Orygen YOUTH Health
Research Centre

The Australian Health Workforce Institute
Addressing Workforce Challenges for Youth Mental Health Reform

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Addressing Workforce Challenges for Youth Mental Health Reform

The Australian Government's goal of establishing a new national youth mental health service system requires significant and immediate action to address imminent workforce challenges.

Policy Context

Mental ill-health is the major contributor to the health burden of young Australians[1]. The peak period for the emergence of mental ill-health is from the early teens to the mid-twenties, yet young people have the worst rates of access to mental health care of any age group[2]. The financial cost to Australia of mental illness in young people aged 12–25 years has been estimated at $10.6 billion[3]. For these reasons, the Australian Government's National Mental Health Reform package announced in May 2011 invested $420m over five years (additional to the $104m of new money committed the previous year) to establish a new national youth mental health service system comprising 90 headspace centres and 16 Early Psychosis Prevention and Intervention Centres (EPPICs).

Mental Health Workforce Challenges

A major issue to be addressed underpinning the implementation of the policy is the current and projected nationwide skills shortage in the mental health sector. This skills shortage relates to both a fundamental undersupply of mental health professionals[4] in all key disciplines and a pressing need to update knowledge, culture and practice in the mental health workforce[5].

The immediate challenge will be adding up to 1,700 EFT (three quarters of which are from clinical disciplines) to the youth mental health workforce over the next four years. The potential EFT required in the key clinical disciplines to implement current youth mental health policy is illustrated in Graph 1.

1 Australian Institute for Health and Welfare (AIHW) 2010, Australia's Health 2010, viewed 8 January 2012, http://www.aihw.gov.au/publication-detail/?id=6442468376.

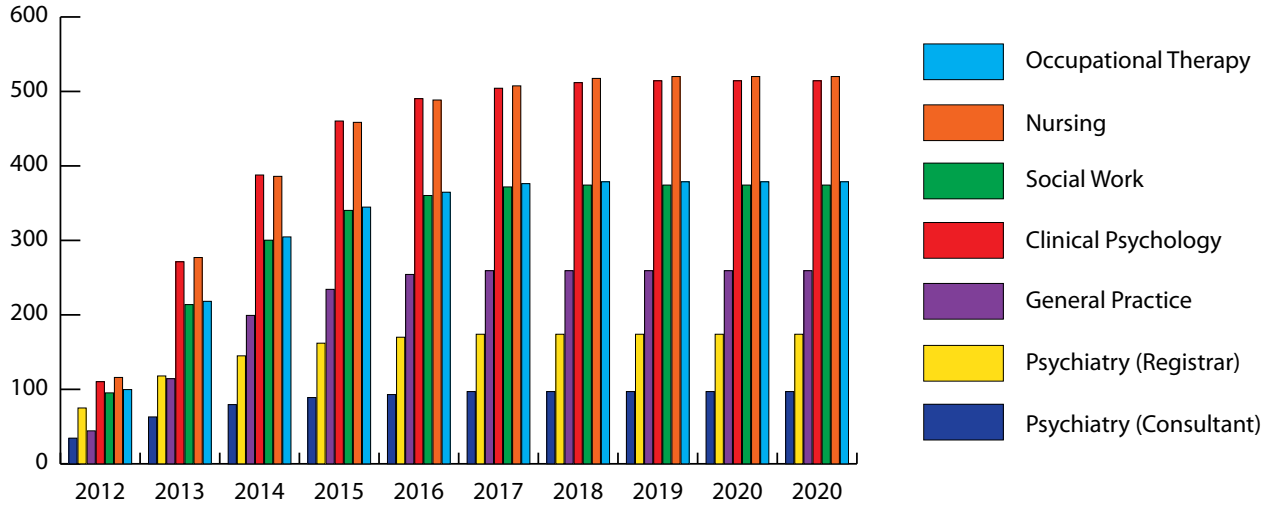
2 Australian Bureau of Statistics (ABS) 2007, National Survey of Mental Health and Wellbeing: Summary of Results, Report 4326, viewed 8 January 2012, http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0.

3 Access Economics 2009, The Economic Impact of Youth Mental Illness and the Cost Effectiveness of Early Intervention, viewed 30 January 2012, http://www.qldalliance.org.au/economic-impact-youth-mentalillness-and-cost-effectiveness-early-intervention.

