

# Shaping the future: The Victorian mental health workforce strategy

## Final report



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September 2009

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## Common abbreviations used in this document

<b>AASW</b>	Australian Association of Social Workers
<b>AHMAC</b>	Australian Health Ministers' Advisory Council
<b>AIHW</b>	Australian Institute of Health and Welfare
<b>AMHS</b>	area mental health service
<b>ANF</b>	Australian Nursing Federation
<b>APS</b>	Australian Psychological Society
<b>ATSI</b>	Aboriginal and Torres Strait Islander
<b>COAG</b>	Council of Australian Governments
<b>EBA</b>	enterprise bargaining agreement
<b>EFT</b>	equivalent full time
<b>HACSU</b>	Health and Community Services Union
<b>HE</b>	higher education
<b>HSU</b>	Health Services Union
<b>HWPC</b>	Health Workforce Principal Committee
<b>IMG</b>	international medical graduate
<b>MBS</b>	Medicare Benefits Schedule
<b>MHNET</b>	Mental Health Nurse Education Taskforce
<b>MHNIP</b>	Mental Health Nurse Incentive Program
<b>MHSC</b>	Mental Health Standing Committee
<b>MHWAC</b>	Mental Health Workforce Advisory Committee
<b>MSSH</b>	mutual support and self-help
<b>NBV</b>	Nurses Board of Victoria
<b>NHWSF</b>	National Health Workforce Strategic Framework
<b>NHWT</b>	National Health Workforce Taskforce
<b>NPSMHW</b>	National Practice Standards for the Mental Health Workforce
<b>NSMHS</b>	National Standards for Mental Health Services
<b>PDRS</b>	psychiatric disability rehabilitation and support
<b>PHAM</b>	personal helper and mentor
<b>PSEN</b>	psychiatric state-enrolled nurse
<b>PSO</b>	psychiatric services officer
<b>RANZCP</b>	Royal Australian and New Zealand College of Psychiatrists
<b>VACCHO</b>	Victorian Aboriginal Community Controlled Health Organisation
<b>VET</b>	vocational education and training
<b>VHIA</b>	Victorian Hospitals' Industrial Association
<b>VICSERV</b>	Victorian Disability Services of Victoria

## Chair's foreword

The Victorian specialist mental health workforce comprises a diverse range of workers committed to providing high-quality care to consumers of specialist mental health services. The workforce includes staff working in public (or clinical) mental health services and psychiatric disability rehabilitation and support (PDRS) services. It comprises medical professionals, nurses, allied health professionals and other direct care and support staff providing specialist care across a broad spectrum from prevention to treatment and rehabilitation.

The workforce has a strong history of impacting positively on the lives of mental health consumers and carers and the wellbeing of the wider community. Into the future, this workforce will be critical to implementing the strategic directions outlined in *Because mental health matters: the Victorian mental health reform strategy 2009–2019*.

The ageing of the population and greater competition for skilled workers presents our workforce and services with new challenges. These challenges have been clustered in the current report according to three key themes: supply and distribution; skills and training; and organisational environments.

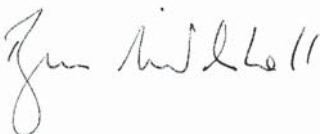
There is a need to attract and retain more mental health workers, particularly in outer metropolitan, regional and rural areas, to ensure consumers have access to specialist mental health services. We need to ensure undergraduate curricula and placements expose students to mental health in positive and rewarding ways. Improved coordination of education and training is required to improve access and better translate research into evidence-based practice and support.

Leadership is critical to developing positive organisational cultures, driving innovation and elevating the status of the specialist mental health sector as a great place to work. We need to identify emerging and current leaders and support them with practical tools to build the culture of their workplace and inspire students and health professionals to pursue careers in mental health.

*Shaping the future: the Victorian mental health workforce strategy* represents a commitment by members of the Mental Health Workforce Strategy Committee to work collaboratively to respond to key challenges facing Victoria's specialist mental health workforce.

The high level of participation and commitment of committee members has resulted in an actions-oriented strategy and a shared vision of the workforce that is responsive to the needs of consumers. I acknowledge the considerable time and effort invested by members during and outside committee meetings. Most importantly, the needs of mental health consumers and carers remained paramount in the committee's discussions.

In recognition of the need for prompt action, this document deliberately focuses on immediate and short-term strategies to further support our specialist mental health workforce. I thank all committee members for their hard work and commitment to further developing Victoria's specialist mental health workforce.



**Bruce Mildenhall**  
Chair  
Mental Health Workforce Strategy Committee

## Minister's message

The Victorian specialist mental health workforce (clinical and psychiatric disability rehabilitation and support) is a recognised leader in the delivery of high-quality mental health services. It has a history of responding successfully to significant reforms, the diverse needs of consumers and carers, and new evidence-based practice and support.

*Because mental health matters: the Victorian mental health reform strategy 2009–2019* builds on the achievements of the past decade and uses as its foundation the expertise and commitment of the existing workforce. The strategy challenges us to become more consumer-focused and responsive to carers, and emphasises the importance of ensuring that practice and support is based on the best available evidence.

*Shaping the future: the Victorian mental health workforce strategy* is a key element of the government's broader commitment to developing Victoria's specialist mental health workforce. It sits within the broader, longer term framework of workforce and system reform provided by *Because mental health matters*. The strategy recognises that the dynamic nature of national health and mental health policy and planning has implications for how we continue to support our workforce. This document describes the challenges currently facing our workforce and outlines the specific actions proposed to address these. The workforce strategy recognises the diversity of the workforce and the complexity of challenges ahead.

The Victorian Government is committed to strengthening Victoria's specialist mental health workforce through implementing this strategy, which builds on existing efforts. Many of the priorities for action can be achieved through collaborative effort and are already underway. Others suggest future directions and ideas that will be considered in the context of priorities that will emerge over the life of this strategy.

Among these is the commitment of \$2.4 million over four years to establish a Mental Health Workforce Development and Innovation Institute. The government will also establish a workforce partnership group to assist with targeted workforce planning and development, incorporating broad expertise from across the mental health sector. Part of their role will be to provide advice on the best way to ensure maximum benefit from the new institute.

Successful workforce development will require strong partnerships between government, services and key stakeholders. I look forward to working in collaboration with you to build on the strength and commitment of our specialist mental health workforce, and to secure the best possible future for our workforce and the people it serves.



**The Hon Lisa Neville MP**  
**Minister for Mental Health**

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## Executive summary

Victoria has a skilled, motivated and progressive specialist mental health workforce (clinical and psychiatric disability rehabilitation and support) with a reputation for responding successfully to significant reforms, the changing needs of consumers and carers, and new evidence-based practice and support. The workforce continues to make a major positive impact on the lives of mental health consumers and carers and the wellbeing of the wider community.

Over time, there has been considerable investment in specialist mental health and broader health workforce development at both the Commonwealth and state level. However, ongoing commitment to workforce capacity-building is required to address key challenges. Notwithstanding the many strengths of our dedicated workforce, additional support is required to enable our workers to continue to provide high-quality care to consumers.

Victoria's mental health reform strategy, *Because mental health matters*, articulates a ten-year vision for Victoria's mental health service system. It identifies workforce as a key focus area and recognises that the success and viability of service system reform depends on the capacity and capability of the specialist mental health workforce.

A contemporary mental health workforce strategy is required to ensure Victoria's mental health workforce is skilled and supported to respond to changes in our environment while continuing to provide consumer-centred care in a seamless and collaborative way.

Over the coming years Victoria's mental health workforce will need to respond to a number of immediate and longer-term challenges. A fundamental undersupply of mental health professionals exists, particularly in regional and rural areas. Net staffing shortfalls of 18–31 per cent for medical, nursing and allied health professionals have been forecast to meet service demand. With 41 per cent of staff aged 45 or over, exit rates from the workforce are likely to increase as staff reach retirement age.

Increased numbers of Commonwealth-supported higher education health places and the overseas recruitment of staff will be important but are unlikely by themselves to meet the projected demand for specialist mental health workers.

Targeted recruitment strategies to fill existing vacancies and ensure qualified staff feel supported to relocate to Victoria, or resume their mental health career in Victoria, are required.

Improved marketing of mental health careers targeting undergraduate students, overseas trained staff and workers in other health and community settings to communicate the positive and attractive aspects of the specialist mental health sector is required. Workforce capacity may be expanded through exploring and developing new roles that improve staff satisfaction and better meet the needs of consumers and carers.

Workforces in regional and rural areas need to be further developed by promoting mental health careers to regional and rural secondary school students, advocating for the allocation of Commonwealth-supported health places to regionally based universities and supporting 'training in place' programs through partnerships between services and education providers. Greater support is required for overseas trained mental health workers, particularly international medical graduates who contribute significantly to service delivery in regional and rural areas, while we continue to invest in 'growing our own' workforce.

Effective education and training are critical to ensuring mental health teams continue to deliver high-quality, safe consumer care while remaining responsive to emerging evidence and new models of care. The challenge for the education and training system is to ensure it is flexible, relevant and responsive. Mental health services need to promote and support the lifelong learning of the workforce. A continued commitment to ensuring undergraduate curricula and placements expose students to mental health in positive and rewarding ways is required. Further development of a mental health major in the Bachelor of Nursing degree may encourage nursing students to pursue mental health careers and improve the preparation to graduate nurses. Additionally, the nine recommendations from the national *Final report: Mental health in pre-registration nursing courses* undertaken by the Mental Health Nurses Education Taskforce will require coordinated implementation.

New graduates need further encouragement to make the transition to mental health. Improved statewide coordination of current post-entry level education and training, that builds upon current arrangements and recommendations of the Statewide Education and Training Partnership (Cluster) Project evaluation, is needed to improve accessibility and evaluation of training. This will also enable the translation of research findings into evidence-based practice and support, and education frameworks.

Organisational culture is crucial to attracting, motivating and retaining skilled staff. Recruitment and retention is improved through effective leadership and management practice, attention to staff wellbeing, excellent supervision and adequate professional and personal support. Emerging and current leaders need to be identified and provided with practical tools to support the building of positive workplace cultures and inspire students and health professionals to pursue careers in mental health.

The successful implementation of the Victorian mental health workforce strategy will depend on partnerships, sound workforce data and research, and the participation of consumers and carers. Partnerships between the clinical and psychiatric disability and rehabilitation support (PDRS) services, employers, unions and the education sectors are key. Data and research are critical to informing the development and implementation of strategies to address current and future workforce challenges. Ensuring that the experience of consumers and carers are well represented in workforce planning, delivery and review is key to the best possible outcomes for consumers of mental health services.

## Priority strategies

The following actions are proposed as a priority for Victoria's mental health workforce strategy.

### Short-term strategies

- Develop and implement a short-term (12-month) recruitment strategy targeting workers who could transition into the specialist mental health workforce to fill existing vacancies. This will include establishing a government-funded recruitment website and hotline to advise on potential employment opportunities, streamlining access to information and promoting other relevant state and Commonwealth Government initiatives (for example, the Bring Nurses Back into the Workforce program). The website will be attractive, informative and easy to navigate and connect public clinical and PDRS employment opportunities.
- Engage universities, area mental health services and the nurse regulatory authority to progress implementation of the recommendations in the Mental Health Nurse Education Taskforce's (MHNET) *Mental health in pre-registration nursing course* report in Victoria.
- Upon release, review the recommendations of the evaluation of the mental health major in the Bachelor of Nursing degree and continue to provide in-principle support for its implementation.
- Undertake a workforce research project for the PDRS service sector that further investigates the workforce profile and analyses skills needs and identifies strategies to address recruitment, retention and career pathway challenges.
- Further develop full-paying scholarships to:
  - support division 1 and 3 nurses to undertake postgraduate education (including master's degrees and PhDs) in mental health
  - support division 2 nurses to undertake further education to enable medication endorsement and expanded scopes of practice, and undertake conversion courses to become division 1 nurses.
- Identify an appropriate, structured, paid undergraduate employment model, similar to that available for nurses working in the acute health sector, in consultation with unions, employers, universities and students to enhance early exposure to the mental health environment.

- Undertake a statewide research project investigating workforce stress and satisfaction levels and reasons for exits from the specialist mental health workforce.
- Establish a mental health education and training institute that supports multidisciplinary and cross-sectoral approaches to delivering further education and training for clinical and PDRS service workers, consumers and carers. This agency will augment the work of the education and training clusters and other training providers (for example, VICSERV) and help strengthen communication and collaboration across the education and training sector.<sup>1</sup>

#### Medium-term strategies

- Lobby the Commonwealth Government to align education and training places with projected supply needs.
- Implement strategies to improve workload pressures within the specialist mental health sector, to enable improved recruitment of workers.
- Implement the recommendations from the evaluation of the Statewide Education and Training Partnership (Cluster) Project.
- Develop programs (for example, scholarships, shadowing, mentoring) that identify emerging leaders (clinical, PDRS and managerial) early and provide these workers with management and leadership training to better place organisations to meet changing service demands. Provide coaching and mentoring to promote high-quality leadership at all levels within an organisation.
- Continue to explore opportunities through the Council of Australian Government's (COAG) process to amend Medicare Benefits Schedule (MBS) mental health items to give providers incentive to work in regional and rural areas.
- In consultation with unions, employers, professional bodies and other key stakeholders, identify, promote and disseminate information about innovative workforce models and roles.
- Identify options for funding and organisational support during candidature to support an increase in endorsed nurse practitioners within the mental health sector.
- Encourage 'grow your own' workforce approaches in regional and rural areas such as promoting mental health careers to regional and rural secondary school students, lobbying for the allocation of Commonwealth-supported mental health places to regionally based universities and developing programs supported through partnerships between services and education providers that offer career paths for local residents consistent with industrial and professional requirements.
- Maximise opportunities for increased scope of practice for registered division 2 nurses through the utilisation of mental health and other relevant units of competency found in the Enrolled nurse qualifications framework of the national Health Training Package.
- Investigate the feasibility of increased scope of practice for psychiatric service officers (PSOs) through the utilisation of the Certificate IV Mental Health, Community Services Training Package, ensuring such work remains consistent with the classification standards of the *2007–11 Psychiatric Services Agreement*.
- Facilitate transition of workers from other areas within the health sector to mental health services through improved portability of benefits, transferability of qualifications, identification of core competencies and development of bridging courses to orient existing knowledge and skills to mental health service provision.

<sup>1</sup> It is anticipated that establishing an institute will have a short-term impact on the delivery of education and training as well as longer term outcomes.

### Long-term strategies

- Contribute to the development of an agreed national framework for mental health competency standards and support implementation of existing standards and professional codes.

## Implementation

Key to implementing these strategies will be establishing a ministerially appointed statewide mental health workforce partnership group comprising key stakeholders, including unions, to provide advice on the implementation of workforce strategies identified in the Victorian mental health workforce strategy and *Because mental health matters*. The group will bring together senior government and non-government stakeholders to provide expert advice and leadership on specialist mental health workforce planning and development that supports Victoria's mental health reform agenda. It is anticipated the group will make a significant contribution to:

- developing a specialist mental health workforce priority reform agenda
- establishing the Victorian Institute of Mental Health Workforce Development and Innovation to drive workforce development and evidence-based practice
- designing a process for mapping competencies in specific roles, as a precursor to the development of a training and education agenda
- supporting leadership development to drive reform
- considering the development of shared public and MBS-funded mental health services, with particular reference to sustainable workforce arrangements
- advocating for a focus on mental health in national health workforce policy and planning initiatives
- reviewing the uptake of national mental health workforce initiatives in Victoria.

# 1. Introduction

Victoria is recognised within Australia and internationally for its highly skilled and progressive specialist mental health workforce. Its expertise and commitment is reflected through the positive outcomes achieved by people accessing the Victorian mental health system.

Notwithstanding the many strengths of our dedicated workforce, better targeted support is required to enable our workers to continue to provide outstanding support and care to consumers. That means we need the right number of staff in the right localities, skilled to provide the best quality care, in partnerships where consumers experience seamless treatment and support.

We need to support our workforce to enable them to respond to new evidence and models of care, and ensure access to quality training and development in supportive workplaces. Above all, the specialist mental health sector needs to provide valued, rewarding work and be a great place to build a career.

Over time, there has been considerable investment in mental health and broader health workforce development at both the Commonwealth and state levels. However, ongoing commitment to workforce capacity-building and development is required to address several key challenges.

Meeting the demand for mental health workers is a key challenge. Increased numbers of Commonwealth-supported higher education health places and overseas recruitment of staff are unlikely to meet the projected growth of clinical services.<sup>2</sup> New Commonwealth initiatives supporting private practice, while welcome, may also draw away mental health professionals working in the specialist mental health sector. We need to better understand the projected demand for PDRS services.

A continued commitment to ensuring undergraduate curricula and placements expose students to mental health in positive and rewarding ways is required. New graduates need further encouragement to make the transition to mental health.

Outer metropolitan, regional and rural areas continue to be more acutely affected by shortages of mental health staff and some continue to rely on overseas trained workers, particularly international medical graduates who often require additional assistance to transition into our specialist mental health services.

Improved coordination of current entry to post-employment education and training is required to improve access to and consistency of training, competence, assessment and the translation of research findings into evidence-based practice and support. Despite opportunities for expanded scopes of clinical practice, particularly for nurses, more work is needed to provide clinical and PDRS mental health workers with clearly articulated and coherent career pathways offering specialisation, leadership, academic and research opportunities.

Leadership is critical to developing positive organisational cultures, driving innovation and elevating the status of the specialist mental health sector as a great place to work. We need to identify emerging and current leaders and support them with practical tools to build the culture of their workplace and inspire students and health professionals to pursue careers in mental health.

Consumers and their carers provide a critical input in the delivery of services. Improved approaches to meaningful consumer involvement will build the quality of our services and knowledge of our staff. Inclusion of consumers and carers more consistently in service planning, delivery and review is a necessary next step in our system's development. Without prompt action that addresses these areas Victoria's mental health workforce and high-quality service standards may be compromised.

In recognition of these and other challenges, the parties to the *2007 Victorian Psychiatric Services Agreement* agreed to establish the Mental Health Workforce Strategy Committee to oversee the development of a strategy for Victoria's clinical and PDRS mental health workforce. The committee was chaired by Mr Bruce Mildenhall, former parliamentary

<sup>2</sup> Australian Productivity Commission 2005, *Australia's health workforce research report 2005*, Australian Government, Melbourne, p.xvi.

secretary to the Premier and Cabinet and member of the Victorian Legislative Assembly, and comprised representatives from unions, employers, professional associations, VICSERV, the Senior Psychiatric Nurses' Forum and the Department of Health (formerly the Department of Human Services).

The committee's terms of reference were to investigate and oversee the development of a workforce strategy that aims to develop a sustainable workforce with the necessary range of skills to meet client needs across Victorian mental health services. It had a focus on practical short- and medium-term solutions to workforce supply, recruitment and retention issues.

The committee's establishment reflects the collaborative approach adopted between the Victorian Department of Health, Australian Nursing Federation, Health and Community Services Union and the Victorian Hospitals' Industrial Association to jointly address current and anticipated challenges facing the mental health workforce. It is also recognition by the parties to the agreement that reform of the mental health system is required and that the workforce and service delivery system must be equipped to respond to this change.

The workforce strategy complements and sits within the overarching framework of Victoria's whole-of-government mental health reform strategy, *Because mental health matters*, which articulates a 10-year vision for Victoria's mental health service system. It is a key element of the government's broader commitment to developing the specialist mental health workforce, focusing on immediate and short-term responses to workforce development needs. *Because mental health matters* identifies workforce as a key focus area and provides a longer term, strategic direction for reform. Extensive consultations undertaken as part of the development of *Because mental health matters* informed the development of this mental health workforce strategy.

*Because mental health matters* recognises many ways in which our workforce needs to be supported and nurtured. It encourages our workforce to build on new ways of engaging with consumers, carers and the community. It suggests a new approach to care that places greater emphasis on recovery, reducing the impact of mental illness and ensuring that people have improved quality of life. It proposes a strengthened approach to prevention and earlier intervention and provides a vision for a new system where hope for the future and wellbeing is enshrined in our models of care. This workforce strategy is critically important. It acknowledges the existing solid foundation of specialist expertise and outlines the key challenges that need to be addressed in order to meet existing needs and achieve the vision outlined in *Because mental health matters*.

## 1.1 Purpose

Given the current environment within which the specialist mental health sector operates, including key factors such as an ageing population, a tighter labour market and the need to adapt interventions so that they reflect emerging evidence around effective mental health practice and support, a contemporary workforce strategy is required.

The purpose of this strategy is to propose a range of actions designed primarily to address the immediate and short-term challenges facing the specialist mental health workforce. It acknowledges that a skilled, motivated and responsive specialist mental health workforce, able to embrace the challenges outlined in *Because mental health matters*, needs to be nurtured and opportunities for further investment pursued.

The strategy considers the diverse disciplines and staff working across the clinical and PDRS sectors and aims to build the capacity of the workforce to respond successfully to evolving consumer and carer needs, new research-based evidence and future changes in service delivery models. It recognises that workforce development is a shared responsibility and requires collaboration and active partnerships between the state and Commonwealth governments, the mental health and education sectors, professional bodies, unions, consumers and carers and other key stakeholders. It also recognises that the specialist mental health sector is competing with the private mental health sector and the broader health sector to attract sufficient numbers of staff to meet service demand.

The actions in this strategy are grouped according to three priority areas and identified according to short, medium and long implementation timeframes. The three themes are: supply and distribution; skills and training; and organisational environments. The strategies build on existing evidence, good practice and state and Commonwealth initiatives and strategic directions, articulated in documents such as the *National health workforce strategic framework* (NHWSF).<sup>3</sup>

## 1.2 Vision

Victoria will have a skilled, motivated and responsive specialist mental health workforce where all workers in clinical and PDRS services are valued and professionally supported throughout their careers. It will provide consumer-centred, multidisciplinary and coordinated care in a seamless and collaborative way through strong partnerships with consumers, carers, families and other services and sectors. Mental health workers will be supported to ensure that consumers experience high-quality assessment, care, treatment, rehabilitation and support services.

