



**MENTAL HEALTH
WORKFORCE**
ADVISORY COMMITTEE

National mental health workforce literature review

LITERATURE REVIEW

This literature review was prepared by Siggins Miller Consultants as part of a project to develop a national mental health workforce strategy and plan.

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Executive summary

A review of international and national literature and documents is in progress as part of the development of the National Mental Health Workforce Strategy and Plan.

There is an enormous amount of activity, in Australia and internationally, that targets workforce development in both the general health workforce and the specialist mental health workforce. The specialist mental health workforce includes the public, private and non-government community mental health sectors, and includes mental health nurses, psychiatrists, psychologists, social workers, occupational therapists, mental health workers, Aboriginal health workers and increasingly, consumer workers and carer workers in a range of roles.

Many of the initiatives and strategies being mooted or trialled in Australia and overseas have significant industrial, HR and funding implications. Concerns are expressed in the literature about the impact of the initiatives and strategies on traditional professional boundaries and about the regulation of the workforce. Simultaneously, others express concern about the unintended negative consequences of those professional boundaries for our capacity to meet the needs of consumers, carers, families and communities.

Through an extensive consultation and research process, the Mental Health Workforce Advisory Committee nominated these areas of work for the strategy:

1. developing, supporting and securing the current workforce
2. building capacity for workforce innovation and reform
3. building the supply of the mental health workforce
4. building the capacity of the general health and wellbeing workforce
5. data and monitoring and evaluation.

This executive summary presents a snapshot of the key points emerging from the literature and document review that have informed the development of the strategy. This snapshot is followed by more detailed review of the information, research outcomes and data.

Policy context

Since 1992 Australian health ministers have agreed to a whole-of-government approach and have worked towards a national mental health strategy. The original strategy consisted of the 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 the National Mental Health Plan, which coordinates mental healthcare reform in Australia through national activities.

Successive national mental health plans have emphasised structural reform and less reliance on acute psychiatric inpatient settings (1993–98); cross-agency collaboration in caring for people with high prevalence, less acute conditions and the de-stigmatisation of mental illness (1998–2003); mental health promotion, mental illness prevention and service quality improvement and innovation (2003–08).

In response to concerns about insufficient progress in some areas of reform under the plans, the Council of Australian Governments (COAG) developed the *COAG National Action Plan on Mental Health 2006–11*, 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 healthcare delivered by psychologists and other allied health professionals, general practitioners and psychiatrists. It also led to increased investment by states and territories in community-based mental health services, enabling them to respond better to consumers with severe and persistent mental illnesses and their carers and families.

In December 2008 health ministers adopted a new National Mental Health Policy. It has a vision for a mental health system that:

- enables recovery

- prevents and detects mental illness early
- ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community (Department of Health and Ageing 2008).

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 *National Standards for Mental Health Services* defines recovery as:

A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability (DoHA 1997).

A review of the National Standards is nearing completion at the time of writing, and consultations to develop national recovery principles have taken place, auspiced by the National Standards Implementation Steering Committee. The *Principles of Recovery Oriented Practice* provides the following definition:

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 (NSMHS 2010).

The *Fourth National Mental Health Plan* and the *Revised National Standards for Mental Health Services* are underpinned by this policy vision. The plan requires a whole-of-government approach to achieve effective change and emphasises that services must meet the specific needs of different cultural groups, backgrounds and experiences. It highlights that specific groups may be more vulnerable to mental illness and issues must be assessed in a culturally sensitive manner and targeted across the lifespan.

The revised standards state that the mental health service 'actively supports and promotes recovery oriented values and principles in its policies and practices'. Standard 10: Delivery of care stipulates 'supporting recovery', and the criteria outline an approach that is consumer- and carer-focused. At present the service system is moving towards a consistent recovery-based approach, and there appears to be considerable variation between services.

Common themes emerging from the literature for successful implementation of a recovery approach to care are the need to move towards evidence-based practice (Easterly 2009; Lambert 1999; Lehman et al. 1998; Hoge et al. 2004; 2005; Rosen et al. 2004); the need to close the gap between what is being taught to the workforce and what is needed by consumers and services (Easterly 2009; Glover 2005b; Hoge et al. 2004; 2009; Huang et al. 2004; Onken et al. 2002); the need for advocacy (Williams et al. 2006); and the need to foster values, skills and attitudes to make new models work (Bryson 2004; Crocker et al. 1998; Fletcher et al. 2008; Glover 2005b; Hoge et al. 2004; Huang et al. 2004; Van de Ven 2007).

Fletcher et al. (2008) found that a critical factor in the successful transition to mental health service provision by multidisciplinary teams in community settings is the engagement and support of service managers and sound governance. Hoge et al. (2009) suggest that the crucial elements to successful implementation of the new model are the commitment of institutional resources, the attitudes of program leaders and the organisational climate. Onken et al. (2002) found that a shift to a recovery orientation requires

attention to wellness and health promotion – not simply attention to symptom suppression or clinical concerns, and collaboration between agencies to attend to basic needs in safe and affordable housing, income, employment, education and social integration, as well as healthcare.

The literature from other federal systems such as the US (Martin 2007; Lok et al. 2009a), provides evidence of the benefits of developing a cross-jurisdictional, national approach to building workforce capacity. Differences in remuneration levels, working conditions and scope of practice between similar positions in different jurisdictions are a potential barrier to the attraction and retention of the mental health professionals, and can exacerbate the misdistribution of the workforce (Robinson et al. 2005; Fletcher et al. 2008). In addition to cross-jurisdictional cooperation, cross-sectoral cooperation (government and non-government) in workforce strategy is also indicated (Rasquinha et al. 2009).

Snapshot of the current mental health workforce

While there are several data sources from which information on the mental health workforce can be drawn, developing an accurate profile of the mental health workforce in Australia remains a challenge. Available data collections vary considerably in terms of their coverage of the mental health workforce and workforce data items. Variations in the understanding of the scope of the mental health workforce and workforce data definitions, and state and territory differences in workforce legislations, registration requirements and service arrangements further add to the difficulty of aggregating different data collections to provide a national picture.

Together with Medicare data, the Mental Health Establishment National Minimum Data Set (MHE NMDS) produced by the Australian Institute of Health and Welfare (AIHW) provide coverage of the majority of the mental health workforce. These two data sets cover the mental health workforce in specialised mental health services that are funded by state and territory governments and in private practice settings. Medicare data on mental

health service provision in the private sector was requested, but was not available to this project. Further, the coverage of the community mental health non-government organisation (NGO) sector in the AIHW data was limited. For instance, recovery support workers and consumer peer support roles are likely to be predominantly based in the community mental health NGO sector, and therefore not reflected in the data below. The NGO sector is large and diverse, and definitions vary as to what constitutes a community mental health service. The sector is thought to consist of over 800 independent organisations nationally (based on membership figures from the Community Mental Health Alliance 2009). The Commonwealth has identified a need to better define and quantify the NGO community mental health sector workforce, and at the time of writing, a Commonwealth-funded project to map the NGO mental health workforce was in progress.

With the above limitations and caveats in mind, the most recent data from the MHE NMDS (2007–08) was provided by the AIHW (2010) before publication. It provides a snapshot of the Australian mental health workforce employed in publicly funded organisations identified as specialist mental health service providers.

In order to monitor and evaluate the impact of national initiatives on the capacity of Australia’s mental health workforce adequately, it is important to have well-designed and integrated data collection systems. The capacity for workforce planning, modelling, monitoring and evaluation in the mental health sector is limited by the nature of existing data collections as well as resource constraints. Stakeholders uniformly recognised the difficulty and complexity of, and agreed on the need to enhance, mental health workforce

Table 1: Snapshot of Australian mental health workforce employed in publicly-funded organisations identified as specialist mental health service providers 2007–08

Staffing category	FTE	Workforce %
Salaried medical officers		
Consultant psychiatrists and psychiatrists	1,094.0	5.1
Psychiatry registrars and trainees	1,086.0	5.1
Other medical officers	335.8	1.6
Subtotal	2,515.8	11.8
Nurses		
Registered	11,517.9	53.9
Enrolled	2,209.1	10.3
Subtotal	13,727.0	64.3
Diagnostic and allied health professionals		
Psychologist	1,740.7	8.2
Social worker	1,592.2	7.5
Occupational therapist	859.4	4.0
Diagnostic and health professionals	920.2	4.3
Subtotal	5,112.5	23.9
Carer consultants	26.6	0.1
Consumer consultants	63.5	0.3
Total ¹	21,445.4	100.0

See [Table 2](#) on page 67 and [Table 3](#) on page 68 for a state-by-state breakdown of these data and explanatory footnotes. [Tables 4–10](#) on pages 69–71 also provide more detailed workforce information from the AIHW and other sources.

data collections in Australia for workforce planning purposes. This need is addressed in the strategy document that was developed from the consultation process. Further details of existing data sets, data sources and good practice in workforce data collection are provided in the workforce data section this document.

Supporting, developing and securing the current workforce

Given the difficulties in achieving an adequate supply of mental health workers, the retention and further development of people already working in the sector is critical. Support, education and training are important for existing workers in a range of areas. Studies report that the current mental health workforce may sometimes feel they have inadequate knowledge and training to work effectively and lack confidence in their ability to identify and treat co-occurring alcohol and other drug problems (Lubman et al. 2007; Petrie et al. 2009); to treat consumers with complex needs, such as in prison populations (Hughes 2006); to deal with aggressive or potentially aggressive situations (Petrie et al. 2009; Happell 2008; Rogers et al. 2007); or to meet the demands of their role, despite several years' clinical experience (Sands 2007). These issues suggest the need to evaluate training methods and programs, if some workers feel inadequately prepared for relatively common workplace issues.

Strategies put forward in the literature to address low job satisfaction (and thus improve workforce retention) include more clinical supervision (Aoun & Johnson 2002; Hemsley-Browne et al. 2008; Cleary & Happell 2005; Crocker 1998; Knudsen et al. 2008; McAdam 2005a; Sands 2007; White & Roache 2006); clear role definition (Crocker 1998; Lambert 1999; Maybery & Reupert 2006); opportunities for advancement (Crocker 1998; Hoge et al. 2009; Perkins et al. 2007; Sands 2007); improved conditions of service for workers (Eley & Baker 2007; Huang et al. 2004); improved support networks and respite for workers in isolated rural and remote services (Carers NT 2009); changes to medical rebates and funding arrangements to provide incentives to private practitioners (Hickie 2006); increased provision of trained 'assistant' staff (CSHISC 2009); protected training

and professional development time (CSHISC 2009; Huang et al. 2004); resources to backfill positions while staff are on leave or in training (Hoge et al. 2009; Lambert 1999; Maybery & Reupert 2006); retraining the existing workforce (Huang et al. 2004); and greater use of local opinion leaders in continuing professional development (Huang et al. 2004; Lee 2008).

Based on the US experience, Huang et al. (2004) suggest that traditional providers would benefit from retraining as advocates, supervisors, system managers, consultants in assessment and treatment planning, administrators and policy makers, as opposed to primary providers of direct treatment services. Onken et al. (2002) conclude that resources for re-educating families, consumers, the professions and paraprofessional providers about the recovery process, and for developing consumer advocates, consumer leadership and active consumer roles are essential ingredients for developing and retaining the current workforce in services that are recovery focused. Respondents to Sands' (2007) Australian study of mental health nurses indicated that paid study leave, increased remuneration for the completion of courses and involvement of service providers in curriculum development were strategies that would support and motivate nurses to stay in the workforce.

Among the community services and health workforce, researchers identified the degree of organisation of professional groups and employee receptiveness to training as preconditions for the building of pride in their work, their skills and their sector (Van Wanrooy et al. 2008). The CSHISC (2009) report suggests that the under-analysis and undervaluing of psychosocial rehabilitation (PSR) work contributes to its low status, and that the creation of a unified body of PSR practice would be beneficial to service quality and workforce development.

The health and community services sector is already heavily reliant on casual, part-time, fixed-term and agency-based workers (Buchanan 2005), and research shows that consumers and carers engaged in providing mental health services are mostly casual, part-time or unpaid and untrained (Stewart et al. 2008). ABS data indicates that, on every measure used, casual employees have the

worst access to training (Van Wanrooy et al. 2008); and Carson et al. (2007) found that participation rates in formal training are higher where there is a requirement to undertake training for accreditation purposes.

Retention steps taken in New Zealand include defining the role of psychiatrists; expanding the scope of practice for non-psychiatrists, including nurse practitioners; considering ways in which more psychologists could work in services; reducing the administrative burden on clinicians and support workers; and increasing peer support worker roles.

Building supply of the specialist mental health workforce

Supply of an adequate number of trained workers is an important prerequisite to providing quality care. It is generally accepted that Australia, like many other countries, will continue to experience increasing demand for healthcare workers. Without significant change to the approach to workforce development, the rate of increased demand will challenge Australia's training and service delivery systems (NHWT 2009). Mental health, as a specialty area in disciplines (such as medicine and nursing), faces particular challenges to supply.

Mental health nurses are the largest single profession working in Australian mental health services. With the shift over time towards the delivery of community-based mental health services, the work context and focus of mental health nursing has changed. Armstrong (2000) suggests that mental health nursing should be promoted as being about wellness, rather than disease. In a UK study, Woolnough et al. (2006) found that acting as career mentors to mental health nurses increased the insight of executive and non-executive directors and senior managers in relation to nursing staff and the patients they care for; increased their awareness of career barriers for female mental health nurses; and gave the managers more insights into organisational issues.

The deployment of mental health nurse practitioners to provide clinical services has slowly become accepted in the face of the shortage of

psychiatrists, especially in rural and remote areas, and it could be argued that Australia is ahead of some comparable countries in this area (Hanrahan & Hartley 2008). However, the number of advanced practice psychiatric nurses is inadequate, and there are different barriers to their full scope of practice in each jurisdiction.

Psychiatry continues to be perceived as an option less attractive to medical students than other specialties (Lyons 2009; Robertson 2009). Suggested strategies to overcome these perceptions (Feldmann 2005; Pidd 2003) include fostering more positive views of psychiatry through exposure to role models, innovative teaching methods and opportunities to expose students to the diversity and range of specialisation.

Evidence of the success of an 'immersion' program run by the University of Toronto for medical graduates led to a trial of a similar program in Western Australia (Lyons 2009). The Canadian program achieved a 43 per cent success rate in encouraging participants to begin psychiatry residency (Andermann et al. 2009).

Boyce et al. (2008) identify that the first year of training for psychiatrists is 'aversive', because trainees see few patients other than those with psychotic disorders, and do not have the opportunity to work in outpatient or community settings. This is being addressed under the RANZCP Board of Education's five-year work plan and by the Psychiatry Training Outside Teaching Hospitals (PTOTH) program, which has now been incorporated into the Specialist Training Program (STP) funded by the Commonwealth. The program explores the number and range of training places in expanded settings outside teaching hospitals, such as community-based locations and private clinics. For Victorian RANZCP trainees, a complement to the traditional apprenticeship model of training is now included in the curriculum in the form of a Master's degree completed as part of the basic training program.

The role of clinical psychologists, social workers and occupational therapists in providing mental healthcare has been recognised more formally in Australia in recent years, particularly owing to the Better Access Initiative (BAI), which provides Medicare rebates for appropriately qualified

practitioners providing mental health services to consumers referred by general practitioners.

Notwithstanding the challenges in measuring the workforce, by any measure, the numbers of professionals in these disciplines working in mental health have increased. Under the Commonwealth's Mental Health in Tertiary Curricula initiative, the Australian Association of Social Workers (AASW) has completed a project introducing core curriculum mental health content for all undergraduates from 2010. Thus, all graduate social workers will have core mental health competencies in whatever setting they work. This is also expected to provide greater opportunities for social workers to change workplace settings and potentially provide greater opportunities to work in the mental health field (in any sector). The core curriculum is also expected to increase mental health literacy in other work settings, thereby contributing to improving mental health literacy in the broader community. The AASW has also established and updated practice standards for accreditation as a mental health social worker (April 2010). Similarly, Occupational Therapy Australia has developed the Australian Competency Standards for Occupational Therapists in Mental Health, which describes the units of competency expected of occupational therapists who have been practising in mental health settings for two years (Australian Association of Occupational Therapists 1999).

The mental health practitioner (MHP) program in the UK aims to provide graduates from the social sciences with a new point of entry into the mental health workforce (Brown et al. 2008) to produce a new trans-disciplinary role that works in multidisciplinary mental health teams. In Australia, the CSHISC (2009) proposed a vocational graduate level qualification that would bridge the VET and higher education sectors and provide mental health training for graduates from other disciplines and a degree-level qualification for people who have progressed through VET programs beyond diploma level. This proposed new career pathway would equip university graduates for work with mental health consumers and provide a structured pathway for career progression through the VET system.

Beinecke and Huxley (2009) suggest that potential exists to build capacity between mental health social workers and nurses because of the extent to which their skills and values overlap, and that this should inform future workforce planning. Increasing interest is emerging in the development of 'assistant' roles for graduates from relevant disciplines in Australia (for example, in psychology, social work and allied health), following the example of physician assistant roles in North America and the current piloting of similar roles in surgery in New Zealand. Holmes (2006) suggests that the future mental health workforce should be a graduate specialist who stands outside existing disciplinary identities. There is advocacy in the literature for the creation of an agreed uniform, national, competency-based and evidence-based foundation curriculum for all mental health workers, regardless of professional group or role (Andrews & Titov 2007; Easterly 2009; Huang et al. 2004).

The non-government community mental health sector has grown rapidly in recent years, and also faces shortages in the supply of workers. The Community Services and Health Industry Skills Council (CSHISC 2009) argues that the separation between 'clinical' and 'non-clinical' is an artificial one, because many community workers (in the public, private for-profit and private not-for-profit sectors) are involved in, for example, monitoring indicators of wellness, symptoms of mental illness; assisting with and/or monitoring administration of medications; and providing an increasing variety of psychosocial rehabilitation services.

Other groups (such as counsellors and psychiatric rehabilitation professionals) propose greater use of accredited counsellors and therapists from diverse backgrounds to assist primary healthcare workers in early intervention and prevention – similar to 'gateway workers' in the UK model (Armstrong 2007), and to support rehabilitation and recovery.

Infrastructure support, governance and evaluation resources for organisations training Aboriginal health workers are being developed and supported through the Aboriginal and Torres Strait Islander Health Registered Training Organisations National Network (ATSIHRTONN), and training programs for Aboriginal mental health workers (such as those offered in western New South

Wales) are demonstrating success in producing skilled local mental health workers. However, numbers remain small, graduates are in high demand from other human services providers and they are often recruited by agencies outside the mental health sector.

The curriculum of an articulated suite of recovery-focused training programs has recently been revised, and the Certificate IV in Mental Health is now available through 79 registered training organisations (RTOs), and articulates to the Diploma in Mental Health (offered by 14 RTOs) or to the Diploma in Mental Health and Alcohol and Other Drugs (offered by 23 RTOs). The alliance of the eight Australian peak bodies for NGOs in mental health service provision, Community Mental Health Australia (CMHA), has agreed to accept the recently revised Certificate IV in Mental Health as the voluntary national minimum entry level qualification for employment in their services.

Structuring a workforce based on the needs of consumers and carers

In the recovery approach, the skills required for any team are defined by the needs of the local communities and service users, rather than by the needs of the professions, the organisations in which they work and the health system. In the UK health system, *New Ways of Working* involves a cultural shift, one element of which is to move from a workforce defined and restricted by professional qualifications to one defined by skills, competencies and capability (Morris & Nixon 2008).

Challenges in moving towards a skills-based multidisciplinary team include unclear definitions and clarity about roles; professional bodies being protective of boundaries; fear of change; and insufficient change management (Nixon 2007). Armstrong (2000) calls for the removal of professional barriers to collaboration that impede professional team work. She suggests that the professional colleges need to come together via a formal process to seek to overcome issues of 'ownership' of different types of therapy by particular members in multidisciplinary teams

(for example, CBT is 'owned' by psychologists; family therapy by social workers).

A view commonly expressed in the literature is the need to maintain balance between clinical management of mental health services, and the psychosocial model of support and rehabilitation (Huang et al. 2004). Based on the US experience, Hoge et al. (2009) and Huang et al. (2004) argue that professionals rarely receive training in the values, skills and attitudes consistent with reforms that call for partnership with consumers and carers, cultural competence in service delivery, comprehensive cross-agency interventions, individualised care and home and community-based approaches. Nicholls et al. (2007) argue that the current Australian training programs for consumer-based care are inadequate, and that the transfer of knowledge to practice is not a single event, and is not achieved by including of modules or 'guest lectures' in a training program. Rather, it must be continuous, so that sustainability can be achieved. Farkas et al. (2008) suggest that more than just staff training is required to achieve a workforce and service delivery approach that is based on the needs of consumers and carers, and they argue that while training builds capacity to work in a new way, the organisation's culture and a commitment to change, and to meeting the needs of consumers and carers, are essential prerequisites.

Models of care and consequent role design for service delivery to Indigenous communities (for example, the 2008 AMSANT model for integrating alcohol and other drugs, community mental health and primary healthcare in Aboriginal medical services in the Northern Territory) emphasises the critical starting point and maintenance of community engagement in identifying needs and driving the development of appropriate roles to support consumers with complex needs.

Building the capacity of the consumer and carer workforce

Essential to implementation of the recovery approach is an acknowledgement that the workforce in mental healthcare has expanded beyond traditional structures, and includes

professionals, specialists, generalists, consumers, carers and support workers. Consumers and carers in the mental health system work in a range of roles – both paid and unpaid – including peer/recovery support in acute inpatient and community settings; educators, researchers and contributors to curriculum development and the delivery of training; services planning and evaluation; and policy and strategy development. In the US, the emergence of Medicaid funding for peer support services provided by certified peer specialists in some jurisdictions is resulting in the development of training programs and certification processes by states and broader scope for employing people with lived experience, beyond consumer-operated programs (Schwenk et al. 2009).

In Australia, consumer and carer worker programs are in various stages of development at the state and territory level, and some evaluation evidence is available. The New South Wales Consumer Workers Forum Project (NSW Consumer Advisory Group 2009) is developing an articulated framework for consumer worker positions consisting of clearly defined roles, remuneration levels, supervision requirements and minimum training standards. Queensland Health has developed consumer companion roles to provide peer support to consumers in acute inpatient units. The program is intended to train people with lived experience of mental illness to assist consumers to become more positive about their care and treatment and the hope of recovery and more comfortable during their stay in an inpatient setting; and to provide a positive recovery role model for staff and consumers (Queensland Health 2009). The evaluation of the program pilot (Queensland Health 2008) found that consumers ranked 'caring people' and 'having someone to talk to' as the most helpful factors during their admission. Consumers, other staff and program coordinators rated the peer support provided by the consumer companions as an important part of the recovery process, providing time for one-to-one support and assistance, reducing the workload of staff, relieving the boredom of inpatient admission and generally improving the consumer's experience during the period of admission.

In their evaluation of a peer support worker (PSW) program in South Australia, Nestor and Galletly (2008) found that PSWs were beneficial in early intervention, in helping young people recognise the symptoms of psychosis, in assisting patients to play an active role in their recovery, in educating families to have a better understanding of psychosis, and in providing role models for recovery. Carlson et al. (2001) suggest that the benefits of employing consumers are that they enhance the team by contributing systems knowledge, 'street smarts', responsiveness, coping strategies, patience and flexibility, relational emphasis, issue identification, role modelling, advocacy against stigmatisation and the opportunity to educate co-workers.

The literature indicates that barriers to employment of consumers and carers have included negative attitudes of mental health professionals (Carlson et al. 2001; Chinman et al. 2006; Felton & Stickley 2004; Lammers & Happell 2004; Gordon 2005; Lloyd & King 2003; McCann et al. 2008); perceptions of tokenism (Lammers & Happell 2003; 2004; Gordon 2005; Hemsley-Browne et al. 2008); perceived lack of professional boundaries and suspicions of divided loyalties (Carlson et al. 2001; McCann et al. 2008); lack of respect (Hemsley-Browne et al. 2008); and lack of financial incentives (Hemsley-Browne et al. 2008; Stewart et al. 2008). Citing previous studies in the UK and Australia, McCann et al. (2008) identify the negative attitudes of mental health professionals and evidence of the view of consumer participation as an assault on deeply imbedded professional roles and responsibilities as being the major barrier to effective consumer involvement.

MacDonald et al. (2006) concludes that the principal enabler of consumer participation is organisational readiness. In addition to role clarity, job descriptions and the preparedness and acceptance of colleagues, other issues of organisational readiness include policies on payment of consumers/carers in consulting roles, which Hemsley-Browne et al. (2008) suggest are significantly lacking; and formal structures for credentialing consumers and carers (Bashook 2005).

Building the capacity of the general health and wellbeing workforce to work with people with a mental illness and their carers

The general health and wellbeing workforce includes GPs, practice and other primary care nurses, social workers and occupational therapists. Generalist providers treat people for 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 (McDonald & Harris 2005).

Mental illness is common, and generalist providers need knowledge and skills to recognise and help people with a mental illness. This is particularly so in rural and remote areas where specialist services are difficult to access. The types of mental healthcare provided may include patient education, pharmacotherapy, psychological treatment and ongoing management. Mental health consumers also need 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 (Bennett-Levy & Perry 2009). They also have increased rates of ischaemic heart disease, stroke, high blood pressure, bowel cancer, breast cancer and diabetes than the general population, develop illness at a younger age and die from these conditions earlier (several studies are cited in British NHS Scotland et al. 2008). Most people with mental disorders are seen by GPs, but Issakidis & Andrews (2006) and Andrews & Titov (2007) report that consultation with a GP for any reason is far more common than consultation with a GP for mental health problems.

Training can support the general health and wellbeing workforce in achieving improved health outcomes for consumers (Katon et al. 1996; Hunkeler & Meresman 2000; Rost et al. 2002).

GPs also use referral effectively to improve health outcomes (Gater et al. 1997; Coulehan et al. 1997). Effective referral requires consideration of the interaction of the general health and wellbeing workforce and specialist mental health services.

There is evidence of the effectiveness of skilling the generalist health workforce in mental health first-aid (Kitchener & Jorm 2006), and indeed of providing mental health first-aid training to other frontline workers who come into contact with at-risk population groups (for example, correctional staff, police) to facilitate prompt referral to appropriately skilled mental health workers (Brooker 2006).

Addressing the needs of special needs groups

In their review of issues affecting service delivery in rural and remote areas, Judd et al. (2002) highlight the need to shift the role of specialists in mental health from one of direct service provision to one of consultation, education and indirect service provision.

Robinson et al. (2005) found that the main sources of job satisfaction for rural mental health nurses were caregiving opportunities and supportive working relationships. Other reported elements of job satisfaction that influence intentions to leave are quality of clinical supervision, ratio of qualified to unqualified staff, support from immediate line manager and paperwork.

The most recent data on the prevalence of mental health issues and co-occurring substance abuse (for example, the 2004–05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) (ABS 2006) suggest that the need to provide culturally competent, accessible services to Indigenous communities continues to pose a major challenge for workforce planning and development.

While New Zealand is not necessarily a comparable country (it does not have a federal system and has fewer rural and remote access issues), observation of the New Zealand approach to workforce development may be useful. The Werry Centre (2004) reviewed the barriers and incentives to Maori participation in the psychology workforce and found that overemphasis on

academic achievement at the expense of cultural competency, financial hardship and the absence of support for Maori psychologists were barriers to participation. Incentives developed included the formation of formal and informal networks for students and Maori psychologists, and having a specific focus on Maori psychology. A specific agency, Te Rau Pauwai, offers financial, mentoring and other supports that target these groups, and it has demonstrated improving pass rates for relevant qualifications across a range of mental health occupations. The New Zealand mental health workforce recruitment efforts also target Maori, Pacific Islander and Asian people (Annanadle & Ta'I 2007).

In Australia, Bartik (2007) evaluated a model for training Indigenous Australian health workers in a mainstream general mental health service, and found that: structural issues in the program affected its success; clinical placements were beneficial, but disruptive to coursework; and turnover in management created problems for the acceptance and support of the program in the system. There were frequent periods of 'down time' for the trainees. Existing staff needed clarity on policy and procedures and about the role of the new positions. All these were exacerbated by high staff turnover. Bartik recommended support and mentoring from other Indigenous professionals as crucial to the success of the program. Similarly, the evaluation of the Aboriginal Mental Health Worker Trainee Program in western New South Wales identified organisational readiness in terms of preparation and planning by existing staff to clearly define the trainee's role and to provide mentoring and supervision arrangements for the trainees as crucial in providing a successful placement for the trainee.

Judd et al.'s (2002) review of rural psychiatry services identifies common barriers for Indigenous people in seeking and accessing treatment as: language; how symptoms are manifested and communicated; and practitioners' stigmatising of mental illness and racial intolerance combine to result in inappropriate or inadequate treatment. The primary action outlined in the New Zealand workforce plan is the development of a new framework of core dual competencies (that is, clinical and cultural) for mental health workers in both the public system and NGOs. This includes

a continued focus on dual competencies for community-based mental health and addiction services and recovery approaches that also focus on cultural elements (for example, Maori models of care). In Australia, while cultural competency modules or short programs are required in some circumstances, they are not mandated core components of curricula across professions and sectors in the mental health workforce.

The importance of involving representatives of a particular population is recognised by Palmer and Maffia (2008) in relation to asylum seekers, and they suggest that the lessons learned from this one group could be used with other disadvantaged groups. However, a case is made in the literature that cultural competence is an ongoing dilemma in academic settings where, despite an increasing body of knowledge and the development of new training tools, it is essential to mobilise the political and academic will in order to genuinely adopt them (Goode & Jackson 2003; Goode et al. 2002; Huang et al. 2004; Trader-Leigh 2002).

Better managing of the places where consumers and carers fall through the cracks between professions, settings and the private, non-government and public sectors

Navigating a path through mental health services is often complex for consumers and carers, and coordination and communication between different services can be suboptimal. Service integration can be poor, and there is often fragmentation and complexity at the local level in the overall system of mental healthcare. Kathol and Clarke (2005) argue for system changes that foster coordination of general medical and mental health services, and joint accountability for them. They note that funding approaches can distract from providing effective and economical care, and argue for integrated medical and behavioural care for complex consumers with comorbid physical and psychiatric issues.

Consumers accessing community-based services may now have higher levels of acuity than in the past. The limited data available show that the

workload of community mental health nurses is increased by the greater complexity of needs of community mental health clients. Service change has also resulted in poor integration between inpatient and community services, and tension between generic case management and specialist roles, resulting in nurses undertaking tasks for other case managers. These issues, along with difficulties in recruiting and retaining staff, have led to the intensification of community mental health work and a crisis response to care with less time for targeted interventions (Henderson et al. 2008).

Bartik (2007) identifies open and regular communication among support agencies as crucial to the success of training programs for Aboriginal and Torres Strait Islander health workers. Huang et al. (2004) emphasise the need to develop cross-agency workforce strategic plans with collaborative strategies for investment in recruitment and training. But there is also evidence that the shift to competitive, contractual funding arrangements for health service delivery from non-government providers is fuelling competitive behaviour and creating barriers to collaboration in a range of workforce development and management matters across the health and community services sector (ADCA 2009; Spooner & Dadich 2008; Van Wanrooy et al.; Productivity Commission 2010).

The New Zealand strategy has included establishing four national workforce centres. Some key objectives include ensuring that workforce infrastructures of public and NGO providers are coordinated, and that clear and effective communication promotes information sharing, networking and collaboration.

The literature also suggests expanding the boundaries of the secondary mental health workforce to include the training of frontline workers in a range of areas. Training would include early detection and intervention in mental health and mental health promotion. The secondary workforce to be trained could include field workers who come into contact with farmers and rural communities (Hossain et al. 2008); correctional officers (Adams et al. 2009; Parker 2009); line managers in the primary health system in rural areas (Aoun & Johnson 2002); school

staff (Andrews & Titov 2007); and foster parents, professional and volunteer mentors and families providing peer supports (Huang et al. 2004).

What does evaluation tell us?

Evaluation of mental health workforce initiatives internationally is at an early stage, but to date the literature suggests the following:

- Critical factors in the successful transition to mental health service provision by multidisciplinary teams in community settings include: the engagement and support of service managers; sound governance (Fletcher et al. 2008); the commitment of institutional resources; the attitudes of program leaders; and the organisational climate (Crowe et al. 2007; Hoge et al. 2005).
- Wide-ranging changes to curricula in most mental health professions may be required. Curricula that prepare professions for medical settings may not adequately prepare graduates for the pace, culture and broad spectrum of needs in primary and community care (Blount & Miller 2009; Henderson et al. 2008).
- A crucial factor in the successful mental health training of graduates in social sciences (Hemsley-Browne et al. 2008), registered nurses (Cleary & Happell 2005) and primary care staff (Aoun & Johnson 2002) is the provision of adequate clinical supervision.
- In order to be effective, broadening of the mental health workforce to include non-professional and peer support workers (for example, consumers and carers, both paid and unpaid) requires clear role definitions, clear expectations, supervisory support and mentoring (McCrae et al. 2008; Mitchell 2009; Nestor & Galletly 2008; Stewart et al. 2008). These roles can enhance the mental health team and have beneficial effects for consumer experience of treatment, workloads of existing staff and the sustained recovery of the people with lived experience of mental illness who are working in the support roles (Queensland Health 2008).

In learning from and implementing ideas from elsewhere, planners, policy makers and managers need to consider local factors, systems of care and effective change management.

The impact of mental illness

Mental illness or disorder can have a profound impact on an individual's social, emotional, psychological and cognitive ability, and on their physical health. According to the 2007 *National Survey for Mental Health and Wellbeing* (ABS 2008b), approximately one in five Australians aged between 16 and 85 years will suffer from one common form of mental illness (anxiety, affective or mood disorders, and substance use disorders) in any 12-month period, while approximately three million Australians may experience a major depressive illness during their lifetime. Individuals suffering from mental illness are at higher risk of experiencing adverse social, economic and health outcomes, and the economic costs to the community remain high (approximately \$4.6 billion were provided in services in 2006–07).

However, the full economic burden of mental illness is likely to be far greater, especially as disability associated with mental illness requires individuals to seek additional assistance beyond what can be provided by specialist mental health treatments and interventions. As such, it is important to understand the specific needs of those suffering from mental illness and implement an effective and sustainable national workforce strategy, ensuring that healthcare services and providers promote a healthier and productive society.

Purpose of this review

This literature and document review, together with input from interested parties at consultation workshops, and interviews with and written submissions from stakeholders, is intended to inform the development of a national strategy and plan for the Australian mental health workforce.

The information is presented in the context of the directions of the *Fourth National Mental Health Plan* and the *Revised National Standards for Mental*

Health Services, which are the cornerstones of the development of a national approach to mental health service delivery and desired workforce outcomes in Australia, based on the recovery approach.

Much of the literature and documentation examined in this review represents initiatives, programs, policies and projects in Australia and overseas that are relatively recent, and therefore may not yet be adequately evaluated, or if evaluated as initially successful, are not yet proven sustainable. Australia is in a similar stage of development with comparable countries in terms of mental health workforce strategies. While other countries (such as the UK and New Zealand) face similar workforce shortages, the solutions developed in countries with a single level of government face fewer complexities than countries like Australia, which has federal systems and multiple jurisdictions.

This review, therefore, does not purport to provide advice about proven solutions to longstanding workforce problems, but lays out information about what is happening both nationally and internationally, what has been trialled or commenced, what efforts have experienced early initial success or failure and what authorities judge to be the key components of successful solutions to issues of workforce shortage and capacity.

The Fourth National Mental Health Plan and National Standards

Background

Since 1992 Australian Health Ministers have agreed to a whole-of-government approach and have worked to a national mental health strategy. The original strategy consisted of the 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 the *National Mental Health Plan* to coordinate mental healthcare reform in Australia through national activities.

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

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

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

In response to concerns about insufficient progress in some areas of reform under the national mental health plans, the Council of Australian Governments (COAG) developed the *COAG National Action Plan on Mental Health 2006–11*, which committed governments to a significant injection of new funds into mental health, including the expansion of the Medicare Benefits Schedule to improve access to mental healthcare delivered by psychologists and other allied health professionals, general practitioners and psychiatrists. It also led to increased investment by states and territories in community-based mental health services, enabling them to respond better to consumers with severe and persistent mental illnesses, their carers and families.

The recovery approach

Australia’s national mental health response clearly sits within the recovery approach of care as the agreed model for mental healthcare in Australia. The mental health workforce response must therefore be both underpinned by, and enable, the recovery approach.

In December 2008 health ministers adopted a new National Mental Health Policy. The vision of the policy is for a mental health system that:

- enables recovery
- prevents and detects mental illness early
- ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.

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* and the revised *National Standards for Mental Health Services* are underpinned by this policy vision.

The *National Standards for Mental Health Services* defines recovery as:

A deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of psychiatric disability (DoHA 1997).

A review of the national standards has been completed, along with consultations to develop national recovery principles, auspiced by the National Standards Implementation Steering Committee. The *Principles of Recovery Oriented Practice* provide the following definition:

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 (NSMHS 2010).

The Fourth National Mental Health Plan

The *Fourth National Mental Health Plan* was released by health ministers in November 2009. It notes that recovery is not synonymous with a cure; rather, those with a mental illness may have recurring or persistent problems. Consequently, recovery must be viewed as both a process and an outcome, and adopting a recovery philosophy is important across severity levels and diagnosis, because it is likely to be different for everyone.

Maximising individual potential and coping skills is important, and services must provide support and appropriate treatment to all Australians with mental illness a sense of identity, purpose, self-determination and the empowerment to participate fully and competently in the community.

The plan notes that 'good mental health' is a critical component of 'good general health', and is determined by a complex set of interrelated factors within the individual, the family or the community. The plan also adopts a population health framework, acknowledging that the result of mental health and illness is based on a complex interplay of social, psychological, biological, environmental and economic factors (p. 8).

The framework requires a whole-of-government approach to achieve effective change, and emphasises that services must meet the specific needs of different cultural groups, backgrounds and experiences. The plan highlights that specific groups (for example, Indigenous Australians, youth and the elderly) may be more vulnerable to mental illness, and issues must be assessed in a culturally sensitive manner and targeted across the lifespan.

Eight principles underlie the plan:

1. Respect for the rights and needs of consumers, carers and family – including engagement, provision of information and service choices, support, acknowledgement and privacy.
2. Services delivered with a commitment to the recovery approach – both as a process and an outcome.
3. Social inclusion – recognition of the importance of social, economic and cultural factors in mental health, including the barriers that lead to social exclusion.
4. Recognition of social, cultural and geographic diversity and experience – recognition of the need for cultural competency when planning mental health services, and the specific issues faced by some groups, such as women, Indigenous persons and rural and remote communities.
5. Recognition that the focus of care may be different over the lifespan – mental health services should be tailored to different age demographics.
6. Services delivered to support continuity and coordination of care – collaboration between services and integrated models of service delivery means there is less chance for people to fall through the gaps.
7. Service equity across communities, areas and age groups – services should be accessible, equitable in quality, responsive and evidence based, and the levels and outcomes of care should be transparent to consumers.
8. Consideration of the spectrum of mental health, mental health problems and mental illness – the range of services needs to consider the spectrum of mental health from wellness through to mental illness, from primary care to greater involvement, and be responsive to different demographics.

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

Five key areas for national action within the plan

Despite past achievements from previous Australian mental health reforms and action plans, the *Fourth Mental Health Plan* highlights that there is much that can still be achieved at the state and national level, and that greater emphasis on improving the accountability for both mental health reform and service delivery is vital.

Both the *Fourth Mental Health Plan* and the *COAG National Action Plan on Mental Health (2006–11)* state the necessity for workforce development and increasing workforce capacity. Recruiting and retaining a workforce that is supported to maintain skills and knowledge and is responsive, culturally competent and sustainable remains an ongoing challenge.