4 Victorian Government 2009, Shaping the Future: The Victorian Mental Health Workforce Strategy, Department of Health, viewed 30 January 2012, http://www.health.vic.gov.au/mentalhealth/publications/mhworkforce.pdf.

5 Australian Government 2011, National Mental Health Workforce Strategy, Department of Health and Ageing, viewed 30 January 2012, http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/3545C977B46C5809CA25770D00093C93/$File/MHWAC%20Workforce%20Strategy.pdf.

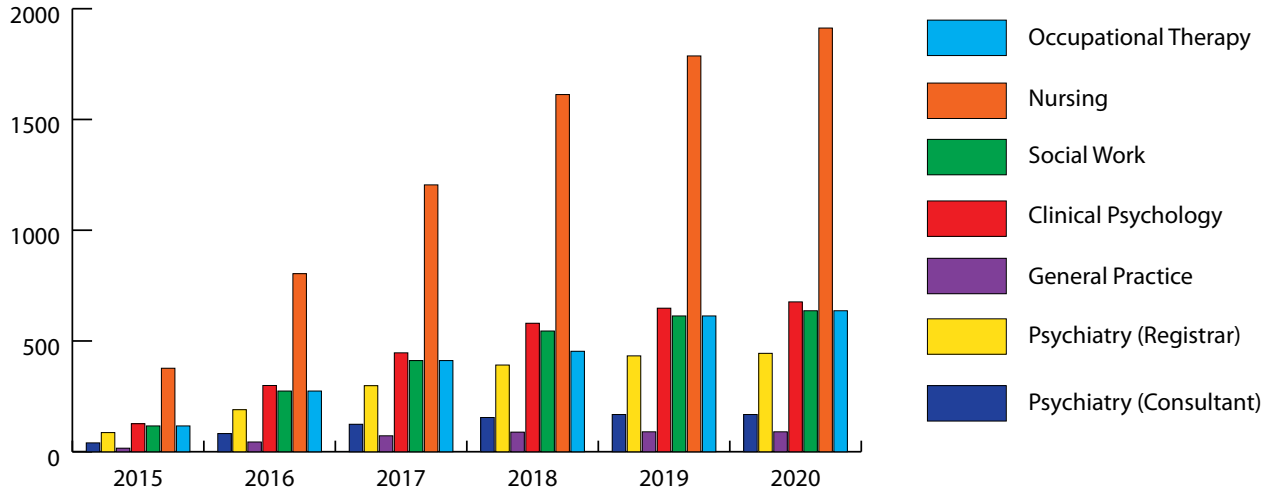
Graph 1. Projected additional cumulative workforce EFT requirement in key clinical disciplines for 90 headspace centres and 16 EPPICs (average catchment 750,000 people)



***The rates of demand are predicted to continue to grow modestly between 2017 and 2020**
Source: Data supplied by Orygen Youth Health Research Centre and headspace, 2012

It is equally important to plan for foreseeable potential extensions of the new youth mental health policy direction in the years between 2015 and 2020. Potential policy development in this area would include providing for whole of population coverage through increasing the numbers and/or sizes of individual headspace centres (potentially adding a further 30 headspace centres) and EPPICs (adding up to 16 additional EPPICs, depending on the average size of the catchment areas), evolution of EPPICs into full specialist youth mental health services providing expert care to young people with both psychotic and non-psychotic mental disorders, and establishment of new youth mental health inpatient units and sub-acute facilities. The expansion of the policy to a comprehensive national youth mental health service system may require an additional 5,500 EFT of workforce supply[6] (over 85% of which will be EFT in clinical disciplines). The projected EFT in key clinical disciplines for the expanded policy is illustrated in Graph 2.

