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Title

The Therapy Capability Framework and Mapping Process: Perspectives of mental health clinical case managers

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Ethical approvals were obtained from ethics committees of both the Metro South Health and Hospital Service (EC00167) and The University of Queensland (2016000185).

Key Words: capability framework, therapy, evidence-based practice, mental health, case management.

Abstract

Objective:

The aim of this study was to investigate the utility of a workforce leadership initiative, the Therapy Capability Framework (TCF), designed to enhance the provision of evidence-informed psychosocial therapies by publicly funded mental health case managers. To understand the experiences and perceptions of "first-time users" of the TCF was conceived as an important first step to help guide service-wide implementation.

Method:

In 2018, a qualitative descriptive research methodology using two in-depth focus groups with frontline mental health clinicians in case management roles was adopted to explore their perceptions and experiences of the TCF and TCF Process across Metro South Addiction and Mental Health Services in Brisbane, Australia. An inductive approach to thematic analysis guided the generation of themes and subthemes.

Results:

Participants understood the purpose of the TCF; however, they identified several factors influencing their experience, including specific features of the framework; how it was used; and organisational, workforce, and leadership factors that restricted its potential utility and impact.

Discussion:

Clinicians reported the TCF as having the potential to facilitate incremental change in the existing case management model. This paper represents a phase of evaluation and continuous

improvement of the TCF, which can assist publicly funded mental health leaders to augment the provision of evidence-informed psychosocial therapies.

Introduction

In Australia, the negative impact that mental health and substance use disorders have on consumers, their families, the community, lost productivity, and the nation's health economy is immeasurable (Mindgardens Neuroscience Network, 2019). Despite multiple decades of national reform, there has been no significant change in the status of this burden since the 1990's. Mental illness and substance use disorders continue to be the leading contributors to non-fatal burden in Australian communities (24.3% of total years lived with disability) (Ciobanu et al., 2018) as further studies have revealed poor access to evidence-based treatment for people with mental illness (Griffiths et al., 2015; Mihalopoulos et al., 2021). An inquiry into mental health by the Australian Government's Productivity Commission (2020) highlighted the need for immediate action within existing budgets and staffing (Whiteford, 2021); therefore, urgent reforms for service-level change within public mental health systems require clear leadership that targets organisational culture that empowers the mental health workforce to develop and implement evidence-based psychosocial interventions (Aarons et al., 2011).

There is broad acknowledgement that mental health consumers, and their carers and family, should be able to access specialised, recovery-oriented, evidence-based interventions (therapies) from a capable multidisciplinary workforce (Curie & Thornicroft, 2008), including publicly funded mental health services (MHS) (Queensland Health, 2016). Despite clinical guidelines and government policies outlining best practice, workers in publicly funded MHS face substantial

barriers developing and implementing these interventions (Griffiths et al., 2015). Furthermore, there have been documented high levels of burnout, disengagement, and exhaustion amongst the Australian mental health workforce (Productivity Commission, 2020). Contributing stressors attributed by the allied health mental health workforce in Queensland include lack of coordination and prioritisation of evidence-based treatment opportunities that enable a full scope of practice and poor governance structures that strengthen and optimise allied health roles and skillsets (Queensland Health, 2017).

In 2022, a parliamentary inquiry into opportunities to improve mental health outcomes for Queenslanders highlighted the need for MHS to leverage the underutilised skills and untapped professional practices amongst the existing workforce. For example, allied health professions were identified as having the potential for significant contributions towards the provision of psychosocial interventions effective in reducing depression, self-harm behaviours, and/or suicidality. As the state's overall public health service, Queensland Health indicated that the universally applied case management model restricted scopes of practice amongst their multidisciplinary MHS teams (Queensland Parliament Mental Health Select Committee, 2022).

Since the 1970's in Australia and many other countries, case management has become the standard means of community-based coordination of care for severely mentally ill people who are consumers of public MHS (Marshall et al., 2000). Case management models are not unique to mental health (Arya, 2020) and aim to provide individualised points of contact for consumers and families (Queensland. Mental Health, 2008). Case management features both brokerage and clinical functions including care planning, coordination of service providers, and generic assessments and interventions to maintain or enhance psychosocial functioning (King et al.,

2004). Case managers are most commonly from nursing and allied health (occupational therapy, psychology, and social work) professional backgrounds.

