Drygen

The National Centre of Excellence
in Youth Mental Health

National Youth Mental Health **Workforce Strategy** (2016 – 2020)

Acknowledgement

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National Youth Mental Health **Workforce Strategy** (2016 - 2020)

Foreword

Mental ill-health is the number one issue facing young people worldwide. As the leading cause of disability in those aged between 10 and 24 years it contributes 45 per cent of the overall burden of disease.

Australia is leading the world with transformational reform and investment to address the needs of young people experiencing mental ill-health. To support this reform we need a clear road map to ensure we have a sustainable and skilled youth mental health workforce now and into the future.

This strategy is built on the principle that young people with mental ill-health should be able to access the highest quality care wherever they present for support across a range of service systems. It also acknowledges the vital role for young people with a lived experience of mental ill-health, their family and carers within the mental health workforce.

Drawing from recent research and evidence for youth focused mental health service delivery this strategy aims to provide all in the sector with a way forward to build a skilled, capable, collaborative and sustainable youth mental health workforce. One that has the flexibility to respond to new and innovative practice now and into the future.

It provides guidance for service planners and funders so that they can respond strategically to existing gaps and emerging opportunities and improve the response to youth mental health, ensuring appropriately qualified and skilled staff are employed in key services and settings.

For mental health services, this strategy describes opportunities and enablers that they can consider and adopt in their own recruitment strategies and staff development policies and processes, ensuring support for young people's mental health is part of their core service delivery.

Outside clinical mental health service delivery, this strategy also describes the broader youth mental health workforce, such as youth and community workers, teachers, primary care providers and Aboriginal health workers, and articulates core competencies for these professionals.

This strategy should be read in conjunction with the National Youth Mental Health Training Framework which has also been produced by Orygen. Together they will be of use to all those who plan health and human service workforces, who employ people who come into contact with young people and who research in the area of workforce development.

Contents

Introduction

The National Youth Mental Health Workforce Strategy (2016-2020) provides direction on workforce development, reforms and initiatives to improve the care for young people, aged 12–25 years, who are experiencing mental ill-health.

It outlines a clear roadmap for Australia to build a sustainable and skilled youth mental health workforce across four key domains. These are:

1. A capable and skilled clinical and non-clinical youth mental health workforce which can provide evidence-based and appropriate care to young people across the stages of mental ill-health.
2. A sustainable, secure and ongoing supply of appropriately qualified youth mental health professionals and specialists.
3. A culture of innovation and continuous improvement which is embedded across the youth mental health workforce.
4. A responsive, collaborative and flexible youth mental health workforce.

Within each domain, an overarching goal is articulated, with evidence provided to support the rationale. A set of enablers and barriers to achieve this goal are then described and each domain concludes with a way forward. These proposed actions can be implemented by governments, service planners and funders, service managers, educators and workers ensuring they contribute to the future development of the youth mental health workforce.

This strategy has been shaped and informed through:

- a comprehensive review of peer-reviewed and grey literature;
- advice from national and international experts; and
- the experiences of key stakeholders (including young people with a lived experience of mental ill-health).

Background

At present there is a clear argument for focusing on the youth mental health workforce and developing innovative workforce approaches specific to young people. This includes:

- The scale and extent of the young people's mental ill-health.
- Consistent (global) evidence of low rates of help-seeking by the young people who most need help (McGorry et al., 2014) and emerging evidence of how this might be improved, such as using new technologies, peer care and support and developing new types of services and service delivery (Ivancic et al., 2014).
- The emergence of more effective and targeted youth-specific treatment models of care and recognition of the public health, individual and community benefits of prevention and early intervention.
- Evidence of difficulties recruiting skilled workers (particularly GPs and psychiatrists) who are confident, or enjoy, working with young people into youth mental health services (Carbone et al., 2011).
- The broadening concept of the 'youth mental health workforce'.

Prevalence and impact

Mental ill-health is now globally the most prevalent health issue affecting young people (regardless of the level of development of their country) and is the leading cause of disability in people aged 10–24 years, contributing 45 per cent of the overall burden of disease in this age group worldwide (McGorry et al., 2014).

The cost of youth mental ill-health in Australia is estimated to be in excess of $10 billion per annum (Access Economics, 2009). For those young people who are in the workforce, the cost estimates of lost productivity are around $800,000 per hour (Degney et al., 2012).

Three quarters of people with a mental illness first experience symptoms as a young person. As such, many authors and reports suggest that prioritising prevention and early intervention with young people is crucial to reducing the personal, social and economic costs in the whole community (National Mental Health Commission, 2013).

Help-seeking behaviours among young people

Young people have the lowest rates of professional help-seeking among any age group in Australia (Slade et al., 2009). For those who do seek help, they may do so through service providers who are not necessarily recognised as part of the mental health or health workforce (e.g. police, welfare providers, teachers and youth workers). Similarly, young people at risk may be identified by these professional groups.

Recent research found that young people, both with and without a probable serious mental illness, were most uncomfortable seeking information, advice or support from professional services. Rather, friends, family and the internet were among the top sources of information and advice (Ivancic et al., 2014).

There is also evidence that young people who seek professional help do so through a two-step process. In 2012, the Inspire Foundation National Survey of ReachOut.com users found after visiting the website 41 per cent of respondents were more likely to seek subsequent help from a mental health professional, 40 per cent from a friend and 29 per cent from a medical doctor (Metcalf and Kauer, 2013).