Graph 2. Projected additional cumulative workforce EFT requirements in key clinical disciplines to implement a comprehensive national youth mental health service system as part of a future extension of current policy

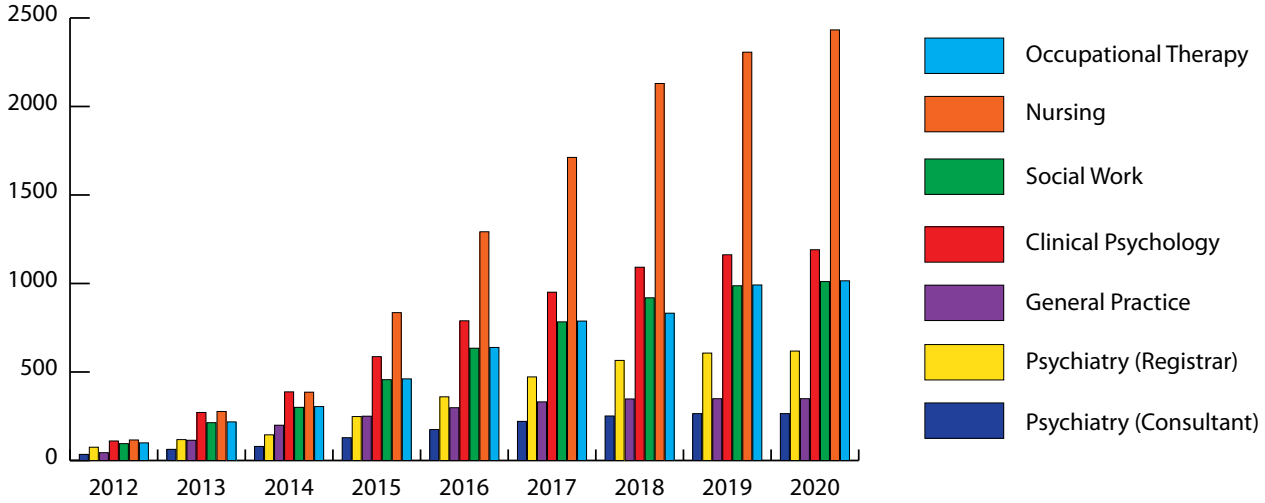


Source: Data supplied by Orygen Youth Health Research Centre, 2012

6 Data supplied by Orygen Youth Health Research Centre, 2012

The additional skills required by the headspace centres, EPPICs and other components of a potential comprehensive national youth mental health service system will overwhelmingly come from the disciplines of psychiatry, general practice, nursing, psychology, occupational therapy and social work, many of whom may require up-skilling to work in the specific area of youth mental health. The potential future demand for these skills under existing and potential future policy is illustrated in Graph 3.

Graph 3. Projected additional cumulative workforce requirements in key clinical disciplines to implement current youth mental health policy (2012–2016) and to then extend that policy to implement a comprehensive national youth mental health service system (2015–2020)



Source: Data supplied by Orygen Youth Health Research Centre and headspace, 2012

As sessional and part-time staff are expected to fulfil a significant component of the EFT in new youth mental health services, the number of individual staff members to be recruited, trained and supported to implement current policy may be 1,500 individuals for the EPPICs and up to 1,500 individuals for the headspace centres. Implementing a comprehensive national youth mental health service system will require recruiting, training and supporting a further 6,800 individuals in specialist youth mental health services and an additional 700 individuals in headspace centres.

Adopting a focus on prevention and early intervention by targeting youth mental health may serve to decrease future demand on mental health services in the acute sector. However, a lag time between implementing these youth services and the potential decrease in the prevalence and severity of mental illness will result in an additional burden on the already under-resourced mental health workforce in the short to medium term.

Immediate action is required to:

- Ensure there will be enough clinicians to meet increasing demand in youth mental health without weakening capacity elsewhere in the mental health system.
- Facilitate workforce development for clinicians entering the youth mental health workforce to ensure they are sufficiently skilled and supported to adopt new ways of working and implement evidence-based practice in youth mental health care.

Service Models: Implications for Supply and Demand

The confidence with which future service demand (and thus workforce requirements) for the new youth mental health services can be predicted varies according to service model. Once fully operational, EPPICs are

expected to experience minimal variation in service demand for their first episode psychosis programmes, which should reliably adhere to a rate of about 230 new cases a year per one million population area[7]. Specialist youth mental health services that have extended EPPIC principles to the care of young people with serious non-psychotic mental illnesses would also be expected to have a predictable level of service demand once they have been developed to scale.

headspace is a new model that relies largely on private providers that cater for young people with mild to moderate mental ill-health with a broad spectrum of needs (ranging from information and advice, to support for employment/education challenges, to counselling for substance misuse, to access to therapies provided by a clinical psychologist, psychiatrist or other mental health clinician). Nationally one in four young people experience a diagnosable mental disorder in any one year[8]. Three quarters of young people experiencing a diagnosable mental disorder do not currently access help from a health care professional[9]. The growth of headspace centres is expected to improve access amongst this group of young people, but it remains unclear what proportion of this group will seek help at headspace centres. The workforce projections for headspace centres are based largely on the size of an average headspace centre resembling that of the average current fully operational headspace centre. However, strong demand for the existing headspace centres has led to waiting lists in many centres, thus compromising the principle of early intervention. It may therefore be prudent to allow for the possibility of demand-led growth in the size (and therefore staffing requirement) of headspace centres.