The plan has five key areas for national action, of which, Priority 4: Quality improvement and innovation is most directly relevant to workforce. There are some workforce implications, however, from each priority.

1. Social inclusion and recovery

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

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

2. Prevention and early intervention

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

- › education for frontline workers that come into contact with people with mental health issues, including police, ambulance, child protection and other services

- › increased training of frontline workers in co-existing mental health and alcohol and substance abuse issues, and risks of suicidal behaviour.

3. Service access, coordination and continuity of care

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

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

4. Quality improvement and innovation

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

- › the development and the initial implementation of a national mental health workforce strategy to inform a national approach to define standardised workforce competencies and roles in clinical, community and peer support areas
- › increased consumer and carer employment in clinical and community support settings
- › expanded and better used innovative approaches to service delivery including telephone and e-mental health services.

5. Accountability – measuring and reporting progress

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

- › improving and standardising across jurisdictions, sectors and service providers, the type and level of data that is collected to map and measure the mental health workforce, its attributes and trends in workforce

- › developing and resourcing of effective monitoring and evaluation of the implementation of workforce strategies.

The National Standards for Mental Health Services

The new *National Standards for Mental Health Services* were produced through a community consultation process that began in 1996–97 (Department of Health and Aged Care 1997). In light of the expansion of services in the intervening years, and the greater focus on the role of the primary care sector in mental health, a review of the standards commenced in November 2006, in consultation with the sector, and with consumers and carers, and at the time of this draft literature review the new standards were in final draft.

The draft revised Standards of Care are as follows:

Standard 1: The rights and responsibilities of people affected by mental health problems and/or mental illness are upheld by the mental health service and are documented, prominently displayed, applied and promoted throughout all phases of care.

Standard 2: The activities and environment of the mental health service are safe for consumers, carers, families, visitors, staff and its community.

Standard 3: Consumers and carers are actively involved in the development, planning, delivery and evaluation of services.

Standard 4: The mental health service delivers services that take into account the cultural and social diversity of its consumers and meets their needs and those of their carers and community throughout all phases of care.

Standard 5: The mental health service works in partnership with its community to promote mental health and address prevention of mental health problems and/or mental illness.

Standard 6: Consumers have the right to comprehensive and integrated mental healthcare that meets their individual needs and achieves the best possible outcome in terms of their recovery.

Standard 7: The mental health service recognises, respects, values and supports the importance of carers to the wellbeing, treatment and recovery of people with a mental illness.

Standard 8: The mental health service is governed, led and managed effectively and efficiently to facilitate the delivery of quality and coordinated services.

Standard 9: The mental health service collaborates with and develops partnerships within in its own organisation and externally with other service providers to facilitate coordinated and integrated services for consumers and carers.

Standard 10.1: The mental health service incorporates recovery principles into service delivery, culture and practice providing consumers with access and referral to a range of programs that will support sustainable recovery.

Standard 10.2: The mental health service is accessible to the individual and meets the needs of its community in a timely manner.

Standard 10.3: The entry process to the mental health service meets the needs of its community and facilitates timeliness of entry and ongoing assessment.

Standard 10.4: Consumers receive a comprehensive, timely and accurate assessment and a regular review of progress is provided to the consumer and their carers.

Standard 10.5: The mental health service provides access to a range of evidence-based treatments and facilitates access to rehabilitation and support programs which address the specific needs of consumers and promotes their recovery.

Standard 10.6: The mental health service assists consumers to exit the service and ensures re-entry according to the consumer's needs.

Standard 10 emphasises Australia's commitment to recovery as the adopted mental healthcare strategy (defined above). Each standard is accompanied by a set of performance criteria to make clear that the approach is consumer and carer focused. Standard 10 has obvious and extensive workforce implications, because it is the workforce that enables delivery of this level of recovery-focused care.

National Primary Health Care Strategy

A draft *National Primary Health Care Strategy* was released on 31 August 2009. The draft strategy recognises the importance of keeping people well, rather than just looking after them when they are ill, and also recognises the importance of community-based care. It acknowledges the difficulty for both patients and providers in navigating the health system with assurance, and this is particularly so for people with complex care needs or historically poor access, such as Indigenous Australians, those living in rural and remote areas the homeless, those with mental health needs, or those moving in and out of the hospital system.

In describing the building block of a skilled workforce, the strategy expects that patients will have improved access to primary healthcare providers and better integration of their care, and providers will be 'equipped with the skills they need, supported in learning and able to pass on hard-earned skills to students and new graduates' (Commonwealth of Australia 2009).

Pressures for change in the primary care workforce reflect and overlap the same pressures evident in the mental health workforce – pressures on demand, inequality of access to services, poor integration among services, workforce shortages and safety and quality outcomes.

Current health workforce planning and COAG reform

The National Health Workforce Agency – Health Workforce Australia

Health Workforce Australia is an initiative of the Council of Australian Governments, and has been established to meet the future challenges of providing a health workforce that meets the needs of the Australian community.

Its initial roles will be to oversee provision of financial support for pre-professional clinical training, facilitate locally-based mechanisms for the placement of students into suitable training

places, establish a health workforce statistical register to assist with longer-term planning initiatives and to provide advice regarding workforce directions.

Health Workforce Australia is still being established. It will subsume the current National Health Workforce Taskforce (NHWT) activities and assume responsibility for its work program encompassing workforce planning and research; education and training; and innovation and reform.

COAG has announced the following major reforms, which the agency will manage and oversee:

- improving the capacity and productivity of the health sector to provide clinical education for increased university and vocational education and training places
- facilitating immigration of overseas-trained health professionals and continuing to develop recruitment and retention strategies.
- system, funding and payment mechanisms to support new models of care and new and expanded roles
- redesigning roles and creating evidence-based alternative scopes of practice
- developing strategies for aligned incentives surrounding productivity and performance of health professionals and multidisciplinary teams.

National Registration and Accreditation Scheme

Development of the Australian health workforce will take place against the background of the new National Registration and Accreditation Scheme, agreed between the Commonwealth and the jurisdictions on 26 March 2008 (NHWT 2008).

The new scheme is being established to deliver a range of benefits to the Australian community, as set out in the agreement:

- providing for the protection of the public by ensuring that only practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- facilitating workforce mobility across Australia and reducing red tape for practitioners

- › facilitating the provision of high quality education and training and rigorous and responsive assessment of overseas-trained practitioners
- › having regard to the public interest in promoting access to health services
- › having regard to the need to enable the continuous development of a flexible, responsive and sustainable Australian health workforce and enable innovation in education and service delivery.

The new system creates a single national registration and accreditation system for ten health professions: chiropractors, dentists (including dental hygienists, dental prosthetists and dental therapists), medical practitioners, nurses and midwives, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists (Australian Health Workforce Online 2009).

The system will be delivered through the Australian Health Practitioner Regulation Agency (AHPRA) and the new national registration boards established for each of the professions. Many of the benefits of the new scheme will be delivered through nationally-consistent registration processes for each profession (NHWT 2008a):

- › registration and renewal against a single national registration standard
- › consistent processes across the country for registration

- › a single national public register for each profession showing who is a registered health practitioner
- › mandatory criminal history and identity checks for all new registrants
- › student registration from 1 June 2011 in each of the ten professions.

In relation to the handling of complaints, there will be:

- › a single national point of contact for assisting members of the public to make a complaint
- › mandatory reporting for all registered practitioners and employers who will be required to report registrants who are placing the public at risk through a physical or mental impairment or a departure from accepted professional standards
- › a public interest assessment process in handling complaints (new in most states and territories)
- › recording of all conditions and undertakings on the public register
- › a public listing of all deregistered practitioners.

In addition to improvement delivered by these major developments, AHPRA will ensure that there is national consistency in administrative processes. Training for staff will be an important element in the move to national consistency at best practice levels throughout Australia.

International comparisons

United Kingdom

The UK National Framework for Mental Health

The *UK National Service Framework for Mental Health* (NSF) was published in 1999 (British Department of Health 1999). It focused on the mental health needs of adults to the age of 65. It drew on the Government's 1998 policy paper, *Modernising Mental Health Services: safe, sound and supportive* (British Department of Health 1998). The framework:

... heralded new standards and a new direction for mental health services, one based on a national network of new community services including assertive outreach, crisis resolution and early intervention underpinned by the needs of service users and carers. The Framework highlighted the need for workforce development and training to underpin these significant changes (Baguley et al. 2006).

The NSF contained detailed information on staffing requirements and ratios, and the types of skills, approaches and knowledge it was expected that workers would possess for the future delivery of care. It created an expectation of workforce planning for mental health services (British Department of Health 2006).

In 2003 the Department of Health published *Mental Health Services – Workforce Design and Development: Best Practice Guidance*. It was designed to help localities carry out workforce planning within local strategic planning, to ensure they could deliver planned services, estimate local demand and supply of staff, and identify the appropriate mix of skills needed to deliver services (British Department of Health 2003).

Despite the real achievements of the NSF (such as the creation of 250 assertive outreach and crisis intervention teams), it soon became clear that the funding was not adequate, there were high levels of staff stress, and administrative and legislative changes were producing uncertainty and resentment in some parts of the mental health workforce (Baguley et al. 2006).

It became clear that the 'aspirations of the NSF cannot be delivered without a combination of increased numbers of staff and the rapid enhancement of skills and competencies' (SCMH 2000). The Sainsbury Centre for Mental Health recognised the challenge that this immediately posed to mental health services. For example, in 2002 only four per cent of registered nurses in the UK were qualified in mental health nursing; and the number of vacant positions for consultant psychiatrists averaged 12 per cent (and was as high as 20 per cent in some areas) (SCMH 2003). Continuing concerns were voiced about recruitment and retention of psychiatrists, mental health nurses, clinical psychologists, approved social workers and occupational therapists (Lynam & Walker 1999; Craik et al. 1999)

The Sainsbury Centre proposed a continuous workforce planning process with these repeated steps (SCMH 2000):

- analyse the current mental health workforce, broken down by the NSF categories
- use expert panels to review the skills capabilities of the existing workforce, and the implications for education and training
- assess the scope, design, and functions of the future workforce model
- concentrate on recruitment and retention, starting with the retention of existing staff
- gain any available information about the labour market for mental health staff

- estimate the supply of staff for mental health services from educational sources
- address the gaps, and trial and evaluate innovative and radical solutions.

In light of these issues, the need for the existing workforce to work in different ways is described as:

...overwhelming... issues surrounding workforce development are now the most significant challenge to the implementation of the National Service Framework... and the NHS Plan.

The challenge was to disinvest in traditional service models and roles, and redirect resources into new ones (Baguley et al. 2006).

New Ways of Working

NWW in mental health grew out of the problems faced by consultant psychiatrists in recruiting and retraining members of the profession, in light of the falling numbers of psychiatrists to meet demand for services. Consultant psychiatrists were perceived to have low morale, feel overworked and reported difficulty in generating motivation for interdisciplinary ways of working. The first result – a joint endeavour of the Care Services Improvement Partnership (CSIP), the National Institute for Mental Health in England (NIMHE), the Royal College of Psychiatrists and the Changing Workforce Programme – was the document *New Ways of Working for Psychiatrists: Enhancing effective person-centred through new ways of working in multidisciplinary and multi-agency contexts* (CSIP et al. 2005).

The declared purpose of *New Ways of Working for Psychiatrists* was a major change of culture – ‘not just tinkering at the edge of service improvement’ (CSIP et al. 2005). It argues that the proper use of the knowledge and experience of psychiatrists was to: concentrate on people with the most complex needs; act as consultants to multidisciplinary mental health teams; promote distributed responsibility for culture change; and work flexibly to achieve a motivated workforce able to offer high quality service.

The document referred specifically to *Ten Essential Shared Capabilities – A Framework for the Whole*

of the Mental Health Workforce, published by the Department of Health in 2004. It attempted to ‘provide in one overarching statement, the essential capabilities required to achieve best practice for education and training of all staff who work in mental health services’. The elements were: working partnership, respecting diversity, practising ethically, challenging inequality, promoting recovery, identifying people’s needs and strengths, user-centred care, making a difference, promoting safety and positive risk taking, personal development and learning (British Department of Health 2004).

New Ways of Working for Psychiatrists set out a series of initial actions to achieve what it called ‘effective, person-centred services through new ways of working in multidisciplinary and multi-agency contexts’. The actions covered not only psychiatrists, but the allied health professions, administrators, and new non-affiliated and locally developed community roles. The recommended steps include:

- hold major regional conferences to launch and implement NWW
- encourage discussion and uptake through the press, journal articles, briefings, national and regional meetings, newsletters and websites, building on existing workforce networks
- ensure that local advisers receive central guidance on the employment of mental health staff, use the Creating Capable Teams Toolkit for workforce redesign and skill mix, and develop a cohort of ‘capable trainers’
- review the role of mental health nursing by engaging with current consultation on the nursing workforce, and implementing the results
- raise the profile of the allied professions and their contributions in mental health
- undertake workforce mapping exercises for the roles of physiotherapists, pharmacists and dieticians in mental health
- explore new ways of working for applied psychologists, physiotherapists, occupational therapists, dieticians, speech and language therapists, their current education and training pathways, career frameworks and new roles, and work in multidisciplinary teams

- raise the profile of social workers and their contributions to mental health services, and establish a joint national program of work
- develop the roles of graduate primary care and gateway workers, non-professionally affiliated staff, and new locally developed roles
- work closely with professional bodies to support the education and training changes required to support NWW, and commission education and training programs for new workers, and create opportunities for multidisciplinary learning
- roll out the 'shared capability' framework and learning materials into pre- and post-qualifying training and CPD for all professional and non-professionally affiliated groups
- support the spread of supplementary and independent prescribing for nurses, pharmacists and others
- monitor and disseminate the outcome of a national evaluation study, and reflect NWW in regular monitoring and inspection (CSIP et al. 2005).

Other parts of the mental health system were showing signs of the same stressors. In the next four years, a series of papers and presentations addressed NWW to various constituencies (mental health pharmacists in 2006; child and adolescent mental health services, applied psychologists, allied health professionals in 2007, and *New Ways of Working in Mental Health for Everyone*, including social workers and administrators, in 2007). NWW was also embraced by other professional bodies, including nursing, occupational therapists and pharmacists.

NWW was widely accepted and has formed a significant part of workforce and services planning in the UK. It was an initiative to change the way mental health staff work, and to introduce new roles in a team-based workforce model (NHS Confederation 2009). The National Mental Health Workforce Strategy includes aims to facilitate new ways of working across professional boundaries; make better use of specialist staff to meet the needs of service users and carers; and create new roles to tap into the recruitment pool and complement existing staff groups (Cuthbert & Basset 2007).

A number of practical planning and workforce development tools were developed within the national planning framework. The NWW initiative focused on the team as the fundamental unit of service delivery, with responsibility for patient care distributed throughout the team. The Creating Capable Teams Approach (CCTA) is a tool to be used by a facilitator across all areas of health and social care. It is a five-step approach to integrate the New Ways of Working Together policy, and the new roles that arise from that, into the structures and practices of a multidisciplinary team (British Department of Health 2006; 2006a). It is an off-the-shelf facilitator-run process requiring ownership by senior management, team building and planning, and then building and creating workforce from the ground up by determining and prioritising service user and carer needs, and finally through a process of implementation and review (British Department of Health 2007b).

The NWW program of the NIMHE is now regarded as having completed its work successfully, having promoted 'a new way of thinking which includes the development of new, enhanced and changed roles for mental health staff, and the redesigning of systems and processes to support staff to deliver effective, person centred care in a way that is personally, financially and organisationally sustainable' (British Department of Health 2007b), and enshrines a recovery approach of mental health practice.

The NIMHE National Workforce Programme finished in March 2009. It was succeeded by the National Mental Health Development Unit UK, funded by both the Department of Health and the NHS, and designed to advise on national and international best practice to improve mental health and mental health services. Its current projects include improving access to psychological therapies; supporting effective mental health commissioning ('commissioning' in the NHS is the process of ensuring that the health and care services provided effectively meet the needs of the population); improving mental health pathways, promoting equalities, social inclusion and social justice, wellbeing and public mental health; and an emerging program in 'personalising' mental health.

The NMH DU's Project 4 addresses workforce, skills and competencies: national profiling of the

mental health commissioning workforce, support for the outcomes of QA processes of Primary Care Trusts in mental health, a self-assessment model for competencies, a training program for commissioners and providers, and exploration of a work-based commissioning 'apprenticeship' or 'internship' scheme combining statutory and non-statutory providers, commissioning organisations and an academic accrediting body (NMH DU 2009).

Workforce planning in CAMHS

Inclusion of the Child and Adolescent Mental Health Services (CAMHS) workforce in wider workforce planning was not always clear – broad workforce policy documents designed to apply generally across the whole UK mental health sector, such as *New Ways of Working for Everyone* (British Department of Health 2007b) did not take into account several earlier policy documents relating specifically to child and adolescent mental health services, such as *Every Child Matters* (Department of Education and Skills 2004). Those working in the child and adolescent sector perceive their services as having some distinct workforce characteristics, such as the wider mix of disciplines in child mental health teams, a broader range of professional groups, and a more dispersed leadership model. As a result:

Omission of the particular considerations... meant that many in the CAMHS world allowed the initiative to pass them by as another adult services-led idea. Equally, it meant that ideas already prevalent in CAMHS were left to be rediscovered by adult orientated services. (Morris et al. 2009).

Workforce development in CAMHS has taken a slightly different path: CAMHS have used NWW and the Creating Capable Teams Approach (CCTA), but created their own planning documents. A tool was developed to address structured workforce planning issues in a national framework, and planning has taken place at a local level.

Anderson & Nixon (2007) describe the CAMHS workforce planning workshops that were rolled out in ten early implementer sites. The general workforce planning tool was used to produce local workforce plans. A template was introduced to each site in stages through workshops, and filled

out by local attendees. The plans reflected six key principles, taken from Nixon (2006):

1. improve workforce design and planning so as to root it in local service planning and delivery
2. identify and use creative means to recruit and train
3. facilitate new ways of working across professional boundaries
4. create new roles to tap into new recruitment pools to complement existing staff types
5. develop the workforce through revised education, training and development at both pre- and post-qualification levels
6. develop leadership and change management skills.

A national workforce planning pilot program was developed and implemented in seven sites to assist them to provide local, integrated joint workforce plans (British Department of Health 2006a). A number of materials were developed to assist with workforce planning.

The emphasis on local planning represented a move away from an approach where multidisciplinary teams were based on a mixture of professions, towards teams based on the range of skills required for a particular clientele:

NWW involves a cultural shift, one element of which is to move from a workforce defined and restricted by professional qualifications to one defined by skills, competencies and capability (Morris & Nixon 2008).

The skills required for any team are defined by the needs of the local communities and service users. Different local populations have different needs, and those needs drive the required skill mix needed to meet those needs, in turn driving the workforce requirements. The skill mix must take account of the fact that staff are required not only in direct care, but also in teaching, clinical governance, management, administration and further training and development (Nixon 2006).

Key factors of the workforce planning in CAMHS are:

- the workforce plans are both macro and micro
- the macro workforce plan involves projected data modelling around workforce trends, training, recruitment and retention on a

national level, while the micro planning involves the use of local knowledge to implement plans that address the needs of local populations and translate the national knowledge into local plans

- › all of the micro plans must be imbedded in the macro plans
- › links between child and adult mental health services are important (Nixon 2007).

Challenges in moving towards a skill-based multidisciplinary team include unclear definitions and clarity around roles; professional bodies being protective of boundaries; fear of change; and insufficient change management (Nixon 2007). Other workforce design and planning challenges from the CAMHS experience have been:

- › insufficient ownership of the workforce design and planning process at a board level within organisations
- › lack of priority given to workforce design and planning in all organisations
- › lack of skills, capabilities and capacities to undertake workforce design and planning
- › lack of appropriate data
- › lack of strategic review for future planning of roles (Nixon 2007).

Workforce issues in CAMHS suggest wider lessons for the mental health workforce. In particular, they flag the need for special attention to access to services for particular groups. For example, the importance of involving representatives of a particular population is recognised by Palmer and Maffia (2008) in relation to asylum seekers, and they suggest that the lessons learned from this one group could be used with other disadvantaged groups.

New Zealand

New Zealand has developed a number of mental health policies and action plans to promote a more productive and healthier community. The National Mental Health Strategy was launched by the New Zealand Government with two primary publications: *Looking Forward: Strategic Directions for Mental Health Services* and *Moving Forward: That National Mental Health Plan for More and Better Services*. In line with Australia's national

mental health plans, these documents highlight a vision of good mental health that can only be fully achieved through the active collaboration and commitment of all those involved in the health and government sector. Accordingly, mental health issues are addressed within a population and 'holistic' health framework that considers the complex factors (physiological, psychological and social) that may affect health and illness. Both documents address mental health as a government priority and focus particularly on establishing 'more and better' services through a shift towards increased community-based specialised services. Since the release of *Moving Forward*, New Zealand's total public sector funding for mental health services increased from \$523.7 million in 1997–98 to \$839.2 million by 2002–03.

The Second National Mental Health Plan (2005–15) is a strategic work plan that builds on the *Looking and Moving Forward* National Mental Health Strategies and addresses a number of important policy and structural changes within the health sector that require further consideration:

- › establishment of 21 district health boards (DHBs) with responsibility for the delivery of health services to their populations, including determining the mental health needs of their communities and planning and organising services to meet those needs
- › implementation of the New Zealand Health Strategy
- › implementation of the New Zealand Disability Strategy
- › implementation of the Primary Health Care Strategy
- › establishment of primary health organisations (PHOs).

The plan is organised around the following seven primary strategic directions, all of which cover similar aspects to the key areas and objectives described in the recent *Fourth Australian Mental Health Plan*. Actions for each of these objectives are discussed within the document with a 'whole of life' focus on specific groups (that is, children and young; adult population; and older people):

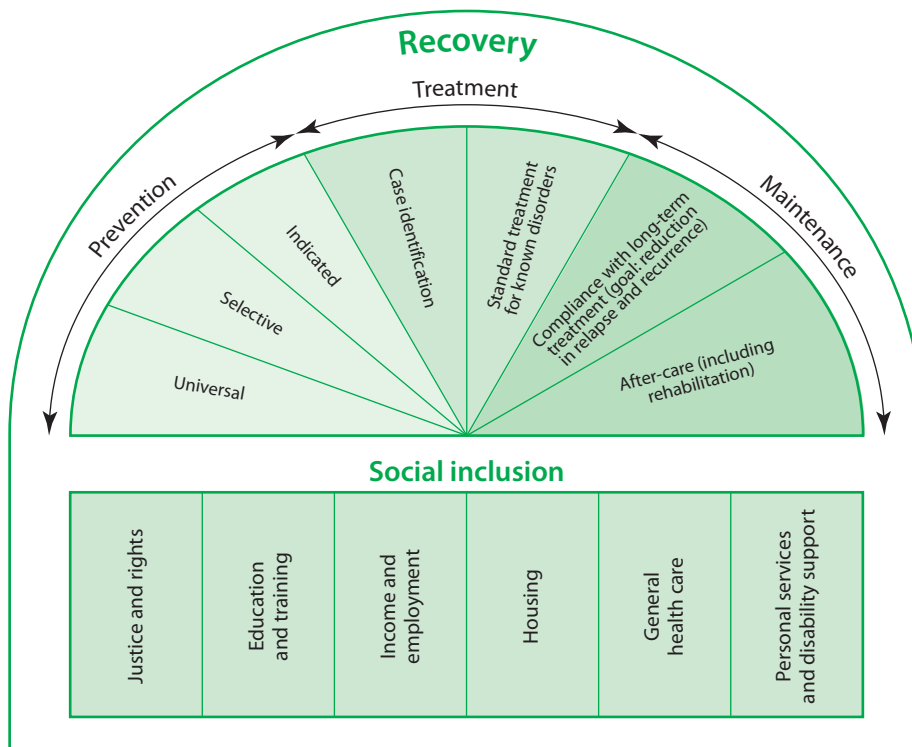
1. more and better specialist services
2. more and better services for Maori
3. responsiveness of services

4. systems development
5. mental health in primary care
6. mental health promotion and prevention
7. social inclusion – removing social and economic barriers to recovery.

In line with Australia's mental health plans, the New Zealand plan adopts a systems approach to mental health and emphasises the importance of 'recovery' as an intervention framework. The significance of recovery promotion is evident across each of the seven strategic directions. Key objectives and actions have identified the need to provide all services with comprehensive recovery plans that take on a whole-person perspective, reduce potential discrimination and address broader social and psychological needs.

Strong emphasis is placed on systems development or a systems approach, recognising that the mental health sector is complex and dynamic and that all community agencies – service users, providers, families, communities, primary and specialist services, funders and planners, policy makers and governments need to work collaboratively to ensure effective mental health outcomes. In addition, workforce development is described as a critical factor to the implementation of the plan. Mental health workforce development has followed priorities identified in both *Looking* and *Moving Forward* and is focused on developing workforce capacity and capability across the health sector.

Figure 1: Spectrum of mental health interventions



The semi-circle depicted in this figure highlights the core health sector responsibilities for prevention, treatment and maintenance, all of which sit within the context of social inclusion and recovery. In addition, social inclusion is supported by a range of social and health inputs that affect mental health recovery. Over all, and in practice, services must be person- or population-centred and draw on a number of resources that may alleviate the negative experiences associated with mental illness (*Second National Mental Health Addiction Plan, 2004*).

In addition, the blueprint developed by the New Zealand Commission (1998) describes the service level requirements of the National Mental Health Plan and also addresses the importance of 'recovery' and a 'systems approach' to mental health. The blueprint targets seven needs groups:

1. adults
2. children and youth
3. older people
4. Maori
5. Pacific people
6. families
7. other special groups (for example, refugees, new immigrants, the profoundly deaf and visually impaired).

Although the specific needs of each of these groups are discussed within the blueprint, particular importance is placed on addressing the cultural needs of Maori and Pacific Islanders. Successive New Zealand governments have committed to adhering to the Te Tiriti o Waitangi (Treaty of Waitangi) and are cognisant of the spiritual, physical, emotional and family values and needs of these cultural groups. Of the 100,505 mental health clients seen by district health boards (DHBs) in 2007–08, Maori and Pacific people made up approximately 25 per cent of the clients (NZ Ministry of Health 2009). Alleviating problems associated with mental health for these populations requires a workforce that is not only highly skilled, but culturally sensitive. The population of New Zealand has become more ethnically diverse, and this trend has implications for mental health service delivery through both healthcare and specialist mental health services. The blueprint highlights significant gaps in the New Zealand's Mental Workforce, and that ongoing strategies are necessary to enhance cultural understanding and awareness.

Mental health workforce in New Zealand

A partnership between DHBs and the NZ Ministry of Health has been established to govern all nationally funded mental health workforce development in New Zealand. The National Mental Health Workforce Development Coordinating Committee provides national coordination and

leadership in workforce development by setting targets, priorities and future directions. The *Workforce Development Framework* outlines five strategic imperatives relating to New Zealand's workforce development:

1. infrastructure development
2. organisational development
3. retention and recruitment
4. training and development
5. research and evaluation.

Workforce strategies and plans

There has been a significant shift towards basing workforce development on a whole-systems approach as opposed to addressing separate workforce aspects in isolation. In order to respond to the development gaps identified in the *National Mental Health Strategy* and the blueprint, two primary workforce strategies were developed: *Tuutahitia te wero: Meeting Challenges* and *Tuutahitia te wero: Embracing the Challenge*.

Embracing the Challenge, the 2006–09 mental health workforce strategy, addresses the five areas outlined in the *Workforce Development Framework*. The key actions, objectives and relevance for each are discussed below, in conjunction with other relevant strategies and programs targeting these core workforce areas.

Infrastructure development

New Zealand's workforce development infrastructure includes national centres and programs, regional coordinator positions, education and training positions and programs, research and policy organisations, and scholarships and governance bodies. In 2006 Te Pou was established as New Zealand's National Centre of Mental Health Research, Information and Workforce Development, and was charged with creating a mental health hub for New Zealand. Te Pou's four programs include workforce, research, information and a national Pacific health workforce development program.

The goal of New Zealand's mental health workforce strategy is to ensure that national and regional infrastructure supports the ability of DHBs and NGOs to progress workforce

development. At present, New Zealand has four national centres for workforce development (Te Rau Matatini – Maori; the Werry Centre – children and young people; the Workforce Development Programme; and the National Addiction Centre – alcohol and drugs). Although each offers an important foundation for strategic planning and development, a key objective is to ensure that workforce infrastructures are coordinated and that clear and effective communication promotes information sharing, networking and collaboration. Another key objective is the formalisation of national workforce performance indicators, which will include specific indicators for Maori, Pacific, child, adolescent and addiction workforces. These objectives further reinforce the view that cultural sensitivity and service alignment is essential in the development of workforce infrastructure.

Organisational development

New Zealand's organisational development goal is to assist the mental health and addiction service providers to develop the organisational culture and systems necessary to sustain their workforce. Two key objectives are highlighted: to continue to build leadership capacity within all mental health services and augment the capacity of mental health services to attract and retain staff. Actions relating to these key objectives include leadership training, mentoring, provision of skills to key personnel (for example, clinical, management, service users) and to encourage potential links between current management initiatives (Knowing the People, Planning and National Resource Group Service Improvement Model). Investigating emerging organisational improvement models and selecting appropriate models that are relevant to Maori and Pacific people are a prime focus of the workforce plan.

Recruitment and retention

Selecting and retaining capable people who are likely to make valuable contributions to the mental health sector and those in need remains a concern. In 2004–05 DHB mental health and addiction services contracted 6,898 full-time-equivalent (FTE) positions, while the national vacancy rate reported by the Mental Health Commission was

approximately eight per cent. The primary goal set out by New Zealand is to develop a nationally coordinated response to issues of recruitment and retention. The workforce strategy outlines four key objectives that are intended to align with the related actions in the DHBNZ's plan:

- human resource capacity and capability
- attract and retain older people
- invest and develop Maori workforce capacity
- action program to promote the health and disability sector as a career option to Pacific peoples.

To achieve these objectives, a national advertising campaign promoting mental health work as a career option was instituted as a primary action. Targeting school leavers, university students, adults and current health professionals, the campaign aimed to emphasise attractive and rewarding attributes and reduce the stigma associated with working in the mental health area. Further, regional links ensure DHBs coordinate recruitment strategies in partnership with NGOs. The promotion campaign was complemented by the development of a mental health and recruitment website, which built on work already undertaken by DHBs and NGOs. Further initiatives with the Te Rau Matatini and the Mental Health Workforce Programme ensure all services have policies and management practices that will attract and retain Maori, Pacific and Asian staff.

Maori and Pacific recruitment

There are a limited number of Maori and Pacific employees in the mental health sector. Mental health education is considered expensive by the majority of these individuals, and this is reflected in the long duration of payback of student loans. The Werry Centre (2004) reviewed the barriers and incentives to Maori participation in the psychology workforce and found that overemphasis on academic achievement at the expense of cultural competency, financial hardship and the absence of support for Maori psychologists were barriers to participation. However, incentives included the formation of formal and informal networks for students and Maori psychologists and having a specific focus on Maori psychology. Te Rau Pauwai offers financial, mentoring and other support targeting these groups, including improving pass

rates for relevant qualifications across a range of mental health occupations.

Training and development

Training and development incorporates all education and training aspects that focus on enhancing the knowledge, skills, and abilities of those working in the mental health service sector. This may include tertiary education, post-entry clinical training and other training associated with mental health support and care.

The primary action outlined in the workforce plan is the development of a new framework of core dual competencies (that is, clinical and cultural) for mental health workers in both DHBs and NGOs to assist in meeting the goal of aligning pre-service entry, orientation and ongoing development of workers with service provision requirements. This includes a continued focus on dual competencies for community-based mental health and addiction services and a recovery approach, which also focus on cultural elements (for example, Maori models of care) and improving information processes and communication processes in line with the National Mental Health Information Strategy. Some NGOs, especially in rural areas where travel is an issue, lack the capacity to offer appropriate training and leadership building. As such, the development of a new core dual competency framework will help form a national training plan, and can be linked to national, regional and sectoral planning processes and build on existing work of the key centres/ programs and DHBs.

Current frameworks, including the Let's get real (2008) program, describe the essential knowledge, skills, and attitudes required to deliver effective mental health and addiction services. The Let's get real program acts as a quality improvement tool aimed at complementing the professional competencies and requirements of the *Health Practitioners Competence Assurance Act 2003*. The competencies and performance indicators within the framework continue to be developed, and provide a consistent basis for recruitment, retention and orientation, such that expectations for those working in the area of mental health and addiction are clearly described – irrespective

of role, discipline or position – and principles are based on the recovery approach. Although the framework is still being implemented, it draws on the competency development of the past decade and supports mental health services to achieve the workforce and culture for recovery as outlined in the national plans.

The development of family involvement training programs for the mental health workforce has also initiated positive change in the inclusion of families by mental health staff. Managers were provided with training and accountability pathways; practitioners received training that enabled them to proceed in a more collaborative and productive way in line with legislative requirements and recovery principles; while families were provided with the opportunity to voice concerns (Steinberg & Whiteside, 2005).

Research and evaluation

The shift towards recovery-based and service user-focused care indicates that services will need to find ways to work more efficiently with current human resource levels. The primary goal is to ensure information is available to the sector to promote workforce development. Key objectives include ensuring robust and uniform data collection across the whole of the New Zealand mental health workforce to improve workforce planning, service quality and forecasting. This will reinforce workforce development and planning capability across the sector; and assist in utilising the current workforce in innovative ways to address staff shortages.

Improving the efficiency and productivity of the workforce was based on the following actions:

- defining the role of psychiatrists
- expanding the scope of practice for practitioners other than psychiatrists, including nurse practitioners
- considering ways that more psychologists could work in services
- reducing the administrative burden on clinicians and support workers
- increasing the peer support worker role.

Workforce strategies: targeting specific groups

Service workers

Individuals with mental illness experience can play an important role in the mental health sector, and New Zealand recognises the need to provide more support for the development of the service user workforce. The *Service User Workforce Strategy (2005–10)* acknowledges that existing service workers working within the mental health services may lack training, work opportunities and professional accreditation. Similarly, individuals who have experienced mental health issues and may have an interest in working in the mental health sector remain an untapped resource. The strategy addresses each of the five strategies as outlined in the *National Workforce Development Framework*. In terms of infrastructure, there is a strong emphasis on establishing and coordinating the service user workforce with the leadership of service users and ensuring adequate resources and maintaining relationships with key people and agencies involved with the Mental Health Development Program.

Recruitment and retention improvements are actioned through guidelines for employers on service user roles, preparation and implementation of HR guidelines and consumer guidelines, as well as ensuring there are adequate career advancement pathways. A number of training and development services focusing on governance, human rights, anti-discrimination and recovery education are proposed. Further, research and evaluation of individual projects and the implementation of the strategy will ensure the service user workforce development is well informed and evaluated.

Maori

The Maori Mental Health Workforce Development Strategy (2005–10) further emphasises the need for both clinical and cultural expertise. The need to promote dual competency within the Maori mental workforce is essential for culturally appropriate services, and represents a symbiosis between Indigenous values and clinical standards. The need for a transferable skill base is also recognised as important, especially given the

growing trend for individuals to transition through a number of occupational roles.

The Werry Centre has identified a number of barriers and incentives specifically for Maori psychologists entering Child and Adolescent Mental Health Services (CAMHS). Although cultural knowledge and specialist assessment and therapy topics were rated as important training for psychologists in this area, Maori respondents viewed the adequacy of training in CAMHS as deficient. Cultural inadequacies of agencies and cultural isolation were additional deterrents to continuing to work for CAMHS. Three recruitment initiatives were suggested: inclusion of Maori content taught by Maori staff, provision of scholarships for Maori students and inclusion of child and adolescent mental health as a specialist discipline in professional psychology programs. Further integration and support of Maori values and knowledge is required not only for CAMHS, but for all sectors.

Information development

Information infrastructure and delivery plays a critical part in the development of workforce strategies, ensuring that good quality information is shared and processed effectively and consistently, thus improving consumer health outcomes. In comparison to other countries, New Zealand is well advanced in the collection of consumer utilisation information for mental health services. This has been enhanced by developments in electronic information systems, with a broad range of infrastructure to support collection, validation, reporting and analysis.

The *National Mental Health Information Strategy (2005–10)* focuses on the application of information at all sector levels, and the key framework objective is to achieve better consumer outcomes and increase accountability for expenditure on mental health services. Three core principles are proposed to guide ongoing information system developments: partnerships (active engagement of consumers in the therapeutic relationship), protection (privacy and information security) and participation (connectivity between individuals and agencies). The success of an information system depends on the way information is perceived by the mental

health workforce. Developing an information-literate workforce at all levels is a priority to ensure the best use of the information and technology available. Actions relating to the information strategy are particularly relevant to the NGO sector, given that NGOs may have limited capacity and access to appropriate systems. While progress has been identified, the necessary infrastructure is not uniform across the sector and national implementation needs to consider the timing of other information developments. This includes technological advances, such as e-learning and internet sites that promote mental health (for example, Te Rau Matatini – specific information related to Maori mental health workforce) (Waetford 2004).

Additional constraints affecting recruitment in the mental health workforce

A 2004 report to the Mental Health Commission revealed that there are a number of constraints that may affect mental health workforce development. In terms of funding, there seems to be less constraint on workforce recruitment and development within DHBs. However, funding shortages may place recruitment and reimbursement constraints on mental health workers in NGOs. Although a number of programs and courses are available, the inability to access basic training programs or continuing education opportunities is a potential barrier. In addition, constraints on the future development of appropriate educational opportunities for mental health workers include: the availability of qualified teachers, highly bureaucratized tertiary institutions, lack of appropriate incentives to develop courses and lack of leadership where no official professional body exists. The provision of training and education programs is not, by itself, enough. Rather, these programs must target the needs of mental health workers and consider potential differences in training for urban and rural areas. Cost is another potential barrier, especially in relation to student debt, which may influence graduates' decisions to seek overseas employment. Work conditions are a significant constraint on the workforce, especially with respect to staff retention. Poor work conditions can lead to higher job stress levels and dissatisfaction, which in turn

increases turnover. Overall, constraints rarely operate in isolation, and all require consideration to improve workforce development.

Canada

Canada is reported to have one of the lowest rates of mental health spending relative to health spending of all OECD countries (Jacobs et al. 2008). The 2006 Senate Committee report, *Out of the Shadows at Last*, pointed out that Canada was the only OECD country without a national mental health strategy. It calls for the establishment of a mental health commission that could become a catalyst for mental health reform in the country, improve knowledge transfer in relation to best practices and develop a campaign to reduce stigma and discrimination (Lurie 2008).

The Canadian Collaborative Mental Health Initiative (CCMHI) was created to implement collaborative consumer-centred care strategies to improve mental health by strengthening collaboration among consumers, families, communities and healthcare providers. Barriers to maximising the effectiveness of mental health human resources and achieving a coherent mental health delivery system included more funding for collaborative mental healthcare delivery, strategies for the mental health workforce, definitions of scope of practice for mental healthcare providers and support for inter-professional education and training (Bosco 2005).

The Mental Health Commission of Canada was created in August 2007, and prepared a consultation paper on a mental health strategy.¹ Since the commission did not have a mandate to direct government action, this strategy would need stakeholders across the country, in each province and territory, to push for action and requisite funding.

Among the priorities proposed for a national Canadian mental health policy, Lurie (2008) lists a human resource strategy to develop plans and incentives for a well-trained mental health workforce to provide services. This would include strategies for recruitment and retention of physicians, nurses and allied health professionals,

¹ <http://www.mentalhealthcommission.ca>

as well as peer support workers across the country, and also the use of telemedicine to improve access to mental health and primary healthcare.

