HealthWorkforce AUSTRALIA

National Mental Health Core Capabilities

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Contents

1 Introduction

Purpose

The National Mental Health Core Capabilities (NMHCC) have been developed to support both good practice and workforce innovation and reform in the mental health sector.

Capabilities

This document describes the shared capabilities and underpinning values required to deliver effective mental health services. The capabilities are explicit in stating the expectations of people who work in mental health, irrespective of their role, discipline or position in the organisational structure. They provide a shared language and common understandings for the provision of high quality services that accord with the needs and expectations of people using services, and their families and carers.

The capabilities are intended to complement the valuable, discipline-specific contributions of each workforce group. They do not replace other workforce frameworks, competencies, standards and requirements. Rather, the capabilities support them, by having a specific focus on the essential values, attitudes and behavioural skills required of all people working in mental health. The capabilities should be used in conjunction with other documents that deal with specific disciplines or groups, such as the National Practice Standards for the Mental Health Workforce (2013).

Implementing the capabilities supports a coordinated approach to professional development and service improvement. Individual members of different disciplines bring their own expertise and professional training to their roles. The capabilities can assist team development, and support a shared understanding of workforce expectations.

Benefits

The National Mental Health Core Capabilities support:

1) Practitioners and workers to:
    - Identify the behaviours required to work effectively with people experiencing mental illness and their families and carers
    - Inform their professional development
2) Teams in services to:
    - Develop a shared understanding of the values, attitudes and behaviours required in the workforce
    - Promote development of good mental health practice across disciplines
    - Identify recruitment gaps, training and development needs
    - Support clarification of roles
    - Provide a career development guide across the four levels

3) Education providers, training providers and services to:

   - Deliver capability based training
   - Collaborate on course development, supervision, placements and research
   - Encourage interprofessional education, training and practice

4) People using services, families and carers to:

   - Know what can be expected regarding levels of behavioural skills and attitudes of practitioners in the sector

5) Managers, planners and funders to:

   - Identify and plan future service delivery based on capability
   - Explore opportunities to optimise the available skills and capabilities of the existing workforce
   - Identify areas of activity where skills can be safely shared and workforce reform activity can be planned

6) Other sectors to:

   - Respond to the needs of people with mental illness, and their families and carers, through having a shared understanding of core areas of activity, behavioural skills and attitudes required to work effectively in the sector.

Application of the capabilities

The mental health workforce includes mental health nurses, psychiatrists, general registered nurses, enrolled nurses, general and other medical practitioners, psychiatry registrars, occupational therapists, psychologists, social workers, Aboriginal health workers, Aboriginal mental health workers, mental health workers, consumer peer workers and carer peer workers. The capabilities apply to these workers in a range of settings, including hospitals, health care and community mental health services and correctional facilities across metropolitan, regional and remote areas of Australia. The capabilities also apply to support or ancillary workers such as receptionists, working in mental health services and primary health care. The mental health workforce is engaged in public, private and non-government services.

Other groups may have a significant role in delivering services to people with a mental illness or mental health problems, particularly as part of interprofessional multidisciplinary teams. Disciplines identified in the Mental Health Workforce Planning Data Inventory include dietitians, pharmacists, and speech pathologists. Some members of these professions may specialise in mental health, or frequently work with people with mental illness, and these members may choose to use the capabilities. More broadly, these disciplines may also find this document useful in education, training, and quality improvement.

Guiding Principles

The principles underpin the development and use of the capabilities.

Principle 1: Person-centred

The NMHCC should provide a platform for understanding what skills and knowledge are collectively available in the workforce, and promote consideration of how to apply these attributes to deliver the services that best meet peoples' needs. This person-centred approach is responsive to individual differences, cultural diversity, and personal preferences, and is in contrast to the historical roles-based approach to workforce planning and design. Capabilities presented in the NMHCC will therefore relate to an analysis of opportunities for shared or delegated task performance in the provision of treatment, care and support to people using services.

Principle 2: Responsive to Families and Carers

The NMHCC should support responsiveness to families, carers and support people, who play a critical and often unacknowledged role in enabling people with mental health problems and mental illness to live and participate meaningfully in the community. Recognising and respecting the role of carers in prevention, early intervention, treatment and recovery can contribute to better practice and improved outcomes for people using services. The NMHCC should support working with families and carers as partners in care, recognising that people exist within a context of family, significant people, community and culture.

Principle 3: Recovery-focussed

The overarching principles of recovery-oriented mental health practice contained within the National Standards for Mental Health Services (2010) are a key foundation for the NMHCC. These are:

- uniqueness of the individual (which includes empowering the individual to be the centre of care)
- real choices (which includes achieving a balance between duty of care and support for an individual to take positive risks)
- attitudes and rights (which includes listening to, learning from and acting on communications from the individual and their carers)
- dignity and respect
- partnership and communication (which includes acknowledging each individual is an expert on their own life, and that recovery involves working in partnership with individuals and their carers)
- measuring progress towards recovery (which includes measuring outcomes on a range of indicators in addition to health and wellness, such as housing, employment and social relationships).

Principle 4: Evidence-based

The NMHCC should build on existing health workforce innovations that have been trialled and proven elsewhere. The framework also needs to draw upon best practice and research as a means of ensuring ongoing safety and quality in the delivery of services by the mental health workforce.

Principle 5: Flexible

The NMHCC should support flexibility in workforce planning and design. This requires an acknowledgment that our ability to meet growing and changing demands from people using services can only be achieved by being flexible in how we utilise the skills of the health and community sector workforce delivering mental health services. An increased supply of skills is insufficient for improving people's access to services. By articulating areas of shared capability, the NMHCC can challenge any unnecessary restrictions on practice resulting from traditional role boundaries, thereby supporting people in working to their full capacity and increasing the health and community service systems' ability to respond to people's needs.

Principle 6: Inclusive

The NMHCC should account for all mental health workforce roles, from degree-qualified professionals to VET

qualified roles, including those with no formal qualification. In this context, the mental health workforce is defined as those whose primary role involves early intervention, referral, treatment, care or support to people with a mental illness, in a mental health service or other health service environment, including non-government community mental health services. Given the breadth of roles covered, the NMHCC will include a range of capability levels, from beginning to advanced practice.

The NMHCC should also be inclusive of both values and behaviours. The National Practice Standards for the Mental Health Workforce articulate five values on which all workers are expected to base their practice. Given the importance of values to occupational success, the NMHCC will need to build behaviours relating to the values into the framework.

Principle 7: Useful

The NMHCC should be adaptable, easily understood, and readily applied. To achieve this, the NMHCC must be relevant to a range of contexts and sectors. Agreed language is required to enhance communication on capability, and it must be possible to broaden or refine the framework so that capabilities continue to reflect the changing needs and demands of people using services. The NMHCC must demonstrate value in a range of applications, including workforce planning and development, role creation and design, inter professional education and training, and personal career transition and progression.

Principle 8: Forward-thinking

The NMHCC should recognise the value, commitment and skills of the existing mental health workforce, while supporting it to evolve and expand. It must consider future capabilities required of the mental health workforce, not just those that currently exist. Areas for consideration include growing or emerging fields, such as cultural competence and eHealth.

The NMHCC should also account for future possibilities of shared or delegated practice, and the capabilities that would enable this to occur.

2 Policy context

Recovery

Recovery-oriented service delivery is centred on and adapts to the aspirations and needs of people using services, and requires shared vision and commitment at all levels of an organisation. People using mental health services are supported to take responsibility for their own recovery and wellbeing, and to define their goals, wishes and aspirations.

Recovery-oriented approaches offer a conceptual framework for practice, culture and service delivery in mental health service provision. The National Framework for Recovery-oriented Mental Health Services (NFROMHS) clarifies expectations with regard to recovery-oriented practice. The capabilities are designed to align with the NFROMHS, as well as other discipline specific standards and frameworks.

This document shares the definition of recovery from the NFROMHS, whereby recovery is defined as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues'.

Recovery, self-determination and safety

Self-determination is a vital part of successful recovery, care and treatment. The principles of recovery emphasise choice and self-determination within medico-legal requirements and duty of care. Striking a balance requires an understanding of the complex and sometimes discriminatory nature of the goal of reducing all harmful risks.[1] Services and practitioners must manage a range of tensions including:

- maximising choice
- supporting positive risk-taking
- the dignity of risk
- medico-legal requirements
- duty of care
- promoting safety.

[1] Slade, M (2009) pp176-179.

Maximising people's self-determination requires continued efforts to reduce coercion, seclusion and restraint. However, involuntary assessment and treatment will continue to be necessary when there is no less restrictive way to protect a person's health and safety.

All Commonwealth and state legislation and standards governing mental health service provision emphasise the importance of working collaboratively with a person and their family irrespective of whether they are receiving treatment voluntarily or involuntarily, or whether that treatment is in a hospital or in the community. The concepts of self-determination, personal responsibility and self-management and the goals of reclaiming control and choice are pivotal regardless of a person's legal status. For people who are treated under mental health legislation— that is, involuntarily — recovery-oriented care will have different characteristics at different phases of their treatment.

Integration with related documents and frameworks

The National Mental Health Core Capabilities should be used in conjunction with other documents relevant to mental health practice. The National Practice Standards for the Mental Health Workforce (2013) (the practice standards) are one key document, that describes the skills, knowledge and attitudes expected of specific groups of staff working in mental health. The National Standards for Mental Health Services 2010 (service standards) apply to the setting in which mental health care is provided.

The practice standards, service standards and capabilities should work together to support the ongoing development and implementation of good practice, and to guide continuous quality improvement in mental health services. The service standards should ensure that systems and processes are in place at an organisational level to provide optimum support for people using the service and their families. Level four of the capabilities is particularly relevant to organizational systems. The practice standards should ensure mental health practitioners' work practices demonstrate person-centred approaches and reflect nationally agreed protocols and requirements. They provide a greater level of detail on the expectations of practitioners new to mental health in five specific disciplines.

The capabilities provide a common language for people from a range of backgrounds or disciplines, who together form the mental health team. They clearly articulate behaviours expected from all members of the team. The capabilities should also assist in workforce innovation and reform, by promoting consideration of the necessary behaviours required to deliver mental health services well, across work roles and professional boundaries.

In considering how the capabilities relate to other frameworks in use in a particular service, a mapping exercise may be helpful. This would involve comparing the capabilities against the organisational, curriculum or national standard as appropriate, to identify areas of alignment and distinction. It is not possible to map every current relevant mental health framework and present the results in this document. However, the practice standards, service standards, and National Framework for Recovery-oriented Mental Health Services have been specifically considered in developing the capabilities.

Elements drawn in part or full from the national practice standards have been annotated with (NPS) to make the overlap and fit of the two documents clear. A significant amount of material has been brought across from the National Common Health Capability Resource. This has not been separately identified.

The Australian Commission on Safety and Quality in Health Care has been working with the Safety and Quality Partnership Standing Committee to show how the National Standards for Mental Health Services

relate to the National Safety and Quality Health Service Standards and the national accreditation scheme[2]. Implementation of the capabilities can contribute to the ongoing process of quality improvement, and provide evidence that may be used by services in accreditation processes.

Aboriginal and Torres Strait Islander People, Families and Communities

Aboriginal and Torres Strait Islander peoples experience a burden of disease two and half times that of non-Indigenous Australians. Mortality rates for mental and behavioural disorders for Indigenous males and females were 5.5 and 2.2 times the rates of non-Indigenous males and females respectively for the period 1999-2003[3]. Adapting the health system to respond to the disadvantages experienced by the Aboriginal and Torres Strait Islander population is a national priority.

The ability to interact effectively with people of different cultures, and to provide them with culturally safe and responsive health services, is referred to at a general level throughout this document. These capabilities are relevant for providing a service to people from Aboriginal, Torres Strait Islander and culturally and linguistically diverse (CALD) cultures.

The availability of mental health services that are equipped to provide services to Aboriginal and Torres Strait Islander peoples, and attuned to their needs, is a key factor that will contribute to improving their health outcomes.

However, the historical and cultural experiences of Aboriginal and Torres Strait Islander peoples are unique. The Australian mental health workforce requires particular knowledge, skills, and values in order to practice optimally with Aboriginal and Torres Strait Islanders. This is critical to ensuring that the care being provided is appropriate and responsive to the specific needs of Aboriginal and Torres Strait Islander people, their families, and communities.

