

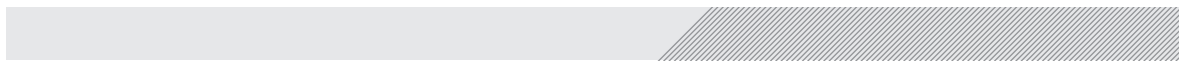


**MENTAL HEALTH  
WORKFORCE**  
ADVISORY COMMITTEE

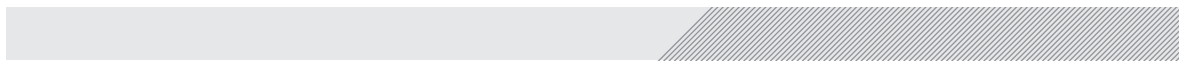
# National Mental Health Workforce Strategy

STRATEGY





# National Mental Health Workforce Strategy



# National Mental Health Workforce Strategy

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# Introduction

Providing effective and appropriate mental health services continues to be a challenge for government at all levels. Mental illness and mental health problems are common, sometimes devastating in their impact, and come at a considerable economic and social cost. Like other areas of health, mental health services are provided in primary, secondary and tertiary service settings. But, perhaps more so than other areas of health, good mental health services also rely on community support services, and have an important interface with areas such as employment, housing, emergency services and the justice system. At the centre of good mental health service delivery is the engagement between the service provider and the consumer. While interventions such as biological and psychological treatments are important, empathy, understanding and expert knowledge are critical to successful outcomes.

In Australia the [National Mental Health Strategy](#) guides mental health policy and practice. The [National Mental Health Policy](#) was revised in 2008, and the latest in a series of plans—the [Fourth National Mental Health Plan](#)—was released in 2009. The new [National Standards for Mental Health Services](#) were released in September 2010.

A sustainable, skilled and appropriate workforce is fundamental to the success of the strategy. Accordingly, the [Fourth National Mental Health Plan](#) contains a specific action to support the development of a national mental health workforce strategy. The plan envisages that greater consistency in roles and responsibilities of service providers across the spectrum of care will be supported by other key actions, such as the development of a national service planning framework and improved reporting and accountability measures.

This *National Mental Health Workforce Strategy* provides key areas for consideration and further development to inform and support initiatives that will ensure that our mental health workforce continues to grow, and is equipped to provide effective and appropriate services across the clinical and community support sectors.

## Aim

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The aim of the strategy is to develop and support a well-led, high performing and sustainable mental health workforce delivering quality, recovery-focused mental health services.

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.

The workforce includes mental health nurses, psychiatrists, general registered nurses, enrolled nurses, general and other medical practitioners, occupational therapists, social workers, psychologists, Aboriginal mental health workers, Aboriginal health workers, mental health workers, consumer workers and carer workers. It encompasses workers in a range of settings, including hospitals, health care and community mental health services and correctional facilities across metropolitan, regional and remote areas of Australia. These workers are engaged in public, private and non-government (NGO)<sup>1</sup> services.

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<sup>1</sup> Community Mental Health Australia, the peak body for the NGO sector in mental health, has advised that the sector is reconsidering how it is described, and that in the future, the sector may be referred to as the community managed organisations (CMO) sector. The sector provides a range of mental health support services, with funding from government at all levels.



## The impact of mental illness

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Mental illnesses or disorders 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 per cent of Australians will experience a mental disorder during their lifetime.<sup>2</sup> Some 2.5 per cent of the population is affected by severe and persistent mental illness, and may require many services over a long period. The overall treatment rate for people with mental disorders remained fairly stable at about 35 per cent from 1997 to 2007. Recent modelling estimates the overall treatment rate in 2010 was approximately 46 per cent.<sup>3</sup>

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. About \$4.6 billion in services were provided in 2006–07.<sup>4</sup> 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 sixty.

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. In particular, a shift in focus is needed away from the primary consideration of clinical care, to a more holistic model, where the notion of personal recovery is given greater attention. While the aim should always include minimising disability experienced as a result of mental illness, there is growing agreement that recovery-oriented services should be provided in a manner that maximises hope, autonomy, choice and full engagement in the community.

## Strategic directions in mental health reform

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The progressive reform of mental health service delivery over the duration of the [National Mental Health Strategy](#) has resulted in significant shifts in where and how mental health services are delivered. In particular, there has been a shift at a state level, from stand-alone services, to inpatient services co-located with general health services linked to a range of community-based services. There has also been growth in the non-government or community support sector funded through state governments. Likewise, there has been an expansion in mental health-related medical rebates, and specific initiatives funded through the Australian Government to improve access to clinical and community support services. These strategic directions are further enhanced in the *Fourth Plan* to support the development of greater collaboration between providers, better continuity of care and improved capacity for early intervention—in life, illness and episode.

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<sup>2</sup> Australian Bureau of Statistics (2008) [National Survey of Mental Health and Wellbeing 2007: Summary of results](#), ABS catalogue number 4326.0, Canberra.

<sup>3</sup> Centre for Health Policy, Programs and Economics, the University of Melbourne (2011) [Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Summative Evaluation](#). This modelling is based on an analysis of service utilisation data from Commonwealth, state and territory sources that provide reliable, unique counts of people treated.

<sup>4</sup> Commonwealth Department of Health and Ageing (2009) [Fourth National Mental Health Plan: An agenda for collaborative action in mental health 2009–2014](#), Canberra.

The *Fourth Plan* also recognises that improved outcomes for people with mental illness will require engagement with other areas of government, and better education and awareness in the whole community. People living with mental illness need access to good physical health care, stable and appropriate accommodation, and meaningful occupation. Recovery-oriented services are expected to give consideration to these broader social areas as well as to treatment and care related to the mental illness, and to work with their client or patient to maximise the realisation of personal autonomy and choice. A competent, multidisciplinary workforce, equitably distributed and well supported, will be crucial if we are to realise these goals.

## Outcome areas for the *National Mental Health Workforce Strategy*

Five outcome areas have been developed as the focus of this strategy based on the literature, data and advice from consultations:

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 the general health and wellbeing workforce.
5. Data and monitoring and evaluation.

## The mental health workforce in Australia

Growing and developing the health workforce is a priority for governments in Australia. Despite increases in the size of the mental health workforce over recent years, many public, private and NGO mental health services are experiencing shortages in workforce supply, and difficulties with recruitment, distribution and retention.

The mental health workforce operates in a complex set of interrelated services. Consumers use a variety of public, private and non-government health service providers for mental health care, treatment and support. Care is now delivered primarily in community settings. A substantial NGO sector has developed, consisting of an estimated 800 organisations of varying size and service type.

Services include hospitalisation and other residential care, hospital-based outpatient services and community mental health care services, home-based and community-based psychosocial rehabilitation and support services, assessment and treatment services in the criminal justice system and consultations with both specialists and general practitioners (GPs). Other related activities include mental health promotion, mental illness prevention and early intervention and referral, assistance with daily living and with maintaining wellness.

Because services are provided in a range of settings, and are funded through different levels of government or different government departments, it can be difficult to develop a reliable and coherent understanding of the size and distribution of the mental health workforce. A recent report on the workforce in non-government organisations that provide mental health services contributes to a greater understanding of that workforce. Data collected through Medicare and by the Australian Institute of Health and Welfare (AIHW) provide reasonable detail about the clinical workforce. For example, the most recent figures from the AIHW show that in 2007–08, there were over twenty-one thousand FTEs employed in public-funded mental health services across medical, nursing and allied health disciplines.<sup>5</sup>

There is a need to further refine and clarify the data collected to allow a better understanding of the mental health workforce across the different sectors. Workforce supply cannot always meet demand, and socio-economically and geographically disadvantaged areas continue to be underserved. Workers from different

<sup>5</sup> AIHW (2010) Mental health services in Australia 2007–08, AIHW Mental Health Series, number 12, Canberra.

disciplines and backgrounds are differentially distributed across sectors and locations. A brief summary of the available information regarding the relevant professions in mental health suggests the following:

## Nurses

The majority of mental health nurses are employed in the public sector, especially in mental health inpatient or community mental health facilities. There is a national shortage of nurses providing mental health care, owing to the higher-than-average age of workers in the profession, increased services, and recruiting difficulties.<sup>6</sup> 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 work in metropolitan areas, in general, they are distributed more evenly than other mental health professionals. The recent expansion of work roles through the [Mental Health Nurse Incentive Program](#) (MHNIP) and nurse practitioner initiatives are widely supported.

## Psychiatrists

Psychiatrists work in the public and private sectors, but rarely in the NGO sector. Their distribution, like that of many medical specialists, is skewed towards major cities.<sup>7</sup> Available data point to a critical shortage in the supply of psychiatrists to meet demands in the next decade.<sup>8</sup> Representing about 85 per cent of the psychiatrist workforce in Australia, RANZCP has 2,622 fellows (as at November 2009), of whom 14.6 per cent are over the age of 65 years, and 39 per cent will reach retirement age in the next decade.<sup>9</sup>

<sup>6</sup> Mental Health Workforce Advisory Committee (2008a) [Mental Health Workforce: Supply of Mental Health Nurses](#).

<sup>7</sup> AIHW (2009) *Mental health services in Australia 2006–07*, AIHW Mental Health Series, number 11, Canberra.

<sup>8</sup> Mental Health Workforce Advisory Committee (2008b) [Mental Health Workforce: Supply of Psychiatrists](#).