The specialist mental health sector will be widely acknowledged as a dynamic and innovative environment providing well-articulated and diverse career pathways. Students and health professionals will be inspired to pursue and remain engaged in careers in mental health by innovative leaders committed to the professional development of the workforce.

Education, training and professional development for specialist mental health workers will be coordinated, consistent and accessible, supporting evaluation and the translation of research findings into evidence-based practice. It will position the specialist mental health workforce to respond appropriately to new evidence that informs service delivery and helps identify consumer and carer needs and shapes models of care.

## 1.3 Guiding principles

The following principles have guided the development of the current strategy.

- **Evidence-based** – Mental health workers and services, policymakers and funding organisations are committed to providing optimal consumer care through high-quality practice and support that reflects the best available evidence. This involves ensuring support for and maintenance of existing systems and structures that reflect best practice and encouraging flexibility to embrace new and improved approaches to workforce development and service delivery.
- **Sustainable** – Enduring mechanisms are established to secure the human, financial and other resources required for delivering high-quality and effective mental health services.
- **Continuously improving** – A culture and practice that encourages services and the workforce to systematically reflect on and evaluate the quality of services delivered to ensure that quality, innovation and governance are supported.
- **Responsive** – Services actively respond to the social, cultural, linguistic, spiritual and gender diversity of consumers and carers and incorporate these differences in policies and practice.
- **Equitable** – Individuals and communities are entitled to receive the best possible service irrespective of where they live, their socioeconomic circumstances, cultural or linguistic background or other personal factors.
- **Consumer- and carer-focused** – Services encourage and support the participation of consumers and carers in determining their individual treatment and support. Services actively promote, encourage and support the participation of consumers and carers in the planning, delivery and review of mental health services. All consumers feel valued, that their differences are respected and that their basic needs are met so they can live in dignity.
- **Integrated** – Mental health workers provide continuity of care through integration and partnerships with other mental health service providers and a range of other organisations to ensure the needs of consumers, carers

<sup>3</sup> Australian Health Ministers' Advisory Council (AHMAC) 2004, *National health workforce strategic framework*.

and family members are met. Mental health workforce planning and development are shared responsibilities requiring collaboration between governments, consumers, carers, public and private service providers, professional organisations, unions and the education and training sector.

## 1.4 Critical success factors

The following critical success factors have been identified for the successful implementation of the strategy. Achieving the vision outlined in this document depends on all stakeholders working collaboratively, informing mental health workforce policy and planning with the best available evidence and strong leadership within services and the sector.

### Investment

Strengthening the specialist mental health workforce is a priority for the government, both to address current challenges and to sustain continuous improvement across clinical and PDRS services.

Government has recently invested considerable additional resources in the mental health workforce, including the allocation of \$2.4 million over four years to establish a mental health workforce institute together with other resources targeted at improving the skills and capacity of key workers.

### Our partners

Clinical and PDRS services are partners in the broader public mental health service system. Together they provide recovery-focused treatment and psychosocial rehabilitation and support to mental health consumers and their carers and families. While differing in role and function, clinical and PDRS services share the same goal of promoting consumer recovery. For example, the recently established Alliance Project involves partnerships between clinical and PDRS services that enable greater collaboration between the sectors. Opportunities for sharing information and developing plans jointly with consumers and carers will lead to a more cohesive and responsive system.

Strengthening the public-private interface is a key aspect of this strategy. The capacity for expanding shared care arrangements between private and specialist mental health services and mixed public and private working arrangements have been identified as areas for further investigation. The recent expansion of the MBS items,<sup>4</sup> announced as part of the Commonwealth Government's commitment to the COAG *National action plan on mental health*, may help alleviate workloads of general practitioners (GPs), improve access for consumers and increase the capacity for shared care between public and private services.

The COAG national action plan has also seen the Australian Government develop and implement new roles in the mental health workforce, including personal helper and mentor (PHAM) positions, and mental health nurses based in primary care settings under the Mental Health Nurse Incentive Program. Recent significant expansion of MBS items provide for a greater role for GPs and improved access to private sector psychologists, social workers, occupational therapists and psychiatrists. This has implications for the mental health workforce and the way in which specialist and non-specialist workers interact and assist in service provision.

The severity and the chronic nature of some mental illnesses often requires a team approach, including shared care arrangements between primary health care providers (for example, GPs, practice nurses, and public and private mental health providers). Building stronger public-private partnerships and referral networks is critical to achieving optimal outcomes for mental health consumers who are receiving primary care from a GP.

<sup>4</sup> Reforms to the MBS are the most significant component of the Commonwealth's COAG package of \$1.9 billion over five years. A total of \$538 million will be expended over five years through the MBS to improve access to and better teamwork between psychiatrists, clinical psychologists, GPs and other allied health professionals.

Improving the skills, knowledge and confidence of workers in the generalist and specialist health sectors (including mental health workers) to enable them to identify and respond to clients with alcohol and drug problems is important. Workers who can apply evidence-based practice and support (including harm reduction strategies for illicit drug users) and refer people with drug- and alcohol-related problems to the specialist treatment system need to be nurtured and valued.

## Consumers

Over the past 15 years, both national and state mental health policy directions have articulated the requirement for the involvement of consumers in broader service and system planning, delivery and review as a component of improving the responsiveness of mental health services to consumer needs. Consumers need to be involved in shaping workforce reform, including having opportunities to contribute to the development of models of care and staffing skill mixes that maximise care and support recovery.

Nationally and internationally consumers are becoming increasingly involved in the provision of direct support and care to people with mental illness and in consultancy to mental health services. This includes developing opportunities for training and professional development for consumers.

Consumers in the workplace can inform practice and support through incorporating the skills and perspectives of consumers' lived experience into the skill mix of the workforce. Consumer participation in the development of short-term and long-term plans for their treatment and support promotes the development of a partnership between the consumer and the mental health professional and a commitment by both to implement these plans over time.

## Carers

Families and carers can play an important role in the early identification, support, care and recovery process of mental health consumers. Often carers play a complex role in brokering, accessing and coordinating care in partnership with consumers and mental health service providers. This informal role can be better recognised and supported through the strengthening of carer participation opportunities in accordance with contemporary policy and care directives.

Victoria's mental health services have an emerging population of paid carer consultants. Opportunities to support and strengthen this workforce need to be explored. The increasing recognition of the importance of engaging effectively with families and carers has implications for the recruitment, training and care orientation of specialist mental health and other health and community service workers. New models of care involving consumer and carer consultants will be strengthened through the implementation of *Because mental health matters*.

## Research and data

Data and research are critical to informing the development and implementation of strategies to address current and future workforce challenges. Proposed strategies need to have a strong evidence base and methodology. The NHWSF suggests that health workforce policy and planning need to be population and consumer based.

There are numerous dimensions to understanding the supply and demand of specialist mental health workers. There are also challenges arising from the diversity of staff who work across a range of settings and services. Quantifying profession numbers is difficult due to the diversity of existing professions and support workers within individual workplaces, variation in data or definitions, the currency of information and the lack of information on specialised areas.

Government needs to draw on a wide range of data sources to inform workforce policy and planning such as the Australian Bureau of Statistics, Australian Institute of Health and Welfare, the new national registration and accreditation scheme, and health service payroll and activity data. Collaboration with these bodies is important to increase the availability and quality of data and reduce duplication of effort and 'survey fatigue'.

Critical research undertaken by funded clinical academic positions contributes to the future development of mental health services, knowledge and research in Victoria. Evaluations of health workforce programs provide a valuable source of information on what works in the Victorian context. Interstate and international research and experience has proven helpful for informing workforce policy and planning. The applicability of such evidence needs to be reviewed to determine its relevance to the Victorian context.

## Leadership

Leadership at all levels within the mental health service delivery and education sectors and government is critical to developing a skilled, motivated and responsive specialist mental health workforce. Maximising continuity of care, nurturing a consumer-focused and culturally competent system and translating evidence from research findings into service delivery to foster continual quality improvement all require strong leadership.

Leadership is one of the most important drivers of change. Leadership involves advocacy, team building and collaboration with stakeholders, services and government. Positive leadership is associated with process and quality indicators such as organisational commitment, positive organisational culture, consumer satisfaction, effective industrial collaboration and strong alliances with clinical and PDRS services.

Leadership requires skills and knowledge that are in addition to direct support and care roles. Strong leadership is required to advance the strategies and actions within this document.

## 1.5 Scope

The specialist mental health workforce in Victoria encompasses a wide range of workers operating across a variety of service settings.

Mental health specialists include more than 5,000 individuals working in clinical mental health services and approximately 1,500 individuals working in PDRS services. The clinical workforce includes psychiatrists, psychiatric registrars and other medical staff, nurses, allied health professionals (psychologists, social workers and occupational therapists) and support staff, including psychiatric service officers (PSOs). The PDRS workforce, with a primary focus on psychosocial support, includes social workers, occupational therapists, psychologists and a broad range of other staff, many with tertiary or vocational health qualifications.

While the main focus of this document is the specialist mental health workforce, the private mental health sector, consumer and carer, peer support and mutual support and self-help (MSSH) workforces are critical components of the broader mental health service delivery system. The private sector workforce includes psychiatrists, nurses, psychologists, social workers and occupational therapists.

The community services sector also has an important role in supporting mental health consumers receive holistic care. These services play a critical role in identifying mental health issues and, where appropriate, directly respond by referring people to more specialised mental health services.

While this document acknowledges the important role played by workers in areas other than specialist mental health services such as justice, community services, the acute health sector, aged care, children's services and education, the scope of this strategy is limited to the specialist mental health workforce in Victoria.

## 1.6 Context

This strategy sits within a broader policy, legislative and industrial context within which the Victorian specialist mental health workforce operates (see appendices for further information).

## 1.7 Current workforce initiatives

Both the Commonwealth and Victorian governments have a longstanding commitment to supporting health workforce development through a wide range of policies and programs. These initiatives seek to address current and future workforce challenges in both the health and specialist mental health sectors. They ensure the workforce is well placed to continue delivery of high-quality mental health care to consumers and their carers.

This document acknowledges the broader context of health and mental health workforce planning that is occurring at both a state and national level. It recognises that national mental health policy and planning activities provide a changing context that is directed by the National Mental Health Strategy, COAG priorities, and other key health and mental health workforce development initiatives. This document refers to and builds upon existing initiatives relevant to the Victorian specialist mental health workforce.

## 1.8 Victoria's specialist mental health workforce

The mental health workforce in Victoria comprises clinical and PDRS service staff working across a broad spectrum from prevention to treatment and rehabilitation.

The clinical mental health workforce includes medical professionals, mental health nurses, allied health professionals and a range of support staff, including PSOs, administrative and clerical.<sup>5</sup> In 2006–07 there were 5,176.7 equivalent full time (EFT) staff employed in the clinical mental health system, comprising 548.1 EFT of medical officers,<sup>6</sup> 3371.6 EFT of nurses,<sup>7</sup> 1,257 EFT of diagnostic and allied health professionals,<sup>8</sup> 226.1 EFT of domestic and other staff, and 515.6 EFT of administrative and clerical staff.<sup>9</sup> These numbers do not include bank and agency employed staff.

Nurses represented 65.1 per cent of total EFT for the clinical mental health workforce in 2006–07. However, there is a diverse mix of professional groups in the system with substantial variations in the proportions of medical, nursing and allied health staff between service types and settings.<sup>10</sup> This reflects both a strong emphasis on a multidisciplinary team-based approach to client care and support, and the varied availability of certain occupations within geographic regions.<sup>11</sup>

The PDRS workforce is a core component of the specialist mental health sector, complementing clinical mental health services. This workforce provides and delivers services that are both funded by state and Commonwealth governments.<sup>12</sup> PDRS services are managed by non-government organisations (NGOs) and focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from illness.<sup>13</sup> In addition to

<sup>5</sup> Department of Human Services 2005, *Victoria's direct care mental health workers: the public mental health workforce study 2002–04 to 2011–12*, State Government of Victoria, Melbourne.

<sup>6</sup> Medical officers include psychiatrists, consultant psychiatrists and registrars.

<sup>7</sup> Nursing includes division 1 and 2 registered nurses and student/trainee nurses.

<sup>8</sup> Diagnostic and allied health includes occupational therapists, social workers and psychologists

<sup>9</sup> Department of Human Services, Mental Health and Drugs Division Information Analysis and Reporting 2006–07 (W048728, MHE\_2006\_07), State Government of Victoria, Melbourne, as at 5 September 2008

<sup>10</sup> Ibid.

<sup>11</sup> Department of Human Services 2005, *Victoria's direct care mental health workers: the public mental health workforce study 2002–04 to 2011–12*, State Government of Victoria, Melbourne.

<sup>12</sup> Department of Human Services 2005, *Specialist mental health service components*, State Government of Victoria, Melbourne, p.6.

<sup>13</sup> Ibid.

direct-care staff the PDRS workforce includes accommodation and residential support, outreach, disability employment and community development staff.<sup>14</sup> The number of volunteers in the sector has also increased with more than 80 per cent of services now employing volunteers across a wide range of functions.<sup>15</sup> These include community visitors appointed by the Governor-in-Council to visit mental health services to enquire into matters such as the adequacy and standards of services provided and the care and treatment consumers receive.

In addition to the local area services, a range of specialist services are delivered on a statewide basis. These include the Victorian Institute of Forensic Mental Health (Forensicare), the personality disorder service (Spectrum), the Early Psychosis Prevention and Intervention Centre (EPPIC), dual disability services, eating disorder services and Koori services. Specialist Koori services offer an additional level of expertise for the particular clinical conditions or high-level needs of the Koori community throughout Victoria.<sup>16</sup> Carer and consumer consultants offer specialist services to help ensure Victoria's mental health services engage and are responsive to the perspective of consumers and carers.

Just over 74 per cent of the public mental health workforce (clinical and non-clinical) work in inner metropolitan areas, with 25.9 per cent of the workforce providing mental health services to rural Victoria.<sup>17</sup>

## Nurses

Mental health nurses are the largest single profession in the Victorian mental health system. Mental health nursing is a specialised field of nursing that focuses on meeting the mental health needs of the consumer, in partnership with the family, significant others and the community in any setting. It is a specialised interpersonal process embodying a concept of caring, which is designed to be therapeutic by:

- supporting consumers to optimise their health status within the reality of their life situation
- encouraging consumers to take an active role in decisions about their health care
- involving family, significant others and communities in the care and support of consumers.

Mental health nurses recognise the need for flexibility, adaptability, responsiveness and sensitivity as they continually shape their practice to the dynamically changing needs of the consumer, family, significant others and the community.<sup>18</sup>

Mental health nurses work in a variety of settings across both public and private services, including acute inpatient units, residential and non-residential rehabilitation programs, community-based teams such as crisis-focused outreach, emergency departments, the forensic system, training and education where the focus of care is recovery.

Nursing practice occurs within legislative requirements and professional standards and codes. All nurses who practise in Victoria must be registered with the Nurses Board of Victoria (NBV). Nurses are registered as either a division 1, 2 or 3. Division 1 describes comprehensively prepared nurses who, since the mid-1990s have completed a Bachelor of Nursing. Prior to that, division 1 nurses undertook a Diploma of Nursing or a three-year hospital certificate.

Division 3 describes nurses who undertook pre-registration studies such as a three-year hospital-based psychiatric nursing certificate or completed the Bachelor of Psychiatric Nursing that was available in the early 1990s. This division register closed in 1993. A number of nurses originally registered on this division have transferred to division 1.

Division 2 describes nurses who work under the supervision of a division 1 or 3 registered nurse. Division 2 nurses are identified in industrial classifications by the term psychiatric state enrolled nurse (PSEN). Their education preparation is

<sup>14</sup> Ibid.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> Department of Human Services, *Mental Health and Drugs Division Information Analysis and Reporting 2006–07* (W048728, MHE\_2006\_07), Melbourne Department of Human Services, as at 5/09/2008.

<sup>18</sup> Australian College of Mental Health Nurses 1995, *Standards of practise for mental health nurses in Australia*, viewed at [www.acmhn.org](http://www.acmhn.org).

now a Certificate IV in Nursing in the vocational education and training (VET) sector. Division 2 nurses who trained prior to the early 1990s undertook a 12-month hospital-based program.<sup>19</sup>

After registration, specialist graduate nurse programs, preceptorship and further postgraduate study allow nurses to further develop specialist mental health nursing skills and knowledge. Recognition of an additional mental health nursing qualification in Victoria is notated by the NBV upon a division 1 nurse completing a specialist postgraduate qualification. Post-registration units of competency, which superseded the post-registration module in mental health, are available to division 2 nurses to provide further skills and knowledge.

NBV's 2007–08 annual report states that in 2008 there were 85,516 nurses registered in Victoria. Of these, 1,389 (1.6 per cent) were registered in division 3 and 1,820 (2.1 per cent) were registered in division 1 with an additional qualification in psychiatric nursing.<sup>20</sup> The number of nurses in division 1 with a qualification but who have not sought notation by the NBV is unknown.

Nurses in the specialist mental health sector are more likely than nurses working elsewhere to work full time, are slightly older on average, and are much more likely to be male than in other areas of nursing.<sup>21</sup> Furthermore, despite 50.7 per cent of mental health nurses having post-registration and enrolment qualifications, only 52.7 per cent of nurses qualified in the field of mental health are currently working in mental health areas.<sup>22</sup>

## Psychiatrists

Psychiatrists hold a specialist qualification awarded by the Royal Australian and New Zealand College of Psychiatrists (RANZCP). Psychiatrists may work as clinicians or non-clinicians across the public or private sectors. Psychiatrists-in-training are medical practitioners who have been accepted by the RANZCP into a training position supervised by a member of the college.

In 2004 there were 710 psychiatrists in Victoria (717 EFT) with 14.1 per cent working exclusively in the public sector and 35.1 per cent working across both the private and public sector.<sup>23</sup> Compared with other medical specialties in Victoria, psychiatrists are more likely to be female (30.2 per cent) and are older with the average age in psychiatry at 52.8.<sup>24</sup> A workforce survey undertaken by RANZCP in 2005 found that 17 per cent of psychiatrists planned to retire in the next five years, while a further third planned to reduce their hours of work.<sup>25</sup> The RANZCP further estimates that between 2006 and 2010 some 22 per cent of the workforce will be lost through retirement or reduced hours.<sup>26</sup>

The World Health Organization recommends 1:10,000 as a psychiatrist: population ratio. On a per 100,000 population comparison Victoria has a higher ratio of psychiatrists to population than most states in Australia (1:7433),<sup>27</sup> but they are unevenly distributed across the state with 14 fewer psychiatrists per 100,000 population in rural Victoria than metropolitan Melbourne in 2004.<sup>28</sup>

<sup>19</sup> Nurses Board of Victoria (NBV) 2008, *Accredited courses leading to recognition of qualification in psychiatric/mental health nursing*, NBV, Melbourne.

<sup>20</sup> Nurses Board of Victoria (NBV) 2008, *Annual report 2007–08*, NBV, Melbourne.

<sup>21</sup> Australian Institute of Health and Welfare (AIHW) 2008, *Nursing and midwifery labour force 2005*, AIHW, Canberra.

<sup>22</sup> *Ibid.*

<sup>23</sup> Department of Human Services 2006, *The medical workforce of Victoria 2000–2004*, State Government of Victoria, Melbourne.

<sup>24</sup> *Ibid.*

<sup>25</sup> Mental Health Workforce Advisory Committee (MHWAC) 2008, *Mental health workforce: supply of psychiatry*, MHWAC.

<sup>26</sup> *Ibid.*

<sup>27</sup> *Ibid.*

<sup>28</sup> Department of Human Services 2006, *The medical workforce of Victoria 2000–2004*, State Government of Victoria, Melbourne.

## Occupational therapists

Occupational therapists address the functional performance needs of a person in order to achieve their maximum independence. They work with people of all ages, abilities and disabilities to overcome the personal, social and environmental barriers to people's participation in the occupations they want and need to do.<sup>29</sup> Occupational therapists work across the whole spectrum of mental health services, including inpatient and outpatient settings, in government and non-government organisations providing services for children and young people, adults and older adults.<sup>30</sup>

The great majority of occupational therapists in mental health work in community-based positions, and in line with current service delivery structures. Their roles predominantly involve case management.<sup>31</sup> Mental health occupational therapists primarily work with consumers, specialising in assessing the impact of mental illness on their ability to function in everyday occupations and roles. They also focus on how a person's lifestyle can support mental health and improve quality of life.

In order to practise in mental health, occupational therapists typically complete a four-year undergraduate degree from an occupational therapy course accredited by the Australian Association of Occupational Therapists (OT Australia). However, recent developments at some universities mean people are now able to obtain entry-level qualifications in occupational therapy by master's degree.<sup>32</sup> Occupational therapists do not require registration to practise in Victoria but those who work for government-funded agencies are required to have appropriate qualifications for full membership of OT Australia.<sup>33</sup>

Occupational therapists in Victoria are mostly female, Australian-born, and work in metropolitan services.<sup>34</sup> Those working in public hospitals average fewer years of practice (8.8 years) than those who practice worked in their own (or a group) practice (17.1 years).<sup>35</sup> From the 696 respondents to the 2004 *Occupational therapy labour force survey* only 36 indicated a mental health speciality.<sup>36</sup>

## Social workers

Social work in mental health is a specialised field of practice that focuses on the social context and consequences of mental illness. The purpose of social work practice in mental health is to promote recovery, restore individual, family and community wellbeing, enhance development of each individual's power and control over their lives, and advance the principles of social justice.<sup>37</sup> Social workers use a bio-psychosocial model to inform their understanding of mental health and mental illness and guide their practice. Social work practice starts with the individual and extends to the contexts of family, social networks, community and the broader society. Social workers are employed in treatment and rehabilitation services across the public, private and non-government mental health service sectors, as well as in primary health care.<sup>38</sup>

<sup>29</sup> OT Australia 2008, *Bridging the Gap: Mental Health Project*, OT Australia, Fitzroy.

