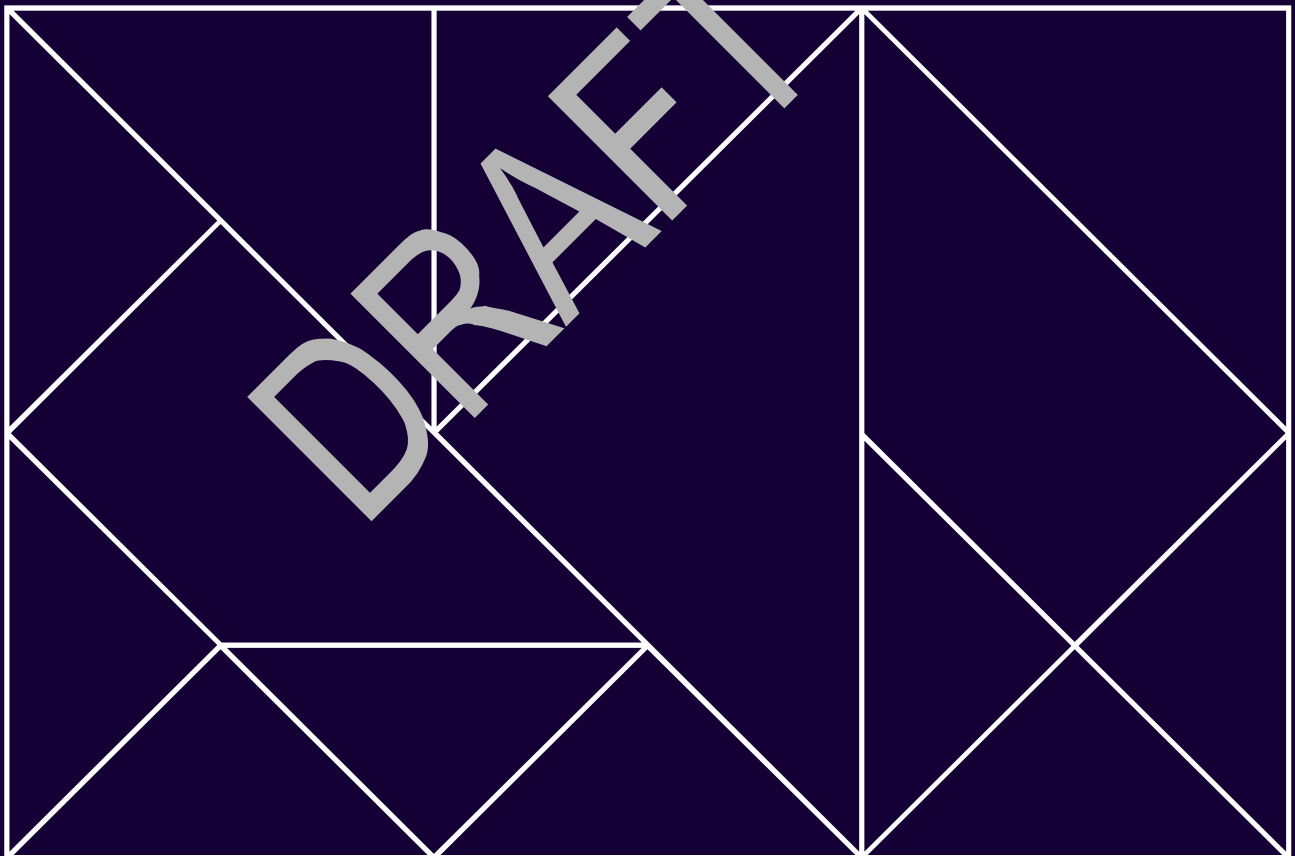


August 2021

National Mental Health Workforce Strategy

Background Paper

DRAFT ONLY



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1.1 The National Mental Health Workforce Strategy 2021–2031

In December 2018, the Australian Government committed to developing a ten-year National Mental Health Workforce Strategy (the Strategy) to attract, train and retain the workforce needed to meet the rising demands of the mental health system in Australia.

The development of the Strategy is overseen by the independent National Mental Health Workforce Strategy Taskforce (the Taskforce). The Taskforce's Terms of Reference are provided at Appendix A, and membership provided in Chapter 2.

1.2 The Consultation Draft

Following consultation with consumers and carers, education and training providers, professional and occupational peak bodies, and state and territory representatives, the Taskforce has developed a Draft Strategy for public consultation (the Consultation Draft). The development process for the Consultation Draft is summarised in Chapter 2.

The Taskforce is now seeking the perspectives of consumers, carers and the sector more broadly through a public submission process. Following the public submission process, a final Strategy will be developed and endorsed by the Taskforce. The Taskforce Co-Chairs and the Australian Department of Health will present the Strategy to the Minister for Health and Aged Care who will seek endorsement from states and territories through the National Cabinet framework.

The contributions of the Taskforce members, Working Group members, consumer and carer representatives and all others consulted in the development of the Strategy are gratefully acknowledged.

1.3 This Background Paper

This document provides background to the development of the Consultation Draft, including underpinning workforce definitions, foundational research and a summary of the issues facing the mental health workforce. The Consultation Draft should be read in conjunction with this Background Paper. The Background Paper is structured as follows:

- Chapter 2 – Development process
- Chapter 3 – Context for the Strategy
- Chapter 4 – Workforce definition
- Chapter 5 – Common workforce issues
- Chapter 6 – Occupation specific issues.

Development process

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2.1 The Taskforce

The development of the Strategy is overseen by the National Mental Health Workforce Strategy Taskforce. The Taskforce members are listed below, and Terms of Reference are provided at Appendix A.

- Jennifer Taylor – Co-Chair
- Thomas Brideson – Co-Chair
- Bill Gye – Community Mental Health Australia
- Di Stow – Australian Register of Counsellors and Psychotherapists
- Faye McMillan – Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group representative
- Gabrielle O’Kane – National Rural Health Alliance
- Genevieve Pepin – Australian Council of Deans of Health Sciences
- Heather Nowak – Consumer representative
- Jeff Borland – Labour Market expert
- John Allan – Royal Australian and New Zealand College of Psychiatrists
- John Brayley – Chief Psychiatrist, SA
- Le Smith – Northern Territory Primary Health Network
- Leanne Beagley – Mental Health Australia
- Lyndall Soper – National Mental Health Commission
- Margaret Doherty – Peer Workforce representative
- Mark Roddam – Commonwealth Department of Health
- Michael Tam / Morton Rawlin – Royal Australian College of General Practitioners
- Peter Heggie – Carer representative
- Ros Knight / Tamara Cavenett – Australian Psychological Society
- Stephen Jackson – Australian College of Mental Health Nurses
- Tricia O’Riordan – Mental Health and Drug & Alcohol Office, NSW Health.

2.2 Working Groups

The Taskforce was supported by five Working Groups focused on the areas of Aboriginal and Torres Strait Islander Communities, Education and Training, Intergovernmental and Interjurisdictional Issues, Lived Experience (Peer) Workforce and Rural and Remote Contexts. A list of Working Group members is provided at Appendix B.

