Centre for Mental Health Learning VICTORIA

Statewide Mental Health Occupational Therapy Workforce

Scoping Summary Report

Prepared by

CMHL Statewide Mental Health Occupational Therapy Educators

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Introduction

The Centre for Mental Health Learning (CMHL) is pleased to provide the Mental Health Statewide Occupational Therapy scoping report to the Department of Health (DH) Victoria.

This summary report is the culmination of 4-months engagement and communication with occupational therapists from AMHS since commencement of the CMHL Statewide Occupational Therapy Educator in October 2020, as well as internal CMHL collation, analysis, and documentation of the data obtained from this process. The Public Mental Health Occupational Therapy Leadership Network were involved in review of scoping questions and process. The need for this scoping was highlighted in collaboration with The Department of Health (DH), Mental Health Reform Victoria (MHRV), The Health and Community Services Union (HACSU), and Occupational Therapy Australia (OTA).

This scoping report identifies the occupational therapy workforce profile across Victorian area mental health services to support leadership, collaboration, growth, learning and development of our profession. Semi-structured interviews with each AMHS examined the topics:

- Staffing profile
- Discipline specific activity
- Leadership structures
- Education, research, and entry-level structures
- Professional development

This report outlines:

- Project background, purpose, and scope
- Data collection
- Key findings
- Project limitations

Project Name: Victorian Mental Health Occupational Therapy Scoping Project

Project Name	Victorian Mental Health Occupational Therapy Scoping Project
Commencement Date	November 2020
End Date	June 2021
Date of Presenting Findings	April 2021
Date of Final Report	Oct 2021

Project Background, Purpose and Scope

Background

The Centre for Mental Health Learning (CMHL) is a Department Health (DH) funded central agency for public mental health workforce development in Victoria. The CMHL vision is to be the centrepiece for mental health learning in Victoria, leading and driving innovation that strengthens and sustains a flexible, curious, knowledgeable and recovery-focused workforce.
Statewide Mental Health Educators for Occupational Therapy, Social Work, and Enrolled Nursing joined CMHL in October 2020. This scoping project was conducted to provide a foundational collective understanding of Statewide mental health OT/SW/EN workforce development priorities, to identify opportunities for CMHL to contribute to workforce development, and inform the work of the Statewide Educator roles.

Purpose

The purpose was to identify the OT workforce profile, and workforce development priorities, across Victorian area mental health services. The aim was to support leadership, collaboration, growth, learning and development of the Occupational Therapy profession. The scoping findings will assist the sector with understanding the Public Mental Health Occupational Therapy workforce professional development needs across Victoria. This activity was critical to establishing baseline knowledge that could be collated and analysed, with the aim of identifying gaps, needs, strengths, innovation, best practice examples, and shared future priorities.

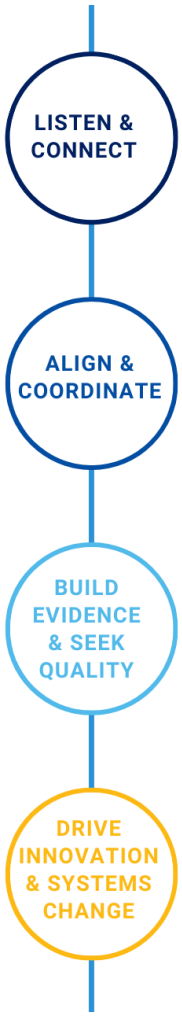
Benefits

- To understand the Public Mental Health Occupational Therapy workforce professional development needs across Victoria
- To collaboratively prioritise the CMHL Statewide Mental Health OT Educator focus
- To establish a centralised, comprehensive baseline data set, detailing the operations of all Mental Health Service's OT functions; as foundation for strategic planning for Victorian Public Mental Health Occupational Therapy leadership and workforce development.

Project scope and aims

The aim of this project was to establish a centralised, comprehensive data set, detailing the Occupational Therapy workforce profile across Victorian AMHS; this baseline information then provides the foundation for strategic planning for Victoria Mental Health workforce development. The scoping project aims are presented in alignment with the CMHL Strategic Leadership Pillars.

Figure 1: Aims of Occupational Therapy Workforce Scoping and CMHL Strategic Leadership Pillars



- To provide a 'statewide helicopter view' to build understanding of the needs and desires of the OT workforce across Victoria
- To create structures, processes and tools that make it easy to create connections, and to find and share OT resources

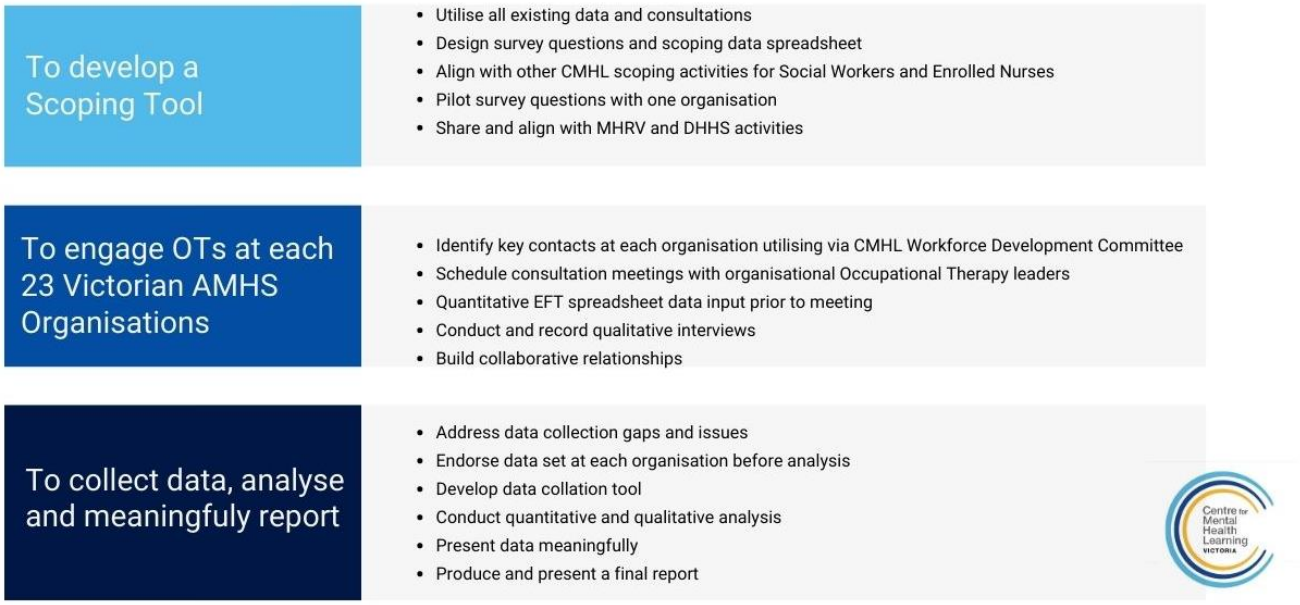
- To develop coordinated statewide solutions in partnership with key stakeholders (DHHS, HACSU, Statewide Training Providers) to assist with OT workforce development needs and gaps
- To ensure training and education resources are well utilised

- To complete benchmarking to provide baseline data for CMHL to ensure quality for learning and workforce development approaches
- Develop structures for measuring the impact of OT/SW/EN in public mental health services

- To embed knowledge translation in key CMHL activities to build capability of OT workforces to deliver high quality services and programs
- To create systems that contribute to strengthening an evidence based, sustainable, and recovery-focused workforce

Project Objectives

Figure 2: Objectives of Occupational Therapy Workforce Scoping



Methodology

Data Collection

All Area Mental Health Services plus Forensicare (n=24) were engaged over a period of five months from the 10th December 2020 to 26th March 2021.

Selection: Participants were identified via the CMHL Workforce Development Committee, who nominated the most appropriate representative(s) of the occupational therapy workforce within each organisation. All CMHL discipline scoping sent consistent letters to services to introduce project.

Pilot testing: Data collection spreadsheet and procedure was reviewed by CMHL Educator Team and The Victorian Public Mental Health Occupational Therapy Leadership Network (PMHOTLN) prior to initial use. Minor changes were made to ensure clarity of questions, and the addition of occupational therapy discipline specific roles. The decision was made to pilot the data collection tool with two AMHS prior to commencing the full scoping project. Following feedback from these two organisations, minor modifications were made to the data collection process before implementing this with the remaining AMHS.

Validation: After each of the consultations, data collected was recorded in an excel spreadsheet and sent back to each of the AMHS for comment and validation, each service was encouraged to make any required changes prior to data validation and endorsement. A final PDF was then provided to each organisation to enable easy sharing.

Scoping Tool: The data collection spreadsheet tool (see Appendices) was accompanied with clear instructions for how to complete the excel spreadsheet. These instructions were explained again during the consultations to ensure that AMHS understood how to complete the spreadsheet consisting of 4 sheets:

Sheet 1. Introduction & Instructions

Sheet 2. Quantitative Data was collected about the Occupational Therapy Workforce Profile. Organisations were encouraged to commence completion prior to the scheduled meeting. Data included:

- Total workforce EFT and Headcount
- Occupational Therapy workforce EFT and Headcount
- Grades
- Positions
- Lifespan
- Area (Inpatient, Community, Community bed-based, Other)
- Service Type
- Designated OT Specific Roles
- Generic Roles

Sheet 3. Qualitative Data was gathered during recorded interview about discipline specific activity, leadership, education and professional development:

- OT Discipline Specific Activity
    - Common activities, assessments, model, intervention, measurements
- OT Leadership
    - Structures, EFT, resources, needs, coproduction
- OT Education & Professional development
    - Structures, roles, EFT, activity, needs
    - Supervision,
    - Students,
    - Graduate and entry level support
    - Research
- CMHL Priorities
    - Learning & development needs
    - Communities of practice
    - OT training priorities

Sheet 4. Feedback & Evaluation questions were asked in the fourth sheet of the data collection spreadsheet.