For information on the knowledge, skills and values specific to working with Aboriginal and Torres Strait Islander peoples, users should access the cultural competency tools/strategies of their organisation, and refer to the *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health*, which provides guidance on mechanisms to strengthen relationships between the health care system and Aboriginal and Torres Strait Islander peoples.

Traditionally, Aboriginal and Torres Strait Islander peoples perceive their health in regard to the social, emotional and cultural wellbeing of the whole community rather than in terms of the physical health of the individual. Mental health practitioners should also refer to the social and emotional wellbeing framework: a national strategic framework for Aboriginal and Torres Strait Islander mental health and social emotional well being 2004-2009 and the National Aboriginal and Torres Strait Islander suicide prevention strategy (2013).

Culturally and Linguistically Diverse Communities

Australia is a diverse society, comprising people from a wide variety of cultural and linguistic backgrounds. People from CALD backgrounds use mental health services at significantly lower rates than

[2] Australian Commission on Safety and Quality in Health Care, Accreditation Workbook for Mental Health Services Consultation Draft, Commonwealth of Australia (2012)

[3] www.aihw.gov.au/mental-health-indigenous/ accessed 12 June 2013

people born in Australia. There is limited research available on prevalence estimates and limited need-for-mental-health-service data for people from CALD backgrounds. However, people from CALD backgrounds are regarded as having a significantly lower level of access to mental health care and support in the wider community.

In June 2011, 25% of Australia's population of 22.3 million were born overseas, and an additional 20% had at least one overseas-born parent[4]. To ensure quality mental health service provision to all Australians, service systems and practitioners need to be culturally responsive. Every person has the right to quality mental health services, regardless of their cultural, ethnic, linguistic and religious background or beliefs. In order for all people to have their health care needs equally well met, attention must be given to factors that support this, for example, access to accredited interpreters, and culturally inclusive care.

Factors that contribute to increased risk of mental health problems in CALD populations include low proficiency in English; separate cultural identity, loss of close family bonds; stresses of migration and adjustment to the new country; trauma exposure before migration; and limited opportunity to appropriately use occupational skills[5]. Factors that appear to promote mental health include religion, strong social support, and better English proficiency.

As noted above, people from CALD populations have lower rates of mental health service utilization than the Australian-born. Key barriers to access to mental health services include greater stigma attached to mental illness and limited knowledge of mental health and services. Cultural responsiveness refers to health care services that are respectful of and relevant to the health beliefs, health practices, culture and linguistic needs of diverse populations and communities.

Language

Words and language are important in shaping ideas and framing concepts. This document draws on recovery approaches, and generally uses language descriptors such as person and people with lived experience, rather than terms such as consumers or service users. For similar reasons, the terms family and carers include family members, carers, partners, significant others, friends and anyone whose primary relationship with the person concerned is a personal, supporting and caring one. This approach draws on that of the National Recovery-Oriented Mental Health Practice Framework. Many people find significant personal meaning in the terms consumers and carers. Their preference for the use of these terms is respected.

It is also acknowledged that some language used by people working in the mental health and drug and alcohol sectors is different, as is the language used across different practice settings. This document includes a glossary to assist in shared understanding of particular terms. Some terms will not be the preferred language of all service providers. These capabilities do not attempt to, nor recommend, change to the language used within individual services and practice. However, shared language may be useful when communicating between services and can be a valuable resource when providing services to a person with mental illness and a coexisting issue such as drug and alcohol use or intellectual disability.

[4] Australian Bureau of Statistics, Census of population and housing: 2011, 2012. www.abs.gov.au/census.

[5] Mental Health in Multicultural Australia, Mental health research and evaluation in multicultural Australia: Developing a culture of inclusion, 2013, www.mentalhealthcommission.gov.au

3 Overview of the Capabilities

Description

The capabilities identify areas of activity shared by the mental health workforce in the delivery of treatment, care, and support, and articulate the underpinning behavioural skills that characterise this work being performed well. They provide a benchmark that individuals, teams, organisations, and the health system as a whole can strive towards when seeking to make changes that improve their ability to respond to the needs and expectations of people using services, and their families and carers.

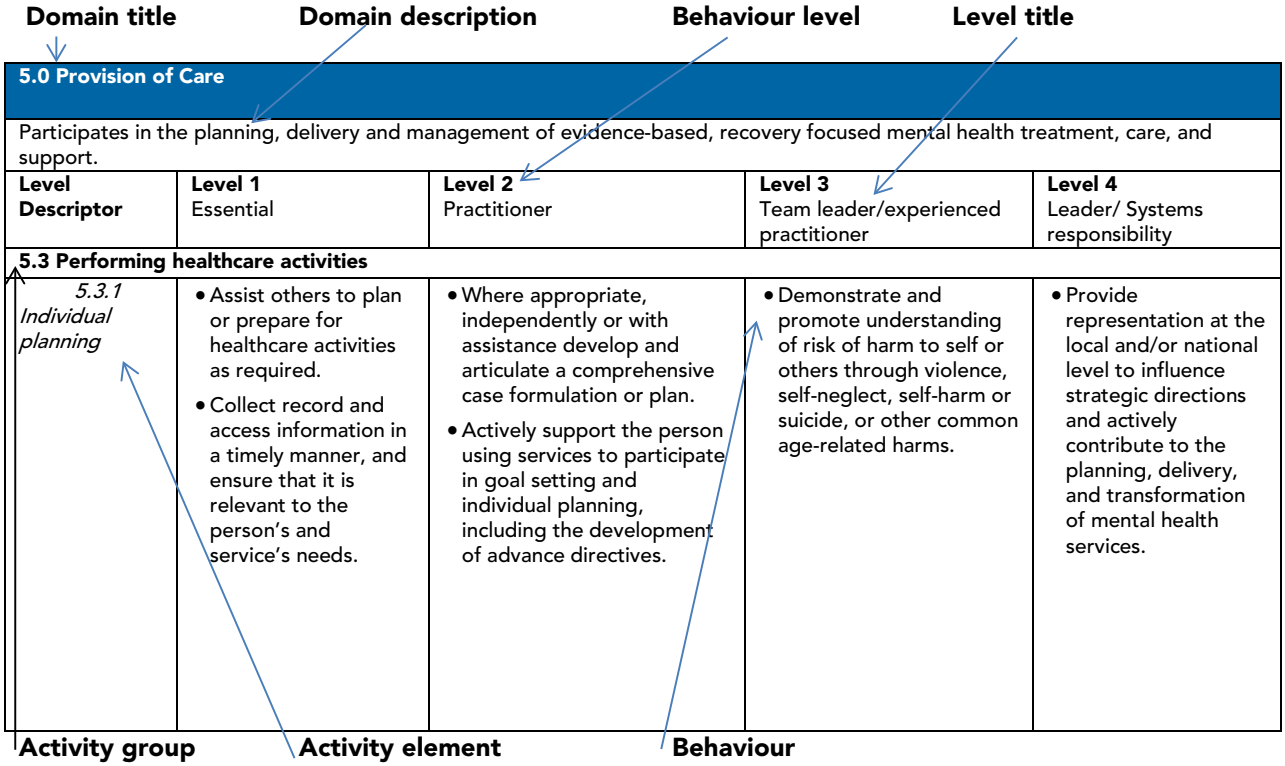

Figure 2. Illustration of structure of the capabilities

Levels do not equate to roles within the workforce. Instead, the levels reflect what standard of behavioural skill is required in order to achieve the desired care goals or outcomes in a given situation or environment. Consequently, mental health workforce roles should be seen as comprising a range of behavioural skills at various different levels, as determined by the practice context.

Essential or level 1 behaviours are required of all workers involved in mental health care. Thus many of the level 1 capabilities would also be expected of staff providing support services, such as reception, catering and cleaning staff. All staff will be expected to demonstrate these behaviours either when they first start in a mental health role, or after an agreed period of orientation and development (e.g. receptionist). Flexibility and discretion should be used when applying some of the capabilities to people in roles with no direct contact or influence on the lives of people using services. All other levels build upon this foundation.

Practitioner or level 2 behaviours are required of mental health practitioners who work in direct service provision with people using the service, families and carers.

Team leader/experienced practitioner or level 3 behaviours are required of mental health practitioners with managerial, team leader or advanced responsibilities. Level 2 behaviours are also required of this group.

Leader/Systems responsibility or level 4 behaviours concern organisations or systems, and are required of those with organisational or system responsibility for a mental health service or services.

Levels 1, 2 and 3 are cumulative. However, it is recognised that some activities may not be relevant for all leaders at level 4. Some leaders will not have a background in mental health, and hence some elements of levels 2 and 3 will not apply to them.

Workers in the same role, for example two nurses or two social workers may be at a different level depending on their experience and other organisational factors.

Given the NMHCC's inclusion of future behavioural requirements, Level 1 may serve as an aspirational standard in some instances, rather than accurately reflecting behaviours of current practice. Workplaces, educators and trainers, and the health workforce may find gaps between current and future practice behavioural skill requirements. Where such gaps exist, workplaces, educators and trainers, and members of the health workforce should aim to meet the capabilities in order to enhance their ability to better deliver individual and community healthcare needs. All mental health services need to recruit workers with the skills and experience to provide safe and good quality mental health care, support or treatment. Having recruited such people, services need to ensure that practitioners continue to grow and develop their expertise.

A capable workforce supports effective service delivery and assists in meeting national quality standards. The capabilities can assist services to develop structured approaches to reviewing the skills of mental health practitioners, and planning for skill development. They offer a common language and way of conceptualising workforce innovation and reform, and tools and templates will be developed to guide and support organisations in their use.

Structure

The capabilities have six sections, which represent the overarching domains of activity common to the Australian mental health workforce (see figure 1).

Figure 1. The six domains

Similar or related activities are grouped together to form a domain. The capabilities specify observable or measurable actions expected of the workforce within each domain. These behaviours are specified at four different levels—essential, practitioner, team leader/senior practitioner, and leader/systems responsibility. The levels reflect an increasing degree of autonomy, complexity, and strategic awareness for the activity being performed.

Potential areas for use include:

Area	Example
Recruitment	Selecting staff on the basis of values, capability and behaviour, along with technical skills
Induction and orientation	Using the capabilities to help new staff understand what is expected of them
Team building	Choosing an area of focus from the capabilities and taking an interprofessional approach
Training needs analysis	Identifying strengths and gaps at a team or organisational level
Interprofessional practice	Delivering interprofessional education, training and practice
Workforce redesign	Identifying behaviours that underpin performance of technical knowledge and skills to be delegated or shared as a result of redesign Assessing current behavioural capability of the workforce, to identify and prioritise areas for development.

The NMHCC should be used in conjunction with other information sources to ensure completeness in workforce development.

Professional competency/capability frameworks and practice standards provide meaningful context for the behaviours specified in the capabilities, and are the primary reference for technical and discipline-specific knowledge and skills, which are not captured here.

The capabilities should be used in conjunction with the service standards, practice standards, and the discipline-specific standards, competencies or curricula that apply to the individual practitioner's profession.

The discipline-specific documents that may apply include, but are not limited, to those listed in Appendix G.

4 Service context

Capability must be considered within a service or system context. The overall intention is to contribute to good practice and continuous quality improvement in mental health services, but the nature of the service and the workforce must be considered in using the capabilities. When capabilities are considered, it is recommended that the following factors are taken into account:

- Broader service context
- Level of experience in the workforce and mental health
- Development principles for people using services
- Developmental contexts

Broader service context

People with mental illness and their carers and families receive services in a wide range of settings. Services are delivered in the public, private and non government sectors to people ranging in age from infants to older people. Services are delivered in a wide range of rural, regional and metropolitan locations. Delivery of mental health services to people of different age groups and cultures in rural and remote areas poses particular challenges, including service access across distances; workforce shortages; and higher levels of socio-economic disadvantage.

Level of experience in the workforce and mental health

The capabilities can be applied in a wide range of settings and to workers with a varying level of experience, training and skills. They can be used to identify an individual's present capabilities, and to identify areas for professional development.

The capabilities can also be used to identify areas for further development of capability at an individual and a team or service level.

Development principles

Human development should be viewed within a broad context of community, culture and spirituality. Particular challenges may occur with disruption to the processes of normal development, losses or displacement from key relationships and places of meaning (for example, children in out of home care; cultural losses; and trauma).