The 2007–08 report on Health Canada’s HR strategy lists three funded training initiatives specifically for mental health: inter-professional collaborative team workshops on mental healthcare in education and practice at the University of Western Ontario; a patient-centred inter-professional team experiences (P-CITE) program on child and youth mental health at the University of Saskatchewan; and modules on rural mental health for residents and practitioners in medicine, nursing and allied health professions in the Inter-Professional Strategy program of the University of Newfoundland (Health Canada 2008). The University of Toronto also runs an ‘immersion’ program for medical graduates.

United States

President George W Bush announced the New Freedom Initiative on 1 February 2001. One component of the initiative was to promote full access to community life by the establishment of the New Freedom Commission on Mental Health. The commission’s mission was to undertake the first comprehensive study in 25 years of the United States mental health service delivery system, including both the private and public sector providers, and advise on methods to improve the system so that adults with serious mental illness and children with serious emotional disturbances could live, work, learn and participate fully in their communities.²

These goals were to be achieved by:

- › reviewing the current quality and effectiveness of public and private providers and federal, state and local government involvement in the delivery of services to individuals with serious mental illnesses and children with serious emotional disturbances, and identifying unmet needs and barriers to services
- › identifying innovative mental health treatments, services, and technologies that are demonstratively effective and can be widely replicated in different settings

² <http://www.mentalhealthcommission.gov/background.html>

- › formulating policy options that could be implemented by public and private providers and federal, state and local governments to integrate the use of effective treatments and services, improving coordination among service providers, and improving community integration for adults with serious mental illnesses and children with serious emotional disturbances.

The New Freedom Commission on Mental Health committed to the following principles:

- › focus on the desired outcomes of mental healthcare, which are to attain each individual’s maximum level of employment, self-care, interpersonal relationships and community participation
- › focus on community-level models of care that efficiently coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services
- › focus on policies that maximise the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers
- › consider how mental health research findings can be used most effectively to influence the delivery of services
- › follow the principles of federalism, and ensure that its recommendations promote innovation, flexibility and accountability at all levels of government and respect the constitutional role of states.

The *Interim Report of the New Freedom Commission* concludes that:

- › the system is not oriented to the single most important goal of the people it serves: the hope of recovery
- › state-of-the-art treatments, based on decades of research, are not being transferred from research to community settings
- › in many communities access to quality care is poor, resulting in wasted resources and lost opportunities for recovery
- › more individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs.

The commission produced a final report in 2003, *Achieving the Promise: Transforming Mental Health Care in America* (New Freedom Commission on Mental Health 2003), that painted a dismal picture of the nation's mental health system, saying the system was so broken that it was 'beyond simple repair' (Goldman et al. 2009). The commission found that current services focused on 'managing disabilities', rather than helping patients achieve a meaningful life in their communities, and that mental health service providers ignored the preferences of consumers and their families.

The recovery philosophy underpinned the commission's final report, and 'recovery' is described as:

...the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery (p. 7).

The five goals articulated by the commission were: public education of the importance of mental health, care that is consumer and carer driven, equitable access to services, early screening, assessment and referral, research-informed care and technology-assisted care.

The workforce implications of the report are articulated in relation to goal of equitable access and include recommendations that:

- the workforce will include members of ethnic, cultural and linguistic minorities who are trained and employed as mental health service providers
- people who live in rural and remote geographic areas will have access to mental health professionals and other needed resources
- advances in treatments will be available in rural and less populated areas
- research and training will continuously aid clinicians in understanding how to appropriately tailor interventions to the needs of consumers, recognising factors such as age, gender, race, culture, ethnicity and locale (p. 15).

Also, in relation to the goal of research-informed care, that:

- the workforce will be trained to use the most advanced tools for diagnosis and treatments
- translating research into practice will include adequate training for frontline providers and professionals, resulting in a workforce that is equipped to use the latest breakthroughs in modern medicine (p. 19).

Although not specified as having workforce implications, the commission's goal of technology-assisted care has clear parallels with current development in the Australian federal system which will impact on workforce training, service delivery and scope of practice, particularly in rural and remote areas. The commission envisages jurisdictions:

...having agreed to use the same health messaging standards, pharmaceutical codes, imaging standards, and laboratory test names, the Nation's health system will be much closer to speaking a common language and providing superior patient care (p. 21).

Such national electronic health records will:

...improve quality by promoting adoption and adherence to evidence-based practices through inclusion of clinical reminders, clinical practice guidelines, tools for clinical decision support, computer order entry, and patient safety alert systems. For example, prescription medications being taken or specific drug allergies would be known, which could prevent serious injury or death resulting from drug interactions, excessive dosages or allergic reactions.

The mandating of recovery-oriented services in the US has increased the prominence of and interest in psychosocial/psychiatric rehabilitation and consumer-led models of service delivery, championed through centres such as the Boston University Center for Psychiatric Rehabilitation.³ The Boston Center conducts research and training to develop systems, organisations and workforce capacity to assist people with psychiatric disabilities to achieve their goals. Its research

³ <http://www.bu.edu/cpr/>

arm is funded by federal government departments and agencies in education, disability and mental health and substance abuse. The Boston Center has written and researched extensively on client-centred practice and the promotion of recovery principles and practices to the mental health and human services workforce.

During the period of the New Freedom Commission, the US Psychiatric Rehabilitation Association established itself as a separate body, and developed a test-based certification process in psychiatric rehabilitation with six pathways and entry points for candidates with different academic backgrounds and levels of experience. The certification is recognised by fifteen states, with varying requirements for practice and supervision stipulated by state authorities.⁴

Seven years after the announcement of the New Freedom Initiative, the US Substance Abuse and Mental Health Services Administration (SAMHSA) released its *Action Plan for Behavioural Workforce Development* in 2008.⁵ The plan describes a 'workforce in crisis'. In addition to citing the US experience of workforce shortages and problems with staff recruitment and retention that are common internationally, the document raises concerns about the capability of the workforce to provide quality care, its lack of understanding of recovery-oriented practices, its failure to engage in collaborative care and shared decision making with clients, its lack of racial diversity and its almost complete absence in some rural areas. In particular the SAMHSA plan raises concerns about the lack of skills to assess and treat people with co-occurring mental and addition disorders. It states that 'the nation continues to prepare new members of the workforce who simply are underprepared from the moment they complete their training' (p. 1).

After an extensive consultation process involving 5,000 individuals, twelve panels and multiple working groups, the Action Plan developed the following key strategic goals (p. 14):

Broadening the concept of workforce

Goal 1: Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

Goal 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioural health and wellness.

Strengthening the workforce

Goal 3: Implement systematic recruitment and retention strategies at the federal, state, and local levels.

Goal 4: Increase the relevance, effectiveness, and accessibility of training and education.

Goal 5: Actively foster leadership development among all segments of the workforce.

Structures to support the workforce

Goal 6: Enhance the infrastructure available to support and coordinate workforce development efforts.

Goal 7: Implement a national research and evaluation agenda on behavioral health workforce development.

Describing mental healthcare its and workforce in the US is as complex as describing Australia's, owing to the mixture of state-based delivery of public services, federal responsibility for Medicaid, the role of health funds and the interaction of the public, private and not-for-profit providers. The peer-reviewed literature (discussed below) contains descriptions and evaluations of studies and initiatives undertaken at the state and federal level in the US.

⁴ <https://www.netforumondemand.com/eWeb/StartPage.aspx?Site=USPRA>

⁵ <http://www.samhsa.gov/>

Australian and international peer-reviewed literature

Implementing the recovery approach

The peer-reviewed literature provides important guidance for Australia in implementing system-wide change that is underpinned by an adequate and appropriately trained workforce. Common themes for successful implementation emerging from the literature are: the need to consult and involve consumers and carers in determining the skills and roles required and in evaluating services (Oades et al. 2005; Salzer et al. 2002); the need to move towards evidence-based practice (Deane et al. 2006; Easterly 2009; Lambert 1999; Lehman et al. 1998; Hoge et al. 2004; 2009; Rosen et al. 2004); the need to close the gap between what is being taught to the workforce and what is needed by consumers and services (Easterly 2009; Hoge et al. 2004; 2009; Huang et al. 2004); the need for advocacy and 'champions' of change (Crowe et al. 2007; Williams, Shore et al. 2006); and the need to foster values, skills and attitudes in order to make new models work (Bryson 2004; Crocker et al. 1998; Crowe et al. 2007; Fletcher et al. 2008; Hoge et al. 2004; Huang et al. 2004; Van de Ven 2007).

The US National Action Plan identifies three areas of implementation of the recovery approach: broadening the concept of workforce, strengthening the workforce and developing structures to support the workforce (Hoge et al. 2009). The goals identified in these three areas include: increasing employment of persons in recovery and their family members in the mental health system; formally engaging consumers and carers as educators; increasing the competency of the existing workforce; designing specific interventions to address poor recruitment and retention outcomes; increasing the relevance, accessibility and effectiveness of training and education; active leadership development in all segments of the mental health workforce; federal

interagency partnerships to coordinate federal workforce interventions; and the creation of a research and evaluation agenda to address the paucity of workforce data.

The literature from other federal systems such as the US (Martin 2007) and Canada (Bosco 2005), provides evidence of the benefits of developing a cross-jurisdictional, national approach to building workforce capacity. Differences in remuneration levels, working conditions and scope of practice between similar positions in different jurisdictions are a potential barrier to the attraction and retention of mental health professionals, and can exacerbate the misdistribution of the workforce (Robinson et al. 2005; Fletcher et al. 2008). In addition to cross-jurisdictional cooperation, cross-sectoral cooperation (government and non-government) in workforce strategy is also indicated (Rasquinha et al. 2009). In its review of findings from the US, Van Wanrooy et al. (2008) conclude that market forces will not deliver recognition and valuing of the role and skill set of psychosocial support workers, and that a more directive role from the government is required to achieve this goal.

Fairlamb (2008) identifies the key elements for enabling a comprehensive primary healthcare approach to delivering mental health services as: acknowledgment of social determinants of health, including trauma and abuse; a move away from pathologising problems that could be interpreted as 'problems of living'; and a reconsideration of clinical data collection requirements that do not allow for social and emotional wellbeing (SEWB) teams' early intervention and health promotion approach.

The move towards community-based recovery approaches to care brings the opportunity to engage a broader range of skills and service providers, and therefore a larger pool of

potential mental health workers. It also brings the responsibility to ensure that training and supervision of multidisciplinary team members and the development of the primary care workforce are adequate to ensure the provision of quality services. Training that has traditionally emphasised clinical impairment and symptom reduction is required to shift to a new focus on building resilience and the client's ability to their manage symptoms (Armstrong 2000; Huang et al. 2004). Marshall et al. (2007) found there are few examples of recovery training programs that clearly attempt to operationalise recovery principles.

Evaluation of mental health workforce initiatives internationally is at an early stage, but to date the literature suggests the following:

- Critical factors in the successful transition to mental health service provision by multidisciplinary teams in community settings are: the engagement and support of service managers; sound governance (Fletcher et al. 2008; McNamara 2007); the commitment of institutional resources; the attitudes of program leaders; and the organisational climate (Crowe et al. 2007; Hoge et al. 2005).
- Wide-ranging changes to curricula in most mental health professions may be required. Curricula that prepare professions for medical settings may not adequately prepare graduates for the pace, culture and broad spectrum of needs in primary care (Blount & Miller 2009; Henderson et al. 2008).
- A crucial factor in the successful mental health training of graduates in social sciences (Hemsley-Browne et al. 2008), registered nurses (Cleary & Happell 2005) and primary care staff (Aoun & Johnson 2002) is the provision of adequate clinical supervision.
- In order to be effective, broadening of the mental health workforce to include non-professional and peer support workers (for example, consumers and carers – both paid and unpaid) requires clear role definitions, clear expectations, supervisory support and mentoring (McCrae et al. 2008; Mitchell 2009; Nestor & Galletly 2008; Stewart et al. 2008).

Developing, supporting and securing the current workforce

The mental healthcare system relies on the current workforce to maintain existing services, to train, supervise and mentor new staff and simultaneously adapt to new structures and new ways of working as the system moves towards a recovery approach.

Some workforce turnover is inevitable, and even desirable. Moving between services, for example, can provide workers with a broader range of experience and career pathways. However, as Humphreys et al. note (2009), minimising avoidable turnover and retaining valuable health workers is important to the delivery of high quality health services. High turnover of staff, combined with recruitment difficulties, can reduce access to care, and may reduce the continuity and quality of care.

The existing challenges to retaining mental health workers have been well documented. Crocker (1998) found that the three main problems for community mental health workers were high expectations and demands with no prospect of relief, lack of clarity of their mission and roles and workers' perceptions of being the scapegoats for shortcomings in the mental health system. Ten years later, Maguire et al. (2008) report that feelings of helplessness, stresses associated with increasing and new demands, an ageing workforce and high expectations from the public are major issues for the occupational health and safety of mental health nurses.

Stuart et al. (2000) found that key frustrations for psychiatric nurses in community settings involved less frequent supervision than is available in an inpatient setting, different remuneration levels in different settings and a focus on non-clinical activities that impedes the provision of direct care. Perkins et al. (2007) found that the most commonly reported reasons for leaving a rural and remote service were lack of career opportunities, fewer options for referral and the availability of fewer resources.

Petrie et al. (2009) found that workplace stress in a rural and remote community mental health team was reportedly caused by unsafe

environmental conditions in the workplace, limited staff knowledge and lack of training and strategies to manage aggressive or potentially aggressive incidents. Knudsen et al. (2008) found that the perceived quality of clinical supervision was strongly associated with perceptions of job autonomy, procedural justice and distributive justice, and was negatively associated with emotional exhaustion and turnover intention.

The global shortage of psychiatrists is also well documented. Goldman and colleagues' (2009) observation of the psychiatrist workforce in the US holds true for Australia: 'older psychiatrists have retreated to their offices and are as busy as they want to be'. Ranz et al. (2001) found that staff psychiatrists report lower levels of job satisfaction than medical directors; that staff psychiatrists perceived their job as 'dead end'; and that the higher satisfaction reported by medical directors was associated with control of the budget, rather than with clinical collaboration or breadth of supervision. Studies also report a history of psychiatrists' dissatisfaction in the public sector due to perceptions of low status, poor conditions and heavy responsibility without adequate authority (Emmerson 1995; Kumar 2007).

Hickie (2006) points to deterrents for psychiatrists in Australia to continue private practice in later life, including medical indemnity insurance costs and consistently lower levels of income for psychiatrists compared to other medical specialties. Older psychiatrists are increasingly working in non-treatment fields, such as medico-legal and third-party insurance (Hickie 2006), and some in the profession perceive the move towards the recovery approach and expansion of the mental health workforce as devaluing the expertise of the consultant psychiatrist (Little 2007).

Research indicates that a continued commitment to training during working life is associated with a longer working life and later labour market exit (Hill 2001). In the context of the broader health workforce, the literature indicates that work intensification does not allow time for training, and leaves workers too tired to undertake training outside working hours (Van Wanrooy et al.), and the ABS *Survey of Education and Training* shows that workers who are motivated to undertake

training report that the principal barriers are workplace constraints (for example, excessive workload), rather than family or financial constraints (Van Wanrooy et al. 2008).

Studies also report that some of the current mental health workforce feel they have inadequate knowledge and training to work effectively and lack confidence in their ability to identify and treat co-occurring alcohol and other drug problems (Lubman et al. 2007; Petrie et al. 2009); deal with aggressive or potentially aggressive situations (Petrie et al. 2009; Happell 2008); treat consumers with complex needs, such as in prison populations (Hughes 2006); or meet the demands of their role, despite several years' clinical experience (Sands 2007).

Andrews and Titov (2007) argue that resource, infrastructure and planning issues, such as the shortage of step-down beds, mean that acute beds are occupied by recovering patients and patients who should be in acute beds have to be managed in the community; therefore, the workforce functions permanently in crisis mode, resulting in staff burnout and high rates of absenteeism.

White and Brooker (2000) found from a census of community practice psychiatric nurses in the UK, that when implementing new approaches to psychiatric care, the following are rarely in place and therefore cause concern to existing staff: operational policies, clarification of team roles, team leadership, team support, accountability and training in evidence-based interventions

Strategies put forward in the literature to address low job satisfaction and thus improve workforce retention include: increased provision of clinical supervision (Aoun & Johnson 2002; Hemsley-Browne et al. 2008; Cleary & Happell 2005; Crocker 1998; Knudsen et al. 2008; McAdam 2005a; Sands 2007); clear role definition (Crocker 1998; Lambert 1999; Maybery & Reupert 2006); opportunities for advancement (Crocker 1998; Hoge et al. 2009; Perkins et al. 2007; Sands 2007); improved conditions of service for workers (Eley & Baker 2007; Huang et al. 2004); changes to medical rebates and funding arrangements to provide incentives to private practitioners (Hickie 2006); increased provision of trained 'assistant'

staff (CSHISC 2009); protected training and professional development time (CSHISC 2009; Huang et al. 2004); resources to backfill positions while staff are on leave or in training (Hoge et al. 2009; Lambert 1999; Maybery & Reupert 2006); retraining of the existing workforce (Huang et al. 2004; Marshall et al. 2007); and greater use of 'academic detailing' or local opinion leaders in continuing professional development (Huang et al. 2004; Lee 2008).

In the US, the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored a public-private partnership that developed *An Action Plan for Behavioral Health Workforce Development* (Hoge et al. 2009). Goal 3 of the plan identifies specific actions to retain and develop the current workforce, including improved wages and benefits, increased non-financial rewards, expansion of stipends, tuition assistance, loan forgiveness and the creation of viable career ladders in the local area.

Based on the US experience, Huang et al. (2004) suggest that traditional providers need retraining as advocates, supervisors, system managers, consultants in assessment and treatment planning, administrators and policy makers, as opposed to primary providers of direct treatment services. Woolnough et al. (2006) found that the experience of acting as a mentor for mental health nurses increased personal enjoyment and fulfilment, and the desire of senior managers and directors to implement organisational change.

Respondents to Sands' (2007) Australian study of mental health nurses said that paid study leave, increased remuneration for completing courses, and involvement of service providers in curriculum development were strategies that would support and motivate nurses to stay in the workforce.

The unpaid workforce

In recent decades the trend away from long-term institutional care for people with mental illnesses has led to transferring care out of inpatient hospitals and into communities (Millar 2007). Consequently, the families and loved ones of people with serious, long-term mental illness have increasingly become part of the unpaid workforce.

In Australia, it has been suggested that carers are 'sustaining the fabric and operational effectiveness of mental health service systems' (Mental Health Council of Australia 2008). One estimate is that carers spend an average 104 hours a week caring for people with a mental illness (Carers WA 2008). In its 2007 international survey of 982 carers of people with serious mental illness, the World Federation for Mental Health (2007) found that 61 per cent of caregivers reported serious disruption to their lives, 56 per cent reported a worsening of their own physical and mental health, and 26 per cent reported a worsening of their financial circumstances (due to inability to maintain paid employment) when their family member experienced relapse (World Federation for Mental Health 2007).

In such circumstances, to refer to this essential group of carers as a 'volunteer' workforce would be inappropriate, and it is also difficult to measure the size of this unpaid workforce, because many do not identify as carers for a range of reasons, including privacy and fears of stigmatisation. (Mental Health Council of Australia 2008).

However, a large number of carers and consumers also work outside the home in a range of settings in the mental health system, and in a voluntary or honorary capacity. These roles include: 'consumer consultants', who advise on policy and service delivery and represent the views and needs of consumers and peer support workers (PSWs), who work as part of the mental health team in supporting the treatment and recovery of clients; instructors for in-service training of mental health staff and in postgraduate education of nurses; developers of policy, procedure and information for consumer and carer involvement; and contributors to the identification of competencies for staff and contributors to the development of job descriptions for staff (Faulkner & Goldman 1997; Hemsley-Browne et al. 2008; Huang et al. 2004; Happell & Roper 2003; Hayman & Fahey 2007; Hoge et al. 2005).

The literature on sustaining such unpaid workforces is extensive, and we present a summary of key points that are equally relevant to the unpaid workforce in the mental health sector.

Attracting and recruiting volunteers

Volunteerism takes multiple forms, each inspired by a different set of values, while the different groups attach different values to the same voluntary work (Wilson 2000). Therefore, understanding individual motivation to volunteer has implications for volunteer recruitment. Dutta-Bergmann (2004) points to the need for 'an exchange' between the organisation and the volunteer, not simply shared values. She argues that:

the choice to actively participate in the community is driven by a strong sense of reciprocity and exchange, with an understanding that responsible participation in the community rewards the individual in the form of better resources, stronger impact on policy, better health and so forth.

Chapman et al. (2005) provide the following advice for recruitment:

- ensure fair and considerate treatment throughout the process
- provide explanations for selection procedures
- keep applicants informed
- avoid undue delays in responses
- focus on the values and needs of the organisation that seem most in line with the values and needs of the applicant.

Volunteer retention

Research on volunteer workforce retention highlights a number of factors that influence volunteers' decision to continue or cease their participation.

Self et al. (2001) found that volunteers were more likely to continue when they felt:

- needed, appreciated and competent
- a sense of accomplishment
- job satisfaction
- opportunities existed to express their belief or support to the organisation's purpose
- respected as a team member
- opportunities existed to develop friendships, communicate and develop support groups
- opportunities existed for personal recognition.

In contrast, factors associated with ceasing volunteerism include:

- work and family obligations
- poor communication within the organisation or team
- perceived low status
- acceptance problems between volunteers, paid staff and clients
- unrealistic expectations
- unclear roles
- inadequate training
- insufficient use of volunteer staff.

Organisational commitment is also important in volunteers' decision to stay or leave an organisation. Boezeman and Ellemers (2007; 2008a; 2008b) found that normative commitment (feelings of responsibility) was a stronger predictor of intention to stay in an organisation than affective commitment (emotional attachment). This finding is in line with Dutta-Bergman's (2003; 2004) research into the psychographic variables of volunteerism, which emphasised the need to embody social responsibility in the strategic choices and actions of the recruiting organisation. Boezeman and Ellemers (2007; 2008a; 2008b) also found that volunteers were more likely to stay when the organisation contributed positively to the volunteers' self-image. Pride and respect emerged as the two key reasons for attachment to an organisation, which in turn led to identification with and commitment to the organisation.

According to Cuskelly and Auld's model (Active Australia 2000a; 2000b; 2000d) five core elements need to be considered in addressing the retention of volunteers:

1. Orientation to provide information about the organisation and the roles and responsibilities of the volunteer.
2. Training and development, which involves:
 - identifying training needs to allow the organisation to identify the skills, knowledge and area of training required and plan program and allocate resources
 - implementing a training program that makes clear the links between training activities, organisational objectives and the volunteers' immediate work, and tailored to individual needs where possible

- transferring and maintaining skills gained by encouraging the use of skills developed while volunteering – having a team leader or ‘buddy’ to assist and guide the application of skills and knowledge obtained during the training is important
 - evaluating the benefits of the training program to the organisation and the services it provides by monitoring the performance of volunteers and the impact of their training.
3. Performance appraisal provides a formative way by which to recognise and reward volunteers and identify areas for improvement (Active Australia 2000a). Performance management is a valuable learning experience and is vital in the development of the volunteer (Active Australia 2000e), particularly as an individual’s knowledge of how they are progressing in their role can influence their job satisfaction and determine their level of competence. Feedback should be provided more frequently when the volunteer is new to the organisation. Even when volunteers are established in their role, feedback should be provided at regular intervals. Further, it should address the core issues of their role, namely their progress, areas for improvement and recognition of achievements (Brighton and Hove Volunteer Bureau 2004).
 4. Rewards and recognition programs allow an organisation to demonstrate the value of volunteers to the organisation (Vineyard & McCurley 2001). Research has found that rewards and recognition can provide a link between an individual volunteer’s motivation and the satisfaction that they receive from the role (Self et al. 2001). Effective reward and recognition is immediate, specific, and genuine and should be presented enthusiastically (Noble et al. 2003). To retain volunteers, it is important to reward those who contribute to the organisation in a greater capacity than what is expected of them to maintain their motivation to serve the organisation and for the volunteer to experience a sense of satisfaction (Active Australia 2000b). The acknowledgement of volunteers’ contribution to and involvement in the organisation should be continual.
 5. Retention or replacement of the volunteer by having an exit strategy in place is important. An interview or questionnaire may be used to discuss and understand why a volunteer decides to leave and identify ways to improve the organisation (Feldman & Klass 1999). By attempting to discover the specific reasons for turnover, the concerns of remaining employees can also be addressed and appropriate adjustments can be made to the volunteer program (Active Australia 2000b; Feldman & Klass 1999).

These five core elements, however, will not succeed unless they are implemented and endorsed in a supportive organisational environment (Self et al. 2001).

Organisational support of volunteers

Positive organisational support will be achieved if the organisation is flexible in adapting to the needs of the individual volunteer, if the supervisor and managers are accessible and support is available from a number of people and sources. The main components of effective organisational support are effective communication, relationships and leadership. Organisational support can also lead to perception of respect, which can be achieved through expressions of appreciation for time and effort; personalised communication to individuals; and concrete forms of assistance, such as mentoring, guidance or additional resources when confronted with a problem (Self et al. 2001; Noble et al. 2003; Vineyard 1991).

Leadership and change management

The recovery approach involves a new way of working: shifting clinicians from working as individuals to working as members of a multidisciplinary network, and teams consisting of the consumer, recovery support workers and clinical staff. Compared to some other areas of health service delivery, mental health has a history of working in multidisciplinary teams, although discussions about the concept of, and need for training and improvements in mental healthcare teams continues to appear in the literature. It involves a significant cultural change that goes

against a culture of clinical individualism and traditional medical models of training, represents a move away from inherited hierarchical structures and focuses on consumer, carer and community needs, rather than the providers' or the system's needs (Eveland et al. 1998; Fiol et al. 1993). Similarly, it involves community-based support workers shifting from being 'disability support workers' to becoming 'recovery support workers' and working within a new philosophy, approach and framework (Crowe et al. 2007).

With the Australian governments' adoption of the recovery approach clearly articulated in plans and strategies over several years, the challenge for mental health service providers and policy makers is to move from the 'exposure phase' to the 'implementation phase' (Marshall et al. 2007; Simpson 2002). Themes around leadership and change management emerge from the literature regarding the implementation of recovery approaches to care. For instance, Fletcher et al. (2008) found that a critical factor in the successful transition to mental health service provision by multidisciplinary teams in community settings is the engagement and support of service managers and sound governance. Hoge et al. (2005) suggest that the crucial elements to successful implementation of the new model are the commitment of institutional resources, the attitudes of program leaders and the organisational climate. Chinman et al. (2006, p. 188) suggest that crucial to moving from exposure to implementation are:

...personal motivations of staff and resources provided by the institution (for example, training, leadership), organizational characteristics such as 'climate for change' (for example, staff cohesion, presence of opinion leaders, openness to change), staff attributes (for example, adaptability, self-efficacy), and characteristics of the innovations themselves (for example, complexity, relative benefit, observability).

The literature also provides ample evidence of doubt, scepticism or resistance on the part of some professional and stakeholder groups about the need, benefits, timing and approach of changing the model of care (Buckley et al. 2007; Clossey & Rowlett 2008; Davidson, O'Connell et

al. 2006; Little 2007; McCann et al. 2008; Warne & McAndrew 2005).

Farkas et al. (2008) suggest that while training builds capacity to work in a new way, the organisation's culture and a commitment to change and to meeting the needs of consumers and carers are essential prerequisites. Ashcroft and Anthony (2010) describe the 'three phases of fear' that emerge when introducing change to services, and propose leadership, ownership, customer input, identification of 'passion holders' (often consumers, who should be given lead assignments in the change) and accountability (keeping on track and benchmarking) as the key ingredients to successfully implementing new approaches to service planning and delivery. The study of three Australian mental health services by Crowe et al. (2007) found that successful transition to a recovery approach involved:

...the establishment of leaders or 'champions' within the organisation to provide clear direction and ongoing support, mentoring and supervision for the mental health workers, addressing their concerns and resistances along the way (p. 56).

Chinman et al. (2006) emphasise that the dissemination of evidence of the efficacy of a change (for instance, the benefits of the use of consumer providers) is not sufficient to bring about the adoption of new practices, and that 'passive approaches' (like distributing guidelines) do not impact on behavioural change or improve services. Similarly, in their review of change management literature, Clossey and Rowlett (2008, p. 322) found that 'changed structures, new funding streams, altered mission statements, and even paperwork modifications will not shift attitudes by themselves'.

The change management literature points to a number of enablers and barriers for effective change management. Similarly, the literature on the implementation of the recovery approach identifies the importance of clinical leadership and the attitudes and values of those implementing the recovery approach. These experiences highlight the importance of a number of the key processes identified in Kotter's well-known eight-step change model (1996): establishing a sense of urgency and need for change; forming

a powerful guiding coalition; creating a vision; communicating the vision; empowering others to act on the vision; planning for and creating short-term wins; consolidating improvements and producing more change; and institutionalising new approaches.

Chinman et al. (2006) summarise the common factors of several theories and approaches to successfully implement innovations within organisations – such as the diffusion of innovation theory (Rogers 1995), Simpson transfer model (Simpson 2002), PRECEDE planning model (Green et al. 1980) and social marketing framework (McDonald et al. 2005; Weinreich 1999). The authors highlight the importance of tailoring innovation adoption strategies to local contexts and ensuring that: the approach to change is based on assessed needs, barriers and incentives of targeted end-users; support and involvement from local stakeholder groups and opinion leaders in the planning process is secured; experts are involved in planning, especially for complex practices; marketing principles are adopted for developing and disseminating intervention tools; sufficient education, resources and tools are provided to support adoption; and monitoring and feedback procedures are established to reinforce performance.

Clinical leadership

There is a growing body of literature that argues that clinical leadership must be in place for effective change in the healthcare sector (Ham 2003; Reinerstein 1998; Ward 2005). In a multidisciplinary approach, clinical leadership includes medical, nursing and allied healthcare provider clinical leaders, and leaders at all levels of the network, including senior decision makers and clinicians delivering services on the ground (Siggins Miller 2009). Clinical leaders ‘...define what the future should look like, align people with that vision and inspire them to make it happen despite the obstacles’ (Reinerstein 1998).

Clinical leaders engage people who are difficult to engage, serve as role models for their peers and pioneer an environment in which quality improvements can thrive. They are potential leverage points for improvements in the healthcare sector because, compared with workers

in many other contexts, clinicians have a large measure of control in healthcare organisations. That is, healthcare organisations tend to ‘have an inverted power structure, in which people at the bottom generally have greater influence over decision-making and day-to-day business than do those who are nominally in control at the top’ (Ward 2005). Consequently, the ability of reformers (managers, policy makers and so on) to influence decision making in health services is constrained, and there is a need to rely on collegial mechanisms and clinical leaders who can persuade their colleagues to do things differently. In general, clinicians are more likely to be influenced by leaders who are also clinicians because they believe they have ‘walked a mile in their colleagues’ shoes’ and view them as trustworthy, confident, articulate and willing to make mistakes (Reinerstein 1998).

In addition to these attributes of clinical leadership, the recovery approach adds an additional dimension. Clossey and Rowlett (2008) suggest that, because the recovery approach is based on empowerment of consumers and carers, an effective leader must be aware of their power in creating and transmitting a culture conducive to recovery, must be capable of ‘honest and humble’ self-reflection and have a commitment to making the inner changes necessary to lead and model systems transformation efforts. Recovery-oriented leaders need to share power with staff, consumers and carers and to convey to agency personnel that they are valued.

The literature points to some key potential barriers to effective clinical leadership in the mental health sector, including workloads clinicians’ lacking the leadership skills required for the role and a lack of adequate support for clinicians who take leadership roles (Davidson, Elliott & Daly 2006; McCann et al. 2008). Just as with the provision of training and professional development, a critical element in leadership development appears to be the ability to free up the time of clinical leaders to allow them to pursue the larger change agenda. Similarly, confusing clinical leadership with the management of services means that potential professional leaders are consumed by management tasks and accountabilities. It is a misunderstanding of leadership to assume that it requires positional power to be effective. Counter-

intuitively, having to carry positional authority does not enhance, but reduces the capacity to spend the time in the necessary direct modelling, communication and persuasion and support roles of leadership.

In a recent evaluation of multidisciplinary teams working in managed clinical networks (Siggins Miller 2009) participants observed that being an effective clinical leader requires a set of skills different from those required to be a good clinician. Similarly, the literature acknowledges the importance of supporting and equipping clinical leaders with the high level skills they will need (for example, leading and developing teams, understanding organisational systems, processes and interdependencies, redesigning services and so on). It also suggests that there must be recognition and reward systems in place for clinical leaders, and organisational cultures that value and encourage clinical leadership as vehicle for improving service delivery and performance (Ham 2003; Reinerstein 1998).

Stakeholder engagement and involvement

Change can be exciting and stimulating for those who are directly involved in it – and threatening for those who are not involved (Gill 2003). It is also important continually to involve more and more people in the change process and build momentum until a critical mass is achieved (Moran & Brightman 2000). If the change enjoys a broad base of support, it is less likely that old ways of doing things will creep back into practice. These requirements align with literature that says getting out and talking to a wide range of the people who will be affected by the change is an important change process (Moran & Brightman 2000).

Cashin et al. (2008) report on a Californian strategy for transforming the culture of their mental healthcare systems into more consumer- and family-driven, culturally competent systems with strong community collaboration. Through funding initiatives to encourage consumer and carer involvement in services planning, the authors found that new approaches in service planning and delivery were evident, including creative partnerships proposed with other local

government agencies and institutions, such as law enforcement and the criminal justice system, physical healthcare providers, educational institutions and the private sector. However, key weaknesses in the new planning process identified by the authors were the lack of policy guidance and information on evidence-based practices provided by the state framework and inadequately developed concrete steps to translate intentions into implementation.

These findings are consistent with Simpson's (2002) transfer model four action stages. In Cashin et al.'s (2008) Californian study, the system has passed the 'exposure' stage (that is, the government is dedicated to introducing and training in the new approach) and has provided funding stimulus and supports for the 'adoption' stage (intention to try a new approach through a leadership decision and subsequent support). However, the change process has the potential to stumble between the 'implementation' stage (exploratory use of the approach) and the final 'practice' stage (routine use of the approach, likely with customisation at the local level, and performance feedback) because of a gap between intention and practical implementation.

The importance of marrying 'intention' with concrete implementation steps is consistent with Kotter's (1996) change management step of planning for and creating short-term wins. In the Siggins Miller (2009) experience with the introduction of Cancer Australia's Cancer Networks initiative (CanNET), national evaluation of the project highlighted the importance of having realistic and achievable project plans. Stakeholders were likely to be more willing to participate in projects when they were perceived as achievable. Realistic project plans also allowed project teams to achieve some early wins that provided potential participants with proof that the new model could provide results superior to 'the old way of doing things'.

The CanNET evaluation also confirmed that a top-down, bottom-up approach was critical to successful change management. In addition to effective local governance and clinical leadership, it was critical that a broad range of stakeholders across all regions, levels, services and sectors were effectively engaged as early as possible to ensure

the new networks would be relevant to people on the ground and meet local needs and interests. It was apparent that areas where broad stakeholder engagement was lacking faced significantly greater difficulty and achieved considerably less. In addition, there was evidence that consumer stories and personal experiences were effective in obtaining buy-in and commitment from senior management and executive levels, and that early involvement of consumers and carers in planning resulted in 'peer pressure for change', helped stakeholders get used to multidisciplinary groups and therefore helped drive cultural change.

In identifying the successful ingredients for refocusing mental health service planning provision to the needs of consumers, carers and communities, Ashcraft and Anthony (2010) identify 'ownership' by the stakeholders and the strategic involvement of prominent 'passion holders' as important to successful development of a new service approach.

Perceptions and status of work

Wigney and Parker (2008) explore the aspects of mental health work that were attractive to medical students. These included patient contact, lifestyle and the interesting nature of the science. However, psychiatry continues to be perceived as a less attractive option to medical students (Emmerson 1995; Lyons 2009; Robertson 2009). The negative perceptions of medical students about psychiatry include a low degree of effectiveness in helping the patient, an unreliable scientific foundation and negative attitudes of other medical students and practitioners. Suggested strategies to overcome these perceptions (Feldmann 2005; Pidd 2003) include fostering more positive views of psychiatry through exposure to role models, innovative teaching methods and opportunities to expose students to the diversity and range of specialisation.

Evidence of the success of an 'immersion' program run by the University of Toronto for medical graduates led to a trial of a similar program in Western Australia (Lyons 2009). The Canadian program achieved a 43 per cent success rate in encouraging participants to commence psychiatry residency (Andermann et al. 2009).

Boyce et al. (2008) found that the first year of training for psychiatrists is 'aversive', since trainees see few patients other than those with psychotic disorders, and do not have opportunity to work in outpatients or community settings. This is being addressed under the RANZCP Board of Education's five-year work plan to review the curriculum and the Department of Health and Ageing's Specialist Training program (formerly called the Psychiatry Training Outside Teaching Hospitals (PTOTH) program). This program explores the number and range of training places in expanded settings outside teaching hospitals, such as community-based locations and private clinics. There is evidence of success in attracting trainees to these non-traditional training settings, with 83 per cent of new full-time training positions filled consistently in 2009–10 (O'Connor & Spratt 2010).

The chronicity of the caseload is identified as a reason for leaving and a deterrent from joining the mental health workforce (Robertson 2009). Experiences from Canada's Innovative Clinical Placements project (Reimer Kirkham et al. 2005) suggest that nursing training in expanded settings (such as community services, Indigenous services and corrections health services) can improve the perceptions, learning opportunities and skills of nursing trainees, including trainee mental health nurses. Armstrong (2000) suggests that mental health nursing should be promoted as being about wellness, rather than disease.

Deacon, Warne et al. (2006) identify features of attraction that encourage nurses to work in the acute care setting: the nurses' responsibility for the total ward environment; 'surviving and thriving in chaos and crisis'; and the highly sophisticated skills employed by acute nurses to ensure the promotion of health for the majority of service users. In a UK study, Woolnough et al. (2006) found that acting as career mentors to mental health nurses increased the insight of executive and non-executive directors and senior managers in relation to nursing staff and the patients they cared for; increased their awareness of career barriers for female mental health nurses; and gave them more insights into organisational issues.

The evaluation of the consumer companion program in acute settings in Queensland (Queensland Health 2009) found that, at the

end of the pilot and in spite of some initial uncertainty about the role and its benefits, mental health staff members were overwhelmingly positive about the value added by including a person with lived experience in the mental health team. The consumer companions themselves reported increased confidence, self-esteem and self-understanding as a result of working in the role for six months.

The degree of organisation of professional groups, and employee receptiveness to training, have been identified as preconditions for the building of pride in their work, their skills and their sector among the community services and health workforce (Van Wanrooy et al. 2008). The CSHISC report (2009) suggests that the under-analysis and under-valuing of psychosocial rehabilitation (PSR) work contributes to its low status and that creation of a unified body of PSR practice would be beneficial to service quality and workforce development. Carson et al. (2007) found that participation rates in formal training are higher where there is a requirement to undertake training for accreditation purposes.

For lower skilled or undervalued roles in the mental health sector, the requirement to train or upskill can cause further challenges for employers since the devaluation of health sector work due to low pay, when added to the requirement to train, can exacerbate turnover because workers can find better pay arrangements working in other sectors that don't require a commitment to train or upskill (Meagher & Healy 2006). Alternatively, other authors emphasise the benefits to individual employees, to consumers, and to services of supporting minimum levels of training and supervision for emerging new roles, and for roles that have traditionally been undervalued (Crowe et al. 2006; Marshall et al. 2007).