Table 1: Quantitative Data Collection Questions

OCCUPATIONAL THERAPY WORKFORCE EFT DATA								
What is approximate size of the mental health workforce employed within your area mental health service? Approximately how many occupational therapists are employed within your area mental health service? Can you provide a breakdown of the Grades of the OT workforce? What positions are the occupational therapists employed in? (Clinical, Service Development, Management, Education, Research, Project, OT Leadership, Other) How many entry level OTs did your service employ each year? (2019, 2020) How many OT student placements does your service provide each year? (2019, 2020) Where are the occupational therapists employed within your service? (Lifespan, Area, Service, OT specific/dedicated/generic role)								
SETTINGS LIFESPAN	AREA	SERVICE	EFT	HEADCOUNT	1. OT SPECIFIC	2. DEDICATED OT GENERIC ROLE	3. GENERIC	NOTES
e.g. Adult	e.g. Inpatient							

Table 2: Qualitative Data Collection- Semi-structured Interview Guide

DISCIPLINE SPECIFIC ACTIVITY	
What are the common OT specific activities provided in your service? (e.g. Consultation, Assessment, Intervention: individual, family, group, Education) Is there a preferred OT model or framework used within your service? What are the most common OT Assessments provided at your service? (e.g. COPM, AMPS, ESI, Sensory Profile, MOHO) What are the most common OT Interventions provided at your service? (e.g. approaches or occupational domains) How do you measure the contribution/impact of the role of occupational therapy in your service?	
OCCUPATIONAL THERAPY LEADERSHIP	
What is the current OT leadership structure within your organisation? What EFT is allocated to OT leadership roles? What % of OT leadership roles have associated clinical responsibilities (direct client service provision)? What resources and/or models do OTs currently use to influence change within this area mental health service? What does your OT workforce require to develop future leaders to drive innovation and systems change? What opportunities does your OT workforce have to engage in co-production, co-design or co-delivery with the Lived Experience Workforce? Please provide any examples	
EDUCATION & PROFESSIONAL DEVELOPMENT	
Education	What OT Education structures are in place specific to OT in your service? Do you have roles for an OT Educator, graduate coordinator, knowledge translation or research positions? If yes, please advise role and approx. EFT? What are the OT education and professional development activities provided within your service? What are the OT education and professional development needs that CMHL could support with?
Research	What OT research activities or structures are provided? Can CMHL support your OT workforce to enhance research capability?
Entry Level	Do you have a graduate OT Allied Health entry level program? Please describe
Supervision	What is the current OT supervision structure currently in your service? How have you implemented the Victorian Allied Health Supervision Framework? Please describe What group supervision and/or reflective practice is currently provided?
CMHL Priorities	What OT specific training topics would your service prioritise for 2021? Please 5 list in order of priority for those you would like CMHL support:

Data Analysis

All data was collated and analysed using Microsoft Excel data collation spreadsheets, developed for the study. Qualitative data analysis occurred for each question, and was subjected to thematic analysis to elicit repeated patterns of meaning. It involved familiarisation with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes. The initial themes that surfaced were then compared across interviews to corroborate and refine the findings. Finally, themes were finalised and reflected in the recommendations section of this report.

Key Findings

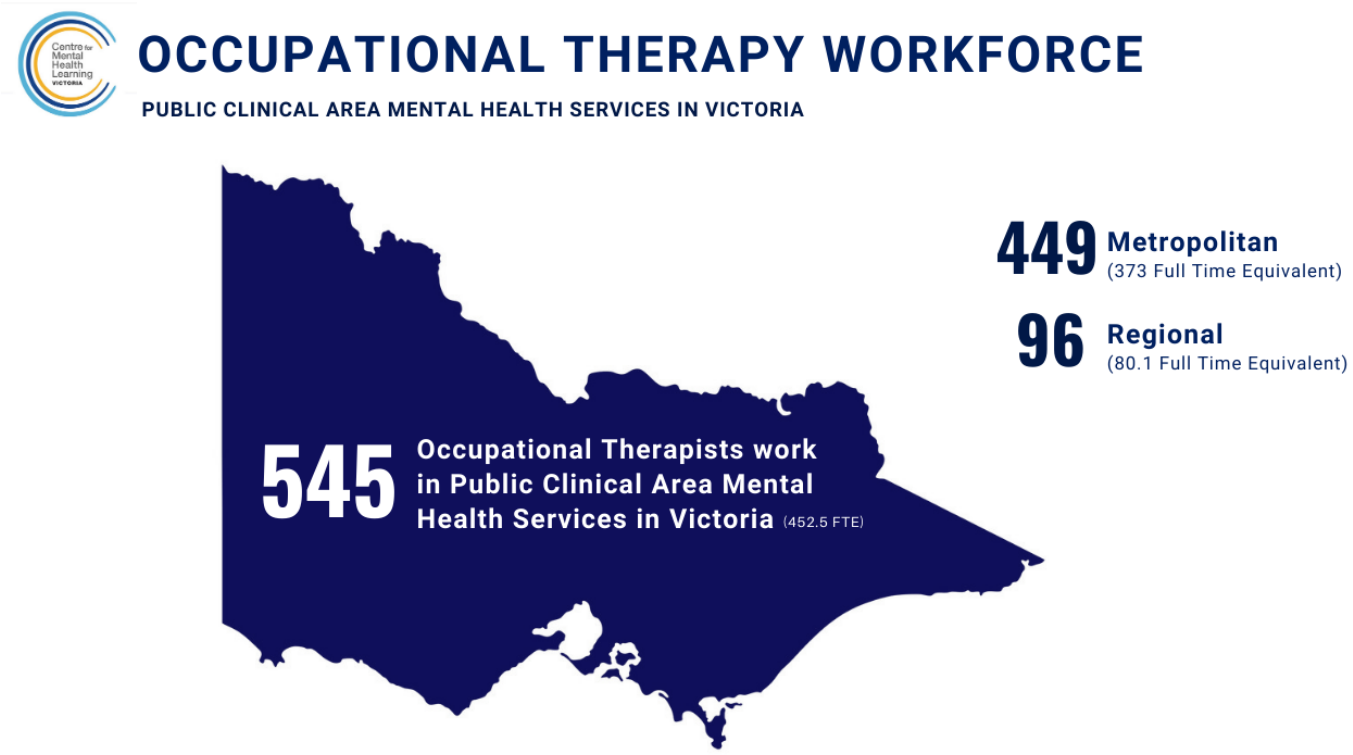
The key findings from the data analysis are presented for Occupational Therapy workforce profile, discipline specific activity, leadership, education and professional development.

Workforce Profile

Occupational Therapy Workforce Size

In Victorian Area Mental Health Services (AMHS) a total headcount of 545 occupational therapist are employed, or 452.5 full time equivalent (EFT).

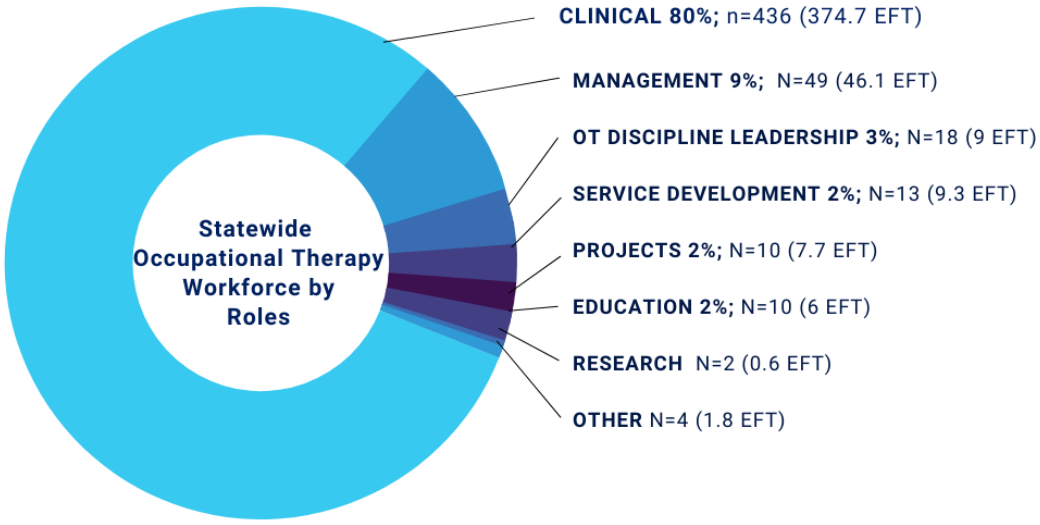
Figure 3: Total Occupational Therapy Workforce in Victorian Area Mental Health Services.



Roles of Occupational Therapy Workforce

The roles of occupational therapists working in area mental health services are many and varied, 80% of the workforce are employed in clinical roles. The remaining 20% of roles include management, service development, education, research, project and OT discipline specific leadership roles, as shown in Figure 4 below.

Figure 4: Occupational Therapy Workforce by Roles

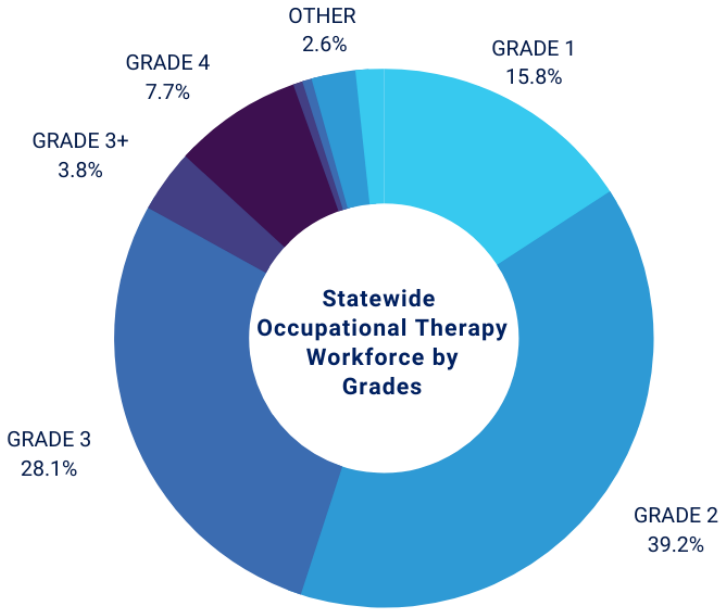


Service Development roles included dual diagnosis, Families and Parents with Mental Illness (FAPMI), Forensic Specialists, Specialist Family Violence Advisors, Aboriginal Engagement, Mental Health Promotion, Community Engagement, Youth Justice, and similar positions. Project roles included positions such as Quality Improvement Project, Family Services Project Worker, NDIS Project Leads, and Victorian Transcultural Mental Health Service Projects. These were time limited contract roles often with small EFT.

Grades of Occupational Therapy Workforce

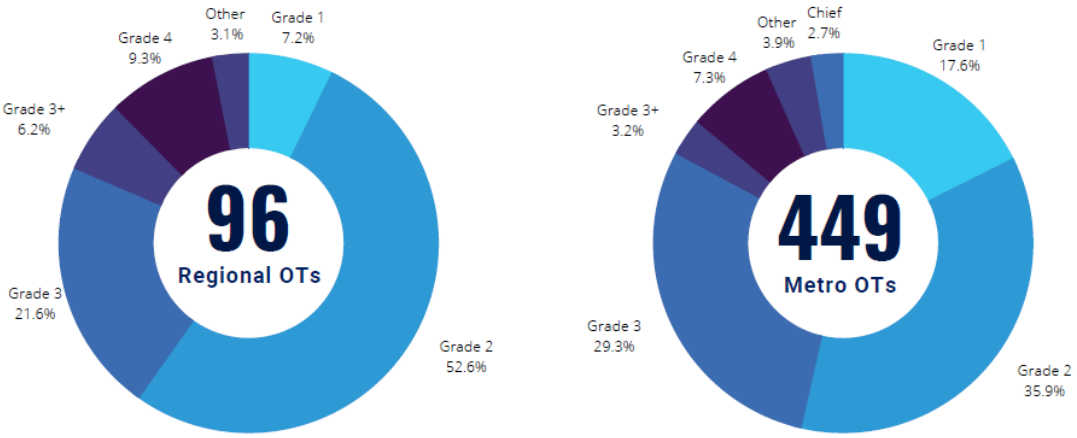
Across Victoria, occupational therapists are employed as grade 1 (15.8%), grade 2 (39.2%), grade 3 (28.1%) 'grade 3 plus' team leader supplement (3.8%), grade 4 (7.7%) and other (2.6%).

