Final report on workforce requirements in support of the 2014 NATIONAL REVIEW OF MENTAL HEALTH PROGRAMS AND SERVICES

October 2014

Human Capital Alliance (International) Pty Ltd (HCA) for the National Mental Health Commission, Australian Government
Human Capital Alliance

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Suggested citation


Acknowledgements

We acknowledge this country as belonging to the Aboriginal and Torres Strait Islander peoples of Australia. Australia is the only place in the world where Aboriginal and Torres Strait Islander Australians belong. There is no place in Australia where this is not true.

We acknowledge and appreciate the time and efforts of the many stakeholders who made themselves available in interviews that provided extremely valuable information for this research project. In addition, we appreciate the direction and contribution from the National Mental Health Commission’s (NMHC) project team.
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Executive summary

Background

The National Mental Health Commission (NMHC) is currently undertaking a national review of mental health programs and services. As part of the review NMHC commissioned Human Capital Alliance (HCA) to examine and advise on the workforce requirements to respond to new mental health service and support approaches in Australia across clinical, non-clinical, community and personal programs and supports in the health, community and other relevant sectors.

The specific issues to be examined included: workforce trends, workforce requirements for services and approaches broadly and with a focus on specific communities and groups, workforce supply/demand issues, and training and education needs of the workforce.

In addition to these issues, HCA has carried out this project in the context of the Terms of Reference of the national review, namely:

“This review will examine existing mental health services and programmes across the government, private and non-government sectors. The focus of the review will be to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community.”

Conceptual approach

A fundamental principle and philosophy of the workforce analysis approach taken to this study was that workforce thinking needs to be demand driven. Demand for workforce is derived from the work performed, which in turn is determined by demand for services.

In this analysis two types of service scenarios or pathways are considered — one which follows current service delivery trends and another which follows an aspirational service model where future services are consumer centred and recovery oriented. That is, the needs of consumers who require services and supports should inform how the workforce is planned, prepared and developed.

In the short term the workforce interventions for both pathways overlap, but over the longer term interventions intended to develop a workforce for an aspirational service model are significantly different.

Short term workforce interventions

In the short term the emphasis needs to be on removing current shortfalls in supply of key mental health workforces including mental health nurses, psychiatrists and key allied health professions. Mental health nurse workforce numbers constitute the most immediate threat to both short and long term service ambitions, and so should be the primary focus. Investment in increased postgraduate nursing training (one year) should yield the best return, particularly if the newly trained nurse supply can be deployed almost exclusively in the primary health care setting.
The psychologist workforce also seems like a good context for investment although the uncertainty about many aspects of supply need to first be removed to support more informed decisions.

**Interventions to support an aspirational service model**

The workforce requirements needed to meet the demands and to respond to new services and approaches, would largely fall into three broad workforce groups:

1. Primary Health Care;
2. Self-help strategies; and,

A strong theme that emerged from this project is that the peer support workforce will feature in each of these workforce groups and will need to be considered in the workforce planning process.

**Summary of key workforce interventions**

A number of workforce interventions have been recommended throughout the report with suggested implementation timeframes (a full list is provided in Chapter 7). There are too many to list in this executive summary however, the ones that will provide the most significant return on investment include:

- **Retrain Registered General Nurses into Mental Health Nurses** — In the short term the projected shortage of mental health nurses in 2016 of just over 1,000 (or approximately 7% of the workforce demand) is best reduced by a stop gap training intervention, one that can deliver supply quickly. The only way that is possible is to train current registered nurses into mental health nurses, which in theory requires only one year. Transferring 1000 nurses from the general to the mental health workforce will have limited impact on the general registered nurse population (less than 0.5%) but will dramatically impact on the number of mental health nurses.

- **Undertake a specific study of the psychologist workforce** — The psychology workforce, whether registered or not, seemingly holds the greatest potential for a rapid and sustained response to demand from mental health services for labour. And yet, so much about the workforce and its actual capacity is unknown or shrouded in uncertainty. A study needs to be commissioned to clarify actual supply of the clinical and support, registered and non-registered workforce, currently working in mental health services.

- **Build the capacity of the Primary health care (PHC) sector to significantly and pragmatically increase service access to a greater proportion of persons with a mental health problem and improve the delivery of mental health promotion and the likelihood of earlier intervention**. Recommendations have been made to develop the mental health competence of General practitioners (GP) and PHC collaborative teams to provide them with appropriate support services and decision making tools to assess and manage the mental health needs of their patients.

- **Colocation of a proportion of Community mental health team (CMHT) resources within PHC to provide advice, support, educate and mentor the PHC sector in its role in mental health assessment and management** – Creating a PHC mental health consultancy team in
each Local Health District (LHD) to support general practices would provide second opinions, support assessment practice and provide opportunistic training of GPs and practice nurses.

- **Support the development of the Peer support workforce throughout all sectors of the mental health workforce** - twelve recommendations have been made to enable this workforce to continue to develop as a key occupation within the mental health workforce.

- **Establish the infrastructure for capability [competency] based workforce planning and development for mental health services** — includes improved data collection systems based on care plans with associated workforce impact assessments.
1. Introduction

The brief

Human Capital Alliance (HCA) was contracted by the National Mental Health Commission (NMHC) to provide expert advice on workforce requirements for the 2014 National Review of Mental Health Programs and Services (the Review). The scope of the Review is established by the following Terms of Reference:

“This review will examine existing mental health services and programmes across the government, private and non-government sectors. The focus of the review will be to assess the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill health and their families and other support people to lead a contributing life and to engage productively in the community.”

Within these broader Terms of Reference advice was sought from HCA on the current, emerging and potential mental health workforce and in particular workforce requirements to respond to new service and support approaches in mental health programs and services in Australia. The scope included clinical, non-clinical, community and personal programs and supports in the health, community and other relevant sectors. More specifically the workforce study was intended to address the following requirements:

a. Document the main workforce trends for mental health services and supports, especially with regard to new models of care and psychosocial disability support services;

b. Examine and identify the workforce required for new service and support approaches;

c. Examine and identify workforce responses and successful approaches used in working with specific communities and groups;

d. Identify elements for inclusion in education and training programmes for new workforce categories;

e. Identify workforce supply/demand issues at the current time and the foreseeable future;

f. Review of training programmes/courses for the mental health workforce, identifying current and potential curricula issues within these programmes; and,

g. Review of training programmes for para-professionals within the mental health workforce, identifying current and potential curricula issues within these programmes.

HCA conducted a review of the literature on mental health policy, service structures, and workforce implications. The NMHC’s Interim report (June 2014) provided an important core document for HCA to determine the direction of future mental health services being advocated for by the NMHC, however many other references were explored some of which are cited in this report.

In addition a valuable understanding of the current and potential face of future mental health services was able to be collected through fourteen key informant interviews, the subjects for which were selected in conjunction with the NMHC.
Finally data was able to be obtained from mostly published sources and re-analysed for the purposes of this study. This included data from Health Workforce Australia (HWA) on a series of mental health workforce projects and from the Australian Institute of Health and Welfare (AIHW) sourced from the registration authorities and from a public sector services minimum data set. Further data being collected by NMHC on services funded by the Commonwealth Government (through Medicare Benefits and the Pharmaceutical Benefits Schemes) and text data from submissions was not able to be made available in time to HCA.

**Key principles of workforce analysis adopted**

Workforce analysis and planning often tends to focus on workforce supply, and as several authors have pointed out (e.g. Scott, et al., 2012; HWA, 2014), the services delivered through a workforce supply focused approach tend to reflect the needs not of persons demanding services but those delivering them.

A more appropriate approach to workforce thinking, one especially appropriate to mental health services with its pronounced consumer activism, is *demand driven*, that is the focus starts with the needs of people who might require services and support. An overview of the demand driven process is provided in Figure 1 below.

**Figure 1: Overview of the HCA approach to (health) workforce planning**

Figure 1 demonstrates a crucial point — the demand for labour (workforce) is a derived value, dependent upon what it is that the labour will do, that is, what consumers want from their [mental] health services. The National Disability Insurance Scheme (NDIS) service structure, where disabled clients (or their carers) ‘purchase’ a service package directly applicable to their needs, is a very contemporary illustration of a potentially demand driven workforce approach in
action. Early indications are that the NDIS will severely test the capacity of the current disability workforce supply to flexibly adjust to, and satisfy, identified needs of individuals (NDS 2014).

**Two pathways for analysis**

Given the adoption of a demand driven approach to workforce analysis, a critical question is the direction of mental health services in the future, and therefore the derived demand for mental health workforce in terms of numbers and type of workforce.

This report considers and describes two possible service pathways:

1. the mental health workforce structure and composition required for future services that essentially represent a status quo, a continuation of past service development; and,
2. the main focus in this report, a workforce planned, prepared and developed to meet the needs of a future ‘aspirational’ mental health service delivery approach.

An overview of these two pathways is provided in Figure 2 below.

We anticipate the two possible service pathways will experience similar workforce interventions in the short term, but gradually the types of interventions will begin to differentiate. Workforce changes take years generally to achieve, and therefore moving towards a new service delivery structure will not be achieved fully in the short or even medium term — so workforce interventions and solutions are offered across a ten year implementation of a new mental health service structure.

An appropriate workforce response to new service and support approaches necessarily must consider the type of workforce required (and relative numbers), but also must consider issues of training and development (current and new workforce entrants), deployment between geographic locations and within service delivery structures, regulation and quality control, and work design and management to achieve optimum performance.

**Use of terminology**

The mental health field has over the last 10 to 20 years paid increasing attention to the use of words and the power they can have in fanning or dampening levels of stigma in the community and helping (or hindering) processes of individual recovery. It is therefore important to take advantage of opportunities where language can be reframed to be more thoughtful, respectful and supportive.
Throughout this report we have made an effort to use person-centred language that is unambiguous, positive and inclusive, and that places the individual first and understands that people are not defined by their mental health issues.

In this report we have opted to use the term ‘consumer’ to refer to an individual who experiences or lives with a mental health issue. While this is a term that is widely used and adopted, in Australia and worldwide, by individuals with mental health issues, we recognise that it is not a universally accepted or preferred term.
‘Support people’ or ‘support person’ has been used to describe people, typically family members, who provide ongoing care and support to a consumer. We recognise that the term ‘carer’ is also used widely by consumers and throughout the mental health sector.

The term ‘mental health issue’ has been used in this report to describe the range of mental health problems or disorders that can cause distress on an individual, affect their behaviour or perhaps their ability to live a contributing life. We acknowledge that other terminology is used and preferred by consumers and their support people and the mental health sector broadly.

Where possible we have also avoided using language and terminology that is typically associated with clinical or medicalised models of care, which can have negative and punitive connotations for many people with mental health issues and their support people. However, there may be instances where such language or terminology will be appropriate in reference to mental health services and programs.
2. Current mental health services

Currently Australia’s mental health services are provided through a combination of Commonwealth and State government funding mechanisms that overlap and produce gaps in service delivery requirements. A large proportion of Commonwealth mental health funding is provided for Medicare payments to general practitioners (GPs), psychiatrists and psychologists as well as a broad range of community mental health and suicide prevention programs delivered by a range of non-government (NGO) providers. State and Territory governments provide much needed acute and community mental health services and to a lesser extent fund community NGO services.

Types of service support have to some extent been developed for different levels of need of persons with mental health issues. Mental health needs can be described on a continuum as displayed in Figure 3 below, ranging from high levels of need (for types of illness that are not very prevalent in the population) to low levels of need for a range of disorders that are highly prevalent in the population. The diagram follows the NMHC’s A Population Approach to Mental Health: Person Centred model (Figure 1 in its Interim report). Persons with low prevalence illnesses tend to be supported by services in the acute care sector and specialist community services funded by States and Territories. Persons with high prevalence disorders are more likely to be supported by services in primary health care (PHC), however these arbitrary demarcations are increasing being challenged. As well, due to the nature of mental health issues, individuals continue to move across the continuum of mental health services – not necessarily remaining within one sector as described below.

**Figure 3: Guide to mental health services terminology used in this report**

![Figure 3: Guide to mental health services terminology used in this report](image-url)
The current service support mix has been described as an unstructured range of variable quality programs, projects and services that consumers and their carers find difficult to access at best and, at worst, are oblivious to the range of services available to suit their needs (NSW MHC, 2013).

The challenges for consumers with existing or potentially serious mental health problems (low prevalence) to access specialist mental health services can include high intake criteria and excessive waiting periods, which in combination provide an impediment to timely intervention. Individuals with high prevalence, early stage and manageable mental health problems (e.g. depression and anxiety, substance abuse) often do not meet the criteria for acceptance into mental health services and remain undiagnosed and unsupported within the community. Consumers are often therefore dissatisfied with the existing service structure which does not match their needs. Stigma exists around mental health from both within mental health services and the broader community, again reducing the opportunities for individuals to access safe supportive services (NSW MHC, 2013). Australian Bureau of Statistics (ABS, 2008) estimates that one-fifth of the adult population (or 3.2 million Australians) will experience a mental difficulty within any one year however, only a small proportion will be able to access services.

Putting aside issues of accessing current mental health services, these services are not sufficient to meet the increasing future needs of the population. If services continue to be provided under current structures and the mental health workforce continues to be developed along current lines in a ‘steady as you go’ fashion, mental health services will never meet the needs of the Australian population (MHWAC, 2011). To meet the actual demand for mental health services while retaining the existing service structure, the workforce would require unrealistically large additional investment. Hence authors argue more of the same is not good enough (Hosie et al, 2014).

A number of recent commentaries on mental health services, noting the significant current estimated unmet service needs of persons experiencing mental health issues, have highlighted the limitations of current workforce capacity and the longer term difficulty of overcoming workforce shortages. For instance the National Mental Health Workforce Strategy (MHWAC, 2011) notes:

“Workforce shortages are a significant long-term problem, and despite efforts and resources being applied to recruitment and retention, and an increased number of training places, these interventions will not, of themselves, be sufficient to meet ongoing workforce requirements.”

A stronger statement of the entrenched and enormous scope of the workforce limitations has been articulated by the Inspire Foundation (Hosie et al, 2014):

“... even a relatively modest increase in the proportion of people seeking help for mental health difficulties, combined with projected Australian population growth, would produce a cumulative increase in the use of mental health services ranging from 135% to 160% for select mental health professions, over 15 years. ... It is highly likely that existing services will not meet this demand.”
It is therefore considered essential that the mental health workforce is given appropriate attention and strategic responses are designed to prepare and develop mental health services into the future. Continuing to develop this workforce along current lines will not be sufficient to support the current service delivery structures and will definitely not be able to support proposed changes to mental health service structures into the future.
3. The current mental health workforce

**Boundary issues**

In estimating the current mental health workforce size, one must first provide a boundary around services to be included in which the workforce is working. One definition is provided in the *Roadmap for National Mental Health Reform 2012-2022* (COAG, 2012) where mental health services are comparatively narrowly defined as:

“... services in which the primary function is to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers”.

This is the definition adopted by HWA (2013). Within this service definition HWA identified primary [mental] health care (GP services), community care (community based ambulatory care and community based NGO services such as supporting people in their homes, residential rehabilitation, etc.), private sector specialist mental health services and hospital and residential care (emergency and acute admitted care, sub-acute care, etc.).

Using this service definition allows the mental health workforce to be similarly prescribed as:

“... those workforces whose primary role involves early intervention, referral, treatment, care or support to people with a mental illness, in a mental health service or other health service environment, including non-government community mental health services.”

The workforces that fit this definition include mental health nurses, psychiatrists, general registered nurses, enrolled nurses, general and other medical practitioners, occupational therapists, social workers, psychologists, Aboriginal mental health workers, Aboriginal health workers, mental health workers, consumer [peer support] and carer workers.

Even after defining the workforce boundary (in terms of work performed and type of occupation), the challenges still remain, since apart from mental health nurses, psychiatrists and mental health workers, all the other occupations have only part of their workforce providing mental health services (sometimes only part of the time). For instance psychologists can work in mental health services but also in education, commercial businesses, sport, defence organisations, etc. Similarly social workers and occupational therapists can work in many other non-mental health areas of the health system and outside of the health system completely. Given these boundary issues, compounded by significant data limitations for many mental health occupations, it is not surprising few attempts have been made to enumerate the mental health workforce.

**Total mental health workforce available data**

In fact current workforce counts have tended to focus on only a few health professions where the data is detailed and robust and the bulk if not all of the profession works in ‘mental health services’. The generally covered professions are mental health nurses, psychiatrists and psychologists, all who have been registered professions since the commencement of the national registration process and
therefore regular data has been gathered for the National Health Workforce Dataset (NHWDS). Broad descriptive data on these three professions from the AIHW is provided in Table 1.

**Table 1: Workforce data on registered Psychiatrists, Mental Health Nurses and Psychologists**

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Estimated total number</th>
<th>Workforce characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>2913</td>
<td>The average age of psychiatrists in 2012 was about 53 (^2) making it an ‘older’ workforce. Just over 7 in 10 psychiatrists were aged 45 and over (71.9%) and 2 in 5 (41.9%) were aged 55 and over. More than 1 in 6 employed psychiatrists (17.1%) were aged 65 and over. In 2012 about two-thirds of employed psychiatrists (64.7%) were male. Since about three–quarters of all medical specialists (72.9%) were male in 2012, this places the psychiatry workforce as slightly more feminised.</td>
</tr>
<tr>
<td>Registered nurses working in mental health</td>
<td>16,153</td>
<td>The average age for mental health nurses in 2012 was 47. About three-fifths (61.6%) were aged 45 and over a quarter (29.2%) were aged 55 and older. Less than 1 in 20 mental health nurses (3.8%) were aged 65 and over. Almost one-third (31.5%) of the mental health nursing workforce in 2012 were male, compared with about 10% of all nurses in Australia.</td>
</tr>
<tr>
<td>Psychologists working in mental health (^3)</td>
<td>14,753</td>
<td>The average age of psychologists in 2012 was around 46. About half of all psychologists were aged 45 and over (49.7%) and just over one-quarter (26.9%) were aged 55 and over. In 2012 more than three-quarters of employed psychologists (76.7%) were female.</td>
</tr>
</tbody>
</table>

*Source: 2012 National Health Workforce Data Set*

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\(^1\) The NHWDS is collected through annual registration processes administered by the Australian Health Practitioner Registration Authority. HWA and the Australian Institute of Health and Welfare (AIHW) are custodians of the NHWDS.  
\(^2\) By way of comparison, the average age of people employed in health occupations in 2006 was 42 years. This was slightly higher than the average age of people employed outside the health workforce, which was 39 years (AIHW).  
\(^3\) In 2012 there were an estimated 22,404 registered psychologists working. Not all registered psychologists work in mental health services (as defined by HWA). In Appendix A the distribution of psychologists by work setting is provided, offering a means to estimate how many might be working in mental health. Using the data in Appendix A an estimate of 14,753 registered psychologists working in mental health is developed.
Public sector mental health workforce

Another way to approach the current workforce description is not through analysis of professions but through analysis of data from mental health services.