The deliberations of the Working Groups informed the scope and development of the Strategy. Each Working Group considered issues, gaps and potential solutions relevant to their priority area including:

- expected skill set
- equity of access to training and education
- career pathways
- readiness in the health system to support the emerging workforce
- access to mentoring support and supervision
- prevalence of trauma informed practice
- uptake and suitability of alternative service delivery models such as telehealth; and
- appropriate measures by which to determine the adequacy of the mental health workforce.

2.3 Consumer and carer consultation

The perspectives and experiences of consumers and carers have been captured throughout the development process. The Taskforce membership and each Working Group included consumer and carer representatives to ensure feedback was integrated at each stage.

Two Consumer and Carer Roundtables have been held, facilitated by Mental Health Australia. The first Roundtable examined on the draft recommendations produced by the Working Groups. The second Roundtable considered the Consultation Draft of the Strategy.

2.4 Research inputs

The Department of Health commissioned the following pieces of research to inform the Taskforce and the development of the Strategy:

- A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries, conducted by the University of Queensland
- An analysis of national mental health workforce demand and supply using the National Mental Health Service Planning Framework (NMHSPF) to better understand current and future mental health workforce supply and demand, conducted by the University of Queensland
- A labour market analysis to review of workforce trends for different occupations within the mental health workforce, conducted by ACIL Allen
- An education institutes review to examine current trends in enrolments and completion, and the capability of providers to scale up delivery, conducted by ACIL Allen.

These activities involved consultation with carer and consumer representatives, employers in the mental health sector, peak bodies and professional associations, and vocational and higher education providers. The Working Groups' reports and the research inputs have informed the development of the Consultation Draft and provide the evidence-base for this Background Paper.

Context for the Strategy

3

3.1 Introduction

Suicidality, mental distress and/or ill-health affects people of all ages from all backgrounds and locations across Australia. Mental distress and/or ill-health is often linked to experiences of disadvantage, trauma and other social issues. Risk factors can include genetic predisposition, homelessness and unemployment, alcohol and other drug use, discrimination and racial injustice, and stressful life events (such as the COVID-19 pandemic and 2019-20 bushfire crises).

Supporting Australians to be mentally well is no longer restricted to supporting those experiencing suicidality, mental distress and/or ill-health, but also encompasses prevention and early intervention to promote mental wellbeing and assist people at risk. The mental health workforce helps to build protective factors that support wellbeing, including social inclusion, healthy behaviours, engagement in meaningful roles and activities, and physical activity.

Respecting and responding to the diversity of need means accommodating understandings of health and wellbeing that are appropriate for each individual, family and community. A person-centred view of mental health recognises the indivisibility between physical, psychological, social, emotional and cultural wellbeing.

3.1.1 Mental health conditions, severity, support and treatment

Almost half of all Australians (45.5%) aged over 16 will experience mental ill-health in their lifetime and one in five (20.0%) do so in any given year.¹ The first onset of mental ill-health typically occurs in adolescence and early adulthood. About three quarters of adults with mental ill-health experience symptoms before the age of 25.² Young Australians aged between aged 16 to 25 years also have a higher prevalence of mental ill-health than any other age group.

Other groups that are at greater risk of mental ill-health include Aboriginal and Torres Strait Islander peoples, LGBTIQ+ peoples, people who experience homelessness and incarceration, people experiencing unemployment and people not in the labour force.

Mental ill-health covers a wide range of conditions. The most common conditions in Australia are anxiety disorders (14.4% of the population), affective disorders such as depression (6.2%), and substance abuse disorders (5.1%) and eating disorders (estimated between 4 and 16%).³ These conditions can often occur in combination. Less common conditions include psychotic disorders,

¹ Productivity Commission. (2020). Mental Health. Productivity Commission Inquiry Report, No 95. Pg 9.

² Ibid.

³ Australian Institute of Health and Welfare. No date. Mental health services in Australia. Accessed at <https://www.aihw.gov.au/getmedia/8c6e5410-55cc-498d-9772-d3f9d7fcd351/Overview-of-mental-health-services-in-Australia.pdf.aspx>; <https://www.aihw.gov.au/getmedia/ab86db9d-410a-4c93-89c4-99c8bdbdf125/aihw-aus-221-chapter-3-13.pdf.aspx>

such as schizophrenia (0.5%).⁴ Mental ill-health also impacts on the rate of intentional self-harm and suicide. Suicide is a significant cause of premature death in Australia, accounting for over one-third of deaths for people aged 15 to 24 years.⁵

The severity of these conditions varies widely. In Australia, most people with mental ill-health experience mild (2.3 million) or moderate (1.2 million) symptoms, with a smaller proportion experiencing severe mental ill-health (0.8 million).⁶ There is also a significant proportion of people at risk of mental ill-health presenting with emerging symptoms (5.9 million).

The level of support and treatment needed varies with the effects and severity of conditions. People at risk of and people experiencing mild conditions can generally be self-managed or managed with low intensity services in primary care or community settings. People experiencing moderate conditions typically require specialist clinical services, while people with severe mental health conditions require a coordinated care approach, which may include hospital-based care.⁷ Support and treatment of varying intensity may be accessed simultaneously, in line with the individual needs of people experiencing mental distress and/or ill-health.

3.1.2 Impact on people experiencing mental distress and/or ill-health, families and carers

Mental distress and/or ill-health has significant and far-reaching impacts not only for individuals affected but for their families, carers, and friends, and those who provide support and treatment.

For people experiencing mental distress and/or ill-health, it can affect their functioning at work, at school and in social situations. The onset of mental ill-health early in life can prevent young people from finishing school or successful transitioning into employment. In the workplace, mental ill-health can lower productivity, reduce earnings and decrease employment potential. These factors all contribute to an individual's increased risk of disadvantage.⁸

People with mental ill-health are more likely to experience physical health problems, such as obesity, diabetes and cardiovascular diseases, and poorer quality of life through loss of life satisfaction and opportunities.⁹ For those affected by severe mental ill-health, average life expectancy is reduced, due mainly to untreated physical health conditions.^{10,11} Carers also often experience psychological distress, objective and subjective burden, and poorer health outcomes.

The flow on impacts of mental distress and/or ill-health highlight the need for broader workforces (such as social services and first responders) to have the skills and capabilities to support those experiencing mental distress and/or ill-health.

⁴ Ibid.

⁵ Australian Bureau of Statistics. (2020). Causes of Death, Australia, 2019: Intentional self-harm (suicide), Catalogue No 3303.0. Retrieved 23 October 2020.

⁶ Productivity Commission. (2020). Pg 115.

⁷ Australian Government. (2017). Fifth National Mental Health and Suicide Prevention Plan. Accessed at <https://www.mentalhealthcommission.gov.au/getmedia/0209d27b-1873-4245-b6e5-49e770084b81/Fifth-National-Mental-Health-and-Suicide-Prevention-Plan>

⁸ Department of Health. (2014). The magnitude of the problem. Accessed at <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-f-plan09-toc-mental-pubs-f-plan09-con-mental-pubs-f-plan09-con-mag>

⁹ Equally Well Group. (2019). The physical health of people living with a mental illness: A narrative literature review. Charles Sturt University.