Figure 5: Occupational Therapy Workforce by Grades.



The 2016-2020 EBA includes Grade 3+ which is a supplement utilised by some AMHS for Team Leaders. Not all AMHS utilised the Chief classification. Current information available through HACSU indicated that new structures are proposed to include management, education and research streams in order to address longstanding existing issues related to Grade 3+, Grade 4 and absence of Grade 5 and Grade 6 classifications under current EBA. Other roles represented in the donut chart above do not fit within the Victorian Public Mental Health Services Enterprise Agreement 2016-2020.

Figure 6: Comparison of Victorian Metropolitan Versus Regional Occupational Therapists by Grades.



Entry Level Clinicians

This scoping study illuminated the need for increased positions, pathways and opportunities for mental health occupational therapists and career development. Across the state, Entry Level Programs are essential for graduate occupational therapists and those entering mental health occupational therapy workforce. In comparison to mental health nursing graduate programs, there is a major disparity in opportunities and resources for allied health. Entry Level Programs open to occupational therapists existed in 15 of the 23 services (Four regional and 11 metropolitan area mental health services). The five services that did not provide entry level programs described challenges not limited to insufficient access to occupational therapy supervision, supervisors, recruitment challenges, insufficient OT workforce numbers, structures, or capacity to support the positions. Recruitment challenges were also highlighted. Participation in CMHL Statewide Entry Level Training Program was recognised as a key component. There was some desire to support mental health rotations from general hospital in future, with supervision from mental health OT.

The need for competencies for mental health occupational therapists across the grades was highlighted in the scoping, especially for new graduate occupational therapists.

Key Finding: Competencies are needed for mental health occupational therapists across grade levels.

Occupational Therapy Workforce across the Lifespan

For the first time we are able to understand the total number of occupational therapists who contribute to Victoria's public clinical area mental health services across the lifespan settings: Child Youth and Families, Adult Services, and Older Adult mental health services. This scoping study has also revealed the exact teams that exist within each area mental health service, this information was not known or available prior. There are considerable differences in the titles of each service, setting and team across the sector.

Figure 7: Snapshot of Total Number of Occupational Therapists working across Lifespan Settings.

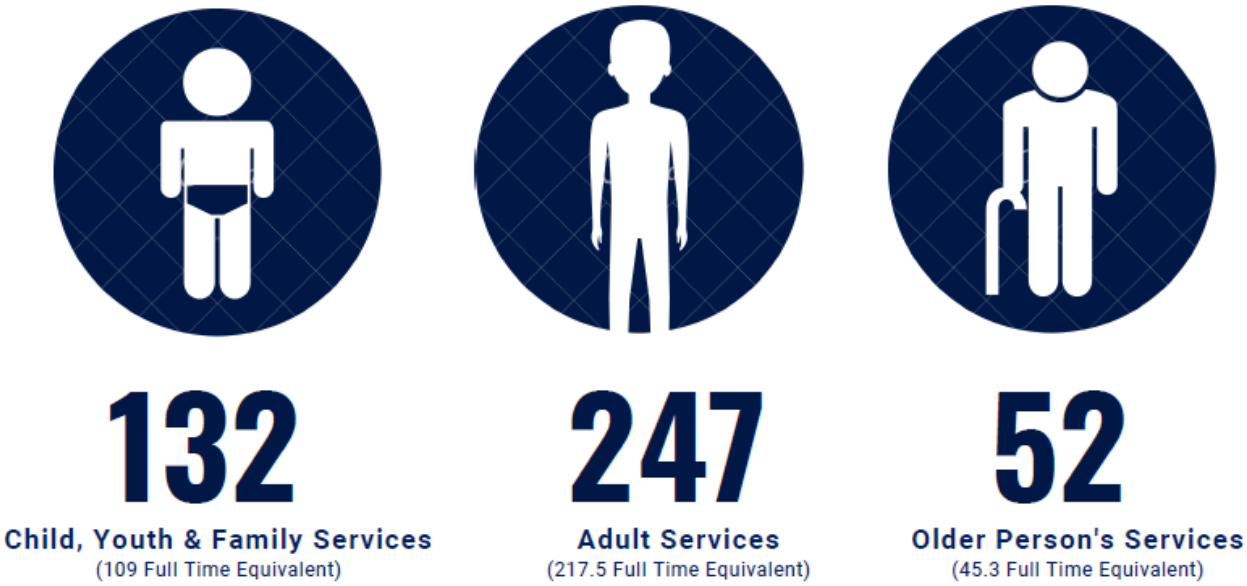


Figure 8: Statewide and/or Speciality Roles (n=100 Occupational Therapists)

Figure 9: Summary of Occupational Therapists Working in each Lifespan Setting and Service, for both Regional and Metropolitan Services.

132

Child, Youth & Family Services
(116 Full Time Equivalent)

Child, Youth & Family Services

Regional = 27	(21.3 EFT)
Metropolitan = 105	(89.7 EFT)
Inpatient = 14	(5 Regional; 9 Metro)
Community= 110	(20 Regional; 90 Metro)
Community bed based = 0	
Managers = 8	(2 Regional; 6 Metro)

Community Teams included Early Psychosis, Mood, Child, Perinatal, Intensive Youth Outreach, Child Adolescent Schools Early Action, Triage/Access (specific to child and youth), Autism Assessment, Integrated Community Team, Community Engagement, Health Promotion, Refugee Access, Youth Justice, Secondary Consultation for Out of Home Care, Psychosocial Services Program, Day Program, PACE, YAT, Triage/ Access, Hospital in the Home

*Note some programs that provided care for children, youth and families included within adult or service wide teams.

247

Adult Services
(217.5 Full Time Equivalent)

Adult Mental Health Services

Regional = 43	(35.7 EFT)
Metropolitan = 204	(181.8 EFT)
Inpatient= 59	(12 Regional; 47 Metro)
Community= 138	(27 Regional; 111 Metro)
Community bed based= 43	(4 Regional; 39 Metro)
Managers= 7	(0 Regional; 7 Metro)

Community Teams included Mobile Support & Treatment, Continuing Care, Homelessness Outreach, Integrated Community Teams, Brief Intervention, Suicide Prevention Teams, Crisis Assessment & Treatment, Triage and Access

52

Older Person's Services
(45.3 Full Time Equivalent)

Older Persons Mental Health Services

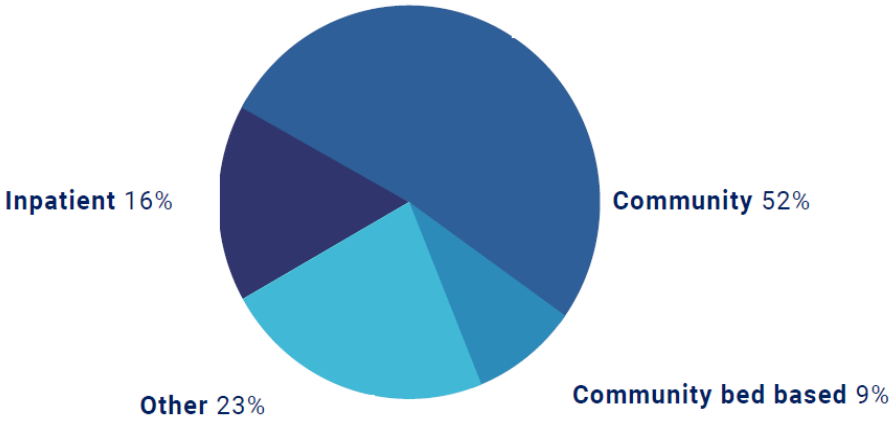
Regional = 13	(11.5 EFT)
Metropolitan = 39	(33.8 EFT)
Total Inpatient = 13	(3 Regional; 10 Metro)
Total Community= 27	(7 Regional; 20 Metro)
Total Residential care = 5	(0 Regional; 5 Metro)
Total Managers = 7	(3 Regional; 4 Metro)

Community Teams included Community Assessment and Treatment Teams, Aged Persons Assessment Teams, Intensive Community Treatment Team, Behavioural Ax & Specialist Intervention Consultation Service (BASICS), Healthy Ageing Program

Settings for the Occupational Therapy Workforce

Occupational therapists employed in mental health inpatient settings accounted for 16% of the workforce. Of these, 20 were located in regional services and 66 in metropolitan services. Of the 52% occupational therapists employed in community mental health settings, 54 were located in regional services and 221 in metropolitan services. Of the 9% of occupational therapists employed in community bed-based mental health settings, four were located in regional services and 44 in metropolitan services. Other settings included discipline leadership, service development, education, research, projects etc.

Figure 10: Pie Chart of Occupational Therapists working across Inpatient, Community, Bed-based and Other settings



Occupational therapists were employed across the lifespan, in diverse teams across many clinical settings. Details are provided in the table below, including a breakdown of those occupational therapists located in regional versus metropolitan settings. This information will be invaluable in connecting occupational therapists working in similar settings in communities of practice, education, and other workforce development activity.

Table 3: Number of Occupational Therapists Working in Settings and Teams across the Lifespan.

Child, Youth & Family Settings		Adult Settings		Older Adult Settings	
Inpatient Mental Health Occupational Therapists TOTAL (Regional + Metropolitan)					
Child Inpatient	**2** (0+2)	Adult Inpatient	**47** (9 + 38)	Older Adult Inpatient	**13** (3 + 10)
Adolescent Inpatient	**3** (0+3)	Psychiatric Assessment Planning Unit (PAPU)	0		
Youth Inpatient	**8** (4 + 4)	Secure Extended Care Units (SECU)	**12** (3 + 9)		
Parent-Infant Inpatient	**1** (1 + 0)				
Community bed-based Occupational Therapists TOTAL (Regional + Metropolitan)					
Youth Prevention and Recovery Centre	**0** (0 + 0)	Prevention and Recovery Centre (PARC)	**12** (2 + 10)	Nursing homes & hostels	**5** (0 + 5)
		Community Care Units / Community Recovery Programs	**31** (2 + 29)		

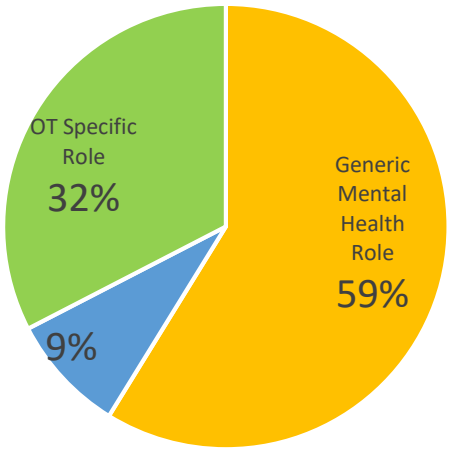
		Secure Extended Care Units (SECU)	**12** (3+9)		
Community Occupational Therapists		TOTAL (Regional + Metropolitan)			
Community care team	**42** (15 + 27)	Mobile Support and Treatment	**15** (2 + 13)	Community assessment & treatment teams	**23** (7 + 16)
Early Psychosis teams	**25** (0 + 25)	Continuing Care Teams	**57** (7 + 50)	Intensive Community Treatment Team	**1** (0 + 1)
Child team	**2** (1 + 1)	Homelessness Outreach Services	**3** (0 + 3)	Behavioural Ax & Specialist Intervention Consultation Service (BASICS)	**2** (0 + 2)
Perinatal team	**3** (1+2)	Integrated Adult Community Team	**20** (4 + 16)		
Intensive Youth Outreach Teams	**4** (0 + 4)	Brief Intervention Teams	**5** (0 + 5)	PHN Healthy Ageing Program	**1** (0+1)
Day Programs	**1** (0 + 1)	Lived Experience Workforce	**1** (0 + 1)		
Child Adolescent Schools Early Action (CASEA)	**4** (1 + 3)	'Therapy Team'	**1** (1 + 0)		
Autism assessment team	**2** (1 + 1)	Suicide Prevention Teams	**5** (1 + 4)		
Youth Justice Clinicians	**2** (0 + 2)	Consultation and Liaison services	**1** (0 + 1)		
Hospital Consultation Liaison	**3** (0 + 3)	Crisis assessment and treatment	**12** (2 + 10)		
Refugee Access Team	**2** (0 + 2)	Triage / Access	**17** (10 + 7)		
Personal Assessment & Crisis Evaluation	**3** (0 + 3)				
Psychosocial services program	**1** (0 + 1)				
Mood Team	**0** (0 + 0)				
Youth Access Team	**2** (0 + 2)				

Key Finding: OTs work across most lifespan and service settings, often as the sole OT in the team. There is a need for connecting OTs working in similar settings.