<sup>9</sup> Royal Australian and New Zealand College of Psychiatrists, *Workforce Survey 2009*, RANZCP, Melbourne.

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, coupled with 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. The current increase in medical graduates offers opportunities to recruit a larger number of junior doctors into the specialty.

## General practitioners

General practitioners (GPs) deal with a wide range of physical and mental health issues. The AIHW estimates that there were 13.2 million mental health-related GP encounters in 2008–09.<sup>10</sup> These are encounters in which at least one mental health-related problem was managed. GPs often manage multiple problems in one encounter, and also frequently manage chronic conditions such as depression.

GPs are often the first point of contact in the health system, and may act as a gateway to more specialised services. The most common types of management for mental health-related problems are medication, counselling, pathology tests and referrals. More than 40 per cent of GPs work in practices with between two and four full-time equivalent doctors. Significant efforts are being made to improve recruitment into GP training programs because of workforce shortages, which are particularly acute in rural and remote areas.

## Psychologists

The majority of psychologists currently work in the public sector and in metropolitan areas.<sup>11</sup> According to the Skills Shortage List, clinical psychologists were considered to be in statewide shortage in New South Wales, Victoria, Queensland, South Australia, the Northern Territory and Tasmania, with Western Australia

<sup>10</sup> AIHW (2010).

<sup>11</sup> AIHW (2006) *Psychology Labourforce 2003*, catalogue number HWL 34, Canberra; AIHW (2010).

noted as having recruiting difficulties in rural and remote areas. Increasing uptake of psychological services, particularly through the Better Access Program, may lead to increased demand for psychologists in the future. The availability of Medicare rebates for psychologist interventions means that an increasing number of psychologists may opt to work in the private sector, putting strains on supply and potentially providing a pathway for senior clinicians out of public mental health services. Psychologists in the private sector may also undertake visiting services in the public setting, and psychologists are employed in NGO settings.

In a member survey conducted by the Australian Psychological Society (APS) in 2009, about 22 per cent of survey respondents indicated an intention to cease or reduce work in the public sector in preference for work in the private sector. However, 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

While available data suggest that a growing number of social workers are working with people with mental health conditions, there is limited data relating to the supply of social workers relative to their demand in mental health settings.<sup>12</sup> Social workers are employed in a diverse range of sectors, including the NGO sector. Opportunities for work in the private sector have broadened through changes to Medicare in recent years. The recent inclusion of core mental health content as a requirement for accreditation of social work qualifying courses may increase the pool of social workers interested in mental health.

Based on the Skills Shortage List, statewide shortages of social workers were recorded in New South Wales (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, Western Australia, the Northern Territory and the Australian Capital Territory, with Tasmania experiencing shortages in rural and remote areas.

## Occupational therapists

The available data also suggests that a growing number of occupational therapists (OTs) are working in mental health services. National registration of OTs from 2012 will improve data considerably. Opportunities for private practice in mental health by OTs have also increased through Medicare, although numbers are relatively small.

For occupational therapists, the Skills Shortage List records statewide shortage for New South Wales (particularly in specialised areas such as aged care and mental health), Victoria, Queensland, Tasmania, Western Australia and the Northern Territory.

## Vocationally qualified mental health workers

Vocationally qualified mental health workers include community support and recovery support workers. They are usually located in the community NGO sector, where historically, workforce data has not been routinely collected, and they are identified on the Skills Shortage List. Community Mental Health Australia supports the Certificate IV in Mental Health as a voluntary minimum qualification for work in the NGO sector. The outcome of the current NGO Mental Health Workforce Study, together with monitoring of enrolment and completion rates for the updated VET community services training programs in mental health may provide some interim mechanisms to track supply of the workforce in the short term.

## Consumer and carer workers

Consumer and carer workers are employed in public mental health services and the NGO sector. Under the [Targeted Community Care \(Mental Health\) Program Guidelines](#), particularly in the Personal Helpers and Mentors (PHAMs) service stream, opportunities for employment have increased. Roles may include consumer advocate,

<sup>12</sup> AIHW (2010); Australian Association of Social Workers Survey.

carer advocate, consumer consultant, carer consultant, consumer manager, peer support worker or mentor. Workers may be engaged in systemic advocacy work, the provision of support to consumers, carers and families, and education or training roles. Limited data is available in regard to this workforce.

## Overseas-trained mental health professionals

The recruitment and credentialing of international medical graduates and other overseas-trained health professionals is and will continue to be an ongoing activity of jurisdictions, professional accrediting bodies and of Health Workforce Australia. There is strong evidence that the same workforce shortages and trends are experienced globally. 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.

## Working in mental health

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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 and social outcomes for the Australian community.

Working in mental health offers particular challenges and benefits, and can be exceptionally satisfying. As well as the more traditional areas of treatment and care, mental health work offers the opportunity to contribute to the personal recovery of consumers, including assisting them in addressing the challenges they meet daily and providing support to their families and carers.

Mental health services are delivered in a range of settings, and frequently utilise multidisciplinary teams. Working with people from a range of professional backgrounds is a positive aspect of employment in mental health. People bring a different range of qualifications, experience and skills which can contribute to better treatment, care and support. Inter-professional collaboration

can offer benefits to both consumers and workers. The interface with primary care and other types of health and community services is also an important part of the provision of effective services.

There are opportunities to work in crisis teams that intervene quickly to prevent or reduce the impact of crisis and relapse; assertive outreach teams which provide support and treatment for people with long-term mental health problems who have complex needs and who may find it difficult to engage directly with services; and recovery-oriented services which assist people to stay well and engage with their community. The range of work settings is diverse, and potentially supports skill development in varying roles and environments.

Some of the challenges particular to the area include providing care, support and treatment to people who may sometimes 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. The work can be stressful, and can test the capabilities, resources or needs of workers. Adequate training and support can and should ameliorate job stress. Services need to be aware of such issues and provide appropriate supervision, particularly to more junior staff.

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 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 learned, and are not working to their potential.

Working in mental health has both positive and negative aspects, as is true of many areas of work. This strategy considers ways of further enhancing the positive areas, and addressing some of the challenges.

## The current policy context for this strategy

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The mental health workforce is affected by developments in the broader health workforce, as well as by mental health policy changes and developments. Health workforce shortages are a national and an international issue. Major policy and program developments are under way in both the mental health and health workforces in Australia.

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

Since 1992 a [National Mental Health Strategy](#) has provided a framework for reform. 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.

In addition to the [National Mental Health Strategy](#), the Council of Australian Governments (COAG) developed the [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 private sector 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. This included a significant increase in mental health service provision by NGOs.

The original National Mental Health Policy was updated in 2008. It reiterated the need for a whole-of-government approach to mental health and identified 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 and prospects for promotion).

The [Fourth National Mental Health Plan \(2009–2014\)](#) was released in November 2009. The development of recovery-oriented services that are community needs-based and align with the principles of the *Fourth Plan* has implications for developing the mental health workforce in Australia, including continued development of services across sectors and in community settings, in order to maximise treatment options and outcomes.

The need to develop the workforce and increase its capacity is noted in both the *Fourth Plan* and the COAG [National Action Plan on Mental Health 2006–2011](#). Recruiting and retaining a workforce that is supported to maintain and further develop skills and knowledge, and is responsive, culturally competent and sustainable, remains a continuing challenge.

### Five key areas for national action within the plan

Despite the achievements of previous Australian mental health reforms and action plans, the [Fourth National 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.

The plan has five key priority 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.

#### Priority area 1: Social inclusion and recovery

The plan recognises that to achieve greater social inclusion there must be increased understanding of mental health and wellbeing in the community, and that delivery of services must be coordinated across health and social domains. It includes

the following actions which have workforce implications:

- re-focused workforce development that supports the recovery approach
- further expansion and development of a peer support workforce.

### **Priority area 2: Prevention and early intervention**

The plan endeavours to support outcomes where people have a better understanding of mental health problems and are thus more able to seek help or support others early. Actions are directed to ensuring greater recognition and response to mental health issues, including to co-occurring alcohol and drug problems, physical health issues and suicide risk.

The workforce implications include education and training for front-line workers who come into contact with people with mental health issues, including police, ambulance, child protection and other services. Training should include greater awareness and understanding of co-existing mental health and alcohol and substance abuse, and of behaviour that may indicate risk of suicide.

### **Priority area 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 the development of a national service planning framework (models of care) which will include consideration of the workforce components required.

### **Priority area 4: Quality improvement and innovation**

The outcomes intended in this area include improved information about mental health service availability and standards of care, and support for emerging models of care. A key outcome is expected to be the development and the initial implementation of this *National mental health workforce strategy* to inform a national approach to define standardised workforce competencies and roles in clinical, community and peer support areas.

Other actions that will have workforce implications in this area are:

- 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.

### **Priority Area 5: Accountability—measuring and reporting progress**

Monitoring and reporting on progress are crucial in ensuring that the public can make informed judgments about mental health reform and the implementation of the plan. There should be adequate, reliable information available about services to compare against national benchmarks. In order to achieve this, there needs to be:

- an improvement in the type and level of data collected to map and measure the mental health workforce, its attributes and trends
- effective monitoring and evaluation of the implementation of workforce strategies.

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

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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 COAG.

Responsibility for monitoring and coordination of the implementation, evaluation and reporting effort is vested in the MHSC. The AHMC has agreed to establish a Cross-Sectoral National Mental Health Plan Implementation 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 in April 2010.