<sup>30</sup> Ibid.

<sup>31</sup> Hayes R, Bull B, Hargreaves K, Shakespeare K 2008, 'A survey of the recruitment and retention issues for occupational therapists working clinically in mental health', *Australian Occupational Therapy Journal*, 55, 12–22.

<sup>32</sup> Department of Human Services 2006, *Occupational therapy labour force survey: Victoria 2003–04*, State Government of Victoria, Melbourne.

<sup>33</sup> Ibid.

<sup>34</sup> Ibid. p.1

<sup>35</sup> Ibid. p.9

<sup>36</sup> Ibid. p.13

<sup>37</sup> Australian Association of Social Workers (AASW) 2008, *Practice standard for mental health social workers*, AASW, p.9

<sup>38</sup> Australian Association of Social Workers (AASW) 2006, *Social work in mental health care*, AASW (see at <http://www.aasw.asn.au/adobe/medicare/MHSocialWork.pdf>)

A social work degree is typically four years' full-time study or part-time equivalent in an accredited social work course. In recent times some universities have introduced a qualifying master's degree as an entry-level qualification. The Australian Association of Social Workers accredits social workers with specialist qualifications and training in mental health to work as service providers in the Enhanced Primary Care for Mental Health Workers and Better Access to Mental Health Care initiatives.<sup>39</sup>

In 2006 there were 323.6 EFT of social workers employed in Victoria's specialist mental health services. They specialise in working with individuals and families where mental health problems exist in connection with social problems such as family distress, unemployment, disability, poverty and trauma.<sup>40</sup>

## Psychologists

Psychologists must be registered with the Psychologists Registration Board of Victoria.<sup>41</sup> The number of registered general psychologists in Victoria in 2008 was 6,214.<sup>42</sup> Clinical, health, forensic, counselling, educational and neuro-psychologists are all employed in the specialist mental health workforce.

Clinical psychologists have specialist training in the assessment, diagnosis and treatment of mental illnesses and psychological problems. Clinical psychologists are specialist psychologists with a minimum of six years' university training, including approved postgraduate clinical studies and placements in psychiatric settings.

Clinical psychologists complete all the same basic training as other specialist psychologists (eight other specialist areas) but undertake a master's or doctorate in clinical psychology in order to be eligible for membership of the Australian Psychological Society (APS) College of Clinical Psychologists.

In 2006 the Australian Institute of Health and Welfare (AIHW) produced its first study of the psychology labour force, using 2003 data. The report noted that 98.3 per cent of registered psychologists in Victoria identified their main work location as being in a metropolitan area and fewer than half (47.1 per cent) reported working mainly in the public sector.<sup>43,44</sup>

Under the MBS *Better Access to Mental Health Care* items, there are different rebates for services provided by registered psychologists and clinical psychologists. Many psychologists have more than one position and may provide services in both the public and private sector.

## Consumer consultants

Consumer consultants are an integral part of Victoria's clinical mental health services. They have an important role in improving service responsiveness to the perspective of consumers with direct experience of mental health services. In Victoria there are currently 19 consumer consultants working to ensure that consumer perspectives are included in all aspects of mental health service planning, delivery and evaluation.<sup>45</sup>

<sup>39</sup> Ibid.

<sup>40</sup> Department of Human Services, *Mental Health and Drugs Division Information Analysis and Reporting 2006–07* (W048728, MHE\_2006\_07), State Government of Victoria, Melbourne, as at 5 September 2008

<sup>41</sup> Note that there are nine specialty areas of psychology plus generalist psychologists – clinical psychologists are one such specialty. See: <http://www.psychology.org.au/community/specialist/clinical/#s1>

<sup>42</sup> Psychologists Registration Board of Victoria 2008, *Annual report 08: Year ended 31 December 2008*, Psychologists Registration Board, Melbourne, p. 7

<sup>43</sup> Australian Institute of Health and Welfare (AIHW) 2006, *Psychology Labour Force 2003*. AIHW cat. No. HWL 34. Canberra: AIHW (National Health Labour Force Series No. 33).

<sup>44</sup> 'Metropolitan' refers to major city and inner regional areas of Australia.

<sup>45</sup> Department of Human Services, *Mental Health and Drugs Division Information Analysis and Reporting 2006–07* (W048728, MHE\_2006\_07), State Government of Victoria, Melbourne, as at 5 September 2008

Consumer consultants are primarily positioned within adult area mental health services. However, some consultants have also developed collaborative relationships and extended their scope to include aged persons mental health, child and adolescent mental health and PDRS service. A 2006 stocktake of the characteristics of Victorian consumer-delivered services identified that of the small sample of 25 participating PDRS services, 28 per cent employed consumers.<sup>46</sup>

## Carer consultants

Carer consultant positions are a relatively recent addition to clinical mental health services. They have largely been developed in recognition of the value carers contribute to treatment planning, consumer outcomes and service responsiveness to the needs to the families and carers of consumers.<sup>47</sup> Their role is to provide support, information and referral to families and carers and work collaboratively with area mental health services to develop improved service responsiveness to the needs of families and carers.

Carer consultants are predominantly employed within adult mental health services, though a small number of positions exist in child and youth and aged mental health services. There are currently 13.1 EFT carer consultants employed in area mental health services across the state.<sup>48</sup> A review of the Mental Health Carer Support program, undertaken in 2006, suggested carer consultant positions are now an integrated and well-accepted function of clinical mental health services.<sup>49</sup> It also found the positions have further strengthened the range of support available to carers and complement the pre-existing network of carer support in the community.

## Consumer and carer support workforce

MSSH services provide information, support and assistance to families and other carers and consumers of mental health services. This can involve sharing experiences and coping strategies, providing information and referral services, and promoting community awareness. The specialist, statewide MSSH workforce includes service managers, volunteer coordinators, support workers and administrative support staff. Their role is to address mental health conditions within a developmental approach. They promote mutual support from others living with mental illness as well as encouraging consumers to be active in their own recovery.

Caring for a relative or friend with a serious mental illness presents carers with many challenges. Carer support and resource workers (mental health) form an integral part of the model of the generalist carer service system that supports carers in this role. They assist services by providing information resources, acting as community education and referral pathways and delivering carer support.

Recurrent funding is provided for carer support and resource workers (mental health) across metropolitan and rural Victoria (\$461,000 in 2005–06) and there are currently 5.45 (EFT) of carer support and resource workers (mental health) positions located across the Commonwealth carer respite centres and Carerlinks services.<sup>50</sup> There is variability across the state in the functions of carer support and resource workers (mental health).<sup>51</sup> In some regions, the role is a blend of direct service provision to carers and service development and in other regions the role is either direct service or service

<sup>46</sup> Department of Human Services 2006, *A needs assessment of Victorian consumer delivered services: draft final report*, State Government of Victoria, Melbourne.

<sup>47</sup> The Victorian Government's *In partnership: families, other carers and public mental health services*, published in 1996, recognised the importance of good collaboration between mental health professionals and carers and proposed strategies to achieve this.

<sup>48</sup> Department of Human Services, Mental Health and Drugs Division Information Analysis and Reporting 2006–07 (W048728, MHE\_2006\_07), State Government of Victoria, Melbourne, as at 5 September 2008

<sup>49</sup> Department of Human Services 2008, *Review of the Mental Health Carer Support Program and carer support and resource workers (mental health): Final report*, State Government of Victoria, Melbourne.

<sup>50</sup> *Ibid.*

<sup>51</sup> *Ibid.*

development. However, stakeholder feedback on the carer support and resource worker (mental health) positions is very positive with stakeholders reporting that they are very responsive to carers' respite needs and have strong partnerships with mental health services to achieve good support outcomes for carers.<sup>52</sup>

## Psychiatric disability rehabilitation and support (PDRS) services

The PDRS sector is an important partner with clinical services, providing the rehabilitation focus that assists consumers remain well within the community. PDRS staff focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from mental illness. PDRS service provision is a specialist function and staff work within a recovery and empowerment model to maximise people's opportunities to live successfully in the community. PDRS service staff provide specialist programs for people with psychiatric disabilities that are not available to them through generic community services. They assist consumers to regain or develop skills they may need to actively participate in daily life, personal and social interactions, and community life and activities.

PDRS services employ a range of workers with diverse qualifications and experience, including many from the disciplines described above. In 2000 the main areas of qualification for the sector were social work (19 per cent), psychology (19 per cent), social sciences (15 per cent), welfare studies (14 per cent) and education (10 per cent).<sup>53</sup> PDRS service workers frequently have experience in more than one other sector such as community and welfare (32 per cent), disability (28 per cent) and mental health (24 per cent).<sup>54</sup> A high proportion of workers are relatively new to the sector with 56 per cent working in the sector for less than three years.<sup>55</sup>

## Koori workforce

The Koori mental health workforce assists area mental health services to provide culturally appropriate services, develop cultural expertise and improve Aboriginal people's confidence that mental health services will be culturally sensitive.

The Commonwealth Office for Aboriginal and Torres Strait Islander Health (OATSIH) funds Indigenous health practitioners, including Aboriginal health workers, counsellors and clinic staff to: identify and address mental illness and associated substance use issues in Aboriginal and Torres Strait Islander (ATSI) communities; recognise the early signs of mental illness; and make referrals for treatment where appropriate.<sup>56</sup>

The Commonwealth also funds social health teams within a small number of Aboriginal Community Controlled Health Services (ACCHSs). These teams provide a range of social health services within the sector including responses to Stolen Generation issues, grief, loss, trauma, anger, substance misuse, family and parenting problems, suicide and mental health crises.<sup>57</sup> At a state level, Victorian Government funds the Koori mental health liaison officers (KMHLO) project,<sup>58</sup> which is based at the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). There are currently 11.4 EFT of KMHLOs employed in rural Victoria.<sup>59</sup> These officers play a vital role in assisting rural clinical mental health services to provide culturally appropriate services, develop culturally sensitive policy, and provide practical support to Aboriginal people engaged these services.

<sup>52</sup> Ibid.

<sup>53</sup> Psychiatric Disability Services of Victoria (VICSERV) 2000, *VICSERV member census and worker survey*, VICSERV, Melbourne.

<sup>54</sup> Ibid.

<sup>55</sup> Ibid.

<sup>56</sup> [http://www.healthinonet.ecu.edu.au/html/html\\_community/social\\_health\\_community/programs\\_projects\\_lessons/social\\_capac.htm](http://www.healthinonet.ecu.edu.au/html/html_community/social_health_community/programs_projects_lessons/social_capac.htm)

<sup>57</sup> OATSIH 2004, *A national strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional well being 2004–2009: The social and emotional well being framework*, Commonwealth Government of Australia, Canberra.

<sup>58</sup> VACCHO, *Koori Mental Health*, viewed 11 November 2008, <[http://www.vaccho.org.au/programs/programs\\_mental.asp](http://www.vaccho.org.au/programs/programs_mental.asp)>

<sup>59</sup> Ibid.

## 2. Priorities for action

The considerable support and commitment dedicated to workforce development over the past decade has provided Victoria with a solid basis of expertise and skill across the existing specialist mental health workforce. In order to effectively implement *Because mental health matters* and ensure ongoing development and long-term sustainability, there are three priority areas that need to be addressed. These priorities reflect current health workforce research findings and incorporate the NHWSF's guiding principles. The three areas for attention are:

- supply and distribution
- skills and training
- organisational environments.

### 2.1 Supply and distribution

An adequate and sustained supply of mental health workers is necessary to ensure consumers have access to high-quality mental health services. Workforce supply may be improved through a number of strategies, including building on education and training places, greater promotion of the specialist mental health sector (where available education and training places outstrip supply), overseas recruitment, re-entry programs and improved staff retention. In an increasingly tight labour market, the specialist mental health sector competes with other health and community service sectors to attract school leavers, trainees, new graduates and workers.

The issue of workforce distribution is a challenge that extends beyond the specialist mental health system to other sectors and industries, especially where this relates to outer metropolitan, regional and rural communities. The distribution of the specialist mental health workforce occurs across geographic regions, the public and private sector and within the service components of the specialist mental health sector. In responding to recruitment and retention challenges, regional and rural specialist mental health services, along with professional bodies, unions and education and training providers, have developed innovative approaches to support workforce development. Services have also explored flexible approaches to retain specialist mental health staff within specific service settings and the specialist mental health sector as a whole.

### Our challenges

The main challenges currently facing the Victorian specialist mental health sector regarding the supply of workers are shortages and turnover. Supply challenges relating to the distribution of the workforce are exacerbated in outer metropolitan, regional and rural areas. The interface between the private and public mental health sectors also impacts upon the staffing of specialist mental health services.

### Shortages

Shortages of health professionals have been well documented in Australia<sup>60</sup> and internationally. For the past two years the community services and health sectors have been identified as requiring the fastest rate of workforce growth in the next five years.<sup>61</sup> Twenty-four per cent of all new workforce growth will be from community services and health to 2012, growing at a rate of 3 per cent each year, or 170,000 jobs.

Australia's total labour force participation rate is projected to decline in the coming decades as the proportion of the population aged over 65 years increases. Forty-six per cent of workers in the community services and health sector are over the age of 45, which is 9 per cent above the average for all sectors. Workforce growth requirements over the next five years will be affected by the need to replace retiring workers as well as add to the overall number.<sup>62</sup>

<sup>60</sup> Australian Productivity Commission 2005, *Australia's health workforce research report*, Australian Government, Melbourne.

<sup>61</sup> Community Services and Health Industry Skills Council (CS&HISC) 2008, *Environmental scan 2008*, CS&HISC, Sydney, p.5.

<sup>62</sup> Department of Employment and Workplace Relations 2007, *Australian jobs 2007*, Australian Government, Canberra.

In Australia and Victoria, significant shortages have been projected for the clinical mental health workforce.<sup>63</sup> A workforce study released in 2005 investigating the Victorian clinical mental health workforce found, based on past service utilisation trends and assuming no policy changes, the following net increases would be required to meet emerging demand:

- a 31 per cent increase in medical EFT
- a 25 per cent increase in division 1 nursing EFT
- an 18 per cent increase in division 2 nursing EFT
- a 25 per cent increase in allied health EFT.<sup>64</sup>

Clinical and PDRS services have difficulties filling existing vacancies. Anecdotally, clinical services report delays recruiting psychiatrists, nurses and occupational therapists and average waiting times of six weeks to fill vacancies in child and adolescent and aged program areas.<sup>65</sup> Investment in additional staffing levels, service expansion and capital works projects will increase the demand for specialist mental health workers in the future. While these are critical, they will also exacerbate current supply challenges. For example, some clinical services have reported difficulties recruiting to additional nursing staffing positions in high-dependency inpatient units provided for by the *2007 Psychiatric Services Agreement*.

Accurate data profiling and forecasting the demand for the PDRS workforce is required. Available data is dated and limited to position titles, qualifications and length of time working in the sector.<sup>66</sup> More comprehensive data is needed to understand the existing workforce and inform workforce planning and policy. This data would include the demographic characteristics of PDRS workers, qualifications, workforce characteristics (such as labour force status, job tenure, classification level, hours worked) and geographic location. Measures of current and projected entrants to and exits from the workforce are also needed to analyse changes in the workforce.

PDRS services currently report difficulties recruiting qualified base-grade workers, particularly occupational therapists, social workers and middle managers.<sup>67</sup> Anecdotal evidence suggests recruitment and retention difficulties for this sector are compounded by less attractive employment conditions, including lack of portability of entitlements, and the limited availability of information about PDRS careers to school leavers and other workforces.

Shortages of health workers exist in Indigenous communities.<sup>68</sup> At present, Indigenous people make up 2.4 per cent of the population, but only 0.9 per cent of the health workforce.<sup>69</sup> There is a need to facilitate greater Indigenous participation in the mental health workforce through increasing access to education and training.

Evidence suggests limited exposure of students to the specialist mental health sector may constrain workforce supply. Some professional bodies believe a component of this is related to insufficient higher education places for undergraduate health students. Specifically, the projected nursing requirements may not be met based on the number of available university places. Anecdotal evidence suggests difficulties filling psychiatric training positions, particularly

<sup>63</sup> Community Services and Health Industry Skills Council (CS&HISC) 2005, *Industry skills report*, CS&HISC, Sydney, p.16.

<sup>64</sup> Department of Human Services 2005, *Victoria's direct care mental health workers: the public mental health workforce study 2003-04 to 2001-12*, State Government of Victoria, Melbourne.

<sup>65</sup> World Health Organization, *World health report 2006 - Working together for health*, available at <<http://www.who.int/whr/2006/en/index.html>>.

<sup>66</sup> Meeting with area mental health service managers and clinical directors - 1.

<sup>67</sup> VICSERV 2000, *VICSERV member census and worker survey*, VICSERV, Melbourne.

<sup>68</sup> Meetings with representatives from the PDRS service sector and area mental health service managers and clinical directors.

<sup>69</sup> Australian Productivity Commission, *Australia's health workforce research report 2005*, Australian Government, Melbourne, p.xvii.

<sup>69</sup> Ibid. p.249.

child and adolescent advanced training positions. Research investigating psychiatry<sup>70</sup> and mental health nursing<sup>71</sup> has identified the need to improve the image and profile of mental health work. Media portrayals of mental illness and the views of mental health work by other health professionals may lead to a misunderstanding of mental health.

Considering the projected staffing shortfalls, workforce supply will need to be increased through a multifaceted approach. Accurate and accessible information about employment opportunities in the specialist mental health sector and mental health careers that communicates the positive and attractive aspects of mental health work may increase the awareness of students and other health workers. Currently, there is no centralised website or resource promoting career opportunities in the specialist mental health sector. Some clinical services advertise vacancies on the Victorian Government *Health Jobs* website ([www.health.vic.gov.au/jobs](http://www.health.vic.gov.au/jobs)) and other employment websites such as *SEEK* and *MyCareer*. However, the *Health Jobs* website does not include vacancies in the PDRS service sector. Coordinated information on careers and specific vacancies via a user-friendly website is critical. Research into mental health nursing suggests the engagement of mental health nurses and consumers and carers is important in the promotion of mental health and likely to raise interest in and increase the attractiveness of mental health careers.<sup>72</sup>

Services may respond to workforce shortages by engaging overseas and agency staff, or exploring new service delivery models and ways to increase the capacity of existing staff. Services are increasingly relying on overseas trained mental health workers, particularly psychiatrists, to meet their immediate workforce requirements. The mental health workforce study identified a high proportion of Victorian psychiatrists (11 per cent) and psychiatry registrars (16 per cent) holding temporary residency.<sup>73</sup> Similar data is required for other mental health disciplines.

Services may attract overseas staff by undertaking overseas recruitment drives and supporting their relocation to Victoria. This may include specific campaigns, information packs, orientation programs and professional support. As many other countries experience shortages and aggressively target overseas trained staff, it may become more difficult to source appropriately trained professionals from overseas.

A reliance on overseas trained workers presents particular challenges. Variability may exist in the skills equivalence of workers from different countries and even within countries depending on the educational institution attended. Recruited staff may require workloads to be managed, additional support and supervision, and appropriate matching of experience to employment roles.<sup>74</sup> Staff recruited from overseas may also require enculturation, assistance with English language proficiency, orientation to the Australian health care system and integration into the community, particularly in regional and rural areas. Anecdotal evidence suggests difficulties retaining international medical graduates trained in Victoria who often work interstate or in private practice after gaining fellowship to the RANZCP.

Staff shortages may mean that mental health services have to rely on other staffing options including overtime and employing fixed-term, casual and agency staff. The greater use of agency staff has implications for staffing costs and the quality of care provided to consumers as agency staff may be unfamiliar with the mental health service and other staff, the consumers they are caring for and local procedures and practices.

Improving the supply of an optimally trained workforce across all areas is important. However, increasing workforce supply alone will be insufficient to manage workforce demand and to ensure longer term service sustainability. Initiatives that explore new service delivery models and ways of utilising existing staff may increase workforce capacity and improve client care and staff satisfaction by making best use of available skills.

<sup>70</sup> Malhi GS, Parker GB, Parker K, Carr VJ, Kirkby KC, Yellowlees P, Boyce P and Tonge B 2003, 'Attitudes toward psychiatry among students entering medical school', *Acta Psychiatrica Scandinavica*, 107 6: 424–429.

<sup>71</sup> Australian Health Workforce Advisory Committee (AHMAC) 2003, *Australian mental health nurse supply, recruitment and retention*, AHMAC.

<sup>72</sup> Ibid.

<sup>73</sup> Department of Human Services 2005, *Victoria's direct care mental health workers: The public mental health workforce study 2003–04 to 2011–12*.

<sup>74</sup> McGrath B 2004, 'Integration of overseas-trained doctors into the Australian medical workforce', *MJA*, December, 181, pp.640–642.

Services need to respond to the broader strategic directions of the Victorian and Commonwealth governments for mental health service delivery. Victoria's mental health reform strategy, *Because mental health matters*, proposes a greater emphasis on prevention and early intervention, particularly for children and young people, and a broader response to the spectrum of mental health needs. It emphasises the need for local partnerships to promote shared planning and improved coordination of service delivery at the local level. Services will need to ensure that recruitment and retention activities align with these strategic directions.

Nationally and internationally, attention is shifting to strategies that maximise the effective use of specialist mental health staff through different workforce configurations and new and amended workforce roles, including expanded scopes of practice (for example, nurse practitioners). The *2007 Psychiatric Services Agreement* includes productivity requirements that allow up to one-third of staffing in inpatient units to be filled by division 2 nurses with specific mental health nursing education. Services are to work in collaboration with unions towards an increase of up to 15 per cent of community mental health staff to be division 1 (grade 2) nurses,<sup>75</sup> division 2 nurses or PSOs.