Workforce development – mental health specialists and non-specialists

It is essential to implementing the recovery approach to acknowledge that the 'workforce' in mental healthcare has expanded beyond traditional structures and includes professionals, specialists, generalists, consumers and carers

and support workers. The Australian Health Ministers' report (2003) defines a consumer as 'a person utilising, or who has utilised, a mental health service' and a carer as 'a person whose life is affected by virtue of a close relationship and caring role with a consumer'.

The Burdekin Report (1993) led to consideration of consumer participation in service provision, and empowering consumers is now the cornerstone of developing public policy in mental health. Hemsley-Browne et al. (2008) identify two types of roles that have emerged: 'consumer consultants' who advise on policy and service delivery and represent the views and needs of consumers; and peer support workers (PSWs), consumer companions or consumer development workers who work as part of the mental health team in supporting the treatment and recovery of clients. Other roles for consumers and carers identified in the literature are as instructors for in-service training of mental health staff and in postgraduate education of nurses (Huang et al. 2004; Happell & Roper 2003); developers of policy, procedure and information for consumer and carer involvement (Hayman, Fahey et al. 2007); contributors to identifying competencies for staff (Hoge et al. 2005); and contributors to developing job descriptions for psychiatrists (Faulkner & Goldman 1997). Boyd (2008) advocates involving young people with personal experience of receiving treatment to be advisors in establishing community mental health services, as part of asset mapping – tapping into the inherent strength and existing resources of communities.

Weavell and Goodrick's (2009) evaluation of the consumer-run Community Connections Project in New South Wales concludes that services (consisting of a hospital-to-home service and a 'warm'-line telephone support service) were less expensive than public, clinic-based home visiting treatment teams; had an impact on modifiable risk and protective factors related to suicide, such as decreased social isolation; increased social connectedness; increased self-esteem through peer support and peer role modelling; and increased coping skills. Although the project provided an opportunity for consumers to work in consumer-run support services, the casual nature of the work may act as a deterrent to recruitment

of consumers because of the effect on receiving Centrelink benefits.

In a review of recent literature on the use of PSWs, Nestor and Galletly (2008) found that treatment outcomes from consumer-assisted agencies were of a similar standard to clinic-based care, and that the majority of studies demonstrate positive attitudes of clients to the availability of PSWs and their usefulness in treatment, as well as benefits to the PSW such as reduced hospitalisations, increased confidence, opportunity to develop skills and paid employment. The same authors found that PSWs in a South Australian project were beneficial in early intervention, in helping young people to recognise the symptoms of psychosis; assisting patients to play an active role in their recovery; educating families to have a better understanding of psychosis; and providing role models for recovery. Carlson et al. (2001) suggest that the benefits of employing consumers are that they enhance the team by contributing systems knowledge, 'street smarts', responsiveness, coping strategies, patience and flexibility, relational emphasis, issue identification, role modelling, advocacy against stigmatisation and the opportunity to educate co-workers. These findings are consistent with Chinman et al.'s (2006) review of empirical studies of consumer provided services.

The literature indicates that barriers to employing consumers and carers have included negative attitudes of mental health professionals (Carlson et al. 2001; Chinman et al. 2006; Felton & Stickley 2004; Lammers & Happell 2004; Gordon 2005; Lloyd & King 2003; McCann et al. 2008); perceptions of tokenism (Lammers & Happell 2003; 2004; Gordon 2005; Hemsley-Browne et al. 2008); perceived lack of professional boundaries and suspicions of divided loyalties (Carlson et al. 2001; Cleary & Happell 2005; Davidson, Chinman et al. 2006; McCann et al. 2008); lack of respect (Hemsley-Browne et al. 2008); and lack of financial incentives (Hemsley-Browne et al. 2008; Stewart et al. 2008). Citing previous studies in the UK and Australia, McCann et al. (2008) identify the negative attitudes of mental health professionals and evidence of the view of consumer participation as an assault on deeply imbedded professional roles and responsibilities as major barriers to effective consumer involvement.

The identified obstacles to the employment of PSWs in the Nestor and Galletly (2008) study were lack of buy-in from staff – particularly junior nursing staff, who felt that their jobs were threatened; concerns about overlap of roles; concerns about confidentiality of information and being observed and evaluated by PSWs; concerns about the access of PSWs to patient notes and their ability to add to the notes; and about the possibility that the PSW may relapse. In a 2008 study, Stewart et al. (2008) found that consumers working in one state mental health system in Australia had been engaged with unclear job descriptions and no training. One-third of the respondents were unpaid, and the paid workforce was largely casual or part time. There was lack of consistency in job titles and roles and little preparation for the job.

MacDonald et al. (2006) concludes that the principal enabler of consumer participation is organisational readiness. In addition to clarity of role, job descriptions and preparedness and acceptance of colleagues, other issues of organisational readiness include policies on payment of consumers/carers in consulting roles, which Hemsley-Browne et al. (2008) suggest are seriously lacking, and formal structures for credentialing consumers and carers (Bashook 2005).

Hoge et al. (2005) argue that it is essential for consumers and carers to increase their involvement in identifying and assessing the required competencies for the mental health workforce, and for governments to invest in developing the paraprofessional workforce. Faulkner and Goldman (1997) stress the need to include consumer and carer workers in discussions and negotiations between psychiatrists, other clinicians, administrators, patients and families to clarify the treatment needs of patients. Bashook (2005) identifies the need for competency-based training modules and appropriate assessment for consumer and carer workforce participants, which can be web-based, low-cost, reliable and valid.

The Community Services and Health Industry Skills Council (CSHISC 2009) argues that, although a number of contested boundaries are embedded in the existing mental health workforce structure, attempts to divide tasks neatly between

occupations and services are fraught, because in reality the boundaries are blurred. Further, the CSHISC argues that the separation between 'clinical' and non-clinical' is an artificial one. Lambert (1999) cites the Thorn study in the UK, where professional and non-professional groups were trained in providing support to specific types of disorders, and the ensuing evidence that workers develop skills in clinical interventions.

Education and training, CPD, supervision, mentoring and coaching

The key themes emerging from the literature around education and training are curricula (silos, content and responsiveness to evidence), supervision and program format, program articulation and the changing definition of 'workforce'.

Curricula

Blount and Miller (2009), Easterly (2009), Hoge et al. (2004) and Huang et al. (2004) identify the current mismatch between training, preparation and actual practice in service delivery in mental health.

Based on the US experience from the Presidents' New Freedom Commission on Mental Health (2003), Huang et al. 2004 argue that, in addition to the mandated shift from traditional inpatient, outpatient and residential care to home- and community-based services and supports, there needs to be a shift in education and training to develop changes in values, skills and attitudes and increase the use of evidence-based treatments. The authors argue that rarely do professionals receive training in the values, skills and attitudes consistent with reforms that call for partnership with consumers and carers, cultural competence in service delivery, comprehensive cross-agency interventions, individualised care and home and community-based approaches. Further, lack of understanding and support of changes in curricula and training can threaten to undo the benefits:

...a competent individual placed in an organisation where a competency is not understood, valued, supervised, supported

or rewarded is unlikely to display that competency on an ongoing basis. (Hoge et al. 2005, p. 552).

A case is made in the literature that cultural competence is an ongoing dilemma in academic settings where, despite an increasing body of knowledge and development of new training tools, it is essential to mobilise the political and academic will in order genuinely to adopt them (Goode and Jackson 2003; Goode et al. 2002; Huang et al. 2004; Trader-Leigh 2002). Others emphasise the need for practitioners and stakeholders to develop shared visions and goals, based on their recognition of a need for change (Bryson 2004; Easterly 2009; Van de Ven 2007). Huang et al. (2004) contend that a major barrier to the development of evidence-based curricula is the fact that most professional training programs have curricula determined by the professional associations, and consequently, curricula can be siloed and discipline specific.

In a study of non-medical primary health and social care providers who provide services to mentally ill clients, Mitchell (2009) identifies an opposite view to the previously assumed roles of mental health specialists: an informal as opposed to a formal approach; a normalising as opposed to a pathologising approach; holistic social and emotional health and wellbeing; and an individualised or client-focused model of care as opposed to an illness-focused model. The impact of this change in approach on the relevance of curricula is clear.

Nicholls et al. (2007) argue that the current Australian training programs for consumer-based care are inadequate, and that the transfer of knowledge to practice is not a single event and is not achieved by including of modules or 'guest lectures' in a training program. Rather, it must be continuous, so that sustainability can be achieved. The authors propose an 'inverse model', where staff and students come to understand consumer perspectives during the course of the study, rather than first 'learning' about the value of these perspectives and then expecting them to work in a collaborative framework at a later date.

The CSHISC study (2009) argues that the separation between 'clinical' and non-clinical' is an artificial one, because community workers (in the

public, private for-profit and private not-for-profit sectors) deal with medication for mental illness on a daily basis; are required to assist consumers with understanding the purpose, dosage and management of their medication; and need to know the effects and side-effects of taking or failing to take medications. There is advocacy in the literature for the creation of an agreed uniform, national, competency- and evidence-based foundation curricula for all mental health workers (Andrews and Titov 2007; Easterly 2009; Huang et al. 2004).

Lambert (1999) argues for developing training to focus on specific target groups or illnesses, using interventions with a sound research base (for example, use of general trained nurses in the management of depression); and that mental health professionals should focus on severe illness and on supporting primary healthcare staff in treating less-severe mental health problems (Cooper & Stoflet 2004; Lambert 1999). Similarly, Bacon and Stallings (2003) suggest that to overcome the shortage of psychiatrists, training needs to be modified to adapt care to the new environment and maximise the use of limited clinical resources.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Board of Education (Boyce et al. 2008) identifies the priority areas of reform of the education program for Australasian psychiatrists over the next five years. These include: streamlining administrative processes; investigation of reasons for prolongation of the training period (up to seven years for a substantial proportion of trainees); curriculum development based on adult learning principles, competency and performance; expanding training settings beyond public hospitals and associated support and materials for clinical supervisors; expanded options for lateral entry into the program (by other specialists or overseas-trained doctors); and greater flexibility for part-time or interrupted training. The RANZCP is in discussion with the Australian Medical Council about several aspects of the assessment and examination processes for psychiatrists. Consideration will be given to a possible move away from summative assessment to formative, multi-source assessment, although no changes to the current system of assessment are foreshadowed in the five-year work plan. The

Commonwealth's Psychiatry Training Outside Teaching Hospitals (PTOTH) program (now incorporated into the Commonwealth's specialist training program) is exploring the number and range of training places in expanded settings outside teaching hospitals, such as community-based locations and private clinics, and is piloting training positions in these settings.

In Victoria, a model has been developed whereby basic trainees in psychiatry are required to enrol in a formal qualification to augment their training, with a postgraduate psychiatry program jointly offered by Melbourne and Monash universities as the recommended program. This model represents a move away from traditional sole reliance on the apprenticeship model for specialist medical education by supplementing trainees' learning with an accredited academic program. Importantly, it may also assist in addressing the system's current reliance on the mature specialist workforce to provide postgraduate medical education – a workforce that the data show is declining in size and hours of availability and is ageing.

In Sands' (2007) survey of mental health triage nurses in one Australian state, respondents indicated a low level of understanding or use of the theoretical models of triage that underpin practice, and 38 per cent of respondents had received no triage training. Armstrong (2000) was highly critical of postgraduate education provided in mental health nursing in Australia; in particular, the emphasis on diagnosis and treatment, and the lack of emphasis on therapeutic relationships and 'basic human skills'. The ANZCMHN suggests that while more than 25 schools offered mental health courses, in reality there is only the expertise to offer one course in each state and territory.

Huang et al. (2004) maintain that to be consistent with new models of service delivery and practice, training programs must incorporate partnership-building tools, such as facilitation, negotiation and consensus building. Lambert (1999) suggests that training should: be evaluated; target clients most in need; include evidence-based approaches such as assertive community treatments, medication management, CBT and family interventions; and prepare mental health workers in the core competencies needed to implement these

approaches. More recent research by the CSHISC (2009) indicates that psychosocial rehabilitation skills and training continue to be undervalued and lacking in curricula.

This literature search revealed a debate among the professions in Australia about where the services of child and adolescent mental health services and adult mental health services should start and finish, and the entry criteria for young adults to access adult services (Birleson 2009). The issue is included in this review for its argument that training should be broadened to better equip mental health professionals to work with consumers across the age spectrum.

The Australian Association of Social Workers has completed a project (*Mental Health in Tertiary Curricula*, 2009) that introduces core curriculum mental health content for all undergraduates from 2010. Thus, all graduate social workers will have core mental health competencies in whatever setting they work. It also provides greater opportunities for social workers to change workplace settings, and potentially provides greater opportunities to work in the mental health field (whether specialist or NGO sectors). This also increases mental health literacy in other work settings along the same lines as suggested by some of the other strategies (improving mental health literacy in the broader community).

Research in the UK concludes that increased emphasis on specialist care comes at the expense of investment in generalist skills (Kendall & Lissauer 2003). However, the same researchers argue that in order for workers to value, preserve and upgrade skills, there needs to be a professional or skills-based fraternity to which they can belong. The CSHISC (2009) proposes a new professional grouping for psychosocial rehabilitation to consolidate an evidence base and curricula for training in this field.

Barriers to training and CPD

The shortages and 'churn' in the workforce are repeatedly cited as major barriers to the successful implementation of evidence-based training. Woltmann et al. (2008) found that staff turnover had a major negative impact on the implementation of and training in evidence-based

practice in mental healthcare. The reasons cited for high turnover were lack of pre-existing clinical skills, inadequate supports at the workplace, difficult interpersonal team dynamics and practitioners' unwillingness to change practices. Bartik (2007) found that unfilled positions limit the time and availability of mental health staff to provide training and clinical peer support, especially in rural areas. In Maybery and Reupert's (2006) study, adult mental health workers reported time and resource limitations, as well as skill and knowledge deficits regarding assisting clients to develop parenting skills and working with children of people with a mental illness. Kowanko (2004) found that the major gap in knowledge reported by Indigenous health and human services workers was the lack of training in the quality use of medicines. Factors accounting for the lack of training were reported as availability, cost, access, suitability and time to be released from service delivery. Workforce shortages and churn also impact negatively on the provision of adequate supervision, which has been well documented as an essential element in the education, training and support of mental health workers (Cooper & Stoflet 2004; Fletcher & Schofield 2008).

Several authors (Andrews & Titov 2007; Easterly 2009; and Huang et al. 2004; to name a few) advocate the development of a standard, national, web-based curriculum that, as well as providing minimum competencies and performance measures, also addresses issues of access and cost. In an assessment of an online training program in cognitive behavioural therapy for rural and remote mental health practitioners, Bennet-Levy and Perry (2009) conclude that: brief courses are ineffective without additional supervision; concurrent and subsequent supervision is a prerequisite for adequate skill development in trainees (preferably weekly and sustained over several years); and extended courses (one day a week over a year) were highly effective.

Articulation

The consequence of training programs based on standard national curricula could be articulated from the VET sector through to the higher education sector to enhance career paths. However, the CSHISC (2009) found that not all

Australian universities have clear credit transfer or articulation arrangements for relevant VET qualifications in mental health, and that the extent of credit or recognition of prior learning varies considerably between institutions.

The literature from other federal systems such as the US (Martin 2007) and Canada (Bosco 2005) provides evidence of the benefits of developing a cross-jurisdictional, national approach to building workforce capacity, including standardised curricula and portable qualifications.

The mental health practitioner (MHP) program in the UK aims to provide graduates from the social sciences with a new point of entry into the mental health workforce (Brown, Simons et al. 2008) to produce a new transdisciplinary role that works in multidisciplinary mental health teams. In Australia, the CSHISC (2009) has proposed a vocational graduate level qualification that would bridge the VET and higher education sectors and provide mental health training for graduates from other disciplines and a degree-level qualification for people who have progressed through VET programs beyond diploma level. This is a proposed new career pathway that would equip graduates for work with mental health consumers.

Transition-to-practice programs have been established in the majority of Australian jurisdictions to skill registered nurses in mental healthcare.

The changing definition of 'workforce' – whom to train?

In addition to curricula and training for mental health professionals, the literature suggests training for a range of frontline workers in the community. Adams et al. (2009) report that training 90 corrections officers at a large metropolitan prison reception centre delivered beneficial outcomes by providing valuable observation of newly-arrived prisoners and support for nursing staff. An evaluation of a 10-hour mental health training program for correctional officers in the US by Parker (2009) demonstrates the effectiveness of training in reducing incidence of the use of force by officers and physical abuse of officers by prisoners. Aoun and Johnson (2002) found that the training of line

managers was essential to the success of a mental health training program for primary healthcare workers in rural Western Australia. Andrews and Titov (2007) emphasise that mental diseases are predominantly disorders of the young (the median age of onset being 22 years), and that school staff are therefore an important part of the preventive workforce who need to be trained to deliver programs to young people. Huang et al. (2004) identify new providers who need to be trained: foster parents, professional and volunteer mentors, school staff and families providing peer supports.

Access to training

The Workplace Research Centre (Van Wanrooy et al. 2008) identifies Australian spending on health and community services as being in the low-cost funding category, which creates 'efficiency pressure' on those working in the system (Blendon et al. 2003) and limits the ability to fund training, release staff and backfill positions. The WRC also argue that low funding levels limit the ability of organisations to recruit and fill higher-skilled positions, or to pay for the upskilling of existing staff, and that these constraints apply particularly to the not-for-profit sector. Hall and Lansbury (2006) found that the failure to include protected time for training occurred at both the high and low ends of the occupational spectrum.

Recent reports and submissions from the NGO sector (Australian Capital Territory Community Sector Taskforce 2006; ADCA 2009; Spooner & Dadich 2008) identify the impact of competitive tendering and fixed-term, contract-based funding from governments to services providing healthcare. The research indicates that, despite increased funding, NGOs are experiencing financial deficits that impede workforce development and service delivery. The suggested reasons for this include: the failure of funders to pay the full cost of services/projects, including infrastructure; increasingly complex clients; increased organisational costs (including the compliance burden of different reporting requirements of different funding bodies); increased competition for funds; and the tendency for funding to be short term and project specific. The ANCD calls for funding of the 'real cost' of treatment service delivery, and minimum

project funding of three years (up to 10 years) (Spooner & Dadich 2008).

Van Wanrooy et al. (2008) suggest that, for both the government and NGO sectors, a low-cost funding model and insecure funding arrangements affect organisational capacity to plan and invest in training and skills development or to monitor the outcomes of training. A low-cost funding environment also affects senior staff's ability to mentor and train and the ability of workers to use 'down time' for professional development (ACIRRT 2003).

Keep (2002) identifies differential access to employer-sponsored training for different employee groups within organisations. The health and community services sector is already heavily reliant on casual, part-time and agency-based workers (Buchanan 2005), and research shows that consumer and carers engaged in mental health service provision are mostly casual, part-time or unpaid and untrained (Stewart et al. 2008). ABS data indicates that, on every measure used, casual employees have the worst access to training (Van Wanrooy et al. 2008).

Scope of practice

Armstrong (2000) calls for the removal of professional barriers to collaboration that impede professional teamwork. She suggests that the professional colleges need to come together via a formal process to seek to overcome issues of 'ownership' of different types of therapy by particular members in multidisciplinary teams (for example, CBT is 'owned' by psychologists; family therapy by social workers).

The deployment of mental health nurse practitioners to provide clinical services has slowly become accepted in the face of a shortage of psychiatrists, especially in rural and remote areas, and it could be argued that Australia is ahead of some comparable countries in this area (Hanrahan & Hartley 2008). However, the number of advanced practice psychiatric nurses is inadequate, and there are differential barriers to their full scope of practice in each jurisdiction. Bacon and Stallings (2003) also argue for making greater use of advanced practice nurses and other

allied health professionals, and more effective use of psychiatric nurse practitioners.

Beinecke and Huxley (2009) suggest that there is potential to build capacity between mental health social workers and nurses because of the extent to which their skills and values overlap, and that this should inform future workforce planning. Holmes (2006) suggests that the future mental health workforce should be a graduate specialist who stands outside existing disciplinary identities.

White's (1983) analysis of GP referrals to community psychiatric nurses (CPNs) in the UK found that for a range of reasons, GPs tended to use CPNs for 'clients for whom there was no hope'; and that the referral system limited access of CPNs to clients, and consequently restricted their professional development and reduced job satisfaction because of limited opportunities to work with consumers towards positive outcomes. However, in examining the role of CPNs in Ireland, McCardle's later study (2007a) concludes that the CPN's role is much broader than that suggested in the literature; and that the role not only includes being an assessor of clients, therapist, consultant, clinician educator and manager, but also involves health promotion, client support and family support. Nolan's (2007) study of the views of mental health and non-mental health nurses in the UK found that nurses viewed prescribing rights as an opportunity to explore alternatives to medication, rather than increase the amount of prescribing.

Sands (2007) found that the involvement of nurses in mental health triage services in Australia has required nurses to expand their clinical roles to include areas of practice that were previously the exclusive domain of medicine, such as point-of-entry psychiatric assessment, provisional diagnosis, and making decisions about early treatment. Like the McCardle et al. (2007) study, Sands found that the role of mental health nurses also extended to providing support for consumers and their families in the community; helping to negotiate pathways to care, advice and education to the community and other service providers; and consultation services to emergency departments.

Some authors caution against expecting too much of the new graduate and primary care

mental health workers recruited in the UK system (Warne & McAndrew 2005), and are critical of the polarisation of need between 'common' mental health problems and severe mental illness, and the assumption that one year of training will equip workers adequately to recognise complex symptoms.

Koppelman (2004) reports on shifts in the composition of the children's mental health workforce in the US and speculates that, in the future, clinical social workers might assume the role of psychologists in extended psychotherapy; psychologists, in turn, would provide the care typically offered by psychiatrists; and psychiatrists would be specialists in biomedical aspects of mental illness. The shift of psychiatrists away from psychotherapy and into medication therapies is partly driven by the 'managed care' system in the US, which renders drug treatments more economically attractive to psychiatrists. Koppelman reports that many managed care organisations in the US have policies that favour social workers over psychologists for the provision of talk therapies, and that the variability of training of different professions means that their ability to deliver care that demonstrably improves the patient's condition urgently requires more evidence.

Fairlamb (2008) proposes a comprehensive primary healthcare approach to delivering mental health services that is 'a universal approach that transcends traditional boundaries and can provide a fundamental understanding of service provision that is not bound by professional disciplines or economics'.

Composition of mental health teams

A commonly expressed view in the literature is the need to maintain a balance between the clinical management of mental health services and the psychosocial model of support and rehabilitation (Huang et al. 2004). O'Sullivan et al. (2009) report early success with a 'resource team' model in a metropolitan centre. The team includes expertise in management, multicultural mental health, Indigenous mental health, dual diagnosis, nutrition, employment assistance,

research and evaluation (psychologist) and clinical support, and is guided by consumer and carer consultants. The team coordinates specialist clinical support positions, provides access to current evidence-based clinical information and facilitates engagement with the community and non-government sectors.

Rosen and Callaly (2005), in examining interdisciplinary team work and leadership issues for psychiatrists, point to a difference between multidisciplinary teams (service providers from several disciplines working simultaneously with the same consumer and carers, with a division of labour or components of intervention coordinated by one case manager) and network teams (early exchange of information between service providers who may otherwise work separately). Rosen and Callaly (2005) advocate retaining differentiated disciplinary roles and developing shared core tasks within the team, and also argue that the issue of ultimate legal responsibility for case management needs to be clarified and that the leadership and ultimate responsibility need not always be with the psychiatrist. Armstrong (2000) also asks 'Why does every director of a mental health service have to be a psychiatrist?' Some authors broaden the composition of teams to include frontline staff in the community to be trained in symptom identification for common mental illnesses, mental health promotion, early intervention and referral. This broader team membership can include departmental officers (in any field) working in rural areas (Hossain et al. 2008), teachers and school staff (Andrews & Titov 2007), correctional officers (Adams et al. 2009; Parker 2009; Hughes 2006; Brooker 2009) and police.

Lamb (2002) presents several models for including trained police and mental health professionals in mobile crisis teams and evidence that such teams reduce the rate of incarceration of mentally ill people, increase the rate of acceptance of police referrals for acute inpatient care by hospitals and may reduce police-related shootings. Brooker's (2009) study of the effectiveness of mental health 'in-reach teams' in UK prisons found that, although intended to work only with 'severe and enduring mental illness' within the prison population, the needs of the consumers were more complex due

to the co-existence of substance abuse and/or personality disorder. This complexity, combined with the fact that the median size of the in-reach team was three staff, allowed for little more than assessment upon reception and provided little capacity for ongoing support and treatment. Sirdifield (2006) describes a pilot program in the UK where prisoners were recruited and trained as 'health trainers' to work to a set of competencies in health promotion and stress management. The trained prisoners could become accredited trainers and therefore potentially increase their employability after release.

The RANZCP was engaged by the Department of Health and Ageing to provide training and to develop multidisciplinary education and information resource packages for mental health professionals who use the Better Access Initiative (BAI), and to assist them to collaborate more effectively in the delivery of mental healthcare. The (2008) RANZCP report on the environmental scan component of the project found:

- knowledge gaps for mental health professionals about the roles of social workers and occupational therapists in the BAI, which affected referrals and collaboration
- the roles of allied health professionals in focused psychological strategies were not well understood
- heavy reliance on the central role of the GP
- occupational therapists were perceived to have the least role in the BAI
- GPs, psychiatrists and psychologists provide the majority of therapeutic interventions
- clients, carers and families did not understand the role of social workers and occupational therapists in mental health.

The report identifies the barriers to collaborative care under the BAI as:

- insufficient role delineation, especially mental health nurses, social workers and occupational therapists
- inequity in Medicare rebates between professions
- perceptions of irrelevance of social workers and occupational therapists by other mental health professionals

- exclusion of mental health nurses from the initiative.

The RANZCP report also found low levels of awareness of the Mental Health Nurses Incentive (MHNI) package, and low impact of the MHNI on the day-to-day private practice of most mental health professionals.

Future developments

The workforce implications of the increased use of technology in the broader health sector have been well documented, but its relevance to the mental health sector is still emerging. Hult and Svallfors (2002) found that the introduction of new technologies into a labour-intensive work environment can lead to the deconstruction and reclassification of the work. There is some evidence that greater use of technology can lead to higher levels of workplace training and lower levels of staff turnover (Weber 2000).

The continued development of tele-psychiatry, telephone and email counselling, web-based self-assessment tools and web-based interventions could go some way towards improving access, relieving workforce and skills shortages, increasing the preventive focus and reshaping the roles of the mental health workforce.

There is a growing body of evidence of the effectiveness (for some disorders) of tele-treatments as a strategy to overcome shortages in the specialist mental health workforce. Antonacci et al. (2007) found indications that inexpensive and less time-consuming telephone counselling may be just as or more effective than video conferencing in the treatment of some disorders, and that further research is warranted. The use of tele-psychiatry as the solution to logistical issues posed for the diagnosis and treatment of people at court and in correctional facilities has been proposed in several studies (Antonacci et al. 2007; Brett & Blumberg 2006; Saleem 2008).

Web-based self-assessment and interventions that are in the various stages of development and evaluation include treatments for problem gambling (Raylu et al. 2008), smoking cessation (Borland & Segan 2005) and depression (Barrera et al. 2007).

Insel (2009) examined advances in neuroscience and genomics that have not yet translated to public health impact in psychiatry and suggests that future mental healthcare will involve: identifying the neural circuitry of mental disorders, detecting the earliest manifestations of risk or illness, personalised care based on individual responses and implementing a broader use of effective psychosocial interventions.

Some studies point towards targeted public health preventive measures using internet-based interventions targeted at groups identified as being at high risk of mental illness. O'Donovan (2009) reports early evidence of mapping the genetic basis of schizophrenia. Barrera et al. (2007) point to evidence to suggest that psychosocial interventions may function as protective interventions against relapse in depression; that web-based interventions can be effective in preventing depression onset and recurrence; and that by using genetic markers to identify populations at high risk of developing depression, specifically targeted interventions in specific populations are more likely to be effective in reducing the incidence of major depressive episodes than the usual widespread interventions.

Changes to professional/disciplinary boundaries are foreshadowed by some authors. Fava (2009, p. 220) suggests that the influence of the pharmaceutical industry on the practice of psychiatry will decline, and that:

...emerging trends of renewal may be subsumed under the rubric of psychological medicine [including]: use of a multidisciplinary approach, emphasis on psychotherapeutic strategies leading to self-management, reliance on repeated assessments, integration of different treatment modalities.

In examining the future of psychotherapy for mentally ill children and adolescents, March (2009) suggests that psychotherapy will be replaced by CBT, and that CBT will develop to better account for comorbidity and individual patient needs and become the basis of psychosocial interventions by 2030. March predicts that: psychiatry will merge with some elements of psychology and will move to a unified cognitive-behavioural intervention model; a new discipline will emerge; economic

forces and progress in science will result in a single professional umbrella for providers of psychosocial treatments; and former departments of psychiatry will merge in with neurology under the broad frame of neuroscience medicine.

In the treatment of early stage psychotic illness, Barton et al. (2009) found early evidence that social recovery CBT (that is, CBT plus vocational case management) was more cost-effective than CBT alone, which could have implications for curriculum content, training and the composition of treatment teams.

Hogan (2008) presents increasing evidence in the US of an epidemic of comorbid chronic physical illness among people with a severe mental illness. He argues that the cross-training of the general health workforce in mental health needs to be two-way; that is, mental health professionals need to be trained to assess indications of chronic physical illness in patients presenting for treatment of mental illness, 'ensuring that people with severe mental illness receive convenient general medical care; and orienting care to a goal of overall wellness, not just recovery from mental illness' (p. 7).

Access to services for particular groups

Rural and remote access

In their review of issues affecting service delivery in rural and remote areas, Judd et al. (2002) highlight the need to shift the role of specialists in the mental health area from one of direct service provision to one of consultation, education and indirect service provision. They identify three weaknesses in providing mental health services to rural communities: inconsistent and inappropriate training, constraints on performing the traditional role of service provider and limited service availability.

Common models implemented in remote areas are the provision of tele-psychiatry and telephone support for medication management, and the provision of 'fly-in, fly-out' specialist services supported by local trained primary healthcare workers (such as the operations of Cape York Well

Being Centres managed by the Royal Flying Doctor Service) (RFDS 2009).

Strategies for service provision to remote areas, however, are not appropriate for large outer metropolitan or rural/regional centres where severe workforce shortages are experienced in medium-density population areas. There is still a need to attract mental health service providers to these areas. In evaluating a recruitment strategy for rural psychiatrists in Queensland, Emmerson (1995) found that the opportunity to work with a high-functioning mental health team was the main factor in attracting and retaining psychiatrists outside metropolitan areas. Wilks et al. (2008) conducted a 10-year review of a rural recruitment program for psychiatrists and conclude that the factors influencing increased recruitment and improved retention rates were the building individual rapport with new psychiatrists at the time of their recruitment; an extensive and culturally-sensitive orientation program; working to meet individual and family needs; providing both community and inpatient settings; and educational support to prepare for the RANZCP fellowship exams.

Robinson et al. (2005) found that the main sources of job satisfaction for rural mental health nurses were caregiving opportunities and supportive working relationships. Other reported elements of job satisfaction that influence intentions to leave were: quality of clinical supervision, ratio of qualified to unqualified staff, support from immediate line manager and paperwork.

Bennet-Levy and Perry (2009) argue that, while internet-based treatments and telephone counselling can be effective in overcoming shortages of mental health professionals in rural and remote areas, some patients (particularly severe cases) still need one-to-one treatment with a local provider who understands the local context, has community contacts and can identify community resources.

In recent research conducted by the CSHISC (2009), it was evident that collaboration between VET and higher education providers in outer metropolitan and rural areas is more advanced and that articulation arrangements, and recognition of prior learning is more developed. While the CSHISC acknowledges that this is likely

to be driven by lower levels of student demand, such collaboration underpins a 'grow-your-own' approach to workforce development. Such a strategy is advocated in several national mental health workforce strategies, including the UK and US, and it has been identified as the most culturally appropriate and effective strategy for the development of the health workforce in Aboriginal and Torres Strait Islander communities.

Aboriginal and Torres Strait Islander People

The prevalence of mental health issues and co-occurring substance abuse in Indigenous communities is well documented, and has informed a number of strategies and policies, particularly since the publication of Swan and Raphael's (1995) report. More recent data, for example, the 2004–05 *National Aboriginal and Torres Strait Islander Health Survey* (ABS 2006) suggests that the need to provide culturally competent, accessible services to Indigenous communities continues to pose a major challenge for workforce planning. Judd et al.'s (2002) review of rural psychiatry services identifies common barriers for Indigenous people in seeking and accessing treatment as: language; how symptoms are manifested and communicated; and practitioners' stigmatising of mental illness and racial intolerance combining to result in inappropriate or inadequate treatment. Other issues identified in Judd's review of rural service delivery in general are of particular relevance to Indigenous communities, including: the tendency for individuals to rely on family and friends for support; problems for service providers in maintaining confidentiality in small communities; and the challenges of dual relationships between the local service providers and the community.

Bartik (2007) evaluates a model for the training of ATSI health workers in a mainstream, general mental health service. The training needs included skills in negotiating different working styles and provided support from other ATSI professionals. The program included employment, on-the-job training and an academic program leading to a qualification, clinical supervision and mentoring. Bartik identifies structural issues within the program that were barriers to success: clinical

placements were beneficial but disruptive to coursework and turnover in management created problems for the acceptance and support of the program. There were frequent periods of 'down time' for the trainees. Existing staff needed clarity regarding policy and procedures and about the role of the new positions. All these were exacerbated by high staff turnover.

Fielke et al.'s (2009) evaluation of the establishment of Indigenous teams in mainstream mental health services suggests there is a role for traditional healers as part of the healing process in some communities.

Programs have been developed to train Indigenous (Jones & Brideson 2009) or non-Indigenous health and allied health staff (Hampton & McCann 2007) in Indigenous Australian mental health and wellbeing, with positive early signs of take-up within the sector.

From consultation with Indigenous stakeholder groups and service providers, Tsey et al. (2007) suggest empowerment at personal, family, group, organisational, community and structural levels, and successful mechanisms to address Indigenous social and emotional wellbeing issues such as family violence and abuse, suicide prevention and incarceration.

Several authors point to the need to train more ethnically diverse workforce (Bacon & Stallings 2003; Hoge et al. 2009; Ziguras 2003). Ziguras' study matches clients from culturally and linguistically diverse backgrounds to bilingual and bicultural mental health professionals, and found that matching produced longer duration and greater frequency of contact with community care teams and shorter duration and less frequent contact with crisis teams and inpatient services.

Co-existing mental health and substance use issues

The co-occurrence of mental illness and substance use disorders (dual diagnosis or comorbidity) presents particular challenges for workforce development, not the least of which is that effective management and care requires collaboration across two currently separate sectors of the health system that traditionally have different theoretical underpinnings. Estimates

of prevalence depend greatly on the particular dual diagnosis in consideration, the specificity and overlap among diagnostic criteria, important demographic sub-populations (particularly the homeless and the incarcerated), the occurrence of multiple substance use disorders, the various diagnostic tools used and other determinants (Donald et al. 2005).

International and local research indicates a high prevalence of comorbidity in clients of alcohol and other drug services and mental health services (Donald et al. 2005). Johnson (2000) reports that people with co-occurring mental health and substance use disorders: have worse psychiatric symptoms, treatment compliance and prognosis; use more treatment and service resources; have a greater propensity for suicidal and self-harming behaviours and poorer physical health habits; have fewer social supports or financial resources with which to seek treatment other than on an outpatient basis from public sector community providers; and exhibit the highest rates of expensive public psychiatric hospital admissions and criminal justice system involvement.

The study of effective treatments for dual diagnosis is fraught with methodological challenges, principally a very high rate of attrition. People with co-occurring mental illness and substance abuse problems are highly likely to drop in and out of treatment, and to 'fall through the gaps' between service providers. Additionally, the sheer number of potential combinations of particular dual diagnosis and the number of corresponding treatment options substantially limit the evidence base around specific combinations of dual diagnosis and effective treatment.

Researchers report that mental health workers identified lack of confidence in their ability to identify and treat substance abuse co-occurring with mental illness as an important factor in their lack of job satisfaction (Lubman et al. 2007). Similarly, recent research by Siggins Miller (unpublished 2009) found that lack of confidence about dealing with co-occurring mental illness was a major concern to frontline workers in AOD services. This situation appears relatively unchanged since McDermott and Pyett's (1993) study found that providers often felt both:

overwhelmed and scared when confronting people with these dual problems... [and] inadequate, lack specialised training and have insufficient resources, support or validation for their efforts; they have little confidence in themselves or in client's capacity to benefit from any program or treatment.

A review in Queensland by Jenner et al. (1999) found that while some locally provided training was useful, there remained the need to provide training across mental health, alcohol and other drug and non-government organisations to address knowledge deficits of staff in both alcohol and other drug and mental health services. They identify inadequate resource manuals and the need for greater access to study leave as barriers to learning. Also emphasised is the lack of knowledge among AOD workers about recent improvements in medications for mental health treatment and the need to target existing prejudice among staff from both services (Kavanagh et al. 2000). Cupit et al. state that:

Joint training enables a better understanding of each other's professional approaches and engenders mutual learning. It is also clear from the literature that just being exposed to consumers with dual diagnosis does not help clinicians learn how to engage them, treat them and assist them. Meeting the needs of consumers with dual diagnosis can be very difficult, and the most appropriate intervention methods need to be learnt (2000, p. 37).

They argue that the most effective way to train staff is to integrate training with the day-to-day experience of working together, so that staff learn from each other in the process. However, such an approach needs trust and willingness to cooperate between all staff, as well as mutual respect. The principles that underlie such training are stated as:

- an integrated approach with people jointly trained should be used as much as possible
- consumers or advocates for consumers should contribute to the training process
- carers of people with a dual diagnosis should contribute to the learning process

- course facilitators should aim to build respect for consumers and carers and between agencies so that a joint working relationship can be developed.

An audit of dual diagnosis training and education programs in Australia found that the workforce responding to comorbidity consisted of specialist mental health professionals, principally psychiatrists and mental health nurses and, to a lesser extent, clinical psychologists and social workers. These professions also dominate the AOD services, but with a broader array of medical and nursing specialties and greater input from vocational trained community workers and volunteers. Particularly in caring for consumers with dual diagnosis, the role of community workers, volunteers, healthcare consumers and their families must not be underestimated in the total of care systems.

Many workers in the mental health and AOD fields are what Cuthbert and Basset (2007) describe as the 'non-professionally affiliated' workforce. These workers come from a variety of education and life experience backgrounds, often with tertiary or VET qualifications in a number of fields, and deliver a significant proportion of counselling, rehabilitative and support services. There are also large groups of administrative, clerical and ancillary staff involved with the direct provision of services to consumers with co-existing mental health and substance use disorders. These workers are often the first point of contact with clients, and often have more regular contact than many senior clinicians. Their training needs are often overlooked. Also critical to the provision of services in this field are the multiple roles undertaken by carers, with whom consumers often have strong and complex family and personal relationships. Furthermore, healthcare consumers with complex co-existing conditions themselves contribute to service provision through both self-care and peer support.

It is clear that workforce development strategies must address training and education within a framework of organisational change that builds the capacity of services to provide effective services to clients with co-existing mental health

and drug and alcohol disorders. In particular, improvements in the organisation of care are required to create environments in which professional knowledge and skills acquired through education and training can be applied in practice. From an extensive literature and document review and stakeholder consultations, a comorbidity study reports that a range of workforce development and organisational strategies have been proposed to support translation of professional knowledge skills and attitudes into professional behaviour and work practices. They include:

- development and effective dissemination of plain language, concise clinical guidelines, care pathways and policy documents that support the provision of integrated care to clients with dual diagnosis
- evaluation of practice guidelines
- staffing rotations and interagency placements
- establishment of demonstration sites where clinical consultation is used as a teaching strategy for clinical staff
- quality improvement and organisational learning systems
- input by carers and consumers to training.