## Reforms and developments

Several significant national reforms, projects, policy and governance initiatives that will affect the mental health workforce are underway, or will soon begin. Some of these are directly related to work under the *Fourth Plan*, such as the development of a national mental health service planning framework and the revision of the [National Standards for Mental Health Services](#). Others are linked to developments in the broader health context, such as the national e-health strategy and the work of the Australian Commission on Quality and Safety in Health Care. Several initiatives will support the mental health of people from culturally and linguistically diverse backgrounds (such as transcultural mental health centres), and Indigenous health workforce development initiatives (for example, the work of the Aboriginal and Torres Strait Islander Health Registered Training Organisation Network, or ATSIHRTON). Work is already under way on 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). A workforce study on the non-government organisation mental health workforce was completed in early 2011.

### National Practice Standards

The [National Practice Standards for the Mental Health Workforce](#) were developed in 2002 to guide the practice of mental health nurses, occupational therapists, psychiatrists, psychologists and social workers. The *Practice Standards* outline the knowledge, skills and attitudes required of any member of the five disciplines employed in the mental health workforce, and can also be used by others involved in the provision of services to people with mental health problems or disorders (for example, carers and emergency room staff).

The twelve core standards establish a two-year timeframe, during which professionals can work towards meeting the requirements of the *Practice Standards* from the time they begin work in a mental health service. In addition to individual practitioners, the *Practice Standards* are aimed at services and the five national professional

organisations representing psychiatry, psychology, social work, nursing and occupational therapy. The *Practice Standards* are intended to complement each of the professional groups' discipline-specific practice standards or competencies and address the shared knowledge and skills required when working in a multidisciplinary mental health environment. It is the responsibility of services and professional organisations to encourage the incorporation of the *Practice Standards* into routine practice.

### National Standards for Mental Health Services

While the [National Practice Standards for the Mental Health Workforce](#) relate to the skills, knowledge and attitudes expected of those who work in mental health services, the [National Standards for Mental Health Services](#) apply to the setting in which mental health care is provided. The revised *Standards* cover ten areas. The tenth standard relates to the delivery of care and includes a recovery standard. (See Table 1 on the following page.)

The [Principles of recovery-oriented mental health practice](#) state that:

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 must be viewed as both a process and outcome. The National Recovery Principles identify six principles to ensure recovery-oriented mental health practice. These are:

1. uniqueness of the individual (including empowering the individual to be at the centre of care)
2. real choices (including achieving a balance between duty of care and support for an individual to take positive risks)
3. attitudes and rights (including listening to, learning from and acting on communications from the individual and their carers)
4. dignity and respect



Table 1: Service standards and related practice standards

National standard	National practice standard
1. Rights and responsibilities	Standard 1: Rights, responsibilities, safety and privacy
2. Safety	
3. Consumer and carer participation	Standard 2: Consumer and carer participation
4. Diversity responsiveness	Standard 3: Awareness of diversity
	Standard 4: Mental health problems and mental disorders
5. Promotion and prevention	Standard 5: Promotion and prevention
	Standard 6: Early detection and intervention
	Standard 7: Assessment, treatment, relapse prevention and support
6. Consumers	
7. Carers	
8. Governance, leadership and management	Standard 9: Service planning, development and management Standard 10: Documentation and information systems
9. Integration	Standard 8: Integration and partnership
10. Delivery of care (supporting recovery, access, entry, assessment and review, treatment and support, exit and re-entry).	
	Standard 11: Evaluation and research
	Standard 12: Ethical practice and professional responsibilities

5. 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)
6. evaluating recovery (including measuring outcomes on a range of indicators in addition to health and wellness, such as housing, employment and 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 problems. There are consequent implications for education and training curricula, professional development and the mix of skills and roles in service teams.

## Health Workforce Australia

Health Workforce Australia (HWA) is an initiative of COAG, and was established to support the provision of a health workforce that meets the needs of the Australian community. Its initial roles are to consolidate and integrate workforce planning, policy and research across the health and higher education sectors, including the establishment of a [National Statistical Resource System](#) for the health workforce to support longer-term planning initiatives and advise the Australian Health Ministers Conference about workforce directions. HWA is also managing funding and training reforms for health professional clinical training. COAG has announced that the agency will oversee the following major reforms:

- › improvement in the capacity and productivity of the health sector to provide clinical education for increased university and vocational education and training places
- › system, funding and payment mechanisms to support health workforce reforms, including new models of care and new and expanded roles
- › the redesign of roles and creating evidence-based alternative scopes of practice
- › the development of strategies for aligned incentives surrounding productivity and performance of health professionals and multidisciplinary teams
- › facilitation of immigration of overseas-trained health professionals and the continued development of recruitment and retention strategies.
- › 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
- › consideration of the public interest in promoting access to health services
- › consideration of the need to enable the continuous development of a flexible, responsive and sustainable Australian health workforce, and enable innovation in education and service delivery.

## National Registration and Accreditation Scheme

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The new National Registration and Accreditation Scheme commenced on 1 July 2010. The new system creates a single national registration and accreditation system for ten health professions (initially): chiropractors, dentists (including dental hygienists, dental prosthetists and dental therapists), medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists. Mandatory continuing professional education (CPE) will apply to these professions. The system is being delivered through the Australian Health Practitioner Regulation Agency (AHPRA) and the new national registration boards established for each of the professions. From July 2012, occupational therapists, Aboriginal and Torres Strait Islander health workers, Chinese medicine practitioners and medical radiation workers will also be included as nationally registered professions.

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

## Commonwealth Mental Health Investment Package

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In May 2011, the Commonwealth Government announced a \$1.5 billion investment package over five years. These reforms are aimed at improving the lives of people with mental illness by:

- › providing more intensive support services, and better coordinating those services, for people with severe and persistent mental illness who have complex care needs;
- › targeting support to areas and communities that need it most, such as Indigenous communities and socioeconomically disadvantaged areas that are underserved by the current system; and
- › helping to detect potential mental health problems in the early years, and supporting young people who struggle with mental illness.

This investment focuses on five key reform areas:

- › better care for people with severe and debilitating mental illness, who are amongst the most disadvantaged people in our community
- › strengthening primary mental health care services
- › prevention and early intervention for children and young people
- › encouraging economic and social participation, including jobs, for people with mental illness
- › improving quality, accountability and innovation in mental health services.

Consistent with these reform areas, the 2011–12 Commonwealth Budget provides: \$571 million

to expand services and improve their delivery for people with severe mental illness; \$492 million for prevention and early intervention mental health services for children and young people; \$220 million to improve access to the primary health care system for people with mental illness; and \$32 million for a National Mental Health Commission to increase accountability and transparency (including \$12 million in new funding).

In addition, \$201.3 million will be made available in a competitive funding pool through a proposed National Partnership Agreement (NPA) on Mental Health. The NPA will be negotiated with all jurisdictions and finalised at COAG in 2011. The NPA aims to address identified gaps focusing on accommodation support, and presentation, admission and discharge planning in emergency departments.

Through the Budget, the Commonwealth Government also stated its commitment to ongoing reform and will develop a ten-year Road Map for Mental Health Reform, which will be finalised in 2011. The Road Map, to be further developed in consultation with stakeholders, and the states and territories, will create a vision for long-term reform of the mental health system. The ten-year Road Map will provide a long-term guide and a framework for national direction and investment.

When combined with the 2010–11 Commonwealth Budget and election commitments, which provide \$624 million over the same five-year period, the Commonwealth Government will commit \$2.2 billion in funding over the next five years for mental health services.

In addition, and under the broader health reforms previously announced at COAG, the Australian Government is investing in subacute mental health beds; and providing \$78.5 million for mental health projects through the Health and Hospitals Fund.

## Other relevant policy work

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The Intergovernmental Committee on Drugs, on behalf of the Ministerial Council on Drug Strategy, is developing a national planning framework for drug and alcohol services to identify resource needs and functional distribution across the country into the future. This process will identify relevant care packages for people with drug and alcohol problems, including specific care packages for those with a comorbid mental illness. This will allow the future identification of workforce supply numbers and skill sets required for addressing comorbid conditions when considered alongside the similar tool being developed in mental health through Action 16 of the [Fourth National Mental Health Plan](#).

## Developing this strategy

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### The process to develop the strategy

In October 2009, the Mental Health Workforce Advisory Committee (MHWAC) engaged Siggins Miller to develop a national mental health workforce strategy and plan. The project included national consultations and a review of the literature and available mental health workforce data. From this base, background papers and a draft architecture and content for further consultation were developed. A project steering committee was set up to guide the development of the strategy (a list of members is at Appendix 1).

Between October 2009 and February 2010, 368 stakeholders attended one of 17 workshops, 53 key informants were interviewed and 34 written submissions were received. Workshops were held in all capital cities and in four rural or remote locations.

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.

The information presented in this strategy is drawn from the workshops, informant interviews, written submissions, advice from jurisdictional and sector representatives, available data and the literature. Where current initiatives are highlighted, these are presented as an illustration only.

Information from consultations and research 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
- › where the Australian Government holds the policy or funding levers
- › at state and territory level, which can be taken up and further developed to be a national approach, if appropriate and more cost-effective
- › of national significance which could be trialled in one state or territory and then rolled out if successful
- › 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 fall under both Commonwealth and state/territory responsibility, and also include non-legislative 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, and therefore outside the remit of this strategy.

Industrial issues in the public and NGO health and community services workforces remain largely the responsibility of the states and territories.