The NHWSF, adopted by Australian Health Ministers in 2004, supports a realignment of existing health workforce roles, or the creation of new roles, to make optimal use of skills and ensure best health outcomes. The key objectives of workforce redesign are to improve consumer outcomes and staff satisfaction by ensuring professionals with the highest levels of skills and training work directly with clients with the most complex needs, minimising duplication of effort and enabling delegation of aspects of care that do not require high-level education and training to workers with lesser levels of qualifications and training experience.

Exploring new and amended roles, including expanded scopes of practice of existing professionals, may expand the overall capacity of the mental health workforce. For example, the recent changes in the scope of practice enable division 2 nurses with medication endorsement to undertake this function under the supervision of a division 1 or 3 nurse. The potential to utilise division 2 nurses and other staff in the specialist mental health sector requires further investigation, implementation and evaluation. Extensive work in this area has been carried out in the United Kingdom with the trialling of a large number of new roles in recent years across the spectrum of health care. Any imported models considered for trialling will need to have been positively evaluated, consider the Victorian context (including the legislative and industrial environment) and be refined as required.

## Turnover

In addition to the issues relating to an overall shortage of workers, turnover also presents the sector with a challenge. Annual staff turnover in the clinical mental health workforce has been estimated to be up to 22 per cent in some occupational groups.<sup>76</sup> Staff mobility is highest among young nurses and allied health staff in rural areas.<sup>77</sup> Data also shows that of the staff who moved from or within the public mental health system in 2001–02, a third left after less than 12 months with their current employer and 63.4 per cent departed within three years of commencing.<sup>78</sup> While it is not possible to accurately determine the destination of staff departing a public mental health employer, data collected suggests that up to one-third leave the public mental health sector altogether.<sup>79</sup> Similar turnover data is required for the PDRS service workforce.

Research examining the recruitment and retention of 'generation Y' workers (born between 1980 and 1994) has highlighted their increased mobility compared with 'generation X' (1965–1979) and baby boomers (1946–1964). It

<sup>75</sup> This is a new community entry training position for grade 2 division 1 nurses (or registered psychiatric nurse).

<sup>76</sup> Department of Human Services 2005, *Victoria's direct care mental health workers: the public mental health workforce study 2003–04 to 2001–12*, State Government of Victoria, Melbourne, p.1.

<sup>77</sup> *Ibid.*

<sup>78</sup> *Ibid.*

<sup>79</sup> *Ibid.*

suggests this high job mobility is the product of new career expectations, today's market opportunities and a solid job market created by the economic and demographic times.<sup>80</sup> In response, employers are developing retention strategies focusing on work–life balance, social and collaborative workplace cultures, varied job roles, management style and training.<sup>81</sup>

Discussions with area mental health services suggest the extent of retention challenges may vary across services. Larger services may be able to draw on their critical mass and larger resources to establish internal 'staff banks' and recruit staff, particularly overseas, on the basis of expected turnover rather than existing vacancies.

Despite this, services have identified two key drivers of attrition within the specialist mental health sector. First, disparities in pay and working conditions between the public and PDRS service sectors may contribute to attrition from the PDRS service sector and impede the operation of a functional and cohesive specialist mental health system. Second, heavy workloads in a crisis-driven system may lead to mental health clinicians feeling disenchanted due to limited opportunities to fully apply their skills and expertise and engage clients in a holistic way.<sup>82</sup>

It is sometimes argued that differential conditions, including salaries, between jurisdictions represent a competitive disadvantage for Victorian medical professionals, particularly relative to Queensland. This has led to calls for Victoria to address the potential loss of doctors by raising salaries and improving conditions of employment. However, the Queensland Medical Board has cited data indicating a 36 per cent fall in the number of doctors from Victoria registering in Queensland in 2007–08, compared with the previous year. The board suggests Victorian doctors are completing their internships in Queensland before returning to Victoria and that overall numbers remaining in Queensland have decreased as in previous years.

The Ministerial Review of Victorian Public Health Medical Staff (2007)<sup>83</sup> was similarly unable to find any evidence that remuneration packages in other jurisdictions played a significant part in the capacity of Victoria's public health services to recruit or retain medical staff. Instead, the review found senior medical staff in Victoria have considerable flexibility in the negotiation of salaries and conditions. This suggests factors influencing the recruitment and retention of medical staff are complex and multifaceted. While salaries may be important to some psychiatrists, issues such as access to professional support, academic activities and organisational culture are influential and need to be better understood and addressed.

### Outer metropolitan, rural and remote issues

Data indicates there is geographic maldistribution of the clinical mental health workforce relative to the client population. Although Victoria meets the World Health Organization psychiatrists: population ratio<sup>84</sup> its psychiatry workforce is heavily skewed to the cities, with only 11 per cent of medical staff working in rural areas.<sup>85</sup> This reflects national trends with 90.1 per cent of psychiatrists identifying their main place of work as a major city.

Major cities had 22 EFT employed psychiatrists and psychiatrists-in-training per 100,000 of population and the following ratios in the following other geographic areas:

- 6:100,000 in inner regional areas
- 3:100,000 in outer regional areas
- 3:100,000 in remote and very remote areas.

<sup>80</sup> McCrindle Research 2006, *New generations at work: attracting, recruiting and training Generation Y*, McCrindle Research, Sydney.

<sup>81</sup> Ibid.

<sup>82</sup> Mental Health Reform Strategy Roundtable – Workforce, 28 July 2008.

<sup>83</sup> Ministerial Review Panel, November 2007, Ministerial Review of Victorian Public Health Medical Staff.

<sup>84</sup> The World Health Organization recommends 1:10,000 as a psychiatrist: population ratio. Victoria has 733 Fellows of RANZCP and a ratio of 1:7,433 which is the second highest ratio of all states and territories, behind South Australia (1:6,701).

<sup>85</sup> Mental Health Workforce Advisory Committee, February 2008, *Mental Health Workforce: Supply of Psychiatrists*.

Approximately 5 per cent of psychiatrists residing in capital cities or inner regional areas report servicing, at least part time, outer regional, remote or very remote areas.

Only 16 per cent of division 2 nurses currently work in rural areas<sup>86</sup> and the distribution of the 13 state-funded Koori mental health liaison officers may need to be improved to ensure they are distributed relative to the Koori population in Victoria. Equivalent data is required for the PDRS service workforce.

There is evidence of numbers of unfilled psychiatric positions in public services, particularly in rural and remote areas. Access to private psychiatrists in Victoria is uneven with services concentrated in inner and middle metropolitan areas in Victoria. People living in rural areas have the least access to private psychiatrists. Those who do access these services are estimated to receive about one-third fewer consultations.

The rural workforce appears to be quite mobile, particularly among younger staff. Mobility is highest among young nurses and allied health staff in rural areas. Although the overall level of staff turnover in rural areas is less than in metropolitan areas, the proportion of younger allied health practitioners and division 1 nurses departing rural employers is substantially higher than their overall proportion of the workforce.

Geographic workforce maldistribution has a range of underlying causes, encompassing such things as remuneration, professional and career development and lifestyle. Remuneration levels for individual professionals are perceived to be generally lower than in metropolitan areas. This is partly because care needs can be more demanding in the absence of shared care options, leading to longer treatment times and lower throughput.

While many workers emphasise that working in outer metropolitan, rural and remote areas can be very rewarding, a variety of professional considerations can discourage health staff from working in these areas. Hours of daily work tend to be longer than in the cities and the pressure greater due to an expectation that workers will be able to perform a wider range of services and be available to do so at any time. As a result of the relative shortage of other mental health service providers, rural mental health services often see a broader client group, providing a service response to a greater proportion of the eligible client population compared with their metropolitan counterparts.<sup>87</sup> Professional development opportunities and career pathways are more limited, increasing the risk that those working in these areas will become 'locked in.' Lack of supervision may also compound feelings of professional isolation.

Although living in rural and remote areas has lifestyle benefits there are a variety of offsetting lifestyle costs that add considerably to recruitment and retention difficulties. Apart from work-life balance considerations, outer metropolitan, rural and remote areas often have less well developed community infrastructure – including housing and transport services – than the major population centres. Reduced access to emergency support services, such as the police and ambulance, also affect job satisfaction and retention. Social isolation can be a concern and spouse and family considerations, especially relating to more limited employment and education opportunities and the greater difficulty of accessing childcare services, can further militate against work in these areas.

## Public and private issues

Locally trained psychiatrists are unevenly distributed between private practice and the public sector. The public system has difficulty recruiting local graduates and has an increasing reliance on overseas graduates, particularly in rural areas.

Although the proportion of health professions working exclusively or predominantly in the public system varies across disciplines,<sup>88</sup> two recently introduced COAG initiatives (Medicare items for psychologists, social workers and

<sup>86</sup> Department of Human Services 2005, *Victoria's direct care mental health workers: the public mental health workforce study 2003–04 to 2001–12*, State Government of Victoria, Melbourne, p.2.

<sup>87</sup> Department of Human Services 2007, *Planning framework for public rural mental health services*, State Government of Victoria, Melbourne, p.9.

<sup>88</sup> Mental Health Workforce Advisory Committee 2008, *Mental health workforce: Supply of psychiatrists; Supply of psychologists*; Human Capital Alliance 2006, *Recruitment and retention of allied health professionals in Victoria – literature review*

occupational therapists and the Mental Health Nurse Incentive Program (MHNIP)) may increase competition from the private sector for mental health professionals.<sup>89</sup> Preliminary surveys indicate a significant proportion of psychologists intend to reduce their working hours in the public sector in order to move to, or increase their, private practice.<sup>90</sup>

The increased use of private practitioners also has the potential to undermine the development of a coherent multi-agency/practitioner service response for mental health consumers of specialist mental health and primary care services.

The deed of agreement of the *2007-11 Psychiatric Services Agreement* provides for parties to jointly develop arrangements for employment in private practice.<sup>91</sup> This is mirrored in the *Heads of Agreement - Medical Scientists, Pharmacists and Psychologists Workplace Agreement* which provides for further discussions under the auspices of the Department of Health with a view to agreeing to a model providing private practice rights for psychologists in the public sector.

Several examples already exist of services facilitating public-private working arrangements with the collocation of private consulting suites such as the Harvester Private Consulting Suites Clinical and Melbourne Clinic.

## Settings

The specialist mental health sector includes a diversity of work settings, including inpatient units, long-term residential facilities, day patient treatment services, crisis response teams, after hours' teams, community treatment teams, regional mental health services and specialist psychiatric services. As each setting has its unique characteristics, further work is required to better understand recruitment and retention challenges across different mental health settings.

## What we are currently doing

There are a number of initiatives being implemented that seek to address the issues and challenges of workforce supply and distribution. Highlighted below are examples of some of these.

## Supply

- Kangan Batman TAFE delivers the health and community services careers program ([www.hcscareers.vic.edu.au](http://www.hcscareers.vic.edu.au)) funded by the Department of Health, which promotes higher education and VET health career pathways to secondary school students, parents and careers advisors.
- The Commonwealth Government has committed to funding additional higher education and VET places. For Victoria, this includes 179 mental health nursing and 62 clinical psychology higher education places. Nationally, this includes 50,000 of the 640,000 additional training places that have been quarantined for identified priority areas in community services and health over four years from 2008-09.<sup>92</sup>
- In 2009 the Commonwealth Government will introduce the National Priority Scholarships that will target national priority disciplines such as medicine, nursing and allied health. A National Accommodation Scholarship will assist students who need to relocate more than 100 kilometres to study the discipline of their choice when it is not available close to their home location.
- The Victorian Government provides funding for medical intern, postgraduate year 2 and specialist training positions.
- The Victorian Government provides funding for specialist mental health nursing and allied health graduate programs, division 1 nursing postgraduate scholarships and post basic mental health modules for division 2 nurses.

<sup>89</sup> The MHNIP was further revised in April 2008 to allow shared employment arrangements between the public mental health service and the GP.

<sup>90</sup> Gleeson J and Brewer W, June 2008, *Medicare and public mental health psychology services*, InPsych, p 36.

<sup>91</sup> *Mental Health Reform Strategy Roundtable - Workforce*, 28 July 2008.

<sup>92</sup> *Skilling Australia: Productivity Placement Program*, see <[www/skillingaustralia.gov.au](http://www/skillingaustralia.gov.au)>.

- The *2007 Psychiatric Services Agreement* provides for 60 additional EFT of nursing positions for inpatient and community settings and service improvements and productivity requirements, including increasing the proportion of PSENs (division 2 nurses) working in inpatient units and RPN2, PSENs [division2] and PSOs working in community settings.
- To assist overseas recruitment of staff, the Victorian Government offers funding to health and community services for incentive packages to recruit overseas trained medical and allied health professionals and pre-registration scholarships of up to \$2,000 to support international nurse graduates to meet Victorian registration requirements. It also jointly funds the Cultural Diversity Education Program for overseas trained nurses to assist eligible nurses who have completed their qualifications overseas to transition to practice and is contributing to the development of nationally consistent assessment process for international medical graduates.
- The Victorian Government supports the recruitment and retention of international medical graduates (IMGs) through funding for medical clinical educators in health services, implementing projects within health services to improve assessment, orientation and upskilling and providing cross cultural communication workshops.
- The Victorian Government is developing statewide processes and resources through the Postgraduate Medical Council of Victoria to implement the national IMG assessment process. It also supports IMGs and their employers through upskilling of health service personnel in recruitment, supervision and teaching practices and developing a statewide orientation and cross-cultural communication framework.
- The Department of Health supports former nurses returning to nursing practice in public health services, through the Return to Nursing Program. A grant is paid to health services to assist individual nurses to complete programs leading to the competence required for re-registration and the confidence to return to work in the public health system.
- Registered nurses who participate in the Return to Nursing Program may also be eligible for incentive grants under the Commonwealth government-funded Bringing Nurses Back into the Workforce program. This program encourages registered and enrolled nurses who have been employed previously in the Australian nursing workforce but have not worked as a nurse or midwife in Australia for 12 months to return to work in a public or private hospital or residential aged care home.

## Distribution

- The Victorian Government funds the Metropolitan and Rural Medical Workforce Partnership Initiative to enhance professional supervision for and increase the retention of medical staff working in regional and rural public mental health services
- The Victorian government-funded Region of Choice program is an allied health recruitment and retention service in regional Victoria for publicly funded health and community services, allied health workers and employers.
- The Commonwealth government-funded Australian Rural and Remote Health Professional Scholarship Scheme assists qualified health professionals who live and provide clinical services in rural and remote areas by providing financial assistance to support the maintenance and upgrading of skills and knowledge relevant to the needs of their community.
- The Commonwealth government-funded Mental Health Nurse Incentive Program provides a non-MBS incentive payment to general practices, private psychiatrist services and other appropriate organisations (such as divisions of general practice) who engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental disorders.

- The Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS program provides Medicare benefits for psychological therapy and focused psychologically strategies. These services can be provided by psychiatrists, GPs, eligible clinical and non-clinical psychologists, social workers and occupational therapists.
- The heads of agreement for the *2007 Psychiatric Services Agreement* and the *Heads of Agreement Medical Scientists, Pharmacist and Psychologists Workplace Agreement* provides for the joint development by parties of arrangements for employment in private practice.

## What we plan to do

**Objective:** To substantially improve the supply and distribution of mental health workers to promote the long-term accessibility and sustainability of mental health services.

In addition to initiatives currently being implemented, this strategy proposes the implementation of a range of new actions to address the challenges of workforce supply and distribution including the following.

### Supply

- Develop and implement a short-term (12-month) recruitment strategy targeting workers who could transition into the specialist mental health workforce to fill existing vacancies. This will include establishing a government-funded recruitment website and hotline to advise on potential employment opportunities, streamlining access to information and promoting other relevant state and Commonwealth Government initiatives (for example, the Bring Nurses Back into the Workforce program). The website will be attractive, informative and easy to navigate and connect public clinical and PDRS employment opportunities.
- Undertake a workforce research project of the PDRS service sector that further investigates the workforce profile and analyses skills needs and identifies strategies to address recruitment, retention and career pathway challenges.
- Develop and implement a clearly articulated marketing strategy targeting undergraduate students, overseas trained staff and workers in other health and community settings that communicates the positive and attractive aspects of the mental health sector. Such a strategy should include the participation of mental health workers, consumers and carers and should highlight the challenging and dynamic nature of mental health work and its positive impact on the lives of consumers and carers and the broader community.
- Through the health and community service careers program ([www.hcscareers.vic.edu.au](http://www.hcscareers.vic.edu.au)) develop mental health career pathway maps that highlight articulation pathways between VET and higher education. Promote the resource through the Indigenous and rural pages on the website, as well as more broadly.
- Lobby the Commonwealth Government to align education and training places with projected supply needs.
- Work with universities and provide resources to improve the quality and quantity of mental health content in undergraduate curricula for all relevant disciplines.
- Evaluate the existing consultation and liaison psychiatry program to identify services gaps.
- Research consumer and carer work roles and models of care from other jurisdictions and countries to articulate pathways for improving the consumer and carer workforce within Victorian mental health services.
- In partnership with VACCHO, develop a competent ATSI mental health workforce by improving the effectiveness of training, recruitment and retention measures.
- In partnership with VACCHO, promote greater ATSI participation in the health workforce by improving training, career pathways and remuneration structures. Improve the use of existing resources through changes to scopes of practice and greater use of telemedicine.

- In partnership with VACCHO, develop training programs for mainstream health care workers to highlight awareness of and sensitivity to ATSI issues.
- In partnership with VACCHO, improve service quality for ATSI consumers through a greater emphasis on culturally appropriate models and methods of delivery in training programs. This may require different ways of working that considers family, community and improved mentoring and support.
- Improve the use of existing resources through changes to scopes of practice and greater use of telemedicine.
- Review the role of overseas recruitment in addressing workforce shortages in Victoria's mental health system.
- Provide targeted pre-exam support for psychiatric trainees to assist them gain fellowship to the RANZCP. This measure may potentially improve their retention in Victorian public mental health services.
- Evaluate the success of rural placements for international medical graduates and identify the key professional and social factors that will assist their integration and commitment to the local community.
- In partnership with Ethnic Communities Council of Victoria, identify priority actions to better respond to the needs of culturally and linguistically diverse consumers and carers by providing targeted education and training.
- Facilitate transition of workers from other areas of the health and community services sectors to mental health services through improved portability of benefits, recognition of prior learning, identification of core competencies and development of bridging courses to orient existing knowledge and skills to mental health service provision.
- Support NGOs to implement strategies to improve the salary and conditions for the PDRS service workforce.
- In consultation with unions, employers, professional bodies and other key stakeholders, identify, promote and disseminate information about innovative workforce models and roles.
- Maximise opportunities for an increased scope of practice for division 2 registered nurses through the utilisation of mental health and other relevant units of competency found in the *Enrolled nurse qualifications framework* of the national Health Training Package.
- Investigate the feasibility of increased scope of practice for PSOs through the utilisation of the Certificate IV Mental Health, Community Services Training Package, ensuring such work remains consistent with the classification standards of the 2007-11 *Psychiatric Services Agreement*.

(See 'organisational environments' section for other strategies to address workforce shortages and turnover.)

## Distribution

- Encourage 'grow your own' workforce approaches in regional and rural areas such as promoting mental health careers to regional and rural secondary school students, lobbying for the allocation of Commonwealth-supported mental health places to regionally based universities and developing programs supported through partnerships between services and education providers that offer career paths for local residents consistent with industrial and professional requirements.
- Continue to explore opportunities through the Council of Australian Government's (COAG) process to amend Medicare Benefits Schedule (MBS) mental health items to give providers incentives to work in regional and rural areas.
- Identify incentives and disincentives to work in rural areas and sectors of greatest need and workforce shortage including consideration of secondments from metropolitan to rural services.
- Lobby for increased rural clinical placements and regional training positions, and Commonwealth support for mental health students' accommodation and travel costs for rural clinical placements.
- Lobby for the expansion of the Medical Specialist Outreach Assistance Program to allied health professionals.

- Promote positive rural clinical placement experiences through appropriate education of supervisors, adequate student preparation for placements and infrastructure support, such as accommodation and technological resources (for example, teleconferencing and videoconferencing).
- Support the directors of psychiatric training to address the specific training needs of IMGs.
- Expand collaborative approaches to clinical support, mentoring and discipline-specific supervision such as rural-metropolitan partnerships for allied health staff in rural services.
- Work with services to develop shared cross-agency employment models in rural areas to increase employment security and viability.
- Negotiate with the Commonwealth Government to revise the current MBS mental health items to provide incentives for providers to work in rural and regional areas.
- Improve the placement experience of students in rural and regional areas by promoting the grouping of students together.
- Incorporate mental health within broader rural and regional health workforce initiatives such as Region of Choice (an allied health recruitment and retention service), undergraduate and postgraduate scholarships, continuing professional development subsidies, mentoring programs and improved use of information and communications technology.
- Undertake a survey of psychiatrists and other mental health professionals to explore the effectiveness of public-private working arrangements in retaining mental health staff within the public mental health sector.
- Investigate employment models that consider Commonwealth and state funding arrangements (such as the Better Access initiative) and allow mental health professionals to undertake private sector practice while continuing to contribute to public sector mental health service delivery.
- Investigate the use of technology to provide supervision to support rural and remote health professionals (such as tele-psychiatry).

# Summary of strategies/actions

**Objective:** To substantially improve the supply and distribution of mental health workers to promote the long-term accessibility and sustainability of mental health services.

## Theme 1: Supply and distribution – strategies and actions

### Short-term (1–2 years)

Develop and implement a short-term (12-month) recruitment strategy targeting workers who could transition into the specialist mental health workforce and fill existing vacancies. This will include establishing a government-funded recruitment website and hotline to advise on potential employment opportunities, streamlining access to information and promoting other relevant state and Commonwealth Government initiatives (for example, the Bring Nurses Back into the Workforce program). The website will be attractive, informative and easy to navigate and connect public clinical and PDRS employment opportunities.

Undertake a workforce research project of the PDRS service sector that further investigates the workforce profile and analyses skills needs and identifies strategies to address recruitment, retention and career pathway challenges.

Lobby the Commonwealth Government to align education and training places with projected supply needs.