The researchers also conclude that increased understanding about the relationship between education and training and behaviour change in organisations and professions is essential to improving the quality of healthcare services.

Use of technologies

Much of the overseas literature on advancements in the use of technologies and their likely future impacts on mental health service delivery reveals little for the Australian context, since Australia's geography and the dispersal of its population has mandated the use of these technologies for many years.

However, measures of the effectiveness of these technologies can inform future workforce planning and development. Alemi et al. (2007) found that the use of emails by counsellors and psychologists for online support of substance abusers was effective, although issues of confidentiality, security and some legal considerations were yet to be clarified.

Antonacci et al.'s (2008) review of forty-five studies of the clinical effectiveness of tele-psychiatry concludes that the outcomes of diagnosis and treatment by video conference were equivalent to face-to-face consultations. The review also found that patient and clinician acceptance of tele-psychiatry was relatively high; that CBT delivered by video conference produced the same reduction in depression scale scores as in-person treatment, but that tele-treatment achieved the results faster; and that CBT for obsessive-compulsive disorders achieved the same outcome as in-person treatment with half the therapy time using telephone counselling. Based on another study (Fortney et al. 2007) the Antonacci review suggests that the optimum treatment results for clients with depression were achieved through in-person primary healthcare assisted by collaborative psychiatric medication monitoring through tele-treatment.

Borland and Segan (2005) report that interactive personalised computer advice (Quitcoach) has been effective in facilitating smoking cessation and reducing relapse, and that Quitline (Victoria) has successfully integrated support for psychiatric conditions with smoking cessation counselling.

Bennett-Levy and Perry (2009) found that online training in CBT can effectively provide declarative knowledge (reading, lectures, theory concepts), modelling (to bridge declarative knowledge and procedural skill) and assist with self-experience of CBT techniques (self-reflection and deepened skills and understanding of CBT), but that online training cannot provide the role plays necessary to embed procedural skills.

Woltmann et al. (2008) suggest the increased use of consumer and clinician electronic decision supports and other technologies that are not human resource dependent as a strategy to overcome the negative impact of high staff turnover on the implementation of and training in evidence-based practice in mental healthcare.

Fletcher et al. (2008) established a quality improvement collaborative to assist in embedding the new graduate mental health workforce in one health district in the UK. The collaborative technology used to bring together groups of practitioners from different organisations to work in a structured way was evaluated as a success.

However, while the technological aspect of the project was effective, other aspects were not. There were high rates of attrition of the new workers, attributed to widespread variation in the level and quality of supervision and in payment and terms of service of workers, lack of governance arrangements and the use of relatively unsupported and inexperienced people as agents of change.

Data collection

Baldwin et al. (2006) suggest the use of state/national registration and licence renewal processes to collect data on service providers and to assist in workforce planning.

Huang et al. (2009) suggest that the ICT infrastructure can support efforts to re-engineer care processes, manage the burgeoning clinical knowledge base, coordinate care across providers and settings, support the functioning of MDTs and facilitate outcome measurement for improvement and accountability.

In their study of VET articulation into higher education programs in Australia, the CSHISC study (2009) points to the dearth of information on the composition of the NGO mental health workforce and its impact on skills mapping and workforce planning.

Cross-sectoral links

There is evidence that the shift to competitive, contractual funding arrangements for health service delivery from non-government providers is fuelling competitive behaviour and providing barriers to collaboration in a range of workforce

development and management matters across the health and community services sector (ADCA 2009; Spooner & Dadich 2008; Van Wanrooy et al. 2008).

Bartik (2007) identifies open and regular communication between support agencies as crucial to the success of training programs for Aboriginal and Torres Strait Islander health workers. Huang et al. (2004) emphasise the need to develop cross-agency workforce strategic plans with collaborative strategies for investment in recruitment and training.

The limited data available show that the workload of community mental health nurses is increased by the greater complexity of needs of community mental health clients. Service change has also resulted in poor integration between inpatient and community services, and tension between generic case management and specialist roles, resulting in nurses undertaking tasks for other case managers. These issues, along with difficulties in recruiting and retaining staff, have led to the intensification of community mental health work and a crisis response to care with less time for targeted interventions (Henderson et al. 2008).

The literature also suggests the expanding of the boundaries of the secondary mental health workforce to include the training of frontline workers in a range of areas. Hossain et al. (2008) point to the need to train field workers who come into contact with farmers and rural communities in early detection and intervention in mental health and recommend a 12-hour course developed by Jorm and Kitchener in mental health first-aid (MHFA).

Mental health workforce data collections

Workforce data collection is important for describing and analysing supply and demand for planning purposes, and for monitoring and evaluating the impact of workforce initiatives.

This section first presents a summary of good practice in data collection for workforce (supply and demand) modelling and monitoring and evaluation. The second part describes the main data sources for Australia's mental health workforce. These data sources include those reported at the national level, as well as additional data sources that are available at the state and territory level and data collections of professional associations. An analysis of the strengths and limitations of these data sources is also provided, together with consideration of the literature on Australia's health workforce data collections (for example, Schofield & Fletcher 2007), and good practice in workforce data collection, planning and modelling.

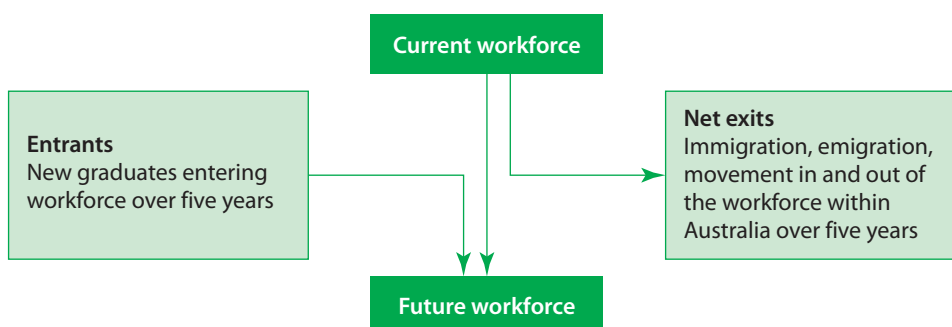
Good practice in workforce data collection

Data collection in workforce modelling – modelling the supply of workforce

Supply-side modelling is well established in Australia. The basic components include the current workforce, entrants into and exits from the workforce. A summary of the basic components of supply-side modelling is provided in [Figure 2](#).

The essential basic variables for this modelling include age, gender, working hours, immigration, emigration, entrants to the workforce (new graduates preferably by age and gender), geographic location and regional socioeconomic status.

Figure 2: Overview of supply modelling



Issues for consideration include:

- Longitudinal or time series data – estimation of transition probabilities (that is, the probability of moving in and out of the workforce) requires a form of data collected over an extended period of time – preferably over at least a 10-year period. In the absence of longitudinal data, this is usually undertaken across sectional time series.
- Response rate – the response rates to the professions' surveys are never 100 per cent, and therefore a separate estimate of the number of professionals in the workforce is required. Survey data must be 'grossed up' to provide a representation of the whole workforce. This process typically assumes that the distribution of non-respondents' characteristics (for example, age) is similar to the distribution of respondents.
- Not in the workforce – currently, there is little information of people qualified to work in health occupations who are not working in those professions, or are out of the workforce, unless they remain registered with their professional bodies. This means that policies to attract people back to health occupations may not be underpinned by data on the size of this group or the likelihood they would return to clinical practice.

There are also a number of individual level variables that are valuable for workforce planning and modelling. They include:

- year qualifications were obtained
- time spent on clinical practice, administration and education
- sector of employment
- number of practitioners planning on leaving the workforce (for example, maternity leave, leaving the profession, retirement, migrating overseas or extended travel)
- intention to return to the workforce
- qualifications
- expenditure on services (public and private)

- deaths
- intake to training programs (undergraduate and postgraduate)
- movement between occupational groups.

Expected retirement (as gauged by the responses to professions' survey) can be very different to actual retirement over a 10-year period. This difference is due to factors leading to early unplanned retirement, such as a practitioner's ill health or death, the ill health of a family member, or a need to work longer for financial or other reasons as retirement approaches.

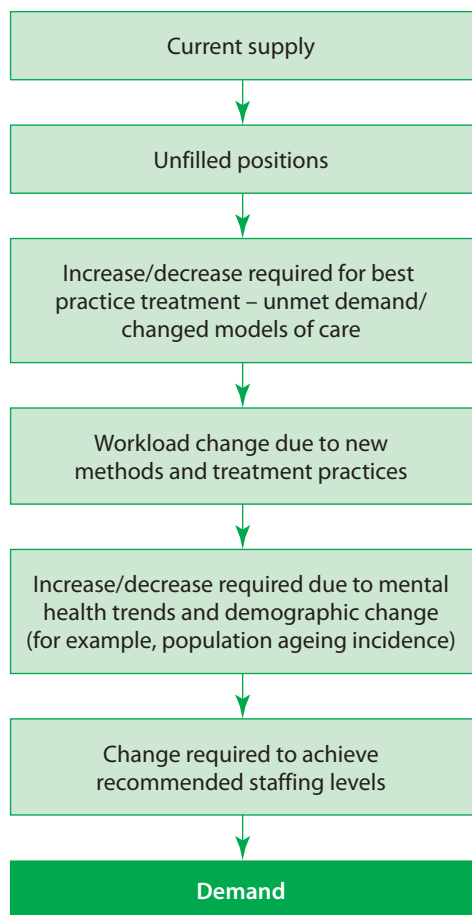
Modelling the demand for workforce

The basic components of a demand model may take into account factors such as those represented in [Figure 3](#). In practice, demand models currently often simply take current supply and changes to the population such as population ageing. However, this tends to perpetuate unmet demand owing to workforce shortages, lack of provision of services to disadvantaged populations and differences between current staffing and best practice and treatment.

Essential basic variables in demand modelling include:

- number of unfilled positions
- workforce increase or decrease required to provide best practice treatment to the whole population
- mental health trends and demographic trends
- new approaches to treatment where they impact on workforce requirements
- workforce increase or decrease required to provide best practice staffing
- personal socioeconomic status, income and employment status of the population services
- geographic remoteness and socioeconomic status
- health status of the population serviced.

Figure 3: Overview of demand model



Data collection for monitoring and evaluating health workforce and related initiatives

Developing performance indicators

A framework used to guide the development of performance indicators is the Outcome Model for Health Promotion developed at the National Centre for Health Promotion, University of Sydney (Nutbeam 1998). This model highlights the importance of identifying the full range of possible outcomes of an initiative, while recognising that these outcomes will occur at different stages.

Specifically, performance indicators are identified for each of the following stages:

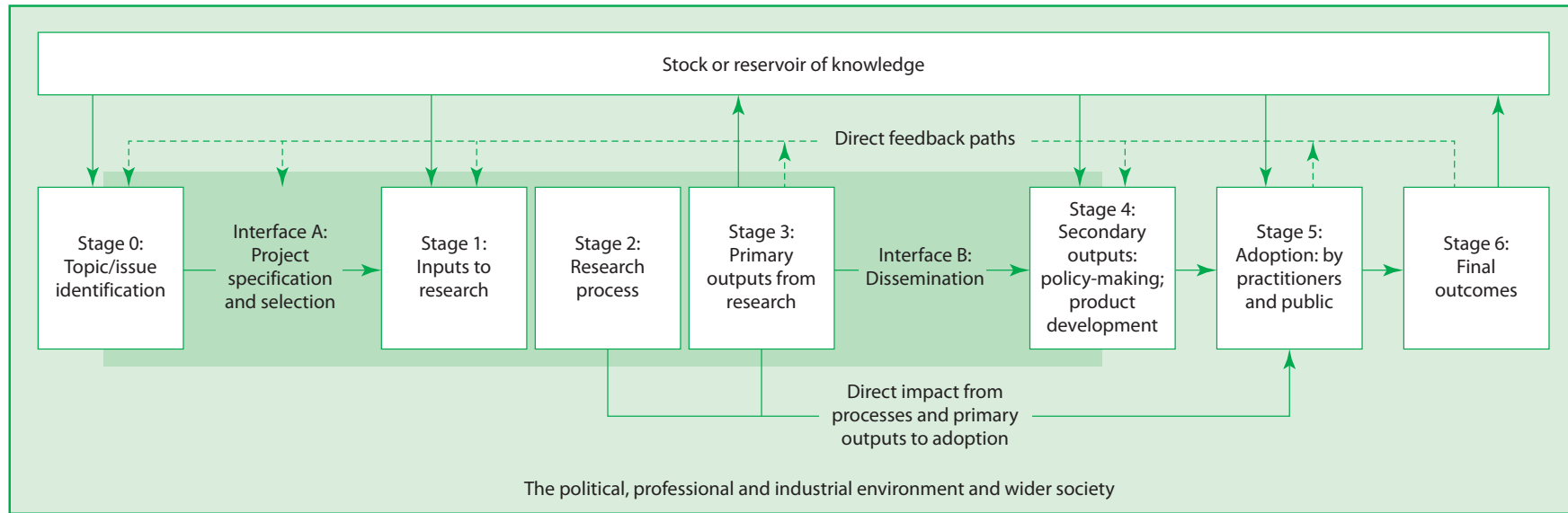
- social and health outcomes (goals)
- intermediate outcomes
- intervention modifiers
- intervention impacts
- interventions (process)
- infrastructure support.

A report by the Health Economics Research Group at Brunel University describes a framework that traces the return on investment in research and development (Buxton & Hanney 1996). The model divides the research process into seven stages, with two interfaces (Figure 4), and outlines five main categories of benefit: knowledge, research benefits, political and administrative benefits, health sector benefits and broader economic benefits. While the model was designed to assess the payoff from research, it is also useful on a broader level for evaluating interventions.

Many other relevant frameworks exist. For example, Rossi's framework emphasises the need to collect information on problems related to multiple outcomes (Rossi 1999). The RE-AIM framework is a model for comprehensively evaluating public health interventions that includes five dimensions: reach, efficacy, adoption, implementation and maintenance (Glasgow et al. 1999). It is beyond the scope of this document to analyse these and other relevant frameworks.

From this overview, however, some suggestions for performance indicators can be made. Timescales for outcomes from investments can be considerable, and there is therefore a need for realism about the change that can occur that on performance indicators in a given timeframe. Further, some outcomes at later stages result from intermediary outcomes, rather than directly from initial inputs. It is therefore appropriate to focus on different outputs and outcomes at different times. Ideally, a staged review of performance will be conducted. Finally, indicators of multiple outcomes are required, with concern for positive as well as negative outcomes.

Figure 4: Outline input-output model for assessing payoff from applied research



Source: Hanney et al., 2003 and 2004

Criteria for performance indicators

Performance indicators should ideally meet as many of the criteria outlined below as possible. These are not mutually exclusive. Performance indicators should:

- provide useful information for evaluation and further planning
- reflect the efforts of the intervention, rather than multiple other possible factors (that is, be specific)
- detect the size and range of intervention achievements (that is, be sensitive)
- be clearly related to the goals, objectives and strategies of the intervention
- reflect the priorities of stakeholders
- be specific; for example, to a specific behaviour among a particular group within a defined geographic space and time
- be measurable, in that it is feasible to measure them and the data are reliable and valid
- be attainable: some change should be expected from the planned strategies within the timeframe of the intervention
- be affordable or available; for example, already being collected and likely to continue to be collected, or able to be collected with minimal modifications of existing data collections.

WHO Human Resources for Health Minimum Data Set (2008)

In recognition of the importance of an adequate, equitably distributed, well supported and competent health workforce for the provision of quality healthcare, the World Health Organization (2008), in collaboration with the University of Technology Sydney, has produced a minimum data set (MDS) to facilitate human resources planning in health. Four domains of data were identified in the MDS:

1. the population of the country, with demographic variables stratified by gender, age and geographic region (for example, rural, remote, urban)
2. the current workforce (stock):
 - a) current number of health professionals (whether they are presently working or not) stratified by age and gender

- b) current numbers (headcount and FTE) of health professionals according to their employment sector (for example, public/government, private or NGO) and employment status (for example, full time or part time)
 - c) current number of health professionals by FTE distribution stratified by age, gender, employment sector, status and setting (for example, acute or primary care)
3. workforce additions:
 - a) number of new supply of health professionals stratified by pre-service domestic graduates, pre-registration domestic workforce entrants into practice and age and gender
 - b) immigration (number of health professionals joining the workforce from other countries)
 - c) workforce re-entry (number of health professionals re-entering the workforce after a period of absence stratified by age, gender, sector and employment status)
4. workforce losses:
 - a) number of retirements (FTE)
 - b) deaths (annual mortality rate of health professionals in the sector)
 - c) out-migration (number of active health professionals leaving the country expressed as a headcount and FTE)
 - d) other resignations/outflow (annual number of active health professionals leaving the workforce but staying in the country expressed as a headcount and FTE).

Workforce innovation and reform: demonstration projects – National evaluation framework (NHWT, 2008)

An evaluation framework was developed by the NHWT (2008) to facilitate a consistent national approach to the prospective evaluation of NHWT demonstration projects relating to workforce innovation and reform. The evaluation framework identifies a number of key data indicators that are relevant for workforce planning and modelling (see above). These indicators include:

- vacancy rates (for example, number and duration of vacancies, number of applications)
- training and development opportunities (for example, number and type of training opportunities and attendances, number and type of competencies or skills developed per staff)
- workforce entry and departures (for example, number of staff entering, and departing from, the various areas of the health workforce)
- staff adaptability and collaboration (for example, number and type of shared skills and activities, number of staff and professional groups involved in project activities)
- staff morale or job satisfaction.

Current data collections: Australia's mental health workforce

Australia's mental health workforce encompasses a number of professional groups. While a number of health workforce data collections exist, they vary considerably in their coverage of the mental health workforce and workforce data items (for a more detailed discussion of mental health workforce data sources, see below).

Based on the advice provided by experts in the area of mental health workforce data, the best indication of the size of Australia's mental health workforce can be drawn from data collected through the Mental Health Establishments National Minimum Data Set (MHE NMDS) as well as the Medicare data system. Together, they provide coverage of the mental health workforce in specialised mental health services that are managed or funded by state and territory health authorities and those working in private practice settings. While there are key limitations associated with each of these data collections (and the fact that the non-government community sector is not covered), they represent the most consistent sources of comparison across states and territories, and provide the most comprehensive coverage of the mental health workforce in Australia.

The most recently publicly available data of the mental health workforce from the MHE NMDS are presented below. Medicare data for mental health-related items were requested and were not able to be obtained.

Australia's mental health workforce: specialised mental health facilities

The MHE NMDS collects information from all specialised mental health services that are managed or funded by state and territory health authorities. Specialised mental health services are defined as services that have a primary role of providing treatment, rehabilitation or community health support targeted towards people with a mental disorder or psychiatric disability (AIHW 2009). Data for a financial year are prepared by each state and territory (in a standardised format and based on the same data definitions) and are to be supplied to the AIHW by 30 April the following year. Data reported at the state, regional and organisational levels include revenue, grants to NGOs and indirect expenditure. Organisational-level data also include salary and non-salary expenditure, and numbers of full-time equivalent (FTE) staff.

The MHE NMDS does not cover the private and the non-clinical sector, nor NGOs nor services that are not funded by state or territory governments. Given its purpose of providing a national picture of mental health establishments and state and territory comparisons, its data categories focus on the organisational level, rather than on the individuals or professions that make up the mental health workforce. There is limited disaggregation

of staff categories; for example, no distinction is made between clinical psychologists and other psychologists, or between mental health nurses and other registered or enrolled nurses. Data on staffing is presented in FTE terms, rather than the number of personnel, and no person-level demographic information on staff is collected.

Numbers and percentages of FTE staff based on the staffing category specified by the MHE NMDS for each state and territory in 2007–08 are presented in [Table 2](#) and [Table 3](#).⁶ From these data, it is evident that nurses were the largest group of the national workforce in specialised the mental health area, with a total of 13,727 FTE (64 per cent). Diagnostic and allied health professionals (24 per cent) represented the second largest group of the workforce, and the majority of staff in this group comprised psychologists and social workers. Salaried medical staff, including consultant psychiatrists and psychiatrists, psychiatry registrars and trainees) accounted for 12 per cent, psychologists and social workers represented approximately eight per cent each, occupational therapists accounted for four per cent, and consumer and carer consultants represented approximately 0.4 per cent of the total workforce in specialised mental health facilities in Australia.

At the state and territory level (see [Table 3](#)), the proportion of nurses employed in specialised mental health facilities was highest in Tasmania (72 per cent) and lowest in the Australian Capital Territory (60 per cent). The proportion of salaried medical officers was highest in the Northern Territory (14 per cent) and lowest in Tasmania (nine per cent), while the proportion of diagnostic and allied health professionals was highest in the Australian Capital Territory (29 per cent) and lowest in Tasmania (19 per cent).

In terms of the number of FTE staff per 100,000 population (see [Table 4](#)), there is considerable variation in staff distribution per 100,000 population across states and territories. South Australi had the highest number of FTE staff per 100,000 population for consultant psychiatrists and psychiatrists, psychiatry registrars and trainees, registered and enrolled nurses and social workers in specialised mental health facilities. The Australian Capital Territory had the highest number of psychologists and Western Australia had the highest number of occupational therapists per 100,000 population in specialised mental health facilities.

[Table 5](#), [Table 6](#) and [Table 7](#) show the number of FTE staff in specialised mental health facilities based on the Australian Standard Geographic Classification (ASGC 2006) for remoteness. The staff in specialised mental health facilities are concentrated in major cities, and the imbalance between major cities, regional areas and remote areas is greater for salaried medical officers compared to nurses or diagnostic and allied health professionals.

[Table 8](#), [Table 9](#) and [Table 10](#) show the number of FTE staff in specialised mental health facilities based on the SEIFA Index of Relative Socio-economic Disadvantage.

As illustrated in [Figure 5](#) (on page 72), people in higher deciles (that is, lower socio-economic disadvantage) generally had greater access to salaried medical officers, nurses and diagnostic and allied health professionals in specialised mental health facilities compared to people in lower deciles (that is, higher socio-economic disadvantage).

⁶ Tables 2 to 10 are on pages 67–71.

Table 2: Full-time-equivalent staff by staffing category, states and territories, 2007–08

Staffing category ³	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total ¹
Salaried medical officers									
Consultant psychiatrists and psychiatrists	384.3	224.6	235.2	102.6	96.8	27.0	14.8	8.7	1,094.0
Psychiatry registrars and trainees	371.3	250.6	231.9	101.6	89.2	16.0	16.5	8.8	1,086.0
Other medical officers	57.9	111.9	36.6	77.2	44.9	0.9	1.4	5.0	335.8
Subtotal ¹	813.5	587.1	503.8	281.4	230.9	43.9	32.7	22.4	2,515.8
Nurses									
Registered	3,857.5	2,652.5	2,170.8	1,304.9	1,006.4	293.6	139.8	92.5	11,517.9
Enrolled	598.3	749.1	343.3	188.9	236.3	54.6	29.6	9.1	2,209.1
Subtotal ¹	4,455.8	3,401.6	2,514.1	1,493.8	1,242.7	348.1	169.4	101.6	13,727.0
Diagnostic and allied health professionals									
Psychologist	600.6	389.6	395.5	159.1	109.7	24.8	48.9	12.5	1,740.7
Social worker	320.3	464.3	319.0	203.5	225.6	27.8	23.4	8.3	1,592.2
Occupational therapist	228.7	233.4	163.7	144.7	68.7	11.0	7.4	1.6	859.4
Diagnostic and health professionals ²	385.6	173.6	127.0	121.7	69.1	29.4	0.6	13.2	920.2
Subtotal ¹	1,535.3	1,260.9	1,005.3	628.9	473.1	93.0	80.4	35.7	5,112.5
Carer consultants	7.0	15.5	1.5	0.8	1.8	0.0	0.0	0.0	26.6
Consumer consultants	27.9	20.0	9.7	1.2	4.7	0.0	0.0	0.0	63.5
Total¹	6,839.4	5,285.1	4,034.3	2,406.1	1,953.2	485.0	282.5	159.7	21,445.4

¹ Totals may not add due to rounding.

² Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff) (METeOR identifier 327164).

³ Data definitions of each staff category are provided below (METeOR):

- Consultant psychiatrists and psychiatrists refer to medical officers who are registered to practice psychiatry under the relevant state or territory medical registration board.
- Psychiatry registrars and trainees refer to medical officers who are formal trainees within the Royal Australian and New Zealand College of Psychiatrists Postgraduate Training Program.
- Other medical officers refer to those who are employed or engaged by the organisation who are neither registered as psychiatrists within the state or territory or formal trainees.
- Registered (Division 1 and 3) represent persons with at least a three-year training certificate or tertiary qualification, and are certified as a registered nurse within the state or territory registration board. This category is comprehensive and includes general and specialist categories of nurses.
- Enrolled (Division 2) second level nurses represent those who are enrolled (except in Victoria – registered) to practice in this capacity. This category includes general enrolled and specialist enrolled nurses.
- Psychologists refer to those who are registered with the relevant state or territory psychologists registration board.
- Social workers refer to those who have completed a recognised training course and are eligible for membership of the Australian Association of Social Workers.
- Occupational therapists are those who have completed a course of recognised training and are eligible for membership of the Australian Association of Occupational Therapists.
- Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff)
- Other personal care staff includes staff engaged primarily in the provision of personal care to patients or residents, not formally qualified, for example attendants, assistance or home assistance, home companions, family aides, ward helpers, warders, orderlies, war assistance and nursing assistants.
- Other staff includes administrative and clerical and domestic and other staff categories. Administrative and clerical staff refers to staff engaged in administrative and clerical duties. Medical, nursing, diagnostic and health professional and domestic staff wholly or partly involved in administrative and clerical duties are excluded, and should be counted under their appropriate occupational categories. Domestic staff are those engaged in the provision of food and cleaning services, including domestic staff primarily engaged in administrative duties such as food services manager. Dieticians are excluded. This category also includes staff not included elsewhere for example, maintenance staff, tradespersons, gardening staff.

Source: National Mental Health Establishments Database.

Table 3: Full-time-equivalent staff by staffing category, states and territories, 2007–08 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers									
Consultant psychiatrists and psychiatrists	5.6	4.3	5.8	4.3	5.0	5.6	5.2	5.4	5.1
Psychiatry registrars and trainees	5.5	4.8	5.8	4.2	4.6	3.3	5.8	5.5	5.1
Other medical officers	0.9	2.1	0.9	3.2	2.3	0.2	0.5	3.1	1.6
Total salaried medical officers	12.0	11.2	12.5	11.7	11.9	9.1	11.6	14.0	11.8
Nurses									
Registered	56.7	50.5	54.0	54.3	51.7	60.5	49.5	57.9	53.9
Enrolled	8.8	14.3	8.5	7.9	12.1	11.3	10.5	5.7	10.3
Total nurses	65.5	64.8	62.5	62.1	63.8	71.8	60.0	63.6	64.3
Diagnostic and allied health professionals									
Psychologist	8.8	7.4	9.8	6.6	5.6	5.1	17.3	7.9	8.2
Social worker	4.7	8.8	7.9	8.5	11.6	5.7	8.3	5.2	7.5
Occupational therapist	3.4	4.4	4.1	6.0	3.5	2.3	2.6	1.0	4.0
Diagnostic and allied health professionals ¹	5.7	3.3	3.2	5.1	3.5	6.1	0.2	8.3	4.3
Total allied health professionals	22.6	24.0	25.0	26.2	24.3	19.2	28.5	22.4	23.9
Carer consultants	0.1	0.3	0.0	0.0	0.1	0.0	0.0	0.0	0.1
Consumer consultants	0.4	0.4	0.2	0.1	0.2	0.0	0.0	0.0	0.3
Total FTE staff	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

¹ Diagnostic and health professionals includes qualified staff (other than qualified medical or nursing staff) engaged in duties of a diagnostic, professional or technical nature and covers all allied health professionals and laboratory technicians (but excludes civil engineers and computing staff) (METeOR identifier 327164).

Source: National Mental Health Establishments Database.

Table 4: Full-time-equivalent staff per 100,000 population by staffing category¹, states and territories, 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Salaried medical officers									
Consultant psychiatrists and psychiatrists	5.5	4.3	5.5	4.8	6.1	5.4	4.3	4.0	5.2
Psychiatry registrars and trainees	5.3	4.8	5.5	4.8	5.6	3.2	4.8	4.0	5.1
Other medical officers	0.8	2.1	0.9	3.6	2.8	0.2	0.4	2.3	1.6
Subtotal salaried medical officers ³	11.7	11.2	11.9	13.2	14.5	8.9	9.6	10.3	11.8
Nurses									
Registered	55.6	50.4	51.2	61.0	63.2	59.3	40.9	42.5	54.2
Enrolled	8.6	14.2	8.1	8.8	14.8	11.0	8.7	4.2	10.4
Subtotal nurses ³	64.2	64.6	59.3	69.9	78.0	70.3	49.5	46.7	64.6
Diagnostic and allied health professionals									
Psychologist	8.6	7.4	9.3	7.4	6.9	5.0	14.3	5.8	8.2
Social worker	4.6	8.8	7.5	9.5	14.2	5.6	6.9	3.8	7.5
Occupational therapist	3.3	4.4	3.9	6.8	4.3	2.2	2.2	0.8	4.0
Diagnostic and allied health professionals ²	5.6	3.3	3.0	5.7	4.3	5.9	0.2	6.1	4.3
Subtotal diagnostic and allied health professionals ³	22.1	24.0	23.7	29.4	29.7	18.8	23.5	16.4	24.1
Carer consultants	0.1	0.3	0.0	0.0	0.1	0.0	0.0	0.0	0.1
Consumer consultants	0.4	0.4	0.2	0.1	0.3	0.0	0.0	0.0	0.3
Total FTE staff	98.5	100.4	95.1	112.5	122.6	97.9	82.6	73.4	101.0

¹ Crude rate is based on the preliminary state and territory estimated resident population as at 31 December 2007.

² Diagnostic and allied health professionals includes psychologists, social workers, occupational therapists and diagnostic and allied health professionals.

³ Totals may not add due to rounding.

Source: National Mental Health Establishments Database.

Table 5: Full-time-equivalent salaried medical officers¹, by remoteness area², 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Major cities of Australia	571.4	498.6	358.4	210.5	230.6	0.0	32.5	0.0	1,902.0
Inner regional Australia	207.8	81.2	67.8	61.0	0.3	35.9	0.0	0.0	453.9
Outer regional Australia	32.2	6.4	64.4	3.9	0.0	7.5	0.0	15.0	129.4
Remote Australia	1.6	0.9	10.5	1.3	0.0	0.0	0.0	6.0	20.3
Very remote Australia	0.2	0.0	2.6	4.8	0.0	0.0	0.0	1.4	9.0
Total	813.2	587.1	503.8	281.4	230.9	43.4	32.5	22.4	2,514.7

¹ Excludes some staff employed at a higher organisational level.

² The number of staff in each remoteness area were estimated based on the geographical location of service units (ASGC 2006). Some organisations had a number of service units in different remoteness areas. Where this was the case, the data were apportioned based on the total salary and wages expenditure reported by the service units.

Source: National Mental Health Establishments Database.

Table 6: Full-time-equivalent nurses¹, by remoteness area², 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Major cities of Australia	2,724.0	2,520.5	1,574.5	1,153.1	1,187.5	0.0	169.4	0.0	9,328.9
Inner regional Australia	1,473.6	831.8	517.4	276.9	20.4	288.0	0.0	0.0	3,408.1
Outer regional Australia	238.9	38.3	343.9	36.1	27.1	55.6	0.0	71.2	810.9
Remote Australia	16.7	11.0	52.4	15.8	7.9	0.0	0.0	26.4	130.3
Very remote Australia	2.7	0.0	25.9	12.0	0.0	0.0	0.0	4.2	44.8
Total	4,455.8	3,401.6	2,514.1	1,493.8	1,242.9	343.6	169.4	101.8	13,723.0

¹ Excludes some staff employed at a higher organisational level.

² The number of staff in each remoteness area were estimated based on the geographical location of service units (ASGC 2006). Some organisations had a number of service units in different remoteness areas. Where this was the case, the data were apportioned based on the total salary and wages expenditure reported by the service units.

Source: National Mental Health Establishments Database.

Table 7: Full-time-equivalent diagnostic and allied health professionals¹, by remoteness area², 2007–08

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Major cities of Australia	967.3	974.6	661.5	422.4	438.1	0.0	80.4	0.0	3,544.3
Inner regional Australia	422.4	256.9	132.4	156.9	13.5	54.5	0.0	0.0	1,036.6
Outer regional Australia	126.2	24.1	161.0	34.5	15.4	32.8	0.0	20.2	414.2
Remote Australia	16.4	5.3	28.7	4.3	5.5	0.0	0.0	12.7	72.9
Very remote Australia	2.9	0.0	21.7	10.9	0.6	0.0	0.0	2.7	38.8
Total	1,535.3	1,260.9	1,005.3	628.9	473.1	87.3	80.4	35.7	5,106.9

¹ Excludes some staff employed at a higher organisational level.

² The number of staff in each remoteness area were estimated based on the geographical location of service units (ASGC 2006). Some organisations had a number of service units in different remoteness areas. Where this was the case, the data were apportioned based on the total salary and wages expenditure reported by the service units.

Source: National Mental Health Establishments Database.

Table 8: Full-time-equivalent salaried medical officers¹, by SEIFA decile², 2007–08

SEIFA decile	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1	12.2	0.3	60.1	0.0	41.2	1.6	0.0	0.0	115.3
2	10.2	101.9	38.5	1.4	2.9	7.9	0.0	0.2	163.1
3	24.3	16.8	22.5	1.3	5.3	11.6	0.0	0.0	81.8
4	30.8	12.8	57.7	3.4	14.3	0.0	0.0	0.0	119.1
5	186.8	78.8	15.3	41.9	19.8	0.0	0.0	0.0	342.5
6	179.7	33.6	104.4	24.2	10.7	5.4	0.0	1.0	359.0
7	75.0	50.3	68.7	34.3	22.0	0.0	0.0	4.8	255.2
8	36.8	95.1	58.5	18.2	0.0	16.9	3.8	16.4	245.8
9	107.2	84.6	37.3	45.8	60.1	0.0	4.2	0.0	339.1
10	150.1	113.0	40.7	110.9	54.6	0.0	24.5	0.0	493.8
Total	813.2	587.1	503.8	281.4	230.9	43.4	32.5	22.4	2,514.7

¹ Excludes some staff employed at a higher organisational level.

² The SEIFA Index of Relative Socio-economic Disadvantage was used. The number of staff in each SEIFA decile was estimated based on the geographical location of service units (ASGC 2006). Some organisations had a number of service units in different remoteness areas. Where this was the case, the data were apportioned based on the total salary and wages expenditure reported by the service units.

Source: National Mental Health Establishments Database.

Table 9: Full-time-equivalent nurses¹, by SEIFA decile², 2007–08

SEIFA decile	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1	81.0	2.5	359.1	0.0	218.1	14.0	0.0	0.0	674.7
2	71.3	558.1	214.8	9.3	26.9	65.4	0.0	1.1	947.0
3	211.5	136.1	109.0	15.8	27.6	65.5	0.0	0.0	565.5
4	186.6	109.9	346.7	22.0	62.5	0.0	0.0	0.0	727.7
5	1,292.0	627.3	73.6	172.3	118.2	0.0	0.0	0.0	2,283.4
6	967.9	303.0	431.7	115.9	45.4	48.2	0.0	4.3	1,916.3
7	330.0	257.3	309.0	198.3	112.9	0.0	0.0	22.8	1,230.2
8	155.1	417.7	387.2	122.0	0.0	150.5	19.1	73.7	1,325.2
9	550.5	411.4	134.7	199.6	215.1	0.0	19.9	0.0	1,531.2
10	609.9	578.2	148.4	638.6	416.3	0.0	130.5	0.0	2,521.8
Total	4,455.8	3,401.6	2,514.0	1,493.8	1,242.8	343.6	169.4	101.8	13,723.0

¹ Excludes some staff employed at a higher organisational level.

² The SEIFA Index of Relative Socio-economic Disadvantage was used. The number of staff in each SEIFA decile was estimated based on the geographical location of service units (ASGC 2006). Some organisations had a number of service units in different remoteness areas. Where this was the case, the data were apportioned based on the total salary and wages expenditure reported by the service units.

Source: National Mental Health Establishments Database.

Table 10: Full-time-equivalent diagnostic and allied health professionals¹, by SEIFA decile², 2007–08

SEIFA decile	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
1	29.8	0.6	111.9	0.0	103.4	3.0	0.0	0.0	248.6
2	30.5	186.9	84.8	11.2	20.7	24.5	0.0	0.5	359.1
3	62.5	38.8	47.8	4.3	16.4	17.9	0.0	0.0	187.7
4	70.7	42.4	122.9	23.0	40.8	0.0	0.0	0.0	299.9
5	348.9	208.4	36.8	95.1	55.3	0.0	0.0	0.0	744.4
6	279.9	127.2	188.0	70.8	13.9	10.2	0.0	1.3	691.3
7	180.1	64.0	131.2	72.6	29.8	0.0	0.0	11.2	488.9
8	82.2	231.9	114.9	31.3	0.0	31.8	10.5	22.7	525.1
9	233.6	141.5	100.9	74.8	96.0	0.0	11.4	0.0	658.2
10	217.0	219.2	66.0	245.9	96.8	0.0	58.5	0.0	903.5
Total	1,535.3	1,260.9	1,005.2	628.9	473.1	87.3	80.4	35.7	5,106.8

¹ Excludes some staff employed at a higher organisational level.

² The SEIFA Index of Relative Socio-economic Disadvantage was used. The number of staff in each SEIFA decile was estimated based on the geographical location of service units (ASGC 2006). Some organisations had a number of service units in different remoteness areas. Where this was the case, the data were apportioned based on the total salary and wages expenditure reported by the service units.

Source: National Mental Health Establishments Database.

Figure 5: Total FTE salaried medical officers, nurses and diagnostic and allied health professionals by SEIFA decile, 2007–08



Current data collections

The importance of timely and reliable health workforce data for the purpose of workforce planning and the monitoring and evaluation of workforce development initiatives are recognised in national and state and territory health workforce strategy and plan documents.

Several data sources provide information about Australia's mental health workforce. Each data collection provides information about a particular component of the mental health workforce. Aggregation of multiple data collections to provide a single picture of the mental health workforce, however, is challenging, owing to variations in the quality and usefulness of available data collections. These variations derive from a number of factors, including the lack of a unified definition of the mental health workforce, differences in data definitions and the range of data items across data collections, time periods

and professional groups, and state and territory differences in workforce-related legislations, registration requirements and service design.

Mental Health Establishments National Minimum Data Set (AIHW)

The Mental Health Establishments National Minimum Data Set (MHE NMDS) began on 1 July 2005. It is a replacement and an expansion of the Community Mental Health Establishments National Minimum Data Set and incorporates data collected through the National Survey of Mental Health Services, which was established in 1994.

The MHE NMDS provides a national view of mental health establishments. It collects information from all specialised mental health services that are managed or funded by state and territory health authorities annually. Specialised mental health services are defined as services that have a primary role of providing treatment, rehabilitation

or community health support targeted towards people with a mental disorder or psychiatric disability (AIHW 2009). Data for a financial year are prepared by each state and territory (in a standardised format and based on the same data definitions) and are to be supplied to the AIHW by 30 April the following year. Data are published by the AIHW approximately two years after the end of the financial year period for which the data are collected.