Remuneration levels (differences in remuneration within and between state/territory public services, and between the public and NGO sectors) are important factors in the attraction, retention, mobility and sustainability of the mental health workforce. These industrial issues apply to the whole health and community 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-wide issue raised in consultations. This is of particular concern in regions where the cost of housing in the private market is exorbitant.

The mental health sector has not always been well connected to mainstream efforts to support and develop the health workforce either in general, or in underserved areas and populations. There are significant national and state/territory strategies, funding programs and plans to support rural and remote workforce, Aboriginal and Torres Strait Islander health workers, and overseas trained doctors. Efforts are under way to develop clinical leadership and improve clinical governance, improve workplace supervision and support, and increase continuing professional development.

Strategies for the mental health workforce should not be developed in isolation from the rest of the health and human services workforce. The environment is dynamic, with significant reforms affecting the mental health and health workforce either under consideration or in train. This strategy focuses on mental health-specific workforce strategies that can build on existing Commonwealth, state and territory initiatives and link to opportunities arising from system reforms.

## Implementing the strategy

### Resourcing

This strategy and plan provide an overarching framework for the ongoing development of the mental health workforce in Australia, and include a range of specific activities. There is a sound base to build on, and some of the identified activities are already underway or in train. It is intended to

build on a number of key pieces of existing work, including, for example, broader health workforce initiatives, the role of HWA and more specific activities such as the Mental Health in Tertiary Curricula Measure, and Mental Health Professional Online Development.

Activities in the *Plan* have been broadly identified as short-term, medium-term or long-term, defined as 0–2 years, 2–5 years or 5–10 years respectively. The *Strategy* and *Plan* chart the way forward for a national, coordinated approach to the mental health workforce over a ten-year period. It is intended to commence implementation by undertaking a workforce scan that identifies both a baseline and examples of good practice identified against specific activities. Further detailed consideration can also be given to the relative priority of different activities in the plan.

There is no single dedicated source of funding to support implementation of this strategy and plan. However, early discussions indicate that HWA may be able to support some areas of this strategy and plan that are consistent with HWA's directions. Other areas of the *Strategy* and *Plan* will need to be considered by state, territory and Commonwealth governments as well as by non-government and private sector bodies. Wherever possible, implementation will build on existing resources and initiatives. The workforce scan will identify some activities that are progressing; some where funding has been identified; and some gaps.

This National Mental Health Workforce Strategy and Plan will direct current activity, and inform future decisions on where government can make strategic workforce investments to further develop workforce capacity and contribute to improved consumer outcomes over the next ten years.

## Monitoring and evaluation

It is essential to monitor and evaluate progress over the course of implementation of this strategy and plan. This will require development of a detailed evaluation strategy to be undertaken concurrently with implementation of the strategy. Appropriate resources to enable an effective evaluation to be commenced with implementation will be required.

A first key step in evaluation will be ensuring a clear approach to implementation and associated timelines. Not all activities will be undertaken concurrently or immediately. Performance indicators will need to be developed for each of the strategies and actions. Qualitative and quantitative information regarding performance will assist in assessing to what extent indicators are met.

Monitoring and evaluation of implementation of the strategy and plan will be the responsibility of the Mental Health Standing Committee, through MHWAC. Governance may be supported by establishing a Strategy and Plan Monitoring Committee, which could report on progress of the strategy and plan to the Chair, MHWAC and Chair MHSC, and on to Health Workforce Principal Committee. The Monitoring Committee could provide advice at the outset on the detailed implementation planning and timeline for the strategy and plan, and accompanying evaluation approach.

# Outcome area 1

## Developing, supporting and securing the current workforce

The mental health 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, increasing demands and different ways of working.

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

### Developing the current workforce

#### Implementing change

The [Fourth National Mental Health Plan](#) envisages considerable change in the way people will work in providing mental health care. It calls for changes in structure, philosophy and approach; changes in the place of treatment and support; a growing emphasis on early intervention; and the need to address the broad social determinants of mental health and illness relapse. These changes have stretched existing training programs and those who teach in them, and have 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.

As noted above, the [National Practice Standards for the Mental Health Workforce](#) provide guidance regarding the skills, knowledge and attitudes expected of professionals working in mental health. These standards remain relevant, but more work is required to achieve a shared understanding of what is meant by the *recovery approach*. The values, skills 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. Supporting recovery is given additional impetus in the revised [National Standards for Mental Health Services](#). Bringing a more inclusive approach requires changes and improvement in workplace culture which must be embraced by workers at all levels—those in leadership roles, management and in direct care.

Improved practice in the current workforce has a significant bearing on engagement of the workforce of the future. The attitudes and values of the existing workforce powerfully shape those of the entry level workforce as they undertake clinical placements during training or as graduates in their early years. Early workplace experiences have been shown to have a major impact on the retention of new staff in mental health services.

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. New approaches and guidelines need to be communicated effectively and implemented consistently in work settings.

Several jurisdictions have considerable investment in centres, institutes and programs that provide continuing professional development (CPD), vocational education and training (VET) and postgraduate training in mental health. At this stage, 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.

In recent years, the role of consumers and carers as members of the paid workforce has increased steadily. There are several 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. This area is considered in greater detail in the section on workforce innovation and reform.

Mental health workers would also benefit from training in how to work well with consumer and carer colleagues, and provide them with supervision and support as part of the multidisciplinary team. Some jurisdictions have developed policies and frameworks for the inclusion of consumers and carers in service provision.

## Support for training and development

As mental health services shift to provide care consistent with a recovery focus, the current workforce will need access to materials and training relating to recovery-based care. This means greater inclusion of consumers, families and carers in discussions about treatment and care, moving to more supported decision making, and considering the broader health and wellbeing needs of consumers. A recovery approach is also supported by better communication between providers, and involvement of other areas such as housing and employment agencies. For some mental health workers, these shifts will mean significant changes in how they engage with consumers. Access to support and mentoring will be of benefit during this time of change in culture.

There are some key groups and settings where the current specialist and generalist workforces need more support and training. Studies report that some members of the current mental health workforce feel they need more knowledge and skills in areas of relevance to their current work. Some lack confidence in their ability to: identify and treat co-occurring alcohol and other drug problems; deal with aggressive or potentially aggressive situations; treat consumers with complex and diverse health and social needs, such as prison populations; or meet the demands of their role, despite several years' clinical experience. The need for supervision or opportunities to be mentored and access additional experience or training in such areas warrants consideration.

Several jurisdictional plans include attention to these areas of skill development.

People working in mental health need to be aware and able to address the needs of consumers of all ages and cultures. Within mental health services, because of geographical location, setting or time of day, a specialist response will not always be available. However, there are several areas where specialised services have developed and where the workforce is expected to have particular skills and knowledge.

## Young people and adolescents

In recent years there has been increased awareness of the importance of experiences during childhood and adolescence as determinants of later mental health. Several significant mental illnesses first emerge during adolescence or young adulthood. Increased capacity in the present workforce for early identification and appropriate treatment and support for young people could potentially reduce the damage done by a mental illness to lifelong educational, employment and social inclusion outcomes. Several youth-specific services have been developed, such as early psychosis teams and [headspace](#) sites. The emphasis on early recognition and intervention means that direct care staff may need greater training and support to bring a youth focus to their work.

## Older people

There has also been increased attention to the mental health service needs of older people. 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. Working in the older persons mental health area requires close collaboration with other health care providers and engagement with family members. As with other areas of mental health, ensuring that older people with capacity are able and supported to make decisions regarding their care and treatment is an important aspect of recovery-oriented care in this age group.

## People from Aboriginal and Torres Strait Islander and CALD backgrounds

In order to provide culturally appropriate services for people from Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) backgrounds, the workforce needs to be technically *and* culturally competent. In some situations, the mental health workforce may be able to be drawn from people of an appropriate cultural background, but in most situations, services to people from Aboriginal and Torres Strait Islander and CALD backgrounds are provided by workers from a different cultural background who need training and support to ensure they are culturally aware and competent.

Aboriginal and Torres Strait Islander mental health workers may need support, owing to their dual roles at work and in their own family groups and communities. These workers, particularly in remote communities, face particular pressures and are often on call 24 hours a day, seven days a week. To compound the pressure, they work in many rural and remote areas of Australia, and Indigenous workers may not be eligible for housing and other supports made available to non-Indigenous staff and visiting specialists.

Stakeholders supported practical field placements for exposure to different cultural perspectives of mental illness. Ongoing cultural competence in-service training, rather than brief awareness sessions, was the favoured strategy for building workforce capacity. The generalist mental health workforce may also benefit from education programs that focus on the settlement challenges of newly arrived migrants and refugees, and how failure to overcome these challenges can develop into acculturation difficulties and subsequent mental health deterioration. This understanding can help guide workers to facilitate pathways to appropriate services.

## Rural and remote areas

Mental health workers in rural and remote areas face particular challenges. Problems may include a lack of career opportunities, fewer options for referral, longer hours with on-call and emergency requirements, unsafe environmental conditions

in the workplace, lack of suitable accommodation and a perception that the quality and availability of clinical supervision is less than in major urban settings.

In many jurisdictions efforts are underway 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.

## Progress towards national consistency and collaboration

While there is considerable activity in these areas in different jurisdictions, greater sharing of training and support initiatives is needed. Greater coordination of effort should lead to less duplication and greater consistency in approach. While it is recognised that different approaches may be required in different service settings and geographic locations, there is scope for service areas to learn from each other what has worked and why. People trained or experienced in one geographical area should be able to transport their skills easily between different service locations. The development of national competencies and an educational framework for mental health services could underpin this effort. The competencies would provide guidance to the development of general educational principles, and an educational framework would inform curricula development for mental health services across Australia. This would assist education providers to ensure that the health workforce is competent and capable of providing safe mental health care. National collection, collation and sharing of resources, policies and programs could reduce duplication of effort, speed change and increase synergies and consistency.