Maximise opportunities for increased scope of practice for registered nurses division 2 through the utilisation of mental health and other relevant units of competency found in the *Enrolled nurse qualifications framework* of the national Health Training Package.

Investigate the feasibility of increased scope of practice for PSOs through the utilisation of the Certificate IV Mental Health, Community Services Training Package, ensuring such work remains consistent with the classification standards of the *2007-11 Psychiatric Services Agreement*.

Develop and implement a clearly articulated marketing strategy targeting undergraduate students, overseas trained staff and workers in other health and community settings that communicates the positive and attractive aspects of mental health sector. This will include the participation of mental health workers, consumers and carers and highlight the challenging and dynamic nature of mental health work and its positive impact on the lives of consumers and carers and the broader community.

Through the health and community service careers program ([www.hcscareers.vic.edu.au](http://www.hcscareers.vic.edu.au)) develop mental health career pathway maps that highlight articulation pathways between VET to higher education and promote the resource through the Indigenous and rural pages on the website, as well as more broadly.

Evaluate the existing consultation and liaison psychiatry program to identify services gaps.

Research consumer and carer work roles and models of care from other jurisdictions and countries to articulate pathways for improving the consumer and carer workforce within Victorian mental health services.

Review the role of overseas recruitment in addressing workforce shortages in Victoria's mental health system.

Provide targeted pre-exam support for psychiatric trainees to assist them gain fellowship to the RANZCP. This measure may potentially improve their retention in Victorian public mental health services.

Evaluate the success of rural placements for IMGs and identify the key professional and social factors that will assist their integration and commitment to the local community.

Promote positive rural clinical placement experiences through appropriate education of supervisors, adequate student preparation for placements and infrastructure support, such as accommodation and technological resources (for example, teleconferencing and videoconferencing).

Undertake a survey of psychiatrists and other mental health professionals to explore the effectiveness of public-private working arrangements in retaining mental health staff within the public mental health sector.

<b>Medium-term (3–5 years)</b>	Encourage ‘grow your own’ workforce approaches in regional and rural areas such as promoting mental health careers to regional and rural secondary school students, lobbying for the allocation of Commonwealth-supported mental health places to regionally based universities and developing programs supported through partnerships between services and education providers that offer career paths for local residents consistent with industrial and professional requirements.
	In consultation with unions, employers, professional bodies and other key stakeholders, identify, promote and disseminate information about innovative workforce models and roles.
	Continue to explore opportunities through the Council of Australian Government’s (COAG) process to amend Medicare Benefits Schedule (MBS) mental health items to give providers incentives to work in regional and rural areas.
	Work with universities and provide resources to improve the quality and quantity of mental health content in undergraduate curricula of all relevant disciplines.
	In partnership with VACCHO, develop a competent ATSI mental health workforce by improving the effectiveness of training, recruitment and retention measures.
	In partnership with VACCHO, promote greater ATSI participation in the health workforce by improving training, career pathways and remuneration structures.
	Improve the use of existing resources through changes to scopes of practice and greater use of telemedicine.
	In partnership with VACCHO, improve service quality for ATSI consumers through a greater emphasis on culturally appropriate models and methods of delivery in training programs. This may require different ways of working that considers family, community and improved mentoring and support.
	In partnership with the Ethnic Communities Council of Victoria, identify priority actions to better respond to the needs of culturally and linguistically diverse consumers and carers by providing targeted education and training.
	Support NGOs to implement strategies to improve the wage and conditions for the PDRS service workforce.
	Identify incentives and disincentives to work in rural areas and sectors of greatest need and workforce shortage including consideration of secondments from metropolitan to rural services.
	Advocate the expansion of the Medical Specialist Outreach Assistance Program to allied health professionals.
	Support the directors of psychiatric training to address the specific training needs of IMGs.
	Expand collaborative approaches to clinical support, mentoring and discipline-specific supervision such as rural–metropolitan partnerships for allied health staff in rural services.
	Improve the placement experience of students in rural and regional areas by promoting the grouping of students together.
	Incorporate mental health within broader rural and regional health workforce initiatives such as Region of Choice (an allied health recruitment and retention service), undergraduate and postgraduate scholarships, continuing professional development subsidies, mentoring programs and improved use of information and communications technology.
Investigate employment models that consider Commonwealth and state funding arrangements (such as the Better Access initiative) and allow mental health professionals to undertake private sector practice while continuing to contribute to public sector mental health service delivery.	
Investigate the use of technology to provide supervision to support rural and remote health professionals (such as tele-psychiatry).	

<b>Long-term (6–10 years)</b>	Facilitate transition of workers from other sectors to mental health services through improved portability of benefits, transferability of qualifications, identification of core competencies and development of bridging courses to orient existing knowledge and skills to mental health service provision.
	Advocate for increased rural clinical placements and regional training positions, and Commonwealth support for mental health students' accommodation and travel costs for rural clinical placements.
	Work with services to develop shared cross-agency employment models in rural areas to increase employment security and viability, particularly for allied health staff.
	Further develop and implement division 2 and PSO roles in the specialist mental health sector through support for postgraduate mental health modules in the VET sector and mental health modules for PSOs and expansion for roles in clinical community and PDRS services.
	Negotiate with the Commonwealth Government to revise the current MBS mental health items to provide incentives for providers to work in rural and regional areas.

## 2.2 Skills and training

Victoria has a highly skilled mental health workforce. This is largely due to the quality of universities, VET providers and the professional development provided within services. Effective education and training is critical to ensure staff continue to deliver high-quality, safe consumer care and remain responsive to emerging evidence and improved models of care. The challenge for the education and training systems is to remain flexible, relevant and responsive, while ensuring participants continue to achieve competence and are prepared for lifelong learning.

It is important to recognise that both the content for education and training and the method by which it is best delivered varies according to the group of learners involved and the setting in which they work. Effective education and training therefore also needs to ensure varying workforce skills are used optimally to deliver quality, consumer-focused care with an emphasis on early intervention, and that students of all disciplines graduate with appropriate skills and are effectively integrated into the workforce. It is also essential that they have access to ongoing training and development in order to ensure competence and contemporary practice and support in changing environments.

### Our challenges

There are a number of issues that relate to skills and training of the specialist mental health workforce including:

- the current variability of mental-health-specific content in undergraduate courses
- the current variability of student placement experience and support offered to student placement supervisors
- the lack of clarity around articulation pathways between the VET and higher education (HE) systems
- the lack of clear career pathways for advanced practitioners
- the proposed revision of scopes of practice, roles, models of care
- the need for an agreed national framework under which all mental health competencies can be clustered
- the gaps and inconsistencies in service-wide training and professional development.

Each of these challenges is described on the following pages.

#### Variability of mental health content in undergraduate courses

Tertiary education in Victoria has a national and international reputation for the range and quality of its curricula in health and health-related courses. It is well recognised that many specialist areas need to be included in health-specific

courses and students need to prepare for work in a variety of different workplace settings. Mental health is only one of many areas competing for inclusion in a full curriculum. However, concern has been expressed about the ‘falling-off’ of mental health content in undergraduate curricula over the past few years.<sup>93</sup> For example, employers of some new occupational therapy graduates have identified knowledge of assessments, models of care and the occupational therapy role in mental health, as areas that need greater attention in occupational therapy curricula.<sup>94</sup> The *Prepare nurses for the future report* similarly indicates that some health services report knowledge and skill levels of some new nurses are well below industry standards and recently graduated nurses are reporting feeling underprepared for the realities of practice.<sup>95,96</sup>

The challenge is therefore to ensure undergraduate courses have mental health as a core part of the curricula and that they provide opportunities for exposure to practice in a mental health setting. Students will then be prepared for and attracted to a career in mental health.

To address these concerns and recommendations of the Mental Health Nurse Education Taskforce,<sup>97</sup> La Trobe University and the University of Ballarat commenced delivery of a Bachelor of Nursing degree with a mental health major in 2006. The aim of the mental health major is to improve the preparation of beginner-level nurses in mental health and increase the number of nurses committed to developing specialist skills in the field. It involves exposing students to more mental health clinical placements, additional mental health units and lecturers with specific mental health education experience. The evaluation of these two pilots is due for completion. However, preliminary findings indicate that the major provides students with a positive exposure to mental health. On this basis, continued investment in the mental health major is strongly supported.

### Variable student placement experience and support for student supervisors

Currently the sector supports a range of student placements within the mental health system. As a result of the growth in Commonwealth-supported undergraduate and VET health places and the increasing competition for mental health placements between a wider range of disciplines (including nursing, psychology, social work and occupational therapy) there are an insufficient number of traditional placement opportunities in mental health. Financial and administrative requirements for health services and the historical preference towards acute and sub-acute hospital settings as the site of student placements also reduce access to mental health placements.<sup>98</sup>

Mental health student placements are considered essential for the development of specific mental health competencies, as well as being highly significant in career choice and demystifying mental illness. Exposure to positive, well-supported and meaningful learning experiences in mental health settings is necessary to increase the likelihood of students from all disciplines pursuing a career in mental health.

Institutions that do not already have well-developed relationships with health services (including some VET training providers) and rural services may find arranging student placements onerous. Increased student numbers across health disciplines places even greater pressure on staff who supervise students while continuing to meet service delivery requirements. The availability of student placement supervisors in mental health is a particular challenge for the health professions, where discipline-specific supervisors are required.

<sup>93</sup> *Learning together: Education and training partnerships in mental health service. Final report.* Prepared by Deakin Human Services Australia with funding from the Commonwealth Department of Health and Aged Care under the National Mental Health Strategy, Feb 1999 (p.A9)

<sup>94</sup> *Bridging the Gap: Mental Health Project*, Prepared by OT Australia for Department of Health And Ageing, July 2008 (p.26)

<sup>95</sup> Nurse Policy Branch 2006, *Prepare nurses for the future report: Phase 1*, Department of Human Services, Melbourne, pp.13–16.

<sup>96</sup> *Ibid.*

<sup>97</sup> Mental Health Nurse Education Taskforce 2008, *Mental health in pre-registration nursing courses*, Mental Health Nurse Education Taskforce, Melbourne, p.6.

<sup>98</sup> *Ibid.* p.13

## Pathways between the VET and HE sectors

Although pathways between secondary school and tertiary education are clearly defined, existing articulation arrangements between the VET and HE sectors may be less clear. The transfer from VET to HE is recognised as particularly confusing, with articulation largely individually negotiated.<sup>99</sup> Mutual recognition between VET and HE of knowledge and skills would improve articulation pathways in mental health and, consequently, facilitate further career development opportunities, optimise the use of training resources and improve workforce recruitment and retention.

## Optimising the skills and expertise of the workforce

Specialist mental health workers undertake many years of education and training at both the undergraduate and postgraduate level. As they progress in their career they gain additional skills, expertise and practice wisdom. Therefore, services need to continue to provide opportunities for staff to fully utilise their existing skills and acquire further skills through professional development, enhanced scopes of practice and improved career structures.

While for some in the workforce, the logical career pathway is to move from a practitioner role to a managerial position, the challenge for the sector is to support both career pathways. An example is the nurse practitioner role that provides a clearly defined career pathway and expanded role including, but not limited to, the direct referral of patients to other health carer professionals, prescribing medications and ordering diagnostic interventions. Currently there is only one nurse practitioner in mental health in Victoria.

The development of other new workforce roles may need to be considered. The guiding principles should always be to improve outcomes for the consumer, to promote greater workplace satisfaction and to contribute to more efficient and sustainable mental health services.

## Need for a national mental health competency framework

Victoria's specialist mental health sector has medical, nursing and allied health staff working across different service types and settings, all of whom contribute to the range of services and interventions required by mental health consumers, their carers and family members. The PDRS service workforce in particular has a very diverse mix of skills. A qualified and experienced specialist mental health workforce that provides both a clinical and non-clinical service to mental health consumers is critical to the treatment, recovery and rehabilitation goals of the sector.

While each discipline within the specialist mental health workforce is required to comply with either the National practice standards for the mental health workforce (2002) or the *Standards for psychiatric disability rehabilitation and support services* (2000), as well as the discipline-specific competency standards produced by their respective registration boards and professional associations, there is no agreed framework under which all competencies for mental health can be grouped.

An articulated competency framework for the entire mental health workforce may provide a benchmark for the minimum competency required of those working in mental health services. This would not only improve inter-professional and intersectoral dialogue, it would also encourage greater alignment with a consumer-centred model of care. A baseline set of competencies would also serve as a reference point for the development of mental health curriculum, provide a more equitable assessment tool for overseas trained health professionals, and help facilitate smoother articulation between the VET and HE sector.

<sup>99</sup> *Articulation between vocational education and training (VET) and higher education (HE) sectors*. Prepared by the Community Services & Health Industry Training Board Inc for Department of Human Services, Melbourne, 2005.

## Gaps and inconsistencies in statewide education and training

Education and training for Victoria's specialist mental health workforce is delivered by a range of providers, including:

- the Statewide Education and Training Partnership (Cluster) Project
- the HE and VET sectors
- professional and discipline-specific organisations
- VICSERV
- a range of other specialist mental health education and training agencies.

In 2004 the Statewide Education and Training Partnership (Cluster) Project was established to improve opportunities for service managers, clinical leaders and senior educators across the mental health sector to work together to improve access to quality post-employment training for clinical mental health staff. The objectives of the three regional cluster projects are to provide regular access to structured education and training activities that meet the needs of staff, address statewide and local education and training priorities in the clinical mental health sector, and use existing expertise and resources to develop sustainable education and training activities. Statewide training priorities have included orientation programs, graduate programs, support for overseas trained staff and dual diagnosis.

VICSERV currently provides a broad range of accredited and non-accredited programs to meet the training and professional development needs of PDRS service staff. Programs include orientation, professional supervision, applied suicide intervention skills, mental health first aid, introduction to dual diagnosis, managing challenging behaviours and critical incident and debriefing. A range of other mental health education and training agencies provide specialist training in areas such as child and adolescent, eating disorders, transcultural psychiatry, neuropsychiatry and dual diagnosis.

Notwithstanding the quality of training delivered by education and training providers there is the need to improve the coordination, accessibility and consistency of training provided to the staff in clinical and PDRS services. A recent evaluation of the clusters project, for example, found variability in the extent to which the education and training priorities are aligned with the strategic priorities of services. It also identified a need for a statewide approach to improve collaboration and efficiency between the clusters and across the system, drive the modernisation of learning methods and technologies, help to reduce duplication of training modules and ensure that training is better targeted, particularly for child and adolescent mental health services (CAMHS) staff.<sup>100</sup>

The development of a statewide approach will better align the existing education and training providers. Accordingly, a mental health education and training institute is proposed that will build on the work of the clusters and complement and support the specialist training delivered by a range of statewide education and training providers. It is anticipated the proposed institute will strengthen partnerships between the sector research institutions (such as mental health centres of excellence) and relevant Commonwealth bodies, ensure resources are used most effectively through collaboration, assist providers in further meeting the training needs of all specialist mental health staff. The proposed institute will promote a more systematic approach to translating theoretical developments into practical changes in service delivery and models of care, while reducing duplication. Importantly, it would maximise opportunities for developing an integrated approach to training and skills development where mental health statewide competencies are sought.

<sup>100</sup> Dench McClean Carlson 2007, *Evaluation of the Statewide Education and Training Partnership (Cluster) Project*, Dench McClean Carlson, Melbourne.

## What we are currently doing

The challenges relating to skills and training for the specialist mental health workforce are significant. However, there are a number of initiatives currently being implemented to build and enhance skills, training and capacity. While it is not possible to list every action being implemented at the Commonwealth and state levels, some of the key initiatives are summarised below.

- Several health profession accreditation bodies (such as OT Australia<sup>101</sup>, the Australian Association of Social Workers (ASSW)<sup>102</sup> and MHNET<sup>103</sup>) have reviewed the mental health content in their respective undergraduate degrees and their professional accreditation standards in relation to mental health. The aim of these reviews is to identify where current training programs for health professionals can be improved by expanding the mental health components of undergraduate health education and training. The introduction of a major in mental health in two Victorian nursing schools aims to encourage a more flexible nursing workforce, promoting safe beginner levels of skills in mental health and providing a sufficient numbers of nurses committed to developing specialist mental health skills.
- A significant number of new medical Commonwealth-supported places (CSPs) has enabled Victoria to establish a new medical school at the Deakin University campus in Waurin Ponds (120 CSPs), expand the medical school at Monash University's Churchill campus (40 CSPs) and create the Northern Victoria Regional Medical Education Network (NVRMEN), a collaborative arrangement between Monash University (30 CSPs) and the University of Melbourne (30 CSPs).
- The University of Notre Dame will also open a new medical school in western Melbourne in 2010. This school will work in close partnership with the Werribee Mercy Hospital and other local health services to provide on-site clinical training and deliver the curriculum for up to 80 medical students in the final two years of their four-year course.
- Both the Commonwealth Government and the Victorian Department of Health provide grants to support student placements for undergraduates and early graduates in medicine, nursing and allied health. For example, the Training and Development Grant<sup>104</sup> for health services supports training positions for undergraduates and early graduates in medicine, nursing and allied health. The department provides grants to increase the number of nurse supervisors to increase their capacity to support students on student placement. Under the *2007 Psychiatric Services Agreement* some provisions are provided for mental health graduate programs for nurses to support them to obtain postgraduate qualifications in mental health.
- The Department of Health has initiated a number of projects (such as the Clinical Placements in Victoria: Establishing a Statewide Approach and the Best Practice Clinical Learning Environment Project) that aim to address the range of student placement issues identified by key stakeholders and support a more standardised and sustainable approach to student placements in mental health.

<sup>101</sup> Australian Association of Occupational Therapists (OT Australia) 2003 *Review of mental health course content in Australian university occupational therapy programs*, OT Australia, Melbourne.

<sup>102</sup> Australian Association of Social Workers (AASW) 2008, *Australia social work education and accreditation standards: statement of specific mental health curriculum content for social work qualification*, AASW, Canberra.

<sup>103</sup> Mental Health Nurse Education Taskforce 2008, *Mental health in pre-registration nursing courses*, Mental Health Nurse Education Taskforce, Melbourne, available at <[www.nhwt.gov.au/mhwac.asp](http://www.nhwt.gov.au/mhwac.asp)>.

<sup>104</sup> A review of the Training and Development Grant for early graduate stream for nurses is currently underway to provide advice on the distribution and allocation of funded positions, an alternative funding model based on nursing EFT and performance indicators. Implementation of review outcomes is scheduled to take effect from the 2010 calendar year.

- The Community Services and Health Industry Skills Council has recently been funded by the Commonwealth Department of Education, Employment and Workplace Relations (DEEWR) to establish skills-articulation models between the VET and HE sectors in the area of mental health.<sup>105</sup> This project will include consideration of how program provisions outlined in the VET Training Packages could be further aligned to the learning objectives and curriculum of higher education, identification of best practice case studies and research to determine sustainable strategies to support mental health workforce development through expanded articulation pathways.
- The sector currently supports a range of clinical and management professional development opportunities (such as coaching and mentoring programs, frontline management skills training and internal secondments) that enhance career pathways for practitioners. The Victorian Dual Diagnosis Reciprocal Rotation Project specifically supports the development of advanced practitioners by improving the skills and competence of the mental health and drug and alcohol workforces.
- Through participation in *Better Skills, Best Care – workforce design strategy* the Department of Health seeks to encourage health services to explore potential new and evolving work roles. The emphasis is on developing roles that will aim to provide better outcomes for patients, promote greater work satisfaction for staff and contribute to more efficient and sustainable health services. In line with this aim the Nurse Policy Branch has invested in a range of initiatives that help improve the capacity, capability and utilisation of division 2 registered nurses. For example the Division 2 registered nurse strategy, the Enhanced Scope of Practice (ESOP) Project and the division 2 paid study leave package provide support for mental health services and individual nurses by enabling them to maximise their capability and make optimal use of their skills.
- The Mental Health and Drugs Division (MHDD) convenes a forum for mental health statewide education and training providers to identify and discuss common issues, promote collaboration and coordination, and identify strategic opportunities to strengthen education and training opportunities.
- The MHDD is supporting the development of a national project, Mental Health Professional Online Development (MHPOD), involving the development and implementation of an innovative web-based professional education tool for staff from a range of disciplines in specialist mental health services.
- In March 2008 COAG took a major step towards improving Australia's health system by signing an Intergovernmental Agreement on the health workforce. This agreement will for the first time create a single national registration and accreditation system for nine health professions including medical practitioners, nurses and psychologists. The new arrangement will help health professionals move around the country more easily, reduce red tape, provide greater safeguards for the public and promote a more flexible, responsive and sustainable health workforce. For example, the new scheme will maintain a public national register for each of the included health professions. This will ensure that a health practitioner who has been banned from practising in one place will be unable to practise elsewhere in Australia.

<sup>105</sup> Community Services & Health Industry Training Board Inc 2005, *Articulation between vocational education and training (VET) and higher education (HE) sectors*, available at <[http://www.health.vic.gov.au/workforce/downloads/articulation\\_vet\\_and\\_he.pdf](http://www.health.vic.gov.au/workforce/downloads/articulation_vet_and_he.pdf)>.

## What we plan to do

**Objective:** To develop a mental health workforce that is skilled, knowledgeable and engaged in lifelong learning by substantially improving the accessibility of quality, responsive and coordinated mental health education and training.

In addition to supporting the successful initiatives currently being implemented, this strategy proposes the following new actions be implemented.