¹⁰ Ibid.

¹¹ Firth, J., Siddiqi, N., Koyanagi, A., Siskind, D., Rosenbaum, S., Galletly, C., ... & Stubbs, B. (2019). The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. *The Lancet Psychiatry*, 6(8), 675-712.

3.1.3 Impact of disasters on the mental health workforce

Disasters, such as the bushfires and COVID-19, significantly impact our lives and greatly affect the mental health of many Australians. Some of the consequences include loneliness, increased anxiety and distress, depression, poor sleep quality and increased drug or alcohol consumption, job insecurity, unemployment and additional stressors.¹²

In turn, this generates an increase in the number of people seeking support. As an example, during the COVID-19 pandemic, there was a 15% increase in the number of Medicare-subsidised mental health services delivered nationally from March to October 2020.¹³ The impact was felt particularly in Victoria, with prolonged periods of lockdown contributing to a 31% increase in services accessed between September and October 2020. This highlights the need for the mental health workforce to have sufficient surge capacity to meet sudden, unexpected and significant increases in demand for mental health support and treatment.

3.2 Policy context

This is an important moment of reform for Australia's mental health system, with the culmination of Royal Commissions, inquiries and strategies. The *Productivity Commission Inquiry into Mental Health*, *The Fifth National Mental Health and Suicide Prevention Plan*, the final advice from the National Suicide Prevention Advisor, and the *Mental Health and Suicide Prevention - Interim Report*, and will guide national direction for Australia's mental health system and have informed the development of this Strategy.

The Commonwealth is currently developing the *Vision 2030 Blueprint* which shapes a national direction for mental health and wellbeing. Vision 2030 will be delivered through a unified system that takes a whole-of-community, whole-of-life and person-centred approach to mental health; providing easily navigated, coordinated and balanced community-based services that are offered early to meet each individual's needs and prevent escalating concerns.

Related workforce strategies are being developed and implemented concurrently. Examples include the *National Medical Workforce Strategy*, *Stronger Rural Health Strategy*, *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031*, *Primary Health Care 10 Year Plan (currently under development and due to be released in 2021)*, *National Digital Health Strategy*, *National Preventive Health Strategy*, and *Ahpra 2020-25 National Scheme Strategy*. Ensuring alignment across these related strategies has been a priority throughout the Strategy development process.

The forthcoming National Mental Health and Suicide Prevention Agreement (the National Agreement) will provide the platform for all Governments work together to build a better, more connected and accountable, mental health and suicide prevention system for all Australians.

This Strategy aims to complement and integrate with these reports and inquiries, rather than duplicating their content. There are other elements of the policy context – such as system reform and funding arrangements – that impact on the ability to attract and retain the mental health workforce. Related activity in those spaces will also contribute to the effectiveness of the Strategy.

¹² Australian Institute of Health and Welfare. (2021). Mental health services in Australia. Accessed at <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/mental-health-impact-of-covid-19>

¹³ Parliament of Australia. (2021). Mental health. Accessed at https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/BudgetReview202021/MentalHealth

3.2.1 Productivity Commission Inquiry into Mental Health

The *Productivity Commission Inquiry into Mental Health* was established in 2018 to consider how mental ill-health can affect all aspects of a person's quality of life including physical health, social participation, education, employment and financial status. The Final Report sets out a roadmap for reform to create a person-centred mental health system. In particular, Recommendation 16 details suggested actions to increase the efficacy of the mental health workforce.

This requires collaboration between governments, consumers and carers, and a cross-portfolio approach to implementation. The Productivity Commission acknowledges that a well-functioning mental health system depends on high quality workers with the right skills in the right places and recommends that this Strategy aligns the skills, costs, cultural capability, substitutability, availability and location of mental health professionals with the needs of consumers.

3.2.2 National Suicide Prevention Adviser – Final Advice

The first National Suicide Prevention Adviser reported directly to the Prime Minister, with final advice provided in 2020 to drive a whole-of-government national approach to suicide prevention, in support of the Australian Government's 'towards zero' suicides goal.

The Final Advice identifies key opportunities to better understand the factors contributing to suicidal distress and suicidal behaviour, and the reforms needed to deliver a comprehensive and compassion-first approach to suicide prevention. These opportunities include prioritizing lived experience into planning and delivery, supporting early intervention by building workforce capability, co-designing effective interventions, and ensuring that government and community services have the capacity to provide outreach and support.

The Final Advice recognises the broad range of workforces involved directly and indirectly in suicide prevention, and the need to build capacity. This requires including compassionate response as a foundation in training packages, and increasing trauma-informed care skills across the broadly defined workforce.

3.2.3 2021 Australian Government budget commitments

The Australian Government announced funding for a number of mental health workforce-related initiatives aimed at improving access to services for those experiencing mental distress and/or ill-health where and when they need them as part of the 2021-22 budget.¹⁴

States and Territories have also made commitments to strengthening the mental health sector and supporting the mental health workforce, through their respective budgets and priorities.

¹⁴ Department of Health. (2021). Budget 2021–22: Generational change and record investment in the health of Australians. Accessed at <https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/budget-2021-22-generational-change-and-record-investment-in-the-health-of-australians>

3.2.4 Overview of state and territory mental health plans and strategies

The Australian mental health workforce policy landscape is complex and varies across jurisdictions. This is partially related to the challenge of defining the mental health workforce, and the separation of physical health and mental health in policy and funding arrangements. Across jurisdictions, the mental health workforce is categorised and defined in a range of ways within policies and plans.

All jurisdictions have an overarching mental health workforce plan.¹⁵ Some plans focus on the mental health workforce, while others are specific to the suicide prevention workforce or include related workforces, such as the alcohol and other drugs workforce. In addition, some jurisdictions have developed policies specific to each area of the mental health workforce, such as mental health nursing and psychiatry.

Despite the complexity, there are commonalities in the aims and principles of the mental health workforce strategies across jurisdictions. These include commitments to sustainable, accessible and equitable service delivery and care that is:

- holistic person-centred
- recovery oriented
- strengths-based
- culturally safe
- trauma-informed.

Each plan has its own priorities or areas of focus for achieving its vision. The following table provides a brief overview of key state and territory mental health workforce strategies and/or plans.