The method of funding from providers in the headspace workforce has a number of implications for workforce supply. There are a range of provider payment schemes, from fee-for-service to salaries. headspace centres are reliant on a range of federally funded mental health initiatives to provide access to mental health services (including the Better Access Initiative, Better Outcomes, and the Mental Health Nurse Initiative)[10]. Therefore, staffing between centres varies depending on their individual access to these initiatives. Attracting general practitioners to work in headspace centres is subject to the incentives given through these initiatives.

Mental Health Workforce Supply

Ensuring a sustainable, skilled and appropriate mental health workforce poses a significant challenge, as reflected in the National Mental Health Workforce Strategy. The impact of increased demand will exacerbate existing shortages in areas such as psychiatry, nursing, psychology and social work. The estimates provided on workforce demand are predicated on current models of care. In addition, other disciplines such as dieticians and exercise scientists may also be included in future policies.

Psychiatry: In 2011, approximately 3,000 registered psychiatrists[11] and approximately 725 psychiatrists in training[12] are estimated to have been working in Australia. A significant increase of 250 new psychiatry roles will be required by 2016 to implement the current policy, rising to a total of 800 new psychiatry roles by 2020 for the extended policy[13]. The increase for the current policy represents an 8.5% increase in the number of registered psychiatrists in relation to the total psychiatry workforce in 2011. A 25% increase in the total psychiatry workforce by 2020 will be required to also implement the extended policy.

7 Data supplied by Orygen Youth Health Research Centre, 2012
8 ABS 2007.
9 ABS 2007.
10 Headspace National Youth and Mental Health Foundation 2011, Headspace Submission: Commonwealth Funding and Administration of Mental Health Services, viewed 6 January 2012, http://www.google.com.au/search?q=Headspace+submission%3A+commonwealth+funding+and+administration+of+mental+health+services&rls=com.microsoft:en-au&ie=UTF-8&oe=UTF-8&startIndex=&startPage=1&redir_esc=&ei=0mIwT622Iq2hiAef18yTBQ.
11 Australian Health Practitioner Regulatory Agency (AHPRA) 2011, Annual Report 2010–11, AHPRA, viewed 30 January 2012, http://www.ahpra.gov.au/News/2011-11-1-AHPRA-annual-report-released.aspx.
12 Australian Institute of Health and Wellbeing 2012, Mental Health Workforce, mhsa.aihw.gov.au/resources/workforce/psychiatric-workforce/.
13 Data provided by Orygen Youth Health Research Centre, 2012.

However, the supply of psychiatrists is currently expected to decrease, given the proportion of the workforce approaching retirement age (almost 40% are aged 55 years or over), decreased working hours and increasing number of females choosing psychiatry[14]. The Mental Health Workforce Advisory Committee (MHWAC) predicts that the "workforce demand for psychiatrists is expected to significantly exceed supply in the short and medium term"[15].

Psychology: In 2011, approximately 24,450 general and clinical psychologists were registered to practice in Australia[16]. The projected increase in psychologists required to meet the new demand resulting from current policy is 760 by 2016, rising to 1,500 by 2020 if the extended policy is also implemented. These projections represent a 3.2% increase in the current number of psychologists for the current policy and a 6.4% increase for the extended policy. There is a planned growth of psychology university placements in Australia of 6.8%, from 4,500 EFSTL in 2010 (representing students across the six years) to 4,800 EFSTL by 2011[17]. Therefore, the number of new psychologists that graduated in 2010 was 580 and may increase to 620 by 2014 given the projected increase in university placements. It is important to emphasise that two thirds of the psychology requirement to implement current policy, and three quarters of the psychology requirement for the extended policy, is for clinical psychologists.