New and emerging approaches in youth mental health care

New models of specialist care for particular disorders provide different approaches for young people where traditional adult approaches may be unsuitable or ineffective (McGorry et al., 2015; Bateman et al., 2015; headspace, 2009). There has been a shift from episodic, acute, time-limited care, to models that support young people over extended periods across the stages of illness (Box 1). These models also respond to complex comorbidities, compounded by the family, cultural, societal or environmental contexts within which young people live.

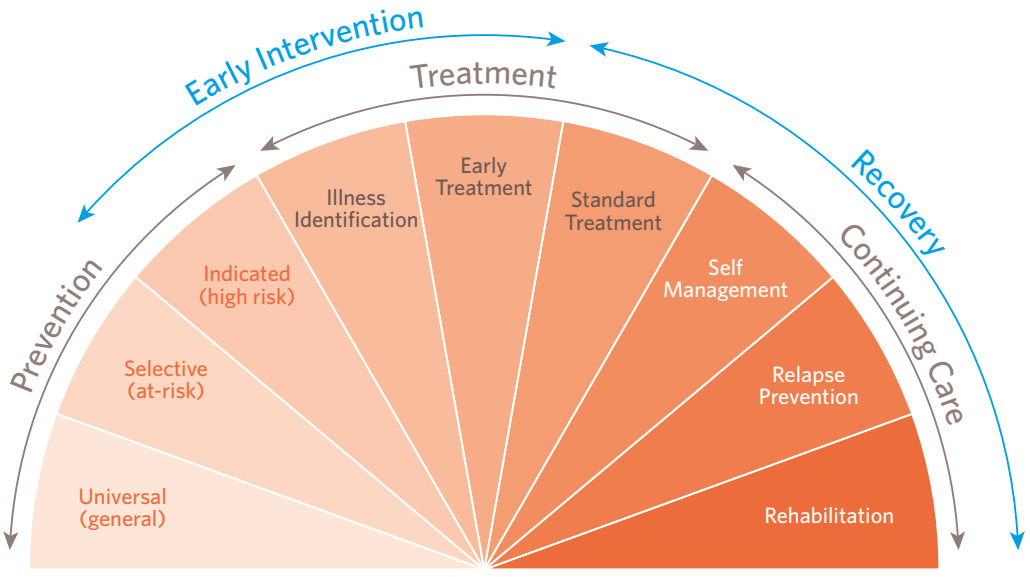
Box 1: **A clinical staging model for youth mental health care**

Much of the Australian Government investment in youth mental health in recent years has been in support of new approaches to service delivery, based on a clinical staging model of care to improve the logic and timing of interventions with young people (McGorry et al., 2006). Clinical staging considers the continuum of the course of an illness. Interventions can be selected that are most appropriate to the stage of illness, starting with benign interventions at the earliest stage. In mental health, research into clinical staging is most advanced in mood, personality and psychotic disorders (the Youth Early Psychosis Program is explicitly designed using the clinical staging model).

The clinical staging model varies considerably from traditional mental health approaches, where treatment for young people was usually later in the course of an illness, and subsequently more intensive and also less effective (McGorry et al., 2006). The model has considerable workforce implications, related to who is involved in treatment and support, what treatments are selected, where treatments occur and for how long. For example, specialist training of clinicians in the early detection, care and treatment of psychotic disorders has been central to providing effective early intervention. This includes skill and knowledge areas not previously included in training curricula (e.g. hope, stigma, values, sexual health) (Stavely et al., 2013).

This strategy is also based on evidence that suggests the skills and competencies the youth mental health workforce will need to operate within the full spectrum of interventions (see Figure 1 below). This includes young people who are at risk of developing mental health problems (selective prevention), those exhibiting early symptoms of a mental disorder (indicated prevention), or experiencing the first episode of mental illness (early intervention) through to those with persistent illness and a need for more continuing care.

Figure 1. **Spectrum of interventions for young people**



Mrazek and Haggerty (1994)

Innovative approaches to youth-specific mental health support services have been developed (including telephone and online support and early intervention and referral). These demonstrate an understanding of the important role of technology, and young people themselves, in youth mental health care. For example, the ReachOut model of online information and support engages skilled young people to create content for its site, translating evidence-based approaches provided by mental health experts into language and imagery more accessible to young people (Burns et al 2007).

Broadening the concept of a youth mental health workforce

As described in Box 2, the youth mental health workforce is likely to be built up from graduate level or early career stage professionals from a range of disciplines and backgrounds and include people with lived experience of mental ill-health. These people will often be working in a context of new services, new treatment approaches, with large numbers of stakeholders.

Many existing roles (mostly in the community-managed sector) also have the potential to broaden and enhance the youth mental health workforce. Professionals working in these roles (such as teachers and welfare officers) are currently working with young people, using a person-centred approach to their care and support. Mission Australia and Black Dog Institute's Youth Mental Health Report 2014 (Ivancic et al., 2014) also identified that the concept of the youth mental health workforce now needs to encompass (among others):

- **Schools:** Provide early recognition and support for students struggling with mental health issues to assist them in remaining actively engaged and participating in schools.
- **Peers:** Build initiatives with young people in 'helper' and 'helpee' roles to enhance their self-esteem, self-efficacy and sense of control over their own lives, resulting in more positive health-related behaviours and greater capacity for care of self and others.
- **Families:** Develop and provide training to family members to increase their understanding of mental health issues and build their skills in dealing with mental health problems.