Although case management remains the preferred model of service delivery for publicly funded community MHS in Australia (King et al., 2004), workforce evaluations have revealed that mental health clinicians in case management roles often feel underutilised and struggle to provide evidence-informed psychosocial therapies (Mental Health Workforce Advisory Committee, 2011). The clinical and evidence-based value of standard case management has been questioned (Marshall et al., 2000) as clinicians in these roles compete with demands dominated by general responses to environmental factors and lament a reduced scope of professional clinical practice (Queensland Health, 2016; Queensland Parliament Mental Health Select Committee, 2022; Reinhard, 2000).

Furthermore, impetus for systemic change has come from mental health consumers themselves, as people with a lived experience of receiving mental health services. These consumer perspectives have highlighted inflexible therapy practice, and a lack of appropriately trained and skilled staff, as concerns and barriers to receiving adequate clinical care (Mental Health Workforce Advisory Committee, 2011). Traditional organisational deficiencies driven by standard case management that fail to value psychological therapies, can impede the potential of strategic responses, (Turpin et al., 2006).

Mental health services must develop strategies to ensure that the mental health workforce develop, maintain, and apply skills effectively; regulate these skillsets; and assess the gap between evidence-based practices and day-to-day clinical efficacy (Productivity Commission, 2020). The aim of this study was to investigate the utility of a workforce leadership initiative, the Therapy Capability Framework (TCF) (Lau et al., 2017), designed to enhance the provision

of evidence-informed psychosocial therapies by publicly funded mental health case managers based in Metro South Health in Queensland, and reduce the psychosocial impacts of mental illness for consumers, their families, and subsequently, the mental health and well-being of their local communities (Hendryx & Ahern, 1997).

Therapy Capability Framework

Capability frameworks can assist organisations to develop a common language, articulate values, and expectations for success (*Capability Frameworks*, 2020), and identify current and future critical workforce factors to steer cultural reform (Australian Public Service Commission, 2003). In 2015, the TCF was developed at the Metro South Addiction and Mental Health Services (MSAMHS) in Brisbane, Queensland (Lau et al., 2017), and was introduced into practice in 2016. This capability framework has been highlighted as a co-commissioned workforce development initiative across a primary care mental health sector to enhance trauma informed practice to support people with emotional dysregulation who may repeatedly present in crisis to mental health and emergency services (Queensland Parliament Mental Health Select Committee, 2022). Recently, a study aimed at investigating changes to workforce self-efficacy from this cross-sectoral initiative, and empirical research related to the use of the TCF and the subsequent impact on evidence-based physical health care at MSAMHS, have both commenced.

The TCF enables clinicians to map five capability "*domains*" (i.e., therapy knowledge and practice skills; autonomy and support required/provided in therapy; dealing with complexity in therapy; supervision role and credentials; and research and evidence-based practice roles) against four hierarchical "*levels of capability"* (Foundation Practitioner; Practice-Informed Practitioner; Therapist; and Advanced Therapist). The five capability domains are useful self-reflection tools for specific therapy modalities. The "best fit" capability level for each of the five domains is

discussed during supervision and an overall capability level determined. A TCF example for a clinician identified as practice-informed for Cognitive Behaviour Therapy (CBT) is provided in Table 1.

Insert Table 1 here.

The TCF is designed to facilitate a workforce focus on evidence-informed psychosocial therapies by:

1. Providing a reflective tool to enhance an evidence-informed psychosocial therapy focus for mental health clinicians in generic case management roles;
2. Assisting service managers and clinical leaders to map the multidisciplinary workforce for strategic planning; and
3. Identifying psychosocial therapy leaders for therapy-related supervision and ongoing development.

Although the TCF was created as an individual reflective practice tool, the TCF Process was designed to capture service-level workforce therapy capability data for strategic purposes.

