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# A capability framework to develop leadership for evidence-informed therapies in publicly-funded mental health services

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## Abstract

**Purpose** – It is difficult to replicate evidence-informed models of psychosocial and assertive care interventions in non-research settings, and means to determine workforce capability for psychosocial therapies have not been readily available. The purpose of this paper is to describe and provide a rationale for the Therapy Capability Framework (TCF) which aims to enhance access to, and quality of, evidence-informed practice for consumers of mental health services (MHSs) by strengthening workforce capabilities and leadership for psychosocial therapies.

**Design/methodology/approach** – Guided by literature regarding the inadequacies and inconsistencies of evidence-informed practice provided by publicly-funded MHSs, this descriptive paper details the TCF and its application to enhance leadership and provision of evidence-informed psychosocial therapies within multi-disciplinary teams.

**Findings** – The TCF affords both individual and strategic workforce development opportunities. Applying the TCF as a service-wide workforce strategy may assist publicly-funded mental health leaders, and other speciality health services, establish a culture that values leadership, efficiency, and evidence-informed practice.

**Originality/value** – This paper introduces the TCF as an innovation to assist publicly-funded mental health leaders to transform standard case management roles to provide more evidence-informed psychosocial therapies. This may have clinical and cost-effective outcomes for public MHSs, the consumers, carers, and family members.

**Keywords** Leadership, Mental health, Evidence-based practice, Capability framework, Therapies

**Paper type** Conceptual paper

## Introduction

Global and Australian prevalence and outcome data continue to reveal disabling impacts of mental health disorders (Whiteford *et al.*, 2013), concerning low treatment rates, and poor access to services for people with mental illness (Griffiths *et al.*, 2015). Publicly-funded

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mental health systems require clear and strategic leadership to create an organisational culture that empowers staff to develop and implement recovery-oriented and evidence-informed psychosocial interventions (Aarons *et al.*, 2011; Mental Health Coordinating Council, 2015; NIMHE, 2004). This paper introduces the Therapy Capability Framework (TCF) as an innovation to guide publicly-funded mental health services (MHSs) to address the shortfall of psychosocial therapeutic treatments provided by clinicians.

The TCF may have broad applications across a diverse range of health and disability service domains around the world. Government strategies to enhance the therapeutic practice of mental health clinicians developed in the UK are of particular relevance to the Australian context. Common challenges faced by clinicians working in either system are shared due to the reliance on standard case management models of care. To emphasise the urgent need to develop innovative service-level solutions for the lack of evidence-informed therapies provided to consumers and carers of Australian publicly-funded MHSs, this paper has drawn upon congruent themes from the UK that influenced the development of the TCF. This paper also aims to provide a thorough description of the TCF and its use for local clinical leaders and service administrators at the Metro South Addiction and Mental Health Services (MSAMHS) in Australia; in particular, the application of the TCF towards the development and evaluation of governance strategies informed by the analysis of uniquely specific workforce data for therapy capabilities.

*Psychosocial therapies in publicly-funded MHSs*

Psychosocial therapy for people with mental illness refers to a broad range of non-pharmacological treatment options including psychological therapies and social and vocational interventions that aim to improve quality of life for consumers and their families. Psychosocial therapies have been shown to be effective for improving outcomes for people with depression and schizophrenia (De Silva *et al.*, 2013; Galletly *et al.*, 2016; McGorry *et al.*, 2003) and can lead to a reduction in hospital re-admissions and improved social and vocational functioning (National Alliance on Mental Illness, 2015).

Clinical guidelines and government policies have reviewed the effectiveness of mental health interventions and have advocated that psychological therapies be considered alongside medication as effective treatment for people with severe and enduring mental illness (NIMHE, 2004). Evidence suggests, for example, that psychosocial treatments, such as interventions involving family-centred practice, combined with antipsychotic medication for the treatment of schizophrenia, can be more cost-effective than medication alone (Phanthunane *et al.*, 2011). Further, depending on the clinical severity of depressive disorders, cognitive behavioural therapy (CBT) can be more cost-effective than standard pharmacotherapy (Sava *et al.*, 2009).

In Australia, despite the cost-effectiveness of psychosocial alternatives, these interventions are inadequately promoted and underutilised compared to pharmacotherapy (Vos *et al.*, 2005), and access to these services has been underdeveloped and inconsistent (Turpin *et al.*, 2006). As highlighted by McGorry *et al.* (2003), implications of the inefficient use of mental health resources have restricted the potential for better consumer outcomes, which has also contributed to poor workforce morale. Vital reform for Australian MHSs must include the implementation of "optimal evidence-based treatment" (McGorry *et al.*, 2003, p. 136).

Priorities for MHSs in both Australia and the UK have highlighted the need to improve access to, and encourage the broader use of evidence-informed interventions to enhance recovery opportunities for mental health consumers (Curie and Thornicroft, 2008; Turpin *et al.*, 2006). Unfortunately, improving consumer access to effective evidence-informed psychosocial therapies is a challenge for both individual practitioners and service leaders. The need for leadership to address these shortfalls in service provision was first highlighted in 2004, when the National Institute for Mental Health (NIMHE reported that the

provision and management of psychosocial therapies in Britain was inconsistent, not well integrated into mental health systems, and potentially unsafe. The report also emphasised that leadership to develop strategies to address these shortfalls is as vital to patient safety as achieving organisational targets set by key performance indicators (NIMHE, 2004).