Box 2: **Who is the youth mental health workforce?**

As reported by the National Mental Health Commission (2014) the mental health workforce is broadening, moving from a clinical and medical-based workforce, including allied health, to one that encompasses the welfare and community sector and the growing peer workforce.

The youth mental health workforce spans a diverse range of professionals - in a variety of contexts - seeking to provide effective assistance to young people (aged 12-25) who are at risk of, or already experiencing, mental health problems. This workforce includes (but is not limited to):

- Teachers and other educational providers in TAFEs or Universities.
- Police, juvenile justice/correctional staff.
- Welfare staff and youth workers (e.g. out of home care, homelessness services).
- Health and mental health professionals in a wide range primary care and specialist mental health settings (including drug and alcohol services). They include occupational therapists, social workers, mental health nurses, psychologists, GPs and psychiatrists.
- Youth and family peer workforces.

Current policy levers to developing a youth mental health workforce

While mental health policies and frameworks for the broader population have evolved nationally and across most jurisdictions, the focus on youth mental health and the development of a system of care which responds specifically to the needs of young people is in the early stages of development. As such, youth-specific mental health workforce strategies are rare. Most mental health plans are generalist, referring to needs 'across the life span' (Mental Health Workforce Advisory Committee, 2011) or identify young people as a high risk population.

Meanwhile, the Australian Government has targeted significant investment into youth mental health care, notably the headspace initiative, through which over 110 headspace centres are expected to be in place by 2019, and six Early Psychosis Youth Services are funded until 2019. These services prioritise early intervention and aim to provide accessible, acceptable, appropriate and sustainable community-based care to young people. They have also been developed with young people and using evidence-based best practice (headspace 2014).

In response to the National Mental Health Commission Review of Services and Programmes, the Australian Government has announced significant reforms to the way mental health services are to be funded and delivered notably:

- From 1 July 2016 31 Primary Health Networks (PHNs) across Australia have responsibility for planning and commissioning Commonwealth funded community-based mental health care (including headspace centres and Early Psychosis Youth Services).
- A digital gateway to mental health care will be developed to provide an integrated web-based access point and single telephone line for first point of contact with the mental health system.
- There will be a focus on delivering an integrated and equitable approach to youth mental health care and, through the PHNs, trial models of care for young people with severe mental illness.
- Existing Commonwealth funded school-based mental health programs will be rolled up into an 'end-to-end mental health education programme' from early childhood to the end of secondary school (Commonwealth of Australia, 2015).

There has also been ongoing investment at the state and territory level in delivery of specialist tertiary mental health services for young people and mental health responses across a range of state/territory funded systems where high risk groups of young people interact, such as community and family services and juvenile justice. Mapping the new regional commissioning model of community-based mental health care to state/territory systems provides a new opportunity to strengthen and integrate the youth mental health workforce.

Principles

A number of principles underpin the development and implementation of this strategy. In themselves, they describe the key elements of an accessible, acceptable and effective system of youth mental health care.

Accessible: Young people have access to a skilled youth mental health workforce that can deliver high quality and safe care through multiple pathways.

Evidence-based: Youth mental health care is underpinned by evidence-based practice and research of interventions is supported to continually develop the evidence base.

Partnership: The youth mental health workforce is designed to work in partnership with young people and their families.

Early intervention: Young people are provided with early, effective and integrated care approach across a range of settings which focus on optimism and recovery.

Holistic and appropriate: Mental health care and services provided to young people are holistic and appropriate to their age and circumstance.

Responsive to diversity: Young people are a heterogeneous population. Diversity is recognised and socially and culturally approaches developed where required.

Flexible: There is no 'one-size-fits-all' approach to youth mental health care. Community-led and driven responses to local workforce needs are supported and recognised.

Evaluation and monitoring: All workforce development activities and strategies are evaluated, monitored and refined to ensure a process of continuous improvement.

Domain 1 – A capable and skilled youth mental health workforce

Domain 1 aims to build the capacity and skills of the youth mental health workforce including clinical and non-clinical youth mental health workers, peer youth and family support, and those working in the wider community settings (for example, teachers and police officers).

Goal: The youth mental health workforce can provide young people with emerging mental health problems with early detection, evidence-based responses that are appropriate to their needs, circumstances and age group.

Rationale

To provide an early and effective mental health care approach for young people a range of roles and skills are required across various settings. The workforce involved in delivering this approach can include: youth workers; family workers; Aboriginal health workers; drug and alcohol workers; vocational support workers; GPs; nurses; mental health nurses; clinical and other psychologists; mental health social workers; mental health occupational therapists; psychiatrists; community development workers; and educators and school/university/TAFE counsellors (Carbone et al., 2011; Ivancic et al., 2014).

There is general agreement about the need for a person-centred and integrated approach (example at Box 3) to youth mental health care across systems (health welfare, education, judicial) and across settings (home, school, community services, acute settings, rehabilitation and support). An integrated care approach is needed because the population group is heterogeneous with varying and clinically uncertain illness trajectories (McGorry et al., 2014). As the time-frame and settings for care of young people are expanding it is important that the youth mental health workforce is well-equipped with the skills and knowledge to ensure that young people receive the highest quality care throughout the stages of illness.