Discipline Specific and Generic Occupational Therapy Roles

Occupational therapists have less opportunity for employment within discipline specific roles within Victoria's public mental health system than generic roles. Generic mental health clinical roles are those positions open to many disciplines, often including nursing, social work and psychology. Occupational therapists have an extensive scope of practice (Occupational Therapy Australia, 2017).

Figure 11: Pie Chart Illustrating Percentage of Occupational Therapists Employed in Discipline Specific Roles



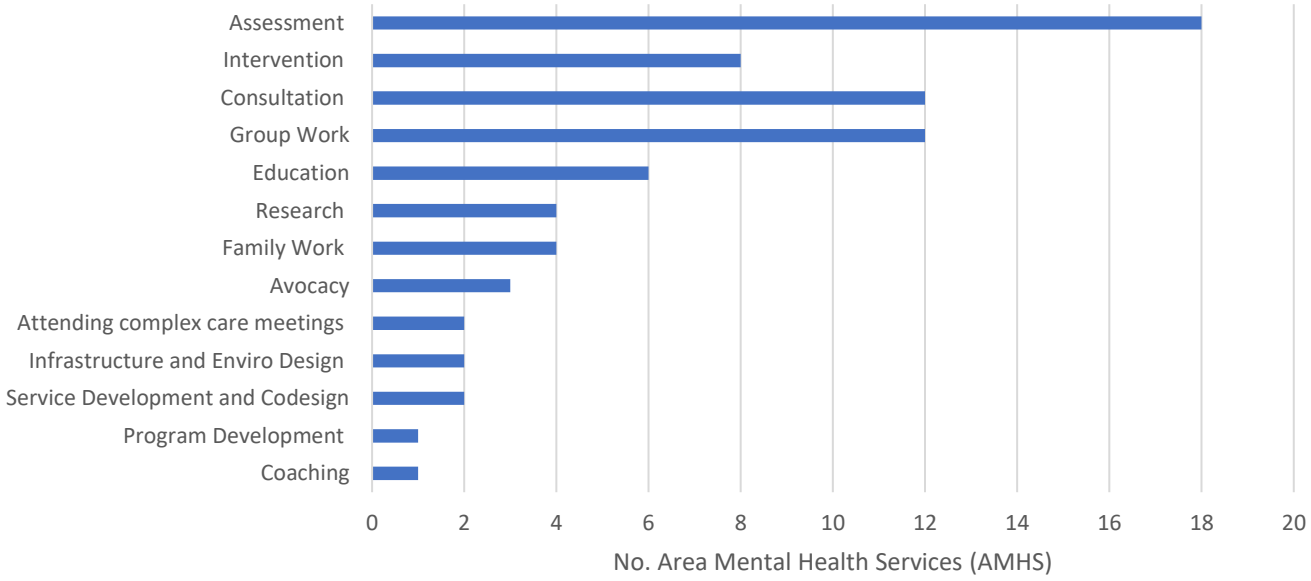
"Mental health service provision is a core area of practice for occupational therapists dating back to the beginning of the profession. Occupational therapists work across the spectrum of mental illness, providing services to people with mild, moderate and severe mental health conditions. They deliver services to people with relatively common conditions such as anxiety disorders, as well as more severe conditions that require targeted interventions, such as psychosis and trauma-related disorders. Occupational therapists also provide services that may have traditionally been considered the domain of other professions, such as psychotherapy and counselling" (OTA productivity commission response, 2019)

Discipline Specific Activity

The most common occupational therapy specific activities identified by occupational therapists in each area mental health service was identified. Following linguistic analysis of open ended responses, a word cloud generated from all words used to describe the common discipline specific activities undertaken by occupational therapists. The total number words was 129, with a minim frequency of 2 and highest frequency of 19. The more frequently the word was used the larger it is shown in the word cloud depicted below.

Figure 12: Word Cloud of Most Commonly Described Occupational Therapy Specific Activity

Figure 13: Common Occupational Therapy Activities Provided across the Area Mental Health Services



Consultation included OT primary, secondary and tertiary consultation. Group work referred to therapeutic activity programs. Educational activities were provided for multidisciplinary staff capacity building. Occupational therapists also identified a role with supporting staff with psychosocial disability and functioning- supporting the workforce with a ‘new way of thinking and shifting from medical model’. One Metropolitan Discipline Senior described the common activities of occupational therapist as “they are the first to put their hand up and they do a little bit of everything".
OTs are often holder of knowledge of connecting people to community based resources and linkages and attend multiagency meetings/service development networking portfolios.

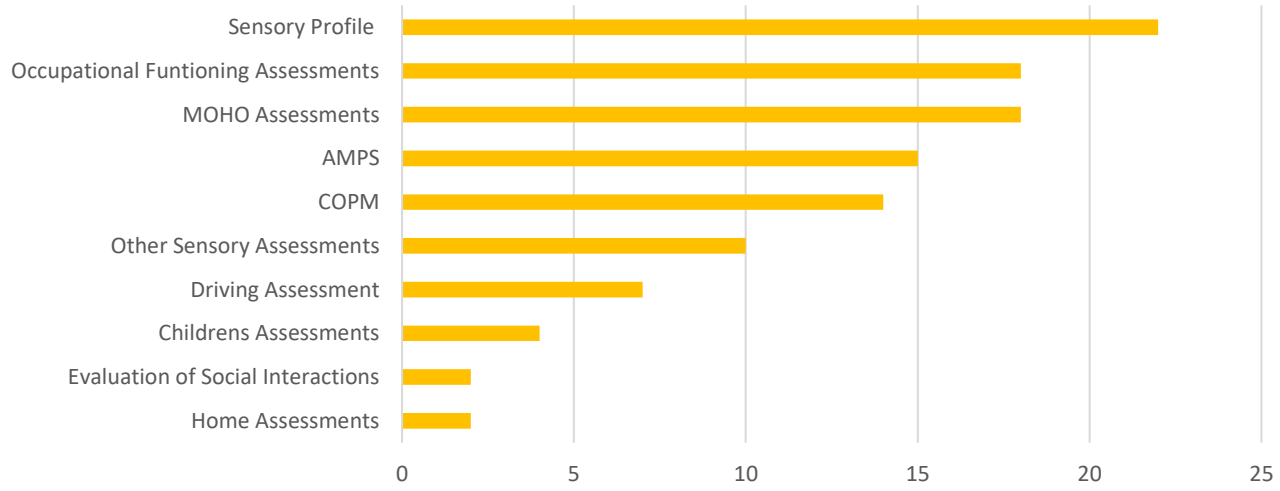
Common Occupational Therapy Models

Organisations were asked if there was a preferred occupational therapy model or framework used across the service.

Two thirds did not identify a consistent model used across the organisation. The minority of services had a preferred model (n=5) this did not include any regional services. The most common preferred model was the Model of Human Occupation (MOHO, Keilhofner, 2008). Two of the four services that identified MOHO as the preferred model also used Canadian Model of Occupational Performance & Engagement (CMOP-E, Polatajko, Townsend & Craik, 2007). Other services described using 'Occupation based model'. A number of services reported plans to develop this across the lifespan.

Common Occupational Therapy Specific Assessments

Figure 14: Most commonly used Occupational Therapy Assessments used in Victorian Area Mental Health Services



The most commonly reported occupational therapy assessment was the Sensory Profile (Adolescent/Adult Sensory Profile, Brown & Dunn, 2002; Sensory Profile 2, Dunn 2014 for use with children). It is assumed, or hoped, that this is used within the context of an assessment of occupational functioning. Other sensory assessments were also described less frequently included Adult Sensory History, Sensory Processing Measure and non-standardized assessments Sensory Wellness Tool, or those from Tina Champagne: Sensory Modulation Screening Tool (2007), Distress Tolerance Checklist, Carer screening questionnaire, Sensory Defensiveness Screening Tool (2007), Sensory tendencies and preferences questionnaire.

Assessments of Occupational Functioning were also used by most services. These were locally developed and there was variation in naming of this e.g., Living skills assessment, ADL (activities of daily living) assessment, observational functional assessment, OT Initial Assessment, Occupational Interview. A small number of services identified using still the DACSA, despite acknowledgement of its old and laborious nature. Home assessments were listed separately by two services, however these may be assumed as part of an occupational functional assessment or AMPS.

The Assessment of Motor and Process Skills (AMPS), which requires training and calibration, was reported as used by 65% of services. The companion interview, the Assessment of Compared Qualities-

Occupational Performance (ACQ-OP) was not identified as a commonly used assessment, neither was the School AMPS. Another internationally standardised, evidence based and occupation based assessment from the Occupational Therapy Intervention Process Model (OTIPM) is the Evaluation of Social Interactions (ESI), which was reported to be commonly used by under 10% of services. This also has a recently released companion tool, Assessment of Compared Qualities- Social Interaction (ACQ-SI) Measure the extent of discrepancy between a person's reported quality of social interaction and what the occupational therapist observed.