For public mental health services the Mental Health Establishments National Minimum Data Set (MHENMDS)\(^4\) provides data on all direct care and indirect care worker employment in all acute care and community mental health service settings. Enumeration of staff numbers in public mental health services by type of health professional for 2010/11 is provided in Table 2.

Table 2: Staff numbers in public mental health services by health profession

<table>
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<tr>
<th>Broad workforce category</th>
<th>Specific workforce categories</th>
<th>Number of staff</th>
</tr>
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<tbody>
<tr>
<td>Medical</td>
<td>Consultant psychiatrists</td>
<td>1,355</td>
</tr>
<tr>
<td></td>
<td>Psychiatry registrars and trainees</td>
<td>1,259</td>
</tr>
<tr>
<td></td>
<td>Other medical officers</td>
<td>271</td>
</tr>
<tr>
<td></td>
<td><strong>Total medical</strong></td>
<td><strong>2,885</strong></td>
</tr>
<tr>
<td>Nursing</td>
<td>Registered nurses</td>
<td>12,592</td>
</tr>
<tr>
<td></td>
<td>Enrolled nurses</td>
<td>2,196</td>
</tr>
<tr>
<td></td>
<td><strong>Total nursing</strong></td>
<td><strong>14,788</strong></td>
</tr>
<tr>
<td>Allied health</td>
<td>Psychologists</td>
<td>1,810</td>
</tr>
<tr>
<td></td>
<td>Social workers</td>
<td>1,867</td>
</tr>
<tr>
<td></td>
<td>Occupational therapists</td>
<td>1,038</td>
</tr>
<tr>
<td></td>
<td>Other allied health professionals</td>
<td>845</td>
</tr>
<tr>
<td></td>
<td><strong>Total allied health</strong></td>
<td><strong>5,560</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>23,232</strong></td>
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Observing Table 1 and 2 in conjunction, it is possible to conclude that almost half the registered and working psychiatrists (46.5%) are employed in public sector services, most mental health nurses (78%) are employed in public mental health services, but only a small proportion of psychologists working in the mental health workforce are employed in public sector services (13%). This data though is contested by 2011 Population Census data which suggests nearly 6000 psychologists are employed in either Commonwealth or State / Territory government mental health services, and by National Health Workforce Data set statistics which identify approximately 3,200 psychologists at least working in government community mental health services and hospitals. Psychologist workforce data is difficult to analyse, and clearly needs more dedicated analysis.

\(^4\) Custodian AIHW
Of equal interest to the above analysis is the historical view that the MHENMDS data source provides, with staffing data having been collected since 1992. The growth in direct care staff (FTE) of persons employed in State and Territory mental health services is shown in Figure 4. The growth is steady and consistent, amounting to an annual compound growth rate of 2.9% per annum. Interestingly though, when this growth is plotted against population growth (in FTE per 100,000 population), the growth rate reduces to 1.6% per annum, possibly suggesting that workforce growth is only slightly ahead of population growth, and that possibly more is being invested in the NGO workforce than in the public sector mental health workforce.

Figure 4: No. of direct care staff (FTE) employed in State and Territory mental health service delivery 1992-93 to 2010-11

**NGO mental health workforce**

Other service sectors are not as well served by comprehensive data collections. For instance, little data has been collected on the NGO services workforce as has been noted by HWA in their inventory of workforce planning data (HWA, 2013). Mental Health NGOs are a vital part of Australia’s mental health system although not always acknowledged as such. Because of more recent funding arrangements that favour NGO services delivery, there has been, according to observers, strong growth in employment. The National Health Workforce Planning and Research Collaboration (2011) describe the sector as:

“... diverse and delivers a wide range of services. Mental Health NGOs may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness and carers or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by these organisations include housing support, individual
support, day programs, prevocational training, education, residential services, home based outreach and respite care.”

Some of the key informants interviewed for this study indicated the role of NGOs may expand in the future.

A recent survey of NGO mental health services by the National Health Workforce Planning and Research Collaboration estimated the workforce size (persons employed in the NGO services sector) as between 14,739 to 26,494 employees for the entire mental health NGO workforce. This estimate was extrapolated from the findings of a survey of NGO employers to which 268 responded, which was estimated to be 34% of the total number of NGOs providing mental health services. The sector itself conservatively estimated the size of the direct care workforce to be approximately 12,000 FTE (about 14,000 headcount) which compares with the public mental health service workforce of approximately 21,000 FTE. Mental health services in Victoria where valid surveys have been completed show there are more than 5,000 individuals working in clinical mental health (public and private) and approximately 1,400 individuals working in NGO services (Department of Health, 2014).

The majority (60%) of employer respondents to the National Health Workforce Planning and Research Collaboration survey indicated that they employ some clinical/health professionals on the basis of their health qualifications. They employ other types of workers on the basis of their broader professional backgrounds. Clinical/health professionals employed in Mental Health NGOs included psychologists (21% of employer organisations), occupational therapists (8%), social workers (24%) and registered nurses (13%). Only 3% of organisations reported having one or more psychiatrists employed.

In a more recent survey of the Victorian NGO workforce which achieved a high response rate, the level of education of the workforce was found to be surprisingly high, with only 17% of the workforce unqualified and over half (56%) with a degree or higher qualification as shown below:

<table>
<thead>
<tr>
<th>Qualification</th>
<th>% of workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate III</td>
<td>0.4%</td>
</tr>
<tr>
<td>Certificate IV</td>
<td>7.4%</td>
</tr>
<tr>
<td>Diploma</td>
<td>15.5%</td>
</tr>
<tr>
<td>Advanced diploma</td>
<td>1.8%</td>
</tr>
<tr>
<td>Associate degree</td>
<td>1.8%</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>36.0%</td>
</tr>
<tr>
<td>Graduate certificate</td>
<td>0.9%</td>
</tr>
<tr>
<td>Graduate diploma</td>
<td>9.9%</td>
</tr>
<tr>
<td>Master’s degree</td>
<td>8.6%</td>
</tr>
<tr>
<td>PhD</td>
<td>0.7%</td>
</tr>
<tr>
<td>None</td>
<td>16.9%</td>
</tr>
</tbody>
</table>
PHC mental health workforce

The PHC workforce includes GPs (with and without additional training in mental health), peer support workers, clinical and general registered psychologists, mental health and practice nurses, social workers, pharmacists, and a range of other allied health professionals. There is no data set that covers all of the workforce in this sector, nor is there a data set that covers all of the services delivered.

The NMHC has been assembling data from Medicare Australia that links specialist and GP mental health related Medicare item numbers and relevant Pharmaceutical Benefit Scheme prescriptions with GP consultations. This data will provide a reasonable picture of general practice and private psychiatrist activity (consultations) associated with individuals with a mental health issue. This data was not available to this project prior to the report being completed. A listing of key GP Medicare Item numbers with a count of the total occasions of service for each of the last three financial years is provided in Appendix B. These services include:

- Prepare mental health treatment plan
- Review of mental health treatment plan
- GP mental health treatment consultation
- Focus psychological strategies by a GP.

Appendix B shows that in the last year (2013/14) there were in total 2,611,007 occasions of service claimed. The number of services has been growing steadily over the last three years at over 10% per annum.

Workforce numbers associated with specific Commonwealth Government funded mental health services in the PHC sector can be identified more precisely, essentially the workforce providing services through the ‘Better Access’, ‘Access to Allied Psychological Services (ATAPS)’, and the Mental Health Nurse Incentive Program (MHNIP)’. These three programs in 2010-11 funded over 3,000 FTE of mental health workforce including:

- 817 psychiatrists;
- 240 mental health nurses;
- 1928 psychologists; and,
- 134 other allied health professionals (social workers).

While significant numbers, it is believed this represents only a portion of the mental health services delivered in a PHC setting. As noted above many more mental health occasions of service are accounted for in GP surgeries through general or specific (see Appendix B) consultations, ‘Better Outcomes’ trained GPs delivering cognitive behavioural therapy treatment, and privately funded clinical psychology services that can be accessed without a referral.

Peer support workforce

Peer support workers have been utilised within mental health workforces for over two decades, and yet the role remains unclear and inconsistent across services providers and estimates of the population vary.
It is difficult to enumerate the workforce as it is not a recognised occupation or profession and therefore not classified in the *Australia and New Zealand Standard Classification of Occupations* (ANZSCO). Since there is no specific code for peer support workers, the ABS Population Census data is not useful to enable a national count of peer support workers. Complicating matters is that there are no doubt an appreciable number of mental health professionals with undeclared lived experience, who have applied for and successfully been recruited to their jobs. It would be difficult to know how much their lived experience contributes to them fulfilling their roles.

In interviews with stakeholders for this project, workforce estimates were anecdotally provided at around 1,000 peer support workers\(^5\). The HWA (2014) reported on data collected for their study which indicated a count of just over 300 peer support workers (in a combination of NGO and specialist mental health services). In order to deliver the future mental health services described above, it will be important to initiate proper data collection processes to establish a count of peer support workers. It is hard to recommend more peer support workers when the current number is unknown.

Still, the inclusion of peer support workers at all levels of service delivery is considered important for the future mental health services change as outlined later in regard to aspirational mental health services, which would suggest that an investment needs to be made into supporting the development of the occupation through a range of workforce recruitment and development strategies.

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\(^5\) Such workers have been recruited to a post which states a lived experience as an essential (but not necessarily sufficient) selection criteria.
4. Mental health workforce projections for a ‘status quo’ services pathway

Some workforce planning in the Australian mental health space has been undertaken by HWA as part of a broader study of the medical and nursing workforces (HWA, 2012). These studies have utilised a traditional workforce planning approach which is described in Appendix C, and the three main limitations of which are elucidated in Appendix D.

In Volume 1 of the three volumes of the HWA study’s publication, broad workforce projections for both psychiatry and mental health nurse professions are provided. As well, some details of the methodology are detailed. In short, the base year chosen for the study was 2009 and projections are to 2025; wastage rates from the workforce vary across the study years but are highest after 2016, especially for nurses; graduate supply is set at a constant from 2012 onwards as is supply from skilled migration. In regard to workforce demand, HWA adopt a service utilisation approach and assume that the trend in service growth is at a compound rate of 4.5% per annum constant across the projection period.

**Mental health nurse workforce**

In Volume 2 of the series, nurse areas of specialist practice, including mental health, are detailed. The ‘comparison’ supply and demand projections for registered mental health nurses (a benchmark or best guess estimate of the future) are shown in Figure 5.

According to the comparison projections, the mental health nurse workforce is predicted to be in significant shortage by 2025, by nearly 8000 workers or nearly 36% of total projected demand.

HWA modelled a number of different scenarios that can affect workforce supply either positively or negatively as follows:

- Positive - lower net wastage rate (that is losses from the workforce net of gains from workforce re-entry);
- Positive - higher graduate supply;
- Negative - lower supply from immigration because of restrictions.

These scenarios are modelled in isolation, and independent of change in other supply parameters. The supply outcomes of these scenarios are summarised in Figure 6. The lower net workforce wastage scenario (effectively cutting net wastage from 6% per annum to 3% per annum) delivers the highest benefits to workforce supply, resulting in 2025 in an additional 3,890 workers in the active mental health nurse workforce when benchmarked against the ‘comparison’ scenario. This amounts to nearly a 30% increase in total workforce size.

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6 ‘Wastage’ here refers to wastage net of losses from the workforce (e.g. temporary absence, retirement, death) and gains to the workforce (e.g. workers re-entering after an absence).
Figure 5: Registered mental health nurses supply and demand projections

<table>
<thead>
<tr>
<th>Year</th>
<th>Demand</th>
<th>Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>12500</td>
<td>12500</td>
</tr>
<tr>
<td>2011</td>
<td>13750</td>
<td>13200</td>
</tr>
<tr>
<td>2013</td>
<td>15000</td>
<td>13750</td>
</tr>
<tr>
<td>2015</td>
<td>16250</td>
<td>14000</td>
</tr>
<tr>
<td>2017</td>
<td>17500</td>
<td>13750</td>
</tr>
<tr>
<td>2019</td>
<td>18750</td>
<td>13400</td>
</tr>
<tr>
<td>2021</td>
<td>20000</td>
<td>13000</td>
</tr>
<tr>
<td>2023</td>
<td>21250</td>
<td>12500</td>
</tr>
<tr>
<td>2025</td>
<td>22400</td>
<td>12100</td>
</tr>
</tbody>
</table>

Figure 6: Registered mental health nurse workforce supply outcomes of selected HWA scenario models

<table>
<thead>
<tr>
<th>Year</th>
<th>Comparison</th>
<th>Reduced wastage</th>
<th>Reduced immigration</th>
<th>Increased graduate supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>12626</td>
<td>12626</td>
<td>12626</td>
<td>12626</td>
</tr>
<tr>
<td>2012</td>
<td>13675</td>
<td>13802</td>
<td>13623</td>
<td>13675</td>
</tr>
<tr>
<td>2016</td>
<td>14235</td>
<td>15359</td>
<td>13994</td>
<td>14361</td>
</tr>
<tr>
<td>2020</td>
<td>13681</td>
<td>16377</td>
<td>13114</td>
<td>14235</td>
</tr>
<tr>
<td>2025</td>
<td>13116</td>
<td>17007</td>
<td>11947</td>
<td>14570</td>
</tr>
</tbody>
</table>
HWA also modelled a number of different demand scenarios with both positive (lower demand the result of increased workforce productivity\(^7\) or a healthier population) and negative consequences (higher demand the result of poorer population health, for instance because of limited early intervention). The different demand scenarios are outlined in Table 3 — again HWA modelled each scenario on a single parameter while holding all other parameters constant.

**Table 3: Registered mental health nurse workforce demand outcomes of selected HWA scenario models**

<table>
<thead>
<tr>
<th>Demand scenarios</th>
<th>2009</th>
<th>2012</th>
<th>2016</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>Productivity increase</td>
<td>12,626</td>
<td>14,270</td>
<td>16,490</td>
<td>18,610</td>
<td>21,069</td>
</tr>
<tr>
<td>Lower demand</td>
<td>12,626</td>
<td>13,644</td>
<td>15,064</td>
<td>16,336</td>
<td>18,052</td>
</tr>
<tr>
<td>Comparison demand</td>
<td>12,626</td>
<td>14,405</td>
<td>16,859</td>
<td>19,272</td>
<td>22,178</td>
</tr>
<tr>
<td>High demand</td>
<td>12,626</td>
<td>15,167</td>
<td>18,654</td>
<td>22,108</td>
<td>26,305</td>
</tr>
</tbody>
</table>

HWA’s different scenarios can be combined to find more favourable labour market outcomes, that is, where the gap between future projected supply and demand is minimised. This is a reasonable exercise since by and large, HWA’s supply projections seem overly pessimistic and appear to be determined primarily by an assumption that an ageing mental health nurse workforce will inexorably lead to future high rates of workforce wastage, an assumption for which there is growing evidence to the contrary for several other health workforces (See for instance Ridoutt, et al., 2010). Moreover, within the nursing workforces, mental health nursing with its high proportion of male practitioners seems less vulnerable\(^8\).

Accordingly, a supply scenario that assumes lower workforce wastage seems acceptable. On the demand side, again it appears reasonable to assume that workforce productivity will increase over the next 10-12 years, the result for instance of emerging e-mental health technology that reduces face to face counselling requirements and better developed care protocols. If these two scenarios are combined, a more favourable labour market outcome as shown in Figure 7 is projected.

This labour market projection still delivers a future workforce shortage, but a much more manageable one of just over 4000 mental health nurses by the end of the projection period in 2025 (19.3% of total demand). In the interim, smaller cumulative shortages occur in 2016 (1,131) and 2020 (2,233), shortages that may be at least partially ameliorated through short term workforce interventions.

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7 Increased productivity can be modelled as increased supply (greater capacity to perform work therefore it seems like there are more workers) or decreased demand (need less workers to do the same amount of work). By convention the latter approach is invariably adopted.

8 In any case, the rate of participation in the general workforce of females is gradually rising and this has been the case since 2001 (ABS, Gender Indicators, 4125.0)
Suggested interventions:

1. Retrain Registered General Nurses into Mental Health Nurses — In the short term the projected shortage of mental health nurses in 2016 of just over 1,000 (or approximately 7% of the workforce demand) is best reduced by a stop gap training intervention, one that can deliver supply quickly. The only way that is possible is to train current registered nurses into mental health nurses, which in theory requires only one year. Transferring 1000 nurses from the general to the mental health workforce will have limited impact on the general registered nurse population (less than 0.5%) but will dramatically impact on the number of mental health nurses.

In order to entice nurses to the mental health specialty, which has not traditionally been an attractive area of work, incentives will need to be offered. The largest incentive will be an offer to obtain a free or at least low cost qualification through a scholarship program at the attainment of which an increased income prospect would be high — this would make studying mental health more attractive than alternative areas of specialisation. Selection for the scholarship would need to ensure generalist Registered Nurses (RNs) already working in mental health were not included, this would have no net benefit for workforce numbers.

Ideally the scholarship would apply to courses delivered mostly or even entirely on the job, similar to registrar training for medical practitioners. In this way, some workforce benefits are obtained even during the training process.

Figure 7: Mental health nurse labour market projection using optimistic scenarios
The scholarship could also include an incentive to employers\(^9\) to take on ‘trainees’ in the form of an employment subsidy. This would hopefully ensure that clinical practice settings do not become a limiting factor to the success of the scholarship program uptake. It would also help to distribute the trainees more equitably across employer settings, ensuring the NGO and PHC sectors also participated in the training effort.

\(^9\) Must be eligible specialist mental health service in a community mental health, NGO or general practice setting.

### Psychiatrist workforce

In Volume 3 of the HWA 2025 series, specialist medical practitioner workforces are discussed in detail, including the psychiatry workforce. The ‘comparison’ supply and demand projections for psychiatrists are shown in Figure 8.

#### Figure 8: Supply and demand projections for Psychiatrists

According to the HWA comparison projections, in 2025 there will be a shortage of psychiatrists of 452. This is equivalent to approximately 9% of total demand, not as critical as projected shortages of mental health nurses but still a problem.

The comparison modelling, similar to the mental health nurse workforce, seems to allow for too high a net wastage rate from the workforce, especially in the latter projection years, presumably because of concerns about the age of the workforce. New fellow (graduate) and immigration supply estimates also seem to be conservative.
HWA provides a separate modelling of the ‘comparison’ situation by assigning a work value to registrars in the last years of their advanced training, which is arbitrarily assessed at 50% of a consultant value (or essentially half a fulltime equivalent). This effectively increases total workforce supply although only marginally. For instance in 2025, the projected shortage of psychiatrists reduces from the ‘comparison’ modelling of 452 to 374 where trainees are assigned a work value, a 17% reduction in the workforce shortage even though it is only a 2% increase in workforce supply.