Box 3: **Integrated care**

Taking a young person-centred, rather than a purely illness focused approach has been adopted in other areas such as the treatment of alcohol and other drug use. For example, the *Victorian Government's Blueprint for Alcohol and Other Drug Treatment Services 2009-13* requires 'interventions that are evidence-based, client-centred, grounded in a therapeutic framework, provided as early as possible and delivered where a young person first presents for help. The goal of treatment is to assist young people to cease or reduce their substance use, reconnect them with their families and communities and ensure they are linked with other health, welfare, employment and training services to get their lives back on track' (Victorian Department of Health, 2009, p.10).

Core competencies for a youth mental health workforce

Although there are similarities in the core competencies of generalist mental health workers and youth mental health workers, there are additional and specific competencies for those working with young people who are at risk of, or are experiencing, mental ill-health. They include:

- The capacity to build strong relationships and develop partnerships with young people and their family members during treatment, assisting them in decision making to analyse risks, responsibilities and opportunities in their life (Jivanjee et al., 2012; Bateman et al., 2015).
- The capacity to incorporate hope, optimism and empathy when working with young people, an attitude that can promote positivity and motivation for recovery at different stages of mental illness (Stavely et al., 2013).
- Strategies to challenge the stigma of mental ill-health (Stavely et al., 2013; Jivanjee et al., 2012). This includes the workers' capacity to provide information about stages of illness and spectrum of care to the general public and to community service providers.
- Knowledge of the developmental changes which occur between late childhood to early adulthood, using this to tailor interventions to meet the specific needs of this age group (Jivanjee et al., 2012; Orygen Youth Health Research Centre, 2011).
- The capacity to supervise and mentor young people with lived experience who will be joining care teams as peer support workers (Orygen Youth Health Research Centre, 2012; Health Workforce Australia, 2014a).

Further to this, the youth mental health workforce also should be aware of the tailored services, resources and tools available and appropriate for specific groups of young people at increased risk include homeless young people, Aboriginal and Torres Strait Islander young people, and Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) young people (Orygen Youth Health Research Centre, 2011). In tapping into these supports youth mental health workers will have the opportunity to connect to and collaborate with other service providers across the system, ensuring that young people are assisted in all the domains of their life.

Enablers and barriers

Enablers for growing the capacity and skills of the existing and future youth mental health workforce include:

- The availability of national frameworks for recovery oriented mental health services and core capabilities in the mental health workforce.
- Consistent calls (in national, state/territory and sectoral strategies) for the expansion of the mental health workforce and the development of new roles.
- The conceptualisation and recognition of the peer workforce, identifying its needs and capabilities, which has resulted in the development of resources and support materials for this new workforce and those who work with them.
- Access to an existing pool of committed people who are working with young people in other important settings, such as education, welfare and justice.
- Growing awareness of the need for, and benefits of, person-centred, community-based service models for young people.
- Increasing evidence for new models of care across prevention, early intervention and clinically staged care for young people.
- The strong economic evidence of the individual and social benefits of functional recovery for young people who experience mental illness.
- The financial commitment from government to achieve change in youth mental health care.

Barriers to growing the capacity and skills of the existing and future youth mental health workforce include:

- The slow pace of reform of the health workforce, largely due to the persistence of traditional approaches reinforced by siloed professional groups and institutions.
- Young people experiencing mental ill-health continue to be stigmatised.
- Requiring knowledge of the different approaches for youth mental health could be perceived as increasing expectations and pressure on the generalist health workforce.
- There are inequities accessing professional development opportunities depending on profession and geographic location.
- Newer roles, peer roles and non-clinical roles in mental health care are often perceived as lower in status. This is compounded by ongoing pay inequality between sectors and roles.
- There is often inadequate acknowledgment where professional development has been completed and the structures and systems to apply new knowledge are not available.

"[T]eachers, apart from parents and family, are the main interaction that a kid has, especially through development as well. Within five years [of high school], parents might divorce, or there could be a death in the family, parents may leave and go abroad but you'll still have the same set of teachers and faculty at a school for that entire time. And that may become the backbench support for a kid. Especially given the impact and role that those people have in the lives of that young person. It should definitely be mandatory to at least have a basic understanding."

Young Person

The way forward

In order to grow the capacity and skill base of the existing workforce and strengthen the foundation for the future youth mental health workforce, the following strategies are suggested:

- Develop an overarching national set of youth mental practice standards that aligns with existing mental health practice standards, inclusive of the:
  - Mental health workforce
  - Peer workforce
  - Family workforce.
- Develop a statement of national youth mental health workers core capabilities.
- Promote and raise awareness of specific youth mental health capabilities and treatment approaches across a range of settings and services.
- Build, develop and maintain the youth peer workforce and the family peer workforce through the design and implementation of peer worker courses and qualifications, as well as, support, training and evaluation of the current peer workforce.
- Build capacity for interagency collaboration and service integration (see also Domain 4).
- Develop a research framework to support the development of the youth mental health workforce across the full intervention spectrum (see also Domain 3).
- Provide and promote clinical and service delivery leadership in youth mental health services.

"The capacity and skillset of generalist health and human service workers needs to be improved to enable these workers to identify and more effectively respond to mental health problems and suicide risk"

Stakeholder

Domain 2 – A sustainable and qualified professional youth mental health workforce

Domain 2 describes the current and continuing shortage of specialist workers within the youth mental health workforce, and aims to provide strategies to attract and retain the workforce.

Goal: Develop and grow a sustainable, professional and suitably qualified youth mental health workforce.