## Supporting the current workforce

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### Clinical leadership

Clinical leadership is an important workforce element of good mental health services. Experts in mental health have a leadership role in health services. An explicit emphasis on clinical quality, and the ability of the organisation to strengthen



service quality and safety, can contribute to improved outcomes for consumers. Clinical leadership across all disciplines needs to be strengthened to support cultures of continuous improvement and a focus on consumers, carers and families. At present there are examples of excellent clinical leadership in mental health services, but they emerge despite—and not as a property of—the system.

There are jurisdictional programs focused 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. A more systemic investment in developing clinical leadership is an important part of delivering better care for consumers.

Leadership is also important in the non-government sector, for similar reasons. A focus on quality and continuous improvement is of benefit to consumers, carers and families.

## Supervision

Improvements and more consistency in career pathways, access to continuing professional development (CPD), clinical supervision, general workplace supervision and development of supervision skills are also needed. The development of tools and templates, linked to national standards, would be a practical resource services could use and adapt as needed.

Where possible, investments in training and development should be complemented by supervision, to promote the translation of learning into improved practice.

Identification, development and support for proven initiatives that could be disseminated nationally could reduce current levels of duplicated effort.

## Use of technology

Access to enabling technologies allows for support of shared care between nurses, nurse practitioners, general practitioners, psychiatrists, psychologists, social workers and other members of the multidisciplinary team. Technologies can be

used for e-health and for supervision, mentoring and support. Where they are skilfully used, and where staff are trained and supported to use them effectively and efficiently, they can also provide powerful retention tools in isolated settings away from major teaching services. This may encourage redistribution of the workforce, because people are more likely to work in underserved areas if they feel that it will not limit their career progression and that they will be well supported.

An ongoing investment in e-learning, training and system use would support workers and managers to maximise benefits from e-health developments. Many service providers said they had access to a reasonable standard of e-health technology, but were not using it owing to lack of support and confidence.

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 provides a seventy-hour core curriculum aimed at workers in mental health services. The content is linked to the [National Practice Standards for the Mental Health Workforce](#), and has been piloted at eleven services nationally. To date, MHPOD has been well received and positively evaluated, and is an example of what can be achieved by pooling resources nationally to support the workforce.

## Stress, workload and expectations

Stresses associated with increasing and new demands, an ageing workforce and high community expectations are major issues for the occupational health and safety of mental health workers. Intensified work demands reduce the time available for training, and may leave 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.

There is a need to strengthen management and governance capacity in mental health services. Service providers across Australia consistently

described the pressure and intensity of work and often expressed concern about the risks of burnout, and loss of experienced staff from the specialist mental health sector to the general health sector. Generic case coordination roles that restrict opportunities to apply specialist skills can reduce job satisfaction and skill levels.

There is a need to look at the best ways to support, develop and continually upskill those who have chosen a career in the mental health workforce. There is a need to attract those who have left the sector to return to mental health. To achieve this, it is essential to ensure adequate supervision, leadership and support for all mental health roles in all types of services.

### Securing the current workforce

Minimising avoidable turnover and retaining valuable health workers is important to the delivery of high quality mental health services. High turnover of staff, combined with recruitment difficulties, can reduce access to care, and may compromise the continuity and quality of care. Good workforce retention is vital to ensuring well-functioning health services capable of delivering improved outcomes for consumers. Length of employment is important because it takes time for the worker and consumer to build enough trust to interact successfully, and because it provides the service with a more experienced group of workers who have a higher level of job mastery and require less direct supervision. Experienced workers can also support and supervise more junior staff and students.

Workers in mental health make decisions to stay or leave an organisation on the basis of a complex set of trade-offs between professional, personal and environmental factors. Professional issues relate largely to the job itself, and a particular concern in mental health appears to be the opportunity to use discipline-specific skills (for example, occupational therapy or psychology skills). Support, remuneration, workload and work environment may also be important. Personal issues may include family commitments and lifestyle-related factors, and broader environmental factors may include climate, geographic location and infrastructure.

Some movement of workers is necessary and desirable; for example, so that individuals can gain a range of experience. However, the avoidable loss of mental health workers is expensive in terms of recruitment, temporary replacement and training costs. Less tangible costs include reductions in morale, organisational memory and increased pressure on remaining staff. Improved retention can offer significant benefits to mental health services.

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

All jurisdictions have made efforts to increase the attractiveness of the mental health working environment, and to provide incentives to support or retain the mental health workforce. The attractiveness of working in mental health may be enhanced by family-friendly initiatives such as childcare or eldercare, implementing work/life balance policies, providing flexible working environments or promoting attractive roster arrangements. Improvements in the workplace environment include areas such as occupational health and safety policies for preventing and managing violence and aggression and offering good access and support to information and communication technology (ICT).

Attention needs to be given to career pathways and to options of working across different sectors. Supporting workers to be involved in treatment and care planning across clinical and community support sectors, providing options for placement in different service settings and considering senior roles in clinical and managerial pathways may improve retention and enhance work satisfaction. In particular, there should be pathways that allow career progression while retaining people in direct care roles. Linking clinical practice to academic and teaching responsibilities has been an effective mechanism to keep senior and talented staff engaged in practice in several jurisdictions. This requires agreement between academic institutions and service providers in the health and community support sectors.

Recent developments such as the [Mental Health Nurse Incentive Program](#), and new Medicare items for psychiatrists to encourage detailed diagnostic assessment and treatment planning, are examples of practice areas that could be further explored to improve work satisfaction. The Better Access initiative funded through Medicare, and the Access to Allied and Psychological Treatment and Support

(ATAPS) initiative, enable psychologists and allied health professionals to work in the private sector. If combined with work in the public sector, they have the potential to support more varied work practices and at the same time to improve collaboration between providers and thus improve continuity of care.

## Objectives and strategies for Outcome area 1

Outcome area 1: Developing, supporting and securing the current workforce	
Objectives	Strategies
Objective 1.1 Through strengthening the workforce, promote increased quality and safety for consumers, families and carers and for staff.	1.1.1 Develop national core competencies and an educational framework for mental health services (including clinical, community and peer support services).
	1.1.2 Include management of comorbid drug and alcohol and mental health issues in the national core competencies for mental health.
Objective 1.2 Improved workforce capacity to contribute to reducing inequalities in health outcomes for Aboriginal and Torres Strait Islanders living with a mental illness.	1.2.1 Provide better career pathways, supervision, mentoring and locum support programs for Aboriginal mental health workers in a range of settings.
	1.2.2 Incorporate training in Aboriginal and Torres Strait Islander mental health in mental health workforce training programs.
Objective 1.3 Improved workforce capacity to deliver culturally appropriate services to people from culturally and linguistically diverse (CALD) backgrounds.	1.3.1 Incorporate training in cultural competence in mental health workforce training programs.
Objective 1.4 Service cultures that support hope and optimism.	1.4.1 Support the adoption of a recovery-oriented culture within mental health services, underpinned by appropriate values.
	1.4.2 Develop a shared understanding of recovery-oriented practice and the implications for workforce development.
	1.4.3 Link into and build on the work of the <a href="#">National Practice Standards for the Mental Health Workforce</a> .
Objective 1.5 Increased opportunities for effective supervision, lifelong learning and continuing professional development.	1.5.1 Work with Health Workforce Australia and the jurisdictions in promoting and supporting access for the mental health workforce across all sectors to investments in the areas of the development of clinical leadership, management development and clinical supervision.
	1.5.2 Build on current initiatives, such as <a href="#">Mental Health Professional Online Development (MHPOD)</a> . Develop a national mental health e-learning portal where all mental health workers can access a one-stop shop for current and credible sources of information regarding evidence-based approaches to treatment, care, support and service development.
	1.5.3 Continue to develop and implement on line discussion groups where mental health professionals and service managers, in both government and non-government (NGO) sectors, can engage with colleagues to share innovation and discuss solutions to challenging issues.

**Outcome area 1: Developing, supporting and securing the current workforce**

Objectives	Strategies
<p>Objective 1.6 Increased retention of staff.</p>	<p>1.6.1 Support timely and high quality induction and orientation programs for new entrants to the mental health workforce.</p> <p>1.6.2 Support the provision of clinical supervision.</p> <p>1.6.3 Develop clinical career pathways that encourage clinicians to stay in clinical roles.</p> <p>1.6.4 Pilot modified case or care coordination work roles that include the capacity for workers to utilise discipline-specific expertise.</p> <p>1.6.5 Develop mechanisms to showcase the achievements of the sector.</p> <p>1.6.6 Develop flexible work arrangements across public, private and non-government settings.</p>
<p>Objective 1.7 Improved capacity to retain and support the mental health workforce in rural, regional and remote locations.</p>	<p>1.7.1 Maximise opportunities for isolated mental health staff to further develop skills, work with mental health teams and access advice, support and education.</p>

## Outcome area 2

# Building capacity for workforce innovation and reform

Workforce shortages are a significant long-term problem, and despite efforts and resources being applied to recruitment and retention, and an increased number of training places, these interventions will not, of themselves, be sufficient to meet ongoing workforce requirements. Innovation and workforce redesign can contribute to making optimal use of mental health workforce skills, and are essential to ensure the best health outcomes for consumers, carers and communities.