Data are reported at state, regional, organisational and service unit levels. Data reported at the state, regional and organisational levels include revenue, grants to NGOs and indirect expenditure. Organisational-level data also include salary and non-salary expenditure, and numbers of full-time equivalent (FTE) staff. Staff categories include consultant psychiatrists and psychiatrists, psychiatry registrars and trainees, other medical officers, registered and enrolled nurses, psychologists, social workers, occupational therapists and other diagnostic and health professionals, as well as consumer and carer consultants, and administrative, clerical and other staff. Numbers of FTE staff are also presented for each state and territory, by staff category and per 100,000 population. Service unit data include target population (general, child and adolescent, older person, forensic), program type (acute or non-acute), number of available beds, number of accrued mental healthcare days, number of separations, number of contacts and episodes of residential care.

The MHE NMDS does not cover the non-clinical sector and NGOs or services that are not funded by state or territory governments. Given its purpose of providing a national picture of mental health establishments and state and territory comparisons, its data categories focus on the organisational level, rather than on the individuals or professions that make up the mental health workforce. There is limited disaggregation of staff categories; for example, no distinction is made between clinical psychologists and other psychologists, or between mental health nurses and other registered or enrolled nurses. Data on staffing are presented in FTE terms, rather than the number of personnel, and no person-level demographic information on staff is collected.

The MHE NMDS was not developed with the intention to provide data for work planning or modelling purposes, and is viewed as a valuable benchmarking resource for state and territory health authorities. The lack of person-level data and the time lag between data collection and report publication reduce its capacity to be used as data source for workforce planning.

Medicare data (Department of Health and Ageing and Medicare Australia)

Medicare data provide information on the number of providers (who have a Medicare provider number) delivering mental health services through mental health-related items on the Medicare Benefit Schedule (MBS). It represents an important source of data for identifying the size and characteristics of the mental health workforce practising in private settings.

It provides complete coverage of the workforce since 1984 for specialties in which all specialists are active Medicare providers, and the annual growth in the Medicare provider workforce is a good indicator of annual growth in the workforce funded through Medicare as a whole. Demographic information about the provider, such as gender, age and location, are available. It is also useful because Medicare data can be easily linked from one financial year to the next, and has the capacity to identify providers of outreach services to rural areas and interstate populations. Moreover, reliable data are available within weeks after the end of a reference period.

Medicare data are less useful in disciplines with a high level of salaried employment and data. Other limitations include that data cannot distinguish between type of doctor for 'other medical practitioners' in primary care; and doctors who render one or more Medicare services in a given period are counted as providers, but would be classed as inactive in other data collections. Some services not specific to mental health may not be counted, such as many services that are provided by GPs. For some doctors, their gender, year of birth and year and place of basic qualification are not known, and some providers with more than one item number may be counted more than

once.⁷ Medicare data indicate service utilisation, rather than workforce oversupply or undersupply.

National Census of Population and Housing (Australian Bureau of Statistics)

Census data are collected every five years and provide comprehensive coverage of all occupations based on self-description. Its strengths are that it provides a measurement of long-term trends in Australian health workforce numbers and characteristics. It collects data that are not included in other collections, including labour force participation by age and gender of persons with a highest qualification in medicine, marital status, age of children, country of birth and language spoken at home. Small area data on composition of the health workforce are also collected.

However, the capacity of census data to provide an accurate picture of the size and characteristics of the mental health workforce profile and inform workforce planning is limited for a number of reasons. They include the fact that not all workforce categories are sufficiently disaggregated for use in detailed workforce planning, and the lack of definitions of nurses by area of specialty practice. Self-classification of occupational group (for example, social worker) may not be consistent with the intended definition of the occupational group. In addition, the census is only undertaken every five years, and the data for one census are considered out of date well before the next census.

National Health Labour Force Survey Collections (AIHW)

Annual surveys are conducted for the medical labour force (all registered medical practitioners) and the nursing and midwifery labour force. Surveys are conducted to coincide with the annual registration renewal process and by state

and territory departments of health with the cooperation of the registration boards in each jurisdiction and in consultation with the AIHW. Labour force surveys of health and community services are conducted every five years. Surveys for specific occupational groups such as psychologists and occupational therapists are conducted occasionally as resources become available.

Data collected in the labour force surveys include:

- age group
- gender
- weekly hours worked
- Indigenous status
- qualification level
- field of study
- weekly income
- birthplace
- location (by state or territory)
- industry (based on ANZSIC classification)
- geographic location (based on ARIA classification).

The strengths of these surveys are that they provide a comprehensive annual profile of the Australian medical, nursing and some allied health workforce. All registered health professionals are surveyed at annual renewal of registration, including those overseas and those not in the labour force. The cooperation of registration boards maximises response and minimises cost.

However, uneven and low response rates (for example, response rates can vary from less than 30 per cent to over 75 per cent among jurisdictions, and data from some jurisdictions are absent for some years), and the time lag between data collection and reporting, are key limitations of the labour force surveys. There is variation in response rates by state and territory and by regions within each state and territory, and local area estimates are untenable. Interns, short-term temporary resident doctors are usually not included in the data collection. There is also limited disaggregation of some workforce categories (for example, for psychologists and nurses).

While the labour force surveys contain a more comprehensive set of data items for workforce planning purposes, its response rate and timeliness limit their usefulness.

⁷ The provider number issued by Medicare Australia comprises a six-number provider stem, an alpha character or number denoting the practice location and an alpha character. Provider numbers are unique, and a new provider number is issued for each practice location of a provider.

Professional associations' surveys

Medical, nursing and allied health professional associations collect information about members, including age, gender, location, area and hours of employment, higher qualification, students, continuing professional development, place of work and sector of main employment. However, these data are limited in their usefulness for workforce planning, owing to the fact that membership is not mandatory and therefore data do not reflect the workforce in its entirety. The level of information collected varies across associations. The capacity of professional associations to undertake data collections also varies as a function of resources and registration requirements.

Descriptions of data collections and data collection issues for key professional associations in mental health are presented below, based on information gathered through available documentation and stakeholder interviews.

Australian College of Mental Health Nurses (ACMHN)

The ACMHN has approximately 2,300 members, representing approximately 17 per cent of those who provide mental healthcare in specialised mental health services in Australia (AIHW 2009). Based on the MHE NMDS data, there were 13,221.6 FTE nurses in specialised mental health services in 2006–07 and 13,727 FTE in 2007–08. The 2006 *ABS Census of Population and Housing* data indicates that there were 7,714 registered mental health nurses.

ACMHN collects data on its members through membership registration. Data collected include name, postal address, date of birth, employer, place of work, work address, position, clinical area or speciality, nursing registration number, location (state or territory), academic and professional qualifications (institutions, qualification, year awarded), research interests and experience. However, there is no current or planned (mandatory) data collection to identify the number of mental health nurses in Australia. Existing data on nurses working in mental health facilities do not differentiate between mental health nurses (that is, specialised nurses with qualifications in mental health) and non-specialised enrolled or

registered nurses who provide mental healthcare. There is also a lack of data on postgraduate qualifications in mental health. It is therefore difficult to accurately determine the size and capacity of the mental health nurse workforce.

The distinction between mental health nurses and non-specialised nurses who provide mental healthcare is important, because it can provide valuable information about the impact of postgraduate training in mental health on nurses' capacity to address mental health issues and mental health outcomes in the broader community. Furthermore, the distinction is important, because it may be related to the duration of a person's career spent working in mental health. Data on mental health qualifications (as a function of demographic categories) will also assist with identifying training gaps in the workforce.

Australian Association of Social Workers (AASW)

The AASW has approximately 6,000 members, representing approximately 48 per cent of the total number of social workers in Australia (12,440) based on the 2006 Census of Population and Housing data. Approximately 1,000 members are accredited to provide services through the Better Access Initiative, and the number of social workers employed in specialised mental health facilities in Australia was 1,541 FTE in 2006–07 and 1,592.2 FTE in 2007–08 (AIHW 2009; 2010).

Since 2009 the AASW has undertaken a general survey of its members. Survey items included:

- age and gender
- location of residence and affiliated AASW branch
- employer (for example, government agency, private practice, NGO or NFP organisation, state or territory government department, university or further education, not working, federal government department, employee in the private sector, other)
- employment status (full or part time, currently studying/not working)
- area of social work practice (for example, mental health, health, family relationships, disability, management, aged care, domestic and family

violence advocacy, counselling and support, community development, alcohol and other drugs, housing and homelessness and other)

- main practice approach (for example, individual counselling largest, family work, information and referrals, policy or program management, administration/management, line-management (supervision of staff), community development, group work, individual advocacy and other)
- length of AASW membership
- years of postgraduate social work experience.

Over one-third of social workers are located in regional, rural and remote areas (AASW survey). Social workers are also employed in a diverse range of settings, including NGOs, and are practising in the private sector. The number of social workers accredited to work in mental health in private practice has increased almost fivefold since the introduction of the Better Access Initiative (AASW survey). While data from the AASW membership does not represent the entire social worker workforce, the information from the AASW survey suggests that social worker numbers may not be accurately reflected in the MHE NMDS.

A member survey on employment issues has also been conducted. This survey was designed to ascertain members' intention to look for permanent or locum work in the next six months, the field of practice of interest, the location of work desired, the notice (length of time) they require to commence the new permanent or locum position, and how they would like to be informed about permanent or locum vacancies.

Key data gaps for social workers include the a lack of data on social workers who work in private settings. In particular, those who are self-employed and not accredited to provide mental health services are not captured in available workforce data. There is also a lack of data on the type of agency in which social workers are employed in the mental health sector (for example, NGO or specialised mental health services, psychiatric disability).

Occupational Therapy (OT) Australia

Based on the 2006 Census of Population and Housing, there were 6,835 people who identified themselves as occupational therapists. A total of

814 FTE occupational therapists were reported in specialised mental health services in 2006–07, and 859.4 FTE in 2007–08 (AIHW 2009; 2010).

Based on the advice received from OT Australia, its membership exceeds the numbers reported in the 2006 census data, because membership includes those practising as occupational therapists as well as non-practising individuals in management and other positions. Registration is not required in all states and territories. It is also possible to register in more than one state or territory.

OT Australia conducted a member survey in 2006. The survey included a wide range of items to collect member demographic information, education and training, and work history, setting and practices. Survey items included length of time as a qualified occupational therapist, primary areas of practice, primary role, hours worked per week and employment sector and setting.

Australian Psychological Society (APS)

The APS has nearly 18,000 members, representing approximately 60 per cent of registered psychologists in Australia. It conducts regular internal surveys of its members. Based on the 2006 Census of Population and Housing, there were 8,921 clinical psychologists. The MHE MNDS indicates that there were 1,662.3 FTE psychologists in specialised mental health services in 2006–07 (AIHW 2009) and 1,740.7 FTE in 2007–08 (AIHW 2010). In 2008 it is estimated that there were approximately 25,800 registered psychologists in Australia (Australian Mental Health Workforce Committee 2008c).

The APS conducted a National Psychology Workforce Survey in partnership with the Psychology Registration Boards in late 2008 to ascertain workforce characteristics. Responses from 9,330 fully registered psychologists were received. The survey included items assessing qualifications and training, number of years of experience, work settings, primary roles and psychological roles undertaken.

The APS also conducted a survey in 2009 to assist planning in psychology workforce recruitment and retention. This survey was conducted using a large sample of psychologists working in the public or NGO sector, and assessed psychologists'

intention to remain working in their main job and active plans to reduce or cease their currently employment in favour of private practice, their motivations for pursuing private practice and incentives that would motivate them to reconsider their intentions and stay in the public or NGO sector.

Royal Australasian and New Zealand College of Psychiatrists (RANZCP)

There are conflicting data about the number of psychiatrists in Australia. The ABS Census of Population and Housing counted 2,180 psychiatrists, while the contemporary AIHW Medical Labour Force Survey counted 3,258 psychiatrists. More recently, the AIHW estimated 2,088.8 FTE consultant psychiatrists, psychiatrists and psychiatry registrars and trainees in specialised mental health services in 2006–07 (AIHW 2009). However, the specialised mental health services data in the AIHW survey capture only those in government-funded mental health services.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) conducts its own workforce survey. One was conducted in 2005, and was repeated in 2009. According to the college, its members represent approximately 85 per cent of the psychiatrists in Australia, and it has approximately 4,000 members in Australia, of whom 2,622 are fellows.

The college estimates that nearly 15 per cent of current psychiatrists are over the age of 65 years (past the traditional retirement age), and approximately 40 per cent will reach retirement age in the next decade.

National Registration and Accreditation Scheme: national register of health professions

As part of the National Registration and Accreditation Scheme, a national register has been established and will be implemented commencing on 1 July 2010. The national register has been developed through collaboration between the Commonwealth and state and territory governments, and will be implemented through multiple phases. In the first phase, health

professions that require registration under than National Registration and Accreditation Scheme will be required to provide data during the reference period. These professions include:

- chiropractic
- dentistry
- dental hygiene
- dental prosthetics
- dental therapy
- medicine
- midwifery
- nursing (enrolled, registered, practitioner)
- optometry
- osteopathy
- pharmacy
- physiotherapy
- podiatry
- psychology.

It is anticipated that other professions such as social workers (which is currently a non-registered profession) will be required to provide data in subsequent implementation phases of the national register.

Registered health professionals (that is, a person currently registered or who has been registered with the Australian Health Practitioner Regulation Agency at any time during the reference period) will provide data to the Australian Health Practitioner Regulation Agency as part of their initial registration and annual registration renewal processes. The data collection period will be determined by the national registration renewal period for the particular health profession, and may differ between health professions. The Australian Health Practitioner Regulation Agency then provides an extract of these data to the AIHW for the purposes of national collation and reporting.

Data to be provided include required information for registration purposes and additional workforce data. Data items include:

- sex
- country of birth
- date of birth
- Australian state/territory of birth

- address (Australian postcode and suburb/town/locality)
- Indigenous status
- main job
- second job
- work setting hours
- principal area of practice
- hours worked in clinical role, health profession and non-clinical role
- hours worked in the private and public sector
- intended number of years in profession
- length of employment in profession in Australia (years).

The national register has therefore immense potential to serve as a data source for identifying Australia's current health labour force and facilitate workforce planning. It eliminates the problem of low response rates seen in other health workforce surveys, because all members of health professions that require registration under than National Registration and Accreditation Scheme will be required to provide information to the national register. However, the majority of workforce items are optional, with the mandatory items being gender, date of birth, suburb and postcode of residence. The non-mandatory nature of critical items (such as principal area of practice and working hours) limit the capacity of data collected to inform workforce planning in the mental health sector.

Non-government community mental health sector

There is currently no national data collection system for the mental health workforce in the NGO sector. Recognising this critical information gap in light of the growing mental health workforce in the NGO sector, the Non-Government Organisation Mental Health Workforce Study was commissioned by the NHWT, which is designed to improve understanding of the existing non-government mental health sector and develop and trial a data collection tool to support mental health workforce planning for the non-government community mental health sector. This study is being undertaken by the National Health Workforce Planning and Research Collaboration (comprising the National Health Workforce

Taskforce, PricewaterhouseCoopers and the Australian Health Workforce Institute) as part of a larger set of research and planning projects.

The project comprises two phases. In Phase 1, a landscape survey was developed and distributed to all non-government organisations that are members of mental health non-government organisation peak bodies. This survey was completed by managers or executives of the organisation, and survey items were designed to provide a snapshot of the sector by obtaining descriptive data on the key features of the non-government mental health sector, including:

- size, location and type of organisation
- services provided by the organisation
- profile of the non-government mental health workforce, including staff categorisation, distribution, qualifications and participation characteristics
- workforce planning and training
- data collection, reporting and quality improvement.

Phase 2 of the project involves developing and piloting a workforce survey to identify suitable processes and data items for gathering more detailed workforce data at the individual level. This survey will draw on a sample of individual staff members, who provide direct and indirect support to mental health consumers and carers, within organisations captured in the landscape survey. The workforce survey will include data items relating to an individual worker's:

- age, gender, Indigenous status, country of birth, language and previous employment
- current employment, including location, status, paid hours, length of employment, primary role, proportion of time allocated to different roles and professional registration
- roles (for example, mental health rehabilitation and support, therapeutic, education and awareness, co-morbidity, administration and management, population focus, salary range)
- education and training (for example, highest qualification, mental health qualifications or training, continuing education activities).

Survey respondents are also provided with the opportunity to make additional comments,

for example, about attraction, retention and workforce needs.

This study is designed to be the next step towards developing a national workforce data collection tool for the non-government mental health sector, the full implementation of which will provide information for future workforce development strategies and plans relevant to the NGO sector.

Private sector

Medicare data (as described above) provide workforce information on health professionals (who have a Medicare provider number) delivering mental health services through mental health-related item on the MBS in private practice.

There are data collections that contain workforce information in the private hospital sector. The Private Health Establishments Collection is an annual census of all private hospitals, including private psychiatric hospitals, conducted by the ABS. Staffing categories include salaried medical officers, registered, enrolled and student nurses, other personal care staff, diagnostic and allied health professionals, administrative and clerical staff and domestic and other staff.

The Australian Private Hospitals Association conducts regular surveys on its workforce and has recently undertaken a survey regarding education and training in the private sector. Private hospitals such as Ramsay Health Care also conduct internal workforce surveys to ascertain the demographic characteristics of their workforce (for example, gender, age, length of service, hours worked, turnover), service and workforce planning needs and activities, workforce mix and recruitment and retention strategies.

State and territory workforce data collections⁸

There are additional health workforce data collections that are developed and implemented

⁸ No information on workforce data collections has been received from Tasmania at the time of writing. Also awaiting more information from the Australian Capital Territory (preliminary briefing from the Australian Capital Territory indicated that data in the Australian Capital Territory fit in with what is described in this section).

by state and territory health authorities. The majority of states and territories do not currently have data collections specific to the mental health workforce as a whole.

Based on publicly available reports and documents, and information provided by informants, it is evident that there is considerable variation across states and territories in the nature and extent of health and mental health-specific workforce data collected across the public, not-for-profit and private sectors. States and territories also differ in their resource capacity to undertake workforce data collection or research activities and work planning and modelling.

Drawing on these state and territory data collections to inform the national mental health workforce profile in Australia is problematic, owing to factors such as jurisdictional differences in health workforce legislations, workforce data definitions and health service arrangements.

Human resource and payroll data

State and territory human resource (HR) and payroll data systems appear to be the main source of health workforce data. HR and payroll data systems contain demographic information (for example, gender, age) and workforce data items such as employment status (for example, full-time or part-time, permanent or contract) and work location.

HR and payroll data are regularly updated and provide relatively accurate and timely information about the health workforce (headcount and number of FTE positions). However, the capacity of HR and payroll data to inform mental health workforce profiles and planning is limited, owing to the broad categorisation of occupational group or lack of disaggregation of data for the mental health workforce. Data are also largely limited to the public sector.

Workforce surveys

While there appears to be no statewide mental health workforce specific workforce data collections, some states and territories undertake workforce research and data collection activities that include the mental health workforce. Some notable state and territory workforce data

collection and modelling activities are described below.

The Mental Health Branch of Queensland Health has established mental health workforce targets (number of FTE staff) for its community mental health programs, and undertakes monthly telephone survey of mental health service to ascertain staffing levels and vacancies. Progress towards meeting the staffing targets is then calculated to inform workforce planning.

The Service and Workforce Planning Branch of the Victorian Department of Human Services conducted a study of the public direct care mental health workforce in Victoria in 2003. HR payroll data were used in conjunction with a census survey. The survey included additional data items that are not measured or consistently measured by the HR or payroll systems of area mental health services.

The census survey items include:

- residency status
- employment patterns or history (length of service in the mental health sector, the Victorian public mental health system and in the current position)
- nature of first role in public MH system by setting, metro/rural location and tenure
- education and training (qualification by occupation, age group, geographic location and year of qualification)
- number and profile of dual qualified staff
- number and profile of staff current studying
- work activities (tasks or roles performance by staff, by occupation and classification, where possible).

Based on the data collated, workforce modelling was conducted and forecasts were made regarding the total FTE required to meet service growth to 2011–12 for medical (including psychiatrists, psychiatry trainees and other medical officers), nursing and allied health. Workforce strategies and actions were also formulated based on this study.

In Western Australia a workforce requirements model and a workforce supply model are being developed to provide projections for workforce demand, supply and the gap between the two,

and evidence for service planning and funding submissions.

The Tasmanian Department of Health and Human Services (DHHS) undertook workforce planning projects in the allied health professional groups in 2001–02. Supply variables examined for psychologists included numbers of and FTE psychologists, age, gender, service region, DHHS division, principal area of activity (for example, mental health, education, rehabilitation), award classification, qualifications, country of birth, numbers of re-entries into and exits from the profession and the expected number of graduates entering the profession. To examine the demand for psychologists, variables such as unemployment rate, staff turnover and psychology service utilisation were considered.

Work has also been undertaken by some states and territories to identify the mental health workforce in the community non-government sector. For example, ACT Health has undertaken surveys of the mental health workforce in the community NGO sector.

Queensland Health has commissioned research to construct a workforce profile of the NGO mental health sector. The Non-Government Mental Health Sector Workforce Survey was developed to collect a wide range of data items, including those relating to the organisational (for example, services offered, service gaps), individual employees (for example, demographics, employment status, skills, experience and knowledge, remuneration and benefits), workplace issues (for example, leadership, workplace culture, role clarity, resourcing, job satisfaction, professional development) and workforce intentions (for example, recruitment and retention, workforce stability and flexibility, job security, career prospects).

Other relevant national data sources include the Public Hospital Establishments National Minimum Data Set, the National Hospital Morbidity Database and the ABS National Health Survey and National Survey of Mental Health and Wellbeing of Adults. These data sources provide information primarily relating to service utilisation, which is important for workforce demand analysis and modelling. A brief description of these data sources are described below.

AIHW Australian hospital statistics

The *Public Hospital Establishments National Minimum Data Set* includes information on hospital resources (beds, staff and specialised services), expenditure, non-appropriation revenue and services provided to and type of non-admitted patients. Staffing categories include nurses, personal care staff, diagnostic and allied health professionals, administration and clerical staff and domestic and other staff.

The *National Hospital Morbidity Database* is a collection of episode-level records from admitted patient morbidity data collection systems in Australian hospitals. Of particular value is the collection of data on principal diagnosis for admission based on the ICD-10-AM disease classification with mental and behavioural disorders being separately identified. The database contains data relating to admitted patients in almost all hospitals, including public acute hospitals, public psychiatric hospitals, private acute hospitals, private psychiatric hospitals and private freestanding day hospital facilities. Data collection commenced from 1993–94.

ABS National Survey of Mental Health and Wellbeing

This survey provides information about the prevalence of lifetime mental disorder and mental disorders reported in the 12 months prior to the survey for each of the major disorder groups

(anxiety, affective and substance use) among Australians aged between 18 and 85 years. Data on age, gender, employment status, living arrangements, experience of homelessness, social contact, health behaviour (for example, smoking, alcohol consumption, drug misuse), suicidal behaviour, disability status and psychological distress are also collected to enable comparison between social groups. In addition, the survey collects information on use of mental health services (for example, GP, psychiatrist, psychologist, other health professions) and self-reported unmet service needs. The first survey was conducted in 1997; the second in 2007.

ABS National Health Survey

This survey collects information on the health status and major conditions of Australians, their use of health services and facilities, and health-related aspects of their lifestyle. It has the capacity to monitor trends in health and healthcare usage over time. It covers urban and rural areas across all states and territories, includes residents of both private and non-private dwellings, and provides information relating to socioeconomic status. Data on consumers' perceptions of their encounters with health providers are also collected. However, the survey is not focused on labour forces, but has the advantage of combining in one data source information in patient characteristics and services used.

Summary and observations

While there is a range of data sources on which information on the mental health workforce can be drawn, developing an accurate profile of the mental health workforce in Australia remains a challenge. In order adequately to monitor and evaluate the impact of national initiatives on the capacity of Australia's mental health workforce, it is important to have well-designed and integrated data collection systems. The capacity for workforce planning, modelling and monitoring and evaluation in the mental health sector is limited by the nature of existing data collections as well as resource constraints. Informants uniformly recognised the difficulty and complexity of, and agreed on the need to enhance, mental health workforce data collections in Australia for workforce planning purposes.

Available data collections vary considerably in terms of their coverage of the mental health workforce and workforce data items; hence, their quality and usefulness for workforce planning and modelling varies. Variations in the understanding of the scope of the mental health workforce and workforce data definitions, and state and territory differences in workforce legislations, registration requirements and service arrangements further add to the difficulty of aggregating different data collections to provide a national picture.

Together, the MHE NMDS and Medicare data provide coverage of the majority of the mental health workforce – they cover the mental health workforce in specialised mental health services that are funded by state and territory governments and in private practice settings. The MHE NMDS, however, does not collect demographic and work-related data on individual health professionals, and was perceived by stakeholders as a data source for benchmarking (comparison with other states and territories may also provide a rationale for funding submissions) but limited in its use for workforce planning. Although the MHE NMDS is

based on a set of agreed data definitions, some state and territory representatives indicated that the data categories and definitions were not appropriate for their state or territory and that data collected need to be qualified.

While the *Census of Population and Housing* and the *National Labour Force Survey* surveys contain a wider range of workforce data items and cover a large component of the mental health workforce, data reliability, response rate and timeliness are key issues, and represent concerns that were also raised by stakeholders. Similarly, although member surveys of mental health professional associations have the capacity to collect richer workforce data, members of professional associations only represent a portion of the workforce.

State and territory governments have relatively reliable data on workforce numbers through their human resource database or payroll system; however, data are generally limited to individuals employed by the government health authority, and there is insufficient disaggregation of occupational groups to accurately identify components of the mental health workforce. There are also variations and limitations in the range of data variables collected through the HR or payroll system.

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

Taken together, the main sources of data for the mental health workforce cover a wide range of data categories relevant for workforce planning,

modelling (in particular, supply modelling) and monitoring and evaluation. While significant work to collect data on the mental health workforce has been undertaken to facilitate workforce planning to meet the mental health needs of the community, there remains some critical data gaps and challenges. Further, the lack of regular longitudinal data in many data collections means that there is no capacity for estimating rates attrition from the workforce over time.

One of the key data gaps 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 healthcare, is problematic.

Professional bodies' representatives agreed on the need to collect professional development information and data on educational qualifications, training and supervision of the mental health workforce. Some of the suggestions for data collections to assess the impact of professional development and supervision on professional practice and client outcomes require the commissioning of special studies, rather than the collection of new data within existing data collections.

All informants emphasised the need for more timely data to enable effective workforce planning. Stakeholders also generally believed in the need to link data collections across sectors (education, training and employment, health) and promote discussions regarding definitions of the mental health workforce. Some also believed in the importance of enhancing regional

and local or service area or district-oriented workforce planning and data collection capacity, owing to differences in legislation, service needs, geography, population distribution and demographic profiles.

Overall, informants expressed high hopes for the new national register to collect of mental health workforce data at the national level to develop a clearer picture of Australia's current mental health workforce and to facilitate workforce planning in the mental health sector. Stakeholders generally believed that the national register will overcome some of the problems (for example, poor response rate or workforce coverage, and the long time lag between data collection and reporting) associated with existing data collections (for example, AIHW national health labour force survey collections and professional association surveys). However, informants believed that the national register was limited, owing to a number of critical items (for example, specialisation) being non-mandatory, and the absence of mental health as an identified specialisation category for some professions. Some also pointed to the need to include occupational therapists and social workers (although social workers are currently a non-registered profession) in the national register.

The Ministerial Council meets to discuss the National Registration and Accreditation Scheme, and will respond to the submissions made by the various national boards, and recommendations will be made about the sub-specialisation categories. The outcomes of the ministerial council meeting will be considered in our development of recommendations to enhance data collections to inform workforce planning, modelling and monitoring and evaluation.

Mental health workforce initiatives in Australia

This section presents a summary of relevant national, state and territory government and non-government strategies and plans relevant to the health workforce, and to the mental health workforce in particular.

The summary of state, territory and non-government mental health workforce initiatives draws on publicly available information as well as additional accessible documentation.

Few state and territory documents exist that deal specifically with a mental health workforce strategy or plan. Nevertheless, workforce strategies and actions are included in mental health strategies or plans. Differences in the extent of this information reflect variations in the structure and content of available strategies and plans in the states and territories.

Details on state and territory initiatives draw primarily on the information supplied by each state and territory to the MHWAC in 2008, in accordance with the principles of the *National Health Workforce Strategic Framework* (NHWSF). Additional initiatives have been planned and implemented since that time.

Based on the advice received, there are initiatives reported in some jurisdictions that are implemented in other jurisdictions, even though they have not been recorded in available documents. There is notable variation in the nature and extent of detail each jurisdiction has provided. Some of these variations may be attributed to differences in interpretation of the initiatives implied by each principle of the NHWSF.

Given the constraints mentioned above, the initiatives presented in this section are therefore not intended to be exhaustive or without error. Our analysis of national and state and territory mental health workforce initiatives will be refined

based on comments received from the PSC and other stakeholders, and as additional information become available.

National health and mental health workforce strategies and plans

The available health workforce and mental health strategies and plans emphasise innovation and reform in workforce development, recruitment, retention and education and training, effective service delivery models, collaboration and partnerships, consumer and carer participation and research and data collection.

The National Health Workforce Strategic Framework

The *National Health Workforce Strategic Framework* (NHWSF 2004) was developed by an Australian health workforce officials' committee working group in consultation with key stakeholders nationally. It is intended to provide a vision, guiding principles and strategies (planned actions) to guide national health workforce policy and planning over a ten-year period.

The vision of the NHWSF is for Australia to have:

a sustainable health workforce that is knowledgeable, skilled and adaptable. The workforce will be distributed to achieve equitable health outcomes, suitably trained and competent. The workforce will be valued and able to work within a supportive environment and culture. It will provide safe, quality, preventative, curative and supportive care, that is population and health consumer focused and capable of meeting the health needs of the Australian community (p. 10).

The key action areas linked to the seven guiding principles are:

1. ensuring and sustaining supply
2. workforce distribution that optimises access to healthcare and meets the health needs of all Australians
3. health environments being places in which people want to work
4. ensuring the health workforce is always skilled and competent
5. optimal use of skills and workforce adaptability
6. recognising that health workforce policy and planning must be informed by the best available evidence and linked to the broader health system
7. recognising that health workforce policy involves all stakeholders working collaboratively with a commitment to the vision, principles and strategies outlined in this framework (adapted from p. 14).

The seven guiding principles and their corresponding strategic actions are outlined below. There is a clear focus on innovation and reform and the use of best evidence to inform workforce planning and development (for example, in recruitment and retention, increasing equitable access to services, education and training and collaborative partnerships). The need to establish data collections and monitoring and evaluation processes was also identified.

Principle 1

Principle 1 points to the need to achieve national self-sufficiency in health workforce supply. Strategic actions associated with this principle are to:

- align education and training supply with projected workforce requirements and health service needs to achieve long-term national self-sufficiency of supply
- reduce immediate shortages through short-term strategies (for example, improving workforce re-entry and ethical overseas recruitment)
- support domestic supply through a multifaceted and sustainable approach to recruitment and retention

- promote retention and effective service delivery through innovative education and training models.

Principle 2

Principle 2 focuses on optimising access to healthcare to meet health needs through equitable distribution of workforce. Strategic actions associated with this principle are to:

- explore innovative approaches to address distribution issues (for example, incentives and disincentives to practise in areas and sectors of greatest need and workforce shortage)
- target training and education in areas of greatest need
- use innovative models of service delivery to improve access to areas of geographic and cultural need and specialties in shortage.

Principle 3

Principle 3 relates to the need to ensure that healthcare working environments are places in which people want to work. Strategic actions associated with this principle are to:

- explore and develop flexible working environments that reflect the changing needs and profile of the workforce
- explore and develop models that enable articulated, multiple career pathways to provide lifelong career opportunities in the health sector
- continue and enhance initiatives aimed at promoting supportive cultures, innovation, leadership and collaboration in work environments.

Principle 4

Principle 4 emphasises the need for cohesive action among stakeholders across health, education, vocational training and regulatory sectors to ensure that the health workforce is sufficiently skilled and competent. Strategic actions associated with this principle are to:

- identify a formal mechanism for the effective engagement of the health and education and training sectors (for example, establishment of a national health and education training council)

- › align education and training programs with health service needs
- › continue to develop new and innovative ways to deliver health education and training, which facilitate accelerated entry to the workforce and flexible delivery of clinical training
- › promote initiatives that encourage practitioners to maintain a level of skills, knowledge and competence that align with evolving health consumer needs and changes in service delivery.

Principle 5

Principle 5 focuses on the optimal use of workforce skills and workforce adaptability. Strategic actions associated with this principle are to:

- › link service development with workforce development approaches and explore opportunities to maximise the flexibility of the workforce (for example, innovative approaches to skill mix and new workforce roles and changes to scope of practice)
- › develop workplace, professional and education and training practices that facilitate team approaches and multidisciplinary care
- › explore regulatory arrangements that facilitate workforce supply and innovative solutions to work design and the recognition of knowledge and skills.

Principle 6

Principle 6 emphasises the need for health workforce policy and planning to be informed by the best available evidence with a population and consumer focus. Strategic actions associated with this principle are to:

- › establish shared health workforce planning methodologies that include comprehensive workforce planning as part of any capital, service or infrastructure planning
- › lead, encourage and support a health workforce research, planning and policy development agenda to meet population and consumer healthcare needs
- › continue to develop health workforce information sharing
- › continually improve health workforce data collections – put in place common language,

minimum data sets and consistent collection and processing arrangements.

Principle 7

Principle 7 highlights the value of collaboration among all stakeholders in health workforce policy development and planning. The strategic actions required under this principle are to:

- › develop national and jurisdictional plans to action the framework
- › establish the monitoring, evaluation and reporting processes to support the framework
- › develop inclusive, consultative processes on the development of health workforce policy and planning that engages all stakeholders
- › promote discussion and awareness of health workforce issues and strategic action amongst stakeholders and the general community.

Workforce initiatives in the non-government sector

The community mental health non-government organisation (NGO) sector is large and diverse. Definitions vary as to what constitutes a community mental health service, but the sector is thought to consist of over 800 independent organisations nationally (CMHA). This figure is derived from the membership of the eight state/territory community mental health peak bodies. The Commonwealth has identified a need to better define and quantify the NGO community mental health sector and, at the time of writing, a Commonwealth-funded project to map the NGO mental health workforce was in progress.

The non-government sector is supported by state/territory mental health peak bodies and through the recently established Community Mental Health Australia (CMHA) alliance. The CMHA alliance allows the peak bodies to work collaboratively to achieve the following sector objectives:

- › provide leadership and direction on behalf of the community mental health services sector across Australia
- › develop a better national understanding of community mental health and recovery services
- › coordinate the development of the community mental health industry/sector across all states and territories

- proactively pursue involvement within national mental health policy and service development arenas
- establish partnerships with national stakeholders to achieve shared mental health reform goals.

Total staff numbers, qualifications and experience is unknown and is believed by the CMHA to exceed 5,000–6,000 FTE, and to be a mix of both university (mostly nursing, psychology and social work) and/or vocational education (mostly certificates in community services or disability work) qualified staff. There is also a high proportion of unqualified staff, many of whom have considerable experience in helping people affected by mental illness. CMHA has agreed to the Certificate IV in Mental Health Work as a voluntary minimum standard for entry-level work in the sector. However, as submissions to the Productivity Commission (2010) reported, while workforce development is seen to be a priority for sector development, NGO community mental health organisations often have little resource or capacity to pursue directions beyond direct service delivery.

At the national level, workforce initiatives in the non-government sector include the scoping of community mental health (NGO) workforce mapping project and the NGO capacity building grants to assist with the capacity building of non-government mental health organisations. Some states and territories have also undertaken workforce initiatives in the non-government sector – typically through leadership of the NGO community mental health peak bodies.

The NGO mental health workforce study seeks to design and test a methodology to support mental health workforce planning for the non-government community mental health sector through the provision of improved data and information on workforce supply and trends.

Historically, sector-based workforce development-related activities have occurred primarily in Victoria and New South Wales. Psychiatric Disability Services Victoria (VICSERV) has provided training services for approximately 10 years, and recently aligned their 'psychosocial rehabilitation training' with opportunities to

achieve the Certificate IV in Mental Health through a partnership with TAFE. Leadership and management training has more recently been offered.

The Mental Health Coordinating Council (MHCC) in New South Wales implemented a NGO development strategy for mental health (2004–07) with workforce development a key initiative, which is continuing. This resulted in establishment of the MHCC as a registered training organisation (RTO) – the Learning and Development Unit (LDU) – which had an initial focus on sector uptake of the Certificate IV Mental Health. Recent additions to the LDUs RTO scope of registration include qualifications in leadership and management and in alcohol and other drugs work. More recently, the MHCC was funded \$1.6 million to administer the Mental Health Scholarships Program in 2009–12. The MHCC attends the New South Wales Health Mental Health Workforce Advisory Group.

More recently, the NGO community mental health peak bodies in the Australian Capital Territory and Victoria received Mental Health Council of Australia capacity building grants to collect workforce data and explore training needs by July 2009. Previously, only New South Wales and South Australia had detailed quantitative workforce and training needs data.

Disability Services Queensland, with the involvement of the Queensland Alliance Mental Illness and Disability Group, has commissioned a project to undertake a workforce analysis in the non-government sector. This activity is to complement earlier work undertaken by the Queensland Alliance during 2007.

In Tasmania, an NGO workforce development project has been established to identify NGO workforce requirements and issues in mental health and improve workforce planning in the non-government sector. In Western Australia, NGO standards implementation and monitoring has occurred. In South Australia, workforce analysis has been conducted of NGO mental health sector relating to training through the VET sector. In New South Wales, Victoria and Tasmania, mental health work traineeships are available for the health and community service workforce.

State and territory health and mental health workforce strategies and plans

Australian Capital Territory

ACT Workforce Plan 2005–10: Building a sustainable health workforce for the people of the Australian Capital Territory

The *ACT Workforce Plan 2005–10* identifies four health workforce objectives for ACT Health and their corresponding desired outcomes and strategies:

1. A workforce profile. This objective has the desired outcome of having access to replicable and reliable data for effective analysis of the workforce through the enhancement of workforce supply and demand data (including an evaluation tool), the development of models of care planning and analysis tools, and the construction of workforce supply and demand scenarios based on predictions of models of care.
2. A responsive workforce. The desired outcome of this objective is to develop and maintain a responsive, flexible, productive and happy workforce through research on workforce redesign, extended job roles and scopes of practice, development of safe and effective workplace practice models and alignment of workforce planning with clinical service planning.
3. Education and training. This objective has the desired outcome of having access to a pool of workplace ready graduate health professionals by developing formal partnerships with the tertiary and VET sectors, facilitating better alignment between education outcomes and health workforce needs, developing new models of learning through multidisciplinary approaches and simulated environments and increasing access to learning and further education.
4. Effective linkages. The desired outcome for this objective is participation in, and contribution to, comprehensive policy discourse in cross-sectoral national health committees by participating in, and contributing to, national health workforce committees, developing joint

government and intra-agency partnerships, developing joint agency work programs with other Australian Capital Territory Government bodies, and maintaining links with relevant health workforce strategies, policies and plans through local and national forums and networks.

ACT Mental Health Services Plan 2009–14

This plan aims to achieve and maintain mental health and wellbeing for the people of the Australian Capital Territory in 2020. It comprises three foundation areas: recovery focus, consumer and carer participation and partnership and collaboration.

Four strategic directions are specified:

1. reinforcing capacity in the mental health service system (one of the objectives under this strategic direction is the development of a mental health services workforce strategy)
2. extending the mental health service system
3. innovation in the mental health service system
4. planned implementation of change.