It is important to understand critical development periods, but also to view them flexibly, as there is a broad range of 'normal'. Practitioners should also have regard for concepts of plasticity and resiliency, that is, the capacity for change in response to the environment.

Developmental contexts

The National Mental Health Core Capabilities are for all people working in mental health services across the lifespan of people in the community, inpatient and specialty settings.

Developmental contexts can be used to assist in identifying the distinct stages of people's lives. The contexts used in this document are drawn from the draft NSW Mental Health Services Competency Framework, and have been constructed with regard to three key relationship domains of self, other and world. When working with people and their families or carers, mastery should be considered within the following relationship domains:

1) The person in relationship to **self**- observed in self-care and self-regulation- responses to limit-setting, participation in routines, managing emotions and behaviour.

2) The person in relationship to **others**- observed in relationships, including attachment style in relation to parent/carer, siblings/other family members; significant others and peers.

3) The person in relationship to the **world**- observed in industry, play, recreation and work, including their capacity for imagination, flexibility and creativity.

Developmental contexts for the age groups outlined below are provided in appendix D. Different jurisdictions organize their services in different ways for children and young people, and for older people. They may not use age groupings that are identical to the ones in this document.

- Infant (0-4 years)
- Child (5-11 years)
- Adolescent (12-17 years inclusive)
- Young adulthood (18-25 years inclusive)
- Adult (26-40 years inclusive)
- Middle years (41-64 years inclusive)
- Older people (65-84 years inclusive)
- Very old people (85 years plus)

5 The Capabilities

Summary

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- 1.4 Working in partnership
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- 4.2 Interprofessional collaboration
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  - 4.2.2 Collaboration within and across teams
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  - 4.3.2 Integrated care

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- 5.1 Access & engagement
- 5.2 Assessment
- 5.3 Performing health care activities
  - 5.3.1 Individual planning
  - 5.3.2 Deliver care
  - 5.3.3 Monitor, evaluate and revise plans
- 5.4 Supporting processes and standards
  - 5.4.1 Evidence-based practice
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  - 5.4.3 Dignity of risk

6.0 Life-long learning
- 6.1 Holistic learning and development
- 6.2 Self-reflection
- 6.3 Professional support relationships
- 6.4 Feedback and peer assessment

Domain 1 – Values

1.0 Values				
Reflect on and use values and beliefs in a positive way at work.				
Level Descriptor	**Essential-**required of all workforce members – level 1	**Practitioner**- required of mental health practitioners who work in direct service provision – level 2	**Experienced practitioner/team leader** – required of mental health practitioners with managerial, team leader or advanced responsibilities. (Level 2 is also required). – level 3	**Leader/ Systems responsibility** –required of those with organisational or system responsibilities – level 4
1.1 Respect				
	• Treat people using services, families & carers, and colleagues with courtesy and kindness. • Act to uphold people's privacy, dignity and confidentiality. • Respond to people from particularly vulnerable groups, such as those with co-existing alcohol and drug use, in a non-judgemental, compassionate manner. • Report disrespectful and discriminatory behaviour in the workplace.	• Recognise the power differential between the person using services and the practitioner, and support the person to make decisions about their health care.	• Role model working in partnership, respect for human rights, and upholding dignity and privacy. • Exhibit a high level of emotional intelligence, self-control and flexibility in complex, changing, or ambiguous situations and when confronted with obstacles. • Work positively with any tensions created by conflicts that may arise between partners in service delivery.	• Create a culture of mutual respect which encourages staff to understand individual and group differences and embrace diversity. • Implement mechanisms to respond to identified disrespectful and discriminatory behaviour in the workplace.

1.0 Values				
Reflect on and use values and beliefs in a positive way at work.				
1.2 Advocacy				
	• Act to uphold the legal and human rights of people using the service, and families and carers. • Actively challenge stigma, discrimination and inequality encountered in role.	• Recognise and maintain the rights of people experiencing mental illness to privacy, dignity, safety, effective treatment and care. • Support people to exercise their rights and make decisions about their mental health, well-being and lives. • Facilitate and create pathways for people, their families and carers to contact peer advocates and consultants (NPS).	• Engage with external advocacy bodies to ensure that the rights and interests of people using the service are protected. Actively promote, develop and participate in local interagency networks. • Actively promote the value of lived experience in designing and delivering person-centred care.	• Act to ensure the organisation supports people to access appropriate services. • Systematically establish relationships with community organisations and networks to build the capacity of organisations to work with people accessing mental health services. • Systematically establish relationships with consumer leaders and their networks to build the capacity to work toward recovery and learn from lived experience.

1.0 Values				
Reflect on and use values and beliefs in a positive way at work.				
1.3 Recovery				
Work to enable recovery, valuing people's own frameworks of understanding and search for meaning. Support people and their carers and families to tackle mental health problems with hope and optimism, to achieve a meaningful life and a positive sense of belonging in the community.	• Express hope and optimism, valuing the person and their families/carer's knowledge and perspectives (NPS). • Make every effort to ensure people's safety, comfort and well-being at all times. • Support people's self-determination (NPS).	• Act to ensure recovery, care, or treatment planning involves routine conversations about people's aspirations and hopes. • Work from a strengths based perspective. • Establish meaningful engagement and relationships with people, their families and carers. • Support participation in meaningful roles, activities and full citizenship. • Support people to make informed decisions about their mental health care by providing information, resources and other assistance.	• Model recovery-oriented behaviours and language. • Model the use of strengths-based practice and encourage and support others to do so. • Support staff to work effectively with people and their families and carers regarding positive risk taking as an important part of promoting people's choice and self-determination. • Work towards creating environments that facilitate recovery.	• Support and promote a culture of hope and optimism that actively enables people's recovery efforts. • • Act to ensure policies including risk and recovery have been developed with input from people with lived experience, and reflect recovery-oriented practice. • Make it easy to provide feedback and make complaints. • Act to ensure that feedback is considered in the continuous improvement cycle.
1.4 Working in partnership				
Working collaboratively with people, families and carers	• Establish trust with the person using services by demonstrating understanding, respect and acceptance. • Work with people and their families and carers as partners (NPS). • Listen actively to achieve an understanding of the person's point of view. • Be readily available to answer questions and concerns from people using the service, and	• Encourage and facilitate family and carer involvement, addressing barriers and supporting connections with the person (NPS). • Engage in family-focussed practice reflecting that the person is not viewed in isolation, but is situated within a context of family, significant people, community and culture (NPS). • Demonstrate respect for	• Support staff to prioritise the time and space necessary for effective collaboration with people and their families and carers. • Establish and sustain effective, collaborative working particularly with people who have had past adverse experiences with services or may wish not to engage with mental health services. • Support active shared	• Lead and promote activity that includes the person using services as part of the care team. • Act to encourage and support service user and carer input into strategic planning and monitoring processes, and development of policies and procedures. • Embed a lived experience (person and family) focus into policy, planning and practice. • Promote active shared

1.0 Values				
Reflect on and use values and beliefs in a positive way at work.				
	families and carers.	family members' and carers' roles, by acknowledging diverse family capacities, experiences, value systems and beliefs (NPS).	decision making.	decision-making processes and documentation of same. • Act to ensure that people using services, families and carers are involved in training, education and evaluation.
1.5 Excellence				
	• Complete work to the best possible standard that circumstances permit. • Contribute constructively to organisational or system change processes. • Look for ways to make improvements within own area of work	• Seek the views of people who use the service, their families and carers regarding own practice and service delivery. • Demonstrate a focus on positive results/outcomes.	• In consultation with people using services, families and carers, generate healthcare strategies/innovations that improve delivery of mental healthcare. • Capitalise on opportunities presented by technology to improve services. • Encourage positive response to, and safe exploration of, new ideas within teams or the workplace. • Provide constructive feedback to staff and show appreciation for their efforts.	• Lead by example, and motivate staff to strive for excellence by providing recognition, rewards and incentives. • Maintain focus and energy of staff by remaining confident, optimistic, and determined, even under adversity and during times of uncertainty or change. • Investigate the use of new service delivery models, and champion their adoption to address contemporary healthcare problems, where appropriate.

Text annotated with (NPS) is taken wholly or to a significant extent from the National Practice Standards for the Mental Health Workforce (2013)

Domain 2 –Whole person focus

2.0 Whole person focus				
Demonstrates an understanding and appreciation of cultural differences and diversity, recognises the complexity of social determinants of mental health & wellbeing, and engages in processes and activities that promote safe, quality, effective services for all.				
Level Descriptor	**Essential-**required of all workforce members – level 1	**Practitioner**- required of mental health practitioners who work in direct service provision – level 2	**Experienced practitioner/team leader** – required of mental health practitioners with managerial, team leader or advanced responsibilities. (Level 2 is also required). – level 3	**Leader/ Systems responsibility** –required of those with organisational or system responsibilities – level 4
2.1 Diversity				
Every person has the right to quality mental health services, regardless of their culture, gender, class, religion, spirituality, disability, power status, gender identity, sexuality, sexual identity or age. *One quarter of Australian's population was born overseas, and an additional 20% have at least one overseas-born parent (Mental Health in Multicultural Australia 2013).*	• Respond positively to individual and cultural differences by showing tolerance and acceptance. • Demonstrate respect for the diversity of people, families, carers and communities, in areas including age, gender, class, culture, religion, spirituality, disability, power, status, gender identity, sexuality, sexual identity and socio-economic background (NPS). • Use culturally sensitive language and preferred terminology (NPS). • Communicate in a culturally sensitive and respectful way (NPS).	• Be aware of, and responsive to, a wide range of people, and take conscious action to avoid prejudice, stereotyping, or exclusion of others. • Demonstrate culturally safe and sensitive practice by considering the values, beliefs and practices of the person and their family or carers, and adapting services as needed. • Act to incorporate cultural issues into care planning. • Link people, with their agreement, to support groups relevant to their recovery goals, matched wherever possible on characteristics including age, gender, and cultural origin.	• Foster a team culture that recognises and values diversity, and uses knowledge of differences to develop best practice care. • Support initiatives that build the cultural capability of staff. • Plan, implement and evaluate strategies for providing safe services to: – people across the lifespan. – people of different cultures and religions – people with physical, sensory or intellectual disabilities. – people of different genders and sexual identities. • Monitor appropriateness of service to cultural, age, disability and other groups in the community, and implement strategies to address gaps. • Actively support needs	• Actively create an environment that values and utilises the contributions of people with different backgrounds, experiences and perspectives. • Embed a cultural capability focus into policy, planning and practice. • Actively create structures that incorporate and value contributions of people with diverse backgrounds, experiences and communities. • Establish a workplace diversity program to make best use of diversity in the workplace and to address any disadvantage experienced by people and/or groups. • Ensure local policies and procedures incorporate principles of responsiveness to diversity including

2.0 Whole person focus				
Demonstrates an understanding and appreciation of cultural differences and diversity, recognises the complexity of social determinants of mental health & wellbeing, and engages in processes and activities that promote safe, quality, effective services for all.				
			stemming from cultural differences, such as diet and spirituality, in service planning and processes.	people's culture and community background, disability, gender, and sexual identity.
2.2 Working with Aboriginal and Torres Strait Islander people, families, carers and communities				
	• Demonstrate awareness of Aboriginal and Torres Strait Islander history (NPS), current health challenges and outcomes relevant to service and role.	• Seek to understand and work within local cultural protocols and kinship structures of Aboriginal and Torres Strait Islander Communities (NPS). • Apply concepts of cultural safety and cultural competence in working with Aboriginal and Torres Strait Islander people (NPS).	• Support culturally specific practices as described in relevant national, state and local guidelines, policies and frameworks with regard to working with Aboriginal and Torres Strait Islander peoples. • Act to ensure team awareness and respect for the needs and aspirations of the Aboriginal and Torres Strait population within the service. • Develop cultural knowledge and skills to enable communication and relationship development with relevant Aboriginal and Torres Strait Islander services and communities.	• Actively support strategies to recruit and develop the Aboriginal and Torres Strait Islander mental health workforce. • Actively seek input from the Aboriginal and Torres Strait Islander community in the design and delivery of appropriate services. • Ensure service processes and practices meet cultural requirements, such as recognition of Aboriginal and Torres Strait Islander modes of social and emotional wellbeing. • Ensure strategies are in place to support people to access Aboriginal and Torres Strait Islander responsive services or programs.
2.3 Prevention of illness and promotion of wellbeing				
People with mental illness often experience poor physical health. Prevention of illness, and early detection and response to physical and mental health problems, must be part of the overall support, care and treatment of people with a mental illness.	• Support people to access information relevant to their health behaviours or improving their health (including mental health) status where appropriate.	• Identify, recommend, and facilitate access to resources and services to support people in the development and maintenance of healthy lifestyles and disease prevention.	• Actively contribute to the development of strategies that promote, protect, restore and improve health, wellbeing and quality of life. • Promote and deliver early intervention strategies that support health, wellbeing	• Direct the development, implementation, evaluation and dissemination of effective programs for chronic disease prevention, risk reduction, and physical and mental health promotion.