According to the MHWAC (2008), Australia's psychology workforce is largely self-reliant and unlike mental health nurses and psychiatrists, they are not in workforce shortage[18]. However, the Department of Education, Employment and Workplace Relations (DEEWR) skills shortage list identified a shortage of psychologists in 2011.

General Practice: Addressing the mental health needs of Australia's population is heavily reliant upon general practitioners (GPs), with general practice often the first point of contact for those with mental health concerns[19]. An additional 260 GPs would be required by 2016 to implement the current policy, increasing to 400 for the extended policy[20]. Currently, there is a shortage of doctors in Australia, particularly in regional areas[21]. Furthermore, the Royal Australian College of General Practitioners notes that addressing mental health in general practice is more time consuming than addressing physical concerns, and that there must therefore be adequate incentives in place if GPs are to continue to provide high quality, accessible mental health services[22].

Social Work: The MHWAC (2011) highlighted that the number of social workers engaged in the mental health workforce is growing, and there is limited data relating to the supply of social workers relative to their demand in mental health settings[23]. Although the number of social work university placements is expected to markedly increase from around 6,300 in 2011 to 7,800 in 2014, in 2011 the DEEWR skills shortage list identified a shortage of social workers in Australia. In order to implement the current policy an additional 450 social workers will be required by 2016[24]. This figure will increase significantly to 1,100 if the extended policy is implemented[25].

14 Mental Health Workforce Advisory Committee (MHWAC) 2008a, Mental Health Workforce: Supply of Psychologists, MHWAC, viewed 30 January 2012, http://www.ahwo.gov.au/documents/Mental%20Health%20Workforce%20Activities/MHWAC%20Supply%20of%20psychologists.pdf.
15 MHWAC 2008a.
16 AHPRA 2011.
17 Health Workforce Australia (HWA) 2011a, Capturing Opportunities for Growth—Supply (Clinical Training Provider) Study, HWA, viewed 2 February 2012, https://www.hwa.gov.au/sites/uploads/mcp-cog-supply-report-a20111028.pdf.
18 MHWAC 2008c, Mental Health Workforce: Supply of Psychologists, MHWAC, viewed 30 January 2012, http://www.ahwo.gov.au/documents/Mental%20Health%20Workforce%20Activities/MHWAC%20Supply%20of%20psychologists.pdf.
19 AIHW 2010, Mental Health Services in Australia 2007–2008. Mental Health Series No. 12 Cat. No. HSE 88. Canberra: AIHW.
20 Data provided by Orygen Youth Health Research Centre, 2012.
21 Australian Medical Workforce Advisory Committee (AMWAC) 2005, The General Practice Workforce in Australia: Supply and Requirements to 2013. AMWAC Report 2005.2 Sydney: AMWAC.
22 RACGP 2011, RACGP Submission to the Senate Community Affairs Reference Committee: Inquiry into Commonwealth Funding and Administration of Mental Health Services, viewed 7 February 2012, http://www.racgp.org.au/reports/201108RACGPSubmission_mentalhealth.pdf.
23 Australian Government 2011.
24 Data provided by Orygen Youth Health Research Centre, 2012.
25 Data provided by Orygen Youth Health Research Centre, 2012.

Mental Health Nursing: In 2009, there were approximately 12,000 registered nurses and 2,600 enrolled nurses whose main area of work was in mental health[26]. The number of nurses working in mental health has remained stable over the last decade as has the proportion of overall nurses working in mental health (averaging 5.3%), see Table 1. It is difficult to ascertain the number of nurses working in the sector that have graduate training in mental health, and even more so, those with specific training in the area of youth mental health. The current policy increases the need for 700 new mental health nurses by 2016 and up to 2,200 by 2020 for the extended policy[27].

Table 1. Proportion of nurses working in mental health

Year	Enrolled Nurses	Registered Nurses	Total: All MH Nurses	Total: All Nurses	Proportion working in MH
2003	3,254 (6.8%)	9,263 (4.9%)	12,517	236,645	5.3%
2005	2,277 (4.9%)	10,373 (5.2%)	12,649	244,360	5.2%
2007	2,764 (5.4%)	11,290 (5.3%)	14,054	263,331	5.3%
2009	2,644 (5.1%)	11,996 (5.3%)	14,640	276,751	5.3%
Average percentage of nurses working in mental health: 5.3%					

Source: AIHW Nursing and Midwifery Labour Force Surveys 2003, 2005, 2007 and 2009

In 2010, around 9,500 nurses graduated[28]. Using the estimate of 5.3% of all nurses working in mental health, this represents an additional 500 graduate nurses potentially entering the mental health workforce. The number of nursing university placements in Australia is expected to increase by 15.5% from 34,900 EFSTL in 2010 (representing students across the three years) to 40,300 EFSTL by 2014[29]. Therefore, an estimated additional 1,500 nursing graduates may increase the yearly number of graduate nurses potentially entering the mental health workforce to 600 by 2014. Attracting graduate nurses to mental health and particularly youth mental health represents a valuable opportunity to address increasing demand.