¹⁵ NSW Government. (2018). NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022. Accessed at <https://www.health.nsw.gov.au/mentalhealth/resources/Publications/mh-strategic-framework.pdf>; NT Government. (2015). Mental Health Service Strategic Plan. Accessed at <https://digital.library.health.nt.gov.au/prodjspuui/bitstream/10137/988/3/Mental%20Health%20Service%20Strategic%20Plan%202015%20-%202021.pdf>; Queensland Government. (2016). Mental Health Alcohol and Other Drugs Workforce Development Framework 2016–2021. Accessed at https://www.health.qld.gov.au/_data/assets/pdf_file/0037/677539/mhaod_workforce_dev_framework.pdf; SA Government. (2020). Mental Health Services Plan 2020–2025. Accessed at <https://www.sahealth.sa.gov.au/wps/wcm/connect/8520124e-0250-4393-819e-71bca0db4ad9/19032.2+MHSP-report-web-no+watermark.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-8520124e-0250-4393-819e-71bca0db4ad9-nwLp6cp>; Tasmanian Government. (2016). Suicide Prevention Workforce Development and Training Plan for Tasmania (2016–2020). Accessed at https://www.dhhs.tas.gov.au/_data/assets/pdf_file/0013/214411/151152_DHHS_Suicide_Prev_WD_Training_Plan_Final_WCAG-1.pdf; Victorian Government. (2015). Victoria's 10-year mental health plan. Accessed at <https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan>; WA Mental Health Commission. (2020). Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2020–2025. Accessed at <https://www.mhc.wa.gov.au/media/3423/workforce-strategic-framework-final-04-08-20.pdf>

State/Territory Strategy	Priorities
New South Wales Strategic Framework and Workforce Plan for Mental Health 2018-2022	<p>Holistic, person-centred care – recovery-oriented services, deliver holistic care, improve physical health care, increase community-based</p> <p>Safe, high quality care – improve safety and quality, intervene early for children and young people, strengthen suicide prevention</p> <p>Connected care – organise local systems of care, improve transitions</p>
Northern Territory Mental Health Service Strategic Plan 2015-2021	<p>Planning for a sustainable workforce – workforce planning, career pathways for Aboriginal and Torres Strait Islander staff</p> <p>Growing skills and capability – training for the mental health workforce and mental health skills for the broader workforce</p> <p>Providing a rewarding and safe work environment – clinical supervision, work health and safety</p>
Queensland Mental Health Alcohol and Other Drug Workforce Development Framework 2016-2021	<p>Designing the workforce – core knowledge and skills, flexible workforce operating at its optimal scope of practice, recruitment and retention</p> <p>Enabling the workforce – flexible workforce practices, workforce planning</p> <p>Strengthening the workforce – education, training and professional development, leadership, culturally safe care, a well and safe workforce</p> <p>Keeping connected – partnerships with other care providers, families and carers, training the broader workforce</p>
South Australia Mental Health Services Plan 2020-2025	<p>Personalised care and support – partnership with consumers, intervene early for children and young people, culturally safe care</p> <p>Integrated care – timely and effective care, partnerships with other care providers, improve physical health care</p> <p>Safe and high quality care – improve safety and quality, promote inclusion and equity, supports for the mental health workforce</p>
Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020)	<p>Strengthening the workforce – education, training and professional development with a focus on suicide prevention</p>
Victoria 10-Year Mental Health Plan – Mental Health Workforce Strategy	<p>Workforce availability and skill – professional development, career pathways for Aboriginal and Torres Strait Islander staff, workforce planning</p> <p>Worker safety and satisfaction – organisational supports, work health and safety</p> <p>Workforce integration – partnerships with other care providers, leadership, coordination</p> <p>Co-design and co-delivery with consumers and carers – expand the lived experience workforce</p> <p>Workforce innovation – innovation grants</p>
Western Australia Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025	<p>Strengthening the workforce – education, training and professional development, culturally safe care, core competencies</p> <p>Workforce configuration – recruitment and retention, expand the lived experience workforce, career pathways for Aboriginal and Torres Strait Islander staff</p> <p>Workforce innovation – workforce planning, co-design with consumers and carers</p> <p>Growing skills and capability – core competencies, equipping the broader workforce with mental health skills</p> <p>Workforce data collection – improve consistency, co-design with consumers and carers</p>

Mental Health Workforce

4

4.1 Definition of the mental health workforce

Australia's mental health workforce includes a diverse range of people who treat, interact with and provide support to those experiencing mental distress and/or ill-health.

This Strategy views mental health through a social and emotional wellbeing lens and conceptualises the mental health workforce accordingly, recognising the indivisible connection between people's physical, psychological, social, emotional and cultural wellbeing. This approach draws heavily on the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*.

While the Strategy defines the mental health workforce broadly, it distinguishes between:

- people who work exclusively in the mental health sector (for example Aboriginal and Torres Strait Islander mental health workers, mental health nurses and psychiatrists)
- those who work in other health settings who frequently treat, interact with, care and support people experiencing mental distress and/or ill-health (for example allied health professionals, general practitioners (GPs) and nurses).¹⁶

It recognises the contribution to suicide prevention and mental health of people working in other settings who are likely to have regular contact with people experiencing suicidality, mental distress and/or ill-health as part of their role (for example aged care workers, educators, drug and alcohol workers, housing and justice services workers) and the knowledge and skills they need to support this contribution.

The mental health workforce overlaps at the individual and occupational level. For example, a nurse may work exclusively in a mental health setting, a health setting, or in a school – or work across all these settings. This overlap influences the way in which the mental health workforce needs to be considered, trained and developed.

The Strategy also recognises the critical role that carers, family, friends and important others play in supporting people experiencing mental distress and/or ill-health in their recovery.

¹⁶ The Strategy also recognises that occupations may work across settings. For example, allied health workers may work exclusively in the mental health sector or in broader health settings. There are also occupations that may require mental health endorsements to work in the mental health sector and those that do not require such additional training.

Size and distribution

The diversity of the mental health workforce makes it difficult to estimate the current size and distribution. The lack of reliable data about the mental health workforce is hindered by:

- different registration requirements across occupations
- different funding sources and arrangements for provision of services across settings
- different reporting requirements.

The mental health workforce is estimated at 39,190 full time equivalent (FTE), based on a relatively narrow definition of the workforce using available data from the National Health Workforce Dataset (NHWD).¹⁷ Taking into account broader range of workforce types, including vocationally qualified mental health workers and lived experience (peer) workers, the best estimate FTE increases to 50,518. Missing national workforce supply data for jurisdictional-funded psychosocial support services and PHN-funded mental health services suggest the true size of the workforce is likely to be somewhat larger than that.

The current workforce is significantly below the 2019 National Mental Health Service Planning Framework (NMHSPF) target of 74,252 FTE mental health staff nationally. This target includes 53% tertiary qualified professionals, 29% vocationally qualified mental health workers, 12% medical professionals and 6% peer workers. There is a moderate under-provision in workforce across nearly all workforce groups (68% average of NMHSPF target reached). The demand for mental health care is expected to grow considerably over the next ten years, with a NMHSPF workforce target of 87,645 FTE by 2030 which highlights the significance of current supply issues.

Based on the Modified Monash Model (MMM), supply trends vary across occupations. For some sectors there is an apparent oversupply in urban areas (registered nurses and enrolled nurses), whereas others indicate deficits (psychiatrists, psychologists and Aboriginal and Torres Strait Islander mental health workers). While workforce shortages are most consistently seen in remote and very remote areas, some workforce types met or exceeded NMHSPF targets in these regions (Aboriginal and Torres Strait Islander mental health workers). Workforce shortages in rural areas may sometimes result from clustering of available workforce in larger regional towns and cities, requiring consumers to travel to access services.