2.0 Whole person focus				
Demonstrates an understanding and appreciation of cultural differences and diversity, recognises the complexity of social determinants of mental health & wellbeing, and engages in processes and activities that promote safe, quality, effective services for all.				
		• Advise people on the reduction of risk factors and recommendations for screening and disease prevention. • Create opportunities for improvement in mental and physical health, exercise, recreation, nutrition, expression of spirituality, creative outlets and stress management (NPS). • Work with people, their families and carers to understand what might trigger periods of illness, and what helps to prevent or resolve these periods (NPS).	and enhanced health status across the organisation. • Build service awareness of the physical health needs of people with mental illness, and the programs and services available to support prevention and wellness strategies.	• Lead development of an environment to support and promote a wellness culture where an emphasis is placed on keeping the community well and engaged in self-management/care. • Establish strategic linkages with partner organisations to support integrated prevention and wellbeing-focussed services.
2.4 Whole person focus				
	• Identify and facilitate access to services and resources that may benefit and support the person as appropriate.	• Recognise the range of personal, social, historic, economic, and environmental factors that influence health status, and contribute to initiatives that aim to improve health outcomes for individuals and populations. • Recognise the complex, multi-factorial nature of the causes of ill-health, and focus on improving the person's physical, psychological, and mind-	• Support the implementation of systems that support a whole of person approach to care and understand the range of care needs of an individual beyond the presenting issues and concerns. • Act to create a team culture that encourages a whole person focus. • Act to understand and promote trauma informed approaches to service delivery.	• Collaborate with others to develop a broader understanding of the population health needs influencing the health service/ organisation, and respond to these factors through needs-based planning. • Encourage, and contribute to building, a health system that values a whole of person approach to service planning and delivery.

2.0 Whole person focus				
Demonstrates an understanding and appreciation of cultural differences and diversity, recognises the complexity of social determinants of mental health & wellbeing, and engages in processes and activities that promote safe, quality, effective services for all.				
		body wellbeing. • Distinguish and relate the physical, functional, and psychosocial causes and consequences of illness and dysfunction to develop individualised plans and interventions. • Utilise a broad ranging assessment of the person's ongoing support and recovery needs, including broader services such as housing and employment. • Be confident and comfortable in discussing alcohol and drug use with people using services. • Implement assessment and intervention strategies for health-compromising behaviours (NPS), including alcohol and other drug use. • Monitor people for evidence of appropriate response to interventions including medication, and for possible side-effects, then communicate results to the team or medical practitioner as appropriate.	• Demonstrate understanding of evidence about the prevalence of childhood and other trauma in the lives of people who seek mental health services, and how this may influence their mental health and well-being. • Act to reduce likelihood of intergenerational transfer of risk, particularly in relation to families with multiple and complex issues.	

Domain 3 – Professional, ethical and legal approach

3.0 Professional, ethical and legal approach				
Acts in accordance with professional, ethical, and legal standards.				
Level Descriptor	**Essential**-required of all workforce members – level 1	**Practitioner**- required of mental health practitioners who work in direct service provision – level 2	**Experienced practitioner/team leader** – required of mental health practitioners with managerial, team leader or advanced responsibilities. (Level 2 is also required). – level 3	**Leader/ Systems responsibility** –required of those with organisational or system responsibilities – level 4
3.1 Ethical and legal practice				
International human rights law confirms the rights of people with mental illness and disability to equality, autonomy and dignity—see the United Nations Convention on the Rights of Persons with Disabilities and the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. Relevant legislation may include the mental health act, guardianship act and child protection legislation, as well as privacy and work, health and safety legislation. Relevant concepts include duty of care and informed consent.*	• Be aware of and adhere to legislation, regulations, standards, codes, policies and ethical requirements relating to work role (NPS). • Recognise potential ethical issues/dilemmas in the workplace, and discuss with an appropriate person. • Develop meaningful professional relationships while maintaining safe and professional boundaries (NPS). • Report illegal or unethical conduct to an appropriate person.	• Demonstrate ethical decision-making in working with people and their families • Identify, document and address any potential ethical issues if and as they arise. • Support and assist people using services to exercise their rights.	• Model ethical work practices. • Create a safe environment for staff to raise concerns regarding ethical or legal compliance issues. • Act to resolve any identified ethical issues raised. • Discuss potential ethical or legal issues/dilemmas with staff in a supportive manner to ensure maintenance of ethical work practices.	• Create organisational systems and a culture that reflect respect for the rights of people using services and their families • Model high standards of ethical and legal conduct in own actions and decisions. • Provide expert guidance and advice to assist others in satisfactorily resolving complex ethical and legal issues. • Establish policies and drive systems that encourage honesty and reward ethical behaviour

3.0 Professional, ethical and legal approach				
Acts in accordance with professional, ethical, and legal standards.				
3.2 Scope of practice and accountability				
	• Operate within own scope of practice and work role, and obtain clarification if uncertain. • Manage own work schedule and notify supervisor when workload or demand exceeds capacity. • Prioritise workload appropriately, and establish realistic timeframes for the completion of work. • Take responsibility for own actions. • Recognise lines of accountability and work within the guidelines of supervision/delegation.	• Complete tasks on time and in a self-directed manner, acting within own knowledge base and scope of practice (NPS) at all times. • Support team members with workload issues and escalate when required. • Constructively explore role expectations with team members/other practitioners when confronted with unclear or conflicting perceptions. • Work within service model of care applying and adhering to policy and procedures.	• Prioritise team activities in response to changing demands, and support staff to manage their workload. • Support staff to establish professional boundaries and understand the scope of their work. • Delegate care activity to others, according to their competence, capability and scope of practice. • Monitor the effectiveness of supervision/delegation arrangements, and revise as necessary. • Set clear expectations upfront regarding the duties and associated outcomes expected of each person in the team.	• Act to ensure workloads are manageable and others have opportunity to self-manage and regulate. • Provide a clear vision of how roles, teams and units relate within the broader organisation and to its larger purpose, and articulate the organisation's role within the wider health system. • Implement governance structures, policies, protocols, and guidelines which focus on delivering more appropriate, efficient and effective mental health service delivery and practice. • Act to periodically review current roles and functions and encourage service and workforce reform based on community need.

3.0 Professional, ethical and legal approach				
Acts in accordance with professional, ethical, and legal standards.				
3.3 Communication and documentation				
Workplace communication	• Speak clearly and directly, and actively listen to others. • Use alternative and additional communication strategies for people with sensory, physical or intellectual disabilities. • Use terminology that can be understood by audience. • Share information promptly and accurately with others, to support them in undertaking their work role.	• Use feedback and disclosure appropriately to increase mutual understanding. • Provide opportunity for questions and/or feedback so that two-way communication can be established and maintained.	• Establish regular patterns of communication where colleagues can share ideas and information quickly and easily. • Use feedback processes to assist teams and individuals to communicate more effectively. • Act to reduce the impact of power and status differentials and relationships on team communication processes. • Use multiple channels of communication to reinforce complex messages and decrease the likelihood of misunderstanding.	• Provide staff with the information and systems they need to work effectively. • Foster and enable a work culture that encourages open and effective communication.
Conflict management	• Recognise issues that may lead to conflict, and constructively address issues as they arise. • Where appropriate, ensure conflict situations are raised with supervisor for advice and resolution.	• Treat conflict as friction between ideas, not people. • Consider different points of view, and compromise, where appropriate, to reach consensus. • Negotiate skilfully in difficult situations to agree on concessions without damaging relationships.	• Identify, document and address dysfunctional team processes. • Act to resolve complex issues by achieving common understanding on diverging interests, and mediating conflict situations as necessary. • Navigate solutions towards desired ends, remaining aware of goals and objectives, maintaining relationships, and supporting consensus.	• Anticipate conflict, and act to keep a relative balance among the interests of relevant individuals and/or groups. • Engage self and others to constructively manage disagreements about values, roles, goals, and actions that arise within and across health care teams/ organisations.

3.0 Professional, ethical and legal approach				
Acts in accordance with professional, ethical, and legal standards.				
Documentation	• Treat personal information obtained in a work capacity as private and confidential (NPS). • Adhere to organisational , professional, legal and ethical requirements for documentation and reporting	• Inform the person, families and carers about information exchanged in relation to their support, care or treatment (NPS). • Maintain accurate, up-to-date and legible client records. • Take prompt and effective action to deal with information that is inadequate, contradictory or ambiguous.	• Provide support for others in relation to effective use of information technology and related practices, for example, electronic records (NPS).	• Create and implement structures and processes to maintain confidentiality. • Manage documentation processes for the organisation to effectively meet legal and reporting requirements.
Information management	• Act in ways that support the safe, secure storage of health information, as part of daily work.	• Act to ensure people using services understand their rights in relation to information, including how to access, request changes or make a complaint. • Use current information technology for documentation and management of information, and to improve communication.	• Promote adoption of best practice standards and technologies for collection and storage of health information. • Identify and implement processes for periodic review of information management to ensure ongoing efficiency and effectiveness.	• Inform and influence the development and adoption of an effective information governance framework for management of the organisation's information. • Develop and implement policies and strategies for information sharing and use. • Promote a multidisciplinary approach to ongoing evaluation/audit of health records to enable continuous quality improvement.
3.4 Self-management and care				
	• Recognise potential effect of stressors or triggers on work performance and relationships • Seek support, where necessary, to maintain own well-being.	• Establish and implement a personal health strategy including self-care for mental health and wellbeing.	• Model good self-care practices to support staff to prioritise their own self-care. • Encourage staff to constructively identify their stressors, and support them to manage these effectively.	• Develop strategies to reduce stress in the workplace and promote workplace well-being. • Foster a culture in which managers are accessible and approachable for staff experiencing stress or difficulty.

3.0 Professional, ethical and legal approach				
Acts in accordance with professional, ethical, and legal standards.				
			• Recognise how own leadership style influences staff experiences of the work environment, and act to reduce any negative impacts.	• Put systems in place to support staff who may be exposed to and affected by vicarious and actual trauma. • Recognise and address own need for support as a leader during times of adversity.

Domain 4 – Collaborative practice

4.0 Collaborative practice				
Builds and maintains effective working relationships, and works in partnership with others.				
Level Descriptor	**Essential**-required of all workforce members – level 1	**Practitioner**- required of mental health practitioners who work in direct service provision – level 2	**Experienced practitioner/team leader** – required of mental health practitioners with managerial, team leader or advanced responsibilities. (Level 2 is also required). – level 3	**Leader/ Systems responsibility** –required of those with organisational or system responsibilities – level 4
4.1 Shared responsibility with people using the service, and families and carers				
Note that section 1.4, working in partnership, is highly relevant to collaborative practice.	• Provide time, space and encouragement for the person using services to practice new skills and build self-efficacy.	• Support people to identify personal aspirations and goals and participate in individual service planning. • Promote self management and support people in developing skills and knowledge required for self management and self empowerment. • Positively reinforce people's success and achievements. • Act to re-engage people who have significant disengagement from supports and services.	• Build effective strategies for informing and empowering people, and increasing their active involvement in their health and healthcare. • Act to ensure knowledge of appropriate services and programs is shared with staff and people accessing services.	• Lead, encourage and support a workplace that values a shared responsibility for best practice healthcare. • Incorporate and uphold a focus on collaborative practice in service policies and procedures. • Foster a culture that maximises collaborative solutions to problems with engagement and minimises coercion.