A more substantial change in the labour market projections is achieved in HWA’s modelling by allowing for significant service and workplace reform thus promoting greater workforce productivity. HWA (2012: 39) define service and workforce reforms as encompassing:

“... changing models of care, adjustments to skill mix, health professionals working to their full or expanded scope of practice, and technology changes (such as eHealth or telehealth). Service and workforce reforms are also not constrained within specialties, they can be pursued across the medical specialty workforce. This may see new roles emerge, such as acute medicine specialists working across the current functions of existing specialty workforces. Such roles may positively affect the balance between generalist roles and specialist roles.”

As noted earlier, workforce planning methodology typically allows for productivity gains as a reduction in demand for workforce. HWA’s improved productivity scenario, which in the case of mental health is a well documented desire of the system to be especially obtained through advances in e-mental health interventions (Andrews and Titov, 2010; Christensen and Hickie, 2010; Mewton et al, 2014) and greater reliance on peer support groups, is detailed in Figure 9 below. This projected labour market scenario allows for a generous decrease in the compound rate of growth in demand from 3.5% annually to 2.4%, a broad reduction of 30% applied over the entire projection period.

**Figure 9: An optimistic scenario projected labour market for psychiatrists**

Under this labour market scenario the outcome is turned upside down, and a projected over-supply of psychiatrists is estimated for 2025 of 321 (or 7% of total demand).
This labour market scenario though seems at odds with the calculations for mental health nurses where a productivity gain over the projection years compounds to only 9%. There seems no compelling reason why changes in technology, especially e-mental health, should impact the productivity of the psychiatry workforce so much more rapidly than that of the mental health nurse workforce. This may cause a further review of the mental health nurse labour market projections discussed earlier.

It is possible that a more balanced psychiatry workforce labour market could be expected in 2025, especially as psychiatrists have a greater capacity to self generate demand particularly in the private sector.

**Suggested interventions:**

1. **Improve productivity of psychiatrists** — Much of the future demand projections for psychiatrists is dependent on an increase in their productivity through (a) clients being able to self-manage more and being less reliant on regular psychiatrist contact (b) actual ‘contact’ comprising less face to face formal counselling and being more through telehealth, opportunistic contact, and (c) psychiatrists working in support of other health professionals (GPs, social workers, etc.) to extend their influence on treatment management to a greater number of clients (for the same level of input).

   Investment in e-mental health, tele-mental health, and self-management technologies is already occurring, and could be more precisely targeted. More important though, psychiatrists need to be trained and appropriately re-deployed to make proper use of the new technology potential and to not undermine the potential for increased productivity by re-investing time in unintended over-servicing.

2. **Review of RANZCP advanced training program to identify any inconsistencies with a contributing life philosophy.**

3. **Develop and implement curriculum changes to RANZCP advanced training program.**

**Psychologist workforce**

HWA were unable to quantitatively model future labour market scenarios for the psychologist workforce but collected qualitative data in order to make an assessment of the current and future workforce situation. They reported on these estimates in a 2014(b) publication *Australia’s Health Workforce Series – Psychologists in Focus* concluding that:

“...from information obtained, the psychologist existing workforce position assessment is clearly in the orange to red scale – [that is] ranging from localised adequate supply and localised shortages, to perceived current shortages across all areas. The distinction between ‘orange’ and ‘red’ related to extended waiting lists, the ongoing nature of some vacancies and demand exceeding supply regardless of location.”

Within this broad assessment they also highlighted concerns about what they call workforce dynamics indicators, key measures to predict potential workforce shortages. The indicators include:
• Average age – workforces with a higher average age are more susceptible to higher exit rates (through retirement) with lower entry rates;
• Percentage of the workforce aged 55 and over – this can be a useful indicator of those potentially retiring or reducing working hours within the next 10 years;
• Change in average hours worked – workforces with falling average weekly hours worked can be an indicator of sufficient workforce supply, or supply exceeding demand; while workforces with increasing hours of work can indicate supply pressures;
• Dependence on internationally trained professionals (ITPs) – workforces with high percentages of ITPs are of greater concern due to their dependence on a less reliable supply stream (for example, changes in immigration policy may impact on supply); and,
• Duration of training program – the greater the duration of training, the longer it takes to train a replacement workforce.

Against all of these indicators HWA found little of genuine concern except for the duration of training. At a length of a minimum of six years requirement to achieve general registration, HWA suggested this could be a significant limitation to regenerating the workforce in response to any shortage that might evolve. They noted too the Australian Psychology Society’s concerns about internship pathways to registration (that is the 4+2 pathway) which are diminishing in number due to the administrative burden for supervisors and placement agencies under national registration requirements. Offsetting these concerns is the actual current number of provisionally registered psychologists which account for almost 10% of the workforce, which equates effectively to a training rate of over 5%, high by any standards.

In truth, and as noted previously, the psychology workforce is difficult to assess. First, not all registered psychologists work in mental health services (as defined by HWA and described earlier in this report), but it is difficult with current data sources to establish sound numbers on the actual levels of participation.

Second, while the focus of most analyses is on registered psychologists, there are many more people in the workforce with psychology as their highest qualification. Indeed, according to the 2011 Population Census, there are just under 60,000 active workers whose highest level of qualification is a psychology degree or higher, and only 16,500 of those self-report as a ‘psychologist’. The distribution of those with a psychology degree is shown in Table 4.

Table 4: Distribution of workforce whose highest qualification is in psychology by occupational category

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Postgraduate degree</th>
<th>Graduate diploma and graduate certificate</th>
<th>Bachelor degree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers</td>
<td>1,490</td>
<td>766</td>
<td>4,573</td>
<td>7,084</td>
</tr>
<tr>
<td>Professionals</td>
<td>14,733</td>
<td>4,557</td>
<td>15,331</td>
<td>35,413</td>
</tr>
</tbody>
</table>

10 In theory only those who are registered are entitled to call themselves a psychologist, but some may do so in the Census survey response who are not registered.
Table 4 suggests that there are likely to be many persons with a psychology qualification, possibly even working within mental health as a ‘counsellor’ or some other designation\(^{11}\), who are not registered. It also suggests that there may be an appreciatively large pool of people with base psychologist qualifications who could seek provisional registration, and would at worst have only two years of supervised practice to complete before achieving general registration.

Third, it is known that the psychology workforce (as self reported in the Population Census survey) has grown very rapidly over the last 15 years as shown in Table 5 below. The workforce has in fact grown at a compound annual rate of 6.8%, much higher than for medical practitioners and nurses. While the impact of growth in numbers is somewhat offset by the changing composition of the workforce (greater proportion of female workers) which can reduce the full time equivalent workforce size, and there is no guarantee that the high rate of growth will be maintained into the future, even a moderate reduction in workforce growth would presumably at least satisfy replacement demand.

### Table 5: Growth in the psychology workforce based on Population Census data

<table>
<thead>
<tr>
<th>Worker gender</th>
<th>1996</th>
<th>2001</th>
<th>2006</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>2,326</td>
<td>2,622</td>
<td>3,305</td>
<td>4,109</td>
</tr>
<tr>
<td>Females</td>
<td>4,633</td>
<td>6,712</td>
<td>10,132</td>
<td>14,494</td>
</tr>
<tr>
<td>Persons</td>
<td>6,959</td>
<td>9,334</td>
<td>13,437</td>
<td>18,603</td>
</tr>
<tr>
<td>% female</td>
<td>66.6</td>
<td>71.9</td>
<td>75.4</td>
<td>77.9</td>
</tr>
</tbody>
</table>

\(^{11}\) Some of the persons interviewed from the NGO sector suggested that many people with a psychology degree only may be employed in that sector performing support roles for persons living with a mental illness.
Suggested interventions:

(1) Undertake a specific study of the psychologist workforce — The psychology workforce, whether registered or not, seemingly holds the greatest potential for a rapid and sustained response to demand from mental health services for labour. And yet, so much about the workforce and its actual capacity is unknown or shrouded in uncertainty. A study needs to be commissioned to clarify actual supply of the clinical and support, registered and non-registered workforce, currently working in MH services. This could be based on the 2013 National Health Workforce Data Set when it becomes available and a re-analysis of 2011 Population Census data.

(2) Explore increased use of psychology qualified workforce — a second (or larger) study would explore the true pool of prospective provisional registrants and the perceived value in having more psychologists provisionally registered and reducing clinical practice limitations on numbers achieving general registration.

(3) Develop and promote a one year postgraduate diploma for allied health professionals (psychologists, occupational therapists, social workers, etc.) to quickly transfer to the mental health workforce — May need to offer scholarship support or increased pay incentives depending on initial uptake.

Ageing and feminisation of the workforce

Human resource research practitioners and many stakeholders with an interest in the welfare of particular professions provide frequent warnings about the impact of an ageing workforce on future supply. They argue that an older workforce has a higher proportion of its members who will be retiring in the near future. They also argue that feminisation of the workforce compounds this problem since females participate in the workforce less (less years of participation and less hours when participating) and retire earlier.

HWA in its projections of the mental health nurse and psychiatrist labour markets emphasised the age of these two workforces as a major contributing factor to a future high net wastage rate. As noted in passing in earlier sections of the report, there is growing evidence to suggest that workforce participation of older workers is slowly increasing. Raymo, et al (2009) documents important changes in retirement behaviour in Japan (the oldest of developed country populations), including the slowing or reversal of the long term trend towards earlier retirement and increases in both gradual retirement and post retirement returns to the labour force. These trends are hypothesised by HCA (2011) to be the result of:

- an increase in the official retirement age;
- a growing realisation that current levels of superannuation provision could be inadequate for a longer post retirement life span (compounded by superannuation losses experienced during the global financial crisis);
- an increase in the general level of uncertainty about the financial situation and a reluctance to leave the workforce too early;
- a desire to stay registered where required, which can only be satisfied by continued practice; and,
a realisation that maintaining an active and productive life for many is strongly linked to continued physical and mental health.

HCA’s (2011) past workforce studies seem to suggest that retirement age will be extended most in those workforces where the worker has greater control over their work conditions and environment. Thus health professions such as medical practitioners, pharmacists, private practice psychologists and physiotherapists for instance, all of who enjoy relative autonomy through self employment, are likely to extend their working age. On the other hand largely salaried professions such as nurses are possibly less likely to extend their working life, although for them the issue of adequate superannuation provision may play a more influential part in decision making.

Actual workforce participation as a whole for males and females of working age (20-74 years) according to ABS statistics has grown over the last decade (ABS, 2012). This is shown in Figure 10 below. The Figure shows that participation rates of female workers are growing faster than for males, gradually closing the gap between the genders. In a similar way, workforce participation rates of males and females at different age cohorts follow very similar paths, although females are always participating at a slightly lower rate than males. The rate for males remains relatively high until men reach their sixties when many retire. For males, participation rates peak in the 25-44 year age group, while for females, the participation rates peak in the 45-54 year age group. For females, the labour force participation rate tends to dip slightly during the peak childbearing years between the ages of 25 and 44 years. Delayed childbearing and an increased propensity for females to combine paid work and family has seen this dip become later and less pronounced than in the past.

Figure 10: Trends in workforce participation (2002 to 2011) of the general working age population (aged 20-74) in Australia by gender

In 2010-11, the labour force participation rate for females in the 20-24 year age group was 76%, and for the 25-34 year age group it declined to 73%. The participation rate for females in the 35-44 year age group was 75% and then it increased to 78% for the 45-54 year age group.
The labour force participation rates for males in the 20-54 age groups have remained relatively stable from 2001-02 to 2010-11, but increased for males in the 55-64 and 65-74 years age groups (eleven and nine percentage points respectively) over this period. For females, while there has been an increase in labour force participation rates across all age groups in the same period, the largest gain has been in the older age groups. For females aged 55-64 years it was sixteen percentage points. During this period, the labour force participation rate for females aged 45-54 and 65-74 years each increased by seven percentage points.

Retention of older workers in the workforce can be enhanced through consideration of occupational health and safety issues, re-design of work, increased training of an appropriate nature to reduce obsolescence, and accommodating the workforce’s own family care needs. Jorgensen (2004) argues that while:

“... the task of accommodating the mixed needs of an age diverse workforce to design sustainable work systems may be complicated by the physical decline associated with ageing, the effective utilisation of the experience, wisdom and motivation of older workers emerges as an important workplace reform success factor.”

One of the key concerns with an ageing workforce often expressed is around physical decline. After the age of 45-50 years, many workers experience a decline in physical work capacity (Jorgensen, 2004). However, increasingly it is believed that the functions of information processing change very little with age, indeed some cognitive functions, such as language or the ability to process complex problems improve with age and in most work tasks, speed and precision can be substituted by the high motivation, experience and wisdom of ageing workers (Jorgensen, 2004). To maintain older worker capability Jorgensen (2004) and others (Cimiotti, et al, 2013) advocate:

- individuals acquire more than one area of professional expertise;
- enjoy opportunities such as project-based and ‘stretch’ assignments and work shadowing;
- secondments and attachments designed to facilitate wider learning;
- trans-disciplinary studies and engagement in multidisciplinary approaches to work, which will assist older workers to continue to grow and learn.

**Suggested interventions:**

1. Create mental health service demonstration sites for best practice personnel management of an aged workforce — A number of employers with a significant number of salaried staff (especially including mental health nurses) can be supported to explore evidence based human resource practices that extend the working life of older workers by up to five years. This would include job re-design, re-training especially in e-mental health technologies, deliberate engagement with challenging (but not threatening) change, and respecting and valuing older workers’ expertise and accumulated knowledge.

2. Re-model the supply of key mental health workforces based on 2013 AIHW workforce data — examine especially the workforce age composition effects.

3. Research workforce demand for key mental health professions based on ‘Clinical Pathways’ — use completed clinical pathways to assess workforce need.
5. Aspirational services to support a contributing life

Strong calls for changes to existing mental health service structures have been made and future services are suggested and described in a range of policy documents for example COAG’s *Roadmap for National Mental Health reform 2012-2022* (2012), Western Australia’s MHC Mental Health 2020: *Making it personal and everybody’s business*, (WA MHC, 2010) NSW MHC *Living well in our community* (2013) and the Inspire Foundation’s *Crossroads: Rethinking the Australian Mental Health System* (Hosie et al, 2014). This section of the report details the characteristics of an ‘aspirational services’ pathway.

The consumer voice is arguably better acknowledged in mental health than in any other area of the health system, and has promoted more forcefully the concept of consumer or self-directed care, a concept which has begun to find resonance in similar areas of health such as aged care and in the language of the NDIS. This feature has found its way to the top of the eight principles of the (latest) *Fourth National Mental Health Plan, 2009* (Gallagher, 2009) viz.:

- Respect for the rights and needs of consumers, carers and families;
- Services delivered with a commitment to a recovery approach;
- Social inclusion;
- Recognition of social, cultural and geographic diversity and experience;
- Recognition that the focus of care may be different across the life span;
- Services delivered to support continuity and coordination of care;
- Service equity across areas, communities and age groups; and,
- Consideration of the spectrum of mental health, mental health problems and mental illness.

Consumer rights are also at the heart of the NMHC’s philosophy with its concept of ‘a contributing life’:

“... a fulfilling life enriched with close connections to family and friends, and experiencing good health and wellbeing to allow those connections to be enjoyed. It means having something to do each day that provides meaning and purpose, whether this is a job, supporting others or volunteering. It means having a home and being free from financial stress and uncertainty.”

(NMHC Report Cards 1 and 2)

This philosophy puts people with lived experience and their families and supporters at the centre of policy and service thinking and fosters a shared objective across all entities that promote mental health and prevent mental illness and suicide – not just government and not just health but education, housing, employment, human services and social support.

These documents have identified common themes that suggest a direction for mental health services in the future. These themes are described below.
Collaboration and integrated services

Collaboration between government agencies and across mental health and drug and alcohol service providers is essential to enable consumers and their carers access to appropriate and effective mental health services and other government supports that enable them to lead ‘a contributing life’.

COAG’s *Roadmap for future mental health services* (2012) provides a vision for the whole of Australia’s society to value good mental health and wellbeing through a ‘social determinants of health framework’ recognising all factors that contribute to maintaining good mental health for an individual. A diagrammatic representation of this model is redisplayed in Figure 11 below. In order to achieve COAG’s vision, future mental health services will require collaboration between Commonwealth and State / Territory Governments to fund a range of appropriate and accountable service options in line with evidenced based best practice. Collaboration will be required across a range of portfolios including mental health, health, housing, justice, education, child protection, youth and employment.

Collaboration at the service level between the full range of public and private mental health and drug and alcohol services is required to ensure timely and effective referrals between services. Consumers and their carers should be assured that referrals to appropriate services will be effective and that protocols have been established and are adhered to.

**Figure 11: COAG social determinants of health**
**Person-centred approach to service delivery**

As mentioned above, the trend to client centred services has begun across the disability sector (NDIS) and similar calls for mental health services to be directed by the individual needs of consumers and their carers has been argued.

“To ensure that mental health outcomes are as appropriate, effective and long-lasting as possible, policy makers and service providers need to adopt a person-centred, recovery oriented approach. This approach allows people flexibility, choice and control over their recovery pathway, and responds to each individual’s unique needs, circumstances, life-stage choices and preferences.” (COAG, 2012)

For individuals who are at the higher need end of service delivery (low prevalence), it has been argued that supports and services should ‘wrap around’ individuals to provide them with the ability to build a recovery focused (see below for explanation) pathway to participating in society to a level that they desire and can achieve. (WA MHC, 2010)

The Inspire Foundation (Hosie et al, 2014) advocates a ‘stepped care’ approach to services that aims to support individuals from the high prevalence end of services with self-help strategies including online programs and peer support worker programs in order to alleviate higher cost face to face services delivery options. They note:

“... developing a stepped care system that integrates effective but low-cost and highly scalable interventions (such as those provided online) with existing ‘traditional’ services while better utilising peer workers to provide support at the lower-intensity end of the system, will be the most effective and efficient way to boost overall capacity and ensure that help and support can be provided to all those who require it. In addition by embracing e-mental health, and better utilising the peer workforce, we potentially have the opportunity to improve help seeking rates by overcoming geographical and attitudinal barriers, providing much greater reach and accessibility”.

Within a stepped care approach the role of primary mental health care is pivotal, particularly the role of the general medical practitioner. Andrews (2006) notes the contribution (centrality in most cases) of GPs to nearly all optimum clinical pathways.