*Workforce challenges for MHS leaders*

Australian MHSs require a diversely skilled and capable workforce (Mental Health Coordinating Council, 2015). Traditional attitudes that focus on standard case management and medication adherence, combined with organisational values and workforce deficiencies that fail to recognise psychological therapies as evidence-informed, has impeded strategic management for therapy development opportunities (Turpin *et al.*, 2006). Mental health consumer feedback has further highlighted staff rigidity in therapy and inappropriately trained and skilled clinicians as service-related concerns (NIMHE, 2004).

To address these deficiencies, mental health leaders need to cultivate workforce values of psychological awareness, supported by supervision and skills development for effective recovery-oriented practice (NIMHE, 2004; Royal College of Psychiatrists, 2008). With pressure on clinical leaders and administrators to respond to service evaluations based on activity data (such as monthly provisions of service) or financial status, it may be difficult to prioritise valuable resources towards improving workforce capabilities for psychosocial therapies. The challenge for publicly-funded MHSs is to achieve high quality best practice whilst meeting the expectations of productivity requirements (Aarons *et al.*, 2011).

Additionally, specialty health services, such as MHSs, may struggle to participate in quality improvement activities or practice-based research that can identify gaps in the provision of evidence-informed care (Timbie *et al.*, 2012). In the absence of rigorous service evaluations, Timbie *et al.* (2012) identified the unconditional need for two critical service improvements:

(1) increasing the delivery of evidence-based assessments and treatments when indicated; and

(2) reducing the unwanted inconsistencies in the way treatments are provided.

Achieving these service improvements in publicly-funded MHSs will require strong leadership to develop workforce capabilities in evidence-informed psychosocial interventions, particularly in a system which is often heavily reliant on a case management style of service delivery.

*Case management in publicly-funded MHSs*

In Australia, case management is a standard service model for publicly-funded MHSs, providing a consistent point of contact for mental health consumers to access a wide range of services (Queensland Government, 2008). Case management has clinical functions including assessments and treatments to maintain or enhance psychosocial functioning (King *et al.*, 2004). Compared to standard care without case management, it has demonstrated better outcomes for consumers with respect to reduced hospital admissions and overall function (Dieterich *et al.*, 2010). However, in an evaluation of the National Mental Health Plan for Australia, Curie and Thornicroft (2008) noted shortcomings of this approach, including the use of evidence-informed treatments. They highlighted the need for publicly-funded MHSs to provide clarification of case management roles and recruit sufficiently skilled psychologically-minded practitioners. In addition, the clinical efficacy and cost-effectiveness of various models of case management for severe mental illnesses is uncertain (King *et al.*, 2004). For example, in evaluations of intensive case management (ICM) where clinicians have reduced caseloads to provide more frequent and mobile services

(Byford *et al.*, 2000; King *et al.*, 2004), consumers were more likely to remain engaged with services compared with non-ICM consumers; however, no other clinically significant differences were detected (Dieterich *et al.*, 2010). Furthermore, routine ICM is difficult to achieve due to increasing clinical caseloads and administrative demands.

Despite this, case management remains the preferred model of service delivery for publicly-funded MHSs within developed countries, including Australia, and remains a key mechanism of service engagement for consumers (King *et al.*, 2004).

*Psychosocial therapies and case management in MHSs*

There has been some suggestion that contemporary and assertive case management models, in which mental health clinicians deliver evidence-informed psychosocial treatments, are more effective than standard case management (King *et al.*, 2004; Rosen *et al.*, 2007; Smith and Newton, 2007). For example, Reinhard (2000) argued that standard mental health case management can be more effective if combined with evidence-informed approaches such as cognitive behavioural strategies. Unfortunately, case management rarely leads to evidence-informed care as the demands on case managers are often dominated by general responses to social and environmental factors, including day-to-day non-clinical care coordination tasks (Queensland Health, 2017; Reinhard, 2000).

The full therapeutic benefits of an assertive case management model may be lost in everyday practice in MHSs compared to the more resourced and outcome motivated research settings. Decreased fidelity of assertive case management for clinical services can result in reduced outcomes for mental health consumers and negative workforce implications including burnout and decreased job satisfaction (Rosen *et al.*, 2007). There is evidence to suggest that mental health clinicians in case management roles do not function at a full professional and clinical scope of practice, including the provision of evidence-informed psychosocial therapies (Queensland Health, 2017). The challenge for leaders of publicly-funded MHSs is to develop workforce-related innovations that maximise the potential impact of case management through the provision of evidence-informed psychosocial therapies.

## The Therapy Capability Framework (TCF)

One such innovation is the TCF. In this section, the rationale and development of the TCF will be described, before the TCF is detailed and application and implementation are discussed.