Rationale

The National Mental Health Commission (2014) concluded that while the mental health workforce is broadening to encompass the welfare and community sector and the growing peer workforce, there are continuing shortfalls in workforce numbers in the 'traditional' specialist mental health workforce, and these shortfalls are likely to increase by 2025.

The Community Services and Health Industry Skills Council's Mental Health Articulation Research Project (2009) also found that the community mental health sector 'is currently on a trajectory that provides limited prospects for raising and expanding its skills base' (p.4).

"We would like to see youth mental health in the curriculum of the standard professions ..."

Stakeholder

Attracting the workforce

Evidence of 'what works' in attracting people to careers in youth mental health is patchy. For the generalist mental health workforce, too, there is much documentation of strategies to attract workforce, but little evaluation of their success.

Attracting people to new youth mental health services in Australia has had mixed success, with recruitment of youth workers and allied health staff, especially psychologists, being relatively more successful than recruitment of GPs and psychiatrists (Carbone et al., 2011).

Psychiatry supply problems have long been evident. Most strategies to address psychiatry under supply have been developed within the profession. These have included fostering positive views of psychiatry through exposure to role models, innovative teaching methods, modification of first year curriculum and opportunities to expose students to the diversity and range of specialisation, e.g. through expanded settings for clinical placements (Siggins Miller, 2010).

The continuing under supply would suggest that most strategies and other government incentives have not had an appreciable impact on the supply or distribution of the psychiatry workforce, and that new strategies to attract psychiatrists to youth mental health work are warranted.

"The (mental health education and training structure) has evolved over time and is therefore laden with historic tensions and problems including unresolved differences in paradigms of care; sub-optimal care coordination; and disparities in reward and opportunities for development and progression for hospital-based and community-based workforces"

Community Services and Health Industry Skills Council 2009 p. 14.

Current qualifications and educational pathways

The field of mental health workforce education, training and development is complex, wide ranging and of variable quality and stability (Community Services and Health Industry Skills Council, 2009) and there is no unified national system of workforce education and training (ConNetica, 2009).

Much of the activity in developing training guidelines or requirements has been discipline or sector specific. For example, the Australian Association of Social Workers introduced a core undergraduate curriculum in mental health in 2010 and upgraded its practice standards for accreditation as a mental health social worker. Other disciplines (such as nursing, psychology, occupational therapy) have introduced new or updated qualifications to meet credentialing needs for the Better Access Initiative in 2006 (Siggins Miller, 2010).

An example of innovation in youth mental health accreditation has been the Graduate Certificate and Graduate Diploma in Youth Mental Health, now offered online through the Melbourne Medical School's Department of Psychiatry (University of Melbourne) in collaboration with Orygen. These courses are open to graduates in multiple disciplines (psychiatry, medicine, psychology, nursing, occupational therapy, social work and other related disciplines) working as health care professionals in the primary health care sector and to other professionals who provide assistance to young people in schools and community agencies.

Workforce retention

There is abundant literature about why people leave the mental health workforce. Commonly cited reasons for high staff turnover in the mental health sector include:

- Remuneration issues in the NGO sector and poorly defined roles in mental health (Health Workforce Australia, 2014a).
- Limited access to professional development, lack of career paths and professional recognition (ConNetica, 2009).
- Excessive workload (Workplace Research Centre, 2008).
- Burn out and high rates of absenteeism due to perceptions of system failure (Andrews and Titov, 2007).
- Inadequate knowledge and training in evidence-based interventions and consequent lack of confidence (Lubman et al., 2007).
- Lack of operational policies, team leadership and team support leading to unclear team roles and role conflict (Health Workforce Australia, 2014a).

"It's tricky when there is one person who's really dedicated in a school. It often is that case in high schools and primary schools that you have a social worker/ youth worker or one counsellor, and they stretch over 600 students."

Young person

Enablers and barriers

Enablers for developing and growing a sustainable, professional and suitably qualified youth mental health workforce include:

- That the need and demand for youth mental health services is now acknowledged.
- There are existing curricula, practice standards, guidelines and accreditation for mental health specialties that can be built on.
- There are current reviews and overhauls of course content and articulation arrangements (in the TAFE sector). New postgraduate programs in Youth Mental Health are available to multiple professions from different sectors and the certificate IV in Peer Mental Health has also been upgraded.
- Competency documents, frameworks and guidelines commonly highlight personal attributes and attitudes that can assist with recruitment targeting and selection.
- New models can provide opportunities that preserve the resources of the highly skilled staff for the more acute and complex cases, and for advisory and mentoring roles and there is good evidence on best practice inter-professional supervision.
- National assets (such as the Community Services and Health Industry Skills Council and new national data sets) and programs (like new Trade Cadetships) provide opportunities for better data collection and new pathways into youth mental health work.
- There is ample data on *why* people leave the mental health workforce that can inform plans and approaches to respond.

Barriers to developing and growing a professional and suitably qualified youth mental health workforce include:

- Absence of a unified national system of education and training in mental health to ensure consistency and equal access to training across Australia.
- Complex, historically based articulation pathways.
- Limited opportunities for supervised practice in community settings and in regional and rural areas.
- Reasons for job dissatisfaction are often industrial and beyond the scope of one part of the sector to address in isolation.
- Psychiatrists continue to be in short supply generally and the problem is unlikely to change in the near future. GPs and psychiatrists also appear to be particularly difficult to recruit to the youth mental health sector.
- Re-training in the use of new models of care and guidelines for implementation will be required.