**Recovery focused services**

An essential theme for future mental health services is to support a ‘recovery’ focus at all stages of service delivery. A recovery focus takes on the belief that all individuals with a mental health issue can ‘recover’ from an episode of mental ill health and with the appropriate support can lead a ‘contributing life’ (NMHC 2012/3). The Fourth National mental health plan (Gallagher, 2009) describes a recovery philosophy:

“A recovery philosophy emphasises the importance of hope, empowerment, choice, responsibility and citizenship. It includes working to minimise any residual difficulty while maximising individual potential. This is relevant to all ages, including the elderly, and to all those involved—the individual consumer, their family and carers, and service providers.”
The HWA Mental Health Peer Workforce Study (2014) also provides a useful description of recovery oriented mental health services.

“Recovery can be defined in a range of different ways, and is often understood to be a philosophy and approach to services focusing on hope, self-determination, active citizenship and a holistic range of services. The Principles for Recovery Oriented Service Provision and the Supporting Recovery Standard of the Australian National Standards for Mental Health Services (2010) require that mental health services incorporate recovery principles into service delivery, culture and practice, providing people with access and referral to a range of programs that will support sustainable recovery.”

Peer support workforce

Peer support or peer workers (also known as consumer and carer consultants or providers) are individuals who have a lived experience of mental health either as a person who has lived with a mental illness or as a carer of someone who has experienced mental illness. They are employed across the public, non-government and to a lesser extent private mental health service sectors. Peer support workers are a key component of recovery oriented mental health services as they illustrate to individuals receiving mental health services that others who have lived with a mental illness can recover to participate in social and employment activities and provide them with support for their own recovery.

Role of peer support workers

Currently in Australia peer support workers assume a wide variety of roles within their organisations dependent on the model and type of mental health services being delivered (Pitt et al., 2013). HWA’s (2014) study identified that their roles may include:

- providing individual support;
- delivering education programs for mental health workers;
- providing support for housing and employment;
- advocating for systemic improvements; or
- running groups or activities.

Pitt et al add coaching, case management or outreach, crisis worker or assertive community treatment worker, and providing social support programs.

Oades et al (2012) also note that peer support itself is not a single concept and that there are several schemes that have been used to describe the different forms that peer support initiatives can take. They first classify peer support groups according to purpose viz.:

- Remedial, focusing on the personal processes of recovery;
- Interactional, emphasising the interpersonal relationships and personal experience; and,
- Social — integrating the personal, interpersonal and political. The social classification involves social change and empowerment.

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12 This report adopts the term “Peer support worker” as it was most commonly used throughout the stakeholder interviews for this project.
An alternative way to look at peer support they suggest is in terms of the role of the consumer in the service delivery as follows:

- Naturally occurring mutual support groups;
- Consumer-run services; and,
- The employment of consumers as providers within clinical and rehabilitative settings.

The NMHC supports a workforce that has the mix of skills and experience to support recovery approaches and this includes having peer workers as part of that workforce. It understands that consumers and carers value peer workers and acknowledges the potential they have on bringing a lived experience to the culture of service delivery settings.

**Benefits of peer support workers**

The increased use of peer support workers has followed the previously mentioned change in the locus of care from inpatient treatment settings to in-community collaborative settings. Davidson et al. (2012) argue that peer support work has been utilised in psychiatric services for centuries but its uptake has “exploded” in the last 20 years. Their review of evidence into the effectiveness of peer support work has found that the inclusion of peer support within mental health workforces has contributed to the reduction in presentations to emergency departments and hospitalisation as well as reducing substance use with co-occurring substance use disorders. Repper and Carter (2011) also found reduced overall hospital admission rates in a literature review and noted more extended community tenure prior to psychiatric admissions when a peer support worker was involved in the care of a consumer.

As well as decreased hospitalisation rates, the involvement of peer support workers in mental health services has numerous benefits to the way in which services are delivered in line with a recovery focus. Davidson et al. (2012) identified that

> peer support that involves positive self-disclosure, role modelling, and conditional regard, peer staff have also been found to increase participants’ sense of hope, control, and ability to effect changes in their lives; increase their self-care, sense of community belonging, and satisfaction with various life domains; and decrease participants’ level of depression and psychosis.”

Repper and Carter (2011) found that consumers supported by peer support workers reported a greater sense of empowerment, increased sense of independence and normalisation of emotional responses, greater social functioning, sense of acceptance and empathy, reduced stigma and sense of hope for recovery. In addition, Walker and Bryant (2013) found recipients of peer support services experienced increased social networks and wellness.

Benefits to peer support workers are also reported as aiding recovery of others realised an increase in confidence and self-esteem (Repper and Carter, 2011), positive experiences in collegiate relationships with non-peer staff, other peers and increased wellness outside their roles (Walker and Bryant, 2013).
Establishing and supporting the peer support workforce within mental health services

Repper and Carter (2011) identify a range of barriers or challenges to the peer support role including barriers of accountability, relationships, power issues (within peer relationships and with other professionals) and stress of the role on peer support workers. These issues were similarly identified by Walker and Bryant (2013) who noted staff discrimination and prejudice, low pay and hours, and difficulty managing the transition from “patient” to peer support worker. Effective human resource management practices are able to address these barriers and a comprehensive list of suggested strategies is suggested by Davidson et. al. (2012) as having been proved to be effective in developing and supporting the role of peer support workers in mental health services. These include:

- A clear job description including required competencies, role clarification and performance appraisal processes;
- Involving non-peer staff, organisational leaders and people in recovery in developing peer positions and recruitment;
- Identifying and valuing the unique contributions of peers relevant to their experience to the program or setting in which they will be working;
- Start with at least two peer staff within any team to allow sharing of job experiences and provision of mutual support;
- Have a senior administrator take on the role of peer staff ‘champion’ to address systemic issues that arise and maintain peer work as a priority for the service;
- Train peer workers with skills and tasks required by their roles including using their recovery story to benefit consumers, effective listening skills, creating positive relationships, goal identification and setting, responding to an emergency situation, documentation requirements, ethics and confidentiality, boundaries, self care and resolving conflicts in the workplace;
- Provide supervision for peer support workers focused on job skills and performance;
- Train non-peer staff in relevant disability and discrimination legislation, expectations of peer staff and respect for all co-workers; and
- Dissemination of success stories that inspire hope and persistence in all parties.

Prevention and early intervention

The NMHC (Interim report, 2014) suggests that the majority of Australians would benefit from mental health prevention activities including wellbeing and resilience programs. Ideally, this might translate into the Mental Health First Aid\(^\text{13}\) course becoming as ubiquitous as the physical health First Aid course that is widely required for workplaces, schools and sporting organisations.

A population approach to promoting good mental health has been commonly advocated in the literature aiming to build awareness of mental health, help seeking behaviours and self-help strategies (including e-mental health and support groups). Increased awareness and understanding of mental health issues across the population is also expected to help reduce mental health stigma. Early recognition and intervention services are expected for an estimated 15% of the population who will have a need for episodic support within their lifetime. These

\(^{13}\) Details of this course can be found at [https://mhfa.com.au](https://mhfa.com.au)
activities support individuals at an early stage of mental ill health which can reduce the likelihood of more serious presentations later in life. The second priority of the Fourth National Mental Health Plan (Gallagher, 2009) is prevention and early intervention stating:

“**In recent years there has been development of a stronger evidence base to support models of intervention in children and young people—especially in areas such as early intervention in psychosis, and school and family based interventions for challenging behaviours. But we also need to recognise the importance of relapse prevention and early intervention for people who experience recurrent episodes of illness, to minimise the distress and disruption experienced by the consumer and their families and carers. Prevention and early intervention activities are therefore best considered from three perspectives: early in life, early in illness and early in episode. The primary care sector has a particularly important role to play in prevention, but in promoting behaviours that support good mental health, and in the management of chronic or recurring illness to lessen the negative impact of illness.”**

**e-mental health technologies**

E-mental health technologies have emerged as accessible and effective interventions for individuals with high prevalence mental health issues as a self-help strategy and as a component of professional mental health treatments.

E-mental health or tele-mental health services can be defined as any electronic communication technology to reduce geographic barriers for mental health services (Hailey et al, 2008) and includes a range of treatment programs that are delivered via telephone, web-based video conferencing or structured internet treatment programs (Christensen & Hickie, 2010; Hailey et al, 2008; Hilty et al, 2013; Kasckow 2014).

Internet-based treatment programs are predominantly being used for depressive and anxiety disorders (Andrews and Titov, 2010; Mewton et al., 2014) and to a lesser extent for low prevalence disorders such as schizophrenia (Kasckow et al., 2014). Tele-mental health services in general are being used for other disorders such as dementia, alcohol and substance abuse and with children, adolescents and the elderly (Hailey et al., 2008; Hilty et al., 2013).

The evidence base for e-mental health interventions is increasing and generally indicates it is an effective method, in terms of consumer outcomes and reduction of mental health symptoms, when compared to face to face interventions; it is also proving to be a cost effective method for health care systems broadly (Andrews and Titov, 2010; Christensen and Hickie, 2010; Mewton et al., 2014).

Effective internet programs:

- In the short term self-help structured programs that do not include any clinician support are effective in treatment for depressive and anxiety disorders (Mewton et al., 2014).
- Long term improvements are associated with guided self-help programs that included minimal clinician support via email, text message or telephone (Mewton et al., 2014).
- Guided programs also associated with higher rates of program adherence (Andrews and Titov, 2010).
• Can be measured by symptom reduction, medication adherence and decreased hospitalisation time, but also by program adherence, ‘mouse clicks’, and online diaries (Mewton et al., 2014).

Benefits of e-mental health:

• Standardised structured programs, therefore easier to measure effectiveness (Mewton et al., 2014)
• Can be used as part of ‘stepped care’ arrangements where other therapy is not meeting the need of the consumer (Mewton et al., 2014; Andrews and Titov, 2010)
• Cost effective because minimal clinician time is needed to provide effective support (Andrews and Titov, 2010; Christensen and Hickie, 2010; Kasckow et al., 2014; Mewton et al., 2014)
• As little as 2.12 hours of clinician time as part of an internet-based program can be effective (Andrews and Titov, 2010)
• Potential for people living in rural and remote areas or any areas where there is limited access to mental health services (Hickie and Christensen, 2010)
• Effective for diagnosis, assessment and treatment (Hilty et al., 2013).

**NMHC approach to future services**

Following the above broad thinking and further research efforts as part of the review of mental health programs and services, NMHC identified areas and options for change that would result in a radically re-oriented mental health services structure that would have significant workforce ramifications (Interim Report, 2014). The strategic priorities to reform mental health services throughout the project period included:

**Priority 1:** The Commonwealth should use its resources as incentives to achieve measurable results and outcomes.

**Priority 2:** A mentally and physically healthy start to life, followed by a whole of person approach as people move through the different stages of their lives.

**Priority 3:** People with severe mental disorders should have services wrapped around them with a focus on maximising participating and recovery.

**Priority 4:** People with moderate or prevalent mental health issues should be supported to stay well and in the community by the most cost effective service platform available.

**Priority 5:** All organisations which come into contact with potentially suicidal people should work to a target of “zero suicides in our care”.

**Priority 6:** Innovative technologies in eMental Health should be established as first-line responses for primary, secondary and tertiary prevention and intervention.

**Priority 7:** The workforce to support people with a mental illness, their families and carers needs to be supported to change practice to reflect innovative approaches, new service paradigms (NDIS), and family inclusiveness, and to eliminate the stigma that still is pervasive.
How these priorities will be achieved through reformed mental health services can be broadly described across the following service delivery sectors:

- **Primary health care (PHC)** – PHC will need to play an increased and important role at the front line for mental health problems in identification, management and referral. The PHC workforce includes GPs, Practice Nurses, Allied Health Care workers, Aboriginal Health Workers, Nurse Practitioners and Peer support workers. The capabilities of the PHC sector will be required to develop and enhance their competence in mental health promotion, prevention, early intervention, medication management and referral to specialist services. The PHC workforce will need to be supported by specialist community mental health services which ideally would be collocated. An aim for PHC will be to ensure all mental health problems are identified and treated in the same way as (and in coordination with) physical health problems — ‘no health without mental health’. GPs will develop mental health care / treatment plans in consultation with consumers and their carers when higher level support is required from a third party.

- **Self-help strategies** – PHC ‘prescribing’ self-help strategies including e-mental health technologies and support groups.

- **Community Mental Health, NGOs and private sector services** will continue to play an important role in the provision of mental health interventions including counselling services, provision of ‘step up, step down’ accommodation and treatment services. *Government Departments such as* Housing, Employment, Alcohol and Other Drugs, Justice and Education all have services and workers that come into contact with people with mental health issues. These organisations will require front line workers to develop mental health competence to support them to ensure appropriate and safe services for individuals with mental ill health. The community mental health, NGO and private sectors will need to collaborate with Government Departments other than health listed above to establish referral protocols to ensure that appropriate referrals can be made when required.

- **Acute sector services** – Community mental health specialist services and acute care services will continue to care for individuals with low prevalence / serious mental health problems, although most observers see a growing role for GPs in the management of these individuals. These services will be improved by embedding the culture of ‘lived experienced’ by including Peer support workers in service delivery.

A diagrammatic representation of these services is displayed in Figure 12.
Primary Health Care

- Prevention activities
- Assessment / Care plans
- CMHT specialist support
- Early intervention activities

CMH, NGO and private sectors

- Intervention
- CMH specialist services
- Step Up Step Down services
- AOD / Accommodation / Employment / Justice services etc. to support recovery

Acute sector (public and private)

- CMH specialist services
- Acute care

Figure 12: Future mental health service requirements
6. **A workforce to support aspirational services**

In the previous section of this report an aspirational services pathway was outlined in keeping with the vision of the NMHC and a range of influential stakeholders in the mental health system. The aim of this section is to identify workforce requirements to respond to the new service and support approaches in mental health programs and services in Australia. That is, to identify policies and programs that achieve the desired workforce to suit future mental health services within a staged approach (over 10 years).

In setting out this section the main point of reference is the service components of the aspirational service model laid out in Figure 12, especially primary health care, NGO services and acute care services. In addition, there are portfolios within government that require attention to support the new mental health service structure. This section is detailed as the ‘non-mental health workforce’ and includes important collaborators who are working with individuals with mental health problems outside the mental health system. Thus, following the general workforce analysis principles of this document, workforce is considered in the context of the services to be delivered. The key workforce issues are overviewed in Figure 13.

Prior to the discussion of specific service area workforce implications, two broader workforce issues are canvassed.

First, the need for a new approach to workforce analysis including planning, development and management is discussed. The limitations of traditional workforce planning, especially for analysis of the mental health workforce, were discussed earlier in this report and detailed in Appendix D. At the start of this section a new approach to workforce analysis and planning based on capabilities is developed and described.

Second, one component of the future mental health workforce requires special mention. The peer support workforce will need to be considered at each level of future mental health services and implications for developing and managing this workforce is described also prior to covering the more specific needs of service sectors.

**A workforce planning approach suitable for aspirational services**

In Appendix D three reasons why the traditional workforce planning approach is deficient methodologically for planning the future mental health workforce were canvassed. One each of the three reasons relates to demand and supply estimation and the other theoretically to both. Given the basic workforce philosophy underpinning this document introduced in the earliest chapters that analysis must be demand driven, then the starting point should be the method deficiency associated with assessing demand.
Figure 13: Future mental health service delivery approach and workforce requirements

### Personal mental health services

#### Primary Health Care
- Prevention activities
- Assessment / Care plans
- CMHT specialist support
- Early intervention activities

#### CMH, NGO and private sectors
- Intervention
- CMH specialist services
- Step Up Step Down services
- AOD / Accommodation / employment services etc. to

#### Acute sector (public and private)
- CMH specialist services
- Acute care

### Workforce requirements

#### Primary Health Care
- Upskilling PHC in mental health competence and assessment
- CMH distributed to provide specialist support to PHC
- Peer workforce / AMHW
- Competency based (fit for purpose) teams constructed to meet client directed services

#### Self Help Strategies
- E-mental health technologies (workforce substitution)
- Self help support groups (NGO sector)
- Access to specialist services as designed on assessment / care plan

#### Community mental health and acute services
- CMH and Acute services system and support enhancements (increase CMH to enable sufficient workforce to support acute services and PHC)
- Peer workforce developed and embedded across all mental health services (and in teams) = culture change
- Competency based (fit for purpose) teams working to meet needs of client
Demand estimation

The traditional workforce approach tends to take a service utilisation perspective. The alternative is to build an understanding of demand from actual service requirements based on individual mental health service consumer demands. Consumers do not generally demand workforce, rather they express a preference for services — which are delivered by a worker or workers with a specific skills mix, a mix uniquely suited to the consumer’s demand. Skills mix is not the same as staff mix (Dubois and Singh, 2009). Skills are generally expressed in terms of knowledge, attitudes, and behaviours while staff are identified by qualification or job title. As Dubois and Singh point out, a focus only on ‘staff’ can fail to account for staff members’ actual skill set and skill level (two mental health nurses may have quite different levels of skill) and their effective utilisation of the skills they possess (because of other factors such as confidence, scope of practice concerns, etc.). Specification of workforce requirements to deliver a service in terms of skill rather than staff types is considerably more accurate. Dubois and Singh would argue this is also the most efficient use of workforce:

“Skill management refers to an organisation’s ability to optimise the use of its workforce. The focus shifts here from achieving a specific mix of different types of personnel to adapting workers’ attributes - such as knowledge, skills, and behaviours - and roles to changing environmental conditions and demands. Skill management enables organisations to optimise patient outcomes while ensuring the most effective, flexible and cost effective use of human resources.”

The conclusion — the demand for mental health workforce should ideally be assessed in terms of skill requirements not types of mental health professional categorised by qualification and / or job title. This requires a unit of labour analysis other than workers (units of mental health nurse, units of psychologist, etc.). The obvious unit of analysis is capability, leading to the advocacy for a capability-based workforce approach. The value for such an approach has been argued elsewhere (Department of Health, 2014):

“A capability-based approach to ... workforce [planning and] development offers a potential solution to shortages and uneven distribution in the health workforce. It creates a common platform for access to and mobility across different health careers. It also supports more integrated work practices across disciplines and sectors. This approach acknowledges and retains the specialist training and development of disciplines and identifies and builds general capabilities that are shared across disciplines. It helps training and work practices to move away from discipline silos towards interprofessional and cross-sector learning and development. This shift relies on significant collaboration between the health sector and the education and training sector.”