The need for reform is recognised by many stakeholders, and is reflected in a range of initiatives, such as the development of new work roles and enhanced use of technology. Health Workforce Australia has a role in innovation and reform. Most states and territories (and some peak NGO groups) fund or provide workforce development units, functions or capacity, and may also undertake workforce-related evaluation research. Evidence about what works to promote sustained change in the workforce is scarce but growing, although the research and evaluation effort is currently fragmented and uncoordinated.

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. This may mean reconsidering the role of psychiatrists in private practice, for example, or greater use of nurse practitioners or mental health nurses in primary care settings. Role redesign would need to provide clinical career pathways that provide clinicians with the option to stay in clinical roles, and build teaching and research capacity into the future. The current and forecasted continuing shortages in psychiatry, nursing and other disciplines call for broader strategies to help professionals function at an optimal level, maximising the use of their clinical skills.

### New and enhanced work roles

The exploration of new roles in mental health care emerges as a commonly proposed supply strategy both overseas and in national research and consultations. Increasing the scope of practice and potential roles of professions such as psychology, social work or other allied health assistants would tap into graduates who have relevant undergraduate study but unclear career paths.

There may also be a need to reconsider the definition of what constitutes the mental health workforce, because there is evidence that involvement of other professional groups such as dietitians, speech pathologists and pharmacists has grown in response to need, but not in any coordinated or consistent manner. The issues of role redesign, task delegation or substitution, and the creation of new roles need considered attention nationally.

In mental health, as with the health workforce more generally, there have been tensions in the demarcation of roles and responsibilities between professions. More flexible approaches, including the development of new roles, and the enhancement of existing roles, could allow more versatile and productive use of the workforce. Some national and international initiatives have worked well to increase access to services; for example, the Increasing Access to Psychological Therapy (IAPT) program, and the Support, Time Recovery (STR) initiative in the United Kingdom. These have allowed more flexible use of the available workforce, and provided innovative models of intervention.

It is imperative that clinical expertise is available, and that more junior or less-skilled staff are supported and supervised. Extending the range

of roles and responsibilities must be balanced by ensuring that people with a mental illness receive expert diagnosis, assessment and treatment of a quality equivalent to that expected in the general health system. Better multidisciplinary participation in treatment planning may result in more appropriate use of the skills provided by particular professions.

Programs under the [National Action Plan on Mental Health 2006–2011](#), including the Personal Helpers and Mentors (PHAMs) initiative, Day to Day Living, community-based programs and mental health respite have led to an expansion of positions in non-government organisations for people to provide psychosocial rehabilitation, recovery support, family and carer support and peer support. Peer support worker roles have been developed as part of PHAMs teams.

The development of mental health nurse practitioners (MHNPs) is a contemporary initiative promoted throughout mental health services in many jurisdictions. Several models are being trialled, although there are still barriers to expanding the numbers of MHNPs. Establishment of roles with a greater scope of practice supports career progression, greater variety in work experience and improves retention. It is expected that MHNPs will have limited prescribing rights in the future, be able to refer and receive referrals to and from medical staff, and order pathology tests and investigations. Under mental health legislation in several states, nurses and other mental health professionals are given specific powers and duties. Further possible role expansions include conducting physical health screenings, management of chronic disease prevention and smoking cessation interventions, drug and alcohol interventions, health lifestyle management and health promotion. The Australian Government-funded [Mental Health Nurse Incentive Program](#) is already well established, and it is anticipated that these positions will be further developed to support general practitioners in such areas. There should be formal evaluation of the outcomes of the [Mental Health Nurse Incentive Program](#) to determine how this area can be best developed and supported to work across primary and specialist areas of mental health.

Other models are provided by the UK Better Ways of Working program for psychiatrists, such as the potential for developing a new category of psychology assistant, and the further development of nurse practitioners.

## Further reforms

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Further work is required to align service delivery with what consumers, carers and families value and need. The key factors suggested by those consulted in order to build a workforce based on the needs of consumers, carers, families and communities included:

- 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 that they extend to quality of life and capacity to manage activities of daily living and social inclusion.
- Identification at the local level what outcomes consumers, carers, families and communities value. 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.
- Development of 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 intervention at the onset of illness or early in any relapse or recurrence of 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 an understanding of the social determinants of severe mental illness.
- Developing expanded and new roles in the workforce that respond to the needs of people with severe mental illness.

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 intended: enhanced outcomes for consumers, carers, families and communities; improved quality and safety of processes; and better support for the workforce.

A nationally consistent package of induction, training and education for entry to the recovery support, psychosocial and peer support workforce, as well as for entry to the growing workforce of consumer and carer advocates, should be developed.

Supported by national competency standards, peer support worker roles could be better tailored to local needs, and could draw on the potential consumer and carer workforce.

Members of culturally and linguistically diverse groups, including refugees, with their knowledge of their respective communities and cultural norms, may have the appropriate skills to be employed as bilingual/bicultural consultants or support workers.

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. The latter group could be usefully deployed in mental health

promotion, community awareness and mental health literacy roles within mental health services.

There should be a focus on developing and providing career progression for a paid carer and consumer workforce in roles such as peer support worker, recovery support worker, educator, manager and adviser. 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 processes and procedures, advocacy, public speaking and assertiveness.

Significant work is already underway across Australia to design and implement new and innovative ways of working. Several well-established and newly established centres, institutes and units at state and territory level are designed to support workforce development and innovation and reform.

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. While expansion of the workforce is supported, the critical role of clinical expertise in assessment, diagnosis and treatment must be retained to ensure continuing quality of care and equivalence with the general health sector.

## Objectives and strategies for Outcome area 2

Outcome area 2: Building capacity for workforce innovation and reform	
Objectives	Strategies
<p>Objective 2.1 Understand better what the work is, where it happens and where it needs to happen, in order to close gaps and improve continuity of care, treatment and support.</p>	<p>2.1.1 Build and define work roles in clinical, community and peer support areas to better meet the needs of consumers, families and carers.</p> <p>2.1.2 Link the development of work roles to the outcomes of the service model framework development arising from the <a href="#">Fourth National Mental Health Plan</a>.</p> <p>2.1.3 Pilot innovative approaches to workforce development that align with a recovery approach.</p> <p>2.1.4 Facilitate 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.</p>
<p>Objective 2.2 Build capacity to adapt to new structures and new ways of working.</p>	<p>2.2.1 Promote and develop innovation, reform and research by developing and supporting a virtual network, building on the existing centres, institutes and units and the tertiary sector.</p> <p>2.2.2 Expand workforce profiles and career pathways for community/ recovery support workers, peer workers and assistants in agreed professions, which link, where appropriate, to nationally recognised vocational qualifications in the <a href="#">Community Services Training Package</a>.</p> <p>2.2.3 Delineate the roles of consumer, carer and support worker, and assistant, necessary support mechanisms and their accountabilities; include training requirements and support mechanisms.</p> <p>2.2.4 Build on recent investment in <a href="#">Mental Health Professional Online Development (MHPOD)</a> and expand access to the non-government sector.</p>



## Outcome area 3

# Building the supply of the mental health workforce

As discussed earlier in this strategy, Australia's mental health workforce faces challenges with limited supply, significant shortages and inconsistent distribution, including distribution across professions and skill sets. There is a pressing need to attract and develop more workers, as well as using the skills and capacities of the current workforce to better advantage. Several factors have contributed to health and mental health workforce shortages, despite the growing number of health and community service workers in recent years. These factors include the choice by some to work reduced 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. Unfortunately, mental illness and mental health services still face some stigma, and even within training settings there may be an implied bias which discourages potential trainees from choosing mental health. There is a need for solid supply modelling to provide better information about our future needs.

### Curricula and training

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Mental health training generally involves both theoretical and practical experience. In order to attract new graduates or trainees, it is vital that this experience is positive. Inspiring leaders and well-supported placements that allow a range of exposure and experience are much more likely to result in mental health becoming a profession of choice. The challenge and opportunity to work within a multidisciplinary setting, to engage with people in their lives and to strive to better understand their concerns, are strong incentives to work within mental health.

However, consumers, carers and service providers were critical of current curricula and training in most disciplines and occupation groups involved in mental health care. Curricula need to: include adequate opportunity to learn from the lived experience of consumers, carers and families; be more integrated and to improve understanding of what other disciplines and professions can contribute to mental health care; offer sufficient early exposure to commonly occurring mental health conditions and to experiences of recovery, and sufficient exposure to service settings other than acute hospital settings. These changes need to be addressed by training institutions and by service providers who support clinical or community placements.

There is a need for consistent inclusion of foundation mental health material, linked to competencies, in the training programs for all health-related professions. Not all students will go on to work in mental health services, but wherever they do work, they will need knowledge and skills in mental health if they are to provide comprehensive care to their patients. There is a need 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 Australian Government has done significant work on the place of mental health in curricula through the [Mental Health in Tertiary Curricula](#) measure, and the funding of reforms in curriculum and placements in expanded settings in psychiatry training. 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 needed 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. A multidisciplinary approach to education and training would complement the work of these teams. 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

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The Bradley [Review of Australian Higher Education](#) (2008) and the subsequent reforms announced by the Australian 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.