*Rationale for developing the TCF for psychosocial therapy leadership*

In 2003, the Australian Public Service Commission reinforced the belief that building capability is integral for effective and efficient organisational performance. This requires systematic management of learning and development for workforce planning. Capability is a quality characterised by a talent or ability that has potential to develop and improve (American Heritage Dictionary, 2011), and is therefore future-oriented. Psychosocial therapy capability implies the possession and application of values, attitudes, knowledge, and skills to overcome a variety of complex challenges that may arise in therapy. Therapy capability is relevant across broad aspects of therapy practice and can also be considered at the organisational level.

Competency, on the other hand, often incorrectly used interchangeably with the concept of capability, refers to the more specific, technical aspects of the practitioner's ability to adequately or successfully undertake specific tasks, and is focused more on the "here and now". Therapy competency is a key component of best practice and is essential for clinical and professional accountability; however, there are limited practical and reliable means to

determine therapist efficacy directly attributable to his or her therapy competencies within publicly-funded MHSs (Fairburn and Cooper, 2011). Whilst an individual's competencies contributes to the overall picture of their capabilities, capability frameworks can identify the current and future critical workforce factors for government organisations to steer cultural reform through leadership development (Australian Public Service Commission, 2003).

Mental health workforce capability frameworks have been developed in the UK, in response to government investigations that discovered significant gaps in pre- and post-qualification training of all mental health multi-disciplinary professions (Hope, 2004). These frameworks outlined the minimum capabilities that all entry-level qualified mental health staff should possess; for example, working in partnership and respecting diversity (Hope, 2004). The broad spectrum of these frameworks, however, does not address the specific issues concerning workforce capability and leadership for evidence-informed psychosocial therapies.

In 2008, the UK Royal College of Psychiatrists developed a model that was also relevant to the Australian context, and was adapted to help clarify the purpose of the TCF at the MSAMHS. This model outlined three fundamental requirements for the sustainable and effective implementation of psychological therapies: competent therapists with psychologically minded attitudes and behaviours, management that recognises psychological intervention resources and support needs, and actual provision of appropriate treatment for mental health consumers. In a similar vein in Australia, the Queensland Plan for Mental Health 2007-2017 (Queensland Government, 2008) recommended workforce development and support to ensure ongoing capability for the delivery of specialist services, utilising clinicians' skills and expertise as key strategic priorities for MHS leaders across the State.

In 2014, quality standards and audits for psychological therapy programs in publicly-funded MHSs were also developed by the UK Royal College of Psychiatrists. However, these were designed as service level checklists rather than a guide for workforce capability and development. Therefore, while the need has been recognised in both Britain and Australia, an effective and relevant framework that supports mental health leaders to measure and develop workforce capabilities for evidence-informed psychosocial therapies across their services has not been readily available. This paper describes one approach which seeks to address this need.

A framework was therefore developed that maps types of capability (domains) against "levels" of capability for each clinician working in MSAMHS based in Queensland, Australia. Known as the TCF, this framework is used as a reflective tool by the individual practitioners and supervisors, helping to direct further competency development for provision of evidence-informed therapies, and strategically identifying therapy leaders amongst the workforce.

### *Development of the TCF*

As a strategic response to achieve more evidence-informed care, the TCF was developed by the MSAMHS in Queensland, Australia, in 2012. Publicly-funded MHSs in Queensland are governed by local Hospital and Health Services (HHS). The MSAMHS is a service facility within the Metro South HHS. It provides multi-disciplinary, tertiary hospital and community-based services for all age groups across a number of campuses in Queensland's south-east area. These services are structured as clinical teams that function under the governance of clinical units which aim to provide effective recovery-oriented and evidence-informed assessment and treatment for people with serious mental illness.

The development of a therapies capability framework was initially considered by the first author, the Director of Therapies and Allied Health (AH), in response to service reports which indicated a distinct lack of evidence-informed psychosocial therapy provision to

consumers and carers; particularly by clinical services using a case management model of care. The strategic intent was to involve and engage all layers of organisational leadership; therefore, the formal agreement to proceed was endorsed by the MSAMHS Executive Committee, and the accountability for the TCF innovation remained with the Director of Therapies and AH under the guidance of the Therapies Oversight Committee.

Considerations for the structure and functional implications of the TCF were informed by collaboration with key stakeholders and reviewing literature on theoretical models of skill acquisition (Dreyfus and Dreyfus, 1980; Hope, 2004), transformational leadership (Bass, 1990), and innovation implementation (Rogers, 2003). Collaboration occurred with local leaders of psychosocial therapies including frontline clinicians, professional practice supervisors, clinical directors, and consumer and carer representatives. The multi-disciplinary background of the participants included occupational therapy, psychology, social work, nursing, and medicine, in order to acknowledge the inter-professional nature and expertise of psychosocial therapy leadership within the organisation.