"Increase Aboriginal Mental Health workers within Child & Adolescent Mental Health services by introducing additional traineeships and/or developing Aboriginal Mental Health specialist teams, with the allowance of culturally appropriate non-Aboriginal workers."

Stakeholder

The way forward

In order to develop and grow a sustainable, professional and suitably qualified youth mental health workforce, the following strategies are suggested:

- Government coordinating industrial changes that provide for accreditation pathways and appropriate role recognition and remuneration.
- Design and build training pathways and placements in youth mental health that include expanded settings across hospital, community, not-for-profit and private sector settings.
- Develop curriculum content and potential new sub-specialties in youth mental health into relevant tertiary education programs to ensure graduates' competency to practice within the youth mental health workforce.
- Ensuring that workplaces have undergone the cultural and structural change required for staff to effectively implement newly gained skills and knowledge. Without this, retention of the best qualified workforce will remain a problem.
- Promote and attract young people to youth mental health careers from the school years onwards.
- Identify and promote existing professional development courses of evidence-based practice in the prevention, early intervention, treatment and support of young people.
- Improve opportunities for workforce re-entry across the career lifespan.
- Provide quality supervision and mentoring across disciplines and settings.
- Build organisational practices that promote and support employee self-care.
- Encourage recognition and reward for accomplishments and successes in the provision of evidence-based interventions for young people.

Domain 3 – An innovative and adaptive youth mental health workforce

Domain 3 focuses on the need to encourage and support the development and implementation of innovative approaches in youth mental health practice, policies and processes. This includes building collaborative partnerships between researchers, evaluators and service deliverers to ensure effective and rapid knowledge transfer and translation.

Goal: A culture of innovation and continuous improvement is embedded across the youth mental health workforce

Rationale

Recent Australian policy and investment has resulted in the introduction of innovative youth mental services, approaches and research/practice partnerships. This has increased the size and broadened the scope, competencies and roles of the workforce, involving them in the implementation of specialised care models for young people.

Crucial to the implementation of these new approaches is the attitudes, engagement, training and ongoing support of the workforce. Much depends on the quality of leadership (at all levels within the health and education systems). It is important that these senior positions and decision makers support local youth mental health service providers and practitioners by:

- minimising uncertainty (both of funding and policy);
- allowing educated risk taking associated with innovation; and
- supporting them to manage changes (Health Workforce Australia, 2011).

It is also important that the evidence base formed through research and the evaluation of youth mental health treatments, services and systems is readily translated into real world applications and that the culture of the mental health workforce values new ideas and possibilities of collaboration and partnership. As Hickie (2011) wrote 'the tasks now are to share our efforts, test our ideas and support those who are willing to see the convergence of evidence in favour of a new and targeted agenda for reform.' (p 67)

Adopting innovative youth-friendly service delivery models

Implementing new and innovative models of care when working with young people could increase the accessibility of treatment and the quality of engagement.

Researching youth-specific mental health service implementation, Santucci et al (2015) conclude that this can be achieved by (a) designing interventions to fit the contexts of where are young person is accessing treatment, (b) structuring interventions that can be tailored to fit individual young person's characteristics, and (c) building programs for non-traditional intervention contexts. Their findings also point to the importance of including consumers of youth mental health services and their peers in the design and implementation of service innovation.

Using technology

The internet, including social media, now offers the opportunity for young people to engage with youth mental health workers, making it an ideal place for workers to identify high risk individuals and those in need of more intense mental health resources.

The rapid advancement of technology and the role of the internet in service delivery also suggests the need for new models of care and treatment techniques. The integration of digital and traditional mental health service delivery modes can increase mental health awareness in young people and make mental health services more approachable and accessible (Montague et al, 2015).

"I've engaged in eHeadspace ... as a client, and it was great. In that online capacity there's so much there to help young people between appointments – it helped me a lot."

Young person

Developing the capacity of the sector to use technology and social media will enable the workforce to provide such forms of care and keep informed about new and current evidence-based practices.

The potential success of technology in youth mental health care will be improved by including consumers of youth mental health services and their peers in the design and implementation.

Workplace cultures that support innovation

Health Workforce Australia (2014b) points to the importance of leadership in supporting and leading health workforce innovation and reform. In particular leadership is needed to achieve organisational stability and continuity in relationships; and to develop the trust required from staff and the community to carry out long-term plans and initiate change. Strategies suggested include involving local community leaders in leadership programs with health professionals; and supporting inter-professional learning and reflection.

Mendoza et al (2014) identified key traits of workplaces (within health-education collaborations) implementing innovative approaches in youth mental health. These included:

- senior leadership reinforcing support for collaborations through action and accountability;
- whole-of-organisation approaches that include a balance between universal and targeted approaches;
- initiatives that are jointly planned and integrated at all points of planning and delivery;
- a change strategy that provides sufficient guidance, builds capacity and sustains engagement; and
- programs that are well articulated, marketed and adequately resourced for sustainability over the medium to long-term.

Rapid translation of the evidence base into policy and practice

There is a growing body of literature focused on implementation of evidence-based mental health programs (Williamson et al., 2015). Research has tended to focus on what may be considered the second stage of implementation – getting clinicians to adopt a practice. However, little evidence is available on factors that influence decision makers' uptake of evidence-based practices, arguably the first stage of implementation (Wang et al., 2010; Williamson et al., 2015).