- Establish a mental health education and training institute that supports multidisciplinary and cross-sectoral approaches to the delivery of further education and training for clinical and PDRS service workers, consumers and carers. This agency will augment the work of education and training clusters and other training providers (such as VICSERV) and help strengthen communication and collaboration across the education and training sector.<sup>106</sup> It will provide a focal point for flexible, consistent and coordinated training and a means to support the implementation of government and sector education and training initiatives. This agency would also act as a ‘clearing house’ of contemporary, best practice training modules developed specifically for the specialist mental health workforce, reducing duplication and improving statewide governance and resource utilisation.
- Upon release, review the recommendations of the evaluation of the mental health major in the Bachelor of Nursing degree and continue to provide in-principle support for its implementation.
- Engage universities, area mental health services and the nurse regulatory authority to progress implementation in Victoria of the recommendations in the MHNET *Mental health in pre-registration nursing course* report.
- Further develop full-paying scholarships to:
  - support division 1 and 3 nurses to undertake postgraduate education (including master’s degrees and PhDs) in mental health
  - support division 2 nurses to undertake further education to enable medication endorsement and expanded scopes of practice, and undertake conversion courses to become division 1 nurses.
- Implement the recommendations from the evaluation of the Statewide Education and Training Partnership (Cluster) Project.
- Support Victoria’s two new medical schools to ensure specialist mental health knowledge is adequately represented in their curricula.
- Streamline the organisation and management of mental health student placements.
- Support services to better promote available student placements opportunities.
- Expand the availability of student placements in PDRS services, and ensure that appropriate discipline-specific educators and supervisors are available to facilitate students’ learning.
- Further develop clinical supervision models that incorporate national standards and consider professional requirements
- Undertake student evaluation of clinical placements.
- Improve placement experiences for students by offering incentives that encourage services to improve student induction to areas of placement and provide supervisors with appropriate training and support.

<sup>106</sup> It is anticipated that establishing an institute will have a short-term impact on the delivery of education and training as well as longer term outcomes.

- Further promote staff to become student supervisors and explore supervision models that incorporate national standards and consider professional requirements.
- Review the recommendations in the Community Services & Health Industry Skills Council Project on articulation pathways between the HE and VET education sectors in the area of mental health when the report is released in early 2009.
- In collaboration with professional and industrial organisations support the state's senior psychiatric nurses to develop a senior psychiatric nurse workforce strategy.
- Provide specific training opportunities in the PDRS service sector that promote psychosocial support as a core competency.
- Investigate the feasibility of traineeships in Cert IV (Nursing), ensuring compliance with the nurse regulatory body, and in Cert IV Mental Health for PSOs.
- Investigate internships and in-service student support programs that provide on-the-job experience and educational focus for new graduates and those who are in continuing undergraduate study (student support programs).
- Negotiate with relevant stakeholders to better define career structures for all mental health disciplines.
- Identify options for funding and organisational support during candidature to support an increase in endorsed nurse practitioners within the mental health sector.
- Support the provision of specific training opportunities in the PDRS service sector that promotes psychosocial support as a core competency.
- Identify an appropriate structured paid undergraduate employment model, similar to that available for nurses working in the acute health sector, in consultation with unions, employers, universities and students to enhance early exposure to the mental health environment.
- Investigate targeted scholarships for community members interested in nursing careers and post-registration professional development in mental health, particularly in areas of shortage including incentives to those who remain in rural service consistent with industrial obligations and professional requirements.
- Create opportunities for delivering the Diploma of Community Services (2009) in a manner that meets the particular needs of the specialist mental health workforce in Victoria.

# Summary of strategies/actions

**Objective:** To develop a mental health workforce that is skilled, knowledgeable and engaged in lifelong learning by substantially improving the accessibility of quality, responsive and coordinated mental health education and training.

Theme 2: Skills and training – strategies and actions	
Short-term (1–2 years)	Upon release, review the recommendations of the evaluation of the mental health major in the Bachelor of Nursing degree and continue to provide in-principle support for its implementation.
	Engage universities, area mental health services and the nurse regulatory authority to progress implementation in Victoria of the recommendations in the MHNET <i>Mental health in pre-registration nursing course</i> report.
	Identify an appropriate structured paid undergraduate employment model, similar to that available for nurses working in the acute health sector, in consultation with unions, employers, universities and students to enhance early exposure to the mental health environment.
	Undertake student evaluation of clinical placements.
	Review the recommendations in the Community Services & Health Industry Skills Council Project on articulation pathways between the HE and VET education sectors in the area of mental health when the report is released in early 2009.
	Further develop full-paying scholarships to: <ul style="list-style-type: none"> <li>•support division 1 and 3 nurses to undertake postgraduate education (including master’s degrees and PhDs) in mental health</li> <li>support division 2 nurses to undertake further education to enable medication endorsement and expanded scopes of practice, and undertake conversion courses to become division 1 nurses.</li> </ul>
	Establish a mental health education and training institute that supports multidisciplinary and cross-sectoral approaches to the delivery of further education and training for clinical and PDRS service workers, consumers and carers. This agency will augment the work of education and training clusters and other training providers (such as VICSERV) and help strengthen communication and collaboration across the education and training sector. <sup>107</sup>
	Implement the recommendations from the evaluation of the Statewide Education and Training Partnership (Cluster) Project.
	Create opportunities for the delivery of the Diploma of Community Services (2009) in a manner that meets the particular needs of the specialist mental health workforce in Victoria.

<sup>107</sup> It is anticipated that establishing an institute will have a short-term impact on the delivery of education and training as well as longer term outcomes.

Medium-term (3–5 years)	Support Victoria’s two new medical schools to ensure specialist mental health knowledge is adequately represented in their curricula.
	Identify options for funding and organisational support during candidature to support an increase in endorsed nurse practitioners within the mental health sector.
	Streamline the organisation and management of mental health student placements.
	Support services to better promote available student placements opportunities.
	Expand the availability of student placements in PDRS services, and ensure that appropriate discipline-specific educators and supervisors are available to facilitate students’ learning.
	Further develop clinical supervision models that incorporate national standards and consider professional requirements.
	Further promote staff to become student supervisors and explore supervision models that incorporate national standards and consider professional requirements.
	Contribute to the development of an agreed national framework for mental health competency standards and support implementation of existing standards and professional codes.
	In collaboration with professional and industrial organisations support the state’s senior psychiatric nurses to develop a senior psychiatric nurse workforce strategy.
	Provide specific training opportunities in the PDRS service sector that promote psychosocial support as a core competency.
	Establish specialist mental health clinical and non-clinical ‘traineeships’ to support people to train as division 2 nurses or PSOs.
	Investigate internships and in-service student support programs that provide on-the-job experience and educational focus for new graduates and those who are in continuing undergraduate study (student support programs).
Foster the optimisation of division 2 nurses within mental health settings (such as through support for specialist mental health training that can expand their scope of practice or conversion courses to division 1 that recognise their prior learning and experience).	
Investigate targeted scholarships for community members interested in nursing careers and post-registration professional development in mental health, particularly in areas of shortage including incentives to those who remain in rural service.	
Long-term (6–10 years)	Improve placement experiences for students by offering incentives that encourage services to improve student induction to areas of placement and provide supervisors with appropriate training and support.
	Negotiate with relevant stakeholders to better define career structures for all mental health disciplines.
	Engage stakeholders in the joint development of and agreement to a framework for minimum mental health content in undergraduate curriculum that better prepares new graduates for work in the specialist mental health sector.

## 2.3 Organisational environments

Significant changes have occurred in the Victorian specialist mental health service system over the past two decades. Services have developed beyond the original framework to provide additional specialist services (for example, the Substance Use Mental Illness Treatment Team (SUMITT) and Spectrum) and PDRS services have grown significantly, both in size and in the number and variety of providers. The system is recognised as having an advanced and innovative workforce that is skilled and committed to the delivery of high-quality mental health care. The service system, however, continues to face significant workforce challenges in both attracting and retaining staff.

### Our challenges

There is considerable research that examines organisational culture and the elements that contribute to making workplaces attractive to employees. Attractive employer models have been developed generally (for example, the Employer of Choice recognition Program and 100 Best Companies) and in health-specific contexts (for example, Magnet Hospitals and the National Health Trust Improved Working Lives).<sup>108</sup> Canadian studies cite three broad strategic business reasons for creating a healthy workplace that include: the financial costs of an unhealthy workplace; the importance of organisational reputation and demonstrating corporate responsibility; and due diligence with respect to employees, customers and stakeholders.<sup>109</sup>

The returns for developing a positive organisational culture include improved staff motivation, fewer insurance and workers compensation claims, less absenteeism, decreased accidents, increased retention of valued staff (which translates into reduced recruitment, training and induction costs), improved staff attitudes towards the organisation, higher staff morale, a more receptive climate for change and enhanced business reputation.<sup>110</sup> While there are often difficulties quantifying some of the results, the evidence from Canada is that the return-on-investment in improving the physical environment of the workplace ranges from \$1.15 to \$6.00 for every dollar invested.<sup>111</sup> Other research has identified critical success factors in promoting health workplaces including senior management involvement, participatory planning, primary focus on employees' needs, optimal use of on-site resources, integration into other organisational policies, evaluation and long-term commitment.<sup>112</sup> Active consultation with employees is also a key component of success in providing and promoting healthy and safe workplaces.

The World Health Organization has identified a range of elements that have been shown to influence the recruitment and retention of health professionals and organisational outcomes. They include adequate remuneration, compensation, purposeful change management, fairness, inclusiveness, interdisciplinary relationships and social support, leadership, management style,<sup>113</sup> open communication, flat organisation structures, access to professional development, worker and effort recognition programs, safety and wellbeing, social responsibility, work organisations,<sup>114</sup> work-life balance and workspace and supportive technology.

<sup>108</sup> See: Improved Working Lives at <[www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modelemployer/Improvingworkinglives/index.htm](http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modelemployer/Improvingworkinglives/index.htm)>, Magnet Hospitals at <[www.nursecredentialing.org/Magnet.aspx](http://www.nursecredentialing.org/Magnet.aspx)>; the Employer of Choice Recognition Program at <[www.employerofchoice.com/stratus.html](http://www.employerofchoice.com/stratus.html)>; and 100 Best Companies at <[money.cnn.com/magazines/fortune/bestcompanies/2008/](http://money.cnn.com/magazines/fortune/bestcompanies/2008/)>.

<sup>109</sup> Burton J, April 2007, *The Business Case For a Healthy Workplace*, Toronto Canada.

<sup>110</sup> Centre for Health Promotion 2004, *The case for comprehensive workplace health promotion*, University of Toronto, Toronto.

<sup>111</sup> Burton J, April 2007, *The Business Case For a Healthy Workplace*, Toronto Canada.

<sup>112</sup> Centre for Health Promotion 2004, *The case for comprehensive workplace health promotion*, University of Toronto, Toronto.

<sup>113</sup> For example, fostering worker participation in decision making, valuing staff feedback, being innovative and collaborative, transparent decision making and instilling a sense of fairness.

<sup>114</sup> For example, developing challenging and meaningful work, adequate resourcing and appropriate workloads.

Unreasonably demanding workloads may contribute to attrition from the public health workforce.<sup>115</sup> This may in part be due to shortages of mental health professionals, particularly in acute settings and in rural and regional areas. Heavy workloads in a crisis-driven system can also lead to staff feeling disenchanted due to the limited opportunities to fully utilise their training and engage with clients in a holistic way.<sup>116</sup> Excessive workloads also contribute to multiple occupational health and safety (OH&S) issues, including stress, fatigue, potential increased occupational violence and aggression, and bullying within organisations.

The organisational environment of clinical and PDRS mental health services will therefore play a key role in influencing an individual's decision to first join an organisation and then to stay. Organisations with a positive and supportive culture and a good reputation, both in terms of service delivery and the working environment will be better able to recruit, motivate and retain staff.<sup>117</sup>

Organisations need good infrastructure to support their staff. The PDRS service sector in particular has had to manage with inadequate IT and human resources support. In addition, as the sector has grown in recent years, so has the need for experienced middle managers. However, the sector has found it difficult to both attract and retain staff who have the appropriate expertise.

Statewide workforce planning and development will be able to assist organisations with broad policy initiatives and guidelines. Nevertheless, it will be local leadership that develops and supports an organisational environment that is attractive to potential and current staff. Services will also need to take account of new Commonwealth initiatives that provide opportunities for mental health workers of all disciplines to engage in private sector work.

It has been noted that work in clinical mental health services carries with it considerable responsibility, involving the management of clinical risk and requiring 24-hour vigilance. As PDRS and clinical staff are engaged in therapeutic work with consumers and their significant others, they are often exposed to daily personal distress. On occasion, distress levels can be very high. Effective support mechanisms for all staff are therefore of critical importance.

If clinical and PDRS mental health services are to attract, motivate and retain their staff, they will need to carefully examine their work culture and environment. There are six key elements that need to be considered:

- leadership and management practice
- work safety and wellbeing
- organisational climate
- professional and personal support
- manageable workloads
- adequate remuneration and work–life balance.

### Leadership and management practice

Leadership and management within organisations are closely intertwined and have been shown to be critical in determining an organisation's culture. Leadership requires skills and knowledge that are in addition to those needed in direct care roles, and has a profound impact on service delivery and quality, and staff satisfaction.

Leadership is key to fostering innovation and advancing every aspect of transformation – for building the momentum for change, making the change happen, and sustaining the change. It is an important factor that provides the impetus to bring evidence-based practices into mental health services delivery through advocacy, consensus-building, and

<sup>115</sup> Human Capital Alliance 2006, *Allied health recruitment and retention*, Human Capital Alliance, Sydney.

<sup>116</sup> Mental Health Reform Strategy Roundtable – Workforce, 30 July 2008.

<sup>117</sup> McCrindle Research 2006, *New generations at work: Attracting, recruiting, retraining and training generation Y*, McCrindle Research, Sydney, p7.

collaboration with stakeholder leaders. Positive leadership has been associated with process and quality indicators such as organisational commitment, organisational climate, clinical alliances, OH&S outcomes and consumer satisfaction.

Research has found that for child mental health service providers, more positive leadership ratings were associated with more positive attitudes towards adopting evidence-based practices.<sup>118</sup> These findings were true for two types of leadership styles: transformational, in which leaders inspire and motivate followers; and transactional, in which leaders emphasise meeting specific objectives without encouraging innovation in subordinates. Transformational leadership styles have been found to be positively associated with mental health team functioning and negatively associated with burnout.

Both clinical and managerial leadership is required to create a culture of quality and health and safety improvement. This includes actively supporting a range of quality and safety measures. Clinical leadership at the highest levels of mental health services is critical to ensuring effective risk identification and management.

Discipline seniors also provide an important leadership role and offer supervision, guidance and ongoing support. Their absence can affect workload management, professional development and discipline morale.

The International Initiative for Mental Health Leaders is one program supporting leadership development. However, other programs are needed to facilitate movement of staff from direct care to management roles in services, and to promote high-quality leadership at all levels within an organisation.

## Work safety and wellbeing

All employers in Victoria, including mental health services, have a legislative responsibility to provide staff with a working environment that is safe and without risks to health.<sup>119</sup> This includes providing:

- a safe physical environment
- safe systems of work
- adequate facilities for the welfare of employees
- information, instruction, training and supervision to enable employees to perform their work in a safe manner, without risk to health.

Mental health professionals, as part of their role, provide care to consumers who may not always provide, or be able to provide, consent to receive care and treatment. These professionals work in an environment where aggressive behaviour can occur in response to a number of issues, such as the perceived unmet needs of an individual. Aggressive and violent behaviour may occur when people are acutely ill or have impaired judgement and may misinterpret their environment. These behaviours should not be tolerated by staff as a 'part of their job' that they must accept. Rather, training in aggression management and the de-escalation of tension should be encouraged, along with the associated OH&S requirements of critical incident debriefing.

The move to community-based services means that many consumers who would previously have been hospitalised are now being managed in the community. The introduction of case management and the provision of care in the least restrictive environment have exposed staff to different kinds of behaviour that might previously have been managed in a more controlled institutional setting.

Preventing and managing aggressive and violent behaviour has become an essential requirement for all mental health services, whether inpatient or community-based. To meet their responsibilities, services must establish a working environment in which consumers' needs can be met while emphasising the priority of eliminating or minimising the risk to the health and safety of staff.

<sup>118</sup> Aarons GA 2006, 'Transformational and transactional leadership: association with attitudes toward evidence-based practice', *Psychiatric Services*, 57 (8), 1162–1169.

<sup>119</sup> *Occupational Health & Safety Act 2004*

Both clinical and managerial leadership is required to bring about change in organisations and to create a culture of quality and safety improvement. This includes actively supporting a range of quality and safety initiatives, with full staff participation. Organisational safety initiatives can encompass a range of strategies such as: supporting design as a key factor in eliminating or minimising risk; supporting staff in their zero-tolerance of violence and aggression; and preventing incidents. They will also include: risk management; adverse events and incident management; monitoring systems; workforce development and innovation; complaints mechanisms; information collection and performance monitoring; implementation of national standards; and external evaluation through accreditation and related in-depth reviews.

Staff training in taking appropriate preventative measures has been identified as a mechanism for reducing serious assault incidents in health settings.<sup>120</sup> De-escalation techniques and training in preventative measures are the preferred means and are more likely to provide safer environments for staff to work in. Organisations have a responsibility to have a framework that clearly outlines the policies, expectations and considerations in responding to violence and aggression, and training is an essential component of this. Training needs to provide staff with a range of guidelines and strategies to respond to violence and de-escalate potentially aggressive situations. Training programs in risk assessment and management of aggression of suicide are currently delivered through the Statewide Education and Training Partnership (Cluster) Project.

Work overload and stress also impact on the work safety of mental health workers. Following musculoskeletal disorders, work-related stress is the second most common compensated illness or injury in Australia. In Victoria, work-related stress, particularly in the public sector, represents a growing percentage of workers' compensation claims.<sup>121</sup> Work-related stress is a health and safety hazard that can have negative impacts on mental health, physical health, work performance (such as incidents and injuries) and social relationships.

## Organisational environment and climate

The issues of organisational environment and climate are also important. Communication and teamwork are often identified as critical to healthy workplace environments. Workplace relationships with peers and supervisors have been shown to impact on workers' decision to remain with an employer. Where staff feel they are supported by colleagues, retention rates are usually higher as job satisfaction is increased. In public hospital settings, the most important coworkers for nurses are other nurses. However, good relationships with doctors and allied health professionals (characterised by mutual respect, trust and integrity) strongly influences retention outcomes.

Sound workplace social relationships are significantly dependent on leadership direction and management style. Procedural and perceived fairness in the workplace and an inclusive approach are key ingredients to strong workplace social relationships.

The importance of OH&S is enshrined in legislation but also extends to concern for the wellbeing of staff and ensuring that there are systems in place to offer support when this is required. The acuity of consumers using mental health services provides a dynamic environment but also may impact on levels of stress on the workers.

## Professional and personal support

Services may seek to rely on a range of financial and non-financial incentives to improve the recruitment, motivation and retention of staff. However, literature on the application of incentive schemes in health care indicates that financial incentives alone are insufficient to retain and motivate staff and non-financial incentives play an equally crucial role.<sup>122</sup>

Staff recognition and rewards offer the opportunity for services to recognise both individuals and teams for outstanding work during a year. A regular staff awards program can reflect both the quality of work and demonstrate the values of the organisation.

<sup>120</sup> Brewer-Smyth K, 'Preventing violence in the healthcare setting', *Nursing Spectrum*.

<sup>121</sup> WorkSafe Victoria 2006, *Stressing the point*, State Government of Victoria, Melbourne.

<sup>122</sup> World Health Organization 2008, *Guidelines: Incentives for health professionals*, WHO, Geneva, p.10.

## Manageable workloads

Staff should be expected to manage reasonable workloads. The *2004–2007 Victorian Psychiatric Services Agreement* included a requirement that clinicians and managers develop and implement an agreed system of case load management for community mental health teams. The parties to the *2007–2011 Psychiatric Services Agreement*, the Department of Health, the Australian Nursing Federation (ANF), the Health and Community Services Union (HACSU) and the Victorian Hospitals' Industrial Association (VHIA), are working together to ensure that a case load management system is fully implemented in all area mental health services. Once put into place, this should lead to increased fairness and equity in the distribution of the clinical workload. The parties anticipate it will be more efficient and effective in managing workers' workloads. This alone will not address the workload issues that will require the implementation of the strategies within this strategy to enable growth of the mental health workforce to meet projected demand.

## Adequate remuneration and work–life balance

If mental health is to remain an attractive career for health professionals, it needs to continue to offer appropriate financial remuneration. Concerns have been expressed, through a range of consultations with the PDRS service sector, that the financial incentives for its members need to be improved. In particular, the disparity of wages and conditions between PDRS and clinical mental health services is cited as the main reason for a high turnover of staff in the PDRS service sector.

A good work–life balance for staff is essential if they are to provide sustained high-quality care to some of the most vulnerable individuals in the community. Managers and their staff need to balance the requirements of the service with time away from the workplace for rest and renewal.

## What we are currently doing

There are a range of initiatives currently being implemented that seek to address the issues of organisational environment. Some of the key approaches have been highlighted below.

- The Department of Health is developing an 'attractive employer' toolkit that will be designed to promote an organisational environment that supports and values staff.
- The International Initiative for Mental Health Leadership offers opportunities for organisations to assist and promote high-quality mental health leaders. It also encourages consumer leaders to participate in this program.
- Expanding the mix of collocated public and private mental health services to provide opportunities to retain public mental health workers who might otherwise be attracted to full-time private practice.
- Providing mandatory training in aggression management and the safe management of acute clinical arousal for all staff commencing work in mental health services.
- The Creating Safety project supports the provision of safer environments for both patients and staff in inpatient units.<sup>123</sup>
- The Department of Health promotes strategies to reduce occupational violence against staff, including developing the *Industry Occupational Health and Safety Interim Standards for Preventing and Managing Occupational Violence and Aggression in Victoria's Mental Health Services*.

<sup>123</sup> The Victorian Quality Council (VQC) and Chief Psychiatrist's Quality Assurance Committee (QAC) have formed a partnership to support the development and implementation of the Creating Safety: Addressing Seclusion Practices project to enable clinicians to apply best available evidence to clinical practice.