Building a Strong Foundation: A framework for promoting mental health and wellbeing in the Australian Capital Territory 2009–14

The purpose of this framework is to guide investment in the development and implementation of activities to promote mental health and wellbeing in the Australian Capital Territory over a five-year period. Its guiding principles are:

- building capacity and understanding of mental health and wellbeing – increasing understanding of factors that affect mental health and wellbeing, the impact of stigma, and the roles and responsibilities in promoting mental health, preventing mental illness and reducing stigma
- workforce development – developing a comprehensive workforce through increased engagement with the consumer and carer sector to enhance consumer and carer capacity to participate at individual and sector levels, and the development of a localised sector workforce strategy to address workforce

leadership, capability and performance, organisational climate and service development framework, models of care and new and emerging technologies.

- › consumer and carer participation.

Four key action areas are identified:

1. enhance the mental health and wellbeing of the whole community
2. support children, youth and families
3. enhance services to those with comorbidity issues or who have received care in closed settings
4. enhance the social equities and reduce the social inequities that influence mental health and wellbeing.

New South Wales

New South Wales: A new direction for Mental Health 2006–07 to 2010–11

The New South Wales five-year plan for mental health aims are to:

- › reduce the prevalence and severity of mental illness
- › reduce the prevalence of risk factors that contribute to the onset of mental illness and prevent longer-term recovery
- › increase the proportion of people with an emerging or established mental illness who are able to access the right healthcare and other relevant community services at the right time
- › increase the focus of services on coordinated care in the community and early intervention
- › increase participation of people with a mental illness in the community, employment, education and training
- › increase the availability and stability of accommodation for people with a mental illness.

The plan identifies four key areas of effort:

1. promotion, prevention and early intervention across the lifespan
2. improving and integrating the care system
3. participation in the community and employment, including accommodation
4. better workforce capacity – enhancement of training and development programs for

existing staff and recruitment of new staff to achieve a highly skilled, stable and well-supported workforce to enhance the quality, effectiveness and responsiveness of services.

New South Wales Community Mental Health Strategy 2007–12: From Prevention and Early Intervention to Recovery

The aims of the mental health workforce strategy on a statewide basis are to:

- › identify and use creative means to recruit and retain people in the workforce, including the 2005–07 Mental Health Nursing Workforce and Skills Acquisition Project
- › facilitate new ways of working across professional boundaries, including identification of service
- › models linked to required skills and competencies
- › develop the workforce through revised education and training at both pre- and post-qualification levels, with funded educational supports, where available
- › develop leadership and change management skills, including participation in programs such as the New South Wales Health Clinical Leadership Program.

The current strategic projects relating to workforce are:

- › nursing – targeted scholarships for nurses who wish to return to the mental health workforce through the Nursing Reconnect Program; development of a standardised transition program for nurses new to mental health; establishing innovative contemporary roles, such as nurse practitioners, across New South Wales
- › medicine – conducting an organisational review of the New South Wales Institute of Psychiatry and other mental health education funding arrangements, with a view to increasing support for psychiatry registrar training; strengthening the role of the Institute and enhancing linkages with other tertiary institutions; continuing the Rural Psychiatrist Project that supports the development and implementation of a range of programs to support the rural mental health medical

workforce (focusing on the recruitment and retention of psychiatrists and trainee psychiatrists in rural areas of the state)

- GPs – the General Practice Mental Health Standards Collaboration of the Royal Australian College of General Practitioners (RACGP) provides access to approved training courses for GPs (through face-to-face, online and distance education formats)
- allied health – engage allied health professional bodies at a policy and planning level, to develop processes that increase the use of the allied health workforce within the mental health services
- mental health support – examine the roles and functions of generic mental health workers, particularly in rehabilitation and older people's services
- consumers and carers – ensure that consumer and carer support worker positions are well defined, are included in the corporate structure and receive managerial support and adequate resources and training
- NGO Workforce Development Strategy – partnership with the MHCC is conducting this strategy to develop linked to the broader COAG and AHMAC initiatives, including an increase in undergraduate places, proactive overseas recruitment, increased recognition of the allied health and psychology workforce, and implementation of minimum core competencies in the National Practice Standards for the mental health workforce.

Northern Territory

Strategic Workforce Plan 2008–11: Working together to strengthen our workforce

The plan outlines four main areas of action:

1. an evidence-based approach based on the recognition that current and accurate evidence is critical to inform workplace decisions and planning models. Identified actions include developing a workforce forecasting and projections model to plan future workforce needs for the Northern Territory, establishing workforce benchmark

figures and a suite of data sets to enable evidence-based decision making, identifying innovative service delivery models and undertaking engagement processes with key stakeholders

2. strengthening a capable workforce, such as by achieving the right workforce mix to lead, support and provide high quality services, enhancing training and learning environment and developing a succession management plan
3. attracting and retaining talent through actions including developing local workforce (particularly in ATSI and remote communities), partnerships with the education and training sector and communities to facilitate training from school to work in the health and community services industry, enhancing workplace practices and processes and recruiting high quality overseas training staff
4. supporting and engaging workplace and culture by expanding career pathways, supporting employee wellbeing and work-life balance, ensuring adequate recognition and reward for staff, and establishing effective performance management and feedback system and a supportive organisational culture.

Queensland

Queensland Health Workforce Strategic Plan 2005–10

This plan identifies five strategic objectives:

1. deliver workforce solutions
2. improve staff health
3. recruit, develop and retain appropriately skilled workforce
4. flexible working conditions
5. drive and support innovation and change.

Under these five objectives are a number of action areas to enhance systems, services and staff and facilitate innovation and change. In relation to workforce planning and development, action areas include workforce education and training, workforce design and utilisation, workforce data quality and innovation.

Queensland Plan for Mental Health 2007–17

The plan outlines the priorities for mental healthcare reform and development in Queensland over a 10-year period. It identifies these guiding principles to support service delivery reform:

1. consumer and carer participation – the active support of participation of consumers, families and carers in the full spectrum of workforce activities to meet needs
2. resilience and recovery – the provision of mental healthcare within an operational framework that promotes resilience and recovery
3. social inclusion – access to a system of treatment, care and support that is comprehensive, community oriented, integrated and socially inclusive
4. collaboration and partnership – the operation of the mental health system through inter-sectoral collaboration and partnerships with a range of stakeholders
5. promotion, prevention and early intervention (PPEI) – PPEI is integral to the mental health system and will occur at all levels.

For each priority, the key actions for from 2007–11 and the expected outcomes by 2011 and 2017 are identified. The priorities are:

- promotion, prevention and early intervention – strengthen collaborative action to build individual and community resilience and wellbeing, effectively target key risk and protective factors and facilitate early intervention in known high-risk groups for mental illness
- improving and integrating the care system – enhance and develop the continuum of mental health treatment and care to promote resilience and recovery
- participation in the community – build capacity to assist and support people with mental illness to live full and meaningful lives in the community
- coordinating care – facilitate the linkage of a range of services to provide an integrated system of care

- workforce, information, quality and safety – enhance service capacity to provide high quality, safe and evidence-based mental healthcare.

In relation to workforce, information, quality and safety, the key actions are:

- increase the availability of a skilled mental health workforce
- improve access to mental health service information, including information on consumer perceptions of care, to inform service evaluation and planning
- improve delivery of safe, high quality care through effective quality improvement processes
- increase access to evidence from research to inform service delivery and development.

South Australia

Towards a South Australian Health Workforce Plan (2007)

This broadly covers the health workforce and which talks about the development of the Health Workforce Plan (including example framework areas and strategies – assuming South Australia is in the process of developing this plan). There are also the South Australia Health *Aboriginal Reform Strategy 2009–13*; the *Aboriginal Health Social and Emotional Wellbeing Strategy 2005–10*; and an *Aboriginal Health Workforce Development Strategy 2005–10*. Although the latter does not specifically refer to mental health, it suggests broad strategies to build capacity in the Indigenous and non-Indigenous health workforce working with Aboriginal and Torres Strait Islander people, including:

- establishing effective statewide and regional coordination and monitoring of health workforce development
- establishing and coordinating state and regional labour force and workforce capacity building initiatives
- ensuring accessible training and development opportunities
- clarifying roles and responsibilities of Aboriginal health workers

- › establishing effective statewide and regional workforce planning mechanisms
- › improving support for Aboriginal and Torres Strait Islander people to choose careers in health and to obtain relevant training and skills development
- › improving educational opportunities and health career pathways for Aboriginal Health Workers
- › increasing numbers of Aboriginal and Torres Strait Islander people undertaking health education/training opportunities.

Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007–12

This report, produced by the South Australian Social Inclusion Board, identifies developing a workforce for the future as a key priority and made the following recommendations (pp. 53–60):

- › immediate commencement of structured workforce planning that is geared to sustaining staffing levels in specialist services, to support a stepped system of mental healthcare
- › short, medium and long-term workforce development planning and initiatives to be coordinated across government and non-government sectors; and a dedicated plan for improving training, recruitment and retention of Aboriginal people in clinical positions
- › state government to negotiate private practice rights for psychologists to enhance their career development and support recruitment and retention – other allied health professions should be encouraged to negotiate similar private practice rights
- › state government to develop a job redesign strategy for the mental health system across the continuum of activity from incremental change in existing roles, to designing new jobs that support a mental health system that puts people first and is recovery oriented.

South Australia’s Mental Health and Wellbeing Policy 2009–14 (draft for public consultation)

The principles of the policy are:

- › every South Australian has rights
- › mental healthcare is focused on recovery

- › mental healthcare is consumer centred
- › consumer and carer participation is valued at all levels
- › early in life, early in illness, early in episode (prevention and early intervention)
- › mental healthcare is accessible, evidence based and meets the highest possible standards of safety and quality
- › partnerships and cooperation are the foundation of mental healthcare in South Australia
- › resources for mental health must be used wisely.

Its strategic areas include:

- › rights and responsibilities
- › health promotion, prevention and early intervention
- › access and integration of services
- › specialist mental health services and interventions for high risk groups
- › partnerships and inter-agency cooperation
- › workforce development and planning for the future (priorities include recognition and support, training and development, recruitment and retention, workforce design and cross-sectoral workforce training in mental health)
- › safety and quality
- › knowledge, information management and research.

Aboriginal Health – Everybody’s Business (Health Workforce Development): A South Australian Strategy for Torres Strait Islander People 2005–10

This strategy document provides a guide for health workforce development implementation plans and regional and organisational levels, with an emphasis on a need for a coordinated approach, and statewide, regional and organisational responsibilities and actions. It has five outcome areas:

1. increased clarity of role, recognition and support of Aboriginal health workers (AHWs) in service delivery to ATSI people
2. effective collaborative working relationships established between education, training and health sectors and ATSI people

3. improved matches between workforce ATSI health needs
4. improved capacity and integration of health workforce to contribute to ATSI health and wellbeing
5. increased participation of ATSI people throughout the health workforce.

Broad strategies to achieve these outcomes include:

- improve support for ATSI people to choose careers in health and to obtain relevant training and skills development
- establish effective statewide and regional workforce planning mechanisms
- clarify roles and responsibilities of AHWs
- establish and coordinate state and regional labour force and workforce capacity building initiatives
- establish effective statewide and regional coordination and monitoring of health workforce development
- ensure accessible training and development opportunities for Aboriginal and Non-Aboriginal workforce to meet the health needs of Aboriginal people
- increase number of ATSI people undertaking health education/training opportunities
- improve educational opportunities and health career pathways for AHWs.

South Australian Health Aboriginal Workforce Reform Strategy 2009–13

The strategy outlines six objectives, which match the key areas for action for Aboriginal employment and workforce development. The areas for action are:

1. Systemic reform proposed actions include:
 - redefine the way SA Health systems impact on the engagement, recruitment, retention and development of Aboriginal people
 - develop accountability across mainstream SA Health for Aboriginal health improvement, including a culture of respect and value for Aboriginal peoples' contribution and commitment to providing better outcomes for their people.

2. Engagement:
 - create partnerships across public, private and community sectors to provide a more holistic approach to workforce development
 - create partnerships with Aboriginal people, communities and community organisations to ensure Aboriginal perspectives are captured and are prominent in all of SA Health's planning processes
 - develop techniques and tools that appropriately and sensitively engage Aboriginal people and communities in career opportunities within SA Health.
3. Attraction and recruitment:
 - attract Aboriginal people to South Australia Health as an employer of choice by developing culturally appropriate promotional and marketing campaigns that connect with and engage Aboriginal job seekers
 - develop culturally appropriate recruitment and selection toolkits
 - develop workforce initiatives that capture Aboriginal people throughout their career planning and at each stage of the learning journey
 - attract Aboriginal males to health-related professions.
4. Retention:
 - develop a range of programs and opportunities for Aboriginal employees that will engender retention of the Aboriginal health workforce
 - collect and analyse qualitative and quantitative data on Aboriginal employees across SA Health
 - encourage participation of both Aboriginal males and females by creating opportunities for coaching and mentoring with Aboriginal leaders within SA Health.
5. Aboriginal leadership and development:
 - provide opportunity for Aboriginal people to grow into leadership roles through access to learning and development programs, mentoring and work shadowing

- establish mechanisms and opportunities for Aboriginal employees to access learning and development opportunities to enable them to become further qualified to undertake professional positions.
- 6. Monitoring and reporting:
 - monitor and evaluate the progress of SA Health towards meeting the objectives of this strategy.
 - ensure the capacity for accountable governance, leadership and teamwork within the senior management team
 - implement a professional and clinical supervision framework
 - implement a performance management system
 - provide training and mentoring opportunities

Tasmania

Bridging the Gap (October 2004)

This project provided the Tasmanian government with recommendations in several areas of mental health service delivery, including provision of community-based care, strengthening provision of specialist services in child and adolescent mental health and developing the capacity of NGOs to deliver services, including recovery services.

The Tasmanian Mental Health Services Strategic Plan (2006–11)

The plan aligns with the (then current) National Mental Health Plan and with the Tasmanian Department of Health and Human Services' whole-of-agency collaboration strategy. The agency collaboration strategy is founded on the following five principles:

1. work together in a spirit of cooperation
2. intervene as early as practicable
3. keep the client and their world at the centre
4. find solutions that are fair, creative and affordable
5. design understandable processes.

The plan introduces a new emphasis on providing services that are recovery focused, based in environments providing the least-restrictive care and involve working in partnership with others international and identifies six priority areas for action. The areas of most relevance to workforce in the strategies identified are:

- governance and leadership:
 - develop a governance structure, systems and processes that support the model of care

- workforce development:
 - develop and implement a comprehensive workforce development and innovation plan, in line with the model of care and National Mental Health Workforce Practice Standards
 - build appropriate infrastructure to allow easy access in the workplace to research and evidence-based practice
 - cost requirements for training and clinical supervision, so that dedicated resources are identified and quarantined for the life of the strategic plan
 - submit a business case for additional funding to support workforce development.

The plan includes a process and schedule for monitoring and evaluation of its implementation.

Building the Foundations for Mental Health and Wellbeing: A Strategic Framework and Action Plan for Implementing Promotion, Prevention and Early Intervention (PPEI) Approaches in Tasmania (September 2009) outlines priorities and strategies for Tasmanian Mental Health Services in mental health promotion, prevention and early intervention. Of most relevance to workforce are:

- build the capacity of the mental health sector to work in family sensitive ways through implementation of the Keeping Families and Children in Mind: A Resource for Mental Health Workers project aims, developed by the National Children of People with Mental Illness (COPMI) initiative
- implement workforce development programs to ensure that the workforce in mental health services and community sector organisations have the skills to implement PPEI.

Tasmania's Health Professionals: Leading the Way; Shaping the Future Discussion Paper 2009

Key ingredients contributing to successful healthcare staff engagement identified are:

1. a strong, shared corporate vision that provides a clear direction for action on widespread service improvement
2. an environment and culture that actively supports strong, effective leadership and action at all levels of the health workforce
3. teamwork across all sectors in the community and the hospitals, and professional and work groupings, and valuing the diversity of roles and the contributions of all the health workforce in patient care
4. a vibrant, energised, supported and responsive workforce with new and expanded roles to meet the emerging challenges in healthcare
5. having the time to care in order to provide safe, high quality services to patients
6. a strong safety and quality culture with effective clinical governance structures, and the ability to collect, measure and improve on a range of meaningful, useful patient and clinical care sensitive indicators.

The subsequent *Leading the Way: Tasmania's Health Professionals Shaping the Future – Implementation Plan* (October 2009) articulated four themes and seven outcome areas.

The implementation projects of most relevance to the mental health workforce include:

- improving leadership and the preparation for management for nurses and allied health professionals
- developing preceptor and mentoring programs for nursing and allied health
- introducing health professional innovations in practice awards
- developing extended scope of practice for nursing
- developing extended roles in nursing
- improving education and training pathways to encourage greater flexibility within the healthcare workforce
- developing and implementing a framework to facilitate full and extended scopes of practice for allied health professionals
- implementing a framework for the employment of healthcare support workers.

Table 11: Themes and seven outcome areas in Leading the Way

Theme	Outcome
Valuing people's experience	Patient care focuses on improving the patient experience, and achieves positive health outcomes and satisfaction for the patient. Health professionals see the person in the patient and work with them as a partner in their care.
Safety and quality	The community has access to safe, high quality services that meet its needs at an acceptable cost. Patients and clients receive care based on quality evidence that demonstrates effective clinical outcomes.
Supporting strong leadership at all levels	Leaders are visible and support a clear vision that provides direction for the organisation and its employees. Strong supportive leadership has led to successful service improvement.
New ways of working	Patient care is provided by the appropriate healthcare professional in the appropriate place and at the appropriate time.

Victoria

Because Mental Health Matters: Victorian Mental Health Reform Strategy 2009–19

Core elements of the reform strategy are prevention, early intervention, recovery and social inclusion. The guiding principles are:

- consumer-centred service provision
- family and carer inclusion
- population-based planning
- a social model of health
- equity and responsiveness to diversity
- evidence-based practice.

The strategy identifies eight reform areas:

1. promoting mental health and wellbeing – preventing mental health problems by addressing risk and protective factors
2. early in life – helping children, adolescents and young people (0–25 years) and their families
3. pathways to care – streamlining service access and emergency responses
4. specialist care – meeting the needs of adults and older people with moderate to severe mental illness
5. support in the community – building the foundations for recovery and participation in community life
6. reducing inequalities – responding better to vulnerable people
7. workforce and innovation – improving capacity, skills, leadership and knowledge (including actions such as developing a sustained recruitment and retention program, a program of mental health workforce redesign, an institution for mental health workforce development and innovation with a collaborative centre of excellence for consumers and carers, and a coordinated rolling program of training of staff across sectors)
8. Partnership and accountability – strengthening planning, governance and shared responsibility for outcomes.

Shaping the future: The Victorian mental health workforce strategy (September 2009)

The strategy acknowledges Commonwealth programs of effort, such as increased funded places in higher education, but suggests that existing activities are unlikely to solve current workforce shortages, especially in rural areas. The following actions are proposed as a priority for Victoria's mental health workforce strategy (pp. 5–7).

Short-term strategies:

- develop and implement 12-month recruitment strategy targeting workers who could transition into the specialist mental health workforce to fill existing vacancies
- engage universities, area mental health services and the nurse regulatory authority to progress implementation of the recommendations in the Mental Health Nurse Education Taskforce's (MHNET) mental health in pre-registration nursing course report in Victoria
- upon release, review the recommendations of the evaluation of the mental health major in the Bachelor of Nursing degree and continue to provide in-principle support for its implementation
- undertake a workforce research project for the psychiatric disability rehabilitation and support (PDRS) service sector that further investigates the workforce profile and analyses skills needs and identifies strategies to address recruitment, retention and career pathway challenges
- further develop full-paying scholarships to for nurses to undertake postgraduate education in mental health; further education to enable medication endorsement and expanded scopes of practice and conversion courses
- identify an appropriate, structured, paid undergraduate employment model, similar to that available for nurses working in the acute health sector, in consultation with unions, employers, universities and students to enhance early exposure to the mental health environment

- › undertake a statewide research project investigating workforce stress and satisfaction levels and reasons for exits from the specialist mental health workforce
- › establish a mental health education and training institute that supports multidisciplinary and cross-sectoral approaches to delivering further education and training for clinical and PDRS service workers, consumers and carers.

Medium-term strategies:

- › lobby the Commonwealth Government to align education and training places with projected supply needs
- › implement strategies to improve workload pressures
- › implement the recommendations from the evaluation of the Statewide Education and Training Partnership (Cluster) project
- › develop programs (for example, scholarships, shadowing, mentoring) that identify emerging leaders (clinical, PDRS and managerial) early, and provide these workers with management and leadership training
- › continue to explore opportunities through the Council of Australian Government's (COAG) process to amend Medicare Benefits Schedule (MBS) mental health items to give providers incentive to work in regional and rural areas
- › in consultation with unions, employers, professional bodies and other key stakeholders, identify, promote and disseminate information about innovative workforce models and roles
- › identify options for funding and organisational support during candidature to support an increase in endorsed nurse practitioners within the mental health sector
- › encourage 'grow-your-own' workforce approaches in regional and rural areas
- › maximise opportunities for increased scope of practice for registered nurses
- › investigate the feasibility of increased scope of practice for psychiatric service officers (PSOs) through the utilisation of the Certificate IV Mental Health, Community Services Training Package

- › facilitate the transition of workers from other areas within the health sector to mental health services through improved portability of benefits, transferability of qualifications, identification of core competencies and development of bridging courses to orient existing knowledge and skills to mental health service provision.

Long-term strategies:

- › contribute to the development of an agreed national framework for mental health competency standards and support implementation of existing standards and professional codes.

The strategy proposes establishing a ministerially appointed statewide mental health workforce partnership group comprising key stakeholders, including unions, to provide advice on the implementation of workforce strategies identified in the Victorian mental health workforce strategy and *Because mental health matters*.

Western Australia

Having a healthy workforce is a key component in *Strategic Intent 2005–10: Delivering a healthy WA*. It highlights the need to ensure that workforce planning is responsive to needs and that appropriate workforce planning tools are available to respond to future demands. Action areas under this component include:

- › developing and implementing a statewide strategic workforce plan
- › establishing a vibrant and positive workplace and system culture
- › attracting and retaining the public health system workforce by reducing or eliminating competition between health services and improving rewards, benefits, recognition, incentives and work conditions
- › promoting workforce innovation through workforce redesign, job redesign, deploying new technology, investing in workforce development and training and developing integrated clinical networks across the health system.

Other components in *Strategic Intent 2005–10* are:

- › healthy hospitals
- › healthy partnerships
- › healthy communities
- › healthy resources
- › healthy leadership.

Western Australia is currently undertaking a project to develop the Western Australia Mental Health Policy and Mental Health Strategy Plan 2010–20. Issues identified through the consultation process of this project include:

- › involvement and valuing of consumers and carers
- › accessibility of services
- › recovery and holistic focus
- › continuity of care and service integration
- › service responsiveness
- › workforce capacity and training
- › regional and remote mental health services
- › leadership, governance and accountability
- › CALD mental health services
- › Indigenous mental health services
- › infant, child, adolescent and youth mental health services
- › older adult mental health services
- › forensic mental health services
- › accommodation and housing support.

In 2009 the Western Australia government commissioned consultations and research to develop the *Mental Health Policy and Strategic Plan 2010–20* for WA. Preliminary reports have provided service mapping and the initial results of consultations.

In March 2010 the Western Australia government announced the creation of a Western Australia Mental Health Commission, which will be a separate department, reporting to the Minister for Health, with responsibility for implementing the strategic plan. Although workforce development is not specifically mentioned in the list of responsibilities for the commission, it is assumed that implementation of workforce strategies as outlined in the plan will be included in the commission's responsibilities.⁹

Initiatives contributing to workforce development

A wide range of initiatives to build and enhance Australia's mental health workforce capacity has been developed and implemented since 2006, following the release of the *National Health Workforce Strategic Framework* (2004) and the *COAG National Action Plan on Mental Health 2006–11*.

Mental health workforce development projects and activities have been initiated at national, state and territory levels, as well as by professional bodies and non-government organisations. While there is variation in the focus and range of initiatives across jurisdictions, there is clear evidence that national level strategies, plans and frameworks have guided jurisdictional program development and implementation, and that there is synergy in effort to develop the mental health workforce in Australia.

These workforce initiatives encompass different components of workforce development. They seek to ensure the sustainability of the mental health workforce by:

- › increasing the supply of mental health workers
- › improving the retention of the workforce
- › increasing the accessibility and distribution of the workforce to meet identified needs (for example, in rural and remote areas)
- › optimising the use of skills and roles
- › enhancing the support for the existing workforce and service delivery through a range of education, training and professional development programs (including supervision and mentoring and programs targeting specific population groups)
- › providing greater leadership in workforce development and service planning and delivery
- › increasing the attractiveness of the work environment for mental health workers
- › enhancing workforce research and data collection for policy and planning
- › increasing consumer and carer engagement in workforce development.

⁹ <http://www.health.wa.gov.au/>

It is evident from the initiatives that have been undertaken that the focus has been on increasing supply of mental health workers (in particular, mental health nurses and psychiatrists) and the development and implementation of education and training programs.

A summary of initiatives relevant to the outcome and action areas at federal, state and territory government levels is below. While some of the initiatives relate to broader health workforce development (rather than specific to the mental health workforce), they are critical in the overall effort to increase the supply of mental health workers.

For a more extensive outline of current health and mental health specific workforce initiatives in each state and territory, please see the tables in the Appendix.

University and Vocational Education and Training (VET) places and curriculum development

There is a concentration of initiatives to increase the supply of mental health workers in Australia through undergraduate and postgraduate education and training in mental health-related disciplines.

Nationally and across states and territories, there is consistency in effort to increase exposure to mental health topics and interest in mental health careers through initiatives that aim to:

- create additional undergraduate positions in nursing
- develop new and expand existing mental health streams and components in vocational and university (undergraduate and postgraduate) programs
- develop programs for the upskilling and transition of health workers to specialist mental health services
- provide scholarships in postgraduate programs in mental health-related disciplines, particularly for nursing and psychiatry.

In the Australian Capital Territory, the Northern Territory and South Australia, student and clinical placement programs have also been developed or enhanced. In Queensland, undergraduate support

officers have been employed to educate and connect final-year mental health undergraduates to career opportunities in Queensland Health. National initiatives in this domain have been well translated at the state and territory level.

The Bradley Report on Higher Education (Bradley et al. 2008), and the subsequent reforms announced by the Commonwealth Government in 2009, changed the mechanisms for government to influence the number of university (and eventually vocational education and training, or 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 does not have similar incentives, and the number of places are 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.

In February 2009, after an extensive consultation and review process, the Community Services and Health Industry Skills Council (CSHISC) introduced the CHC08 Community Services Training Package in the VET sector to replace the former CHC02 Community Services Training Package. As part of the review, the former Certificate IV in Mental Health (Non-Clinical) (CHC41102) was replaced by a restructured Certificate IV in Mental Health (CHC40508), which contains mandatory units designed around evidence-based practice and recovery principles and electives, and which covers aspects of working with alcohol and other drug (AOD) and mental health clients. This review process involved a major redesign of the curriculum so that modules are underpinned by a recovery approach. The Certificate IV articulates to a Diploma in Community Services (Mental Health) or a Diploma in Community Services (AOD and Mental Health).

The CHC08 Community Services Training Package includes key mental health and alcohol and other drugs qualifications. These qualifications and relevant competency standards are well integrated to reflect dual issues relating to mental health and substance abuse. There is an existing joint mental

health/alcohol and other drugs qualification at the diploma level. The relevant qualifications include:

- CHC40508 – Certificate IV in Mental Health
- Diploma of Community Services (Alcohol and Other Drugs)
- Diploma of Community Services (Mental Health)
- Diploma of Community Services (Alcohol, Other Drugs and Mental Health).

There are an additional range of skill sets for these areas:

- alcohol and other drugs skill set
- mental health skill set – including responding to risk of suicide
- mental health skill set – including recognising individuals at risk.

A skill set enables a worker to develop skills without recourse to a full qualification. A person with a Certificate IV in Mental Health may undertake the alcohol and other drugs skill set, which equips them for work with dual presenting clients.

As at May 2010 there were 79 registered training organisations (RTOs) offering the new Certificate IV in Mental Health; 14 RTOs offering the Diploma in Community Services (Mental Health); and 23 RTOs offering the Diploma in Community Services (AOD and mental health)¹⁰.

Enrolment and completion numbers in the new articulated vocational program are collected through a number of processes, and the sources of data will vary depending on whether traineeships are involved, such as whether the RTO is a private provider and so on. As at January 2010 the (New South Wales) Mental Health Coordinating Council's Learning Development Unit reports 1,362 Certificate IV enrolments and 229 traineeships, but this figure is not representative of other jurisdictions, and is likely to be higher. This is because traineeships have been developed in three states only (New South Wales, Victoria and Tasmania); not all NGO coordinating bodies have learning development units or are RTOs; and training provider partnership arrangements may vary between community mental health NGOs in

different states and territories. The National Centre for Vocational Education Research (NCVER) is the repository of the data from the various sources, and is likely to be instrumental in working with the relevant agencies, such as Skills Australia, in providing data to inform workforce planning for the mental health workforce in future (as foreshadowed by the Bradley Report 2008).

The Mental Health Skills Articulation Project was a second (research) project led by the CSHISC to identify strategies to meet the demands for skilled workforce in the community mental health sector via the articulation or linkages between VET and higher education sectors. The project highlights the value of enhancing the articulation between the VET and higher education (university) sectors in mental health through credit transfer or recognition of prior learning for those with VET qualifications to enter into a higher education course in mental health and the development of VET-based qualifications and competencies for VET and university-qualified health workers to work in community mental health settings.

The Community Services and Health Industry Skills Council has commenced a project to develop national peer support worker competency standards. There has been good interest within the peer support consumer sector in the project and the first project reference group meeting was held in July 2010.

Recruitment campaigns

Direct recruitment campaigns targeting health graduates and current health workers, both domestically and overseas, have been developed and implemented.

At the national level, the Bringing Nurses Back into the Workforce initiative sought to encourage qualified nurses to return to the health workforce.

There is a focus on the recruitment of mental health nurses in Victoria and Queensland, and on mental health nurse practitioners in New South Wales. There is also work to develop resource and promotional materials to attract potential mental health workers in Tasmania.

In New South Wales, standardised materials have been developed for overseas-trained graduates,

¹⁰ Figures provided by the Learning Development Unit of the Mental Health Coordinating Council, April 2010.

and work is progress to establish a state agency for overseas recruitment. Overseas recruitment excursions to the UK have been undertaken by Western Australia and a London office has been established to facilitate the recruitment of health graduates and professionals in the UK.

Rural and remote workforce

There is a national focus on increasing the supply and accessibility of health and mental health services in rural and remote areas at the national level by providing scholarships for rural and remote health professionals and undergraduate programs in allied health disciplines; support, education and training in rural health; and placing mental health academics in university departments of rural health.

At the state and territory level, rural and remote mental health initiatives are particularly evident in New South Wales, where significant effort has been made to attract and provide incentives and opportunities for overseas-trained doctors, nurses and mental health clinicians to work in rural and remotes. In Victoria, rural psychiatric registrar positions have been developed and funded.

Aboriginal and Torres Strait Islander workforce

At the national level, the Puggy Hunter Memorial Scholarship Scheme, with contribution from the COAG Mental Health Initiative and the Improving the Capacity of Workers in Indigenous Communities initiative, sought to increase the supply of Aboriginal health workers.

At the state and territory level, initiatives to increase the number of Aboriginal mental health workers are most notable in New South Wales and South Australia. In New South Wales, an Aboriginal Mental Health and Well Being Policy 2006–10 was developed and an Aboriginal health worker training program has been implemented across New South Wales area mental health services to recruit trainees from local communities to work in local communities. South Australia has undertaken work to recruit Aboriginal staff in mental health crisis services and as peer workers in inpatient units, establish Aboriginal cadetships and increase the capacity of services to provide culturally

appropriate services to Aboriginal and Torres Strait Islander peoples.

Role development, review and redesign

To optimise the use of the current workforce and increase the supply of mental health workers, initiatives have also involved reviewing, redesigning and creating new roles in mental health services. For example, role reviews have been undertaken in Victoria (for example, senior psychiatric nurse, psychiatric nurse consultant and psychiatric clinical education), New South Wales (scope of enrolled nurses in mental health services) and the Northern Territory (all positions were reviewed against need).

There have been initiatives to scope new support roles (such as psychiatric services officers) in Victoria and assistants in nursing in Western Australia. Initiatives have also been in Victoria to develop and employ psychiatric nurse practitioners and expand the role of existing staff (such as Division 2 nurses) to optimise role utilisation.

Both the Australian Capital Territory and Tasmania have introduced nurse practitioner positions in mental health services.

Career pathways and succession planning

To ensure the retention and sustainability of the mental health workforce, some states and territories have undertaken activities to enhance career pathways and succession planning. Career structures and pathways for nursing have been refined and reviewed in the Australian Capital Territory and Tasmania. Succession planning for the mental health workforce has happened in South Australia and the Northern Territory.

Postgraduate education, training and continuing professional development (including supervision and mentoring)

Initiatives in postgraduate education, training and continuing professional development for mental health workers represent one of the largest areas of investment in mental health workforce. They

include the development of policies, standards and reforms, leadership and governing structures, networks and specific training programs and resources.

At the national level, these initiatives include development of the National Practice Standards for Mental Health, the General Practice Mental Health Standards Collaboration and the Structural Reform of Psychiatry Training Program to move towards a more competency-based system of training in psychiatry. Nationally, initiative mental health education and training programs also include:

- › the Better Access Initiative – national information and orientation sessions
- › the Mental Health Interdisciplinary Networks Project – to deliver a package of training resources and workshops to mental health practitioners
- › ACRRM mental health disorders package – for rural practice
- › Mental Health Support for Drought Affected Communities Initiative – to provide education and awareness training workshops for health workers and community leaders
- › an expanded specialist training program for psychiatry
- › the Mental Health Articulation Project.

At the state and territory level, governing structures, leadership roles and special centres have been established to facilitate the planning and implementation of programs to provide education, training and support to mental health staff.

A Mental Health Education, Training and Support Working Group has been established in New South Wales. Positions such as nurse education and training positions have been developed in Queensland and Victoria. Candidate care officers have also been created in Queensland to enable a more coordinated approach to the orientation, training and development needs of new staff in mental health services. Mental health education and training centres have been established in South Australia (South Australia Mental Health Training Centre) and Queensland (Queensland Centre for Mental Health Learning).

Networks, conferences and forums have also been established to facilitate information sharing in the mental health sector (for example, the Queensland Mental Health Educator Development Network).

Formal orientation, mentoring and supervision programs can be found in the majority of states and territories. A range of education and training programs can be found across states and territories, including:

- › training and supervision programs for overseas-trained mental health workers (for example, South Australia and Tasmania)
- › formal professional development programs in mental health (for example, Queensland and the Northern Territory)
- › child and youth mental health competency training modules (Queensland)
- › a transition-to-practice nurse education program (Queensland)
- › aggression management training programs (Victoria, South Australia, the Northern Territory and Australian Capital Territory)
- › an online program for eating disorders (New South Wales)
- › mental health first-aid (South Australia)
- › team-based supervision model for the rural workforce (South Australia)
- › MulgaNet – a network for info and resource sharing for all those involved in the provision of mental healthcare and prevention in rural Australia (New South Wales).

In Victoria, a post-employment statewide and local education and training strategy has been established (known as the education and training partnerships clusters) to deliver a range of education and training services. A suite of professional development initiatives were also developed through the EBA of psychiatric services.

In New South Wales, mental health training programs have a focus on addressing the needs of specific population groups (such as people residing in rural and remote areas, ATSI peoples, older people, young people and families).

There is a notable shift towards competency-based training in training programs in recent mental health workforce initiatives.

Training and professional development policies and programs are also developed and reviewed at the state and territory level. For example, in South Australia, a mental health mandatory training policy has been developed. In New South Wales, reviews have been undertaken on the New South Wales Institute of Psychiatry mental health education courses and the national health training package.

As well as nationally developed education and training resources, resources developed at the state and territory level have included mental health orientation manuals (for example, in Victoria and the Northern Territory), online learning materials for mental health practitioners (Queensland), guidelines for the management of violent patient behaviours (Western Australia) and assessment tools (for example, in Queensland and Western Australia).

Collaboration and partnerships

Collaborations and partnerships are a key feature of workforce initiatives at the national, state and territory levels. Partnerships have been developed among government and non-government mental health services, education and training providers (for example, university departments), as well as professional bodies (for example, APS, RANZCP, DGP), particularly in the provision of mental health education, training and support programs for undergraduate and graduate students in mental health-related disciplines and current mental health staff.

Collaborations have also been formed in service delivery (treatment and referral pathways, multidisciplinary approach) to increase the accessibility and quality of mental healthcare services for consumers. The national Access to Allied Psychological Services initiative, for example, facilitates the referral of consumers with a mental health disorder from GPs to allied health professionals. In South Australia, a mental health shared care program has been established

based on partnerships between DGP and mental health services. In New South Wales, local child and adolescent mental health services have strengthened links with the education sector (schools and TAFEs) to enhance services provided to children and adolescents. Sector forums and conferences, and participation in interagency meetings and committees, have also provided avenues for collaboration and partnerships.

In Western Australia, the Drug and Alcohol Office (DAO) offers workers in both the alcohol and other drug (AOD) and mental health sectors valuable training opportunities to increase their skill base and confidence in regards to comorbidity. DAO undertakes extensive work with mental health services to deliver AOD training that is tailored to the needs of their staff. In addition to this ongoing training, DAO, in collaboration with the Mental Health Commission, produces a comorbidity themed calendar of training events each year, with events aimed at workers across the sectors.

Increasing the attractiveness of the mental health work environment

In the Australian Capital Territory, Queensland and Victoria, initiatives to improve the work environment for mental health workers include the development and implementation of safe practices, such as organisational health and safety standards and reviews of workloads for mental health staff. Other initiatives seen in the Australian Capital Territory, New South Wales, the Northern Territory, Western Australia and South Australia are intended to increase the family-friendliness of mental health work. They include the introduction of more flexible working hours, the promotion of work-life balance policy and the provision of childcare services for staff.

Leadership, governance, policies and planning

Leadership in mental health workforce development and service planning is provided through the development of mental health strategies and plans, the establishment of governing structures and leadership positions

and the provision of leadership training and development programs.

The principles, objectives, priorities and outcome and action areas identified in national mental health strategies and plans are well reflected at the state and territory level.

In most states and territories, workforce committees, networks or forums have been established to guide workforce policy and service planning, and facilitate the implementation of mental health workforce initiatives. Leadership programs, both generic and mental health-specific, have been developed and provided to senior health officials and clinicians. Specific positions have also been created to provide leadership; for example, in Queensland and New South Wales, mental health nursing adviser roles have been established to oversee the development and implementation of mental health nursing initiatives.

Workforce research and data collection

There are a number of notable workforce initiatives and research projects that have been undertaken at the national and state and territory level to facilitate workforce innovation and reform.

National Health Workforce Taskforce and Health Workforce Australia

The National Health Workforce Taskforce (NHWT) was established in late 2007 as part of the COAG national health workforce reform package to undertake project-based work and provide advice and develop practical solutions for workforce innovation and reform. It is time-limited, project-based and outcome-focused, and operates within the NHWSF. In 2010 the NHWT was subsumed by the national health workforce agency Health Workforce Australia (HWA), which was established through the COAG Health Workforce National Partnership Agreement to reduce the structural barriers across jurisdictions and professional boundaries in the delivery of health services. HWA will assume responsibility for the work program of the NHWT, which encompass three areas:

1. research, planning and data, which involves work relating to macro supply and demand update, supply and demand projections

for designated medical specialities, acute and aged care nursing workforces, allied health workload measures, national data set, modelling, labour force surveys and reports.