The capacity of the youth mental health workforce to collect, understand, use and disseminate evidence is crucial for its sustainability. To build this capacity, partnerships between government, academics and clinical researchers, and consumers and carers are required, with a focus on evaluating the effectiveness of innovative models of youth mental health care. Through these evaluations future government policy and investment can be better directed.

In particular, improving the capacity of the youth mental health workforce to work collaboratively in interdisciplinary teams at both the service delivery and research levels (see also Domain 4) will ensure evidence-based practices and guidelines can be developed and disseminated effectively and efficiently.

In addition, supporting the research and evaluation workforce will provide the foundation for continuous improvements in prevention, early intervention, treatment, continuing care and service system design.

"It's about supporting people to embed technology in their practice. There's a danger in keeping technology separate. It should be woven through workforce development. If you're doing a model on early intervention – there should be a space to talk about technology. If you're talking about youth participation, there should be a discussion about what is new in technology in that space. Embedding it into broader education and training activities."

Stakeholder

Enablers and barriers

Enablers for building capacity in the youth mental health workforce to develop and adopt innovation can include:

- A growing knowledge base in implementation science.
- Opportunities to create new curricula that include core skills in implementation science.
- Opportunities to build new data collection procedures across new services.
- Opportunities for researchers to collaborate with direct care staff at the front line and the provision of professional development to staff though training in latest detection and treatment approaches.
- Evidence of successful use of technology and social media in youth mental health promotion and care.
- Consistent national and jurisdictional strategies for leadership development to support change.

Barriers to building capacity in the youth mental health workforce to develop and adopt innovation can include:

- A short supply of implementation scientists.
- A lack of implementation data and outcomes data.
- Reports of inadequate ICT skills within the existing mental health workforce.
- Deeply rooted institutional and professional cultures.
- Some policies, such as the Medicare rebate conditions, which can hinder access and collaborative practice.

The way forward

In order to build capacity in the youth mental health workforce to develop and adopt innovation, the following strategies are suggested:

- Build an integrated clinical-research youth mental health workforce (for example, clinicians who engage in research and researchers who are exposed to clinical care).
- Promote, build awareness and facilitate adoption of technology in service delivery through training and professional development.
- Understand and capitalise on the role of technology in the dissemination of innovation and knowledge transfer.
- Promote and invest in collaborations between young people, researchers, community members, funders, policy makers and service providers.
- Provide opportunities for interdisciplinary supervision and mentoring to promote interdisciplinary mental health service delivery and rapid translation of evidence into practice.

Domain 4 – A connected, responsive and flexible youth mental health workforce

Domain 4 describes the need to create a flexible service system that can provide shared care for young people. It also describes the importance of working collaboratively and flexibly with young people in clinical and non-clinical settings and at all stages across the full spectrum of interventions (from prevention to continuing care).

Goal: The youth mental health workforce has the connectedness, responsiveness and flexibility to provide integrated, appropriately sequenced supports across the continuum of young people's life circumstances and illness stages.

Rationale

A responsive youth mental health workforce should apply a person-centred and strengths-based approach that underpins prevention, early intervention and recovery models. It should focus on: trusting and workable relationships; empowering young people to take a lead in their own care process; work collaboratively on mutually agreed goals, drawing on the personal resources of motivation and hope; and create sustainable change through learning and experiential growth (Hammond, 2010).

Recognition of the failings of a 'one-size-fits-all' approach requires a workforce that is flexible and open to identifying where community-based and culturally informed approaches are more appropriate. For example Nagel and Thompson (2006) have suggested that (individual) person-centred approaches may not be appropriate with Aboriginal and Torres Strait Islander people who strongly identify as part of a community, and therefore a community strengths-based approach is preferable.

The coordination of a range of community stakeholders underpins collaborative approaches to youth mental health care. For example, gatekeeper roles are common to many community-based suicide prevention programs. These community facilitators are well placed to provide general preventive and supportive services, such as recognising symptoms, providing support or crisis intervention, referring or facilitating access to adequate mental health treatment, and decreasing stigmatisation (Mann et al., 2005). Some authors argue that other non-geographical communities or social groups (e.g. LGBTIQ communities) offer an equally important

"It's a tricky one for young people as well. We're all talking about empathy and understanding from the services they connect with. Nobody wants to go to a psychologist that just doesn't understand what they're going through … and it is a tricky thing when you add the additional layer. I'm not just a young person who's going through a tough time. I'm a young person who's going through a tough time and I don't speak English very well, or I've seen a lot of things that most fifteen year olds haven't seen, because I have been through a war."

Young person

sense of belonging and should not be overlooked in strengths-based community program development (Boehm and Cnaan, 2012).

Collaborative care models

Successful early intervention requires an approach that is tailored to individual life stages and situations and the multiple environmental and social influences on mental health and wellbeing. It requires a comprehensive, multidisciplinary and collaborative care approach to be integrated across all sectors of care and all levels of society (McGorry, 2011).

Planning models often work on the assumption that health service delivery will occur in existing facilities by existing professional groups. There is a need to develop models that look beyond traditional professional demarcations and organisational structures, and allow planning across different health professions and settings as well as important service domains for a young person's health, safety and wellbeing. These include housing, employment, education and family services.

Investment by the Australian Government in the headspace model currently supports this broader collaborative approach among a range of clinical and non-clinical mental health staff in treatment and support, as well as a broader pool of talents in awareness raising, information collection and dissemination and prevention.