A framework for such an approach has already been constructed by HWA in collaboration with the mental health workforce; the Mental Health Core Capabilities (2014). This framework builds on numerous previous attempts to define workforce requirements not in terms of abstract qualifications but actions to be performed in the workplace. Some of these efforts are compared

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14 Other terms used are ‘competencies’ and ‘capabilities’ which generally are broader in meaning and encompass knowledge, skill, attitude, values expressed as behavioural (observable) outcomes.
with the HWA capabilities in Appendix E. The Mental Health Core Capabilities themselves consist of six domains as follows:

- Values (for instance committing to respect, a recovery approach, working in partnership);
- Diversity (having capability and attitude to work with diverse people in all facets of their life);
- Professional approach (understanding ethical, legal and practice scope limitations and possessing communication skills);
- Collaborative practice (collaborating with consumers, other workers and across time and place);
- Provision of care (capability to engage, assess, plan and deliver care based on evidence and acknowledge the dignity of risk); and,
- Life-long learning (commit to ongoing learning of self and others).

All service requirements for capability should be able to be couched in these terms, possibly with an additional layer of experience in terms target audience (child, adolescent, adult, etc.) or type of condition, especially in regard to more complex co-morbid presentations. Several innovative and well run service organisations in both the public sector and not for profit sector (but mostly the latter) have already shifted their recruitment processes to a capability or competency based approach.

Of course health consumers including those of mental health services may express preferences in terms of perceived skills possessed by different workforce types. For instance they may prefer a clinical psychologist to a psychiatrist. In a consumer-directed service such as that offered by the NDIS where funds can be directly attached to consumer preference, those preferences may be powerful influences on workforce demand.

In essence though that is not what is being proposed in this document, nor it seems elsewhere is this the case, rather mental health service provision is seen as consumer centred, with service decisions based on a collaboration which gives weight to both consumer preferences and professional judgment. **Where this collaboration is made visible and the nature of the service demand articulated is, or should be in a structured care plan**. This is the most fundamental point of service delivery and it is at this point that workforce demand, the workforce required to deliver the outcomes of the care plan, is best estimated through a ‘workforce impact assessment’.

Based on the foregoing discussion about skills vs. staff mix, it is contended that to construct an understanding of each consumer’s workforce demand (based on the services implied by the plan), the assessment needs to be in terms of capabilities. By aggregating data from a collection of care  

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15 Care plans can be in different forms in different settings. In primary health care a specific MBS Item Number (2700, 2701, 2715 and 2717) covers a mental health treatment plan which is meant to cover the objectives of collaboration between GP, psychiatrist and others (e.g. mental health nurse, psychologist, etc.). The significant numbers of care plans developed each year can be understood through the statistics in Appendix B. In community mental health teams each patient must have an individual care plan. In the acute care setting treatment plans and discharge plans are meant to structure the process and objectives of treatment. While it is understood that plans are not always well developed and may even be frequently undertaken as a poorly conceived compliance measure, this document is proceeding on the assumption that care planning will be well structured, comply with minimum standards, and be subject to quality control processes.
plans related workforce impact assessments, a broader workforce demand picture can be built up at a whole service level (for instance a PHC service, a community mental heath team, a non-government organisation, a LHD). This use of capabilities and building a picture of demand from the ‘ground up’ has been advocated elsewhere for the similarly partially regulated public health workforce (Ridoutt, et al, 2002) and trialled successfully with preventive health workforce (Gadiel, et al, 2012). HWA also advocated an approach based on capabilities for study of the aged care workforce (HWA, 2014).

In adopting this approach, if care plans are crafted according to the principles identified earlier in regard to the future of mental health services, that is by genuinely working with the consumer and their carers, adopting a person-centred stance, and care plans focused on recovery and the right to take risks, then the workforce demanded to facilitate these principles should follow automatically. This does not imply that satisfying the workforce demands will be without challenge, but this challenge is no greater than that posed currently of having to identify persons with suitable qualifications and experience. Indeed, as the discussion below will expand upon, the source of workforce supply in a capabilities based approach enjoys greater flexibility in terms of both availability and deployment.

**Workforce supply estimation**

It follows that estimation of supply has to be in the same unit of analysis as estimation of demand — capability. Thus existing workforce resources will be ‘audited’ on the basis not of their qualification, not even the skills and knowledge (capability) that are implied by the supposed scope of practice associated with possessing a particular qualification, but by actual capabilities possessed.

A key question in this vision of supply is how to measure the capabilities of a worker, since in a traditional approach evidence of a qualification is seemingly sufficient data to collect\(^\text{16}\). Assessment of capability against a set of standard requirements (for instance the Capability Framework) can be undertaken by:

- a worker of themselves;
- ideally in conjunction with a supervisor, or separately by the supervisor; and / or,
- an independent third party (for instance a registered training organisation as in the case of assessment for competence recognition in the Vocational Education & Training [VET] system).

The level of formality required in the assessment and recognition of capabilities will vary according to the worker and workplace circumstances. For instance, assessment for in-house capability development needs can be less formal. Assessment for recognition for a qualification or a career progression will need to be formal, and supported by independent and credibly objective institutions.

\(^{16}\) In actuality this is not generally the case, especially at the service organisation level. Employees are rarely recruited based solely on their qualifications. Invariably experience also is taken into account, and this provides a proxy measure of the individual’s (at least broad) capabilities and therefore their fit for the demands of a specific work role.
It is likely that capabilities most in demand are also likely to be comparatively commonplace and most readily supplied (that is most commonly held by a range of workforce types). For instance, capabilities for individual planning, delivering care and devising an intervention may be reasonably in supply but high order assessment capabilities may be in much rarer supply.

Analysing supply from a capabilities unit of analysis perspective can considerably change the way workforce supply is understood. For instance capability ‘gaps’ at the micro level, understood against a workforce impact assessment of an individual consumer’s care plan, or at the larger level of a service, become potentially workforce deployment / management problems rather than planning or development problems.

The challenge in such contexts is to make scarce or critical capabilities (for instance undertaking a complex initial assessment and diagnosis) available through for instance remote technology (telehealth), just in time deployment, distance mentoring by specialists of local resources with more generalist capabilities, etc.

The benefit of considering supply from a capabilities perspective as opposed to people with specific qualifications is that the response options are greater in number. Supply as measured through capabilities may often be quantitatively inadequate just as in using traditional workforce measures there may be a deficiency of say mental health nurses. This might be particularly so when looking more broadly at a whole mental health service or even broader at a Local Health District (LHD). But it will in most cases remain easier to procure a capability in demand than recruit a person with a particular qualification.

In the embedded box, ‘Case study: Small rural town’, illustrates in a very simple way how the supply process using a capabilities approach becomes as much a workforce management process as a development or recruitment process.

**Suggested interventions:**

1. Establish the infrastructure for capability [competency] based workforce planning and development — includes improved data collection systems based on care plans with associated workforce impact assessments.
2. Conduct trial study to translate clinical pathway workforce requirements into capabilities.
3. Conduct a study to assess the level of capability to deliver recovery based care — analyse findings to develop appropriate training and / or peer support worker placements.

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**Case study: Small rural town**

A consumer with complex mental health issues resides in a small town, in which the only workforce resources are a GP and a generalist social worker. The consumer wishes to be treated with minimal disruption to his contributing life. The GP prepares a care plan, but is not entirely confident of her assessment capabilities. The plan is reviewed by a specialist psychiatrist remotely. The plan indicates that a range of capabilities are required to properly support the consumer. The social worker self assesses and concludes she possesses 70% of the capabilities required. It is determined the other capabilities can be supplied through a local farmer with lived experience and a visiting community mental health nurse from a district town. As a ‘team’, the workforce capability demands for the consumer’s treatment management and support are satisfied.
Peer support workforce

Number of peer support workers for the new services?

In the 2013 ‘Contributing Life Report Card’ delivered by the NMHC, a strong recommendation (13) was made for the creation of a ‘National Mental Health Peer Workforce Development Framework’ to progress on a national target for the employment and development of the peer workforce. The Commission advocated:

“Delivering recovery-focused services must involve growing and properly supporting our peer workforce. Without exception, the peer workforce includes both people with lived experience and personal carers. To do this, we need clear employment provisions and working conditions, training opportunities, professional capabilities and workforce development strategies, including supervision and mentoring requirements. All must be standardised nationally.”

The Commission set a target for increased numbers of peer workers in mental health related support services, with 50% of services employing peer workers in meaningful roles in four years and 100% in 10 years.

A more sensitive approach, at least for estimating ‘direct care’ peer support worker requirements (number of workers), such as providing individual support or running groups or activities, is one following the workforce analysis methodology process outlined above, based on care plans and assessing the required worker capabilities. The simple question in each care plan would be ... does lived experience help with the recovery process? The minimal use of peer support workers would be determined by the answer to that question — what other capabilities the peer support worker possesses might dictate the ultimate role to be played (for instance does the worker have more generic capabilities in care provision and working in teams). As noted above, a broader picture of workforce capabilities required (that might coincide with capabilities possessed by peer support workers), can be obtained by pooling the requirements of many care plan workforce impact assessments.

This takes account of the direct care workforce requirements for peer support workers but not those of the other non-consumer related ‘systemic’ roles that might be performed within the mental health services by persons with lived experience. Such roles include as noted earlier:

- delivering education programs for mental health workers and advocating for systemic improvements;
- providing support for housing and employment; and,
- advocating for systemic improvements.

The NMHC argues that critical to future mental health service models is that peer support workers have significant influence on other practitioners, service administrators and service designers. Currently influence is ad hoc and dependent on relative exposure of peer support workers and their individual (communication) capabilities. Like the workforce impact assessment for direct care derived from care plans, similarly the requirements of services for workforce lived experience capability in order to change the culture of the system needs to be assessed. This would be
predicated upon an understanding of, and a clearer delineation of, the role peer support workers need to play in order to effect sufficient influence to create cultural change.

Setting targets for a minimum number of peer support workers in each organisation (regardless of direct care service demands as estimated through care plans and cultural change requirements) as recommended by the NMHC in its 2013 Report may still have merit, at least in the short term, and at least for public sector service providers where resistance to the peer support workforce seems strongest.

**Regulation**

At present there is a concern by a proportion of the current peer support workforce that as the role is extremely unclear and inconsistent across jurisdictions and mental health service sectors there is a need to establish an agreed scope of practice for peer support workers through processes of establishing as an occupation. Those advocating this path would like to see the establishment of guidelines for scope of practice, ethics, training requirements and ultimately registration or some other form of regulation. Other members of the peer support workforce consider this unnecessary and limiting of the free approaches peer support workers bring to the work.

It seems that overly regulating what peer support workers can, and cannot do, at this time would be premature given the evolving nature of peer support work. However, equally clearly, if peer support capabilities are to be used appropriately in services delivery and given due credibility and acceptance by other sectors of the mental health workforce, then some quality assurance measures need to be implemented.

*A first step* in quality assurance would be to ensure that lived experience capability (along with associated capabilities) is only applied to care plans where it is indicated to be appropriate. Thus the peer support workforce is not used generically and routinely, but specifically and efficiently when indicated as appropriate.

*A second step* would be to insure that workers who possess lived experience also possess all other foundation or core capabilities (within the HWA Mental Health Core Capabilities framework, 2014) to work effectively. For instance they commit to respect, a recovery approach (having lived experience does not automatically imply such commitment), they can work in partnership, they have the capability and attitude to work with diverse people in all facets of their life, and they can collaborate not just with consumers, but also other workers and across time and place. Conditions of employment should incorporate these foundation capabilities and recruitment processes establish their possession, either though siting of appropriate documentation (say the Certificate IV in Mental Health Peer Work or a past employer’s assessment) or by an assessment by a recruiter or supervisor.

**Training**

Currently there is no mandatory qualification required to be employed as a peer support worker in the public, private or NGO mental health sectors. In most cases employers require lived experience only as essential criteria for the role (although this is changing as employers chase greater workforce flexibility) and often develop the remaining competencies required specific to the requirements of the organisation.
A nationally recognised qualification was developed in May 2012 and sits within the Community Services Training Package namely, the Certificate IV in Mental Health Peer Work. This qualification was reviewed in May 2013. The course has six core units of competency and nine elective units. The core units of competency include:

- Apply peer work practices in the mental health sector
- Contribute to the continuous improvement of mental health services
- Apply lived experience in mental health peer work
- Work effectively in trauma-informed care
- Promote and facilitate self-advocacy
- Contribute to Workplace Health and Safety (WHS) processes.

Community Mental Health Australia has recently developed training resources to support the streamlined delivery of the Certificate IV in Mental Health Peer Work. Distribution of these resources to all registered training organisations who have the qualification on scope has been funded by the NMHC. Currently there are eight registered training organisations (including SA and NSW TAFEs with numerous campuses) able to deliver the qualification.

Uptake of the Certificate IV in Mental Health Peer Work may be limited within the short term as (a) it is a new course and (b) because informal / in service training arrangements have already been created by different mental health service organisations to meet the needs of their peer support workforce. A research project aimed to validate the Certificate IV in Mental Health Peer Work with the HWA Mental Health Core Capabilities Framework 2014 as well as in service training programs and capabilities would be beneficial to confirm the required capabilities for peer support work in addition to lived experience.

Many observers are beginning to advocate as part of a quality assurance arrangement, and to build the credibility of the occupation, for the Certificate IV qualification to be made mandatory. Given that there is no registration or any other accreditation requirements, a push for a minimum qualification to enter the peer support workforce would need to be initiated and pursued by mental health service employers.

Mandating the Certificate IV course as a minimum passport for workforce entry has several flaws. The first is that the competencies required are currently likely to be widely held although unrecognised, in which case assessment is the priority, not more training. The second is that many peer support roles, either in a direct care or service advocacy situation, do not need the full range of capabilities delivered by the Certificate IV qualification — mandating training to that level would be inefficient. The third is that many [worthy] candidates for peer support work might be dissuaded by a requirement to attend classrooms and undertake anxiety provoking assessment processes.

Prospective peer support workers should be encouraged rather than coerced into formalising and sharpening their capabilities through training to a vocational outcome. The encouragement would be through better matching of worker capabilities to assessed workforce requirements, a better understanding of the capability deficits (by both employer / supervisor and peer support worker), and more flexibly available learning opportunities, in the workplace, to focus on addressing skill gaps.
Career pathways

In a similar vein, individuals should be supported to ‘professionalise’ as a peer support worker rather than be forced. For some, perhaps those for whom working as a peer support is part of their recovery process, the ‘career’ finishes when they have reached a certain point in their recovery pathway.

For others, the end point is to be better recognised for the capabilities they possess and to become a professional partner in the processes of mental health service delivery. For these individuals the gaining of skill sets through appropriate training interventions as proposed above would make sense. Equally valued might be a voluntary capability accreditation process (conducted by a professional association) that acknowledged capabilities assured through quality assurance processes publically. Thus, peer support workers could seek accreditation of generic and core capabilities. They could then seek further accreditation when they mastered capabilities associated with particular roles, for instance providing support to an individual in crisis, or conducting systems advocacy. Collecting capabilities in this way could ultimately deliver them a Certificate IV qualification or equivalent without having had to enroll in a course.

Ideally employers would use the same accreditation structure to influence their recruitment and deployment decision making.

A research project to investigate options for career pathways for peer support workers who wish to continue their career within mental health services would be beneficial. This research would attempt to delineate the steps in different career options and how to effectively articulate between steps where there appear to be ‘hard’ barriers (for instance completing a relevant degree program).

Summary – workforce interventions

1. Undertake assessment of the workforce demand for lived experience capabilities in a sufficiently large and varied sample of care plans — the findings can be used to build an understanding of the required size of the peer support workforce and to estimate possible demand for relevant training programs;
2. Undertake assessment of the demand for lived experience capability, in a sufficient number of service entities, in order to achieve appropriate levels of influence over service and system cultural change (in support of a recovery philosophy);
3. Identify minimum ‘core’ capabilities that must be alloyed with lived experience in order to render the lived experience capability effective in various direct care and systemic situations;
4. Assess employed individual peer support workers in the workplace against the capability requirements of the care plan based actions and / or systemic change aspirations — Depending on employer actions target employment levels may or may not need to be set;
5. Provide moral and financial support to a voluntary accreditation structure established and maintained by a suitable institution that could accredit the development and mastery by workers of particular skill sets or capabilities;
6. Flexible Certificate IV qualification modes of learning, including entire workplace based options, to be developed and offered — these can build on the resources developed by
Mental Health Coordinating Council (MHCC) and pilot tested already with funds from the NMHC;

(7) Undertake a research project aimed to validate the Certificate IV in Mental Health Peer Work with the HWA Mental Health Core Capabilities Framework 2014 as well as in service training programs and capabilities;

(8) Develop and implement peer support worker supervisor training on relevant disability and discrimination legislation, expectations of peer support staff and respect for all co-workers;

(9) Undertake a research project to investigate options for career pathways for peer support workers who wish to continue their career within mental health services;

(10) Contract a single Registered Training Organisation (RTO) or consortium to deliver on the job Certificate IV training — training needs to be non-threatening with limited classroom learning and test based assessment; and,

(11) Help promote the benefits of any accreditation system for improved recruitment to employers.

**PHC workforce**

It is argued that PHC providers can (or should be able to) competently identify and manage adequately consumers with high prevalence mental health disorders, some might argue even better than specialist mental health providers because they can simultaneously address other physical health and general welfare needs. Building the capacity of the primary (health) care sector is the best known way to significantly and pragmatically increase service access to a greater proportion of persons with a mental health problem and improve the delivery of mental health promotion and the likelihood of earlier intervention. A useful definition of primary care is as follows:

> “Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.”

Multiple and chronic illnesses, such as mental illness co-presenting with substance abuse and probably chronic physical issuers, are arguably best managed in the PHC setting (Rothman and Wagner, 2003; Howse, 2012) based on the following logic:

- chronic diseases have a broad spectrum of severity with most patients at the less severe end

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17 Definition developed by the Australian Primary Health Care Research Institute for ADGP Primary Health Care Position Statement 2005, also included in the Australian Medical Association Primary Health Care position paper, 2006.
• for most patients with more prevalent chronic illness the pharmacologic regimens involve a limited number of non-toxic drugs
• most adult patients have more than one chronic condition demanding therefore a more generalist and team approach to care coordination
• expertise in behavioural change and self-management support is critical to successful care, and
• there is a need to ensure a continuum of care.

General medical practitioners

Primary care is normally considered synonymous with general medical practice, since GPs are widely understood to be the key ‘gate-keepers’ for entry to health services. Integrating GPs intimately into the services delivered to persons with a mental health problem is critical to expanding and improving the quality of mental health care, and there are a number of service models that are well supported by evidence (e.g. consultation – liaison with psychiatrists; share care programs with community mental health services; advanced training programs; case management with Medicare funded resources; etc.).

The call for GPs to become involved in mental health services is not only due to their contact with patients but also to achieve better health outcomes for those with existing mental health issues. The physical health of people with mental health issues has recently come to the fore, but to date, has been acutely under-treated. Life expectancy of people with mental health issues is 25 years less than the general population; they experience a higher incidence of diabetes, cardiovascular disease and often experience side-effects, such as weight gain, associated with antipsychotic medications.