4.0 Collaborative practice				
Builds and maintains effective working relationships, and works in partnership with others.				
4.2 Interprofessional Collaboration				
4.2.1 Vision and objectives	• Be able to communicate across disciplinary, professional and organisational boundaries (NPS).	• Collaborate with other health practitioners to establish goals that are clear and measurable, and demonstrate shared ownership of these goals. • Actively seek opportunities to streamline care through the involvement of other healthcare practitioners, where appropriate, both within and external to the organisation.	• Facilitate interprofessional goal setting for people using the service to establish common goals. • Achieve goal agreement through a common commitment to people's needs.	• Lead and motivate staff to strive for and achieve interprofessional team goals to support people using the service. • Ensure available resources, programs and services are identified and regularly communicated to team.
4.2.2 Collaboration within and across teams	• Share responsibility for team actions, and support others as needed.	• Engage team members and other relevant healthcare practitioners in the development and implementation of strategies that meet specific individual care needs.	• Establish and maintain effective and healthy working partnerships, regardless of whether formalised teams exist. • Encourage and model respect, understanding and trust within and across teams, and motivate staff to act in the collective interest.	• Create effective alliances within and across teams and departments of the organisation. • Act to ensure that clear policies are in place to guide the way interprofessional teams work. • Foster and promote a work culture that values cooperation, teamwork, openness, collaboration, honesty and respect for others. • Work collaboratively and actively with consumer and family leadership across the sector.
4.2.3 Collaborative interprofessional decision-making	• Make day-to-day decisions as appropriate to own work role, and in genuine consultation with others.	• Engage other health practitioners in shared person-centred problem-solving, and integrate their knowledge and	• Implement agreed procedures for collaborative decision-making that values and includes the opinions of service users.	• Establish processes that promote shared decision-making, communication of decisions, and community involvement.

4.0 Collaborative practice				
Builds and maintains effective working relationships, and works in partnership with others.				
		experience to inform care decisions.	• Develop and implement processes for evaluating the effectiveness of the decision-making process and resulting outcomes.	• Act to ensure that there are detailed and transparent rules and processes for establishing and/or allocating decision-making authority in the workplace. • Explore and make use of opportunities for improving departmental/ organisational decision making processes and outcomes.
4.3 Collaborating across time and place				
4.3.1 Transfer of care, follow-up, and referral including clinical handover	• Contribute to, and participate in, handover and transfer processes as appropriate to role. • Ensure the person's needs and wishes are communicated in the handover or transfer of care as appropriate to role.	• Conduct a thorough handover to ensure safe care is maintained. • Establish mechanisms to include people and carers in clinical or other handover processes related to their care. • Assess the need for follow-up, and make arrangements if necessary. • Where appropriate, refer person to local alcohol or drug service, or other specialised service.	• Establish a system for coordinating and performing follow-up within the service and based on individual needs. • Educate staff on handover protocol. • Review the clinical or other handover procedure and undertake continuous improvement processes. • Act to ensure effective transfer of care, as permitted within own sphere of influence.	• Contribute to the coordinated development of a standardised, general handover policy for the organisation. • Lead the development of intra- and inter-organisation service user handover systems that ensure care is optimised, timely and appropriate to need. • Seek the advice and guidance of other experts to determine the best transition of care pathway where appropriate.
4.3.2 Integrated care		• Collaborate across health, community, and social service organisations to develop individualised plans that reflect both current and long-term needs and goals for the person. • Provide detailed, timely, and accurate information to the general medical	• Build sustainable partnerships with other service providers to optimise use of resources and provide best practice ongoing recovery care. • Facilitate inter-agency recovery planning, and act to ensure there is a lead agency with responsibility for coordinating or case	• Develop and implement agreements with other agencies that articulate the activities, responsibilities and processes for the coordination of care. • Investigate and promote opportunities to use technology to improve the delivery of healthcare and communication of

4.0 Collaborative practice				
Builds and maintains effective working relationships, and works in partnership with others.				
		practitioner and other healthcare professionals who will provide the next phase(s) of recovery care.	managing the person's overall care. • Encourage and facilitate the involvement of a general medical practitioner at all relevant stages of the person's recovery.	information across multiple agencies.

Domain 5 – Provision of care

5.0 Provision of care				
Participates in the planning, delivery and management of evidence-based, recovery-focussed, treatment, care and support.				
Level Descriptor	**Essential-**required of all workforce members – level 1	**Practitioner**- required of mental health practitioners who work in direct service provision – level 2	**Experienced practitioner/team leader** – required of mental health practitioners with managerial, team leader or advanced responsibilities. (Level 2 is also required). – level 3	**Leader/ Systems responsibility** –required of those with organisational or system responsibilities – level 4
5.1 Access and engagement				
	• Engage respectfully with all people who seek a mental health service or who are referred.	• Support or assist people to locate services in relation to their presenting need, within or outside the organisation.	• Establish a clear process regarding service access and eligibility.	• Establish, monitor and work to improve systems for early referral, timely response and early intervention. • Lead staff in developing a culture of collaboration, respect, acceptance and timely services. • Monitor and correct if required, access to the service by all relevant parts of the community, including across geographical, cultural and age groups.

5.0 Provision of care				
Participates in the planning, delivery and management of evidence-based, recovery-focussed, treatment, care and support.				
5.2 Assessment				
Developmental context is an important element of assessment and other areas of provision of care (see section 4 and appendix D).		• Assess new referrals in a timely manner, applying service acceptance criteria (NPS). • Where appropriate conduct a developmentally relevant risk assessment, taking into account mental state, suicidality, self-harm, violence, and risk of harm to others, and other age-associated risks (NPS). • Conduct or facilitate a relevant and timely physical assessment and examination (NPS). • Act to ensure access to specialised assessment where required • Collaborate with people to generate an initial plan that addresses key risk issues (NPS). • Identify the particular needs and responsibilities of people using services who are carers for others, and support them to locate appropriate supports and services (NPS). • Work with the person to collect and record information that enables identification of the person's health status, strengths, limitations, issues, risks, needs and	• Establish a clear process regarding assessment of service users' needs. • Establish processes to ensure access to specialised assessment where required.	• Ensure systems are in place to identify the particular needs and responsibilities of people using services who are carers for others, particularly those caring for children and young people.

5.0 Provision of care				
Participates in the planning, delivery and management of evidence-based, recovery-focussed, treatment, care and support.				
		concerns including family and carers. • Conduct and document a comprehensive mental health assessment appropriate to the person's developmental age and culture, including a mental state examination. • Identify signs that a person may have an intellectual disability and seek assistance as required with an appropriate assessment. • Screen for alcohol and drug use (NPS). • Recognise the effects of intoxication and withdrawal from alcohol and other drugs, and facilitate or conduct appropriate screening or assessment (NPS).		
5.3 Performing healthcare activities				
5.3.1 Individual planning	• Assist others to plan or prepare for healthcare activities as required. • Collect, record and access information in a timely manner, and ensure that it is relevant to the person's and service's needs.	• Where appropriate, independently or with assistance develop and articulate a comprehensive case formulation (NPS)or plan. • Actively support the person using services to participate in goal setting and individual planning, including the development of advance directives.	• Demonstrate and promote understanding of risk of harm to self or others through violence, self-neglect, self-harm suicide, or other common age-related harms.	• Provide representation at the local and/or national level to influence strategic directions and actively contribute to the planning, delivery, and transformation of mental health services.

5.0 Provision of care				
Participates in the planning, delivery and management of evidence-based, recovery-focussed, treatment, care and support.				
		• Collaboratively work with the person using services and others to plan care using the principle of 'least restrictive care'		
5.3.2 Deliver	• Constructively assist others to implement healthcare activities as required.	• Deliver services and interventions using a recovery, strengths based and family-focussed approach. • Recognise when input is required from more senior colleagues or other disciplines, and act to obtain their involvement.	• Develop, implement and document an effective and tailored person-centred plan or intervention for complex situations. • Identify when a person is unable to make a health care decision, and act in the person's best interests until a proxy can be found, and with due regard for the law.	• Provide expert advice/guidance to other practitioners, as required, to support their safe and effective performance of recovery oriented healthcare activities. • Develop, apply and promote appropriate and innovative models of care.
5.3.3 Monitor, evaluate and revise plans	• Recognise and promptly report changes in the health and wellbeing of the person to the supervising practitioner. • Promptly advise a more senior colleague if the person is at risk.	• Support the person to reflect on their progress, and achievement of their goals. • Document achievements and evaluate outcomes. • Vary plans to meet the person's changing needs or circumstances • Enable, positive risk taking to build confidence and achieve goals. • Review individual plans on a regular basis, and initiate a higher level of care when required.	• Review effectiveness of planning processes, evaluate outcomes and recommend necessary changes. • Educate staff on the local protocol for a higher level of care relevant to their position, and encourage them to react positively to a need for additional care. • Contribute to multidisciplinary efforts that aim to improve the safety of people who are vulnerable to unexpected deterioration.	• Act to ensure formal processes exist for evaluating whether service delivery has met needs and been provided as agreed with the person and any other care contributors. • Act to ensure monitoring plans are in place and actioned appropriately by staff. • Lead continuous improvement cycles to ensure service delivery remains safe, efficient and responsive.

5.0 Provision of care				
Participates in the planning, delivery and management of evidence-based, recovery-focussed, treatment, care and support.				
5.4 Supporting processes and standards				
5.4.1 Evidence-based practice	• Assist with research activities, as required by own role.	• Critically evaluate evidence from literature and research to determine appropriate actions for practice.	• Conduct and collaborate in healthcare research. • Disseminate findings using a range of methods. • Supervise others in the completion of research tasks as required.	• Contribute to the generation of new knowledge through research. • Create opportunities for stakeholders in the design, conduct and evaluation of research. • Facilitate the application of new knowledge and skills into practice.
5.4.2 Quality care provision and general safety	• Perform work activities safely and effectively. • Support the implementation of safety and quality initiatives. • Identify existing and potential hazards or risks in the workplace, report them to designated persons and record them in accordance with workplace procedures.	• Act to reduce error and sources of risk in own practice and within the healthcare team. • Participate in systems for surveillance and monitoring of adverse events. • Act to eliminate workplace hazards and to reduce risks to colleagues and people using the service.	• Integrate quality management principles into operational activities of the healthcare team. • Integrate safety and quality practice guidelines into everyday care. • Manage and maintain a safe working environment. • Support staff who report adverse events or incidents, and follow through on reports.	• Foster a supportive, open culture, in which mistakes are treated as opportunities for improvement and organisational learning. • Lead and promote the adoption of safety and quality guidelines and practices that assist in reducing the causes of harm in healthcare.
5.4.3 Dignity of risk *This area involves working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for people using services, carers, family members and the wider public*	• Facilitate access to individual and service responses to help manage crises and minimise risks when needed. • Adhere to policies and protocols that support safe service delivery. • Act to uphold the right of all people to take informed risks, recognising restriction of this right must only occur within relevant legal frameworks.	• Collaboratively work with the person to jointly identify any risks to their personal recovery goals and plans. • Collaboratively work with the person to jointly identify and assess risks (including self harm, self neglect, and violence to self or others) and develop risk minimisation plans. • Actively work with the person to identify	• Educate people using the service, families and carers about the role, function and limitations of mental health services in relation to promoting safety and managing risk of harm. • Model collaboratively working alongside people using services in identifying, assessing and reducing risks. • Acknowledge that risk cannot be eliminated, and	• Act to ensure safety of people using service by expertly managing risk, and intervene if necessary to achieve optimal outcomes for the person and service teams. • Contribute to the development and implementation of arrangements that ensure positive risk management is an integral part of the planning and management processes and general

5.0 Provision of care				
Participates in the planning, delivery and management of evidence-based, recovery-focussed, treatment, care and support.				
		strengths and resources they can draw on in minimising their risks. • Contribute to the use of a range of psychosocial interventions with the goal of reducing risk in the longer term. • Actively seek to employ strategies to avoid coercion in service provision as far as possible. • Support the person to develop an advanced care plan to guide any actions taken in the event their judgement and decision making become impaired. • Be confident and comfortable discussing suicide with people using services. • Identify the likelihood and consequence of actual and potential risks, and determine which risks need to be managed and treated as a priority.	act to ensure that staff understand their individual roles and responsibilities for risk management. • Support staff to identify, analyse, report and positively manage risks. • Act to reduce error and sources of risk in own practice and within the broader healthcare setting. • Support colleagues who raise concerns about safety in relation to people using services. • Educate staff in harm reduction techniques with regard to alcohol and other drugs, self harm and medication use.	culture of the organisation. • Seek to balance dignity of risk with professional/ organisational responsibilities, and to discourage defensive practice.