The supply of nurses working in mental health is expected to decrease due to the ageing workforce (over 60% are aged over 45 years and 25% are over 55)[30] and changing workforce patterns. The deficit of nurses is predicted to be greater in the mental health field due to the higher average age of mental health nurses, difficulties recruiting nurses to the area, and increasing services (such as the Mental Health Nurse Incentive Initiative)[31].

Occupational Therapy: The current policy requires an additional 450 occupational therapists (OTs) by 2016, increasing significantly to 1,100 if the extended policy is implemented[32]. Given the lack of national registration requirements, the number of OTs in Australia is difficult to pinpoint, and quantifying those working in mental health even more so. However, DEEWR reports from 2011 suggest that there is a skills shortage in regional

26 Australian Institute of Health and Welfare (AIHW) 2011, Nursing and Midwifery Labour Force Survey 2009, http://www.aihw.gov.au/publication-detail/?id=10737419682.

27 Data provided by Orygen Youth Health Research Centre, 2012.

28 Department of Employment, Education and Workplace Relations (DEEWR) 2012, Data Cube: Enrolment Count by Special Course by Citizenship Category by Year, viewed 2 February 2012, http://www.highereducationstatistics.deewr.gov.au/.

29 Health Workforce Australia (HWA) 2011a.

30 Australian Institute of Health and Wellbeing 2012, Mental Health Workforce, mhsa.aihw.gov.au/resources/workforce/mental-health-nursing-workforce/.

31 MHWAC 2008b, Mental Health Workforce: Supply of Mental Health Nurses, MHWAC, viewed 30th January 2012, http://www.ahwo.gov.au/documents/Mental%20Health%20Workforce%20Activities/MHWAC%20Supply%20of%20Mental%20Health%20Nurses.pdf.

32 Data provided by Orygen Youth Health Research Centre, 2012.

areas nationwide. Though data is difficult to obtain, recruitment and retention of OTs into mental health has been found to be difficult[33].

Meeting Youth Mental Health Workforce Demand

The supply of the mental health workforce encompasses three components: retaining the current workforce, increasing the supply of the workforce, and workforce innovation and reform. Currently, the mental health workforce cannot always meet demand, particularly in socioeconomically and geographically disadvantaged areas[34]

It is a significant task to successfully recruit and train the youth mental health workforce over the next eight years, three quarters of which are from scarce clinical disciplines. However, there are a number of factors that can enable this target to be reached.

Increasing Supply of the Youth Mental Health Workforce

New youth mental health service platforms are likely to be highly attractive places for clinicians to work as they will be innovative, optimistic and multidisciplinary working environments that provide significant opportunities for staff to develop new skills.

Youth mental health services tend to have a young staffing profile and are highly suitable environments for clinicians to work and train in at the start of their careers. Therefore, a significant proportion of the growing workforce requirement for the new services may be met by recruiting clinicians as they graduate from clinical training in each annual cohort over the next eight years.