The concept of therapy capability in the TCF is not limited to knowledge and skill. Turpin *et al.* (2008) recommended the development of a framework that identified four essential roles that scope the full range of psychosocial therapy competencies for new graduate to expert therapists: supervision, training, evaluation, and research. The TCF has been designed to capture these essential roles as active leadership components for core practice, regardless of the clinician's clinical experience or professional background. At its core, the TCF depicts the essence of leadership attitudes and values by integrating the emergence of leadership roles with each progressive stage of therapy proficiency.

In summary, the TCF was developed to improve the provision of evidence-informed psychosocial therapies by:

(1) providing a reflective tool to support the development of therapeutically minded practitioners;

(2) enhancing assertive case management by improving the psychosocial therapy capabilities of the multi-disciplinary case management workforce;

(3) assisting service managers and clinical leaders to map the multi-disciplinary workforce for strategic planning for psychosocial therapies; and

(4) promoting, acknowledging, and outlining leadership roles for evidence-informed psychosocial therapies.

*Description of the TCF*

The TCF is characterised by a matrix that maps capability "domains" against "levels" of capability. It is used as a reflective tool by the individual clinician and supervisor, helping to direct further competency development and strategically identify therapy leaders amongst the workforce. The TCF matrix has five core capability domains that are each assessed against four hierarchical capability levels (see Appendix).

*The five capability domains*. The five domains of the TCF represent the core attributes expected of clinicians engaged in psychosocial therapy facilitation across MSAMHS. These five capability domains are as follows:

(1) therapy knowledge and practice skills;

(2) autonomy and support required and provided in therapy;

(3) dealing with complexity in therapy;

(4) supervision role and credentials; and

(5) research and evidence-based practice roles.

Critical self-reflection for the clinician begins with domain 1 (knowledge and skill). In this domain, the clinician is required to reflect on and identify: therapy training completed, use of assessment and treatment modalities, knowledge of therapeutic models, and possession of core practice skills. There is also an emphasis on the clinician's ability to appropriately combine therapy with non-specific therapeutic factors such as connectedness and recovery-oriented principles (Mental Health Coordinating Council, 2015).

Capability domains 2 (autonomy and support required) and three (dealing with complexity) extend the notion of capability beyond knowledge and skill. The nature of these domains highlight the importance of interpreting capability in the context of the clinician's ability to deal with complex scenarios, and subsequent levels of independence and support required from others (Dreyfus and Dreyfus, 1980).

Clinical practice supervisors within the MSAMHS expressed concerns that supervision for psychosocial therapies may have been difficult to access or deemed not important by case managers. Capability domains 4 (supervision role) and five (EBP role) were purposely designed to emphasise the importance of supervision and leadership as core components of therapy capability, for both supervisees and supervisors. These domains also highlight the responsibility of all clinicians to participate in knowledge transfer and quality improvement activities, including: journal clubs, literature reviews, and programme evaluations. In doing this, the TCF articulates an expectation that more proficient therapists will lead evaluations of therapy programs and contribute to research activities as generators of evidence.

*The four capability levels*. Extending across the five domains of the TCF, four hierarchical levels of capability have been defined:

(1) Capability level 1 – Foundation Practitioner.

(2) Capability level 2 – Practice-Informed Practitioner.

(3) Capability level 3 – Therapist.

(4) Capability level 4 – Advanced Therapist.

Practitioner levels (1 and 2). At level 1 (Foundation Practitioner), the practitioner demonstrates a fundamental basis for understanding and working with mental health consumers and a basic knowledge of assessment, alliance building, and formulation in the context of a specific therapy (e.g. CBT). The title "Practitioner" purposely distinguishes these levels from the Therapist levels of three and four. The Foundation Practitioner is able to link basic therapy principles to recovery and evidence-informed practice whilst in the receipt of appropriate supervision, but he or she is not capable of functioning as a Therapist (e.g. a Foundation Practitioner is aware of basic CBT principles whereas a CBT Therapist is able to apply specific CBT skills and techniques).

Capability level 2 (Practice-Informed Practitioner) was designed to represent the transition stage between Foundation Practitioner and Therapist. This level describes a mental health clinician who provides standard care influenced by a therapeutic approach and its principles, as opposed to a clinician who is specifically trained, supervised, and skilled to provide that therapy (Therapist level). The Practice-Informed Practitioner plays a vital role in supporting access to, and encouraging active participation in evidence-informed treatment for consumers. This level also reduces confusion or inaccurate self-assessment by practitioners who may inappropriately describe themselves as Therapists. A self-proclaimed expert may describe themselves as a Therapist whilst only able to apply basic knowledge and skills in treatment without adequate fidelity or practice supervision for therapy. This level was also designed to prevent the potential misperception by colleagues and consumers that some clinicians are Therapists or experts because they

self-proclaim to be so. Therefore, level 2 plays an important role, promoting that only skilled therapists supervise others, maximising patient safety and accountability in therapy.

The essence of leadership development also begins at these practitioner levels (1 and 2). This is characterised by active participation in the education of less knowledgeable clinicians, sharing perspectives with peer groups, and participation in therapy programme evaluations. These leadership components were purposeful in order to establish a consistent understanding and tacit appreciation of these specific expectations for psychosocial therapies across the organisation. Clearly defining leadership accountabilities also reduces the subjectivity regarding roles of therapy leaders, which was primarily defined by individuals and their self-determined functions.