The mental health workforce operates in diverse settings, including public and private practice and within the community setting. Some workers are self-employed, and may be in solo practice, where others work for service providers of varying sizes.

¹⁷ This includes Aboriginal and Torres Strait Islander Mental Health Workers, enrolled nurses, GPs, occupational therapists, psychiatrists, psychologists, registered nurses, and social workers.

Data is drawn from the University of Queensland's (2021) Analysis of national mental health workforce demand and supply: Final report. Some of these FTE estimates are likely over-inclusive.

4.1.2 Aboriginal and Torres Strait Islander health practitioners, workers and mental health workers

Role: Aboriginal and Torres Strait Islander health workers and health practitioners are two roles with distinct training and registration requirements. Both provide a range of clinical and primary care, contributing expertise in cultural safety and social and emotional wellbeing. Aboriginal and Torres Strait Islander mental health workers operate across the mental health sector.

Setting: Predominately employed through Aboriginal Community Controlled Health Services (ACCHS).

Training: Aboriginal and Torres Strait Islander health practitioners must have a minimum Certificate IV qualification, which is an average of two years of training. Aboriginal and Torres Strait Islander health workers generally hold a Certificate III qualification in the field of primary health care or clinical practice, but there is no national requirement to hold this in order to practice. There are no consistent training requirements for Aboriginal and Torres Strait Islander mental health workers.

Regulation: Aboriginal and Torres Strait Islander health practitioners are registered under Aboriginal and Torres Strait Islander Health Practice Board of Australia, supported by the Australian Health Practitioner Regulation Agency (Ahpra). The other roles are not regulated.

Supply: One of the largest shortages in the mental health workforce is Aboriginal and Torres Strait Islander mental health workers, estimated at 53 FTE (37% of the NMHSPF target reached). An ageing workforce is contributing to this shortage with the average age of health practitioners and health workers is 45 and 42 years, respectively. The estimated supply of Aboriginal and Torres Strait Islander mental health workers does not meet NMHSPF targets in most regions (MMM1-5). However, as rurality increases, the availability of Aboriginal and Torres Strait Islander mental health workers meets or exceeds NMHSPF targets (e.g., MMM6-7).

4.1.3 Counsellors and psychotherapists

Role: Counsellors and psychotherapists deliver a range of talking therapies, which facilitate change and enhance self-awareness, as well as treatment for trauma. Counsellors also conduct other therapeutic activities, such as intake interviews and liaising with referral agencies.

Setting: Most counsellors and psychotherapists work in private settings.

Training: Counsellors and psychotherapists registered with the Psychotherapy and Counselling Federation of Australia (PACFA) or the Australian Counselling Association (ACA) must have completed an accredited diploma, bachelor or postgraduate qualification. Training takes four years on average.

Regulation: Counsellors and psychotherapists are self-regulated through PACFA and the ACA.

Supply: There is no national standardised data set on the counselling and psychotherapy workforce, which makes it challenging to estimate the size, distribution or sufficiency of supply of this workforce.

4.1.4 Dietitians

Role: Dietitians provide consumer-focused nutrition services to address the mental and physical health needs of individuals and population groups. Dietitians play an important role in the treatment of people with eating disorders.

Setting: Dietitians work primarily in public and community settings.

Training: Dietitians must have a bachelor or masters degree in dietetics. Training takes, on average, four years to complete.

Regulation: Dietitians are self-regulated through Dietitians Australia.

Supply: There is no national standardised data set on the diatetic workforce, which makes it challenging to estimate the size, distribution or sufficiency of supply of this workforce.

4.1.5 General practitioners

Role: GPs provide primary care and are often the first point of contact for someone experiencing mental distress and/or ill-health. GPs diagnose and treat people with mental illness, have a role in making referrals to specialist mental health services and may provide low-intensity psychological therapies.

Setting: Most GPs work in the private sector in group practices.

Training: GPs undertake a bachelor degree and postgraduate degree in medicine, an internship and specialist general practice vocational training. The length of training to become a GP is eight years on average. Further accredited mental health training is required for GPs to provide services under the Medicare Benefits Schedule (MBS).

Regulation: GPs are registered under Medical Board of Australia, supported by Ahpra.

Supply: The best estimate of GPs providing mental health care is 1,728 FTE, calculated as a mid-point between NHWD FTE (2,415 FTE) and FTE from administrative data (1,042 FTE). This is just over half (56%) of the NMHSPF target reached. Factors that contribute to the shortage include an ageing workforce (average age of 51 years), a lack of Australian trained graduates and restrictions on access to overseas trained GPs due to the impact of policy changes and the COVID-19 pandemic. In terms of distribution, upper estimates of GPs FTE based on NHWD data are largely consistent with NMHSPF targets for all MMM regions. In contrast, lower estimates based on administrative data demonstrate a large deficit across all regions, which is more pronounced in remote areas (MMM6-7).

4.1.6 Lived experience (peer) workers

Role: Lived experience (peer) workers are an emerging workforce. This includes consumer peer workers and carer peer workers. Lived experience (peer) workers are employed on the basis of their personal experience of mental illness including their experience of seeking care and treatment, or of having cared for a person with a mental illness.

Setting: Most work in public settings.

Training: There is currently no mandatory qualification required to be employed as a lived experience (peer) worker, though there is a nationally recognised Certificate IV in Mental Health Peer Work.

Regulation: Lived experience (peer) workers are currently unregulated.

Supply: The largest relative gaps in mental health workforce supply is in lived experience (peer) workers (5% and 14% of the NMHSPF target for consumer and carers respectively). The 2019 NMHSPF target for peer workers is 4,238 and there are currently an estimated 264 FTE lived

experience (peer) workers – 184 consumer and 79 carer peer workers. Lived experience (peer) workers are an emerging workforce and is expected to grow with increased recognition of the value of the occupation.

4.1.7 Nurses, nurse practitioners and mental health nurses

Role: The nursing workforce comprises registered nurses, enrolled nurses, nurse practitioners, and credentialed mental health nurses. The nursing workforce regularly interacts with and supports people experiencing mental distress and/or ill-health, whether they work in specialised mental health settings or not.

Setting: Registered and enrolled nurses and nurse practitioners work across a wide variety of settings include public, community and private settings. Most mental health nurses work in public settings.

Training: Enrolled Nurses must complete a minimum Diploma of Nursing (1.5 years) and Registered Nurses a minimum Bachelor of Nursing (3 years). Nurse Practitioners must complete a master's qualification. Currently, there is no direct entry undergraduate degree in mental health nursing. To be credentialed with the Australian College of Mental Health Nurses, mental health nurses must complete an additional graduate diploma or master's degree.

Regulation: The nursing workforce is regulated through the Nursing and Midwifery Board of Australia, supported by AHRPA.