Domain 6 – Life-long learning

6.0 Life-long learning				
Maintains and extends professional competence, and contributes to the learning and development of others.				
Level Descriptor	**Essential**-required of all workforce members – level 1	**Practitioner**- required of mental health practitioners who work in direct service provision – level 2	**Experienced practitioner/team leader** – required of mental health practitioners with managerial, team leader or advanced responsibilities. (Level 2 is also required). – level 3	**Leader/ Systems responsibility** –required of those with organisational or system responsibilities – level 4
6.1 Holistic learning and development				
	• Demonstrate an interest in, and enthusiasm for continuing learning and development.	• Identify personal and professional development needs, and plan and implement strategies for achieving them. • Monitor and evaluate progress towards learning/ development goals, and identify opportunities for future changes and improvement. • Utilise different learning experiences, methods and forums to inform own practice.	• Model a commitment to continuing professional development. • Support effective approaches to lifelong learning for all staff. • Systematically support staff to identify and follow up on areas for professional development. • Ensure staff complete mandated training and are able to access training related to individual professional development plan. • Enable delivery of comprehensive, lived experience education and training programs. • Advocate for, and encourage the provision of, formal and informal learning opportunities. • Promote development of leadership skills.	• Develop and foster a learning culture and infrastructure which recognises the importance of lifelong learning to organisational development and service improvement. • Influence organisational learning and development strategies to ensure the workforce is supported to develop the abilities it requires to meet current and future business needs. • Build leadership skills and capacity within the workforce and across disciplines and work areas.
6.2 Self-reflection				
	• Take time to reflect on	• Regularly reflect on	• Use self-reflection	• Implement an organised,

6.0 Life-long learning				
Maintains and extends professional competence, and contributes to the learning and development of others.				
Level Descriptor	**Essential**-required of all workforce members – level 1	**Practitioner**- required of mental health practitioners who work in direct service provision – level 2	**Experienced practitioner/team leader** – required of mental health practitioners with managerial, team leader or advanced responsibilities. (Level 2 is also required). – level 3	**Leader/ Systems responsibility** –required of those with organisational or system responsibilities – level 4
	and evaluate own work performance and identify areas for further development.	practice to identify strengths and areas requiring further development. • Formulate learning objectives and strategies for strengthening practice and addressing own limitations.	techniques effectively to enhance service delivery and interpersonal relationships within the service. • Support others to review, reflect on, and evaluate their own practice.	effective and continuing framework for self-reflection, personal and professional development and practice improvement.
6.2 Professional support relationships				
	• Share own learning with others as appropriate.	• Identify and communicate practice issues to the supervising practitioner. • Contribute to the education and development of others, as appropriate to own role and level of experience. • Participate in supervision arrangements, and demonstrate commitment to the process of supervision.	• Provide effective supervision to less experienced practitioners and staff as appropriate. • Plan and conduct teaching sessions, encouraging participation and reflection on experience. • Facilitate staff access to learning outside of own practice area through the development of cross-discipline relationships/ networks and engagement with lived experience.	• Act to create and maintain a culture in which professional and line supervision is treated as part of core business of contemporary professional practice. • Create institutional supports for supervision, including policies, processes, training, dedicated teaching time, and access to support networks and resources. • Support other supervisors in becoming educationally prepared for their role.
6.4 Feedback and peer assessment				
	• Recognise and use opportunities to receive formal and informal feedback on own work performance. • Act on feedback as	• Participate constructively in professional peer review. • Offer feedback that is specific, sensitive, and non-judgmental.	• Provide timely, constructive and regular feedback to staff. • Initiate and lead peer review processes which focus on supporting good	• Act to ensure peer review processes are appropriately resourced, and occur in an open and positive organisational culture which emphasises excellence

6.0 Life-long learning				
Maintains and extends professional competence, and contributes to the learning and development of others.				
Level Descriptor	**Essential**-required of all workforce members – level 1	**Practitioner**- required of mental health practitioners who work in direct service provision – level 2	**Experienced practitioner/team leader** – required of mental health practitioners with managerial, team leader or advanced responsibilities. (Level 2 is also required). – level 3	**Leader/ Systems responsibility** –required of those with organisational or system responsibilities – level 4
	appropriate and ask for assistance as required to improve performance.		practice and building on excellence. • Collaborate and cooperate in the management of peer review outcomes. • Encourage feedback on own performance, and evaluate it systematically.	service delivery. • Foster a culture in which feedback is used as a strategy to enhance goals, awareness, and learning, and is a positive experience for those involved. • Enlist former users of the service and other peers to consult regularly and offer feedback on practice, programs and policies.

Appendix A: Technical Working Group Membership

HWA wishes to acknowledge the contribution of the following individuals and organisations to the development of the capabilities:

Member group/organisation	Representative	Title
Health Workforce Australia	Ms Penny Tolhurst	Project Manager Workforce Innovation and Reform
Health Workforce Australia	Ms Cathy Teager	Program Manager Workforce Innovation and Reform
Alcohol and Other Drug Sector	Dr Mark Montebello	Senior Staff Specialist in Addiction Psychiatry, South Eastern Sydney Local Health District
Australian Psychological Society Ltd	Dr Sabine Hammond	Executive Manager, Science and Education
Community Mental Health Australia	Ms Tina Smith	Senior Policy Officer, Workforce Development, Mental Health Coordinating Council
Community Services and Health Industry Skills Council	Mr Mark Shaddock	Project Officer
Consumer academic (Curtin University)	Ms Lyn Mahboub	Lecturer and Consumer Academic, School of Occupational Therapy and Social Work, Faculty of Health Sciences, Curtin University
Council of Deans of Nursing and Midwifery, Australia and New Zealand	Professor Mike Hazelton	Head, School of Nursing and Midwifery, University of Newcastle
Hunter New England Health Service	Ms Julie Dixon	Manager, Organisational Development
National Mental Health Consumer and Carer Forum	Ms Eileen McDonald	Carer Representative
NSW Aboriginal Mental Health Workforce Program	Mr Tom Brideson	Statewide Coordinator
NSW Ministry of Health	Mr Marc Reynolds	Manager, Clinical Services Development, Mental Health and Drug and Alcohol Office
Occupational Therapy Australia	Ms Karen Arblaster	Lecturer, School of Occupational Therapy, University of Western Sydney
Royal Australian and New Zealand College of Psychiatrists	Dr Rod McKay	Faculty of Psychiatry of Old Age
Additionally, the assistance of Ms Crystal Whitmore, Mr Graham Swift, Mr Ralph Moore, and Dr Becky Walker of NSW Ministry of Health is acknowledged.		

Appendix B: Focus Group Workshops

Participating organisations involved in service visits (alphabetical)
Albert Road Clinic, Victoria
Castlemaine Adult Community Mental Health Service, Victoria
Child and Adolescent Mental Health Services, Perth, WA
Glenside Public Hospital, SA
NEAMI National, Victoria
Southern Adelaide-Fleurieu-Kangaroo Island Medicare Local Limited
Wuchopperen Health Services, Cairns, Queensland

A total of 46 people were consulted at the site visits.

Open or targeted sessions
Educators and trainers, Sydney NSW
Service Planners, Managers and leaders, Sydney NSW
Open meeting, Perth, WA
Open meeting, Adelaide, SA
Open meeting, Melbourne, Victoria
Consumers and Carers, Melbourne, Victoria

A total of 143 people attended the open and targeted workshops.

Appendix C: References

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Royal Australian and New Zealand College of Psychiatrists

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- Code of ethics

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Appendix D: Developmental context

Infant (0-4 years inclusive)

Development in this age group occurs primarily in the context of the adult/child dyad, so the client in relation to 'self' and 'others' is combined in this section.

1 and 2

- Regulation- feeding, sleep/wake cycles, crying/dyadic setting strategies (somatic and/or emotional regulation)
- Relationship patterns-primary caregiver/child relationship-response to care giving, separation and strangers, social seeking or avoidance, development of trust
- Behaviour-including attachment behaviour, responses to limit setting, participation in routines
- Sensory adaptation responses, e.g. to intense stimuli, loss of support and loud noises
- Developing autonomy in self-care, e.g. feeding, dressing, toileting
- Communication-development of linguistic capacity to communicate
- Play- development of play skills and engagement with others

3. The client in relation to the world

- Develops sensory preferences, e.g. food, textures, sounds
- Play- development of play preferences, e.g. favourite toys and books, and development of symbolic play in making sense of the world
- Emerging decisions making about self care and play choices

Child (5-11 years inclusive)

Development in this age group occurs primarily in the context of peers, family and school.

1. The client in relation to self

- Developing a sense of self, acquiring a belief in self-constancy and in relatively permanent psychological traits, and learning to distinguish their thoughts and feelings from those of others
- Developing self-discipline in behavior and task completion, e.g. homework, music or sport practice
- Exercising choice and preferences for activities, time frames, spending and social relationships

2. The client in relation to others

- Relating with peers according to more obvious social rules

- Performance orientation that includes not only task completion but also others' responses to their achievements
- Belonging to a group, participating as a group member
- Developing cultural awareness
- Maintaining longer term friendships
- Negotiation skills
- Managing increasing responsibility, e.g. home duties

3. The client in relation to the world
    - Moving from free play to more structured play that may include elaborate rules and team work
    - Mastering physical coordination tasks related to play, e.g. sport, art, and school performance, e.g. writing, using scissors

Adolescent (12-17 years inclusive)

Development in this age group occurs primarily in the context of emerging identity and independence.

1. The client in relation to self
    - Emerging self-determination and independence form significant figures of attachment and authority
    - Coming to terms with own body- perceived assets, strengths and limitations
    - Maturing but not fully formed judgement and insight
    - Heightened interest in experimentation and risk taking, including drug and alcohol use
    - Greater awareness and at times demonstration of moral, ethical, spiritual and cultural preferences/choices
    - Developing cultural identify
2. The client in relation to others
    - Forming and maintaining intimate relationships
    - Learning to relate to and rely on peers
    - Sharing advice and opinions offering others assistance and psychological support
    - Developing ability to put themselves in another's shoes, experience and demonstrate maturing empathy
    - Managing conflict in relationships
3. The client in relationship to the world

- Increasing independence and autonomy in life roles, particularly as student, employee, team member
- Greater mobility with increasing capabilities for independent use of transport and community based facilities
- Taking on increasing responsibility for self and others. Some adolescents may become parents themselves, may be required to perform home duties or provide care for others, e.g. older adolescents caring for family members with a physical disability, mental health or drug and alcohol problem
- Managing increasing responsibility related to finance
- Developing cultural awareness and participation

Young adulthood (18-25 years inclusive)

Development in this age group occurs primarily in the context of consolidating one's identify and sense of self, maintaining a sustained separation form social, residential, economic and ideological independence upon family of origin.

1. The client in relation to self
    - Consolidating work related skills
    - Continuing risk behaviours, including experimenting with alcohol and drugs
    - Exploring and maintaining adult relationships
    - Taking legal responsibility for decision making, e.g. health and treatment
    - Reflecting on actions, decisions and behaviours
    - Developing strong sense of self and personal identity through meaningful roles, e.g. friends, sportsperson, parent
    - Developing career and career goals
    - Exploring sexual identify
    - Internalizing of morals, ethics, values and beliefs and understanding social consequences
    - Increasing capacity for abstract reasoning and complex cause and effect
    - Making choices relating to physical and sexual maturity, e.g. child bearing
2. The client in relation to others
    - Developing close, committed relationships with others
    - Exploring diverse relationships outside of the immediate family including greater number of carers and peers, e.g. residential circumstances

- Managing feelings in relation to others
- Increased awareness of the need for communication and conflict resolution skills
- Increased capacity for empathy
- Adapting to the views and choices of other generations

3. The client in relation to the world
    - Assuming identity and participating in the world of work either paid or unpaid
    - Completing education
    - Increasing independence and autonomy and implementation of life goals
    - Exploring local, regional and global environments
    - Increasing mobility, e.g. learning to drive, travelling
    - Increasing financial responsibilities, including managing money and planning
    - Holding adult status for legal purposes (voting, jury service, fostering/adoption, gambling, drinking alcohol and joining armed forces)

Adult (26-40 years inclusive)

Development in this age group occurs primarily in the context of strengthening participation in the area of relationships, carers and community.