Model of Human Occupation (MOHO) Assessments Tools were in use at 18 of 23 area mental health services. The suite of MOHO assessments used included:

- 78% MOHOST (Model of Human Occupation Screening Tool)
- 67% OCAIRS (Occupational Circumstances Assessment and Interview Rating Scale)
- 50% Occupational Performance History (OPHI-II)
- 39% Occupational Self-Assessment (OSA)
- 22% Volitional Questionnaire (VQ)
- 11% Assessment Communication and Interaction Skills (ACIS)
- 5% Residential Environment Impact Scale (REIS)

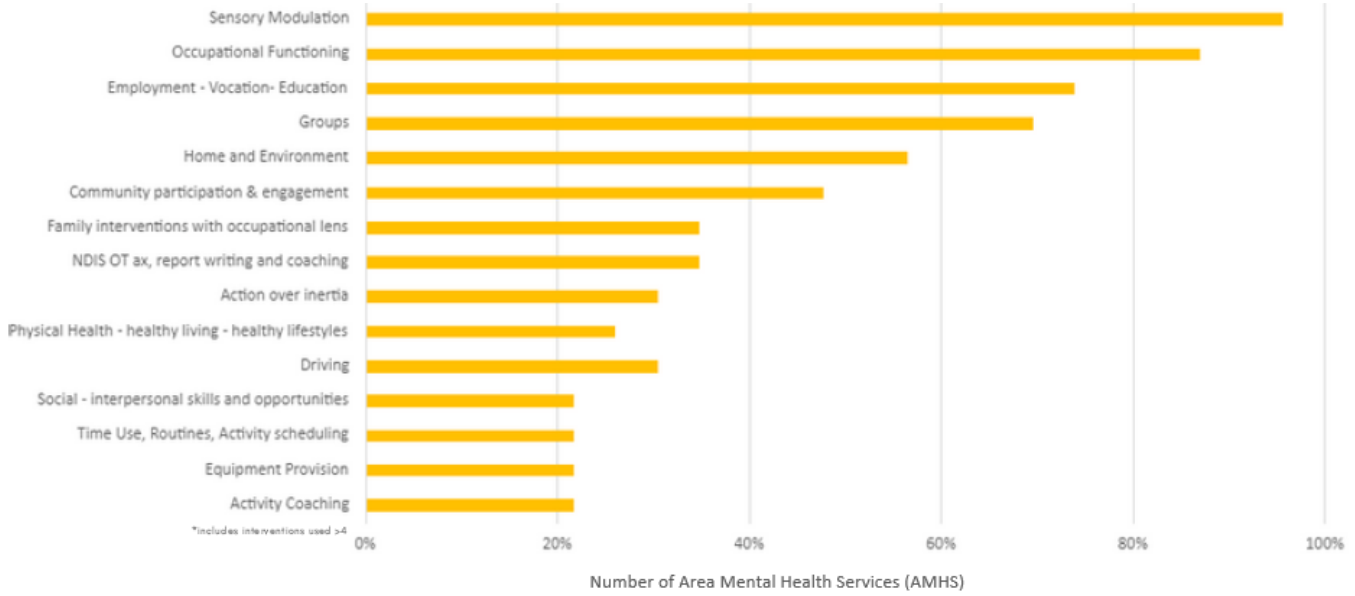
Interest Checklist was identified by five services and Role Checklist by four services, although this was sometimes referred to as a MOHO tool and sometimes listed independently.

Cognitive assessments reported as commonly used occupational therapy assessments were the NUCOG, ACE-R, Minessota assessment, Kettle Test. The Cognistat, Montreal Cognitive Assessment (MoCa), Adaptive Behaviour Assessment System (ABAS, n=3), Autism Diagnostic Observation Schedule (ADOS), World Health Organisation Disability Assessment Schedule (WHODAS) are not included in the above data set as these are not occupational therapy specific assessments.

Specific Children's Assessments were identified by less than three services, they included Stagnetti Play Assessment, Handwriting Assessment Beery Visual Motor Integration VMI, McMaster Handwriting Assessment, Bruininks-Oseretsky Test of Motor Proficiency, TVPS Test of Visual Perception Skills, MFUN Miller Function and Participation Scales, Children's Assessment of Participation and Enjoyment (CAPE), Child Occupational Self Assessment (COSA).

Common Occupational Therapy Specific Interventions

Figure 15: Commonly reported Occupational Therapy Interventions used by AMHS



Occupational therapists provided a breadth and depth in scope of interventions that are discipline specific in addition to interventions commonly provided by general specialist mental health professionals e.g. psychotherapy, counselling, crisis management, suicide prevention, psychological interventions including CBT, DBT, ACT, MFT, solution focused brief therapy, motivational interviewing, wellness recovery action planning, care coordination and targeted interventions for individuals, families, carers groups and communities experiencing homelessness, dual diagnosis, dual disability, family violence, unemployment and financial hardship. Discipline specific interventions were described broadly, both related to specific occupations (e.g. Vocational occupations, domestic occupations, personal occupations, social occupations, community occupations, transport and driving occupations, leisure occupations) and specific approaches (Figure 19). The findings of the scoping reflect the role of occupational therapists defined by OTA in submission to the Royal Commission into Victoria's Mental Health System (OTA, 2019).

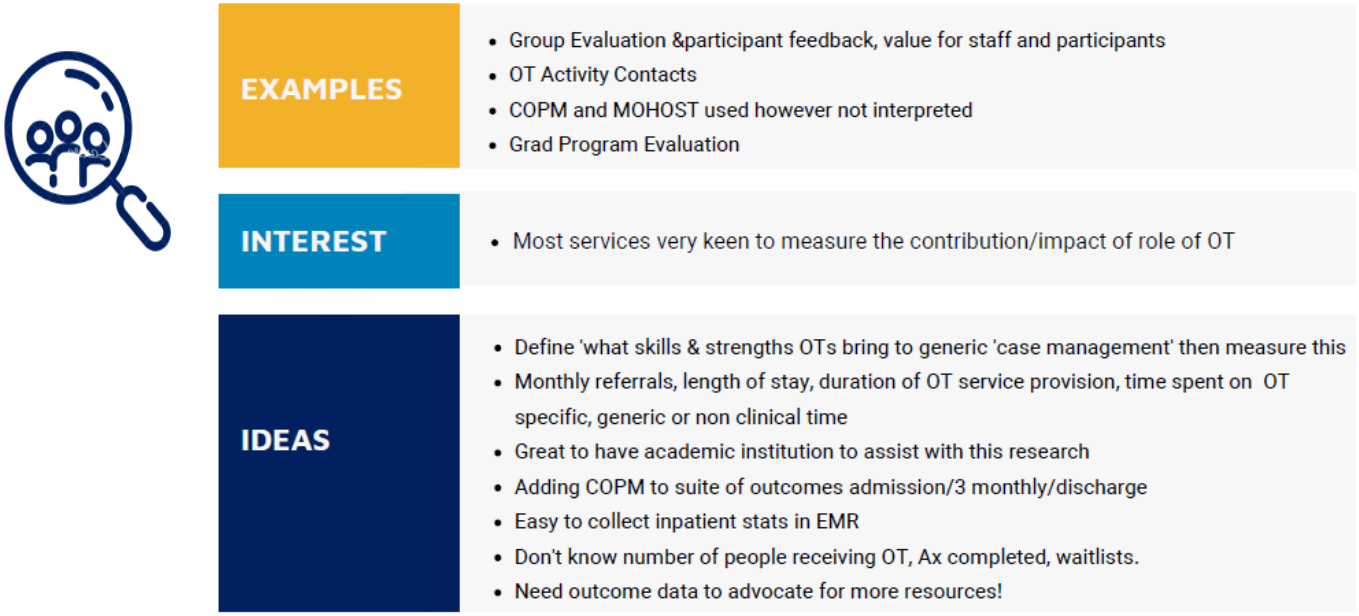
"In Victoria, occupational therapists play a vital role in transforming the lives of people accessing public mental health services, as well as delivering a range of services that address mental health and mental illness among the homeless, those in prison and forensic services, and those in mother and baby units. Clients referred to an occupational therapist working in mental health are assisted to:

- Engage in activities that are personally relevant, such as specific vocational and leisure interests (D'Amico, Jaffe, & Gardner, 2018);
- Find meaningful work and undergo training to improve their career options, particularly where their ability to remain engaged for a sustained period has been affected as a result of their condition (D'Amico, Jaffe, & Gardner, 2018);
- Develop ways to enhance their social connectedness and community engagement (Gibson, D'Amico, Jaffe, & Arbesman, 2011);
- Develop skills and qualities such as assertiveness and self-awareness (Gibson et al., 2011); and,
- Develop or restore skills through focused strategies such as personalised behavioural/ functional goal setting, psychoeducation, graded exposure and skills-based approaches, experiential learning, group and individual work, and adaptive learning strategies (Burson, Barrows, Clark, Geraci & Mahaffey; 2010; D'Amico, et al, 2018)

Common Occupational Therapy Evaluation

The scoping sought to understand how the contribution and impact of occupational therapy is measured in mental health settings. Whilst most services (74%) were not currently measuring this, there was strong recognition of the need to develop a method of evaluating occupational therapy. Regional and smaller services requested support and collaboration to identify how to approach this. In a metropolitan region, six area mental health services worked together under the guidance of an Occupational Therapy Advisor, to evaluate the impact of occupational therapy through a) contact statistics, b) evaluation of therapeutic activity and groups (ETAG), c) Activity and Participation Rating Scale, d) Key Performance Indicators for Activity and Participation, and e) measuring research and publications.
One small speciality service routinely evaluated demand for occupational therapy service provision through referrals and waitlists. A spreadsheet was used to analyse: reason for referral, types of support sought (sensory, motor, functional), assessments conducted, and feedback from participants. Furthermore evaluation included the use of a sensory screening tool in their adolescent inpatient unit.

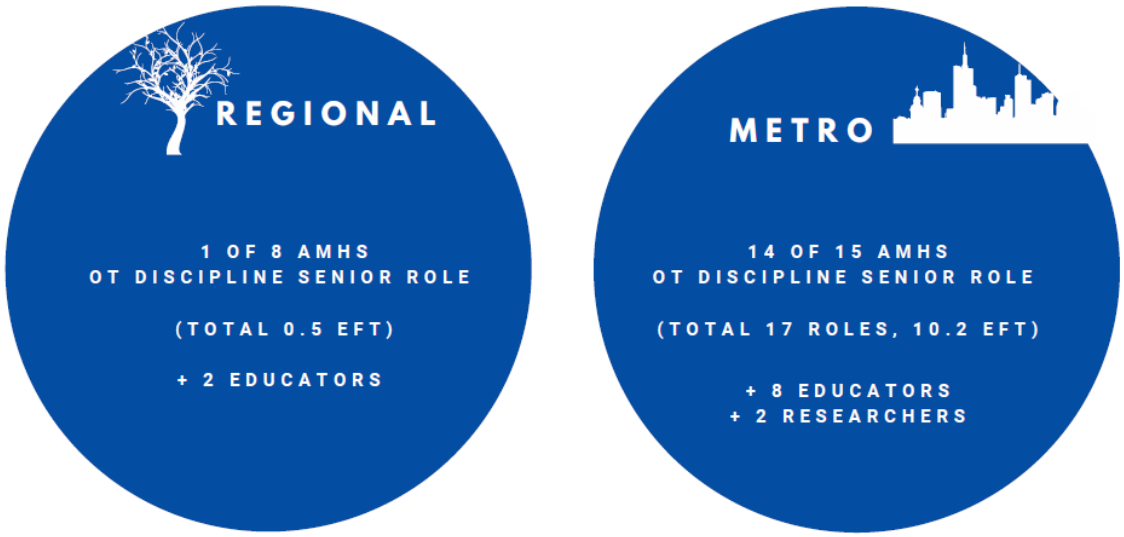
Some Measures were implemented in services, however these were yet to be collated to evaluate the impact of occupational therapy. Services also identified lots of ideas for how this could be approached.
Figure 16: Examples of Tools and Ideas for Measuring the Contribution / Impact of Occupational Therapy



Discipline Specific Leadership

There was an absence of leadership structures across the state, and significant variation in professional leadership structures that did exist. For the 545 occupational therapists working in public clinical area mental health services, there were 18 Discipline Leadership roles, with only 10.7 full time equivalent allocated to these roles (range from 0.1 EFT to 1.0 EFT). There was significant variation in role titles, e.g. OT Senior, OT Program Senior, OT Chief, OT Lead, Lead OT, Mental health Allied Health Coordinator, OT Senior Advisor.