- The Department of Health provides funding for clinical nurse educator and senior psychiatric nurse positions in specialist mental health services to enhance clinical leadership, educational opportunities, career pathways and practice development.
- The Department of Health provides funding for clinical academic positions to provide leadership within services, fulfil teaching and training responsibilities, and undertake high quality research that is translated into practice.
- Parties to the 2007-2011 Psychiatric Services Agreement are developing a new case load management standard that will assist area mental health services to be more efficient and effective in managing individual clinicians' case loads.
- The Commonwealth Chief Nurse and Midwifery Officer has a new leadership role to build the nursing profession as a 'career of choice.'
- The Commonwealth Government is proposing a new project that will place a mental health academic in each of the 11 university departments of rural health. This will assist in creating clinical training capacity and provide support for the expansion of training places in mental health disciplines.

## What do we plan to do

**Objective:** To create supportive, safe and flexible organisational environments by fostering leadership, innovation, and collaboration in mental health services.

In addition to the initiatives currently being implemented by government and the sector, there are a number of new initiatives being proposed, as outlined below.

- Implement strategies to relieve workload pressures within the Victorian mental health sector to enable improved recruitment of workers.
- Develop programs (for example, scholarships, shadowing, mentoring) that identify emerging leaders (clinical, PDRS and managerial) early and provide these workers with management and leadership training to better place organisations to meet changing service demands. Provide coaching and mentoring to promote high-quality leadership at all levels within an organisation.
- Identify and profile services with positive organisational environments and share best practice across the specialist mental health sector (such as employee recognition programs, effective change management, flexible employment packages).
- Undertake a statewide research project investigating workforce stress and satisfaction levels and reasons for exits from the specialist mental health workforce.
- Collect and evaluate exit interview data and ensure the information is fed back to the stakeholders for consideration and inclusion into the continuing mental health workforce strategy.
- Explore initiatives to retain senior, experienced mental health professionals such as more flexible employment options to improve work-life balance, public-private working arrangements, rotations to other sectors and services settings, support for postgraduate study and opportunities for research participation or joint practice-academic appointments.
- Identify new employment models that may better respond to the changing profile and needs of the mental health workforce, including incentives and conditions that support work-life balance goals.
- Investigate employment models that allow mental health practitioners to undertake private sector practice while continuing to contribute to public sector mental health service delivery, including the development of guidelines on assessing potential conflict of interest.

- Improve portability of long service leave and sick leave between clinical and PDRS service sectors.
- Provide better IT and infrastructure for PDRS services to improve working conditions.
- Identify approaches to improve salary and conditions for PDRS service staff to reduce loss of staff to the clinical sector.
- Develop workplace practices of teamwork learning and practice, mutual respect between workers and positive relationships between peers and with supervisors, while at the same time maintaining access to discipline seniors.
- Provide opportunities for work-based learning and development of existing staff in line with ongoing service development and review.
- Ensure appropriate ongoing professional development and education and training arrangements are available to support consumer and carer service participation and leadership.
- Work with agencies and training providers towards the inclusion of psychological first aid competencies in training for staff in a broad range of health and community services.
- Provide opportunities for shared learning and development across different parts of the mental health service delivery sectors, including the development of staff exchange programs.
- Ensure that health and safety risks are proactively identified and managed in line with relevant WorkSafe guidelines.
- Ensure rostered staff have appropriate skills, experience and equipment and knowledge of systems and acuity of consumers to safely manage occupational violence and aggression.
- Ensure students are given appropriate placements with adequate clinical and professional supervision and have clinical support and frequent debriefing.
- Ensure all incidents of workplace violence and aggression, both verbal and physical, are reported to line managers and OH&S committees.
- Ensure debriefing services and teams are made available as soon as practicable following any traumatic event involving workplace violence and aggression.
- Ensure mental health services have discipline seniors to provide leadership and support in their respective discipline areas.
- Incorporate industry standard best practice in the design of new and refurbished facilities to minimise occupational aggression.
- Develop and implement sector-specific leadership and management training in association with formal mentoring programs. This strategy would also be in conjunction with resource packs, developed in consultation with industry needs/key stakeholders, and the proposed centralised training organisation.

# Summary of strategies/actions

**Objective:** To create supportive, safe and flexible organisational environments by fostering leadership, innovation and collaboration in mental health services.

Theme 3: Organisational environment	
Short-term (1–2 years)	Develop programs (such as scholarships, shadowing, mentoring) that identify emerging clinical and managerial leaders early and support them with management and leadership training to better place organisations to meet changing service demands. Provide coaching and mentoring to promote high-quality leadership at all levels within an organisation.
	Identify and profile services with positive organisational environments and share best practice across the specialist mental health sector (such as employee recognition programs, effective change management, flexible employment packages).
	Undertake a statewide research project investigating workforce stress and satisfaction levels and reasons for exits from the specialist mental health workforce.
	Collect and evaluate exit interview data and ensure the information is fed back to the stakeholders for consideration and inclusion into the continuing mental health workforce strategy.
	Ensure health and safety risks are proactively identified and managed in line with relevant WorkSafe guidelines.
	Ensure all incidents of workplace violence and aggression, both verbal and physical, are reported to line managers and OH&S committees.
Medium-term (3–5 years)	Implement strategies to relieve workload pressures within the Victorian mental health sector to enable improved recruitment of workers.
	Explore initiatives to retain senior, experienced mental health professionals such as more flexible employment options to improve work–life balance, public–private working arrangements, rotations to other sectors and services settings, support for postgraduate study and opportunities for research participation or joint practice–academic appointments.
	Investigate employment models that allow mental health practitioners to undertake private sector practice while continuing to contribute to public sector mental health service delivery, including the development of guidelines on assessing potential conflict of interest.
	Identify new employment models that may better respond to the changing profile and needs of the mental health workforce, including incentives and conditions that support work–life balance goals.
	Develop workplace practices of teamwork learning and practice, mutual respect between workers and positive relationships between peers and with supervisors, while at the same time maintaining access to discipline seniors.
	Provide opportunities for work-based learning and development of existing staff in line with ongoing service development and review.
	Ensure appropriate ongoing professional development and education and training arrangements are available to support consumer and carer service participation and leadership.
	Work with agencies and training providers towards the inclusion of psychological first aid competencies in training for staff in a broad range of health and community services.
Provide opportunities for shared learning and development across different parts of the mental health service delivery sectors, including the development of staff exchange programs.	

<b>Medium-term (3–5 years)</b>	Ensure rostered staff have appropriate skills, experience, equipment and knowledge of systems and acuity of consumers to safely manage occupational violence and aggression.
	Ensure students are given appropriate placements with adequate clinical and professional supervision and have clinical support and debriefing daily.
	Ensure debriefing services and teams are made available as soon as practicable following any traumatic event involving workplace violence and aggression.
	Ensure mental health services have discipline seniors to provide leadership and support in their respective discipline areas.
	Develop and implement sector-specific leadership and management training in association with formal mentoring programs. This strategy would also be in conjunction with resource packs, developed in consultation with industry needs/key stakeholders, and the proposed centralised training organisation.
<b>Long-term (6–10 years)</b>	Improve portability of long service leave and sick leave between clinical and PDRS service sectors.
	Provide better IT and infrastructure for PDRS services to improve working conditions.
	Identify approaches to improve salary and conditions for PDRS service staff to reduce loss of staff to the clinical sector.
	Incorporate industry standard best practice in the design of new and refurbished facilities to minimise occupational aggression.

## 3. Partners

Developing effective partnerships is critical to implementing successful workforce reforms.

### Unions

Unions are key partners that are responsible for collectively organising and representing the interests of their members who are employed in the specialist mental health sector. In Victoria, the relevant unions are HACSU, the ANF and the Australian Services Union (ASU). They are responsible for providing representation when negotiating an enterprise agreement or award, arranging workforce inspections for OH&S matters, championing social issues, advocating at the state and Commonwealth levels and engaging in other activities that promote the rights of workers.

The Victorian Government recognises the legitimate role of unions in the workplace and, consistent with this, the right of its employees to have their collective interests considered. Consequently, and in accordance with established policies and procedures, the department works and negotiates collaboratively with relevant unions in an open and accountable way. Through this ongoing cooperation, the department seeks to continue to develop high-performing, cooperative and fair workplaces throughout Victoria.

### Health services and other mental health service providers

Health services and other mental health service providers are described in sections 5.4 and 5.5 in this report.

Statements of Priorities are the key accountability agreements between health services and the Minister for Health. The annual agreement ensures delivery or substantial progress towards the key shared objectives of financial stability, improved access and waiting times, and quality of service provision. The Statement of Priorities incorporates system-wide priorities and statewide benchmarks set by the government but also allows for locally generated health service priorities. It also identifies performance and activity targets and a number of measurable key performance indicators.

The Department of Health has responsibility for funding health care services through the public hospital system, community health services and ambulance services. This includes the specialist mental health services system consisting of clinical services and PDRS services.

### Department of Health

The Department of Health plays a number of roles in supporting the mental health workforce. As the primary funding body, it provides funding for a range of education and training activities delivered locally, and funded as part of consolidated agency budgets. Approximately \$15 million is provided to agencies, including: funding for specific positions with a workforce development focus, such as clinical academics and nurse educators; funding to support education and training, such as support for graduate nurse programs; and funding for specific initiatives aimed at improving coordination and skill development across the sector, such as support of education and training clusters and rural-metropolitan partnerships. The focus of this role is to support the sector in the development of its own workforce, consistent with the industrial parameters in employment agreements.

The department's Service and Workforce Planning Branch and Nurse Policy Branch also play a strategic statewide role in workforce development in the context of health and community services. They do this through initiatives and projects such as *Better Skills Best Care*, and the further development of mental health nurse practitioner roles.

In addition, the department plays a strategic national role in representing the state in activities including: allocating tertiary education places; reviewing industry training packages; and developing more coordinated approaches to registration and accreditation.

## Commonwealth Government

The Commonwealth Government plays an important role in the development and implementation of structural reform of the health workforce. As the Commonwealth Government is responsible for tertiary education, it has a key role in addressing supply issues through the funding of places. It also has a critical role in ensuring that tertiary-level training across the range of professions meets both the current and emerging needs of the mental health workforce.

Key areas for action on the national level include:

- uniform regulation and registration
- uniform training, including undergraduate curricula that provide adequate preparation for mental health work
- career incentives such as tertiary places targeted to nurses and those in other health disciplines seeking a career in mental health as well as bonding arrangements post-qualification/pre-specialist registration
- collaborative national recruitment drives targeted to nursing and medical staff
- collaboration on workforce planning and redesign
- implementation and further development of national practice standards
- investigation of the opportunities for mental health in the proposed Medical Specialist Training Consortia Model, with a particular focus on training professional support to IMGs.

Under the AHMAC review of committees, the Mental Health Workforce Advisory Committee (MHWAC) now reports to the Health Workplace Principal Committee (HWPC) and Mental Health Standing Committee (MHSC). HWPC (formerly the Australian Health Workforce Officials Committee) is a committee of endorsement and review, as well as a forum for high-level policy debate and development. There is an expectation that groups such as MHWAC will clearly articulate and resolve issues to the greatest extent possible before presenting them to HWPC. Three areas are expected to be priorities for HWPC over the next 12–24 months:

- practitioner regulation
- workforce innovation and evolution, linked to education and training models, and workforce competencies and standards
- workforce planning, data and methodology.

## Other key partners

### Education and training providers

Education and training providers aim to deliver educational services that ensure particular groups achieve the required competencies they require to join the workforce at the completion of their courses. Ensuring those competencies reflect the changing needs of clients and models of service delivery is a key element of providing an adequate supply of suitably skilled mental health professionals.

Similarly, ensuring that the range of qualifications available are related and articulated in such a way that supports ongoing skills development and career progression is a key element of supporting retention and workforce capacity across the health and community sectors.

Striking the right balance between meeting current skill needs and providing specialist content, while at the same time structuring courses with wide enough applicability to be viable, is an ongoing challenge.

The formal education and training sector includes the VET sector, which plays a key role in providing education and training for a range of workers. This includes staff employed in PDRS services through access to specialist mental health

competencies, such as the Certificate IV in Mental Health (Non-Clinical). Universities provide graduate-level training for a range of staff including medical staff, nurses, psychologists (clinical and non-clinical), social workers, occupational therapists and speech pathologists.

In both cases, links with service providers are vital. Training providers rely on services to provide opportunities for clinical placements and to contribute to on-the-job supervision and support.

## Colleges and other professional bodies

The role of professional bodies in mental health workforce development is to provide specialist training, access and accreditation. This is closely linked to the regulatory requirements that are intended to ensure quality of care. However, they also play a significant role in the ongoing support, training and development of their members, often linked to ongoing registration.

Each of the five mental health disciplines in clinical mental health services is represented by their own professional body. Professional bodies play a crucial role in both representing the professional interests of their members and in maintaining professional standing.

The RANZCP is responsible for the selection and assessment of candidates seeking to become Fellows of the college. Becoming a Fellow of the college ensures that doctors can independently practise their profession in a range of roles and allows them to supervise junior medical staff seeking to become Fellows themselves. In fulfilling this role, they provide a range of supports for candidates, including those who achieved their medical degree overseas. The college, with support from the Department of Health, also appoints training coordinators who work with universities to coordinate and secure medical placements in health services.

The Australian Association of Social Workers (AASW) is the professional representative body for social workers. It develops, reviews and accredits the education standards for social workers in Australia.

OT Australia is the peak professional body representing occupational therapists in Australia. It aims to ensure that members receive quality responsive services that add significant value to their careers. It also aims to support, promote and represent the profession of occupational therapy as a key element of the allied health sector in Australia. Occupational therapists are currently considering a proposal to replace the current governing body, OT Australia, with a new body, Occupational Therapy Australia. This new body will continue to represent the interests of occupational therapists nationally.

Psychologists are represented by the APS, the largest professional association for psychologists in Australia. The APS's mission is to represent, promote and advance psychology within the context of improving community wellbeing and scientific knowledge. It aims to achieve this mission through a number of goals including increasing advocacy for psychology and community wellbeing and enhancing the profile of APS psychologists and psychology, and increasing public access to and utilisation of psychological service.

The NBV regulates the nursing profession in Victoria. It registers nurses each year and requires an annual renewal of registration for nurses to retain the right to use the term 'registered nurse'. The board also accredits nursing programs in universities and in the VET sector and endorses nurse practitioners. Psychiatric nurses are also represented by the Australian College of Mental Health Nurses, which is the peak professional body for mental health nurses in Australia and has a role in setting standards of practice and encouraging professional accountability, autonomy and partnership.

COAG has signed an intergovernmental agreement committing the states, territories and the Commonwealth to establish a single national registration and accreditation scheme for health practitioners that is to be operational by 1 July 2010. National arrangements will replace the current state and territory statutory registration boards and will initially apply to nurses and midwives and the eight other health professions that are covered by statutory regulation and registration in all jurisdictions.

## Data and research organisations

Sound data and research is critical to informing workforce planning and development and clinical practice. Collaboration with organisations such as the Australian Bureau of Statistics, the AIHW, and various research organisations is important to ensure government policy is based on the best evidence available.

## What we plan to do

- Continue to work with the Commonwealth Government through the MHWAC and national workforce committee structure to progress cross-jurisdictional and national mental health workforce-related issues.
- Establish a pilot 'staff exchange' program for PDRS and clinical mental health services.
- Use the best available evidence in workforce policy and planning, addressing issues of efficiency and effectiveness as well as quality and best practice in service delivery.
- Encourage and support partnerships formed between specialist mental health services and other health care providers, with consideration to rotations or secondments into the specialist mental health sector for existing professionals.
- Undertake data collection and analysis that identifies critical workforce priorities.
- Include workforce planning as part of any capital, service or infrastructure planning.
- Improve the availability of workforce data and research for staff responsible for planning at both local and statewide levels.
- Incorporate workforce planning and support when planning services.
- Improve the collection and collation of Victorian mental health workforce data and support sharing and dissemination of information on workforce trends and developments.
- Undertake regular quantitative data collections for the public mental health workforce using an agreed workforce minimum dataset.
- Identify and utilise other data sources (including qualitative) about professional groups within the public mental health sector.
- Consider regular monitoring of vacancy rates by location and professional group.
- Incorporate: evaluation into all planning and implementation of new workforce roles and models; measures of the quality of service provided to clients; and measures of efficiency and viability.
- Promote the use of a standardised approach to exit interviews within the public mental health system. This would provide evidence for the reasons why workers leave and thereby assist employers to improve their retention strategies.

## 4. Next steps

The MHWSC has proposed short-, medium- and long-term responses to the challenges currently facing Victoria's specialist mental health workforce. These actions seek to promote a sustainable workforce with the necessary clinical and other skills and a supportive organisational environment that will meet consumer and carer needs into the future.

The committee recognises that the successful implementation of its recommended strategies will depend upon collaboration between government and its stakeholders. It is intended that the recommended strategies complement Victoria's new mental health reform strategy and assist in guiding Victoria's contribution to MHWSC.

Following the release of the *Mental health workforce strategy*, the Victorian Government will establish a ministerially appointed specialist mental health workforce partnership group comprising key stakeholders, including industrial representation, to provide advice on the implementation of workforce and mental health reform strategies.

# 5. Appendices

## 5.1 Policy environment

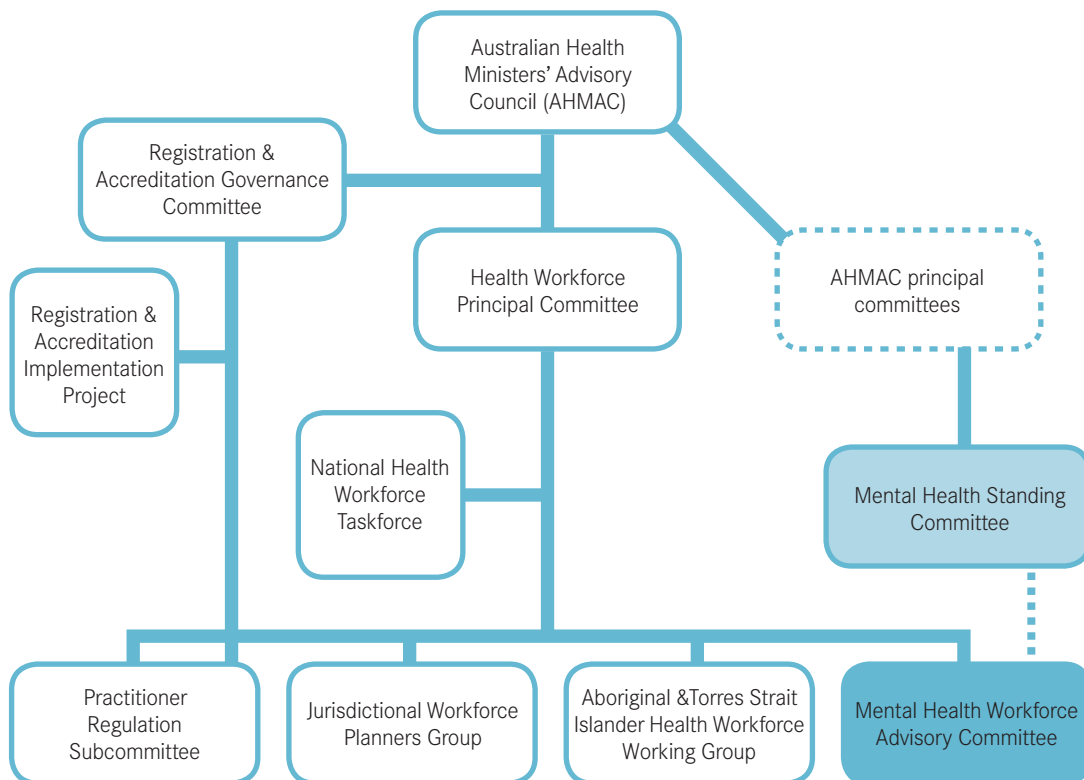
A range of policy frameworks and strategic directions at both the Commonwealth and state levels provide the policy context for Victoria’s specialist mental health workforce. The current strategy aligns with these policy and planning initiatives.

### National

The National Health Workforce Strategic Framework (NHWSF) was adopted by the Australian Health Ministers' Conference in 2004 and subsequently endorsed by COAG in 2006. The framework informs both state, territory and Commonwealth health and mental health workforce policy and planning. It also links to the National mental health plan 2003–2008 and was intended to guide national health workforce planning for a 10-year period.

In June 2004 COAG requested that the Productivity Commission undertake a research study on the health workforce. The study resulted in a significant range of reforms, including the establishment of the National Health Workforce Taskforce (NHWT). The Mental Health Workforce Advisory Committee (MHWAC) was established by the Mental Health Standing Committee prior to the release of the Productivity Commission’s report. Both committees provide advice to the Australian Health Minister’s Advisory Council (AHMAC) via one of AHMAC’s principal committees.

### AHMAC Health Workforce Principal Committee Structure HWPC subcommittees and working groups



The MHWAC reports to AHMAC's Health Workforce Principal Committee (HWPC). HWPC provides a forum for reaching agreement on key national health workforce issues that require government collaborative action. MHWAC provides advice to the HWPC and the Mental Health Standing Committee (MHSC) regarding the implications of broader health and other workforce issues and initiatives for mental health.

The MHSC reports to AHMAC via the Health Policy Priorities Principal Committee and is responsible for progressing policy and priority issues relating to mental health. The most significant of these has been the succession of national mental health plans that have driven mental health reform over the past 20 years. The *Third national mental health plan 2003–2008* identifies improved supply and distribution of the workforce and an improved workforce environment as areas of focus.

The COAG *National action plan on mental health 2006–2011* is a strategic framework that seeks to improve collaboration between the states and territories and to complement service reform at the state level. The plan recognises workforce shortfalls across all mental health professional groups and seeks to build the capacity of the public, private and non-government sectors to deliver services.

## Victoria

Several key policies provide the overarching vision for the Victorian Government's social policy.

*Growing Victoria Together* articulates the government's long-term vision and priorities for Victoria. Within this is a focus on ensuring all Victorians have access to high-quality health and community services, where and when they need them, to restore good health.