TCF Process

Service leaders within each clinical unit identified “priority” therapies (e.g., CBT in services specialising in affective disorders). During supervision, case managers reflected on their levels of capability for each “priority” therapy and other “self-nominated” psychosocial interventions. These therapy capability discussions influenced subsequent professional development plans to be more evidence-based and targeted. Service mangers collated TCF data for workforce profiling, analysis, and strategic planning. The TCF has been described as “a promising attempt” (Williams

& Smith, 2019, p. 1010) to address challenges faced by publicly funded MHS by transforming standard case management roles. The aim of this study was to understand the experiences and perceptions of MSAMHS case managers as "first-time users" of the TCF and TCF Process to inform continuous improvement.

Methods

This study used a qualitative descriptive research methodology (Neergaard et al., 2009). Ethical approvals were obtained from ethics committees of both the Metro South Health and Hospital Service (EC00167) and The University of Queensland (2016000185).

Participants

Staff from MSAMHS adult community MHS were invited to participate if they were case managers from an allied health or nursing background; had used the TCF; and were identified as either a Practitioner Level (PL; Foundation or Practice-Informed Practitioner) clinician, or a more capable Therapist Level (ThL; Therapist or Advanced Therapist) clinician. Separate focus groups were held for PL and ThL cohorts.

Data Collection

Case managers were emailed study information sheets. Two in-depth focus groups were conducted twelve months after the initial TCF Process with those who consented to participate. Focus groups are common for evaluating the planning stages of an innovation and promote reluctant participants to contribute more openly than other methods, such as individual interviews (Leung & Savithiri, 2009). Both focus groups were facilitated using a semi-structured topic guide that allowed pursuit of emergent topics. Perceptions sought included: (a) general thoughts about using the TCF; (b) impact of the TCF on attitudes towards evidence-informed

psychosocial therapies; (c) provision of psychosocial therapies as a case manager; and (d) participation in therapy-related supervision and development. Focus groups were conducted by an impartial moderator and were digitally recorded. They lasted approximately ninety minutes.

Data Analysis

Audio recordings were transcribed verbatim by an external party to retain participant anonymity. All researchers became familiar with written transcripts before two researchers independently coded a small sample of the comments without a pre-existing coding framework (Gale et al., 2013). An inductive thematic analysis approach was used to reduce the potential for bias (Braun & Clarke, 2006). Three researchers engaged in peer reflection, debriefing, comparing, and contrasting interpretations of categorization concepts to establish a rigorous analytical framework (Gale et al., 2013). Given the management role of the primary investigator (GL) within MSAMHS, reflexive journaling by GL was used as an adjunct to peer reflection to minimize imposition of assumptions of the workforce and management onto the data. The coding framework was subsequently applied across the transcripts from both focus groups to identify frequent, dominant, and significant themes (Thomas, 2003). The data was restructured into overarching themes and subthemes, organized into thematic categories, and charted into a matrix spreadsheet in Excel.

Results

Participant characteristics

Ten people (9.6% of invited first-time users) participated in the focus groups (five PL; five ThL) conducted in 2018. Participants were mainly female (one male; nine female) with varying years of experience and all were from allied health professional roles including social work,

psychology, and occupational therapy. Due to the small configuration of professions in each multidisciplinary team, exact numbers of professional backgrounds and work locations were not identified to retain and promote confidence of anonymity amongst participants.

Findings

Whilst the purpose of the focus groups was to explore participants' experiences with the TCF, both PL and ThL participants highlighted the influence of the organisational factors on evidence-based therapy provision. The main themes were largely consistent among PL and ThL participants: (1) Understanding the TCF tool; (2) Impact of the TCF Process; (3) Therapy and therapists are under-valued; and (4) Impact of case management on the provision of evidence-informed therapies. Themes and subthemes are outlined in Table 2.

Insert Table 2 here.