Therapist levels (3 and 4). Clinicians at these levels (Therapists and Advanced Therapists) are described as "Therapists" (e.g. CBT Therapist), and are characterised by completion of advanced training, participation in regular practice supervision, an ability to deal with complex scenarios during therapy, and explicit roles linked to training and supervising the workforce, therapy evaluation, and research. These TCF leadership roles across levels 3 and 4 are reciprocal to the roles outlined in Practitioner levels 1 and 2, which are more participatory in nature. The expectations at these "Therapist" levels are beyond just the provision of therapy, and emphasise the continuum of leadership required from the spectrum of Foundation Practitioner to Advanced Therapists.

*Practical application of the TCF*

A TCF Manual was developed to guide consistent use and provide detailed instruction of how the TCF is to be applied in clinical settings. The content of this manual is summarised below.

*Step 1: identify priority therapies*. Each clinical unit's leadership group, comprised of clinical directors, professional leaders (AH, nursing, and medical), and team leaders, decides on their priority psychosocial therapies for provision of service. This is based on: evidence-informed and best practice relevant for the consumers' needs; and scope of practice aligned with the practitioners' professional backgrounds. For example, the clinical units that provide a service for people experiencing psychosis prioritised CBT for psychosis and cognitive remediation therapy as the core therapies (Galletly *et al.*, 2016). In addition to these evidence-informed priority therapies, each individual clinician is also encouraged to apply the TCF to other therapies that influence their practice, and these are captured as part of the workforce capability map described later.

*Step 2: determine capability levels for each clinician*. In collaboration with his/her clinical supervisor, the five capability domains are used as a tool for self-reflection by each clinician for each priority therapy indicated by the clinical unit (e.g. CBT). The "best fit" capability level for each of the five domains is determined during supervision. Reflecting on every domain will prompt the supervisor and supervisee to recognise that overall capability is not just determined by knowledge and skills, but other parallel elements including autonomy and leadership. For example, a nurse may consider his/her capability level for CBT for domain 1 (knowledge and skill) to be at a Therapist level (level 3) due to completion of advanced CBT training. However, during the course of discussion with their professional practice supervisor, they realise that CBT only influences their practise, and they do not strictly adhere to CBT techniques nor participate in CBT supervision. This would indicate an overall capability level of a Practice-Informed Practitioner (level 2).

The TCF was specifically designed to articulate active roles for the team leader and practice supervisor at the beginning of the clinician's reflective process to emphasise the leaders' responsibilities in enhancing psychosocial therapy provision. The overall capability level for each of the priority and self-identified therapies is documented in the clinician's

performance appraisal and development plan, and this is monitored by the team leader and practice supervisor over a twelve month period.

*Step 3: data collection and analysis*. Once the capability level for each therapy has been agreed upon for each clinician, capability levels are submitted to a central and secure database specifically designed to maximise data analysis. This workforce capability map represents capability levels for various therapies for every case manager across the entire work unit. Team leaders, service managers, and professional leaders then utilise this collective information to inform planning for workforce development and support strategies. Data are de-identified when results are fed back to the team for discussion. An example of how the workforce data are presented to a clinical unit, after collation and de-identification, is represented in Figure 1. These data provide important information to managers and supervisors on a diverse range of therapies which clinicians identify as meaningful and informing their practise, as well as the clinical unit's priority therapies.

The data regarding the capability levels of case managers for a range of therapies can be examined and utilised to identify current workforce gaps and future priorities at the team, the clinical unit, and the Executive leadership level. In doing so, this data can support workforce development strategies and decisions to enhance assertive case management, inter-professional therapeutic practice, and profession-specific scope of practice. For example, it can provide information regarding CBT capabilities for all clinicians in teams working with people with depressive disorders, as well as specific data related to CBT capabilities for just psychologists across the organisation, to map deficiencies in professional scope of practice (Figure 2).

*Implementation of the TCF*

To ensure strategic direction, the three fundamental requirements for implementing effective psychological therapies, developed by the Royal College of Psychiatrists (2008), were adapted to guide service-level implementation and evaluation of the TCF. The term "therapeutically minded" replaced "psychologically minded", to illustrate the broader perspective of biopsychosocial approaches for MSAMHS; for example, physical health and