2. education and training, which focuses on developing effective and sustainable approaches to clinical education and training, identify core competencies frameworks and health sector education pathways and assess health services vocational education and training uptake.
3. innovation and reform, which entails developing national evaluation framework for health workforce innovation, workforce innovation tools, guidelines and frameworks, research on local national and international innovation initiatives, workforce innovation and reform demonstration projects and pilots and workforce innovation information dissemination.

HWA will oversee initiatives to:

- improve the capacity and productivity of the health sector to provide clinical education for increased university and vocational education and training places
- facilitate immigration of overseas-trained health professionals, and continuing to develop recruitment and retention strategies
- reform the workforce through:
 - system, funding and payment mechanisms to support new models of care and new and expanded roles
 - redesigning roles and creating evidence-based alternative scopes of practice
 - developing strategies for aligned incentives surrounding productivity and performance of health professionals and multidisciplinary teams.

The NHWT has developed a national evaluation framework for workforce innovation and reform demonstration projects. The demonstration projects are commissioned by the NHWT to determine what works in relation to workforce innovation, and the framework is designed to assist applicants with project conceptualisation and planning.

The NHWT has also developed a health workforce planning tool, which is Australia's first agreed

and official national tool to project the health workforce required to ensure that supply is sufficient to meet demand at both the macro and individual profession levels. This tool is intended to assist all levels of government and organisations in health workforce planning through shared methodologies and data sets.

At the state and territory level, workforce-related research activities include:

- › caseload workload research and proposal
- › research to review and establish appropriate service delivery models, practice standards, recruitment and retention strategies and training needs
- › demonstration projects (for example, the mature workers demonstration project in New South Wales)
- › the establishment of research positions and fellowships (with an emphasis on rural and remote areas in New South Wales).

Notably, in Victoria, a Better Skills, Best Care workforce design strategy was developed to support workforce redesign and innovation. The strategy has been implemented in multiple stages, and since 2005–06, the Victorian Department of Human Services has funded a wide range of projects to pilot redesigned support and professional roles in a variety of settings, evaluate existing redesigned roles and explore the potential for new roles and service. As part of this strategy, a workforce innovation grant program commenced in late 2008 with a focus on health workforce innovation and reform projects. The program sought to explore, identify and trial innovations that improve utility of the workforce, and has provided funding to support numerous projects since its commencement.

Consumer and carer engagement

Initiatives to engage consumers and carers in workforce initiatives have occurred predominantly at the state and territory level. These initiatives generally include:

- › development and enhancement of policies and frameworks for consumer and carer participation
- › development and distribution of education and training resources for consumers and carers

- › inclusion of consumer and carer representatives in governing bodies (for example, committees), networks and interview panels
- › appointment of consumer and carer consultants
- › engagement of consumers and carers (both as presenters and participants) in education, training and professional development activities for mental health staff
- › development of links with consumer and carer organisations; for example, by establishing structures or positions to facilitate the links
- › investigation of consumer and carer roles and their training and support needs through consumer and carer forums and related research projects.

Queensland has a consumer and carer career pathway, which indicates roles for peer support workers, consumer advocates and consumer consultants, and consumer roles in service planning and service development. Throughout the state there are approximately 100 consumer companions who work in inpatient units to support inpatients in their stay in acute facilities. Forty consumer and carer mental health workers are employed in district mental health services to support consumers and carers in their navigation of the mental health system, and provide specialised input into treatment and care planning. Additionally, five consumer and care positions are involved in statewide service planning, supervision, training and development of the consumer and carer workforce.

Appendix: Summary tables

National and state and territory mental health workforce initiatives are listed in the following tables. National initiatives are presented in [Table A1](#), followed by each state and territory in alphabetical order.

These summary tables draw on the information supplied by each state and territory to the MHWAC in 2008 (using the template developed in accordance with the principles of the *National Health Workforce Strategic Framework* (NHWSF)) and were updated in 2010 by state and territory government representatives as part of this project.

Table A1: Commonwealth initiatives

Area	Completed, current and ongoing initiatives
Leadership, governance, policy and planning	<ul style="list-style-type: none"> National Health Workforce Taskforce – Health Workforce Agency. National Health Workforce Strategic Framework. Mental Health Workforce Advisory Committee. National Mental Health Plan. COAG National Action Plan on Mental Health 2006–11. National Suicide Prevention Strategy. The National Perinatal Depression Plan. National Health and Hospitals Reform Commission. National Health and Hospitals Reform Plan. National Registration and Accreditation Scheme. COAG Health Workforce National Partnership Agreement. Commonwealth chief nurse and midwifery officer.
Education, training and continuing professional development Collaboration and partnerships	<ul style="list-style-type: none"> Additional Education Places, Scholarships and Clinical Training in Mental Health initiative. Mental Health in Tertiary Curricula initiative. Curriculum Improvement Project (CIP) – structural reform of psychiatry training towards a competency-based training system. Better Access: national information and orientation sessions. Mental Health Interdisciplinary Networks Project – to deliver a package of training resources and workshops to mental health practitioners. ACRRM mental health disorders package for rural practice. Mental Health Support for Drought Affected Communities initiative – to provide education and awareness training workshops for health workers and community leaders. Expanded Specialist Training Program for Psychiatry. Mental Health Articulation Project. Access to Allied Psychological Services (GP to refer consumers with a mental health disorder to allied health professionals). General practice mental health standards collaboration. GP Triple P Program.

Area	Completed, current and ongoing initiatives
Recruitment Rural and remote workforce ATSI workforce Service development and expansion	<p>Mental Health Nurse Incentive Program.</p> <p>Bringing Nurses Back into the Workforce.</p> <p>Mental Health Services in Rural and Remote Areas initiative.</p> <p>Rural GP registrar and GP incentives.</p> <p>Scaling of Rural Health Workforce program.</p> <p>Rural GP locum program.</p> <p>Mental Health Support for Drought Affected Communities.</p> <p>Improving the Capacity of Workers in Indigenous Communities initiative.</p> <p>Puggy Hunter Memorial Scholarship Scheme.</p> <p>Better access to psychiatrists, psychologists and general practitioners through the Medicare Benefits Schedule initiative.</p> <p>Support for Day-to-Day Living in the Community initiative.</p> <p>New Early Intervention Services for Parents, Children and Young People initiative.</p> <p>Response Ability Teacher Education initiative.</p>
Workforce research and data collection	<p>National Registration and Accreditation Scheme.</p> <p>National Practice Standards for the Mental Health Workforce Implementation project.</p> <p>National Health Workforce Work program.</p> <p>Scoping of Community Mental Health (NGO) Workforce Mapping project.</p> <p>Mental Health Establishments National Minimum Data Set.</p> <p>Annual Survey of Health and Community Services Labour Force.</p>
Commonwealth NGO sector-related initiatives	<p>NGO Capacity Building Grants.</p> <p>Improved Services for People with Drug and Alcohol Problems and Mental Illness initiative (targeting AOD sector).</p> <p>Telephone Counselling, Self-Help and Web-based Support Programs initiative.</p>
FaHCSIA initiatives	<p>Personal Helpers and Mentors (PHaMs).</p> <p>National Respite Development Fund.</p> <p>Mental Health Community-Based Projects (MHCBP).</p> <p>Support for Day to Day Living (D2DL) in the Community.</p>

Table A2: NGO sector initiatives

Area	Completed, current and ongoing initiatives
NGO sector initiatives that have hitherto been conducted at the state/territory level	<p>Mental health work traineeships for the non-government health workforce (New South Wales, Victoria and Tasmania).</p> <p>The Mental Health Coordinating Council (MHCC) New South Wales: NGO Development Strategy: Mental Health (2004–07) MHCC Learning and Development Unit – focus on Certificate IV in Mental Health Work the MHCC attends New South Wales Health Mental Health Workforce Advisory Group.</p> <p>The Mental Health Community Coalition in the Australian Capital Territory received a Mental Health Council of Australia Capacity Building Grant to collect workforce data and explore training needs by July 2009.</p> <p>Disability Services Queensland, with the involvement of the Queensland Alliance Mental Illness and Disability Group, commissioned a project to undertake a workforce analysis in the non-government sector.</p> <p>Psychiatric Disability Services Victoria received a Mental Health Council of Australia Capacity Building Grant to collect workforce data and explore training needs by July 2009. It has provided training services for approximately 10 years and recently aligned psychosocial rehabilitation training with Certificate IV in Mental Health Work.</p> <p>The New South Wales Consumer Advisory Group received funding to examine the role of consumer workers, including their role in mental health and drug and alcohol services, and how these roles can be expanded and developed.</p> <p>The Community Services and Health Industry Skills Council has developed VET sector competency standards for peer support workers to be added to the CHC08 Community Services Training Package.</p>

Table A3: Australian Capital Territory Mental Health Workforce Initiatives

Area	Completed, current and ongoing initiatives
Leadership, governance, policy and planning	Mental Health Services Plan 2006.
Tertiary education places and curriculum development	<p>Mental health postgraduate program.</p> <p>Dedicated education unit facilitates experience of clinical learning for undergraduate nursing students – dedicated liaison nurses positions to interact between students and clinicians.</p> <p>Undergraduate enrolled nurses are provided with clinical placements within Mental Health ACT.</p> <p>Development of a program to attract and provide training and support to new graduates in Mental Health ACT.</p> <p>Development of a masters entry level occupational therapy course at the University of Canberra.</p> <p>Registrar training program.</p> <p>Postgraduate Master of Psychology offering clinical and forensic psychology placement with Mental Health ACT.</p> <p>Graduate course social work students offered clinic placements with Mental Health ACT.</p> <p>Undergraduate and graduate occupational therapy students from interstate universities offered clinical placements with Mental Health ACT.</p>

Area	Completed, current and ongoing initiatives
Role development, review and redesign Career pathways and succession planning	<p>Recruitment of two designated mental health RNs to the emergency department of Canberra Hospital to work after hours.</p> <p>Implementation of the first nurse practitioner (consultation liaison) position in Mental Health ACT.</p> <p>Consolidation of career structure and pathways in nursing (for example, reclassification of positions).</p> <p>Advancement for RN1 through personnel upgrade.</p>
Increasing the attractiveness of the work environment	<p>Development of flexible working environments.</p> <p>Effective monitoring and evaluation of safe work practices.</p> <p>Australian Capital Territory public sector nursing and midwifery collective agreement 2007–10.</p>
Collaboration and partnerships	<p>Effective engagement of health, education and training sectors.</p> <p>Workers Consultative Committee (WCC) meetings between Mental Health ACT, nursing, principal nurses and clinical support officer, with representation from the Australian Nurse Federation.</p>
Postgraduate education, training and continuing professional development (including supervision and mentoring)	<p>Introduction of the Learning and Development Framework to enable staff to identify their learning and development needs and discuss ways to enhance their effectiveness and efficiency with their manager.</p> <p>Introduction of performance management agreements, which identify common outcomes and improve communication and feedback between staff and management, and build an environment of improvement and accountability.</p> <p>Consolidation of the implementation of clinical supervision for nurses across Mental Health ACT.</p> <p>Consolidation of the implementation of practice and competence enhancement group for nurses across Mental Health ACT.</p> <p>Implementation of practice and competence enhancement group for nurses across Mental Health ACT.</p> <p>Mental Health ACT training and education program provides staff with access to postgraduate training and education to develop core skills.</p> <p>Enrolled nurses with mental health in Mental Health ACT and Clavary are provided with postgraduate training in mental health in collaboration with La Trobe University.</p> <p>Aggression management training for Mental Health ACT staff.</p> <p>Development of recovery-based knowledge and skills development for health professional staff.</p>
Workforce research and data collection	<p>Australian Capital Territory Health Workforce Plan workload research project.</p> <p>Occupational therapy workforce review project.</p> <p>Industry Skills Council – Australian Capital Territory is a site for interviews for future workforce requirements.</p> <p>Ongoing review and evaluation of current education and training programs and promote culture of learning and development.</p>
Consumer and carer engagement	<p>Mental Health ACT consumer consultants present at professional development and training activities and undertake an educator role.</p> <p>Recommendations from the Consumer and Carer Participation Across Mental Health ACT – A Framework for Action are being implemented.</p> <p>Carers' representation on committees (for example, Mental Health ACT professional development and training committee).</p> <p>Increased engagement of carers as educators.</p>

Table A4: New South Wales mental health workforce initiatives

Area	Completed, current and ongoing initiatives
Leadership, governance, policy and planning	<p>Development and implementation of the New South Wales Mental Health Five-Year Plan.</p> <p>Establish and support the New South Wales Mental Health Workforce Development Subcommittee.</p> <p>Establishment of a Mental Health Education, Training and Support Working Group.</p> <p>New South Wales Health Clinical Leadership Program.</p> <p>Mental Health Nursing Skills Acquisition project: appointment of a principal adviser to oversee workforce initiatives to attract, retain and develop mental health nurses.</p> <p>Establishment of an Mental Health Kids and a SMHSOP principal program adviser.</p> <p>Work with the Australian government to explore the introduction of geographically-based provider numbers as a workforce distribution mechanism.</p> <p>Updated training for the <i>Mental Health Act 2007</i>.</p> <p>New registration pathways for overseas-trained doctors (OTDs) agreed at a national level.</p> <p>Establish a statewide eating disorders service development coordinator.</p> <p>Rural mental health research fellowships.</p>
Recruitment campaigns	<p>Standardised international recruitment – established a state agency for overseas recruitment.</p> <p>Review and develop marketing and promotional materials for nursing and midwifery.</p> <p>Standardised recruitment tool kit to assist area health services to attract, recruit and retain local and overseas-trained graduates.</p> <p>Mental Health Nurse Connect – an initiative to attract nurses, in particular, retired nurses and nurses in other areas in health into the mental health workforce.</p> <p>Provision of a step-by-step guide to apply for jobs for OTDs into areas of workforce shortage.</p>
Rural and remote workforce	<p>Work with DoHA to develop a graded incentive system for OTDs wishing to work as GPs in remote locations (five-year OTD scheme).</p> <p>Support scheme for rural specialists – facilitated two video conferences for rural and remote psychiatrists that identified models of clinical leadership in context of farmers' mental health and wellbeing.</p> <p>Provide incentives and opportunities for nurses to undertake work rotations in rural mental health services.</p> <p>Rural clinician mental health training scholarship program.</p> <p>MulgaNet – a network for info and resource sharing for all involved in the provision of mental healthcare and prevention in rural Australia.</p>
Aboriginal and Torres Strait Islander workforce	<p>Aboriginal mental health and wellbeing policy 2006–10.</p> <p>Aboriginal mental health worker training program and implementation review.</p> <p>Aboriginal Mental Health Workers Mentoring Program.</p>
Tertiary education places and curriculum development	<p>Mental health scholarships for nurses.</p> <p>Development of mental health major in undergraduate nursing programs.</p> <p>Introduction to rural mental health practice – a distance education package to provide support for students in rural mental health placement.</p>

Area	Completed, current and ongoing initiatives
Postgraduate education, training and continuing professional development (including supervision and mentoring)	<p>AGPN – orientation and skills development workshops for drought-affected communities initiative for community support workers.</p> <p>Introduction to rural health – New South Wales Institute of Clinical Services and Teaching.</p> <p>Mental health first-aid for regional health services.</p> <p>Mental health transition program – support for transition to mental health nursing.</p> <p>Develop training materials to support rural mental health practice – New South Wales Institute of Psychiatry graduate certificate in mental health for GPs.</p> <p>Online learning and development opportunities for health programs statewide.</p> <p>Review and development of relevant older people’s mental health education and training programs – benchmarking project for older people’s mental health service.</p> <p>Aboriginal mental health workforce mentoring program.</p> <p>Mandatory training programs.</p> <p>Resourceful adolescents program training – evidence-based health promotion program for young people.</p> <p>Crossing Bridges New South Wales – enhance clinical practice for staff in mental health services when working with families.</p> <p>Implementation of accredited person’s role and training program.</p> <p>Eating disorders online learning program.</p> <p>Develop specialised mental health training programs for enrolled, including distance education.</p> <p>Review New South Wales Institute of Psychiatry mental health education courses.</p> <p>Ensure beginning Specialist Mental Health Services for Older People community clinicians are equipped with core competencies.</p> <p>Develop and implement on a trial basis core competencies for beginning Specialist Mental Health Services for Older People community clinicians.</p> <p>Review of national health training package.</p> <p>IMET reviews – vocationally specialty training reviews to provide better governance and support for trainees in area health services.</p>
Role development, review and redesign	<p>Increase the number of nurse practitioner roles in mental health.</p> <p>Promote and review scope of enrolled nurses in mental health.</p> <p>Review of current primary allocation centres – allocation of postgraduate Year 1 and 2 junior medical officers.</p>
Increasing the attractiveness of the mental health work environment	<p>Ensure access to childcare and eldercare services.</p>

Area	Completed, current and ongoing initiatives
Workforce research and data collection	<p>Development of mental health nursing workload tool.</p> <p>Recruitment and retention focus groups with specialist mental health services for older people community clinicians.</p> <p>Rural mental health research fellowship to address mental health needs in rural areas.</p> <p>Enhance the research capacity of New South Wales rural and remote mental health and drug and alcohol workforce – establish research positions.</p> <p>The Mature Workers Demonstration project.</p> <p>Older People’s Mental Health Community Workforce Survey 2007.</p> <p>Clinical placement project – develop a statewide agreement for area health services with education providers and assess demand and supply for clinical placements and identifying existing relationships between education providers and health services.</p> <p>Identification of current and future workforce requirements – workforce projections for key health professions to 2015 (reviewed annually).</p> <p>Staff surveys – regular climate surveys to monitor trends in staff attitudes and satisfaction.</p> <p>Annual labour force surveys of registered health professionals in the public and private sectors.</p>
Collaboration and partnerships	<p>New South Wales rural mental health conference 2008.</p> <p>School link to strengthen links and skills at local and area level between TAFE, schools, school and TAFE counsellors and local child and adolescent mental health services.</p>
Consumer and carer engagement	<p>Consumer workers forum to address consistency in roles, training and support across the state for consumer workers.</p> <p>TeleWest video conference carers session.</p> <p>Funding for New South Wales Consumer Advisory Group to examine the role of consumer workers, including their role in mental health and drug and alcohol services, and how these roles can be expanded and developed.</p>

Table A5: Northern Territory mental health workforce initiatives

Area	Completed, current and ongoing initiatives
Leadership, governance, policy and planning	<p>Annual planning workshops to identify priorities for NTMHS now established.</p> <p>Increase resourcing towards workforce development initiatives.</p> <p>Establishment of clinical governance structure.</p> <p>Establishment of the Northern Territory Quality Coordination Group.</p> <p>Seclusion reduction and restraint initiative ongoing.</p>
Tertiary education places and curriculum development	<p>Graduate nurse program includes mental health placement.</p> <p>Northern Territory scholarships available across all disciplines.</p> <p>Northern Territory-wide review of nurse education being undertaken.</p>
Postgraduate education, training and continuing professional development (including supervision and mentoring)	<p>Training, education and quality group established to provide support for quality initiatives generated by staff and coordination of professional development opportunities.</p> <p>Access to higher education programs for specialist mental health awards supported financially and with study time.</p> <p>Regular aggression management training for all mental health service staff.</p> <p>Mental health workplace and clinical practice orientation manuals developed and distributed to all staff on entry into specialist mental health services.</p>

Area	Completed, current and ongoing initiatives
Role development, review and redesign Career pathways and succession planning	<p>Succession planning to be established for team leaders and other senior staff.</p> <p>Review of all job descriptions of vacant positions against needs – recruit to needs.</p> <p>Establish practice review mechanisms based on professional standards and job descriptions.</p> <p>Work partnership plans being undertaken.</p>
Increasing the attractiveness of the mental health work environment	<p>Appoint staff on full-time permanent basis than short-term contracts, where possible.</p> <p>Development of flexible work hours and rostering systems to accommodate staff and workplace need.</p> <p>Medical staff 2008 EBA provided more attractive conditions/salary.</p>
Collaboration and partnerships	<p>Participate in all of government meetings to ensure awareness of needs of mental health services are maintained.</p> <p>Shared care policy and framework for alcohol and other drugs, FACS, aged and disability, mental health developed and introduced, inclusive of information sharing.</p>
Workforce research and data collection	<p>Surveys to identify potential areas for improvement in recruitment and retention.</p> <p>Identified gaps in staff knowledge and skills and establish discrete professional development opportunities to reduce these gaps.</p>
Consumer and carer engagement	<p>Established client and carer participation policy and framework.</p> <p>Consumers and carers included on relevant recruitment committees.</p> <p>Introduced consumer consultants.</p>

Table A6: Queensland mental health workforce initiatives

Area	Completed, current and ongoing initiatives
Leadership, governance, policy and planning	<p>and Safety. Aims to enhance and strengthen the capacity of services to provide high quality, safe and evidence-based mental healthcare. This will be achieved through: increased availability of a skilled mental health workforce; improved access to mental health service information; improved delivery of safe, high quality care through effective quality improvement processes; and increased access to evidence from research to inform mental health service delivery and development.</p> <p>\$690,000 has been allocated to improve workplace culture and leadership, including programs to provide support to professional supervisors. The leadership development project aims to: promote professional development in the leadership and management through the offering of scholarships and sponsorships to undertake health leadership postgraduate studies; establish cohorts of senior leaders and middle managers from throughout the state to develop actions to operationalise the initiatives associated with the statewide implementation of the Queensland Plan for Mental Health 2007–17; and develop specialised mental health leadership development programs within the mental health directorate.</p> <p>The establishment of clinical governance structures to support clinical reform of service delivery.</p> <p>Queensland Plan for Mental Health 2007–17: Priority 5 – Workforce, Information, Quality Mental Health Workforce Advisory Committee – aims to coordinate multidisciplinary workforce initiatives health and mental health.</p> <p>Mental Health Workforce Executive – aims to: coordinate workforce initiatives and learning and development initiatives across the state; develop a statewide mental health workforce plan to inform resource allocations associated with Phase II of the Queensland Plan for Mental Health 2007–17 (2012–17); and inform the direction for workforce planning and development.</p>

Area	Completed, current and ongoing initiatives
	<p>Mental Health Nursing Reference Group chaired by the mental health nursing adviser – aims to provide high level leadership and coordination in the development and implementation of mental health nursing initiatives statewide</p> <p>Allied health mental health professional leaders provide high level leadership and coordination in the area of professional development and supervision for allied health across adult and child and youth mental health services.</p> <p>Project initiated to develop a <i>Queensland Mental Health Workforce Plan 2011–17</i> to inform the investment in Phase II of the <i>Queensland Plan for Mental Health 2007–2017</i>. This plan will define resource allocation, future directions of the workforce and a learning and development framework which includes strategic partnerships with the tertiary sector.</p> <p>In 2010 Queensland undertook a piece of work to define a workforce development plan for Indigenous mental health workers. This plan looks at professional development, clinical supervision and succession planning issues facing the Indigenous mental health workforce.</p> <p>Queensland has an Older persons’ statewide service which looks at linking service planning and workforce needs.</p> <p>Queensland Mental Health has a rural and remote project which is developing service models, which include service delivery and workforce planning.</p>
Recruitment campaigns	<p>Mental health workforce officers: three statewide positions look at candidate management of new recruits to Queensland’s mental health services, as well as promotion and marketing of mental health as a vocation of choice to undergraduate health professionals considering a career in mental health.</p> <p>Mental health nursing recruitment and retention project (Southern Area and Central Area Health Service).</p> <p>Recruitment, assessment, placement, training and support for international medical graduates.</p> <p>Partnerships with WorkForUs (Queensland Health centralised recruitment and marketing department) to develop recruitment and marketing campaigns for new hospital builds and associated workforce requirements. This includes overseas recruitment, marketing interstate and to skilled clinicians in other industries.</p> <p>The development of an incentive payment scheme/cadet training positions to encourage undergraduates to take up opportunities within mental health services.</p>
Role development, review and redesign	<p>Clinical reform project: supports district mental health services to reform service delivery to align more effectively with the priorities, principles and policies associated with the <i>Queensland Plan for Mental Health 2007–17</i>. The project will involve work with district mental health services to develop, implement and evaluate targeted change management plans that incorporate changes to organisational structures, processes, and clinical practices.</p> <p>Allied health initiated review of models of service delivery for mental health services.</p> <p>Established additional nurse educator positions and training for mental health nurses as preceptors</p> <p>Created, piloted, evaluated and have now expanded consumer companion positions in acute settings, employing people with lived experience. Queensland has a consumer and carer career pathway, which indicates roles from peer support workers, consumer advocates, consumer consultants and consumer roles in service planning and service development. Throughout the state there are approximately 100 consumer companions who work in inpatient units to support inpatients in their stay in acute facilities. Forty consumer and carer mental health workers are employed in district mental health services to support consumers and cares in their navigation of the mental health system, and provide specialised input into treatment and care planning. Additionally, five consumer and care positions are involved in statewide service planning, supervision, training and development of the consumer and carer workforce.</p>

Area	Completed, current and ongoing initiatives
Tertiary education places and curriculum development	<p>Joint appointment between mental health services and University of Queensland in the area of social work. Planning underway to create four additional joint appointments across disciplines between mental health services and the tertiary sector.</p> <p>Transition to practice nurse education program for new graduate RNs entering the mental health sector and general RNs entering the mental health specialty.</p> <p>Postgraduate training in psychiatry – trainees in psychiatry and international medical graduates.</p> <p>Nurse practitioner scholarships.</p> <p>Mental health scholarships for endorsed mental health nurses and other clinically skilled health professional to deliver mental health services.</p> <p>Partnerships with tertiary sector via MHNET project.</p> <p>Queensland has the Queensland Centre for Mental Health Learning (QCMHL), which is a centralised body of learning and development resources and expertise.</p>
Postgraduate education, training and continuing professional development (including supervision and mentoring)	<p>Queensland Centre for Mental Health Learning to provide strategic direction and coordination in mental health education and training.</p> <p>Establish a training resource centre to facilitate access to high quality training and clinical resources at individual or organisational level.</p> <p>Child and youth mental health competency training modules.</p> <p>Statewide mental health workforce development program.</p> <p>Development of the statewide mental health clinical supervision guidelines and implementation strategy to promote clinical and practice supervision for clinicians.</p> <p>Implementation of a standard suite of assessment forms.</p> <p>Mental health e-learning project – e-learning materials for mental health practitioners – <i>QCMHL Mental Status Examination Training</i> interactive DVD.</p> <p>The Acitve8 program, which looks at improving the physical health of mental health consumers.</p>
Increasing the attractiveness of the mental health work environment	<p>Establishment of a project to explore innovative mechanisms to promote and market mental health as a vocation of choice to undergraduate health clinicians and skills health professionals.</p> <p>Promote safe workplaces.</p> <p>Workplace culture surveys and associated action planning in response to same.</p> <p>Workforce officers to facilitate and implement outcomes from workplace culture and leadership survey.</p>
Collaboration and partnerships	<p>Mental health educator development network – to facilitate sharing of information, upskilling and consistency, and broader sharing of education resources and experiences within the current group of designated district educators in mental health services.</p> <p>Interagency collaboration.</p>
NGO sector-related initiatives	<p>Evaluation of the <i>Queensland Plan for Mental Health 2007–17</i> incorporating the development of resources associated with the plan.</p> <p>Provision of resources to provide leadership development to NGO workforce.</p>
Workforce research and data collection	<p>Description of current mental health workforce through collection and analysis of existing data and workforce survey.</p> <p>Specialist models of care – innovative workforce models of care in the Queensland plan for mental health.</p>

Area	Completed, current and ongoing initiatives
Consumer and carer engagement	<p>Develop education package on consumer carer participation that includes guidelines, tools and strategies to inform practice.</p> <p>Establishment of consumer and carer supervision positions to supervise consumer and carer consultants.</p> <p>Implementation of consumer and carer career structure.</p> <p>Creation of new consumer companion roles (see 'Role development' above).</p>

Table A7: South Australian mental health workforce initiatives

Area	Completed, current and ongoing initiatives
Leadership, governance, policy and planning	<p>Statewide workforce development group.</p> <p>Statewide health leadership program – enhance management expertise.</p> <p>Allied health clinical leadership program in mental health.</p> <p>Mental Health and Wellbeing Policy.</p> <p>Stepping Up, the mental health reform plan for 2007–12.</p>
Aboriginal and Torres Strait Islander workforce	<p>Appointment of Aboriginal Families Worker for Murray Bridge CAMHS.</p> <p>Aboriginal/Indigenous cadetship.</p> <p>Recruitment for ATSI staff to be located in the mental health crisis services and for peer workers in inpatient units.</p> <p>Develop modules to assist mainstream Aboriginal health services develop and maintain partnerships.</p>
Tertiary education places and curriculum development	<p>Give broad exposure to child and adolescent mental health for students who are doing their postgraduate training to aid interest in mental health.</p> <p>Targeted entry into workforce as GDMH nurse.</p> <p>MOUs with Flinders University and the US in social work.</p> <p>Establishment of scholarships in psychology.</p> <p>Employ graduate officers in psychology.</p> <p>Student placement program to facilitate recruitment – psychology and social work.</p>
Postgraduate education, training and continuing professional development (including supervision and mentoring)	<p>Adoption of a model of inbuilt supervision in teams to assist with common issues of rural workforce such as lack of supervision and training.</p> <p>Aggression mental health training.</p> <p>Mental health first-aid training.</p> <p>Mentoring and preceptorship program available for all new nursing staff and students.</p> <p>Orientation program redevelopment for all new staff.</p> <p>Training program for overseas-trained psychiatrists.</p> <p>South Australia mental health training centre.</p> <p>Development of Southern Mental Health mandatory/statutory training policy.</p>
Collaboration and partnerships	<p>Mental health shared care program – partnerships between DGP and mental health services.</p> <p>Partnerships between tertiary institutions, professional bodies and mental health services.</p>
Increasing the attractiveness of the mental health work environment	<p>Flexible working environment – good information technology structure and support.</p> <p>Creation of a web page to discuss role of mental health nurses in emergency departments and show supports available to staff.</p> <p>Ensure rosters are attractive (for example, proportion of night duty, possibility of part-time work).</p>

Area	Completed, current and ongoing initiatives
Role development, review and redesign Career pathways and succession planning	Multi-tiered clinical levels from base grade to chief clinician established. Credentialling project – ensure credentials and scope of practice are checked. Emergency mental health alcohol and drug workforce development program. Identification of at-risk workforce groups for purposes of succession planning.
NGO sector-related initiatives	Workforce analysis of NGO mental health sector regarding training through the VET sector.
Workforce research and data collection	Climate surveys in each area of the Southern Mental Health Service conducted on a regular basis to monitor trends in staff attitudes and satisfaction. Strategies to address workforce information collation, provision and quality are being developed. Consultation with stakeholders in the old seven regions regarding issues with service delivery and the accessing of services for Aboriginal people across the state. Metabolic monitoring project – DoH with community mental health nurses.
Consumer and carer engagement	Consumer and carer participation framework – developing structures, resources and training to support the employment of carers as peer specialist workers, consultants and educators. Youthlink project – linking with young people with mental health issues. Working with the One Voice Network – a network of consumers and carers advocating for Mental health services. Statewide consumer and carer forum. Mental health consumers consultant employed at Department of Health. Mental health carer consultant employed at Department of Health.

Table A8: Tasmanian mental health workforce initiatives

Area	Completed, current and ongoing initiatives
Leadership, governance, policy and planning	The <i>Tasmanian Mental Health Strategic Plan 2006–11</i> has a specific focus within action areas on workforce development and sustainability. The <i>Workforce Development Plan 2010–15</i> has a focus on six key areas: workforce competence, leadership and change management, research and innovation, evaluation and monitoring, recruitment and retention and partnerships and collaboration. Workforce innovation and development unit established for the coordination of strategic workforce development across state and correctional health, mental health and addiction services. Implementation of a new clinical governance framework for mental health services, including professional supervision and workforce development committees (multidisciplinary). Whole-of-state policies and procedures adopted for clinical supervision. SMHS involved in planning whole-of-agency program for leadership development. Reform of model of care within the mental health service (to improve coordination of care).

Area	Completed, current and ongoing initiatives
Recruitment campaigns	<p>International recruitment campaign for nursing and medical staff conducted in 2008 and 2010, with a focus on the UK.</p> <p>Development of resources and promotional materials for interested overseas and interstate applicants.</p> <p>Transitional program for new graduate registered nurses extended into addiction and mental health settings.</p> <p>Scholarships available for postgraduate studies in mental health and currently planning to extend to addictions services.</p>
Tertiary education places and curriculum development	<p>Provision of mental health nursing postgraduate diploma scholarships.</p> <p>Collaboration with University of Tasmania for nursing and allied health professionals to gain specific qualifications in postgraduate mental health</p> <p>Undergraduate program through UTAS redeveloped in 2009 to implement relevant MHNET recommendations.</p> <p>Graduate diploma clinical rotation programs to enhance study with relevant clinical experiences continue through variety of settings to give broad exposure and skills.</p>
Postgraduate education, training and continuing professional development (including supervision and mentoring)	<p>Development of education and training practices that target multidisciplinary care-based and team-based approaches.</p> <p>Core training program developed for mental health services staff; planning to extend to correctional and addiction services.</p> <p>Development of proposal for accelerated training programs for allied health staff.</p> <p>International medical graduates supervision program implemented.</p> <p>Statewide supervision and peer-review program implemented.</p>
Role development, review and redesign	<p>Bridging the gap review implementation project – recruitment of 48 new staff to newly established positions.</p> <p>Establishment of director of training position and advanced registrar training positions.</p> <p>Establishment of OT positions in adult community services.</p> <p>Introduce a new level of nurse practitioner into mental health services.</p> <p>Allied health salary scale review – recommendations have been adopted.</p> <p>Review of structure for nursing currently underway outside of EBA process.</p> <p>Psychology review undertaken across whole of DHHS.</p>
NGO sector-related initiatives	<p>Identify workforce issues in mental health service-funded NGO.</p> <p>NGO workforce development project.</p>
Workforce research and data collection	<p>Mapping and profiling of the workforce mental health services.</p> <p>Workforce development review of the community sector mental health. Workforce completed by MHCT and report <i>Growing Forward</i> completed.</p>
Consumer and carer engagement	<p>Development of consumer and carer participation framework and subsequent implementation plan.</p> <p>Appointment of senior consumer and carer consultant to progress implementation of the plan across the state.</p>

Table A9: Victorian mental health workforce initiatives

Area	Completed, current and ongoing initiatives
Leadership, governance, policy and planning	<p>Shaping the future: The Victorian mental health workforce strategy.</p> <p>Establishment of a Victorian mental health workforce development and innovation institute.</p>
Recruitment campaigns	<p>Mental health nurse recruitment and retention campaign.</p> <p>Mental health workforce marketing campaign.</p>
Rural and remote workforce	<p>Development of the rural medical partnership project to identify incentives for medical staff (psychiatrists) to work in rural areas.</p> <p>Development and funding of additional rural psychiatric registrar positions.</p>
Tertiary education places and curriculum development	<p>Development of a mental health stream in undergraduate nursing.</p> <p>Development and enhancement of graduate nurse programs in mental health.</p>
Role development, review and redesign Career pathways and succession planning	<p>Expand the role of Division 2 nurses for better role utilisation within the public mental health system.</p> <p>Review of senior psychiatric nurse, psychiatric nurse consultant and psychiatric clinical educator positions.</p> <p>Scoping (expansion) of psychiatric services officer roles to support nursing and allied health nursing staff to maintain a clinical focus.</p> <p>Develop, support and use of psychiatric nurse practitioners.</p> <p>Review how public mental health services currently utilise psychiatric service officers.</p> <p>Development of a policy framework for clinical academic positions and activity.</p>
Increasing the attractiveness of the mental health work environment	<p>Industry occupational health and safety interim standards for preventing and managing occupational violence and aggression established.</p> <p>Identifying and actively supporting implementation of innovative and safe practices (service implementation of the Interim OHS standards for mental health services).</p> <p>Establishing public-private practice working arrangement for allied health professionals working in public mental health.</p>
Postgraduate education, training and continuing professional development (including supervision and mentoring)	<p>Fund and appoint nurse training and development positions.</p> <p>Support aggression management training for staff across specialist mental health services (part of the education and training partnerships project clusters).</p> <p>Development and distribution of a mental health orientation manual to support education and training in the sector.</p> <p>Post-employment statewide local education and training (the education and training partnerships clusters).</p> <p>Establishment of the Victorian dual diagnosis reciprocal rotation project.</p> <p><i>Victorian Psychiatric Services Certified Agreement 2004–07</i> (2009 varied and extended version) professional development initiatives, including postgraduate mental health nursing scholarships and study placements for Division 2 nurses completing Bachelor of Nursing degrees.</p> <p>Developing curriculum for the newly created Diploma of Community Services (Mental Health).</p> <p>Undertaking a training needs analysis for the psychiatric disability rehabilitation and support workforce.</p>

Area	Completed, current and ongoing initiatives
Collaboration and partnerships	Sector forum and conference support. Convening partnership and stakeholder groups including the Specialist Mental Health Workforce Partnership Group, Statewide Education and Training Providers Forum and the Psychiatric Services Agreement Implementation Group.
Workforce research and data collection	<i>Victoria direct mental health workers: public mental health workforce study 2003–04 to 2011–12.</i> <i>Nurses in Victoria: A supply and demand analysis 2003–04 to 2011–12.</i> Mental health research fellowships. Develop, implement, monitor and evaluate a statewide caseload management standard.
Consumer and carer engagement	Carer and consumer survey – develop and implement tools and processes for meaningful consumer and carer participation in service planning, evaluation and improvement. Support consumers to attend international leadership initiatives. Enhancement of a consumer delivered service model – implement a support model based on needs assessment.

Table A10: Western Australia mental health workforce initiatives

Area	Completed, current and ongoing initiatives
Leadership, governance, policy and planning	<i>Mental health workforce strategic plan 2008–09.</i> Mental health staffing attraction and retention work plan. Mental health workforce strategic committee. Mental health management and leadership program. Declaration of metro and rural regions as areas of unmet need for psychiatrist and junior medical officers. The statewide Clinical Risk Assessment and Management Policy. Development of the statewide Core Competency Framework. Development of statewide generic Cultural Competency Standards for public mental health workforce.
Recruitment campaigns and other incentives	Overseas recruitment excursions – UK in 2008–09. UK marketing campaign. Establishment of London office to provide local contact and coordinate UK-based recruitment excursions. Interstate recruitment drives in Melbourne. Recruitment of HR consultants to assist with recruitment. Relocation cost reimbursement for new overseas and interstate employees. Intensive examination preparation for overseas-trained psychiatrists for IMG RANZCP clinical examination.

Area	Completed, current and ongoing initiatives
Tertiary education places and curriculum development	<p>Postgraduate mental health nursing course with a strong component of clinical experience.</p> <p>Postgraduate mental health nursing scholarships.</p> <p>Postgraduate mental health scholarships for allied health professionals.</p> <p>In Western Australia, the Drug and Alcohol Office (DAO) undertakes extensive work with mental health services to deliver AOD training that is tailored to the needs of their staff. The DAO, in collaboration with the Mental Health Commission, produces a comorbidity themed calendar of training events each year, with events aimed at workers across the sectors.</p>
Increasing the attractiveness of the mental health work environment and other incentives	<p>Work-life balance policy.</p> <p>Family-friendly initiatives (for example, additional childcare programs, flexible work practices, vacation care programs, telecommuting).</p> <p>Valuing of junior staff input into services.</p>
Workforce research data collection	<p>Document and collate current workforce activities as part of the development of the strategic plan.</p> <p>Assistants in nursing pilot.</p>
NGO sector-related initiatives	<p>NGO standards implementation and monitoring.</p>
Consumer and carer engagement	<p>Statewide consumer participation project – a position established in an area mental health service to link consumers, clinicians and policy makers to facilitate effective partnerships between service providers and consumers.</p> <p>Peer advocacy support workers.</p>

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