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 the Greater Western Area Health Service in New South Wales) that could be used as models for national implementation. Such services should be acknowledged and supported as training providers as well as service providers. There are also examples of facilitating entry into health professions by enabling secondary school students to commence VET level subjects in health, and gain both practical exposure and credit towards VET qualifications such as enrolled nursing. Creating such pathways allows interest in working in mental health to be tapped and nurtured.

There are several current jurisdictional initiatives to increase the supply of mental health professionals, but there is also considerable duplication of effort and resources. 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.

## Perceptions of mental health work

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Attracting people to train in mental health continues to be a major challenge, although considerable work is under way at the state and territory level to develop strategies to promote mental health as an attractive career choice. Nationally, there needs to be sustained effort to reduce stigma about mental illness and to better educate the media and the public. This education should include the role of the workforce in promoting wellness. It should also 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.

Mental health service providers need to better market themselves as dynamic and innovative, and to highlight the opportunities for research and development within mental health. The breadth of experience available to workers needs to be reinforced, and the career opportunities in areas such as administration, academia and policy development, as well as direct care in clinical and community support settings.

Some services have less difficulty with recruitment than others. New approaches and service models may attract people because they are seen as innovative or dynamic. Services that previously struggled to attract staff (such as forensic and child and adolescent mental health services) have benefited from greater opportunities for research, evidenced-based practice and increased resourcing. This might have lessons for ‘core services’. However, many employers in specialist

services 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 Health Workforce Australia and the recently released National Workforce Development Strategy [Australian Workforce Futures](#).

## Objectives and strategies for Outcome area 3

Outcome area 3: Building the supply of the mental health workforce	
Objectives	Strategies
<p>Objective 3.1 Support provision of a workforce sufficient in number, skill mix and distribution to meet projected population growth and need.</p>	<p>3.1.1 Use supply modelling with the outputs from the national service planning framework to determine the future quantum of the mental health workforce required nationally; determine targets and timelines for achieving that workforce and a development plan to ensure the availability of that workforce.</p> <p>3.1.2 Utilise the outputs and care packages from the national service planning framework for mental health and the parallel national planning tool for drug and alcohol services to identify the future quantum of mental health and drug and alcohol workforce required nationally to manage comorbid presentations, determine targets and timelines for achieving that workforce, and a development plan to ensure the availability of that workforce.</p> <p>3.1.3 Promote careers in mental health across disciplines and sectors.</p> <p>3.1.4 Support or create workforce re-entry programs across disciplines.</p> <p>3.1.5 Working with the DEEWR and other relevant bodies (such as Skills Australia), monitor and review the impacts of higher education reforms and the number and type of undergraduate and postgraduate enrolments in relevant health courses; and work with the states and territories to complement local targeted schemes.</p> <p>3.1.6 Work with Health Workforce Australia to ensure that mental health continues to be an area of priority in HWA's programs, including clinical placement funding, supervisor support and simulated learning across all relevant disciplines.</p> <p>3.1.7 Ongoing development and implementation of a national approach to the inclusion of foundation mental health material, linked to competencies, in the curricula of all health and human services-related education and training programs.</p>
<p>Objective 3.2 Contribute to the capacity to provide effective and culturally appropriate services for Indigenous Australians.</p>	<p>3.2.1 Support the training of people of Aboriginal and Torres Strait Islander backgrounds to become mental health workers in a range of disciplines by supporting and promoting existing successful programs and piloting new programs.</p>
<p>Objective 3.3 Increase the cultural appropriateness of service delivery.</p>	<p>3.3.1 Work with the culturally and linguistically diverse (CALD) sector and mental health services to promote career opportunities within the mental health sector to meet the changing demographics of mental health populations.</p>
<p>Objective 3.4 Improve the distribution of and access to the workforce across all geographic regions to better serve people in rural, regional, remote and other underserved areas.</p>	<p>3.4.1 Promote regional recruitment mechanisms to engage people in mental health career pathways.</p>

## Outcome area 4

# Building the capacity of the general health and wellbeing workforce

The general health and wellbeing workforce 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
- › 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 diagnosis and assessment, 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. People with severe mental illness have increased rates of ischaemic heart disease, stroke, high blood pressure, bowel cancer, breast cancer and diabetes than the general population.

As well as considering the capacity of the general health workforce, it is also important to recognise that some other areas of employment are likely to have contact with people with emerging or established mental illness as a component of their work. In particular, professions such as teachers, child protection workers, police and pharmacists may be in a position to support people with mental health problems or mental illness to access appropriate treatment and support.

### Training and education

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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 to better understand and be aware of mental illness through additional education and training. Programs such as mental health first-aid have been used as a vehicle to provide training to other front-line workers (for example, correctional staff, police) who come into contact with at risk population groups to facilitate prompt referral to appropriately skilled mental health workers.

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, their carers and families. For instance, understanding the needs of children and young people experiencing early signs of mental health problems, and that of their carers and families, is important for child health clinicians and also for teachers. Health workers need to have confidence in how to intervene early and support referral to specialist services. 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.

Involving consumers and carers in training can be very powerful in enhancing understanding of the lived experience by workers in several areas. Secondary mental health workers who could be or have been trained in mental health literacy, mental

health first-aid, and early intervention include teachers, pharmacists, correctional officers, police and government workers.

## Comorbidities, including alcohol and other drug problems

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. The health needs of clients in underserved and rural and remote areas are complex and commonly involve mental health, substance abuse and chronic physical health problems. In many cases, staff confidence in assessing and treating clients with such complex needs is reported as low. Health workers who commonly deal with people with complex co-occurring health problems

should be routinely trained in mental health, early intervention and referral. Innovative state and territory programs have the potential to be evaluated and applied nationally.

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.

National facilitation of the development of role definitions for the contribution of different professions to mental health was 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.

## Objectives and strategies for Outcome area 4

Outcome area 4 : Building the capacity of the general health and wellbeing workforce	
Objectives	Strategies
Objective 4.1 Improve mental health skills, literacy and confidence to work with and support people with mental illness in generalist health and community service workers.	<p>4.1.1 Facilitate mental health skills, 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 <a href="#">Fourth National Mental Health Plan</a>.</p> <p>4.1.2 Facilitate access to Aboriginal and Torres Strait Islander mental health first-aid training for the front-line workforce of agencies working in rural, regional and remote areas.</p> <p>4.1.3 Support and improve the integration of consumer and carer-informed mental health content into the existing content of relevant VET, undergraduate and postgraduate and CPD programs in the health and human services sector.</p>
Objective 4.2 Improve links and reciprocal supports between specialists and generalists.	<p>4.2.1 Further develop the capacity for specialist mental health professionals to act as secondary consultants at key points in the health and aged care systems (for example, emergency departments, aged care assessment teams, school counselling services, general practice, psychology and so on).</p> <p>4.2.2 Promote shared care, service coordination and cooperation across the government, non-government and private sectors.</p>
Objective 4.3 Further develop the capacity of health and community service providers to support people with complex health and social needs, wherever they present.	<p>4.3.1 Further develop and build on the <a href="#">Mental Health Professional Online Development (MHPOD)</a> as the platform for generalists and drug and alcohol (AOD) specialists to access online self-directed mental health modules, including material on comorbidity, based on a nationally consistent core curriculum.</p> <p>4.3.2 Train drug and alcohol (AOD) workers in a range of sectors and types of services in mental health, early intervention and referral.</p>

## Outcome area 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 agreed 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 the 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 several factors, including differences in workforce coverage, data definitions, the range of data items, time periods and response rate, as well as state and territory differences in workforce-related legislations, registration requirements and service design.

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 [Mental Health Non-government Organisation 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 workforce. 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, years of experience, qualifications and intentions to leave or return to the workforce are not defined and collected consistently. Neither are they 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.

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

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 (that is, to identify the mental health workforce from the general health workforce) and improve data consistency and linkages across the whole of the mental health sector. Workforce planning also requires robust and well-linked service, workforce and client (or population) data collections.

## Objectives and strategies for Outcome area 5

Outcome area 5: Data and monitoring and evaluation	
Objectives	Strategies
Objective 5.1 Monitor and evaluate national workforce initiatives.	<p>5.1.1 Develop and implement a monitoring and evaluation framework for this workforce strategy.</p> <p>5.1.2 Include consumer and carer input as part of the monitoring and evaluation of mental health workforce initiatives.</p> <p>5.1.3 Work with broader data initiatives in healthcare to identify ways to link consumer and provider data to determine equity of access and the relationship between services and outcomes.</p> <p>5.1.4 Continue 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.</p>
Objective 5.2 Support workforce planning and modelling.	<p>5.2.1 Improve consistency and coverage in mental health workforce data collection.</p> <p>5.2.2 Support the inclusion of workers' 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 (for example, in human resource and payroll data systems and/or the national register).</p> <p>5.2.3 Ensure that the work begun through the <a href="#">Mental Health Non-government Organisation Workforce Study</a> 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.</p> <p>5.2.4 Explore cost-effective ways for collecting data, wherever possible, longitudinally and continuing to follow respondents once they leave the workforce either short or long term; understand that both those who leave (for example, through exit interviews) and those who stay in the mental health workforce is equally important for workforce planning.</p> <p>5.2.5 Work with the relevant agencies to identify overlaps and duplications across data collections, both in terms of 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.</p>
Objective 5.3 Increase the capacity to inform workforce planning.	<p>5.3.1 Assess the usefulness of existing data collections and their data items, identifying data gaps and needs, and make better use of existing data systems—both workforce and clinical data—to monitor, analyse and evaluate workforce activities and inform workforce planning.</p> <p>5.3.2 Ensure data such as employment sector (for example, private, government, non-government), workforce intentions (for example, to retire or change industry) and actual workplace transitions (for example, 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.</p> <p>5.3.3 Support development of 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.</p> <p>5.3.4 Establish greater communication and links between data collections and bodies that collect data and across sectors.</p>

# Glossary of key terms

## **Carer**

A person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the consumer and carer.