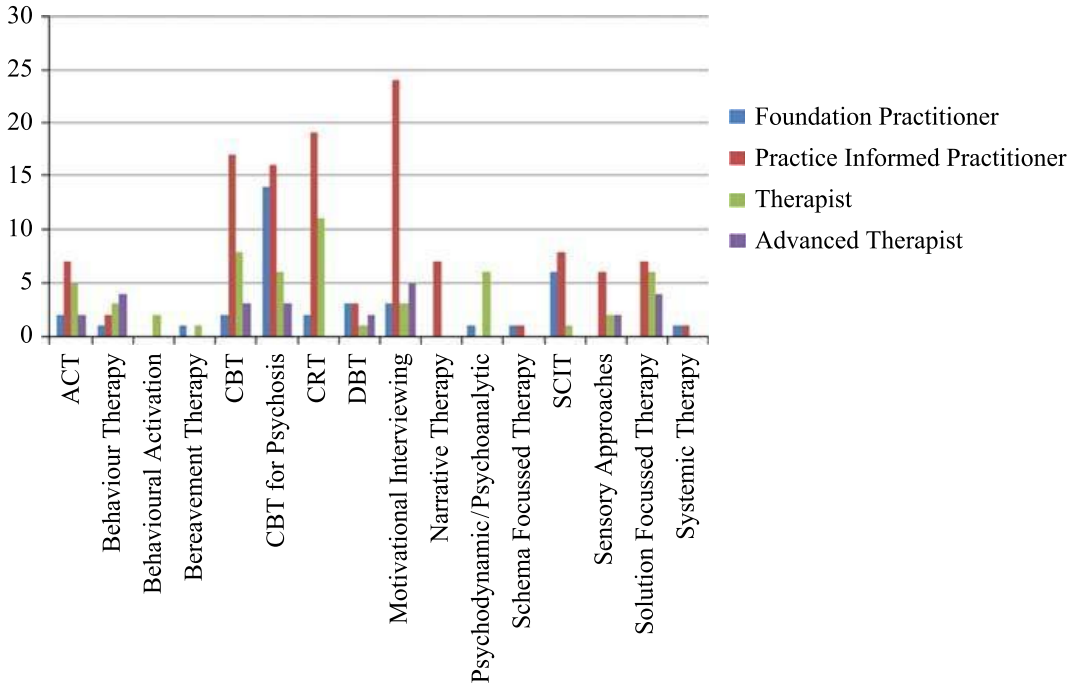


**Figure 1.**
De-identified therapy capability mapping data

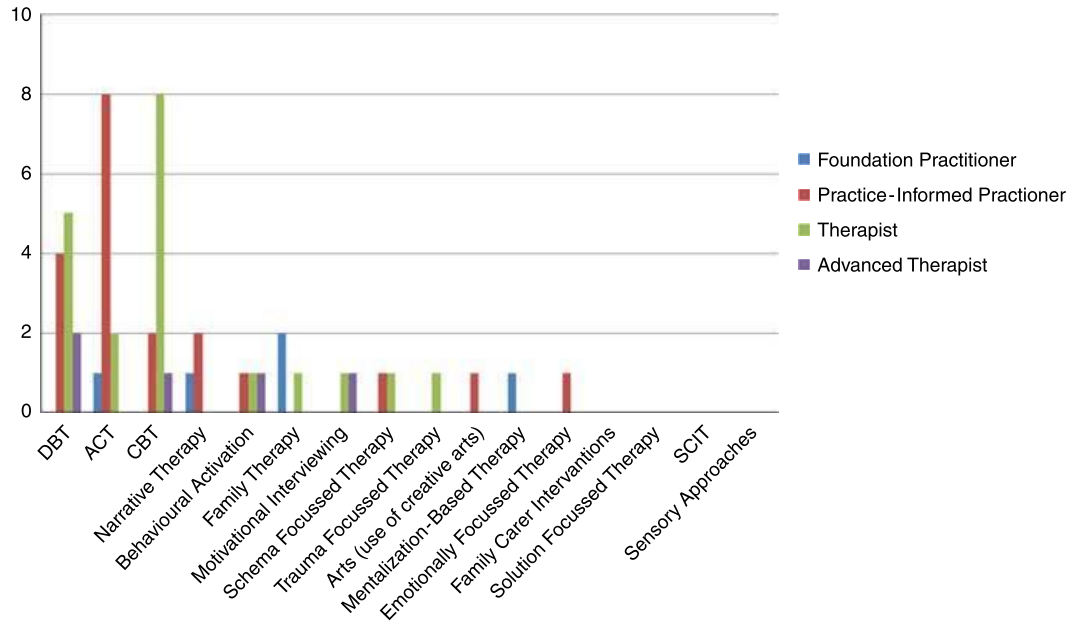


**Figure 2.**
TCF data for psychologists working with people with mood-related disorders

well-being programs. The interdependent relationship of these essential components is illustrated in Figure 3.

This model will guide future research and evaluation of the TCF to influence MSAMHS leadership culture; in particular, redefining roles for case managers, professional supervisors, and clinical leaders in planning, implementing, and evaluating evidence-informed psychosocial therapies. In practical terms, this model will help embed the TCF as an innovation that can improve consumer outcomes by: identifying, supporting and recognising therapy leaders; investing in clinical workforce skills across all professional groups; and maximising and encouraging inter-professional training (Royal College of Psychiatrists, 2008).