Supply: Nurses comprise the largest segment of the mental health workforce and include 15,690 FTE registered nurses¹⁸ and 2,603 FTE enrolled nurses. There is currently a significant oversupply of enrolled nurses in mental health but a shortage of registered nurses (184% and 75% of the NMHSPF target reached, respectively). Distribution of the nursing workforce varies across regions, with a slight oversupply of registered nurses in MMM3 regions followed by notable deficits in remaining rural regions. For enrolled nurses, there is also an apparent oversupply of enrolled nurses in MMM1-3 regions but pronounced shortages in FTE availability as rurality increases. There is a projected shortfall of mental health nurses of between 11,500 and 18,500 by 2030.¹⁹

4.1.8 Occupational therapists

Role: Occupational therapists provide behaviourally-oriented and goal-directed services to assist people with daily living and work skills. There are specialised Mental Health occupational therapists, who assist people who are struggling with mental distress and/or ill-health.

Setting: Occupational therapists are relatively evenly split across public and private settings.

Training: Occupational therapists must complete an entry level course (Bachelor, Bachelor Honours or Masters entry level). Accredited Mental Health occupational therapists are not required to complete any additional training, unless delivering services under the Better Access program.

Regulation: Occupational therapists are regulated through the Occupational Therapy Board of Australia, supported by AHPRA.

Supply: There are 1,738 FTE occupational therapists providing mental health care.²⁰ While there is a shortage, the shortfall is not significantly below required levels (76% of the NMHSPF target

¹⁸ The data used for the University of Queensland (2021) analysis incorporates nurse practitioners into registered nurse data.

¹⁹ Health Workforce Australia. (2014). Australia's Future Health Workforce: Nurses Detailed Report, Sydney.

²⁰ This estimate is based on the Stage 1 supply demand report produced by the University of Queensland. The Final Report does not provide separate workforce estimates for OTs and social workers.

reached) and the occupational therapy workforce is relatively young (average age of 37 years). Distribution is also relatively well aligned with NMHSPF targets.

4.1.9 Psychiatrists

Role: Psychiatrists are medical practitioners specialising in the diagnosis and management of mental ill-health who generally treat people with more severe mental health conditions.

Setting: Most psychiatrists work in private settings.

Training: Psychiatrists undertake a bachelor degree, a postgraduate degree in medicine, followed by specialist training in psychiatry with the Royal Australian and New Zealand College of Psychiatrists (RANZCP). The training pathway takes a minimum of 11 years to complete.

Regulation: Psychiatrists are registered under Medical Board of Australia, supported by AHPRA.

Supply: There is a critical shortage of psychiatrists (66% of the NMHSPF target reached). The current workforce is estimated at 2,310 FTE. Shortfalls are particularly evident in specific sub-specialties, such as child and adolescent, and settings, such as inpatient units and emergency departments. An ageing workforce (average age of 53 years) and time lag to increase supply due to length of training are contributing to the shortage. There is a significant reliance on overseas-trained psychiatrists to meet demand, which has been disrupted by COVID-19. There is a consistent deficit in psychiatrists across all MMM regions, when compared to NMHSPF workforce targets, and these deficits are more pronounced in MMM6-7 regions.

4.1.10 Psychologists

Role: Psychologists provide assessment, diagnosis and treatment to assist people experiencing mental distress and/or ill-health.

Setting: Most psychologists working in private settings.

Training: The minimum training requirements are a Bachelor of Psychology or degree with a major in psychology and a fourth-year honours (or post-graduate diploma), followed by a 1 year master's and 1 year of supervised practice (6 years total). AHPRA Endorsed Clinical psychologists and Counselling psychologists require a further 2 year Master's degree qualification in their specific area of practice and a 2 year regulated registrar program in the relevant area of practice (8 years total).

Regulation: Psychologists are registered through the Psychology Board of Australia, supported by AHPRA.

Supply: In terms of absolute workforce gaps, the largest shortfall compared to the NMHSPF workforce targets is for psychologists (7,787 FTE gap). The current estimated supply of psychologists is 4,227 FTE, reaching only 35% of the NMHSPF target. The undersupply is across all MMM regions, with deficits more pronounced in rural regions (MMM6-7).

University of Queensland. (2020). Analysis of national mental health workforce demand and supply: Stage 1 report. 30 October 2020. Report for the Australian Government Department of Health. Brisbane: The University of Queensland.

4.1.11 Psychosocial support workers

Role: Psychosocial support workers deliver a range of psychosocial support services to assist people experiencing mental distress and/or ill-health, including assessments and counselling, developing treatment plans, care coordination, case management, providing referrals, and progress monitoring.

Setting: Most are employed in public settings.

Training: There is no minimum qualification for psychosocial support workers. However, this occupation often includes those who have completed vocational training (such as the Certificate IV in Mental Health).

Regulation: Psychosocial support workers are currently unregulated.

Supply: The best estimate of FTE staff for vocationally qualified psychosocial support workers is based on analysis of NDIS payments data. This gives an estimate of 17,486 FTE vocationally qualified psychosocial support workers (95% of NMHSPF target reached). It is important to note this FTE estimate may be an overestimate, including other occupations (such as allied health, medical or peer workers) as provider type data was not available.

4.1.12 Social workers

Role: Social workers offer counselling support, community engagement and clinical services utilising a range of evidence-based strategies to assist people experiencing mental distress and/or ill-health. There are also accredited mental health social workers, who are recognised providers through the Better Access program.

Setting: Most social workers work in public settings.

Training: Social workers must complete a minimum Bachelor of Social Work, generally four years. Accredited Mental Health Social Workers must have received at least two years post-qualifying supervision in a mental health.

Regulation: Social workers are self-regulated and accredited by the Australian Association of Social Workers (AASW).

Supply: There are no national FTE counts for the supply of social workers. Based on the Mental Health Establishments National Minimum Data Set (MHE NMDS), there are 2,401 FTE social workers in state and territory-funded inpatient and community setting, which is above set levels (115% of the NMHSPF target reached).²¹

²¹ This estimate is based on the Stage 1 supply demand report produced by the University of Queensland. The Final Report does not provide separate workforce estimates for OTs and social workers.

University of Queensland. (2020). Analysis of national mental health workforce demand and supply: Stage 1 report. 30 October 2020. Report for the Australian Government Department of Health. Brisbane: The University of Queensland.

4.1.13 Speech pathologists

Role: Speech pathologists provide support to people through early identification, assessment and treatment of communication and/or swallowing difficulties associated with mental ill-health.

Setting: Data were not available on speech pathologists.

Training: Speech pathologists must complete a minimum four-year bachelor degree.

Regulation: Speech pathology is a self-regulated profession through Speech Pathology Australia.

Supply: There is no national standardised data set on the supply of speech pathologists.

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Common workforce challenges

5

The mental health workforce is critical to achieving a high quality mental health system that delivers the support and treatment that people experiencing mental distress and/or ill-health, their carers and families require – when and where they need it. The mental health workforce must be available in sufficient numbers and appropriately trained – both pre-service and through continuing professional development – if it is to fulfil this critical role to the standard required.