1. The client in relation to self
    - Balancing priorities between self, partner, family
    - Developing perception of intimacy and commitment, including trust and fidelity
    - Confidently articulating identify, values and beliefs
    - Adjusting to changes in physical self, e.g. first signs of aging
    - Learning to balance increased responsibilities
    - Making lifestyle choices
    - Contemplating the need for financial security
2. The client in relation to others
    - Choosing whether to start a family and managing the associated pressures
    - Consolidating financial responsibilities and longer term planning, e.g. superannuation and buying first home
    - Exploring long term personal relationships which are interdependent, reciprocal and committed

- Negotiating relationships with those in the wider community, e.g. neighbours, co-workers and society
- Exercising capacity for empathy and selfless caring
- Adapting to the views and choices of other generations

3. The client in relation to the world
    - Establishing and progressing careers
    - Investigating and implementing belief systems about health and values
    - Establishing self as a community member, e.g. social group participation
    - Increasing opportunities for community responsibilities, e.g. fostering, parent associations
    - Testing values in a global environment, e.g. travel
    - Balancing responsibility and play, leisure and recreation
    - Exploring and establishing long term financial security goals
    - Enacting social and political beliefs, e.g. voting
    - Increasing choice in occupation, social and political avenues, e.g. joining political parties or community groups
    - Ongoing development of parenting skills, adapting to the developmental needs of children

Middle years (41-64 years inclusive)

Development in this age group occurs primarily in the context of caring for others and community building.

1. The client in relation to self
    - Contemplating mortality and spirituality
    - Experiencing some physical limitations
    - Reflecting on role or position within the family, workplace and social group
    - Experiencing the impact's of one's lifestyle on physical and mental health
    - Consolidating goals and engaging in future planning, e.g. retirement
    - Taking risks in relation to lost youth and last chances, e.g. 'if I don't do it now I'll never do it'
    - Experiencing a heightened interest in personal development, taking on new hobbies, higher learning and recreation/leisure
    - Examining own purposefulness
2. The client in relation to others

- Managing and balancing work/life responsibilities
- Negotiating transitions relating to parenting, e.g. empty nest and adult children moving back home
- Becoming a grandparent, including assuming the primary care giver role for grandchildren
- Managing responsibilities for ageing parents
- Providing guidance and direction to others
- Evaluating relationships, e.g. 'midlife crisis'
- Adapting to the views and choices of other generations

3. The client in relation to the world

    - Increasing participation in community activities and community building via guidance, mentoring or coaching for the next generation
    - Increasing travel and exploration of the wider world
    - Broadening awareness and discussion of world events

Older people (65-84 years inclusive)

Development in this age group occurs primarily in the context of growing older, slowing down and exploring life.

1. The client in relation to self

    - Reevaluating lived experiences and future life goals
    - Coming to terms with own body- perceived assets, strengths, and limitations, e.g. related to appearance, physical health and self-care
    - Increased commitment to time and resources allocated to preserving wellness and function
    - Heightened contemplation of own and other's mortality and related impacts
    - Reevaluating spiritual beliefs and participation
    - Addressing the challenge between preserving autonomy and increasing reliance on others

2. The client in relation to others

    - Maintaining meaningful social and intimate relationships
    - Increasing dependence on others to retain function
    - Increasing participation in helping relationships
    - Continuing to provide guidance and direction to others
    - Adapting to the views and choices of other generations

- Increasing desire to impart own wisdom to others.

3. The client in relation to the world
    - Continuing in paid work, or adapting to retirement or retrenchment
    - Developing a sense of purpose in the absence of paid work
    - Adapting activities within physical limitations
    - Continuing personal development including academic pursuits, interests and hobbies
    - Continuing travel and exploration of the wider world
    - Adapting living environments to suit functional and social needs

Very old people (85 years plus)

Development in this age group occurs primarily in the context of decreasing autonomy and function

1. The client in relation to self
    - Preserving independence where possible
    - Finding new meaning and value in life
    - Coping with physical limitations, seeking or accepting comfort rather than cure
    - Accepting or denying others or own mortality
    - Appraising lived experience
    - Contemplating leaving a legacy
2. The client in relation to others
    - Accepting the necessity of being dependent on outside support while still making independent choices that can give satisfaction
    - Maintaining meaningful social relationships
    - Adapting to the views and choices of other generations
3. The client in relation to the world
    i. Developing a sense of purpose in the absence of paid work
        a. Transitioning to new living environments according to level of support needs
        b. Maintaining and engaging in meaningful activities within physical limitations
        c. Organising finances, possessions and legal arrangements

Appendix E Glossary

Carer	A person who has a caring role for a person with a mental health problem or mental illness. They could be family, a friend or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the person and carer (Commonwealth of Australia 2009).
Community	How the community is defined depends on the purpose, structure and type of service. The community may be determined by a target population, such as people and/or clinicians who access the service or, in the case of public services, a defined catchment area (Commonwealth of Australia 2010).
Confidentiality	Restricting access to personal information to authorised people, entities and processes at authorised times and in an authorised manner (Commonwealth of Australia 2010).
Consent	An agreement based on an understanding of the implications of a particular activity or decision and the likely consequences for the person (Commonwealth of Australia 2010).
Consumer	A person who is currently using, or has previously used, a mental health service (Commonwealth of Australia 2009).
Cultural capability	An individual's capacity to enable and provide quality, safe and efficient services to people from different cultural and linguistic backgrounds, starting with accounting for different cultural perspectives on health and health care (Queensland Health 2010).
Disability	A concept of several dimensions relating to an impairment in body structure or function, a limitation in activities (such as mobility and communication), a restriction in participation (involvement in life situations such as work, social interaction and education), and the affected person's physical and social environment (Commonwealth of Australia 2010).
Diversity	A broad concept that includes age, personal and cultural background, education, function and personality. Includes lifestyle, gender identity, sexuality, sexual identity, ethnicity and status within the general community (adapted from Commonwealth of Australia 2010).
Early Intervention	Interventions targeting people displaying the early signs and symptoms of a mental health problem or mental disorder (Commonwealth of Australia 2010).
Evaluation	Judging the value of something by gathering valid information about it in a systematic way and by making a comparison. The purpose of evaluation is to help the user of the evaluation to decide what to do, or to contribute to scientific knowledge (Commonwealth of Australia 2010).
Exit	When the person no longer requires treatment, support or any other service from the mental health service, and there has been a last review of the case with peers and the case is closed. Exit is prepared for in a collaborative manner with the person. This may be referred to as discharge in some services (Commonwealth of Australia 2010).
Individual plan	It is a written summary of a person's goals and strategies. The plan may vary in length, depending on the types of needs and the time it may take for these needs to be met.
Incident	An event or circumstance that led to, or could have led to, unintended and/or unnecessary

	harm to a person, and/or a complaint, loss or damage (Commonwealth of Australia 2010).
Informed consent	Consent obtained freely, without coercion, threats or improper inducements, after questions asked by the person have been answered, after appropriate disclosure to the person, adequate and understandable information in a form and language demonstrably understood by the person. Such answers and disclosures must be sufficient to enable the person to make a fully informed decision based on all relevant factors including the nature of treatment involved, the range of other options and the possible outcomes and implications, risks and benefits for the person and others. In the context of mental health, this means that the person provides permission for a specific treatment to occur based on their understanding of the nature of the procedure, the risks involved, the consequences of withholding permission and their knowledge of available alternative treatments (Commonwealth of Australia 2010).
Integration	According to the needs of people, continuity of care is maintained over time and across different levels of services.
Interprofessional team	Care or a service given with input from more than one discipline or profession (adapted from Commonwealth of Australia 2010).
Intervention	An activity or set of activities aimed at modifying a process, course of action or sequence of events, to change one or several of their characteristics such as performance or expected outcome.
Involuntary Treatment	Refers to a person being treated for their illness without their consent, in two ways, either in hospital or in the community. This may occur when mental health problems or disorders result in symptoms and behaviours that lead to a person's rights being taken away or restricted for a period of time (Commonwealth of Australia 2013).
Legislation	The body of laws made by Parliament. These laws consist of Acts of Parliament and Regulations, Ordinances and/or Rules, which are also called subordinate or delegated legislation (Commonwealth of Australia 2010).
Mental health	Mental health refers to the capacity of individuals and groups to interact with one another in ways that promote subjective wellbeing, optimal development and the use of mental abilities (cognitive, affective and relational), and the achievement of individual and collective goals consistent with the law (adapted from Commonwealth of Australia 2010).
Mental health problems	A disruption in the interaction between the individual, the group and the environment, producing a diminished state of mental health (Commonwealth of Australia 2010).
Mental health practitioner	A mental health practitioner is a worker within a mental health service who provides treatment, rehabilitation or community health support for people with a mental illness or psychiatric disability (Commonwealth of Australia 2013).
Mental health professional	A person who offers services for the purpose of improving an individual's mental health or to treat mental illness. These professionals include (but are not limited to) psychiatrists, clinical psychologists, social workers, occupational therapists and mental health nurses. See also *Practitioner(s).* (adapted from Commonwealth of Australia 2010)

Mental health services	Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non-government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services (Commonwealth of Australia 2009).
Monitor	To check, observe critically, measure or record the progress of an activity, action or system on a regular basis to identify change (Commonwealth of Australia 2010).
Non-government mental health sector	Private, not-for-profit, community-managed organisations that provide community support services for people affected by mental illness and their families and carers. Non-government organisations may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness, and their carers, or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, pre-vocational training, residential services and respite care.
Outcome	A measurable change in the health of an individual, or group of people or population, that is attributable to interventions or services (Commonwealth of Australia 2010).
Peer worker	People who are employed in roles that require them to identify as being, or having been a mental health consumer or carer. Peer work requires that lived experience of mental illness is an essential criterion of job descriptions, although job titles and related tasks vary
People	The term 'People' refers to anyone who is currently using, or has previously used a mental health service and includes people who have accessed general health services for a mental health problem. For the purposes of this statement, this term includes those with emerging or established mental illness for which they have not yet sought treatment, or for whom treatment has not yet been provided (Commonwealth of Australia 2012).
Personal and health-related information	Any information or an opinion about a person whose identity is apparent or can reasonably be ascertained from the information or opinion. Personal information can include a person's name, date of birth, address, telephone number, family members or any other information that could allow the person to be identified. Health-related information includes symptoms or observations about the person's: health; prescriptions; billing details; pathology or other test results; dental records; Medicare or health insurance numbers; admission and discharge details; genetic information; and any other sensitive information about things such as race, sexuality or religion when it's collected by a health service. In the context of these standards, personal and health related information, where it can lead to the identity of the person, is considered in the same way (Commonwealth of Australia 2010).
Practice	Any role, whether remunerated or not, in which the individual uses their skills and knowledge as a practitioner in their health profession. Practice is not restricted to providing direct clinical care. It also includes using professional knowledge in a direct non-

	clinical relationship with patients or clients, working in management, administration, education, research, advisory, regulatory or policy development roles and any other roles that impact on safe, effective delivery of health services (adapted from AHPRA 2012).
Prevention	Interventions that occur before the initial onset of a disorder (Commonwealth of Australia 2010).
Professional boundaries	Professional boundaries are limits which protect the space between the professional's power and the client's vulnerability (Peterson 1992).
Quality improvement	Ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to people (Commonwealth of Australia 2010).
Recovery	A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability (Commonwealth of Australia 2010).
Recovery-oriented mental health practice	Refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals, wishes and aspirations (Commonwealth of Australia 2013).
Rights	Something that can be claimed as justly, fairly, legally or morally one's own. The term can also refer to a formal description of the services that people can expect and demand from an organisation (Commonwealth of Australia 2010).
Risk	The chance of something happening that will have a (negative) impact. It is measured in terms of consequence and likelihood (Commonwealth of Australia 2010).
Risk assessment	The process of identifying, analysing and evaluating a risk (Commonwealth of Australia 2010).
Safety	Freedom from hazard (Commonwealth of Australia 2010).
Seclusion	The act of confining a patient in a room when it is not within their control to leave. It should not be confused with the practice of time out, where a patient is requested to seek voluntary social isolation for a minimum period of time (Commonwealth of Australia 2010).
Self-determination	The right of individuals to have full power over their own lives. Self-determination starts with the basic ideas of freedom to design a life plan, authority to control some targeted amounts of resources, support that is highly individualised and opportunities to be a contributing citizen of the community (Commonwealth of Australia 2013).
Service provider	A person, usually with professional qualifications, who receives remuneration for providing services to people who have a mental health problem and/or mental illness (Commonwealth of Australia 2010).
Services	Products of the organisation delivered to people or units of the organisation that deliver products to people (Commonwealth of Australia 2010).