Figure 17: Total Discipline Specific Leadership Positions (Headcount and EFT) in Regional and Metropolitan Area Mental Health Services



Leadership structures

Discipline leadership positions and structures are essential for supporting and growing the occupational therapy workforce. Whilst there was no consistency for how occupational therapy leadership is structured across the state, some themes were revealed:

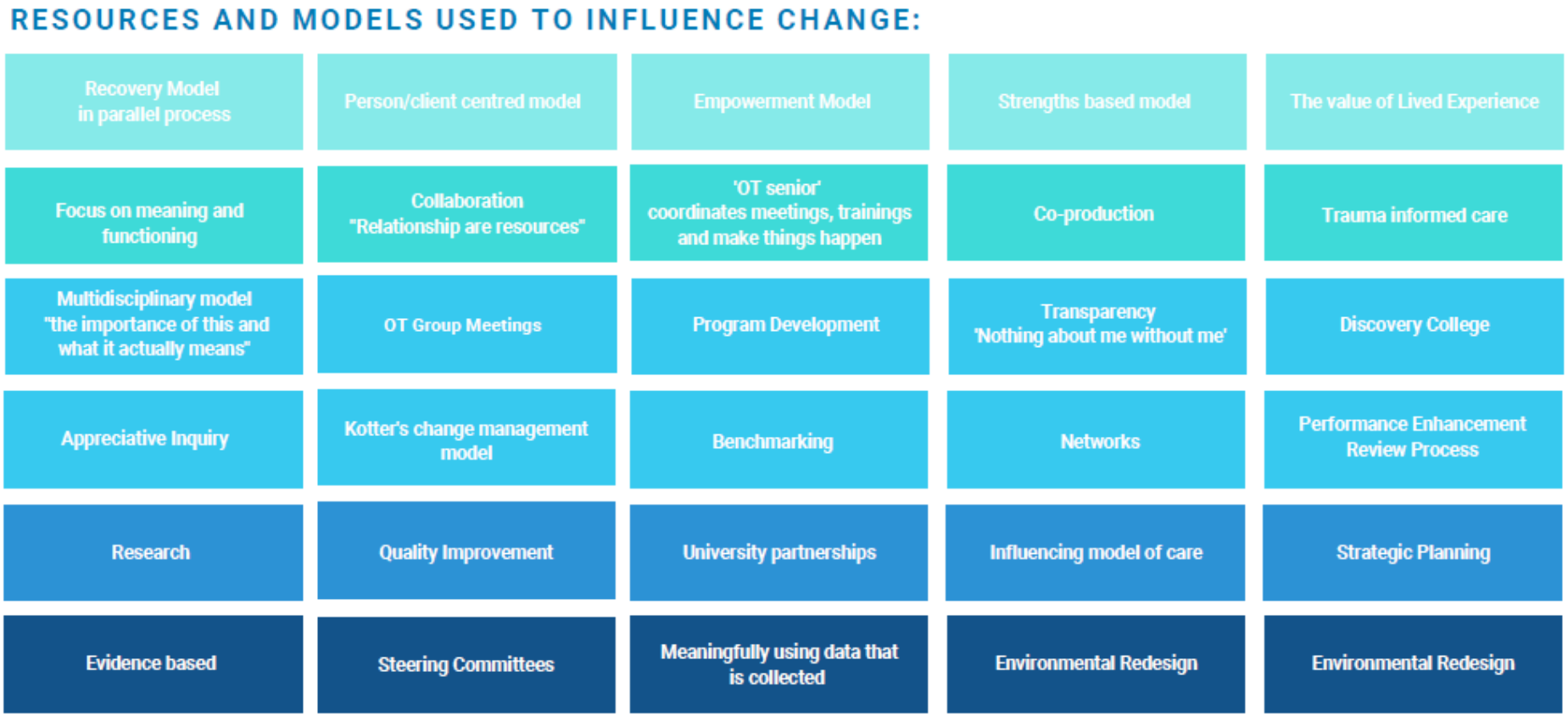
- Allied Health Director Roles (n=4)
- Occupational Therapy Discipline Seniors for either:
    - lifespan settings- Child, Youth, Adult, Older Adults
    - clinical settings- Community, Inpatient, CL & Emergency
    - overarching program senior

Overall there was a need identified for position descriptions to clearly define role responsibilities. Many discipline roles were stretched very thinly with expansive scope and responsibility for occupational therapy (and sometimes all allied health) workforce development, leadership, education, and research. Many roles were coupled with direct clinical service responsibilities. Reporting lines varied between reporting within mental health & to the general health organisation's occupational therapy department. Opportunity exists for increased collaboration between mental health programs and the general health organisation.

Key finding: Inadequate and inconsistent leadership positions and leadership structures exist to support the occupational therapy workforce across Victorian Area Mental Health Services. Many services do not have a designated discipline senior. The issues are exacerbated in regional settings.

Leadership influence

Table 4: What Resources and/or Models do Occupational Therapists Currently use to Influence Change within the Area Mental Health Service?



Each organisation was asked what does your occupational therapy workforce require in order to develop future leaders to drive innovation and systems change? Results are summarised in the table below.

Table 5: Occupational Therapy Leadership Needs

LEADERSHIP NEEDS FOR FUTURE LEADERS TO DRIVE INNOVATION AND INFLUENCE SYSTEMS CHANGE:				
LEADERSHIP STRUCTURES	Dedicated OT Leadership roles & EFT	Supervision and peer reflective practice stuctures	Discipline Governance	Formalised structures to identify & support leadership development
CAREER STRUCTURES	Graduate positions, programs, rotations	Clear career pathways and development opporunities	Pathways, competencies, minimum standards acrosss Grade 5, 4, 3, 2, 1, AHA	Student placement capacity across state
PROFESSIONAL IDENTITY	DISCIPLINE SPECIFIC ROLES AT ALL LEVELS	Ability to use discipline specific skills	Resources and models to support strong professional identity	Strong linkages, connectedness, network structures
RESEARCH & EDUCATION	Educator roles, teams and EFT	Research translation roles, EFT, support structures	Quality improvement program & coaching to translate ideas into practice	OT Resources to support evidence based practice
RECRUITMENT & RETENTION	Ability to recruit OTs	OTs have role in recruitment of OTs	All position descriptions include discipline specific roles	Funding and time within generic roles to offer true OT specific service within our roles.

Co-production

Occupational Therapist value and create opportunities to partner with the lived experience workforce and to enable coproduction.

Figure 18: Co-production involve? (Roper, Grey, Cadogan, 2018)

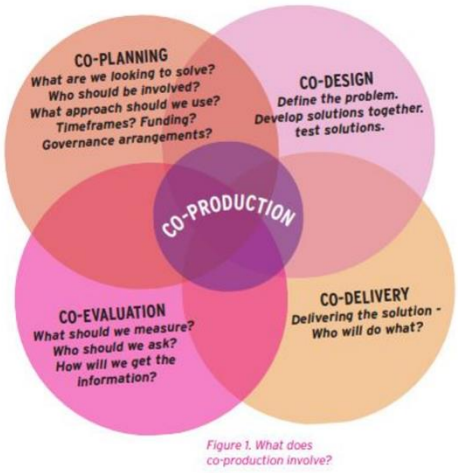


Figure 1. What does co-production involve?

Co-production is defined as co-planning, co-design, co-delivery, and/or co-evaluation with people with lived experience of mental ill health. 'Sees consumers involved in, or leading, defining the problem, designing and delivering the solution, and evaluating the outcome, either with professionals or independently. Co-production requires longer term engagement from professionals or clinicians, but leads to "profound and sustainable change" (p.7).

Whilst 55% of Area Mental health services identified that occupational therapists were creating opportunities for engaging in co-production with the Lived Experience Workforce, the scoping also highlighted a desire of the occupational therapy workforce to better understand co-production and navigate obstacles arising.

Co-creation of OT reports, goals, or notes within the context of the therapeutic relationship is not included as co-production (add Deb's ref). *Lara has emailed Deb about this*

The level of co-production varied amongst the AMHS. All of the AMHS expressed their desires to improve their approach to incorporating consumers and carers in the OT service development, but expressed having limitations with resourcing to employ, and/or challenges in engaging individuals with a lived experience where factors may make this difficult.

"Partnering with lived experience team a key priority for future development"

Key finding: Co-production is a key priority for future development. Overall, the OT workforce were very keen to increase involvement of lived experience/lived experience workers in their practice and workforce development activities. However, they experienced challenges with knowledge, time and resources available.

Discipline Specific Supervision

Professional Supervision structures

Many organisations identified that there was not a formal supervision structure in place for occupational therapy workforce.

The Victorian Allied Health Supervision Framework was reported to have been implemented at 22% (5 of 23) area mental health services. Many were aware of the framework, and requested support to implement this. Many services had local supervision policies or practice guidelines which supported this.

Key Findings:

- Local supervision policies and practice guidelines were in place at some but not all services
- Some AMHS provided policies and training specific for allied health
- Documentation templates included a) supervision contract, b) supervision record, c) evaluation of supervision
- Supervision training was a mandatory online module at a small number of major metropolitan services
- Resource and support for implementation is needed
- Promotion of supervision in mental health

Group Supervision

Thirteen of 23 AMHS were routinely engaging in group supervision, also referred to as Peer OT Reflection, OT Group Supervision, OT meetings have reflective component, Quarterly OT Peer Supervision, Senior OT Peer Supervision, Reflective Practice, Community of Practice for OTs focusing on a specific OT practice area (e.g. sensory modulation, groups, driving).

Key Findings: Occupational Therapists require access to individual and group supervision, as well as access to professional development to support ability to provide supervision, and to implement the Victorian Allied Health Supervision Framework.

Discipline Specific Education and Professional Development

Education structures and roles

Occupational Therapy education structures were identified at 13 metropolitan AMHS, but none of regional AMHS. Statewide there were nine Educator roles with a total of 3.8 EFT allocated (range 0.4 – 1.0 EFT). Only 0.5 EFT was within the EBA. There were two regional services with an Educator role to support the occupational therapy workforce, and seven Educator roles across 12 metropolitan AMHS. Not all educators were employed as OT Educators e.g. Allied Health Educator, Mental Health Educator. Four roles were located within the mental health practice development team, there were varied perspectives about this.

Educator roles for Occupational Therapists across area mental health services:

1 Metropolitan OT Educator (0.5 EFT across 6 AMHS)
1 Regional OT Educator (0.6 EFT in Practice Development Team)
1 Regional Allied Health Mental Health Educator (0.4 EFT)
1 Metropolitan Allied Health Mental Health Educator (0.8 EFT)
1 Metropolitan 'OT Practice Lead' (0.5 EFT) and 1 Clinical Educator within the Practice Development Team (1.0 EFT)
1 'Entry Level Program Coordinator' (0.5 EFT across 6 AMHS)
1 OT Educator (0.5 EFT)

Figure 19: Number of Educator Roles

These Educator roles had a variety of responsibilities, including OT workforce development, graduate/entry level workforce development, multidisciplinary mental health workforce development, student placement coordination, research knowledge translation and quality improvement.