In calling for a greater role for GPs in management of a chronic disease like a mental health problem, authors agree on the need to seek a new way of structuring and delivering PHC. This is well articulated by Rothman and Wagner (2003) when they discuss significant variation in the outcomes of patients with chronic illness:

“... we believe that it [variation] is principally a function of the organization and orientation of practice. We and others have speculated that primary care systems were originally organized to react to acute illnesses and remain that way despite the increased prevalence of most major chronic diseases. In primary care, attention continues to focus on defining the problem; excluding more serious diagnoses; and initiating treatment, usually in the form of drug prescriptions.”

Howse (2012) supports these observations, noting that health care services have been built around an acute episodic model of care that is “... no longer suited to [the] epidemiological circumstances”. In an episodic care approach, addressing say an acute communicable disease condition, the patient’s role is largely passive, and since the full clinical course is often played out over days or weeks, there is little urgency to develop patient self-management skills or tracking programs (Wagner, et al., 2001). Howse (2012) argues that PHC services have to learn to provide person-centred rather than disease-centred care. He argues further that PHC services must get better at:

“... proactively seeking need rather than responding to demand, at involving patients in their own care, and at using alternative care settings to hospitals.” (p. 173)
Wagner, et al. (2001) identify a number of principles for successful management of chronic disease conditions in a primary care setting, that encapsulates much of the foregoing discussion and would be seemingly appropriate to health care for the elderly, which includes:

- Population identification process
- Placing the patient (and carers) at the centre of the process
- Evidence based practice guidelines
- Collaborative practice models
- Patient self-management within a health promotion / prevention framework
- Process and outcomes measurement, and
- Routine reporting and feedback loops, especially to the patient, based on a shared care plan.

All of these principles are applicable to managing mental health problems in the PHC setting.

**Building GP capability**

Most initiatives in the primary mental health care space have focused on GP support or engagement (e.g. Foy et al., 2010; Fuller et al., 2011; Reid et al., 2011). Actions to more fully engage GPs has included building their competence (for instance developing a capacity to practice cognitive behavioural therapy), supporting them through consultation and liaison from psychiatrists or other mental health specialists, and / or co-locating specialist mental health professionals in general practices on a casual or routine basis. By and large this type of service model is widely supported (Fuller et al., 2011; Perkins et al., 2010) and has been shown to deliver services to a wider number of consumers, especially those with low prevalence mental health disorders (Clark et al., 2009). For instance Kates and Mach (2007, p 77) found through a meta-analysis of Canadian literature that management of depression in primary care was associated with...

“... improved outcomes in terms of symptom reduction, relapse prevention, functioning in the community, adherence to treatment ... and satisfaction with care received.”

Efforts to involve GPs in mental health service delivery have always been subject to the willingness of GPs to engage with mental health patients, and their competence to provide effective services, both of which has been highly variable (Fuller et al., 2004). In rural areas the challenges to engaging GPs have been generally considered greater (though not insurmountable, Dunbar et al., 2007), requiring on the part of mental health workers according to Allan (2010, p 311):

“... a good understanding of the pragmatic and practical realities of their day to day practice and the philosophies that underpin these.”

**Other PHC workforce**

While they are most often the first level of care, including for mental health services, GPs are not the only first level source of care, even in the health system. Persons with a mental health problem are quite likely to present to an emergency department, to a child and maternal health service (Harvey et al., 2012), social workers (Thiel, et al., 2013) and psychologists (Gunn and Blount, 2009), a community health service or a drug and alcohol service, and their presentation might not be preceded by any previous history or diagnosis of mental illness. Almost as likely a
person with a mental health problem could make their first contact with services through child protection, while seeking housing support, in the justice system through adult or juvenile justice workers, or through youth services. Kendall et al. (2007) reporting on Victorian statistics, identified a number of primary care workers whose client case load involves a high proportion of people with mental health problems. The main four were:

<table>
<thead>
<tr>
<th>Drug and alcohol workers</th>
<th>approximately 50% of total client presentations</th>
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<tbody>
<tr>
<td>Child protection workers</td>
<td>23% of parents plus high levels of morbidity in children</td>
</tr>
<tr>
<td>Housing support workers</td>
<td>at least 30% of homeless, at least 50% of public housing high-risk tenancies</td>
</tr>
<tr>
<td>Justice workers</td>
<td>at least 25% of youth and adult offenders</td>
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As Kendall et al. (2007) pointed out all these types of health and social support workers can and should play a constructive role in prevention, early identification and support for persons with a mental health problem.

In order to deliver the new model of mental health services described in this report the PHC sector will need to play an important role in the identification, management and referral of individuals with mental health problems. The PHC workforce will need to be upskilled in mental health competence and assessment and provided with support from community mental health specialists. The members of the PHC workforce involved in the provision of mental health services will be GPs, practice nurses, community health nurses, allied health workers, Aboriginal health workers, nurse practitioners and early childhood nurses. Workforce development activities to support the new mental health service structures in PHC are described below.

**Developing mental health competence**

In order to support the PHC sector in its role in mental health service provision, development of mental health competence will be required using a population health approach. This will include development and delivery of educational interventions that:

- Build the mental health competence and literacy of GPs to be able to identify, conduct assessments (see section below), manage and refer appropriately patients with mental health needs.
- Build the competence of GPs in the role of clinical pharmacology.
- Involve pharmacists in medication reviews.
- Build the competence of general Practice Nurses to be able to participate and establish structural systems within practices to ensure ‘follow up’ and reviews are scheduled between patients and GPs. Practice nurses will also require competence and skills to enhance communication between clients, GPs and mental health nurses.
- Develop competence to establish and work within a mental health team appropriate to patient needs.
PHC teams

Within some remote Aboriginal communities in the Northern Territory effective PHC teams are working to support their community’s physical and mental health as a holistic service. Often the core of these teams is effectively someone with peer support worker capabilities. The structure and function of these teams provides a good model for establishing PHC teams across all communities as the particular cultural needs of communities can be addressed as well as their physical and mental health needs. In these service areas, PHC has a role in:

- Mental health promotion and prevention
- Mental health management including intervention and referrals to specialist CMHTs (when available)
- Dealing with psychiatric crisis / suicide attempts
- Acute drug and alcohol problems.

While within urban areas specialist mental health resources may be more readily available to respond to psychiatric crises (Mental Health Crisis Teams) the composition of PHC teams will need to be established by GPs to suit the needs of their communities. Collaborative relationships with an understanding of referral protocols will need to be established from resources available within that community. Following the establishment of these collaborative networks, GPs will establish a team that suits the needs of the individual patient and should consider and include (where appropriate):

- GP
- Practice nurse
- Mental health nurse / specialist CMHT
- Peer support worker, Aboriginal mental health worker or Social and Emotional Wellbeing worker (provides cultural competence for the individual)
- Social worker
- Drug and Alcohol service
- NGO services.

Partnerships between specialist mental health workforce and GPs, practice nurses, child and maternal health nurses, school nurses and counsellors, youth workers, community health nurses, alcohol and other drug workers, etc. that build their competence and confidence to care for persons with a mental health problem can extend the reach of specialist mental health resources while potentially improving the overall quality of services.

Assessments

Consumer focused mental health interventions are about the provision of care that is developed in keeping with the specific requirements of individuals. This encompasses a whole of life recovery perspective for a care plan that acknowledges the extensive breadth of a mental health consumer’s bio-psychosocial needs.

A range of terminology of assessment types is currently used by different sectors of mental health services including mental health care plan, mental health support plan, mental health treatment
plan (GP Medicare item), discharge plans (following acute services) etc. For the purposes of PHC assessment, the term care plan will be utilised in this section.

GPs will need to develop quality assessment skills that provide a good judgment of the individual’s needs. GPs should be just as proficient at identifying mental as physical health issues. In identifying health problems they can use a range of supports — pathology tests, diagnostic imaging — and / or they can seek the advice of specialists through a referral or if their relationship is strong (with a public sector specialist) through a telephone conversation. Similar ‘diagnostic’ support should be available to GPs to assess mental health problems.

Individuals with emerging high prevalence mental health needs (e.g. depression or anxiety) may be assessed by their GP as requiring referral to a self-help therapy or medication which will be continued to be managed by the GP and therefore does not require a care plan. However, when the GP assesses that the individual requires referral to a third party for mental health intervention services, drug and alcohol services or other specific support services (e.g. housing support, employment services etc.), development of a care plan in conjunction with the individual and their carer should become routine.

Care plans should be developed along the following principles:

- Client centred – involve client and carer in choices of support services.
- Allow care plans, and progress on implementation of plans, to be shared between service providers by means of agreed access principles and protocols and / or putting in place ‘consumer held’ record processes. In the longer term some form of swipe card such as that being trialled in Singapore would be appropriate; in the short term these may be paper based or electronically transferred to agreed ‘team members’.
- Availability of assessment tools: PHC need good tools to assess and refer.
- Regular review – structural systems should be developed to ensure that all individuals with an identified mental health issue should be reviewed regularly. Practice nurses should play an important role in this by establishing automated alerts within their patient management systems.

Summary – workforce interventions

1. Create a PHC mental health consultancy team in each LHD to support general practices — this team would provide second opinions, support assessment practice and provide opportunistic training of GPs and practice nurses. The CMHT would be appropriate for this role but might require some incentive or further resources. Model support teams have already been established in regions of Victoria;
2. Locate a significant proportion of community mental health services in co-residence with PHC services or in accessible teams (travelling or virtually accessible) available for advice and consultation;
3. Increase the size of the Mental Health Nurse Incentive Program in terms of actual sessions funded\(^\text{18}\) — possible change to payment arrangements to encourage more efficient use of MHNIP nurses based on types of patients being consulted;

\(^\text{18}\) Note that budget for 2014/15 has been retained at the level of the previous year at $22 million.
(4) Provide evidence based care plan templates that are suitable for use in primary mental health care by a range of workers but especially as a means to improve GP care plans;

(5) Develop and deliver a recognised skill set for practice nurses to be delivered through supported on the job training. This would require incentives for GPs to encourage and allow their practice nurses to enroll (may need to consider introducing an increased mental health related practice nurse item number); Incentivise / motivate more GPs to obtain minimum MH capabilities through negotiation with the RACGP to make a minimum proportion of Continuing Professional Development (CPD) points to maintain vocational registration to satisfy mental health content requirements (e.g. 30 out of 150 points each 3 year period);

(6) Improve GP decision making support resources (e.g. clinical management software) capacity to prompt best mental health practice. For example, pop ups for known long term / chronic health illnesses to ask “Have you asked them how they are feeling?” “Consider running screening tools, schedule follow up etc.” Provide GPs with feedback about how their practice compared with others or with best practice e.g. referral, prescription and use of drugs etc.;

(7) Increase ‘just in time’ support for GP decision making as well as PHC mental health consultancy teams and co-located specialist resources, build remote psychiatric consultancy services available on demand through telehealth. In the longer term, consider developing more GPs with a special interest in mental health; Improve broader workforce mental health assessment capabilities — Discuss and implement curriculum changes with University & College education providers.

Self-help strategies

Evidence shows that mental health promotion, prevention and self-help can often provide effective support to individuals at early stages of mental health problems – often resulting in them resolving problems before they become significant. Delayed access to effective advice and [self] support services on the other hand results in longer periods of illness and possible loss of relationships, employment and housing. For those who require external support, early intervention can also provide a recovery focus and reduce the risk of presenting in a crisis situation at the acute end of mental health services. The WA MHC Strategic Plan 2020 advocates the use of self care:

“Self care is encouraged as the most substantial form of support. People are encouraged and supported to manage their own mental health problems with help from family or friends. This involves learning to monitor their own mental health, maintain a preventive lifestyle, manage emotional problems as they arise and know when and where to seek help.”

Self-help is primarily sought through support groups, self-help clinics, literature and e-mental health technologies. These are described below along with relevant workforce implications.

Support groups

Attempts to introduce self-help within the primary mental health care setting, such as guided self-help clinics (Farrand et al., 2009), self-help booklets and guided self-help interventions (Lucock et
al., 2011) and personal planning and self care management (Gillard et al., 2012). Most of these approaches have shown a degree of promise. A treatment approach developed for persons with a mental health problem in remote Indigenous communities that incorporated self-management principles and engaged family support was shown to deliver statistically significant positive changes in mental health outcomes (Nagel et al., 2009).

Peer support workers have been successful in facilitating self-help support groups for NGO mental health services and other self-help recovery focused educational activities for example, Recovery Colleges. The facilitation of self-help support groups by peer support workers is extremely valuable as it provides the sharing of lived experience in mental health with a recovery focus.

**Effectiveness of e-mental health or tele-mental health**

The development of e-mental health technologies requires substantial input from the mental health workforce to assist in identifying needs and the design of these interventions in conjunction with academic researchers and information technology resources. However, once developed, e-mental health technologies that do not require clinician support provide a large benefit to the mental health workforce as they effectively substitute workforce resources effectively reducing the amount of time spent with individuals and freeing up specialist services to support increased numbers of incoming clients.

GP and mental health specialist resources can ‘prescribe’ these technologies to enable transfer of information to individuals in conjunction with face to face interventions, thereby improving service offering and hopefully over time reducing the need for face to face interventions and building resilience and empowerment in consumers. However, the quality and evidence base of e-mental health technologies needs to be considered and advice provided to GPs and other PHC workers to enable them to confidently prescribe appropriate and best practice resources.

Technologies that involve clinicians in providing email, ‘chat’ or face to face interventions over the internet still obviously require the investment of specialist mental health workforce however, the structure of these services allow the service offering not to be limited by geographic boundaries – greatly improving access for rural and remote individuals.

**Summary – workforce interventions**

(1) Investigate potential agents (pharmacists / National Prescribing Service) who could act as advisors to GPs and other mental health workers on which electronic self-management tools to prescribe — need to keep in touch with the evidence base to make suggestions to prescribe appropriate e-mental health strategies.

**NGO services**

As mentioned earlier in this report, there are numerous mental health services provided by NGOs. In Victoria where NGO services are arguably most valued and integrated within the mental health system they were known as Psychiatric Disability Rehabilitation and Support Services (PDRSS) but are more recently known as the Mental Health Community Support Services (MHCSS). There the workforce is distributed across the following program types (Department of Health, 2013):
Due to the varied structures of funding these services by either (or both) State or Commonwealth sources, there is often a lack of coordination and the result can be duplication, varied quality and gaps in mental health services. A trend has been observed to rationalise NGO services to reduce the complexity of this sector but also to ensure high quality and evidence based services are delivered.

This has led to a quiet revolution in the sector, and providers are increasingly being expected to deliver family-inclusive, trauma-informed support, be responsive to client diversity and work collaboratively with other health and human service providers to ensure continuity of care for clients. In many respects the forward planning of the more business-like NGOs is attempting ensure that providers and clients and their carers and families are well positioned to respond to the opportunities that will come with the implementation of the NDIS (Department of Health, 2013). NGO Staff will be expected to work in new ways in order to perform new functions such as supporting client-directed decision making and delivering individual client support packages (Department of Health, 2014).

Many in the NGO sector have argued, despite relatively high levels of education compared with the rest of the (non-health) Australian workforce, for more pre-employment education. Others have focused more on capabilities. To some extent calls for qualifications represent an effort to seek higher credibility for the NGO workforce in the face of persistent depreciatory attitudes from some elements of public mental health services.

In regard to capabilities a recent survey of Victorian NGO mental health workers (Department of Health, 2013) asked them to nominate five competencies they thought were most important in undertaking their current role effectively. They were then asked whether they needed further training in the chosen competencies. Table 6 shows the most frequently occurring competencies nominated, and the proportion of those nominating who thought they needed further training.

### Table 6: Main competencies identified as required to perform work and training need by competency

<table>
<thead>
<tr>
<th>Competency</th>
<th>% of workers nominating competency</th>
<th>% of workers who need further training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing recovery plans with a client</td>
<td>45%</td>
<td>32%</td>
</tr>
</tbody>
</table>
According to the workers surveyed, ‘Developing recovery plans with a client’ is the highest ranked competency required for undertaking work in NGO services, but less than a third of workers who require this capability need more training. On the other hand, over half of those who nominated another frequently required capability, ‘Mental health relapse prevention and self care’, believe they need more training. A number of less required capabilities (but no doubt occasionally critical to service operations and consumer outcomes) were identified as high needs for training.

Summary – workforce interventions

(1) Conduct follow up studies of the mental health NGO workforce — Surveys of NGO services have been undertaken in recent years at National and State / Territory jurisdictional level. It seems the best results have been obtained where the financial relationship between the NGO and the data collection agent has been strongest. Accordingly, it should be possible to make it a condition of funding NGOs that they provide annual staffing data to AIHW (even if State / Territory funded). Data needs to be collected in a way that allows analysis of workforce allocation to functions, and leaves open to inspection the capabilities being applied;

(2) Where NGOs are on average small, they need to be supported by centralised or shared Human Resources (HR) services19 — Many NGOs are too small to have appropriate in-house HR functionality, leaving them generally speaking at a competitive disadvantage to

<table>
<thead>
<tr>
<th>Competency</th>
<th>% of workers nominating competency</th>
<th>% of workers who need further training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health relapse prevention and self care</td>
<td>36%</td>
<td>53%</td>
</tr>
<tr>
<td>Identifying changes in mental health status</td>
<td>30%</td>
<td>46%</td>
</tr>
<tr>
<td>Explore with clients their understanding of their problems and strengths</td>
<td>29%</td>
<td>36%</td>
</tr>
<tr>
<td>Managing client risk to self and others</td>
<td>21%</td>
<td>40%</td>
</tr>
<tr>
<td>Working with clients with challenging behaviours</td>
<td>21%</td>
<td>71%</td>
</tr>
<tr>
<td>Working with clients who have experienced trauma</td>
<td>18%</td>
<td>85%</td>
</tr>
<tr>
<td>Building and maintaining service partnerships</td>
<td>16%</td>
<td>49%</td>
</tr>
<tr>
<td>Conducting needs assessments</td>
<td>14%</td>
<td>45%</td>
</tr>
</tbody>
</table>

19 In some cases this will not be appropriate as average size of NGOs consolidates and grows.
Community mental health and acute services

The future direction of acute care (hospital) mental health services is expected to remain as is currently in place in respect of the number of hospital based ‘acute beds’. This follows the process of de-institutionalising mental health services and current State governments do not appear to have plans to increase the allocation of hospital beds for mental health patients nor to increase the number or size of existing mental health institutions. Quantitative demand for hospital based mental health services can therefore be expected to follow national population growth.