Social inclusion	Contemporary concepts of disadvantage often refer to social exclusion. Social inclusion refers to policies that result in the reversal of circumstances or habits that lead to social exclusion. Indicators of social inclusion are that all Australians are able to: secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and have their voices heard (Commonwealth of Australia 2009).
Social and emotional wellbeing	An holistic Aboriginal definition of health that includes: mental health; emotional, psychological and spiritual wellbeing; and issues impacting specifically on wellbeing in Aboriginal and Torres Strait Islander communities such as grief, suicide/self-harm, loss and trauma.
Standard	Degree of excellence etc. required for a particular purpose; measure to which others conform or by which the accuracy or quality of others is judged.
Support services	Direct services and interventions provided for a person with a mental health problem and/or mental illness and associated disability aimed at reducing handicap and promoting community tenure, for example, assistance with cooking and cleaning. Support services do not necessarily have a treatment or rehabilitation focus (Commonwealth of Australia 2010).
Transition of care	A set of actions designed to ensure coordination and continuity of care as patients transfer between services. Transitions of care occur in real time, during weekends and overnight, and are usually short lived and often involve clinicians that do not have an ongoing relationship with the patient. They occur when a patient is leaving a health service, or being transferred to a different institution or level of care, and generally consist of one or more clinical handovers. The process ends only when the patient is received into the next clinical setting. Transition of care is heavily involved in the processes of admission, referral and discharge and is considered a unique and distinguished process from any other healthcare setting (ACSQHC 2012).
Treatment	Specific physical, psychological and social interventions provided by health professionals aimed at reducing impairment and disability and/or the maintenance of current level of functioning (Commonwealth of Australia 2010).
Values	Principles and beliefs that guide an organisation and may involve social or ethical issues (Commonwealth of Australia 2010).
Wellbeing	The state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social condition (Commonwealth of Australia 2010).

Appendix F: Background

Policy frame

The origin of these capabilities lies in both national mental health policies and national health workforce directions. The Fourth National Mental Health Plan 2009-2014 includes an action to 'develop and commence implementation of a National Mental Health Workforce Strategy that defines standardised workforce competencies and roles in clinical, community and peer support areas (action 25)'.

The National Mental Health Workforce Strategy and Plan (2011) was endorsed by Health Ministers, and includes the following strategies:

1.1.1 Develop national core competencies and an educational framework for mental health services (including clinical, community and peer support services).
1.1.2 Include management of comorbid drug and alcohol and mental health issues in the national core competencies for mental health.

HWA is charged with leading health workforce reform in Australia, and produced the provisional National Common Health Capability Resource in March 2013.

Nationally, and internationally, work has been done in this area. Frameworks such *as Let's get Real* and the *Ten Essential Shared Capabilities*, from New Zealand and the United Kingdom respectively, have informed these capabilities. The New South Wales Ministry of Health has generously shared the expertise it has gained in developing the NSW Child & Adolescent Mental Health Competencies.

The current document has been developed consistent with both mental health policy and health workforce policy requirements. National health workforce directions have shifted from competencies to capabilities in recent years.

Development Methodology

Development of the capabilities has involved an iterative process, oversighted by a working group of experts knowledgeable in the content and application of existing frameworks and practice standards in mental health. The development process consisted of the following stages:

Stage	Description
1. Definition of purpose	Established a rationale for development of the capabilities, including identification of drivers, articulation of guiding principles, delimitation of scope, and specification of intended applications and their associated outcomes.
2. Research	Collected information on Australian mental health workforce roles, what work they do, and how this work is approached. Existing frameworks and standards were a primary reference source, and also the National Common Health Capability Resource.
3. Identification of shared activity groups	Reviewed existing standards and frameworks to identify activity groupings that recurred across the source documents. Considered the NCHCR and differences relating to mental health.
4. Refinement of activity groups	Tested initial activity groupings through a Project Advisory Group and Technical Working Group, and revised as recommended.
5. Refinement of activity groups and subgroups	Tested activity groups and subgroups through a Technical Working Group, and revised as necessary.
6. Specification of behaviour indicators	Considered best practice for each activity component in order to specify the behaviours required of the workforce for excellent provision of care. Developed a measurement scale to align with the different levels of behavioural expression. This concluded development of a preliminary working draft.
7. Refinement of behaviour levels	Tested the preliminary working draft with a Project Advisory Group and Technical Working Group, and revised as necessary.
8. Validation and revision	Undertook focus group testing to validate the content of the capabilities.

Appendix G: Complementary documents to the Capabilities

Australian Association of Social Workers, (2012) *Australian Social Work Education and Accreditation Standards*

Australian Association of Social Workers (2008) *AASW Practice Standards For Mental Health Social Workers*

Australian College of Mental Health Nurses (2010) *Standards of Practice for Australian Mental Health Nurses:*

Australian Medical Council (2009) Assessment and accreditation of medical schools: standards and procedures.

Australian Psychological Society:

- *Code of ethics (2007)*
- *Ethical guidelines (2012)*

Australian Psychology Accreditation Council (2010) *Rules for Accreditation and Accreditation Standards*

Australian Nursing and Midwifery Accreditation Council (2006) *National Competency Standards for Midwives*

Australian Nursing and Midwifery Accreditation Council (2006) *National Competency Standards for Enrolled Nurses*

Australian Nursing and Midwifery Accreditation Council (2006) *National Competency Standards for Registered Nurses*

Confederation of Postgraduate Medical Education Councils (2009) Australian curriculum framework for junior doctors

Occupational Therapy Australia (2010) *Australian Minimum Competency Standards for New Graduate Occupational Therapists*

Royal Australian and New Zealand College of Psychiatrists

- position statements
- clinical practice guidelines
- ethical guidelines
- *Code of conduct*
- *Code of ethics*

Appendix H Excerpt from National Practice Standards for the Mental Health Workforce 2013

Values and attitudes inform the way that mental health services are delivered and received. Individual practitioners have their own personal beliefs and values; however, there are specific values on which all workers are expected to base their practice. These values are a declaration of what the mental health workforce holds to be important principles and what individuals strive to practice each day. Mental health practitioners are expected to understand, reflect on and use their own values and beliefs in a positive way at work.

The following values and attitudes underpin how mental health practitioners apply skills and knowledge when working with people, families, carers and communities.

Values

Respect

All people have the right to be heard and treated with dignity and respect, have their privacy protected, and have their documentation treated in a confidential manner. Mental health practitioners respect the person, their family and carers, their experience, their values, beliefs and culture. They also respect diversity among people, families, carers, colleagues and communities, in areas including class, gender, culture, religion, spirituality, disability, age, power, status and sexual orientation.

Advocacy

Concern for the welfare of others guides the work of mental health practitioners. They strive to uphold the human rights of people, families and carers, including full and effective participation and inclusion in society. Mental health practitioners support the individual, and others (including children) who may be affected by the illness of a family member.

Recovery

Mental health practitioners support and uphold the principles of recovery-oriented mental health practice articulated in the *National Standards for Mental Health Services 2010*. They use the National Framework for Recovery-oriented Mental Health Services (2013 forthcoming) to guide their recovery-oriented practice. Mental health practitioners recognise the value of lived experience, and work to provide mental health care that:

- Recognises and embraces the possibilities for recovery and wellbeing created by the inherent strength and capacity of all people experiencing mental health issues
- Maximises self-determination and self-management of mental health and wellbeing
- Assists families to understand the challenges and opportunities arising from their family member's experiences.

Working in partnership

Mental health practitioners foster positive professional and authentic relationships with people, families, carers, colleagues, peers and wider community networks. Safe and professional boundaries are maintained. Mental health practitioners work constructively to resolve tensions that may arise between partners in care. The professional diversity that can exist within teams is respected and valued and there is always endeavour to work in positive and collaborative ways that support multidisciplinary and interdisciplinary practice. Mental health practitioners believe that quality service provision is enhanced and underpinned by effective working relationships within the service, with partner agencies and communities.

Excellence

Mental health practitioners are committed to excellence in service delivery, and also to personal development and learning. This is supported through reflective practice, ongoing professional development and lifelong learning.

Attitudes

Attitudes are an established way of thinking or feeling that are typically reflected in a person's behaviour, for example, a positive attitude towards employing people with a disability. Attitudes involve the interaction of beliefs, feelings and values, and a disposition to act in particular ways. Our attitudes help us to define how situations are seen, as well as define what is expected in behaviour towards a situation, person or object.

In working with people, carers and families, mental health practitioners are expected to be:

- respectful
- compassionate, caring and empathic
- ethical, professional and responsible
- positive, encouraging and hopeful
- open-minded
- self-aware
- culturally aware
- collaborative.

Appendix I: Resource Application Areas

Application	Description
Workforce and service planning	The Resource can be used to define the behaviours critical to the achievement of future business goals/targets. This application involves comparison of current workforce characteristics with future requirements, and the development and implementation of strategies to address any skill gaps. The goal of this process is to ensure that health services have the right number of people, with the right skills and experiences, in the right jobs and places, at the right time. It is important to include behavioural skills in forecasts because of their known ability to positively impact the quality and safety of care.
Workforce and service redesign	The Resource can be paired with existing methods and tools to strengthen innovation and reform activities aimed at changing existing skill mix, service models, and technology use to address challenges associated with meet current and future demand. This application involves identifying the behavioural skills that underpin successful performance of tasks in the workplace, and complements the functional analysis process, which informs the potential for task sharing or delegation within the workforce. Behaviours provide a foundation for the broadening and deepening of technical skills, and must be considered as part of the redesign process given their known influence on performance.
Individual and organisational development	*Individual* The Resource can be used to describe the behaviours that will be monitored or measured as part of an individual's performance appraisal process. For this application, behavioural attributes are drawn from the position description to provide a shared understanding of how work is expected to be performed, and must be integrated with aspects of performance that assess what work is done. Inclusion of behavioural attributes within the performance appraisal and development process provide specificity and concreteness for discussions about behavioural deficiencies that are negatively impacting job performance, objectifying the discussion and providing a pathway for development. *Organisational* The Resource can be used to develop behavioural capabilities and a culture that ensures a readiness to meet future healthcare needs and challenges. This application involves using the Resource as a basis for assessing the current situation within workplace/organisation, and designing and implementing an intervention in response to an identified need for change. It is relevant to both systems (e.g. organisations) and subsystems (e.g. teams, departments). Because organisations are made up of teams, behaviour change must occur in groups in order to make a difference in culture. Changing the behaviours of the workforce can produce fundamental improvements in the way individuals, groups and organisations function. Using the Resource to drive organisational development processes can assist users in developing their own ability to change and renew, ensuring they remain relevant and responsive to people's healthcare needs and expectations over time.
Education and training	The Resource can be used to identify and communicate the learning and development needs of

	the workforce from a behavioural perspective. This application could involve: (a) using the Resource to define behaviours crucial to individual or organisational success, and undertaking a training needs analysis to identify any skill gaps that can then be addressed through training. (b) using the Resource as a consensus statement on health industry workforce requirements, which can facilitate discussion between the health and education sectors and inform curriculum design and renewal. The Resource also provides a useful structure and starting point for the development of capability frameworks for specific areas of health/practice, and can help define student learning outcomes for programs of study. When used in these ways, the Resource can contribute to ensuring that workers have the behavioural skills required to be successful in the healthcare field and arrive in the workplace more work ready.
Recruitment, selection and induction	The Resource can be used to write behavioural job descriptions, to facilitate behaviour-based interviewing, and set behavioural expectations upon entry to a workplace/organisation. These applications involve predetermining the behavioural attributes required for effective performance of a role (in addition to requisite knowledge and skills), specifying these in the position description, constructing interview questions that test for these skills, and establishing behavioural expectations during induction. Behaviour-based recruitment, selection and induction are superior to traditional methods because behaviours predict effective job performance beyond what is expected from technical knowledge and skills alone.