data in the non-government community sector becomes part of regular and routine data collection for workforce planning and development in the sector.
9. Establishing greater communication and links between data collections and bodies that collect data and across sectors (eg education, employment and health sectors; AIHW, professional bodies, State and Territory governments)
10. Working with broader data initiatives in healthcare to identify ways to link patient and provider data to determine equity of access and the relationship between services

<sup>7</sup> Section needs to be discussed with MHISS

and outcomes.

11. Continuing to support and enhance efforts to monitor workforce numbers (headcount and FTE), vacancy rates, work practices, and workforce distribution across sectors, geographic regions and professional groups at regular intervals and provide user friendly feedback to the sector.
12. Working with HWA to identify overlaps and duplications across data collections (in data items and workforce coverage) to ensure that there is one authoritative agreed source nationally for mental health professions and the sector as a whole.
13. Developing consistent measures of the ethnicity and bilingual skills of the workforce to better inform workforce planning issues in relation to Aboriginal and Torres Strait Islander and CALD populations

**Other suggestions by PSC members which need further consideration and discussion:**

- May need another strategy on: identifying and agreeing on the scope of a mental health workforce data collection that is purpose-built to inform workforce planning.
- Developing workforce data items relating to recovery oriented community care
- Based on the agreed service framework, developing strategies to model the workforce required to support the service framework
- Improving the capacity to model mental health service demand, hence, the mental health workforce, by linking service, client and workforce data systems.
- In relation to strategy 7, the PSC suggests that one way to track individuals might be to have a unique identification code for each person. This code would be the same regardless of the employer. There would also need to be regular survey of work intentions (eg intentions to stay (short-, medium, long-term) and why, and intentions to leave (short-, medium, and long-term, and to where) and why?). Databases need to be linked and the person's code and data (eg sector of employment, work intentions) then could be extracted from different data systems for analysis. Data would probably need to be collected at the organisational level, and fed up to a national data system.