For each practitioner, the TCF provides a baseline to enhance evidence-informed psychosocial therapy development and leadership pathways. Designed as a self-reflective

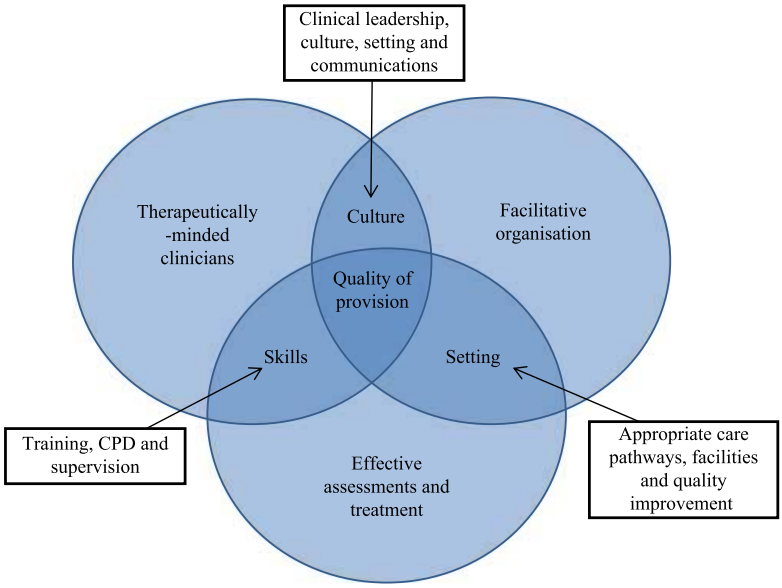


**Figure 3.**
MSAMHS fundamental requirements for effective therapies implementation

**Source:** Adapted from the Royal College of Psychiatrists (2008, p. 26)

tool during practice supervision and routine professional development planning, it is not used for performance management or disciplinary purposes. The TCF also targets each clinical unit's focus on evidence-informed psychosocial therapies during orientation for newly employed or transferred practitioners, particularly case managers.

The TCF was developed to promote assertive case management by facilitating gravitation away from standard case management to more evidence-informed models of practice. As articulated by Smith and Newton (2007, p. 8), "debate around how case management works is largely sterile if it is separated from the more important question of what clinical interventions work for a demonstrated illness and how to ensure that these interventions are delivered in an appropriate way to the individual patient".

## Research and evaluation

The TCF workforce mapping process was introduced in the MSAMHS, Brisbane, Australia, in 2015 and has become a routine quality improvement strategy for community-based services. In 2016, a sequential exploratory mixed methods evaluation of the service-level implementation and utility of the TCF commenced. This research is not an evaluation of the validity or reliability of the TCF as a tool for measuring clinicians' therapy capabilities or competencies. Rather, it is a research evaluation of whether the TCF can be an effective innovation to inform and assist service managers and clinical leaders in decision-making and workforce reform strategies.

The theoretical framework that will guide this research will embrace models of innovation implementation, knowledge transfer, and participatory action (Graham *et al.*, 2006; McWilliam *et al.*, 2009; Rogers, 2003). These approaches will be selected to help augment information derived from practitioner, clinical leader and manager collaborations, and integrate feedback into sustainable strategies for service-level improvement. For example, analysis of the TCF capability data will be used to establish collaborative governance strategies with clinical leaders aimed to improve the knowledge transfer of evidence-informed psychosocial therapies into clinical practice. Subsequent analyses of qualitative feedback gathered from in-depth interviews with practice supervisors, clinical leaders and service managers regarding the utility and effectiveness of the TCF have been scheduled for 2018.

## Conclusion and recommendations

Australian (and other) MHSs have an opportunity to provide evidence-informed services through psychosocial interventions, but this requires innovative workforce planning and development (McGorry *et al.*, 2003). The TCF was designed to enhance the provision of psychosocial therapies by government-funded MHSs and individual case managers. Use of the TCF may improve access to quality evidence-informed care by publicly-funded MHSs and other specialty health services in Australia. Further research aims to strengthen the effectiveness of the TCF to enhance strategic workforce planning for clinical leaders and service administrators. Together, this may lead to clinical and cost-effective outcomes for Australian publicly-funded services, the consumers, carers, and family members.

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## Appendix. Therapy Capability Framework

Please insert the relevant therapy in the "....." space provided (e.g. CBT, DBT, MI)