Flexibility in the youth mental health workforce

The multiple needs and diverse contexts that exist for young people experiencing mental ill-health means there is unlikely to be one single model that suits all Australian contexts and settings. Consequently the workforce needs will vary depending on the contexts. Flexibility in workforce planning and design is important for improving and better targeting workforce development efforts, and ultimately young people's access to services.

As Health Workforce Australia (2014a) argues, 'an increased supply of skills is insufficient for improving people's access to services, and that flexibility is the key. Any unnecessary restrictions on practice resulting from traditional role boundaries can be challenged to support people in working to their full capacity and increasing the systems' ability to respond to people's needs' (p.3).

"Having a flexible workforce that is based on competencies, rather than having siloed health professional categories and disciplines. This will enable people to build a strong suite of skills and abilities, have diverse careers, and work across a range of settings."

Stakeholder

For organisations to be responsive and flexible a number of approaches appear in the literature:

- Flexibility for part-time or interrupted training (Boyce, 2008).
- The introduction of more flexible working hours, the promotion of work-life balance policy and the provision of childcare services for staff. (Workplace Research Centre, 2008).
- Flexibility in rostering, for example building in time away from direct care for training, or to conduct research, or to move back and forth between roles requiring similar capacities and to avoid burn out (WRC, 2008; Hall and Lansbury, 2006).
- Flexibility in accommodating disability in the workplace and the provision of reasonable adjustments, for example in the case of peer workers (Health Workforce Australia, 2014a).
- Flexibility in planning local workforce needs and responding to communities and their context (Harris et al., 2013; Bushe, 2011).
- Appropriate, flexible, affordable, locally delivered programs to assist health professionals in rural and remote areas re-enter the workforce (Health Workforce Australia, 2014b).

Enablers and barriers

Enablers for establishing a responsive, collaborative and flexible youth mental health workforce include:

- Training and support for strengths-based approaches to treatment is available.
- Use of strengths-based community development to broaden the youth mental health workforce.
- Engaging in local level services and workforce planning.
- Flexible guidelines that allow for tailored models of care and workforce structures to meet local need.
- Removing unnecessary restrictions to scopes of practice.
- Enabling staff to work to their full capacity.
- Flexible organisational rules and processes.

Barriers to establishing a responsive, collaborative and flexible youth mental health workforce include:

- Top-down approaches to community-based service development.
- Resistance from established services.
- Traditional curricula and practices that hinder collaborative care approaches.
- Workforce planning that uses traditional models and context.
- Potential for services to retract in areas of care provision and/or for funding to be withdrawn from one area without sufficient funding for new approaches.

The way forward

In order to establish a responsive, collaborative and flexible youth mental health workforce, the following strategies are suggested:

- Promote understanding and opportunities for funding/remunerating the youth mental health workforce (public, private, not-for-profit sectors).
- Strengthen the partnerships and collaborations across paediatric and adult sectors to make it easier for young adults to transition between sectors and address the gap in this in-between period.
- Develop a training framework to assist employers and training providers to understand the evidence base for youth mental health work.
- Develop workers capable of working in partnership with young people across the continuum of care to support self-determination and self-care.
- Build strength-based approaches in community delivered services, particularly for specific population groups of young people.

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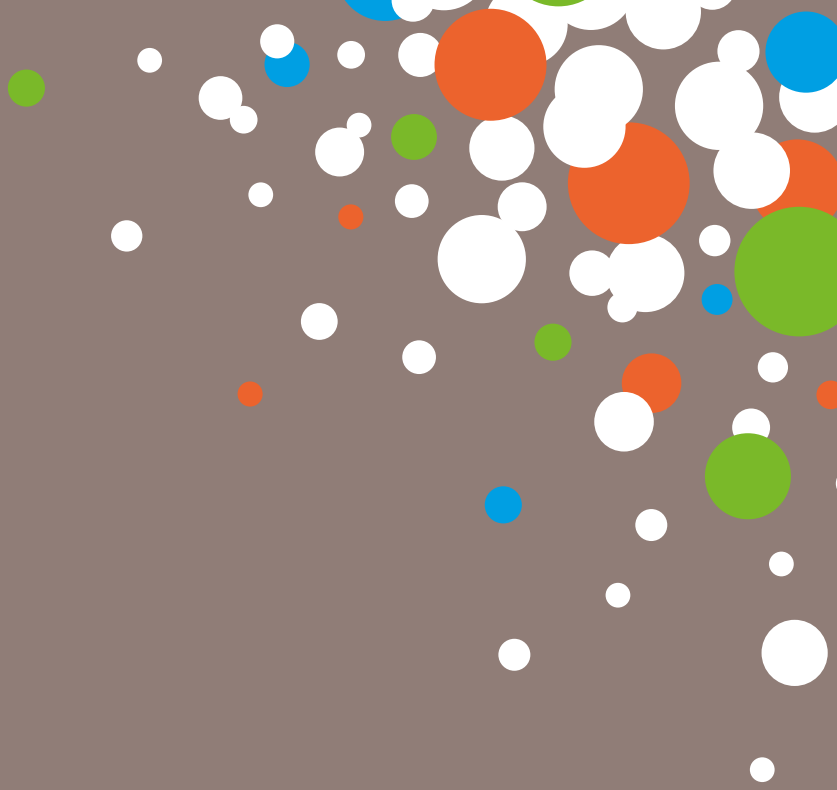

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