Understanding the TCF tool

Purpose of the TCF

Participants of both focus groups believed that the TCF could influence the case management model and support clinicians to become proficient in the provision of psychosocial therapies: "This capability framework is showing us that the case management model has to change to accommodate [therapies]" (PL). Both groups also believed that the TCF could support their professional development in therapies, as well as supporting strategic service-wide workforce planning: "…because you identify whether you're practice-informed or whether you're a therapist or whatever and so, down the track, maybe it allows some room for those skills to be further identified" (PL).

ThL participants articulated how meaningful discussions regarding evidence-informed therapies had been extended to the rest of the multidisciplinary team: “We, as a team, had added some extra things and we’re using it as a tool across therapies [development].”

Perceptions of the TCF criteria

Both groups appreciated the way the TCF criteria were designed with clear descriptions for capability level. Discussions were centered on the following subthemes:

(1) TCF capability levels

Participants from both groups understood the differences between the TCF levels and described how the Practitioner Level criteria was an accurate description of core therapy capabilities for all clinicians: “I really like the beginning, the framework. My understanding is it wants to get everyone to be at least [practice-informed] enough to provide a level of therapeutic input” (ThL). Also, participants seemed to understand and accept the importance of differentiating Practice-Informed Practitioner and Therapist Level clinicians for safe scope of practice.

> I think as an idea, it [Practice-Informed Practitioner] was quite useful because it helps clinicians to remind themselves of where they’re at, and if we’re giving evidence-based treatment we need to do that within our skills that we have and within our scope. (ThL)

> I won’t say that I’m doing CBT with people, because I’m not a CBT therapist. I’ll call it ‘informed’, case management informed by CBT, but I’m not doing therapy. (PL)

In contrast, some PL participants noted that Therapist and Advanced Therapist Level criteria seemed unrealistic for case management roles. They were also concerned that the TCF

supervision terminology downgraded their therapy capability: “We’re going to mark ourselves down, because some of the criteria are not really achievable within our workplace, which I think doesn’t necessarily give a true reflection on what’s happening, on what’s being done” (PL).

(2) Supervision criteria in the TCF

While participants understood the need to participate in clinical supervision, some PL participants described the TCF supervision requirements as unnecessary and unrealistic; particularly as access to therapy supervision seemed challenging.

> I don’t think I put any of them [TCF levels] as above Practice-Informed (Practitioner). I think a lot of that came down to the fact that you’re not getting that supervision, you’re not getting that support. But do I think I’m a good therapist? Hell, yeah. I think I’m a very good therapist. (PL)

Access to supervision for therapies was not a priority for some PL participants who stated, “If I wanted to seek it out, I’m sure I could find it. I’m not that motivated to get supervision.”

(3) Risks associated with self-assessment

Despite the involvement of team leaders and supervisors when using the TCF, participants of both groups expressed concerns about self-assessment. ThL participants suggested that clinicians could inflate their actual therapy capabilities: “You may as well be self-reporting because there are no checks and balances.” In contrast, PL participants shared benefits of their capabilities being under-rated: “…us who got put down from therapist back to practice-informed, we’re happy with that. It’s less work for me.”

Impact of the TCF Process

Team leader’s influence on the TCF experience

Experiences of using the TCF for both groups was related to how the framework had been facilitated by their team leaders. Some participants described how team leaders used the TCF as an opportunity to debate evidence-based practice (EBP), team capabilities, and structured approaches to ensure professional development for psychosocial therapies:

> The [team leader's] idea was to see where you map and then take it to supervision and have it as part of the PAD [Professional Development and Appraisal] so that you could help increase where you're interested in getting professional development.

Similarly, a PL participant described the support provided by the team leader and higher-level management:

> We were given time to do it, we were given a copy of the framework, we were told to talk to our supervisors about it. Then we had a meeting with our supervisor and our team leader. Our Director agreed with what we'd come up with in our, my rating.

In contrast, negative experiences of the TFC Process were attributed to actions of their team leaders. PL participants commented on their team leader's indifferent approach, which under-valued the TCF experience and the importance of confidential clinical supervision: "Two times I've been asked to stand in front of the computer while my team leader ticks, does a flick tick. It's a two-minute thing and each time I've gone, 'what is that therapy?'."