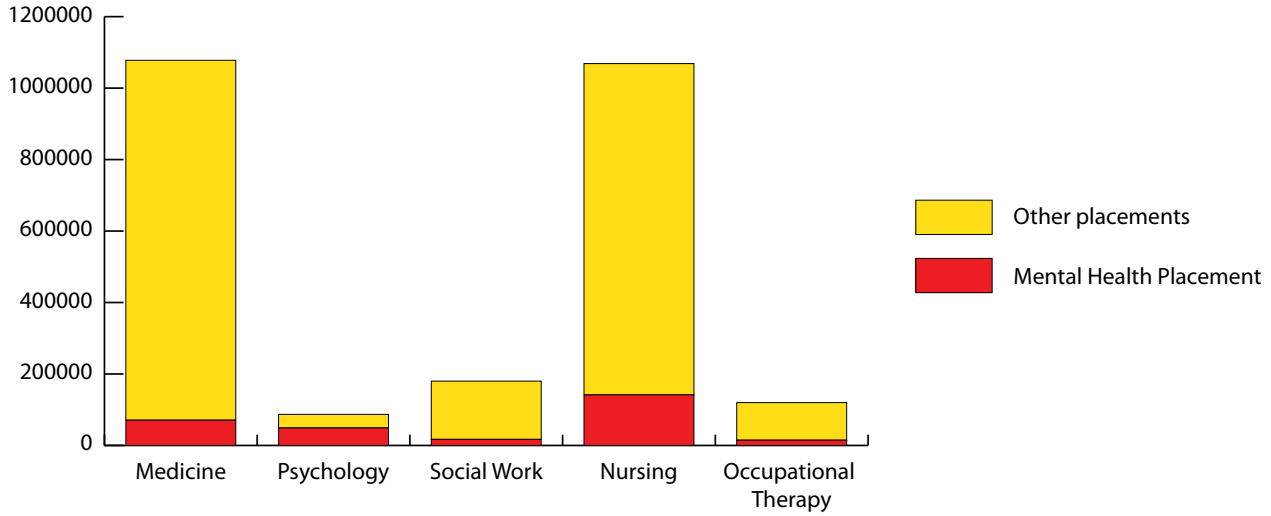
Many of the roles (for example case management) in the new youth mental health service platforms can be fulfilled interchangeably by multiple disciplines. Therefore, local services are likely to have significant flexibility to configure their staffing profile in response to local workforce conditions, in particular in relation to a significant proportion of the clinical psychology, nursing, occupational therapy and social worker roles.

Providing clinical placements in youth mental health settings provides a valuable opportunity to attract new graduates to the workforce. The current proportion of mental health placements particularly for medicine (7%) and nursing (12%) seems relatively low (see Graph 4). Furthermore, the focus of these clinical placements is on the acute setting. The current and expanded policy provides an excellent platform to extend these training opportunities.

33 Ceramidas D. 2010, A case against generalisation of mental health occupational therapy in Australia, Australian Occupational Therapy Journal, vol. 57, p. 409–416.

34 Australian Government 2011.

Graph 4. Clinical placement days in a mental health setting, by profession



Source: HWA 2011, Capturing Opportunities for Growth—Supply (Clinical Training Provider) Study

The combination of a young workforce and attractive working environments creates the opportunity for youth mental health service platforms to be used as "magnets" to attract more clinicians in training to choose careers in mental health.

Realising this opportunity will be important to help grow overall mental health workforce numbers and thus mitigate the risk that EFT growth in the youth mental health platforms will be at the expense of the personnel that other parts of the mental health system require to function effectively.

Clinicians entering the youth mental health workforce may require additional training to ensure that they are sufficiently skilled and supported to provide evidence-based practice specifically in youth mental health care.

In addition, clinical, youth and employment staff not working in youth mental health platforms (e.g., in GP clinics, youth services, employment services) may also seek training and support in youth mental health practice.

Thus, the overall workforce development challenge may go beyond training and supporting the approximately 10,500 individual professionals who may be recruited to work in headspace centres, EPPICs and other specialist youth mental health services by 2020.

Youth Mental Health Workforce Innovation and Reform

The National Mental Health Workforce Strategy (NMHWS) states that:

"workforce shortages are a significant long-term problem, and despite efforts and resources being applied to recruitment and retention, and an increased number of training places, these interventions will not, of themselves, be sufficient to meet ongoing workforce requirements" (2011, p. 22).

The NMHWS advises that attention to innovation in role redesign, task delegation or substitution, and the creation of new workforce models should be considered nationally. The imperative for innovation and reform is recognised by Health Workforce Australia (HWA).

HWA released the National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015. This framework includes "identification and national implementation of evidence-based role redesign"[35],

35 HWA 2011b, National Health Workforce Innovation and Reform Strategic Framework for Action 2011–2015, viewed 2 January 2012, https://www.hwa.gov.au/sites/uploads/hwa-wir-strategic-framework-for-action-201110.pdf.

and highlights the need to identify and develop innovative workforce models and roles to provide more effective, efficient and accessible service delivery[36].