*A Fairer Victoria* is the government's social policy action plan that seeks to improve the lives of disadvantaged Victorians, including those with mental health problems. The plan provides investment to expand community-based mental health services, and support for education and training of staff.

*Victoria. A better state of health* is the Victorian Government's plan to address the health challenges of the future, by improving health services and ensuring a sustainable health system for all Victorians. The plan also identifies the need to consider ways to redesign worker roles to better suit consumer needs, to improve the way health practitioners are regulated and develop ways to better align staff training and education to health service needs.

The Victorian Government's broader social policy framework informs the next stage of mental health reform in Victoria. The consultation paper for the mental health reform strategy, *Because mental health matters*, recognises the responsibility all government departments have in improving the mental health of Victorians. The proposed reforms have a focus on earlier intervention and seek to reduce the prevalence of mental health problems and illness in the community and their associated social and economic costs. This consultation paper also recognises that a skilled and well-supported workforce is needed to help individuals with mental health problems or illness and their carers in an effective and responsive way. It also acknowledges the challenges posed by increased demand for services and an ageing workforce.

## 5.2 Industrial environment

### Current arrangements

In Victoria, the wages and employment conditions of mental health professionals are determined by awards or collective bargaining between unions and employers, with the Victorian Government and professional bodies also party to some EBAs.

The wages and conditions of registered nurses (division 1 and 3 who are classified as a registered psychiatric nurse and division 2 classified as a PSEN) and psychiatric service officers working in Victorian clinical mental health services are governed by *Victorian Psychiatric Services Certified Agreement 2004–2007* and the recent 2007 heads of agreement negotiated by HACSU, the ANF, the VHIA and the Victorian Government.

The wages and conditions of social workers and occupational therapists are governed by the *Victorian Psychiatric Services Agreement 2004–2007*. The HSU (No.3 Branch) negotiates on their behalf. The wages and conditions of psychologists are governed by the *Heads of Agreement Medical Scientists, Pharmacist and Psychologists Workplace Agreement 2008–2011*, negotiated by the Victorian Psychologists Association (VPA) through the HSU (No. 4 Branch). As part of the Heads of Agreement 2008–2011 applying to psychologists, the VHIA and the VPA (HSU4) have agreed that the classification structure applying to psychologists requires review, with the new structure to be implemented on or after 1 July 2009.

The Victorian Institute of Forensic Mental Health has a single comprehensive certified agreement covering all registered nurses, psychiatric services officers, health professionals and psychologists and support staff service.

Victorian public hospital doctors' terms and conditions stem from a heads of agreement negotiated between the Australian Medical Association (AMA), the Australian Salaried Medical Officers' Federation (ASMOF), the VHIA and the Victorian Government. The heads of agreement applies to junior doctors (doctors in training) and informs specific agreements between health services and senior doctors (specialists). The 2006 heads of agreement expired on 30 June 2008 and the parties are currently negotiating a new heads of agreement.

The minimum wages and conditions of mental health workers in the PDRS service sector are described in the Social and Community Services (SACS) – Victoria – Award 2000 to which the Australian Municipal, Administrative, Clerical and Services Union (ASU) is a respondent. Some PDRS services in the non-government community sector also have enterprise agreements that apply to their enterprise.

### Workforce development

EBA negotiations have provided a mechanism for discussion around broader workforce development through professional support, workforce reform and the review of government policy.

Professional development initiatives for mental health professionals introduced through the EBA process include clinical supervision guidelines, pre-graduate employment positions, improved continuing education payments for doctors and nursing graduate and postgraduate programs.

The most recent EBA for doctors provides for a range of workforce reforms including greater task substitution, the annualisation of salaries and agreement on the appropriate breakdown of clinical and non-clinical activities. Similarly, the EBA for the nurses and allied health professionals working in the clinical sector includes service improvements that change the skills mix in inpatient and community settings and targeted reductions in the use of agency staff and overtime. Both agreements also provide for private-practice working arrangements for mental health professionals.

More broadly, the Ministerial Review of Victorian Public Health Medical Staff and establishment of the Mental Health Workforce Strategy Committee are instances where the EBA process has provided mechanisms to develop and review government policy.

Enterprise bargaining in the non-government community sector has traditionally been constrained by single-employer bargaining.

### 5.3 Legislative and authorising environment

The professional practice of Victoria's mental health workforce is guided by a wide range of legislative responsibilities that ensure the provision of high-quality care delivered in a manner that protects the rights, privacy and dignity of people with a mental illness.

The *Mental Health Act (1986)* is the cornerstone of this legislative framework that guides the care, treatment and protection of people with mental illness. The Act establishes procedures for initiating involuntary treatment, informed consent, community treatment orders and independent review by the Mental Health Review Board. The Victorian Government is currently reviewing the Act to ensure it adequately incorporates recent developments in mental health policy and practice and that the *Victorian Charter of Human Rights and Responsibilities* is accorded adequate consideration and attention.

The *Health Professions Registration Act (2005)* ensures the regulatory framework that empowers the statutory health practitioner registration boards in Victoria. Within the mental health context the Act empowers the medical, nursing and psychology registration boards to respond to community needs, reflect changes in service models, adequately protect the public, address emerging issues and ensure mental health system quality.

Several other pieces of legislation also impact on the practices of the mental health workforce:

- The *Health Records Act (2001)* protects the privacy of patients and promotes their autonomy by regulating the collection and handling of health information in Victoria.
- The *Freedom of Information Act (1982)* gives members of the public a legally enforceable right to access information held by the Victorian Government, subject to certain restrictions.
- The *Guardianship and Administration Act (1986)* enables persons with a disability, such as a mental disorder, to appoint a guardian or administrator when needed.
- The *Alcoholics and Drug-dependent Persons Act (1968)* governs the public provision of drug treatment services in Victoria and provides for individuals to be ordered to attend treatment.
- The *Child and Young Persons Act (2005)* provides a legislative framework to strengthen early intervention for children and young adults and the provision of supports for families that are vulnerable and at risk.
- The *Drugs, Poisons and Controlled Substances Act (1981)* and the *Drugs, Poisons and Controlled Substances Regulations* outline the legislative requirements for health professionals responsible for prescribing and administering drugs and poisons defined under the Act.

Alongside the legislative requirements governing workforce matters there are a range of professional codes of practice and guidelines for best practice in the area of mental health service delivery, planning and review. The *National practice standards for the mental health workforce* (NPSMHW) and the *National standards for mental health services* (NSMHS) provide the overarching framework by creating benchmarks for mental health professionals and their employers. They guide education and training curricula and professional development programs within mental health; guide service delivery and help to facilitate informed participation of consumers, carers and relevant others in service planning, delivery, evaluation and improvement.

At a state level the Office of the Chief Psychiatrist is empowered to develop clinical guidelines and circulars concerning application and interpretation of the Mental Health Act and to establish and maintain practice standards. The *Standards*

for PDRSS (2004) and *PDRSS guidelines for services delivery* (2003) have been adapted from the national standards for mental health services in order to reflect the specialist function of PDRS services in facilitating and supporting the integration of people with psychiatric disabilities into their local community and its programs. These two documents guide the development of new services, steer service enhancement and best practice and help to ensure continual quality improvement in existing services. Professional bodies also provide discipline-specific practice standards, competencies or curricula that apply specifically to the practices of their professions.

Key discipline-specific examples include:

- the Australian Psychological Society's code of ethics, ethical and practice guidelines and procedures
- the Australian Association of Social Workers' *Practice standards for mental health social workers* (2008)
- the Australian Association of Occupation Therapists' Accredited Occupational Therapist Program, *Australian competency standards for occupational therapists in mental Health*, *Australian competency standards for entry-level occupational therapists* (1994) and Code of ethics (revised 2001)
- the Australian and New Zealand College of Psychiatrists' position statements and clinical practice guidelines
- the Australian Nursing and Midwifery Council's *Code of ethics for nurses in Australia* (2008), *Code of professional conduct for nurses in Australia* (2008), *National competency standards for the registered nurse* (2005), *National competency standards for the enrolled nurse* (2002), *National competency standards for the nurse practitioner* (2006)
- Australian College of Mental Health Nurses' Standards of practise for mental health nurses in Australia (1995).

## 5.4 Victoria's specialist mental health system

Victoria's specialist public mental health system consists of clinical services and PDRS services. Clinical mental health services are managed by public hospitals and PDRS services are provided by non-government community organisations. Treatment and support is also provided by mental health practitioners in the private sector and by GPs and counsellors in the primary health care sector. In addition, individuals with mental health problems are also seen by workers in other service sectors (for example, drug and alcohol services, justice, housing and acute health).

### Clinical mental health services

Clinical mental health services are structured and delivered on an area basis and are often referred to as area mental health services (AMHS). They include adult, child and adolescent and aged persons mental health services. Each of these services provides assessment, diagnosis, treatment and clinical case management, inpatient care and a range of residential and PDRS services to individuals with a severe mental illness.

A number of services are delivered on a statewide and regional basis. These services offer an additional level of expertise or service response for people with particular clinical conditions or high-level needs. They include forensic, dual-diagnosis, personality disorder, mother-baby, trans-cultural psychiatry, eating disorders, Koori, dual-disability, early psychosis, neuropsychiatry and brain disorder services.

### Psychiatric disability rehabilitation and support (PDRS) services

PDRS services are government funded and primarily delivered through the non-government sector. They provide home-based outreach support, residential adult and youth rehabilitation, day programs, mutual support, self-help and advocacy programs and carer respite and support.

Newer service models such as prevention and recovery care (PARC) services are operated by the PDRS service sector with clinical input from AMHS. PARC are step-up/step-down supported residential facilities for people experiencing a significant mental health problem who do not need or no longer require hospital admission.

### **New service delivery models – ‘youth demonstration’ projects**

New models exploring collaborative mental health service delivery through a coalition of providers – clinical, PDRS services and primary health – are being developed to provide earlier, better integrated and more comprehensive service responses to children and young people experiencing mental health problems.

The Child and Youth Mental Health Service Redesign Demonstration Projects span four years and aim to reduce the prevalence of untreated mental health problems across the 0–25 age group with a designated geographic area by focusing on early intervention for more commonly occurring and less severe mental health problems.

### **Private service providers**

Private sector mental health services play a key role in providing mental health care in Victoria. The 2005 *Victorian public mental health study* found this sector provided 22 per cent of total psychiatric beds and employed approximately 9 per cent of Australia’s mental health workforce. The private mental health sector includes private psychiatrists, psychologists, social workers, psychiatric nurses and occupational therapists working in hospitals and private practice.

The Mental Health Nurse Incentive Program provides non-MBS incentive payments to general practices, private psychiatrist services and other appropriate organisations (such as divisions of general practice) who engage mental health nurses to assist in providing coordinated clinical care for people with severe mental disorders.

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) program provides rebates for GPs to provide continuing management of consumers with mental disorders. Allied mental health services under this program include psychological assessment and therapy provided by eligible clinical and non-clinical psychologists, social workers and occupational therapists.

There has been an exponential growth in the use of private mental health services, with about 500,000 people taking up the offer of Medicare-funded visits to psychologists and other private sector treatment providers in the first year.

## **5.5 Health, community and other service providers**

### **Acute health**

The number of consumers presenting to EDs with mental health problems has increased in recent years, consistent with the growth in general ED presentations. This is due in part to reduced access to general practitioners, increased community awareness of mental health issues, the prevalence of alcohol and drug abuse, and increased pressures on the mental health service system. AMHS provide specialist mental health assessment and treatment in EDs, and assist general ED staff in supporting consumers who present with mental health problems. The recent introduction of the *Emergency department mental health triage tool* is designed to guide mental health clinicians in the triaging of mental health presentations to the ED.<sup>124</sup>

The Victorian Government also funds consultation and liaison psychiatry in all major hospitals. Mental health clinicians provide assessment, diagnosis and treatment recommendations for psychiatric co-morbidity with physical health problems of both hospital in-patients and out-patients.

<sup>124</sup> <http://www.health.vic.gov.au/emergency/mhtrainingmanual.pdf>

## General practitioners

GPs are the primary care providers for many in the community seeking assistance for mental health problems. As well as providing care, GPs play a crucial role in helping people to access other services, including referring to mental health care providers such as those outlined above or, where necessary, referring to a specialist mental health services.

In Victoria there are 116 GPs per 100,000 population, which is slightly higher than the national average. Access to GPs is unevenly distributed with fewer GPs in rural areas.

## Community health and primary care

Over a hundred community health services are funded by the Victorian Government. These provide a range of community health programs and also target population groups that may have trouble accessing appropriate health care. Examples of these groups are Aboriginal people, people with disabilities, refugees and people seeking asylum, the homeless and those at risk of homelessness, people from culturally and linguistically diverse backgrounds and living in rural communities.

Counselling services in community health services offer supportive counselling, therapy, practical support, advocacy and referral and linkage to other services as needed. Services can be provided on a one-to-one basis and in groups to adults, adolescents, children and families. The aim is to ensure that all Victorians have access to affordable, effective counselling that is physically accessible, and culturally appropriate.

CHS counselling services can assist with a wide range of issues, for example, family and relationship issues, coping with chronic illness, depression, anxiety and related conditions.

In 2004–05 community health counselling services provided 248,667 ‘occasions of service’ to approximately 48,200 people. The most common problems were depression, anxiety and family and relationship difficulties.

Programs provided by community health services vary according to local needs and include a broad range of services, such as dental, disability and health promotion, which are all part of the community health response to people with mental illness.

There is a range of other health care providers that are likely to have contact with individuals with mental health problems. They include maternal and child health nurses, the Royal District Nursing Services (especially the Homeless Persons Program), school nurses, school psychologists and welfare officers.

In addition, youth workers, financial counsellors and employment services may also have either dedicated services or generalist services for those with mental health problems.

## Alcohol and other drug treatment services

The Department of Health funds 102 alcohol and drug service agencies that provide more than 360 services across Victoria and employ 952 EFT. Services delivered include prevention and education programs, community treatment and rehabilitation services, forensic drug treatment services and needle and syringe programs.

Drug and alcohol treatment services report that just over 50 per cent of all its clients have a mental health problem, particularly depression and anxiety disorders. Services are increasingly working with clients with more complex needs. Drug use impacts upon compliance and relapse rates for people with a mental illness and the consequent need for high-cost inpatient treatment.

## Justice

The justice system encompasses police, courts, prisons, emergency services and victims' services. People with a mental illness are three to five times more likely to be represented in the corrections system than the general community. Just over a quarter of all newly remanded prisoners suffer some level of mental illness, with approximately 8 per cent suffering from schizophrenia or bipolar disorder (a prevalence rate that is almost 10 times greater than the general population). The prevalence of depression in prisons is at least 50 per cent higher than in the general population.<sup>125</sup>

## Housing

The Office of Housing within the Department of Human Services is responsible for the management and administration of public housing properties, through its regional offices. It employs 580 housing services officers across the state. The Office of Housing also funds external non-government agencies to deliver community-based housing and homelessness services.

A comprehensive workforce development strategy is currently being developed by the Office of Housing for its external housing workforce, which will seek to establish core competencies and skills and minimum qualifications, and improve career pathways and further training opportunities to support workers to advance their skills.

<sup>125</sup> Boston Consulting Group 2006, *Improving mental health outcomes in Victoria: the next wave of reform*, BCG, Melbourne.

## 6. Bibliography

- Aarons, G A, 2006, 'Transformational and transactional leadership: Association with attitudes toward evidence-based practice', *Psychiatric Services*, 57 (8), 1162–1169.
- Australian Association of Occupational Therapists (OT Australia), 2003, *Review of mental health course content in Australian university occupational therapy programs*.
- Australian Association of Social Workers (AASW), 2006, *Social Work in Mental Health Care*.
- Australian Association of Social Workers (AASW), 2008, *Australia Social Work Education and Accreditation Standards*, AASW.
- Australian Association of Social Workers (AASW), 2008, *Practice Standard for Mental Health Social Workers*, Second edition.
- Australian College of Mental Health Nurses, 1995, *Standards of Practice for Mental Health Nurses in Australia*.
- Australian Health Ministers' Conference, 2004, *National Health Workforce Strategic Framework*, Sydney.
- Australian Health Workforce Advisory Committee, 2003, *Australian mental health nurse supply, recruitment and retention*, AHWAC Report 2003.2, Sydney.
- Australian Institute of Health and Welfare (AIHW), 2008, *Nursing and Midwifery Labour Force 2005* National health labour force series no. 39. Cat. no. HWL 40. Canberra: AIHW.
- Australian Institute of Health and Welfare (AIHW), 2006, *Psychology Labour Force 2003*, AIHW Cat. No. HWL 34. Canberra: AIHW (National Health Labour Force Series No. 33).
- Australian Productivity Commission, 2005, *Australia's Health Workforce Research Report*, Canberra.
- Boston Consulting Group, 2006, *Improving Mental Health Outcomes in Victoria: The Next Wave of Reform*, Melbourne.
- Burton, J, 2007, *The business case for a healthy workplace*.
- Centre for Health Promotion, University of Toronto, 2004, *The case for comprehensive workplace health promotion*.
- Commonwealth Government of Australia, Office for Aboriginal and Torres Strait Islander Health, 2004, *A National Strategic Framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional well being 2004–2009: The social and emotional well being framework*.
- Commonwealth Government of Australia, Department of Health and Ageing, 2008, *Bridging The Gap: Mental Health Project*, prepared by Occupational Therapy Australia.
- Community Services and Health Industry Skills Council, 2005, *National Industry Skills Report*.
- Community Services and Health Industry Skills Council, 2008, *Environmental Scan 2008*.
- Community Services & Health Industry Training Board Inc., 2005, *Articulation between vocational education and training (VET) and higher education (HE) sectors*, Melbourne. <[http://www.health.vic.gov.au/workforce/downloads/articulation\\_vet\\_and\\_he.pdf](http://www.health.vic.gov.au/workforce/downloads/articulation_vet_and_he.pdf)>
- Dench McClean Carlson, 2007, *Evaluation of the statewide education and training partnership (Cluster) project*, Melbourne.
- Department of Employment and Workplace Relations, 2007, *Australian Jobs* Commonwealth of Australia, Canberra.
- Department of Human Services, 1996, *In partnership: families, other carers and public mental health services*, Melbourne.
- Department of Human Services, 2005, *Victoria's direct care mental health workers: The public mental health workforce study 2003–04 to 2011–12*, Melbourne.
- Department of Human Services, 2005, *Specialist mental health service components*.
- Department of Human Services, 2006, *The Medical Workforce of Victoria 2000–2004*.
- Department of Human Services, 2006, *Occupational Therapy Labour Force Survey: Victoria 2003–04*.

- Department of Human Services, 2006, *A needs assessment of Victorian consumer delivered services: draft final report*.
- Department of Human Services, Nurse Policy Branch 2006, *Prepare nurses for the future report: Phase 1*.
- Department of Human Services. 2007, *Ministerial Review of Victorian Public Health Medical Staff*.
- Department of Human Services, 2007, *Mental Health and Drugs Division Information Analysis and Reporting 2006–07*.
- Department of Human Services, 2008, *Review of the Mental Health Carer Support Program and carer support and resource workers (mental health): Final Report*.
- Department of Human Services, 2007, *Planning framework for public rural mental health services*, Melbourne.
- Gleeson J and Brewer W, June 2008, 'Medicare and public mental health psychology services', *InPsych*.
- The Health Communication Unit, Centre for Health Promotion, University of Toronto, Canada 2004, *The case for comprehensive workplace health promotion*.
- Hayes R, Bull B, Hargreaves K, Shakespeare K, 2008, 'A survey of the recruitment and retention issues for occupational therapists working clinically in mental health', *Australian Occupational Therapy Journal*, 55, 12–22.
- Human Capital Alliance, 2006, *Recruitment and retention of allied health professionals in Victoria*.
- Malhi G S, Parker G B, Parker K, Carr V J, Kirkby K C, Yellowlees P, Boyce P, Tonge B 2003, 'Attitudes toward psychiatry among students entering medical school', *Acta Psychiatrica Scandinavica*, 107 6: 424–429.
- McCrinkle Research, 2006, *New generations at work: attracting, recruiting and training Generation Y*.
- McGrath, B P, 2004, 'Integration of overseas-trained doctors into Australian medical workforce', *Australian Medical Journal*, 181, 640–642.
- Mental Health Nurse Education Taskforce, 2008, *Mental Health in Pre-Registration Nursing Courses*. <[www.nhwt.gov.au/mhwac.asp](http://www.nhwt.gov.au/mhwac.asp)>.
- Mental Health Reform Strategy Roundtable – Workforce, 28 July 2008.
- Mental Health Reform Strategy Roundtable – Workforce, 30 July 2008.
- Mental Health Workforce Advisory Committee (MHWAC), 2008, *Mental Health Workforce: Supply of Psychiatrists*.
- Nurses Board of Victoria, 2008, *Accredited Courses Leading to Recognition of Qualification in Psychiatric/Mental Health Nursing*.
- Nurses Board of Victoria, 2008, *Annual report 2007–08*.
- Occupational Health and Safety Act 2004*.
- OT Australia, 2008, *Bridging The Gap: Mental Health Project*.
- Brewer-Smyth K, 2003, 'Preventing Violence in the Healthcare Setting', *Nursing Spectrum*.
- Psychiatric Disability Services of Victoria (VICSERV), 2000, *VICSERV member census and worker survey*.
- Psychologists Registration Board of Victoria, 2008, *Annual report 2008*.
- Victorian Workcover Authority, 2006, *Stressing the point: A study into what causes stress in a budget sector workplace, and how it can be controlled*.
- Victorian Aboriginal Community Controlled Health Organisations (VACCHO), 2008, *Koori Mental Health*, viewed 11 November 2008 <[http://www.vaccho.org.au/programs/programs\\_mental.asp](http://www.vaccho.org.au/programs/programs_mental.asp)>.
- World Health Organization, 2006, *World health report 2006 – Working Together for health* <<http://www.who.int/whr/2006/en/index.html>>.
- World Health Organization, 2008, *Guidelines: Incentives for health professionals*.