Similar experiences reported by ThL participants indicated a lack of focus and commitment by the team leader to provide opportunities for participants to engage with the TCF and discuss evidence-informed therapies: "It wasn't probably promoted very well within the team from a team leader level. We've not even talked about it as a team since then."

Potential impact of the TCF Process

Focus group participants believed that the TCF Process had the potential to enhance therapy-specific professional support and development; however, they perceived longstanding organisational challenges and competing case management demands as restricting the potential impact.

ThL participants saw potential for the TCF to better connect the broader workforce through peer, group, or individual supervision strategies where participants were aligned with supervisors according to their therapy capability levels: "Actual outcome of using the therapy capability framework might be, 'I've identified that five of us are all at this same level, let's set up a group supervision, and peer supervision'." They also suggested strategic use of the TCF mapping data to counteract less meaningful, compliance-oriented performance metrics, such as "mandatory training" and "hand hygiene". One suggestion was to monitor workforce therapy capabilities across teams and convert the TCF mapping data into service-wide key performance indicators (KPI) to guide evidence-informed practice targets:

> Every consumer…is offered family work. That would be a measurable KPI. Then you would look in the capability framework. These [staff] have done multi-family group work sessions, we've got these people who are trained in Single Session Family Consultation, let's use them.

ThL participants expressed hope that the TCF could assist in cultural reform: to change the organisation's perceived under-valuing of therapy provision and improve investment in therapy-related resources and development opportunities:

> The capability framework will give you an overview of who's trained in [therapy], to what level, what level supervision they are getting…then you

> would know how many people you need to train, how many people you need to get from this level to the other level, and how many people you need to be at the higher levels in order to implement this [therapy]. Then the framework will be well connected to the service provision.

Therapy and therapeutically minded staff are under-valued

Identity and recognition of staff who provide therapy

Participants reported that the TCF Process invalidated a broad range of therapeutic approaches, not prioritized by clinical leaders. PL participants felt this rejected their eclectic or preferred professional skill set:

> [The TCF] is more about what [therapy] the clinical unit wants the clinicians to have, their skills. It's not about our professional identities…my occupational therapy approaches to treatment are more important to me than what has been defined by my clinical unit, which is CBT and [Dialectical Behavioural Therapy].

ThL participants also recounted when clinicians who provided therapy were inadequately recognized and remunerated: "People who don't do many therapies, they are just at the same [salary] level. It's nothing to do with job performance." A PL participant lamented, "I've had doctors not understand exactly what it [therapy] is that I am capable of and totally underestimate what we actually do."

Therapy is not consistently valued

ThL participants indicated a distinct division and, at times, tension between themselves as therapy leaders and members of the team who did not value the TCF Process. They believed that the TCF was "preaching to the converted" and did not influence clinicians who needed to become more therapy-focused and proficient: "Those of us who are passionate about it [therapy] are doing it and those who aren't, aren't. I don't think it's done anything to track them along; if anything, it's created more tension."

Participants of both focus groups expressed concern about insufficient allocation of funds to develop and support staff to provide therapies, limiting potential utilization of the TCF. A PL participant highlighted, "There's not the money for it [training]; not the funding; this is what we get told." A ThL participant expressed concern regarding the lack of therapy supervision: "If you don't get enough supervision, you cannot provide supervision, and if you don't have resources to provide supervision, then this framework will not work."

Impact of case management on the provision of evidence-informed therapies

While the purpose of the focus groups was to understand case managers' perceptions of the TCF as first-time users, participants from both focus groups critiqued the case management model as being a hindrance to evidence-informed clinical interventions. Participants described the tension between wanting to provide individual and group therapies whilst juggling the demands of non-clinical case management, large caseloads, and pressure to discharge consumers.

One PL participant said, "It's ridiculous. There's so much stuff…that could be done by a support person and we could be just delivering therapies because you can't do all of it." A ThL participant reported that, "Clinicians cannot introduce therapy due to caseloads…they don't have the time." ThL participants also expressed concern that working in a service that prioritized case

management will lead to being de-skilled in evidence-informed therapy and reduce their therapy capabilities:

> I will really fight to continue to have the space to do therapy, either in group or individually, because if you don't keep doing that, you lose it, and your capability framework will only go down, it won't go up.