The National Mental Health Strategy (NMHS) also identifies the need to allow flexibility of workforce models to adapt to pressures, such as servicing rural and remote communities, to enable local solutions to workforce shortages[37].

New workforce models are already being trialled in Australia, such as Mental Health Nurse Practitioners, with a broader scope of practice to take on greater responsibilities[38].

A review of the youth health workforce in New Zealand identified the need to ensure that career paths and recognition of those wishing to specialise in youth health are provided; and the development of specific youth mental health roles such as an integrated youth worker in a health role who can support young people to navigate health services[39].

Role redesign and development of new mental health workforce roles have been trialled in the US and the UK, however these roles were not specific to the youth mental health services dealing specifically with early intervention or early psychosis[40]. Australia is well placed to develop and pilot role redesign and new roles that cater specifically for this context.

Caution must be taken in regards to role redesign and development to mitigate the risk of dilution of expertise, to ensure we have a safe, competent and highly skilled youth mental health workforce.

A national set of practice standards specifically for mental health practitioners providing competencies that reflect the required skills and knowledge for each discipline was developed in 2002[41]. A set of national practice standards specific to the emerging field of youth mental health will be integral to ensuring best practice.

Increasing consumer and carer employment in clinical and community support settings was also recommended in the NMHS. However, as stated in the strategy, "there are a variety of models of employment of consumers and carers in community and bed-based settings, but this has not been systematically developed or implemented in Australia compared with other parts of the world"[42].

Further development and expansion of the use of innovative approaches to services delivery, such as the use of telephone and e-mental health services, may also improve the efficiency of the system and lessen the burden on the mental health workforce[43]. These service models may be both effective and appealing to the youth demographic, however significant practical barriers remain to implementing these approaches.

36 HWA 2011b.
37 Australian Government 2009, Fourth National Mental Health Plan: An Agenda for Collaborative Government Action in Mental Health 2009–14, Department of Health and Ageing, viewed 30 January 2012, http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/$File/pla4.pdf.
38 Australian Government 2011.
39 New Zealand Government 2011, Report on Youth Health Service Review, viewed 3 February 2012, http://healthworkforce.govt.nz/sites/all/files/Youth%20Health%20WSR%20formatted%20final.pdf.
40 National Workforce Program 2012, New Ways of Working in Mental Health For Everyone, National Health Service, viewed 3 February 2012, http://www.healthcareworkforce.nhs.uk/nimhe/content/view/33/445/ http://www.healthcareworkforce.nhs.uk/nimhe/content/view/33/445/.
41 Australian Government 2009.
42 Australian Government 2009, p. 51.
43 Australian Government 2011.

Recommendations

- Governments and the community need to appreciate the gravity of current and future youth mental health workforce challenges.
- Immediate action needs to be taken to address the current workforce challenges and build the capacity required to support the feasibility of implementing expanded policy options in the future.
- As the entity responsible for creating a sustainable health workforce by 2025, HWA should be tasked with urgently addressing the mental health workforce challenges.
- There is a need to establish a national plan for workforce training and research in youth mental health to inform robust workforce planning.
- Development of a national approach is required for ongoing skills development and national standards for the youth mental health workforce.
- This would be achieved through a National Centre to develop and coordinate training and workforce development for youth mental health workers, patients, and the community.
- Ensure a significant proportion of workforce is met through growth rather than exacerbating existing shortages in the mental health sector.
- The establishment of systems and resourcing to enable the provision of clinical placements in mental health facilities including headspace centres and EPPICs, to expose relevant disciplines to these models of care and attract new graduates to youth mental health.
- Exploration of new models of care that can be developed and piloted in context of youth mental health.
- Ensure the inclusion of other disciplines such as youth workers, dieticians and exercise scientists that can add value to the wider youth mental health workforce.
- Exploration of the use of and targeting of existing programs and funding streams eg Enhanced Specialist Training Program to support a strategy to grow the workforce.
- Maximise the use of new and emerging technologies to provide access in rural and remote regions, and for clients who are difficult to engage by traditional means. Ensure that new platforms facilitate the use of these technologies through investment in infrastructure and training in the use of ITC supports.

Orygen Youth Health Research Centre is committed to working with Government, Health Workforce Australia, and key stakeholders to progress the development of a national plan and the establishment of a national approach to the development of the youth mental health workforce.