Qualitatively, service improvements have been advocated in three areas:

- Increased emphasis even during the acute care phase on a belief that all individuals with a mental health issue can ‘recover’ from an episode of mental ill health and with the appropriate support can lead a ‘contributing life’. Treatment during acute care can be uplifting and not traumatic;
- Improved inter-disciplinary team work, each team being built around the requirements of an agreed care plan and wherever possible being directed by the consumer and contributed to by a peer support worker; and,
- Improved discharge plans that reflect the input of the consumer and the entire team, and wherever possible involve an input from the community mental health workforce.

The workforce interventions for the community mental health acute care services, as discussed earlier, will be to re-deploy workforce more either in support of PHC or integrated with PHC providers. For the workforce resources that remain in traditional CMHTs, the focus will be on improvements in work organisation and service delivery to maintain consistency with a recovery based mental health system.

It is acknowledged that the acute mental health system (including CMHTs) is the last line of support for people with serious mental health problems. They are the primary responders to individuals in psychiatric crisis situations and deal with the highest level complexity of mental health problems (low prevalence). However, due to historically ‘stretched’ resources and resultant limits on workforce supply these services are strained and the workforce is not able to deliver the services that they aim to deliver for their patients. These services therefore require improved systems and support to enable them to work more efficiently and safely for both consumers and workers and adopt a true recovery focus to the provision of services.

Summary – workforce interventions

(1) Develop and distribute guidelines and tools for assessing workforce requirements of care plans — These tools will need to be sophisticated enough to provide meaningful data but not so complex as to promote avoidance on the part of those preparing or reviewing...
plans. The target for tools includes plans developed in PHC, community MH care, acute care, etc.

(2) Conduct a study of team based discharge planning for acute care – identify capability requirements for including peer support and social work competencies. Explore the feasibility of involving community mental health workers in discharge planning by rotating workers through hospital settings on short term secondments.

(3) Develop capabilities to practice interprofessional team work in hospital and community mental health acute care settings — Training could be undertaken through simulated learning environments.

Non-mental health workforce

As mentioned earlier in this report, a number of government service providers outside the health sector interact with and have clients who have existing mental health issues. These services include housing, education, employment, justice, youth and alcohol and other drugs. These workforces require the development of the following competencies through targeted education strategies to support them in their roles and to ensure individuals with mental health issues are provided with safe services. The mental health competencies to be developed within a population health approach include:

- Mental health competence / literacy
- Cultural competence
- Interagency teamwork
- Working effectively within a team
- Collaboration
- Referral protocols
- Contributing to the development of care plans.

Summary – workforce interventions

(1) Develop and undertake significant training of non-mental health workforce in mental health competence for those who have significant contact with persons with mental health issues.20

(2) Develop population health training (such as Mental Health First Aid21) in mental health competence for all associated workforces. Mandatory for all new appointees.

20 For instance workers in Education, Employment, Justice, Youth, Housing etc.
21 Programs may be needed with a stronger emphasis on mental health rather than illness and a variety of delivery formats to suit different audiences and levels of education and literacy.
7. **Summary of recommended workforce interventions**

A number of workforce interventions that support the change in direction and development of the mental health workforce to suit the aspirational model of mental health services have been recommended throughout previous chapters. These recommended workforce interventions have been inserted in blue text boxes at the end of each chapter following the supporting text.

Implementing these workforce interventions will be required over a ten year period with a number of interventions requiring immediate attention to support the existing mental health workforce. Accordingly, the following table consolidates all recommended workforce interventions and provides a suggested timeframe for implementation that would realise the greatest return on investment.

The recommended workforce interventions are organised in three ways:

First, according to whether they emanate from current workforce analysis and represent a ‘quick fix’ (but still broadly consistent with achieving longer term workforce objectives) or whether they are designed to achieve a change in workforce composition and deployment consistent with delivering future ‘aspirational’ mental health services;

Second, according to whether they impact on priority target objectives (short term, 1-2 year period), drive longer term priorities (medium term, 3-5 year period), or embed longer term [service] outcomes (longer term, 6-10 year period); and,

Third, whether they impact on:

- PHC service workforce (pink),
- peer support workforce (yellow),
- NGO workforce (orange),
- general MH workforce (green),
- specific workforce intelligence gathering (blue) ...
<table>
<thead>
<tr>
<th>Years 1-2 Priority and target setting</th>
<th>Years 3-5 Drive and monitor priorities</th>
<th>Years 6-10 Embedding outcomes</th>
</tr>
</thead>
</table>

**Immediate recommended workforce interventions — ‘Quick fix’ but with a view to the future**

*This includes interventions that are indicated by current analysis as being appropriate but are also consistent with aspirational service direction*

- Increase the size of the Mental Health Nurse Incentive Program in terms of actual sessions funded — possible change to payment arrangements to encourage more efficient use of MHNIP nurses based on types of patients being consulted.

- Retrain Registered Nurses into Mental Health Nurses — Incentivise training program in the following ways:
  - Training to be largely on the job with online conceptual support;
  - Nurses to be offered a scholarship program which pays for any training costs;
  - Employers of trainees to be offered salary subsidy similar to apprenticeships.

- Develop and promote a one year postgraduate diploma for health professionals (nurses, occupational therapists, social workers, etc.) to quickly transfer to the MH workforce — May need to offer scholarship.

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22 Note that budget for 2014/15 has been retained at the level of the previous year at $22 million.

23 Must be eligible specialist mental health service in a community mental health, NGO or general practice setting.
<table>
<thead>
<tr>
<th>Years 1-2 Priority and target setting</th>
<th>Years 3-5 Drive and monitor priorities</th>
<th>Years 6-10 Embedding outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>support or increased pay incentives depending on initial uptake</td>
<td>Develop and deliver a recognised skill set for practice nurses to be delivered through supported on the job training — provide incentives for GPs to encourage and allow their practice nurses to enroll (could consider introducing an increased practice nurse item number)</td>
<td>Create a PHC mental health consultancy team in each LHD to support general practices — to provide second opinions, support assessment practice and provide opportunistic training of GPs (and practice nurses)</td>
</tr>
<tr>
<td>Provide evidence based MH care plan templates to GPs — construct templates that are suitable for use in primary mental health care by a range of workers</td>
<td>Improve broader workforce MH assessment capabilities — discuss curriculum changes with University &amp; College education providers</td>
<td>Improve broader workforce MH assessment capabilities — implement changes in courses based on revised curricula</td>
</tr>
<tr>
<td>Improve productivity of psychiatrists — invest in e-mental health, tele-mental health, and self-management technologies and re-deploy some public sector employed psychiatrists as indirect consultants to PHC</td>
<td>Investigate potential players (pharmacists / National Prescribing Service) who could act as advisors to GPs on which electronic self-management tools to prescribe — need to keep in touch with the evidence base to make suggestions to prescribe appropriate e-mental health strategies</td>
<td></td>
</tr>
<tr>
<td>24 Content to include level 1 capabilities of HWA Mental Health Capabilities, plus Mental Health First Aid, and triaging mental health presentations.</td>
<td>25 This could be a specific role for the Community Mental Health Team but might require some incentive or resource</td>
<td>26 For instance, influence change to the RACGP curriculum to include the principle that there is no health without mental health. Specifically development of mental health and assessment competence.</td>
</tr>
<tr>
<td>27 A review of international practice might be worthwhile, we are not the only ones with this challenge and evidence from NZ, Europe, UK might be worthwhile</td>
<td>28 Key to this is enabling and encouraging PHC staff to use these services</td>
<td></td>
</tr>
<tr>
<td>Years 1-2 Priority and target setting</td>
<td>Years 3-5 Drive and monitor priorities</td>
<td>Years 6-10 Embedding outcomes</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Re-model the supply of key MH workforces based on 2013 AIHW workforce data — examine especially the workforce age composition effects</td>
<td>Explore increased use of psychology qualified workforce — perceived value in having more psychologists registered and reducing clinical practice limitations on numbers achieving registration</td>
<td>Undertake a significant training of non-mental health workforce those who have significant contact with persons with mental health.</td>
</tr>
<tr>
<td>Undertake a specific study of the psychologist workforce — clarify actual supply of clinical, registered and non-registered workforce working in MH services</td>
<td>Research workforce demand for key MH professions based on ‘Clinical Pathways’ — use completed clinical pathways to assess workforce need</td>
<td></td>
</tr>
</tbody>
</table>

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29 Includes MH nurses and psychiatrists.
30 Might want to look at those practicing as counselors who do not have psychology qualifications or registration.
<table>
<thead>
<tr>
<th>Years 1-2 Priority and target setting</th>
<th>Years 3-5 Drive and monitor priorities</th>
<th>Years 6-10 Embedding outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>health issues</strong> (^{31}) -- includes content on mental health, collaboration, referral protocols competence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertake assessment of the workforce demand for lived experience capabilities in a sufficiently large and varied sample of care plans.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertake assessment of the demand for lived experience capability, in a sufficient number of service entities, in order to achieve appropriate influence over service and system change.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify minimum ‘core’ capabilities that must be associated with lived experience in order to render the lived experience capability effective in various direct care and systemic situations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess employed individual peer support workers in the workplace against the capability requirements of the care plan based actions and/or systemic change aspirations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Map HWA mental health capabilities to specific peer support worker roles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertake validation exercise to ensure that Peer Support Certificate IV qualification</td>
<td>Commission development of assessment tools against Cert</td>
<td></td>
</tr>
</tbody>
</table>

\(^{31}\) For instance workers in Education, Employment, Justice, Youth, Housing etc.
<table>
<thead>
<tr>
<th>Years 1-2 Priority and target setting</th>
<th>Years 3-5 Drive and monitor priorities</th>
<th>Years 6-10 Embedding outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>delivers required role specific capabilities</td>
<td>Flexible Certificate IV qualification modes of learning, including entire workplace based options, to be developed and offered</td>
<td>IV competencies</td>
</tr>
<tr>
<td>Provide support to a voluntary accreditation structure that could accredit the development and mastery by workers of particular skill sets or capabilities</td>
<td>Draft and disseminate peer support role specific position descriptions — PDs drafted to highlight capability requirements</td>
<td>Undertake a research project to investigate options for career pathways for peer support workers who wish to continue their career within mental health services.</td>
</tr>
<tr>
<td>Develop and implement peer support worker supervisor training on relevant disability and discrimination legislation, expectations of peer support staff and respect for all co-workers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undertake a research project aimed to validate the Certificate IV in Mental Health Peer Work with the HWA Mental Health Core Capabilities Framework 2014 as well as in service training programs and capabilities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### HCA Final Report to NMHC – Workforce advice

<table>
<thead>
<tr>
<th>Years 1-2 Priority and target setting</th>
<th>Years 3-5 Drive and monitor priorities</th>
<th>Years 6-10 Embedding outcomes</th>
</tr>
</thead>
</table>

### Longer term recommended workforce interventions — a workforce to support a new service direction

Interventions designed to achieve a change in workforce composition and deployment consistent with delivering future ‘aspirational’ mental health services

- **Co-locate a significant proportion of community mental health services with PHC services** — may be for a few sessions a week in a number of different services
- **Develop and distribute guidelines for assessing workforce requirements of care plans** — includes plans developed in PHC, community MH care, acute care, etc.
- **Promote wider adoption of double major nursing degrees with mental health as one of the majors**

**Incentivise / motivate more GPs to obtain minimum MH capabilities** — Negotiate with the RACGP to make a minimum proportion of CPD points to maintain vocational registration satisfy mental health content requirements (e.g. 30 out of 150 points each 3 year period)

**Improve GP decision support resources (e.g. clinical management software) capacity to prompt best mental health practice** — pop ups for known long term / chronic health illnesses “Have you asked them how they are feeling?”, Consider running screening tool, schedule follow up, etc.

**Increase ‘just in time’ support for GP decision making** — as well as PHC mental health consultancy teams and co-located specialist resources, build remote consultancy services available on demand through telehealth.

**Establish the infrastructure for capability [competency] based workforce planning & development** — includes improved data collection systems based on care plans with associated workforce impact assessments

**Conduct trial study to translate clinical pathway workforce requirements into capabilities**

---

32 Ensuring parity for mental health capabilities and expertise
33 Provide GPs with feedback about how their practice compared with others or with best practice e.g. referral, prescription and use of drugs etc.
34 In time consider developing GPs with a special interest in mental health
<table>
<thead>
<tr>
<th>Years 1-2 Priority and target setting</th>
<th>Years 3-5 Drive and monitor priorities</th>
<th>Years 6-10 Embedding outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct a study to assess the level of capability to deliver recovery based care — analyse findings to develop appropriate training and / or peer support worker placements</td>
<td>Conduct a study of team based discharge planning from acute care – identify capability requirements for including peer support and social work competencies</td>
<td>Develop and implement curriculum changes to RANZCP advanced training program</td>
</tr>
<tr>
<td>Review of RANZCP advanced training program to identify any inconsistencies with a contributing life philosophy</td>
<td>Make it a condition of funding NGOs that they provide annual staffing data to AIHW</td>
<td>Sell accreditation system to employers</td>
</tr>
<tr>
<td>Conduct follow up studies of the mental health NGO workforce</td>
<td>Where NGOs are on average small, they need to be supported by centralised or shared HR services ³⁵</td>
<td>Develop a (voluntary) accreditation system for peer support workers — base the system on identified roles and role capability requirements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contract a single RTO or consortium to deliver on the job Certificate IV training — training needs to be non-threatening with limited classroom learning and test based assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop population health training (such as Mental Health First Aid ³⁶) in mental health competence for all</td>
</tr>
</tbody>
</table>

³⁵ In some cases this will not be appropriate as average size of NGOs consolidates and grows.
³⁶ Programs may be needed with a stronger emphasis on mental health rather than illness and a variety of delivery formats to suit different audiences and levels of education and literacy.
<table>
<thead>
<tr>
<th>Years 1-2 Priority and target setting</th>
<th>Years 3-5 Drive and monitor priorities</th>
<th>Years 6-10 Embedding outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>associated workforces. Mandatory for all new appointees</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. References


Department of Health (2013) *The Victorian psychiatric disability and rehabilitation support services (PDRSS) workforce census report 2012*. State of Victoria


Appendix A: Data available on the psychologist workforce

Table: Number of employed psychologists by work setting of main job, 2011 and 2012

<table>
<thead>
<tr>
<th>Practice Setting</th>
<th>2012 Headcount</th>
<th>% of total psychologists</th>
<th>% change 2011 to 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo private practice</td>
<td>4,578</td>
<td>20.4</td>
<td>9.2</td>
</tr>
<tr>
<td>Group private practice</td>
<td>2,726</td>
<td>12.2</td>
<td>12.0</td>
</tr>
<tr>
<td>General practitioner (GP) practice</td>
<td>546</td>
<td>2.4</td>
<td>14.0</td>
</tr>
<tr>
<td>Other private practice</td>
<td>504</td>
<td>2.2</td>
<td>-10.8</td>
</tr>
<tr>
<td>Aboriginal health services</td>
<td>57</td>
<td>0.3</td>
<td>14.0</td>
</tr>
<tr>
<td>Community mental health service</td>
<td>1,793</td>
<td>8.0</td>
<td>5.3</td>
</tr>
<tr>
<td>Hospital</td>
<td>1,427</td>
<td>6.4</td>
<td>12.2</td>
</tr>
<tr>
<td>Drug and alcohol service</td>
<td>266</td>
<td>1.2</td>
<td>-3.6</td>
</tr>
<tr>
<td>School</td>
<td>2,364</td>
<td>10.6</td>
<td>6.4</td>
</tr>
<tr>
<td>Correctional services</td>
<td>492</td>
<td>2.2</td>
<td>1.0</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>14,753</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation/physical developmental service</td>
<td>245</td>
<td>1.1</td>
<td>-9.3</td>
</tr>
<tr>
<td>Other community healthcare service</td>
<td>1,004</td>
<td>4.5</td>
<td>18.4</td>
</tr>
<tr>
<td>Disability institution</td>
<td>222</td>
<td>1.0</td>
<td>-0.4</td>
</tr>
<tr>
<td>Other residential healthcare facility</td>
<td>57</td>
<td>0.3</td>
<td>3.6</td>
</tr>
<tr>
<td>Commercial/business services</td>
<td>927</td>
<td>4.1</td>
<td>0.4</td>
</tr>
<tr>
<td>Tertiary educational facility</td>
<td>1,572</td>
<td>7.0</td>
<td>1.7</td>
</tr>
<tr>
<td>Other education facility</td>
<td>240</td>
<td>1.1</td>
<td>5.7</td>
</tr>
<tr>
<td>Practice Setting</td>
<td>2012 Headcount</td>
<td>% of total psychologists</td>
<td>% change 2011 to 2012</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------</td>
<td>--------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Defence forces</td>
<td>193</td>
<td>0.9</td>
<td>-6.3</td>
</tr>
<tr>
<td>Other government department or agency</td>
<td>1,500</td>
<td>6.7</td>
<td>-4.5</td>
</tr>
<tr>
<td>Other</td>
<td>967</td>
<td>4.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Unknown</td>
<td>727</td>
<td>3.2</td>
<td>-30.2</td>
</tr>
<tr>
<td>Total</td>
<td>22,404</td>
<td>100.0</td>
<td>4.0</td>
</tr>
</tbody>
</table>
Appendix B: Medicare benefit claim statistics for relevant mental health items

<table>
<thead>
<tr>
<th>MBS Item Number</th>
<th>Service</th>
<th>Financial years</th>
<th>Occasions of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>2700</td>
<td>Prepare mental health treatment plan</td>
<td>2011/2012</td>
<td>86,002</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2012/2013</td>
<td>142,277</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2013/2014</td>
<td>154,779</td>
</tr>
<tr>
<td>2701</td>
<td></td>
<td>2011/2012</td>
<td>41,834</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2012/2013</td>
<td>69,786</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2013/2014</td>
<td>74,026</td>
</tr>
<tr>
<td>2715</td>
<td></td>
<td>2011/2012</td>
<td>258,810</td>
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Appendix C: A traditional approach to workforce planning

A concise description of the time honoured methodology for planning health workforces has been provided by the Australian Medical Workforce Advisory Committee (AMWAC, 2000). In this ‘traditional’ approach to planning workforces the estimation of current and future workforce supply is generally considered the easy (at least conceptually) part of the methodology using a standard ‘stock and flow’ type of approach. Health Workforce Australia (HWA, 2012) for instance employed this model to describe people entering and exiting the workforce (flows) leading to periodic adjustment in the initial number in the workforce (stock) in its comprehensive study of the Australian medical and nursing workforces. This process is represented in the Figure below.

Estimating projected workforce demand is more conceptually demanding. There are two major approaches to the estimation of labour requirements — a "demand" approach, or a "needs" approach. Hall and Mejia (1978) describe these two approaches in a conventional workforce environment as follows (emphasis added for this report):

"Demand, ... refers to the sum of the amounts of the various types of health services that the population of a given area will seek and has the means to purchase at the prevailing prices within a given time period. From this demand the health manpower required to produce these services can be derived.