Discussion

The aim of this study was to explore the experiences and perceptions of MSAMHS adult community case managers as "first-time users" of the TCF to inform future development. Both PL and ThL participants understood the purpose (and potential) of the TCF for workforce mapping and profiling; however, team leader behavior, organisational factors, and the case management model of care featured as key determinants of the TCF experience for both PL and ThL participants.

Substantial differences in TCF Process experiences were directly attributed to the attitudes and behaviors of team leaders. For example, when a team leader promoted therapy self-reflection and supervision (as per the supportive process outlined in the TCF manual), the TCF experience for the clinician, and the broader multidisciplinary team, was generally positive. Conversely, the TCF Process was described as confusing, meaningless, and divisive by participants whose team leaders devalued the process. An organisational climate that promotes quality improvement requires transformative leadership (McWilliam et al., 2009), and primary mechanisms for embedding EBP across an organisation are related to the attitudes and behaviours of organisational leaders, such as what they pay attention to, how they react to crises, and how they allocate resources and rewards (Aarons et al., 2014). A workforce development strategic plan co-

designed with staff and people with a lived experience of receiving mental health services, that more explicitly links the TCF with enhanced psychosocial outcomes and reduced symptoms for consumers endorsed by organisational leaders, may also empower staff to prioritize evidence-informed psychosocial therapies across multidisciplinary teams.

The aspiration of the TCF is to support the organization to recognize all therapies that influence each clinician's practice; therefore, prior to the TCF Process, team leaders and managers were provided with verbal and written instruction to encourage and accommodate the therapeutic eclecticism of the workforce. Despite this, some PL participants described a lack of recognition of the therapies they most valued, leading to feelings of invalidation. Future initiatives will require more targeted pre-implementation training, and governance, particularly for team leaders and medical leaders, to strengthen the inner organisational contexts (Aarons et al., 2014). Preparatory interventions targeting team leaders, such as a baseline assessment of readiness for implementing and supporting staff through therapy-oriented innovations, may be a valuable process before future TCF implementation.

Differences in perceptions between PL and ThL clinicians

While PL participants identified the demarcation between Practice-Informed and Therapist Level capabilities as useful, the supervision requirements were considered excessive and unrealistic. Some PL participants (who disclosed that they considered themselves to be ThL) admitted that reduced expectations of them was an indirect benefit of their PL status. Practitioners believing that they were able to function safely and effectively as Therapists, in the absence of routine supervision, may be a concern; particularly when clinical supervision provided to mental health practitioners has been associated with a reduction in psychological symptoms of their consumers (Snowdon et al., 2017). ThL participants, on the other hand, acknowledged the critical link

between practice supervision in psychosocial therapies and the TCF supervision criteria, and the strategic potential to promote access to, and participation in, therapy supervision.

Exploring the case management-related challenges that face the MSAMHS clinicians in providing evidence-informed therapies was not an explicit aim of this study. Despite this, excessive caseloads, workplace tension, and a perceived lack of recognition (by peers and the organisation's leaders) of therapy leaders symbolized the negative impact of the current case management model. ThL participants were more concerned that their therapy capabilities would decline if they continued to work as case managers. Previous mental health workforce studies have indicated that case managers with moderately high caseloads demonstrate a significant decline in self-efficacy, which is a proven indicator of role performance (King et al., 2000).

Aligned with the original aims of the TCF, both PL and ThL study participants suggested that the organisation's leaders should revise the generic case management model of care and proactively support case managers in therapy provision; however, ThL participants articulated more strategic opportunities for the TCF to influence system metrics, such as key performance indicators directly linked to workforce capabilities and resource allocation. This re-focus may reduce subsequent risk factors for case managers, including decreased job satisfaction and burnout (Rosen, 2007), with positive impacts on the effectiveness of service provision to consumers and their carers.