Some AMHS accessed support for OTs via with their MH Workforce development team or general hospital structures.

Education activities

Key education activities included:

- Professional Development meetings
- Communities of practice
- Provide local calendar events, study days or learning programs
- Provide annual OT week events or mini conferences
- Facilitate access to external training events e.g. Tina Champagne training, CMHL Education, AMPS training
- Upskill OTs in assessments, intervention and evaluation
- Supervision
- Reflective practice
- Journal club
- OT presentations and practice examples (often referred to as "case studies")

Key education needs identified in regional AMHS were similar and are included above, however there was a stronger emphasis on assessments, models and connection with the profession.

Key finding: There is a disparity between education structures and activities for occupational therapy compared to nursing and medical mental health staff.

Discipline Specific Research

There is an absence of research structures for mental health occupational therapists across Victorian AMHS. There are a dearth of research roles, currently only two part time, time limited positions exist. This scoping data highlights the strong need and desire for more research capacity, activity, structures and resources to support quality improvement and evidence based practice essential for the occupational therapy profession.

Research structures

Many services identified awareness and intermittent use of research structures provided across their health care service. These were not mental health specific which resulted in inconsistent relevance for mental health occupational therapists. However, the Grade 4 Allied Health Research Roles were identified as being able to provide support to mental health allied health clinicians if actively sought.

Mental health practice development units sometimes offered some form of research support, this was often identified to be nursing driven and focused. A minority of services were establishing research departments within the mental health program. Annual forums for showcase research within the organisation were also seen as great opportunities for occupational therapists

Research participation is enabled by university partnerships and post- graduate student placements. There were very few examples of supervision of honours students. Many organisations expressed strong desire for enhanced linkages with universities.

The ‘Stepping into Research program’, originally designed, implemented and evaluated at Eastern Health (non-mental health specific), was adopted and implemented across NWMHS occupational therapy and social work in 2021. Mentors were required to be sourced externally.

There was a desire to be able to connect in to support learning by doing, 'walking alongside others' and to support capacity within and between organisations.

Research support needs

- “Great to be able to capture our innovations, to contribute to the literature, share findings, have someone with responsibility for this”
- A go-to person
- Ethics application guidance
- Data collection and analysis advice
- Research & Innovation Tutorial training program to engage selected OTs in research. Topics could include:
    - Myth busting around research
    - If you had a research idea where would you begin?
    - Building confidence to present at conference
    - How to turn a quality improvement project into research
    - How to do a literature search
    - How to prepare an ethics application and navigate the process
    - SPSS
- Use of RMH Library and Research support
- Awareness of research grants
- Creating a system to know what occupational therapy research (or participation) is being conducted within AMHS
- Opportunities to partner with other AMHS and other organisation

- Creating protected time
- Developing structures to make it easy to connect into research
- Developing structures for “collecting data as you go” and making evaluation easy to participate in

Figure 20: Number of Occupational Therapy Research Roles in Victorian Area Mental Health Services

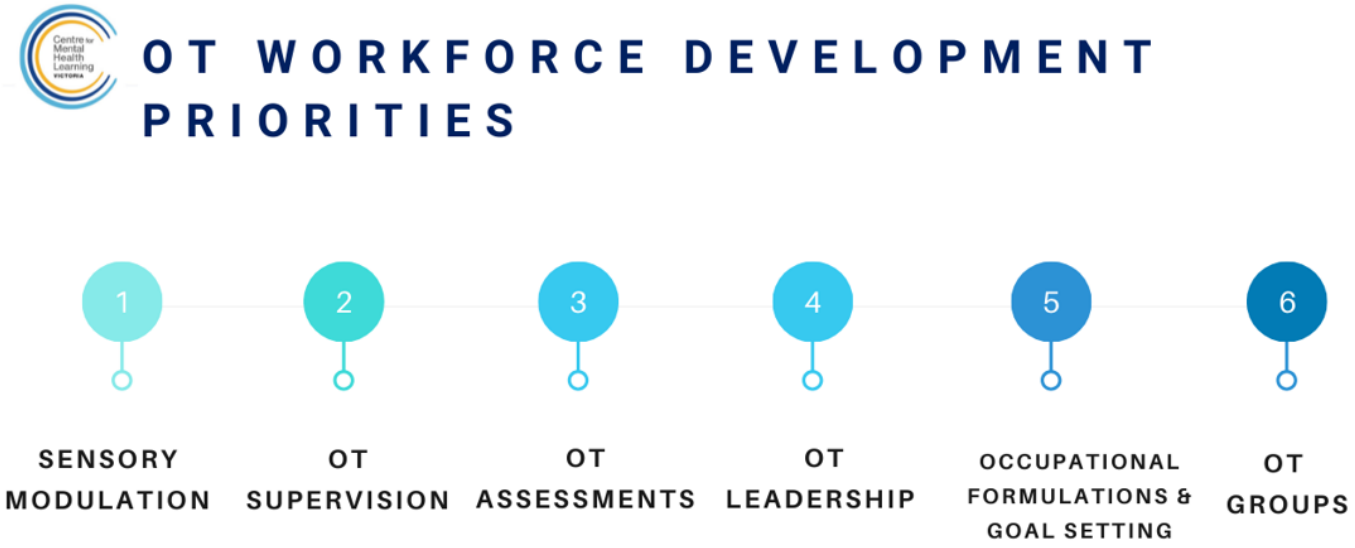
Key finding: No current statewide structures exist to support occupational therapy research, despite strong desire to measure occupational therapy service provision and the impact of our workforce.

Training Needs Analysis

The top 6 statewide occupational therapy workforce development priorities were ranked from a long list of topics. Each organisation was asked to identify and prioritise top 5 OT workforce development and training priorities. A significant list was established and some categories were developed. Each priority was given a numerical rating (priority 1 = 5 points, priority 2 = 4 points etc.).

A summary of topics included:
Sensory Modulation, Leadership, Supervision for OTs, OT professional identity, OT Assessments, OT formulations & goal setting, OT Group Interventions, OT best practice guidelines in mental health Cognition, Vocation, Research & Quality Improvement, OT managing physical health in mental health setting, Action over Inertia, Coproduction, Trauma Informed Care & impact on occupational performance, OTIPM-Occupational Therapy Intervention Process, OT Documentation, Youth & Mental health workforce in schools, Strengths base goal setting, OT outcome measures- capturing change over time, (OT identity- show what we are doing and achieving), Driving Assessments, OT and substance use/AOD, OT and BPD best practice assessment and, Intervention, Research and evaluation, AMPS, NDIS capacity for OTs, Being a solo OT, Teaching Digital Literacy, OT Career Pathways Forum.

Figure 22: Number of Occupational Therapy Research Roles in Victorian Area Mental Health Services



Key Finding: Each area mental health service identified many needs and priorities for OT training and workforce development.

Project Scoping Limitations

A risk assessment and mitigation plan were developed to address anticipated project limitations (stated below).

1. No two AMHS were the same thus qualitative data collection was difficult to compare.
2. Incomplete data sets
3. Accuracy of information from consultations.

Our minimisation strategies included:

- Developing concise and consistent messaging to AMHS regarding the purpose, benefits, and outcomes of the scoping project
- Conducting a 'pilot phase'
- Initiating early engagement with AMHS, well in advance of scheduled scoping meetings, via CMHL Workforce Development Committee and Public Mental Health Occupational Therapy Leadership network
- Utilising multiple communication mediums and follow up strategies with AMHS
- Conducting online research of individual AMHS websites prior to scoping meetings, and reviewing previous CMHL consultation with each AMHS
- Providing written feedback to individual AMHS after data collection/scoping study meetings, to seek feedback on accuracy of CMHL recording and synthesis

Visioning and Strategic Planning

The findings of the scoping informed the development of a strategic plan with the public mental health Occupational Therapy Leadership Network (OTLN). As this scoping process led to connecting and engaging with each AMHS, there was subsequent growth in membership of the OTLN. This meant that for the first time, each service was represented. The CMHL Educator brought the OTLN together over two exciting workshops led by Foresight Lane to collaboratively develop a Strategic Plan

- Shared strategic vision
- Set of principles/values
- Strategic objectives and measures of success
- Plans for strengthening/establishing productive partnerships
- Strategic Roadmap highlighting key priorities and strategic activity for the next 2 years

Figure 23: Visual Summary of the Strategic Planning Process

VICTORIAN PUBLIC MENTAL HEALTH OCCUPATIONAL THERAPY LEADERSHIP NETWORK (OTLN)

STRATEGIC PLAN 2021 - 2023

SHARED VISION: People and communities are engaged in occupations that bring meaning and purpose to their lives, fostering health, wellbeing, participation and inclusion (OTA, 2021).

PURPOSE: We advance the interests of the Occupational Therapy (OT) profession working in Victorian Public Mental Health (VPMH) and seek to influence the VPMH sector so that the occupational needs and recovery aspirations of people and families, carers and supporters connected with VPMH services are met.
When this is done well:

- People have meaningful and connected lives, which leads to better health and well-being outcomes
- Our workforce is equipped, highly valued, influential, motivated, occupation centred and modelling best practice
- People, families, carers, supporters and stakeholders understand and seek the contribution of Occupational Therapy.

CORE VALUES: Occupation centred, person & family led, collaborative, evidence informed & grounded in occupational science.

This is how we will get there...

STRATEGIC DIRECTIONS:	1 INFLUENCE	2 WORKFORCE	3 CONNECT	4 SHOWCASE	
	Shape sector reform	Increase OT workforce capability & capacity	Strengthen OT connections	Build the OT brand	Measure the OT impact
STRATEGIC ACTIVITIES:	Identify and prioritise opportunities for influence	Engage with and influence workforce planning and development at an Industrial, Departmental and Organisational level	Support the development of mechanisms to establish sustainable OT connections and opportunities for innovation	Strengthen OT identity and clearly articulate OT role	Capture and promote the evidence base
	Engage proactively and timely in sector wide initiatives	Utilise OT Workforce Scoping	Strengthen and promote supervision, mentoring and coaching opportunities and structures	Clearly define the value proposition for all key stakeholders	Advocate for resources to develop research and evaluation
	Establishing productive partnerships with key stakeholders	Support training and education to advance current workforce development priorities: 1. Sensory Modulation 2. OT Supervision 3. OT Assessment 4. OT Leadership 5. Occupational Formulations & Goals 6. OT Group work (OVIC OT Workforce Scoping, 2021)		Develop resources that make it easier to communicate OT role, impact and value	Collectively evaluate the impact of OT in Victorian area mental health services
	Establish Action Groups and Pop-Up Consults				

We will know we are making progress when...