There are wide ranging issues that affect the mental health workforce, commonly identified through commissions, inquiries and research. This chapter outlines the key issues common to occupations in the mental health workforce. This chapter draws on evidence collected through the literature review, data analysis and consultations undertaken by the Taskforce to date.

5.1 Attractiveness and awareness of careers in mental health

Awareness of mental health as an attractive career

While enrolments in education and training programs that can lead to employment in mental health have generally been increasing over time, existing workforce shortages are likely to be exacerbated by increasing demand for mental health services.²² This will necessitate further investment in the training system to support increased supply for most professional and occupations.

Education providers are hesitant to scale up training delivery without clear evidence of demand for places. Providers are unlikely to expand or diversify their current offerings without clear market signals that sufficient students will enrol to make courses viable.

The limited awareness of career opportunities and associated training pathways in the mental health sector impacts the ability to attract students into some mental health training programs, which means these visible market signals are not always present.

There is a need to market mental health as an attractive career choice for secondary school students, undergraduates, graduates and the existing health workforce to help build demand for associated training programs. Increasing awareness of mental health careers should occur as early as possible to help maximise the visibility for potential students.²³

Many of the issues that impact upon the attractiveness of careers in mental health are discussed in the sections that follow. It is critical to note that increasing awareness of career opportunities in mental health is not sufficient to address the current workforce shortages.

²² ACIL Allen. (2020). Education Institutes Review. Pg iv.

²³ University of Queensland. (2020). National Mental Health Workforce Strategy - A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries. Pg 38.

Stigma

There are widespread negative perceptions of working in the mental health that reduce the attractiveness of entering the sector. The drivers of this stigma vary, but the quality of placements contributes to the negative perceptions of the sector.

The issues associated with placements vary between occupations. For some occupations, placements are often in acute or high intensity settings which do not provide exposure to the breadth of mental health related settings (including private and community settings). This is particularly relevant for GPs, nurses, occupational therapists, psychiatrists and social workers.²⁴ For other occupations, there is often limited access to placements in any mental health setting – with placements generally hosted in broader health settings. This reduces the visibility of mental health as a potential pathway.

5.2 Workforce data

Lack of data

There is an acknowledged lack of comprehensive data about the mental health workforce that impedes workforce planning. This is particularly apparent for occupations that are not regulated under AHPRA (including self-regulated or unregulated professions), the community managed sector workforce where nationally consistent data regarding workforce size and composition by occupation are not available.²⁵ There are also difficulties in accessing data on the size of the Aboriginal and Torres Strait Islander workforce, with limited distinction in the data between workers whose primary role is to provide mental health care versus other care, as well as clinicians working in Indigenous-specified roles. The table below summarises the sources of data for key occupations.

Occupation	Current workforce data sources
Aboriginal Health Practitioners	National Board supported by AHPRA
Aboriginal Health Workers	-
Aboriginal Mental Health Workers	-
Counsellors and psychotherapists	Peak bodies
Dietitians	Peak body
Enrolled Nurses	National Board supported by AHPRA
General Practitioners	National Board supported by AHPRA; RANZCGP
Lived Experience (Peer) Workers	-
Mental Health Nurses	National Board supported by AHPRA; Peak body
Nurse Practitioners	National Board supported by AHPRA
Occupational Therapists	National Board supported by AHPRA
Psychiatrists	National Board supported by AHPRA; RANZCP
Psychologists	National Board supported by AHPRA
Psychosocial Support Workers	-
Registered Nurses	National Board supported by AHPRA
Social Workers	Peak body
Speech Pathologists	Peak body

²⁴ ACIL Allen. (2020). Labour Market Analysis. No page.

²⁵ University of Queensland. (2020). Pg 13.

There is no nationally consistent approach to data that aligns to the broad definition of mental health workforce across all service settings. This is an important gap in understanding the range of occupations available to support people with mental illness, including their distribution and size.

These challenges are compounded for those who work across sectors and settings, particularly as markets develop (such as the NDIS, which creates different employment patterns). Some occupations work across sectors (holding roles, for example, in aged care, mental health and disability) and in a combination of community and public settings. This can lead to inaccurate data on the number of the individuals available to provide treatment, support and care.

The extent to which national planning processes are linked to local planning is limited. Consultations identified the need for a locally-led process, contributing understanding of local issues, to ensure all issues are identified and suitable strategies are developed for all types of occupations and settings. Collaboration between government, professional bodies, and industry stakeholders varies across settings and occupations. Feedback from stakeholders indicated there is often limited shared understanding of training pipelines, workforce needs and supports.

5.3 Utilisation

Clearly defined competencies core competencies

Consumers and carers require access to safe, high quality treatment, care and support, delivered by skilled workers from a broad range of occupations in diverse service settings. The consultations held by the Taskforce identified that there is great variation in the knowledge, skills and behaviours that regulators and employers require of the occupations in the mental health sector. Some occupations have clearly defined competencies, whereas others have limited national consistency.

There is no clear competency framework that clarifies the core knowledge, skills and attitudes required to deliver different forms of support and treatment in the mental health sector. This makes it difficult to understand the competencies that are shared across disciplines and required for all work in the mental health sector, or those that are discipline-specific and will depend on the occupation itself.

Competencies for the broader mental health workforce

There are other occupations who regularly interact with people experiencing mental distress and/or ill-health outside of health or mental health settings. Examples here include aged care workers, disability workers, education workers and first responders. These workforces have an important role to play in identifying where early intervention is required (for example, in educational settings) or responding safely and compassionately to those experiencing mental ill-health (for example, in policing and justice, maternal and child health).

There are no agreed core competencies for this broader workforce to support the development of basic mental health literacy and skills within the community. This means there are skill gaps in the ability to identify signs that referral to services is required, or to safely interact with people experiencing mental distress and/or ill-health, as appropriate to their role.

Consistent scopes of practice

Nationally consistent, clearly documented scopes of practice vary across the occupations in the broadly defined mental health workforce. While some occupations (such as GPs, nurses and psychologists) have documented and national scopes, many other occupations do not – particularly emerging and self-regulated occupations or the social and emotional wellbeing workforce.

The lack of clear scopes of practice creates confusion about who is able to perform what role in which settings, particularly when working in multidisciplinary teams. This lack of consistency raises

barriers with respect to utilisation of some occupations, as workers aren't able to operate to their full scope of practice. This creates additional challenges for emerging workforces, where there is limited understanding of their knowledge, skills and possible role.

The table below provides a summary of current, nationally consistent scopes of practice for key occupations in the mental health workforce.

Occupation	Nationally consistent scope of practice
Aboriginal Health Practitioners	Existing national scope of practice
Aboriginal Health Workers	No national scope of practice
Aboriginal Mental Health Workers	No national scope of practice
Counsellors and psychotherapists	Existing national scope of practice
Dietitians	Existing national scope of practice
Enrolled Nurses	Existing national scope of practice
General Practitioners	Existing national scope of practice
Lived Experience (Peer) Workers	No national scope of practice
Mental Health Nurses	Existing national scope of practice
Nurse Practitioners	Existing national scope of practice
Occupational Therapists	Existing national scope of practice
Psychiatrists	Existing national scope of practice
Psychologists	Existing national scope of practice
Psychosocial Support Workers	No national scope of practice
Registered Nurses	Existing national scope of practice
Social Workers	Existing national scope of practice
Speech Pathologists	Existing national scope of practice

Occupational regulation

The quality of care and safety of consumers is underpinned by effective regulatory arrangements.