Limitations of this study

As the TCF has not been validated, the stratification of participants based on capability levels may not accurately represent their level of capability. In addition, the well-known role of the primary investigator of the study as a member of the MSAMHS Executive Team, may have

influenced participant feedback. To minimize this risk, an impartial interviewer conducted the focus groups and participants were deidentified. Although focus groups may provide a setting to permit honest and critical responses (Leung & Savithiri, 2009), there may have been outspoken individuals who dominated discussion and altered the group outcomes in this study (Tuckett & Stewart, 2004).

Despite the participants reflecting a range of health practitioners and a variety of multidisciplinary teams across adult community mental health services, the sample size was relatively small, and may not reflect all clinicians in adult case management roles. The relevance of the data captured in 2018 towards current issues also needs to be considered. Subsequent reviews and evaluations of the TCF should incorporate broader consultation and co-production with front-line clinical and peer lived-experience staff across MSAMHS.

Recommendations

Findings from this study highlight a need to align the TCF and TCF Process with service-level governance strategies that directly address the lack of evidence-informed psychosocial therapies provided by public MHS to consumers and their carers. As participants in this study felt that the TCF was restricted by the lack of strategic prioritization and resource allocation to therapies, organisational leaders must clarify and strengthen the symbiotic relationship between workforce capabilities, clinical governance, and strategic directions to strengthen professional scopes of practice of the current and future MHS workforce. A key message for other health services looking to implement a TCF as a workforce capability strategy, is to strengthen engagement between staff, line mangers, and leaders across the organisation. Theoretical models, such as the Participatory Action Knowledge Translation (PAKT) Model (McWilliam et al., 2009), may be useful when developing and introducing frameworks such as the TCF at other health services.

Such models may guide mutual engagement and enhance action-oriented transformative leadership to overcome traditional operational barriers and professional silos (McWilliam et al., 2009).

In response the initial feedback from “first-time users”, a strategic model for person-centered psychosocial therapies has since been established at MSAMHS. This model promoted shared participation, distributed leadership, and led to the evolution and collaborative development of the TCF tailored to four different areas. These specific capability frameworks were co-developed by therapy leaders, consumer representatives, and case managers across the organisation and include (a) Consumer, Carer and Family Engagement, (b) Trauma-informed Care, (c) Physical Health Care, and (d) Cognitive and Behavioral Therapy versions of the TCF. It is imperative that the implementation of these bespoke TCFs strengthen collaboration and emphasize transformational leadership across all roles in the organisation to enhance the provision of evidence-informed care.

Conclusion

A key objective of the TCF Process was to assist service managers and clinical leaders to map the capabilities of multidisciplinary clinicians for workforce strategic planning. Focus group participants’ comments regarding this strategic intent were mostly aligned; however, they expressed a need for more alignment between the TCF and organisational improvement strategies that explicitly benefit outcomes for consumers and carers. Findings from this study indicate that case managers desire service level changes that support both the provision of evidence-based psychosocial therapies and the retention of their therapeutic skills and abilities. The TCF was perceived as supporting psychosocial therapies, and as being a valuable tool to enhance reflective practice and guide professional development. The challenges associated with

developing Therapist or Advanced Therapist level of capability whilst in case management roles amidst the competing demands of the public health service was acknowledged, and the inefficiencies and under-resourcing of current services were considered a fundamental barrier. Clinicians perceived the TCF as having the potential to facilitate incremental change in the existing case management model by re-aligning priorities on clinical therapies. Health services can enhance the provision of evidence-based psychosocial therapies by utilising the TCF Mapping Process to enhance routine workforce monitoring, promote practice-informed therapy capabilities for all clinicians, and engage staff in therapy-related professional development opportunities and supervision. Team leaders and professional leads can be supported to prioritise the TCF by using workforce capability as a key performance indicator to value its application within teams, embedding the TCF into routine line management and supervision processes to ultimately reduce the psychosocial impact of mental illness for consumers.

Conflict of Interest: The corresponding author is xxxxxxx. The authors declare that they have no other conflicts of interest.

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