| Domain 1 | Foundation Practitioner | Practice-Informed Practitioner | ..... Therapist | Advanced .....Therapist |
|---|---|---|---|---|
| **Therapy Knowledge and Practice Skills** | Basic core skills in building a therapeutic alliance including a shared *understanding, history taking, risk assessment and formulation in the context of the ..... therapeutic framework<br><br>Basic knowledge of treatment and referral options for ..... therapy<br><br>Basic knowledge of ..... principles and connection to recovery-oriented and person-centred practice<br><br>Able to deliver basic education and therapeutic support (including dual diagnosis context) for consumers<br><br>* "understanding" refers to stepping into the person's world and conveying this back | General knowledge of ..... therapy concepts and how to incorporate these into current clinical practice<br><br>Practice framework influenced by a general knowledge of the ..... model/s and core practice skills<br><br>Knowledge of ..... in relation to evidence-based practice<br><br>Awareness of ..... therapy in the context of recovery-oriented and social inclusion practices<br><br>Able to evaluate and modify care plan according to individual needs and ..... principles | Sound knowledge of ..... practice competencies for assessment and intervention<br><br>Frequent independent application of a ..... practice framework and specific therapy techniques<br><br>Comprehensive understanding of ..... in relation to the best available evidence<br><br>Application of recovery-oriented and social inclusion practices to enhance therapy outcomes<br><br>Ability to evaluate and refine ..... interventions to improve therapy outcomes with regular supervision | In-depth knowledge of ..... therapy knowledge and skills, contemporary techniques and practice competencies<br><br>Able to provide consultation to service leaders on therapeutic frameworks for complex clinical practice<br><br>Advanced knowledge of best available evidence for ....., including its strengths and limitations<br><br>Leads application of recovery-oriented and social inclusion practices in the evaluation of ..... therapy<br><br>Facilitates the evaluation and reporting of therapy program outcomes |

| Domain 2 | Foundation Practitioner | Practice-Informed Practitioner | ..... Therapist | Advanced .....Therapist |
|---|---|---|---|---|
| **Autonomy and Support (required and provided) in Therapy**<br><br>**(For supervision requirements see Domain 4)** | Able to perform most clinical tasks in a safe manner with regular clinical and professional reflective practice supervision | Completes straightforward clinical tasks incorporating basic ..... skills supported by observation and reflective practice supervision<br><br>Requires frequent support and advice from practice supervisor, multi-disciplinary and professional teams | Independently completes most complex clinical tasks applying ..... techniques confidently using own judgement<br><br>Seeks and provides regular advice within the multi-disciplinary and/or professional team<br><br>Provides support and mentoring for ..... therapy skills to other members of the multi-disciplinary or professional team | Independently and holistically manages complex clinical scenarios in therapy for a multi-disciplinary team or across clinical units<br><br>Independently goes beyond basic standards, creating interpretations and learning tools for self and other clinicians across various clinical units and professions<br><br>Provides support and mentoring for ..... therapy skills within the multi-disciplinary and professional teams across various clinical units |

| Domain 3 | Foundation Practitioner | Practice-Informed Practitioner | ..... Therapist | Advanced ..... Therapist |
|---|---|---|---|---|
| **Dealing with Complexity in Therapy** | Able to deal with complex clinical situations with appropriate mental health interventions<br><br>This is achieved using non-specific factors, and without the specific ..... therapy modality or framework perspective | Able to identify opportunities and provide intervention in complex situations with only partial understanding of therapy frameworks and techniques<br><br>..... therapy is used as a limited range of techniques that can enhance current clinical practice<br><br>These are applied safely as sub-skills of routine treatment | Ability to manage complexity through purposeful analysis and reflection utilising supervision from a more proficient therapist on a regular basis<br><br>Sees overall picture and how own actions contribute to consumer outcomes as a result of engagement in therapy | Deals with clinical situations considered by the treating team to be highly complex using ..... therapy<br><br>Holistic grasp of complex situations, moves between intuitive and analytical approaches with ease<br><br>Sees overall picture and alternative approaches; vision of possibilities in therapy |

| Domain 4 | Foundation Practitioner | Practice-Informed Practitioner | ..... Therapist | Advanced ..... Therapist |
|---|---|---|---|---|
| **Supervision Role and Credentials** | Recipient of core clinical and professional practice supervision from senior clinician and/or relevant peer group process as per usual business | Frequent reflective practice supervision from a more capable practitioner with an emphasis on specific ..... skills and direct observation of practice | Ongoing and routine reflective practice supervision with a more proficient ..... therapist, utilising individual, peer supervision and/or direct observation | Routine ..... therapy practice supervision with a more proficient therapist or peer group |
| | Core clinical practice skills endorsed by performance coaching and appraisal process | | Provides ..... practice supervision to Foundation and Practice-Informed Practitioners as well as other less proficient ..... therapists | Provides therapy practice supervision for less proficient therapists |
| | Participates in the identification of own learning needs and development activities | Provides basic ..... education to less knowledgeable clinicians and foundation practitioners | | Identifies ..... therapy development needs for others and delivers appropriate continuing professional development activities |
| | Professional registration and/or credentialing requirements met | Completed introductory training in ..... therapy skills | Certified core training in ..... therapy | Certified advanced or intensive training in ..... therapy |

| Domain 5 | Foundation Practitioner | Practice-Informed Practitioner | ..... Therapist | Advanced ..... Therapist |
|---|---|---|---|---|
| **Research and Evidence-Based Practice (EBP) Role** | Awareness of best available evidence in relation to ..... therapy practice and clinical unit models of care | Consumer of literature and knowledge of best available evidence in relation to ..... therapy practice<br><br>Active participant in peer discussion in relation to ..... therapy practice | Regular active participation in EBP activities including peer review and ..... therapy evaluation and development | Leads EBP initiatives including facilitation of peer review<br><br>Active participation by driving .....therapy evaluation and/or research and service initiatives |



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