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37 In HWA’s modelling of supply, the workforce is broken down into age and gender cohorts and different flow rates are applied to each cohort. The model then takes these different flow rates into account by progressive ageing of the workforce through iteration of the stock and flow process.
Need represents estimation based on professional judgment and (available) technology of the number of workers or amount of services necessary to provide an optimum standard of (service). Need exceeds demand when there are insufficient resources to purchase services in accordance with professionally determined needs.

The most commonly employed methodology is a ‘service utilisation’ approach — without possibly knowing it, by adopting a ‘service utilisation’ methodology, most planners are taking a ‘demand’ approach. The service utilisation method assumes current service utilisation serves as a good measure of satisfied demand. Past trends in service utilisation are also assumed to be a good estimation of the likely future changes in utilisation patterns. HWA’s 2025 workforce study demand projections for doctors and nurses are all based essentially on a service utilisation approach (HWA, 2012). Gadiel, et al (1999) and more recently HCA (2010) have used this method to effect in studying the pharmacy workforce. An example of a ‘needs’ approach would be the ‘practitioner / population ratio’ method —a theoretical relationship (ratio) is established between the population (segmented into different age categories) and the requirement for health service professionals. This method was popular in the past in estimation of medical manpower needs (e.g. DHEW, 1977).

The practitioner to population (or similar relationship such as practitioner to beds, practitioner to live births, etc.) ratio methodology has largely been discredited in more recent times. So too, the service utilisation method has come under criticism (e.g. Scott, et al, 2011) because it does not allow for a change to service delivery that departs from the status quo or ‘trend’ delivery patterns, for instance as a result of changes in consumer service preferences; changing social, political and economic circumstances; availability of government funding; the level of private sector investment, or the type of technology available.

While still operating within a traditional workforce planning methodology paradigm, several alternative methods for estimating demand have been proposed that attempt to overcome the deficiencies of the ‘service utilisation’ approach. Two proposed by Ridoutt et al (2013) include:

- **Service-based workforce planning approach** — involves planning from the ‘bottom up’ starting with the provision of specific health care services at a local or regional level. Demand is determined by staffing requirements to operate the service effectively. There are an increasing number of models available that can inform local level staff planning such as the World Health Organisation’s ‘Workload Indicators of Staff Need (WISN) (Shipp, 1998) for whole health services and many others for specific types of staff (see for instance Schoo, Boyce, Ridoutt and Santos, 2008).

- **‘Best practice’ or ‘models of care’ approach** — this defines the need for workforce in terms of evidence based ‘best practice’ guidelines; generally for care in specific disease areas. The assumption is that once best practice care guidelines have been established the staffing / workforce requirements will be transparent. Recent exponents of this approach in Australia have been Segal, Dalziel and Bolton (2008) who argue for a “… process for estimating care within a region, building on population health status and published best practice guidelines, and translated into a service requirement in the context of a local service system.”
A potential application of the latter of these alternative demand estimation approaches applied to the mental health workforce is explored in Box A.

**BOX A:**

A ‘Clinical Pathways’ project commissioned by the National Mental Health Commission is constructing future ‘best practice’ care pathways for a number of clinical conditions, for instance post natal depression, bipolar disorder, anorexia nervosa, and depression. These pathways prescribe ‘optimal’ service delivery in quantitative terms of visits, days, hours, etc. and can be translated into units of time requirements for specific mental health professionals (psychiatrist, psychologist, GP) or more generalist mental health workforce (mental health team, peer support). Thus, each ‘average’ consumer (within say mild, moderate and severe classifications) can be translated into a measurable workforce requirement in terms of full time equivalents of each mental health workforce type. Estimates of consumer numbers\(^1\) (current and projected) allow extrapolation to a total workforce demand.
Appendix D: Limitations of a traditional approach to workforce planning

A number of authors have highlighted deficiencies in the traditional approach to health workforce planning but in regard to the mental health workforce the Victorian government possibly states it best (Department of Health, 2014):

“Traditional workforce planning and development approaches are often focused on the development of individual workers. They are ‘top down’ and typically aim to secure workforce supply and build individual capability through education and training, often with limited success … Such approaches are inadequate to meet the dynamic and changing environment of contemporary health and human services delivery. A contemporary approach to workforce planning and development is needed in the specialist mental health sector that is reflective of the evolving evidence in relation to effective workforce planning and development.”

There are three main reasons why a traditional workforce planning methodology approach is limiting for planning the mental health workforce.

The first of the three reasons relates to workforce supply. In order to quantify workforce supply (essentially count people who are working) a definition of what constitutes the workforce is first required, that is boundaries must be set around the workforce that is to be included in the count.

This is a major challenge to undertaking workforce planning of the mental health workforce. It is problematical because it is difficult to agree first upon a boundary for mental health services and therefore who is performing mental health work — for instance is population based mental illness prevention included within a service boundary definition? What about recovery support services such as employment and housing? Are services to individuals with dual, mental illness and drug and alcohol, diagnosis to be included? In a recent survey of the NGO mental health services (National Health Workforce Planning and Research Collaboration, 2011) for instance, 15% of the services surveyed indicated they were not a mental health service, but then responded to survey questions in a way which clearly placed them within the definition employed for the sample population of services.

Setting boundaries around the workforce is therefore somewhat arbitrary. HWA attempted to address the workforce boundary problems by setting parameters on the services to be included (see below) and then identified twelve occupations which they believed predominantly worked in these services (HWA, 2013). A major flaw in this approach is that apart from two of the occupations (psychiatrists and mental health nurses), members of the other occupations (especially psychologists, social workers and occupational therapists) all participate in the workforce outside of the boundaries set by HWA. Alternative workforce boundaries can be drawn on the basis of service type (so called ‘specialist’ services), by service sector (e.g. only public sector), or by consumer contact. Depending on the boundaries drawn, the workforce might be smaller (for instance only the ‘specialist’ workforce) or very large (for instance by including other health workers in PHC, support workforce such as social housing workers, employment support workers, etc.).
The second of the three main reasons concerns intra-workforce substitution issues, which affects both supply and demand analysis. It is commonly accepted that different types of workers (for instance nurses, psychologists, occupational therapists, etc.) can be recruited and/or deployed (seemingly interchangeably) to certain mental health roles. HWA (2013) notes:

“... there is a lack of information on associating specific workforces with mental health service delivery. While some information is available from Medicare and the Private Health Insurance Administration Council (PHIAC) on which workforces are providing services, from many of the NMDS collections, it is not known what workforces deliver what services to the consumer. While the NMDS information can be used to measure an overall expressed demand for mental health services, applying this demand to individual workforces is problematic.”

The problem can be illustrated by reference to an optimum clinical pathway for a female diagnosed with post natal depression and at risk of hospitalisation (reference). The pathway identifies the following services as integral to the optimum treatment approach:

Web-based self-help
- General Practice
- PANDA (self-help group)
- Psychologist
- Psychiatrist
- CMHT
- Group therapy
- Enhanced Maternal and Child Health Nurse (EMCHN)
- Mother-baby unit
- Day patient
- Emergency Department
- Parenting Program

Apart from psychologists, psychiatrists, EMCHNs and GPs, no other types of mental health workforce are specified, and for some integral services (e.g. CMHT, group therapy) there are many different workforce staff mix possibilities. Issues of workforce substitution within a partially regulated workforce like mental health — similar to other poorly or unregulated workforces (for instance the public health workforce, the health information workforce) — are difficult to account for in the traditional workforce planning process.

The third of the reasons relates to assessment of workforce demand. Many commentators, as noted previously, have argued that traditional workforce planning efforts based on trends in service utilisation limit the understanding of future workforce requirements in service areas where the status quo is in question. Scott et al (2011) make a strong case against using such a methodology:

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38 Mental health professions may argue the potential for substitution, but employers clearly behave in ways to promote flexibility in recruitment by adopting generic job titles and pursuing generic recruitment approaches.

39 The term ‘staff mix’ is often used interchangeably with ‘skills mix’ (Dubois and Singh, 2009), but in fact the two are quite separate. Currently the mix, say for instance in the counsellors employed in a community mental health service, is based on choices between types of staff. Later in this document we will explore a mix based on skill.
“Utilisation is used as a proxy for need that has been met through contact with the health system. Utilisation data are regularly used in health workforce, and in health care planning models more generally ... Utilisation in terms of whether an individual visits a health care provider is partly determined by the preferences of patients (demand) and partly determined by the availability of and access to a health care provider (the location of health providers, i.e. supply), and the views of health care providers as to what health care the patient and the population need (supply). Once a patient is in the health care system, how much they use health care (e.g. length of stay and number of visits) is determined largely by the preferences of [health care providers] rather than patients ... Utilisation represents the result of the interaction between demand, need and supply. Having health workforce planning models that forecast supply and forecast utilisation assumes that utilisation is independent of supply when it is not.”

There are many commentators on mental health services delivery (references), including the NMHC itself, who have strongly advocated a radical change to both the size and structure of service delivery. A vision of this future mental health service was provided in an earlier section (see Figure 4). The future demand for mental health workforce will therefore be anything but the status quo, a continuation of past growth trends in service utilisation.

For these three reasons at least a new methodology approach to planning the mental health workforce is required. An alternative method based on capability is discussed in the main body of the report.
### Appendix E: Analysis of available mental health capability or competency sets

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<tr>
<th>HWA(24)</th>
<th>NSW MHS(12)</th>
<th>Te Pou</th>
<th>LMH MoC(42) CF</th>
<th>VIC DoH(13)</th>
<th>Cert IV in MH (CHC40512)</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓✓✓ ✓✓</td>
<td>✓ Applies the principals of responsible, safe &amp; ethical practice</td>
<td>✓ Works empathetically, sensitively &amp; respectfully, with non-judgmental attitude- Accepting &amp; valuing people as they are</td>
<td>✓ Privacy, dignity &amp; confidentiality are maintained &amp; safety is actively promoted. Mental health practitioners implement legislation, regulations, standards, codes &amp; policies relevant to their role.</td>
<td>✓ CHCCS400C Work within a relevant legal &amp; ethical framework</td>
<td></td>
</tr>
<tr>
<td>✓✓✓ ✓✓</td>
<td>✓✓ ✓✓</td>
<td>✓✓ ✓✓</td>
<td>✓✓ ✓✓</td>
<td>✓✓ ✓✓</td>
<td>✓✓ ✓✓</td>
</tr>
<tr>
<td>✓ Advocacy - Whole person focus - Recovery - Shared responsibility with people using services, and their families and carers</td>
<td>✓ Works with clients, families &amp; carers in recovery focused ways</td>
<td>✓ Working with Families &amp; whanau</td>
<td>✓ holistic approach- see the ‘whole person’ rather than seeing someone just in terms of ‘a problem’ or ‘a diagnosis’ - Working within an understanding of the concept of recovery &amp; recovery based approaches in care,</td>
<td>✓ support people to become decision-makers in their own care, implementing the principles of recovery oriented mental health practice.</td>
<td>✓ CHCMH402B Apply understanding of mental health issues &amp; recovery processes</td>
</tr>
</tbody>
</table>

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40 Health Workforce Australia (HWA) National Mental Health Core Capabilities
41 NSW Mental Health Services Competency Framework
43 London mental health models of care – competency framework
44 Victorian Government Department of Health, National practice standards for the mental health workforce
<table>
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<tr>
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<th>NSW MHS(12)</th>
<th>Te Pou</th>
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<th>VIC DoH(13)</th>
<th>Cert IV in MH (CHC40512)</th>
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</thead>
<tbody>
<tr>
<td>✓ Diversity - access &amp; engagement</td>
<td>✓ Meets diverse needs</td>
<td>✓ Working with disabled people</td>
<td>✓ demonstrates non-discriminatory behaviour - recognises influences on MH (e.g. physical health, social crisis, housing crisis, financial crisis, etc). - Demonstrates understanding &amp; respect of diversity</td>
<td>✓ social, cultural, linguistic, spiritual &amp; gender diversity of people, families &amp; carers are actively &amp; respectfully responded to</td>
<td>✓ HLTHIR403C Work effectively with culturally diverse clients &amp; co-workers &amp; CHCLLN403A Identify clients with language, literacy &amp; numeracy needs &amp; respond effectively</td>
</tr>
<tr>
<td>✓ Works with ATSI people, families &amp; communities</td>
<td>✓ Works with Aboriginal children, adolescents, families &amp; communities</td>
<td>✓ Working with Maori &amp; working within communities</td>
<td>✓ actively &amp; respectfully reduce barriers to access, provide culturally secure systems of care, &amp; improve social &amp; emotional wellbeing.</td>
<td>✓ HLTHIR404D Work effectively with ATSI people</td>
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<tr>
<td>✓ Communication, documentation and conflict management</td>
<td>✓ Communicates appropriately</td>
<td>✓ communicate clearly, sensitively &amp; effectively</td>
<td>✓ Actively works to develop a connection &amp; rapport with people to build &amp; support effective therapeutic &amp; professional relationships, maintains a high standard of documentation &amp; use information systems &amp; evaluation to ensure</td>
<td>✓ CHCMH403A Establish &amp; maintain communication &amp; relationships to support the recovery process</td>
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<td>HWA(24)</td>
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<td>LMH MoC(42) CF</td>
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<tr>
<td>✓✓ ✓✓ Self-management &amp; care - Supporting processes and standards: Evidence based practice, Quality care provision and general safety, Dignity of risk - Holistic learning &amp; development - Self-reflection - Feedback and peer assessment</td>
<td>✓ Applies the principals of continuous quality improvement</td>
<td>✓ maintaining professional &amp; personal development</td>
<td>✓ Self awareness of the impact of one's own behaviour, language, and body language - take responsibility for positively addressing a situation - accepting responsibilities that accompany own professional role, demonstrates ability &amp; willingness to take responsibility for positively addressing a situation</td>
<td>✓ takes active steps to improve services &amp; mental health practices using quality improvement frameworks. - takes responsibility for maintaining &amp; extending professional knowledge &amp; skills, including contributing to the learning of others.</td>
<td>✓ CHCORG428A Reflect on &amp; improve own professional practice</td>
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<tr>
<td>✓ Working in partnership - Interprofessional collaboration: Vision &amp; objectives, Collaboration within &amp; across teams, Collaborative interprofessional decision making - Professional support relationships</td>
<td>✓ Works in a manner conducive to partnership, integration &amp; collaboration</td>
<td>✓ Applies knowledge of appropriate sources of help &amp; support - Works collaboratively, including in a crisis situation</td>
<td>✓ delivers quality, evidence-informed health &amp; social interventions. - supports the provision of coordinated &amp; integrated care across programs, sites &amp; services.</td>
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</tr>
<tr>
<td>✓✓✓✓ Scope of practice, and accountability</td>
<td>✓ Follows intake processes &amp; protocols</td>
<td>✓ Upholding law, policy &amp; practice</td>
<td>✓ ability to signpost people experiencing a mental health crisis to appropriate sources of help and support</td>
<td>✓✓✓✓ Upholding law, policy &amp; practice</td>
<td>✓✓✓✓ CHCCH410B Manage &amp; maintain tenancy agreements &amp; services</td>
</tr>
<tr>
<td>✓ Assessment</td>
<td>✓ Undertakes assessment, formulation &amp; care planning</td>
<td>✓✓✓✓ Assessing law, policy &amp; practice</td>
<td>✓✓✓✓ Upholding law, policy &amp; practice</td>
<td>✓✓✓✓ Upholding law, policy &amp; practice</td>
<td>✓✓✓✓ CHCMH404B Conduct assessment &amp; planning as part of the recovery process &amp; CHCCS514B Recognise &amp; respond to individuals at risk</td>
</tr>
<tr>
<td>✓✓✓✓ Performing health care activities : Individual planning, Deliver care, Monitor, evaluate &amp; revise plans</td>
<td>✓✓✓✓ Plans &amp; implements a range of engaging, creative, safe &amp; effective interventions</td>
<td>✓✓✓✓ Providing help &amp; support to ensure the immediate safety of someone experiencing a mental health crisis. - Apply de-escalation skills including verbal &amp; non-verbal communication skills – aim of reducing a person’s anger, aggression, agitation, hostility or distress &amp; preventing disturbed, unsafe or violent behaviour. - Recognition of signs of de-escalation</td>
<td>✓✓✓✓ Providing help &amp; support to ensure the immediate safety of someone experiencing a mental health crisis. - Apply de-escalation skills including verbal &amp; non-verbal communication skills – aim of reducing a person’s anger, aggression, agitation, hostility or distress &amp; preventing disturbed, unsafe or violent behaviour. - Recognition of signs of de-escalation</td>
<td>✓✓✓✓ Providing help &amp; support to ensure the immediate safety of someone experiencing a mental health crisis. - Apply de-escalation skills including verbal &amp; non-verbal communication skills – aim of reducing a person’s anger, aggression, agitation, hostility or distress &amp; preventing disturbed, unsafe or violent behaviour. - Recognition of signs of de-escalation</td>
<td>✓✓✓✓ HLTWHS300A Contribute to WHS processes</td>
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45 Clinical Competencies are relevant to the 5 professions (Psychiatry, Nursing, Social work, Psychology & Occupational therapy) and relate to Core and Advanced elements of clinical practice.
<table>
<thead>
<tr>
<th>HWA(24) 40</th>
<th>NSW MHS(12) 41</th>
<th>Te Pou 42</th>
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<td></td>
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<td></td>
<td>✓ CHCAOD510B Work effectively with clients with complex alcohol &amp; /or other drugs issues</td>
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</table>

**Collaborating across time and place : Transfer of care, follow up and referral, including clinical handover , Integrated care**

- ✓ Works proactively with clients, families, carers, service providers & professionals for the transfer of care
- ✓ Applies care & services that are person-centred & based around each individual’s needs, references & choices. - maintains constructive working relationships with service users, carers, families, colleagues, lay people & wider community networks. Works positively with any tensions created by conflicts of interest or aspiration between partners in care.
- ✓ facilitates timely access to services & provide a high standard of evidence based assessment -On exit from service or transfer of care, people are actively supported through a timely, relevant & structured handover, in order to maximise optimal outcomes & promote wellness

**Diversity**

- ✓ Prevention & promotion of wellbeing
  - ✓ Implements mental health promotion & primary prevention best practice
  - ✓ Challenging stigma & discrimination & promoting value
  - ✓ seeks necessary help & support to ensure the immediate safety of someone experiencing a
  - ✓ Uses mental health promotion & primary prevention principles, seeks to build resilience in communities, groups & individuals, to prevent or reduce the

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*Population Approach Competencies are relevant to those workers who are engaged in health promotion and primary prevention activities.*
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