## **Carer consultants**

People who have experience of caring for a person with a mental illness. They are employed by mental health services, and have knowledge of the mental health system and the issues that are faced by families and other carers. They work with mental health staff in developing service responsiveness to the needs of carers and families.

## **Carer worker**

People who have experience of caring for a person with a mental illness, and who work (paid or unpaid) in the mental health sector. They may be engaged in several roles, including as educators, community support workers, advocates, advisers or planners.

## **Clinical**

Related to the diagnosis and treatment of medical/mental health conditions within established health care guidelines, and therefore primarily describing health care workers.

## **Clinical governance**

Policies or frameworks that addresses structures, systems and processes that assure the quality, accountability and proper management of an organisation's operation and delivery of service.

## **Clinical leadership**

Formal and informal leadership within a service to improve service quality and approach and to set direction.

## **Clinical supervision**

Clinical supervision is a process by which two or more professionals formally meet to reflect and review on clinical situations with the aim of supporting and enhancing the clinician in their professional environment. See the Government of Western Australia Mental Health Commission [Clinical supervision](#) site.

## **Consumer**

A person who uses or has used a mental health service.

## **Consumer consultants**

Consumers who are employed to advise on and facilitate service responsiveness to people with a mental health problem or mental illness, and the inclusion of their perspectives in all aspects of planning, delivery and evaluation of mental health and other relevant services.

## **Consumer worker**

Consumers working (either paid or unpaid) in the mental health sector. Consumers may be engaged in several roles, including as educators, community support workers, consultants, advocates, advisers and planners.

## **Discipline**

A body of knowledge and approach to assessment, treatment and support. Historically in mental health, the five 'disciplines' typically involved in delivering care have been psychiatry, nursing, psychology, social work and occupational therapy (as reflected in the [National Practice Standards for the Mental Health Workforce](#)).

## **E-health**

Health services or information delivered or enhanced through the Internet and related technologies. In the case of mental health,



e-health can include mental health promotion, prevention, early intervention, treatment, relapse maintenance and emergency services. E-health solutions can also facilitate professional training for the mental health workforce and secondary consultations between mental health workers.

#### ***Forensic mental health services***

Refers to mental health services that principally provide assessment, treatment and care of people with a mental illness who are in the criminal justice system, or who have been found not guilty of an offence because of mental impairment. Forensic mental health services are provided in a range of settings, including prisons, hospitals and the community.

#### ***General health and wellbeing workforce***

Refers to the professions and roles that contribute to the general physical and emotional care and support of individuals, families and communities (as distinct from specialist mental health roles). For the purposes of this National Mental Health Workforce Strategy, the term refers to general practitioners, practice and other primary care nurses, Aboriginal Health workers, social workers, occupational therapists, speech pathologists, pharmacists and psychosocial support and workers.

#### ***Mental health problem***

Diminished cognitive, emotional or social abilities but not to the extent that the criteria for a mental illness are met.

#### ***Mental health services***

Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.

#### ***Mental health worker***

A broad, generic term that encompasses people who work in mental health service delivery, regardless of role, training or qualifications.

#### ***Mental illness***

A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

#### ***Non-government organisations (NGOs) in the mental health sector***

Private, not-for-profit, community-managed organisations that provide community support services for people affected by mental illness and their families and carers. Non-government organisations may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness, and their carers, or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, pre-vocational training, residential services and respite care. The nomenclature for NGOs that are not-for-profit and community managed may be amended by the relevant peak bodies during the period of this Strategy so that such organisations will be referred to as community managed organisations (CMOs).

#### ***Peer support***

Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis.

#### ***Primary care services***

Community-based services which often constitute the first point of contact for people experiencing a mental health problem or a mental illness and their families. The primary care sector includes general practitioners, emergency departments and community health centres.

### ***Private sector specialist mental health services***

The range of mental health care and services provided by psychiatrists, mental health nurses and allied mental health professionals in private practice. Private mental health services also include inpatient and day-only services provided by privately managed hospitals, for which private health insurers pay benefits, and some services provided in general hospital settings.

### ***Professionals in mental health***

Refers to members of the workforce who are specifically trained in mental health and are expected to work to particular standards and/or meet registration requirements. In some cases, this term is used interchangeably with the term 'mental health worker'.

### ***Psychiatric disability***

Refers to the impact of a mental illness on a person's functioning in different aspects of a person's life such as the ability to live independently, maintain friendships, obtain or remain in employment, and to participate meaningfully in the community.

### ***Recovery***

Various definitions are described in the [Fourth National Mental Health Plan](#).

### ***Secondary consultation***

A service delivered to a professional from another agency or service provider about a specific client of that other agency. In contrast to primary consultation, in secondary consultation the client is not present during the consultation. A secondary consultation may involve discussion about several clients of the other agency or service provider.

### ***Social inclusion***

Contemporary concepts of disadvantage often refer to social exclusion. Social inclusion refers to policies which result in the reversal of circumstances or habits which lead to social exclusion. Indicators of social inclusion are that all Australians are able to secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crises; and have their voices heard.

### ***Specialist***

If used to describe the workforce, see 'professional' above. When used to describe a service, the term refers to facilities or services that primarily or solely provide assessment, treatment, support or education in mental health. Within mental health services, there may also be 'specialist' services, such as those for young people, Indigenous people, older people, children, refugees and so on; or services for specific mental health problems, such as depression or anxiety or suicide prevention.

*Please note that new definitions are currently being developed in the peer worker area, but are not yet nationally endorsed as at the time of publication.*

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# Appendix 1

## Project steering committee

Representative	Organisation	Jurisdiction	Name
Chair	Australian Government Department of Health and Ageing	Commonwealth	Ms Virginia Hart, Assistant Secretary, Mental Health Reform Branch
Consumer representative	Mental Health Council of Australia	Queensland	Mr Mick Burge, Member, National Register, MHCA, Queensland
Carer representative	Mental Health Council of Australia	Australian Capital Territory	Ms Judy Bentley, National Mental Health Consumer and Carer Forum, ACT
Health Workforce Principal Committee	Victorian Department of Health	Victoria	Ms Kim Sykes, Director, Service and Workforce Planning, Victoria
Professional bodies	Australian College of Mental Health Nurses	Australian Capital Territory	Ms Kim Ryan, Executive Officer, ACMHN, ACT
	Royal Australian and New Zealand College of Psychiatrists	Queensland	Associate Professor Brett Emmerson, Executive Director of Mental Health Services, Royal Brisbane and Women's Hospital, Queensland
	Australian Psychological Society	Victoria	Mr Harry Lovelock, Senior Manager, Strategic Policy and Liaison, Australian Psychological Society
	OT Australia	Victoria	Mr Ron Hunt, CEO
	Australian Association of Social Workers	Victoria	Ms Elizabeth Sommerville, Mental Health Professional Officer, Australian Association of Social Workers
	Royal Australian College of General Practitioners	Victoria	Dr Darra Murphy, RACGP
Educational sector	Deans of Health Sciences	South Australia	Professor Justin Beilby, Faculty of Health Sciences, University of Adelaide, South Australia
	Community Services and Health Industry Skills Council	New South Wales	Mr Robin Flynn, Research and Policy Manager, CS&HISC
Australian Private Hospitals Association		Victoria	Ms Sue McLean, CEO, Albert Road Clinic, Melbourne
NGO sector	Community Mental Health Australia	New South Wales	Ms Tina Smith, Community Mental Health Australia, NSW

Representative	Organisation	Jurisdiction	Name
Private Mental Health Alliance		Victoria, South Australia	Dr Bill Pring Proxy: Ms Carol Turnbull, Chief Executive Officer, Ramsay Healthcare, South Australia
Government	Commonwealth and state/territory governments—mental health	Australian Capital Territory	Mr Kevin Kidd, Principal Nurse, Mental Health, ACT Health
		New South Wales	Mr Marc Reynolds, Manager, Clinical Service Development, NSW Mental Health and Drug and Alcohol Office
		Northern Territory	Ms Lorin James, Senior Policy Officer, Northern Territory Workforce Development and Clinical Standards
		Queensland	Dr Aaron Groves, Director, Mental Health Proxy: Ms Sandra Garner, Senior Policy Officer, Mental Health Plan Implementation Team, Queensland
		South Australia	Derek Wright, Director, Mental Health Operations, Mental Health Unit, Department of Health, South Australia
		Tas	Ms Coral Muskett, State Director of Nursing, Mental Health, Tasmanian Department of Health and Human Services
		Victoria	Mr Paul Smith, Director, Mental Health and Drug Operations, Mental Health and Drugs Division, Victorian Department of Health
		Western Australia	Mr Wynne James, Manager, Mental Health Network, WA Health
		Commonwealth	Mr Craig Winfield, Director, Health Workforce Reform Section, Health Workforce Division, Australian Government Department of Health and Ageing
	Secretariat—national	Ms Penny Tolhurst, Secretariat Manager, Mental Health Workforce Advisory Committee	
	Department of Families, Housing, Communities and Indigenous Affairs	Commonwealth	Ms Deb Winkler, Mental Health and Autism Branch, FaHCSIA