SIGNALS OF SUCCESS:				
	Signals	**Signals**	**Signals**	**Signals**
	▶ Identified and formalised partnerships with key stakeholders	▶ Data indicators for workforce demonstrate growth in workforce structures, numbers and skill	▶ Established sustainable Communities of Practice	▶ Resources to support OTs to communicate their role, value and impact
	▶ Guidelines developed for OTLN to establish and evaluate Action Groups and Pop-Up Consults	▶ Equitable access to purposeful and effective training in priority areas	▶ Regional services are connected and supported	▶ Partnership with lived experience and universities to support a coordinated approach to quality improvement, evaluation and research of impact of OT
	▶ Active participation in consultations and committee representation	▶ Proactive participation regarding workforce at an Industrial, Departmental and Organisational level	▶ Increased participation OTLN activities and communities of practice	▶ Best practice summaries and/or position statements are available
	▶ Statewide leadership role established			

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Appendices

Data collection template – Qualitative and Quantitative (sent to AMHS)
De-identification Codes for each AMHS

Victorian Area Mental Health Services Scoping

[OCCUPATIONAL THERAPY/SOCIAL WORK/ENROLLED NURSING]

Thank you for taking the time to complete this spreadsheet. Completion time will vary depending on the size of your disciple workforce and organisation.

CMHL scoping of the Victorian mental health system will be conducted in four parts: 1) Occupational Therapy workforce, 2) Social Work workforce, 3) Enrolled Nursing workforce, and 4) Practice and Development Leads will scope the clinical educator workforce and training and development needs.

Purpose

This scoping data seeks to identify the OT/SW/EN workforce profile across Victorian area mental health services to support leadership, collaboration, growth, learning and development of our profession.

Objectives

The information you provide will assist CMHL with understanding the Public Mental Health workforce professional development needs across Victoria. The learnings are crucial for developing work priorities of the CMHL Statewide mental health OT/SW/EN Educators. We aim to:

Listen and connect:

- Produce a report that provides a 'statewide helicopter view' to build understanding of the needs and desires of the OT/SW/EN workforce across Victoria
- Create structures, processes and tools that make it easy to create connections, and to find and share OT/SW/EN resources

Align & Coordinate:

- Develop coordinated statewide solutions in partnership with key stakeholders (DHHS, HACSU, Statewide Training Providers) to assist with OT/SW/EN workforce development needs and gaps
- Ensure training and education dollars and resources are used well

Build evidence and seek quality:

- This baseline data will be used by CMHL to ensure quality for learning and workforce development approaches
- Develop structures for measuring the impact of OT/SW/EN in public mental health services
- The AMHS specific data will be provided back to the service. A deidentified report will be provided at the end of the scoping which summarising statewide discipline workforce findings

Drive innovation & systems change:

- Knowledge translation is embedded in key CMHL activities to build capability of OT/SW/EN workforces to deliver high quality services and programs
- Create systems that contribute to strengthening an evidence based and sustainable recovery-focused workforce

How do you fill in the survey?

Your participation is divided into two parts:

1) Part 1 is providing quantitative EFT/HEADCOUNT data on worksheet 1. This can be completed by you or your colleagues prior to our scheduled meeting or soon after.

2) Part 2 we will complete together during our meeting. We would like to record this conversation for accuracy if agreed by all parties. This is qualitative data covering Leadership, and Education & Professional Development

Completion and return

Please note that this spreadsheet contains drop down box options that may not appear on devices that do not have Excel.

We would appreciate that you return the completed survey within 7 days of our consultation

If you have any questions, please contact:

OT Educator: Phoebe Williamson, Statewide Mental Health Occupational Therapy Educator, Centre for Mental Health Learning via email (phoebe.williamson@cmhl.org.au)

Victorian Area Mental Health Services Scoping

OCCUPATIONAL THERAPY WORKFORCE EFT DATA

Name of Area Mental Health Service:	
OT Discipline Senior/Chief Details:	Name, role

		EFT	Headcount	
What is approximate size of the mental health workforce employed within your area mental health service?				*(CMHL to insert total number AMHS extracted from SW/EN Scoping Project Results)*
Approximately how many occupational therapists are employed within your area mental health service?				*(CMHL to insert total number AMHS extracted from 2018 National Workforce Data Set)*
Can you provide a breakdown of the Grades of the OT workforce?	Grade 1			
	Grade 2			
	Grade 3			
	Grade 3 Plus			*Team leader above award allowance*
	Grade 4			
	Grade 5			
	Grade 6			
	Other			
What positions are the occupational therapists employed in?	Clinical			
	Management			
	Education			
	Research			
	Project			
	Service Development			
	Other			
How many entry level OTs did your service employ each year?	2019			
	2020			
How many OT student placements does your service provide each year?	2019	*		** Please provide Total Number of placement days*
	2020	*		

SETTINGS: Where are the occupational therapists employed within your service?

Lifespan	Area	Service Type	NA (If service not applicable at AMHS)	Total OT EFT	Total OT Headcount	1. Designated OT Specific Role (Headcount)	2. Designated OT generic role (Headcount)	3. OT in generic role (Headcount)	Notes
Older Persons Mental Health Services	Inpatient	Acute inpatient services							*If service type not available at this AMHS, write NA
Older Persons Mental Health Services	Community teams	Community assessment & treatment teams							*If service has none of this discipline, write 0
Older Persons Mental Health Services	Residential care	Nursing homes and hostels							* If serivice is available, leave blank, proceed to EFT & Headcount
Older Persons Mental Health Services									* Please add any further details/differences if neccessary
Adult Mental Health Services	Inpatient	Acute inpatient units							*If your team is called something different please use the service listed that n
Adult Mental Health Services	Inpatient	Psychiatric Assessment Planning Unit							*If nothing matches, please use the blanks and add in
Adult Mental Health Services	Inpatient	Secure extended care units							
Adult Mental Health Services	Community bed-based	Prevention and recovery units							
Adult Mental Health Services	Community bed-based	Community care units / Community recovery program							
Adult Mental Health Services	Community teams	Mobile support and treatment							
Adult Mental Health Services	Community teams	Continuing care teams							
Adult Mental Health Services	Community teams	Homelessness outreach services							
Adult Mental Health Services	Community teams	HOPE Hospital outreach post suicide engagement							
Adult Mental Health Services	Community teams	Consultation and Liaison serivces							
Adult Mental Health Services	Community teams	Crisis assessment and treatment							
Adult Mental Health Services	Community teams	Triage / Access							
Adult Mental Health Services		Managers							
Adult Mental Health Services									
Adult Mental Health Services									

Child, Adolescent, Youth services	Inpatient	Child acute inpatient services							
Child, Adolescent, Youth services	Inpatient	Adolescent acute inpatient services							
Child, Adolescent, Youth services	Inpatient	Youth acute inpatient services							
Child, Adolescent, Youth services	Comunity bed-based	Youth Prevention and recovery centre							
Child, Adolescent, Youth services	Community teams	Community care team							
Child, Adolescent, Youth services	Community teams	Early Psychosis teams							
Child, Adolescent, Youth services	Community teams	Child team							
Child, Adolescent, Youth services	Community teams	Perinatal team							
Child, Adolescent, Youth services	Community teams	Intensive youth outreach teams							
Child, Adolescent, Youth services	Community teams	Day Programs							
Child, Adolescent, Youth services	Community teams	Conduct disorder services							
Child, Adolescent, Youth services	Community teams	Triage / Access							
Child, Adolescent, Youth services									
Statewide &/or specialist services	Inpatient	Parent-Infant Units							
Statewide &/or specialist services	Inpatient	Brain disorder Service							
Statewide &/or specialist services	Community teams	Brain disorder Service							
Statewide &/or specialist services	Inpatient	Neuropsychiatry Service							
Statewide &/or specialist services	Community teams	Neuropsychiatry Service							
Statewide &/or specialist services	Inpatient	Forensic service							
Statewide &/or specialist services	Community bed-based	Forensic service							
Statewide &/or specialist services	Community teams	Forensic service							
Statewide &/or specialist services	Inpatient	Alcohol and drug service							
Statewide &/or specialist services	Community bed-based	Alcohol and drug service							
Statewide &/or specialist services	Community teams	Alcohol and drug service							
Statewide &/or specialist services	Community bed-based	Personality disorder service							
Statewide &/or specialist services	Community teams	Personality disorder service							
Statewide &/or specialist services	Inpatient	Eating Disoder service							
Statewide &/or specialist services	Community teams	Eating Disoder service							
Statewide &/or specialist services	Community teams	Dual Disability Service							
Statewide &/or specialist services	Community teams	Koori Service							
Statewide &/or specialist services	Inpatient	Koori Service							
Statewide &/or specialist services	Community bed-based	Koori Service							
Statewide &/or specialist services									
Statewide &/or specialist services									
	Specialty roles	FAPMI							
	Specialty roles	Dual Diagnosis							
	Specialty roles	Specialist Family Violence Advisors							
	Specialty roles	Forensic Clinical Specialists							
	Specialty roles	Aboriginal Engagement							
	Specialty roles								
	Specialty roles								
	Education								
	Research								
	Projects								

To be commenced prior to scheduled meeting with OT senior & CMHL Educator

Victorian Area Mental Health Services Scoping

OCCUPATIONAL THERAPY QUALITATIVE DATA

DISCIPLINE SPECIFIC ACTIVITY			
	What % of the overall OT workforce are employed in OT specific roles?		
	What are the common OT specific activities provided in your service? (e.g. Consultation, Assessment, Intervention:		
	Is there a preferred OT model or framework used within your service?		
	What are the most common OT Assessments provided at your service? (e.g. COPM, AMPS, ESI, Sensory Profile, MOHO)		
	What are the most common OT Interventions provided at your service? (e.g. approaches or occupational domains)		
	How do you measure the contribution/impact of the role of occupational therapy in your service?		
OCCUPATIONAL THERAPY LEADERSHIP			
	What is the current OT leadership structure within your organisation?		
	What EFT is allocated to OT leadership roles?		
	What % of OT leadership roles have associated clinical responsibilities (direct client service provision)?		
	What resources and/or models do OTs currently use to influence change within this area mental health service?		
	What does your OT workforce require to develop future leaders to drive innovation and systems change?		
	What opportunities does your OT workforce have to engage in co-production, co-design or co-delivery with the Lived Experience Workforce? Please provide any examples		
EDUCATION & PROFESSIONAL DEVELOPMENT			
Education	What OT Education structures are in place specific to OT in your service?		
	Do you have roles for an OT Educator, graduate coordinator, knowledge translation or research positions? If yes, please advise role and approx. EFT?		
	What are the OT education and professional development activities provided within your service?		
	What are the OT education and professional development needs that CMHL could support with?		
Research	What OT research activities or structures are provided?		
	Can CMHL support your OT workforce to enhance research capability?		
Entry Level	Do you have a graduate OT Allied Health entry level program?	Please Select	Describe:
Supervision	What is the current OT supervision structure currently in your service?		
	How have you implemented the Victorian Allied Health Supervision Framework?	Please Select	Describe:
	What group supervision and/or reflective practice is currently provided?		
CMHL Priorities	What are the needs for OT Community of Practices? (e.g. OTs in PARCs, IPUs, Sensory Modulation)		
	What OT specific training topics would your service prioritise for 2021?		
	Please list in order of priority for those you would like CMHL support:	1	
		2	
		3	
		4	
		5	

Thank you for completing this survey and for your valuable contirbution to supporting leadership, collaboration, growth, learning and development of our mental health OT workforce.