The current arrangements for regulating the occupations that constitute the mental health workforce have evolved over time. Some occupations have long-established, mature regulatory. The Australian Health Practitioners Registration Agency (AHPRA) regulates a range of occupations and regulatory arrangements include codes of conduct, ethics, continuing professional development and registration components. There are no regulatory arrangements in place for emerging occupations.

The variation in regulation across occupations creates issues in workforce utilisation (related to scopes of practice) and ensuring consumer safety and quality of care.

Regulation type	Occupations
AHPRA regulated (through National Boards)	Aboriginal and Torres Strait Islander health practitioners, medical practitioners, nurses, occupational therapists, physiotherapists, psychiatrists, psychologists
Self-regulated	Counsellors and psychotherapists, dietitians, social workers, speech pathologists
Unregulated	Aboriginal and Torres Strait Islander health workers and mental health workers, lived experience (peer) workers, psychosocial support workers

5.4 Skills

Contemporary capability needs

The changing needs and expectations of consumers, their carers and families, alongside the complexity and co-occurrence of conditions, has increased the knowledge, skills and behaviours required of both new graduates and the existing workforce.

Although regulatory bodies set the education and training standards for many occupations, there are also specific capability gaps that need to be acknowledged within the core competencies and embedded in pre-service training, as noted through recent inquiries and commissions. These include the development of the skills consumers value, including:

- empathy and service navigation abilities²⁶
- delivery of inclusive and culturally safe services including for Aboriginal and Torres Strait Islander peoples, LGBTIQ+ and culturally and linguistically diverse communities.

There is also a need for the mental health workforce to have knowledge of co-occurring neurodevelopmental disorders. These skills are necessary for the mental health workforce to recognise and respond to co-occurring conditions, ensuring adequate treatment responses.

Skills for the generalist mental health workforce

Given the broad definition of the mental health workforce and recognising that many graduates will not work in the mental health sector, programs outside those that train graduates specifically for mental health roles are often designed with little mental health content.

This limited coverage of mental health at the undergraduate level for some occupations (such as nursing and general practice) and the absence of undergraduate mental health specialisations (including for occupational therapists and speech pathologists) creates skill gaps for the generalist workforce who may enter into the mental health sector.

Skills for the broader mental health workforce

There has been limited recognition historically of the role that the broader workforce can play in supporting the mental wellbeing of Australians, which means there is little focus on mental health within training.

This means that many workers who interact with people experiencing mental distress and/or ill-health do not always have the mental health literacy or skills to appropriately care for, support and refer on those they come into contact with. As a consequence, important preventative or early intervention opportunities are lost which may result in worse outcomes for consumers and carers.

Low completion rates

Building the mental health workforce pipeline begins with entry level training. Low completion rates are experienced in courses that train Aboriginal and Torres Strait Islander health and mental health workers, lived experience (peer) workers, and psychosocial support workers.²⁷

Barriers to completion for these groups include financial pressures (for example, income foregone due to participation in training), personal circumstances (such as caring responsibilities) and difficulty in attending face-to-face training (due to travel time and costs).

²⁶ Productivity Commission. (2020). Pg 705.

²⁷ ACIL Allen. (2020). Education Institutes Review. No page.

Skills for supervision

Placements play an important role in the attractiveness of the mental health sector. Poor quality placements arise when students receive insufficient supervision and support, which can be driven by supervisors having poor supervisory skills or insufficient time to devote to planning for and supporting students in their placement.

Supervision requires a different skill set to delivering treatment, care and support. There is a need to ensure those responsible for facilitating placements have the knowledge, skills and attitudes required to improve the educational experience for students.

As an example, psychiatry supervisors report there are increasing demands on them for service delivery which impacts on their capacity to provide appropriate and adequate supervision to meet the accreditation standards of the RANZCP Fellowship program. This is having significant flow-on effects on the mental health and resilience of supervisors as well as their capacity to undertake training to enhance their supervision.

5.5 Workforce retention

Negative perceptions

Negative perceptions of the mental health sector across the community broadly are reinforced if students in pre-service training experience poor quality placements.

Beyond the pre-service experiences, there are other factors that drive negative perceptions. Mental health is often seen to be less prestigious than other health settings. The ongoing stigma relating to mental health impacts not just on attitudes toward consumers and carers, but also graduates' willingness to work in the sector.

Observations of under-resourcing and overwork, particularly in public settings, make mental health roles unappealing when other sectors may have better conditions. Unsuitable physical infrastructure can limit the way in which support and treatment are provided, particularly in rural communities. These issues are not experienced universally across settings, nor are they unique to the mental health sector, but do need to be addressed to improve retention.

Employment conditions

Employment conditions vary considerably across occupations and employers in the mental health sector in terms of remuneration and employment stability.

The drivers for this variation are multi-faceted. Industrial awards differ across sectors and settings (for example between disability and mental health, and between the community and public sector). The structure of pay rates set by State and Territory governments means there are often limited progression points available alongside experience and access to penalty rates may vary across locations or contexts, both of which impact on potential income for workers.

Short funding cycles, particularly for the community sector, reduce the length of contract and contribute to employment instability. There is also strong competition for employees between community mental health providers, public and private mental health service providers and reflecting the different pay scales that apply to each.²⁸

²⁸ For example, health professionals with a three year degree under the Victorian Public Service Enterprise Agreement will be paid a minimum of \$70,791 annually. By contrast, health professionals with a three year degree employed under the Health Professionals and Support Services Award 2020 will be paid a minimum of \$956.20 a week (which equates to approximately \$50,000 a year).

Viability of private practice

There are diverse factors that influence the viability of private practice, including the level of awareness of roles, the nature of funding arrangements, and the scale of the market. When combined, these factors limit the viability of private practice for roles including counsellors and psychotherapists, mental health nurses, occupational therapists and the vocationally trained workforce in particular.

Current Medical Benefits Scheme (MBS) settings do not encourage GPs to specialise in mental health as the rebates for many mental health consultations are less than the rebates for other services, despite the increased time required to deliver them.

Supervision

Supervision is an essential part of practice improvement for the mental health workforce. The lack of access to quality supervision impacts on employee satisfaction and willingness to stay within the mental health sector.

For some groups (such as occupational therapists and social workers) there is difficulty accessing discipline-specific supervision within mental health settings, when care team structures and roles are more generalist in nature. For other groups (such as lived experience (peer) and psychosocial support workers) there is limited access to supervision of any nature within their practice.

Supervision for the psychiatry workforce is also challenging, with difficulties in accessing sufficient supervisors to support increased numbers of psychiatrists. Rural and remote areas experience greater challenges, with restrictions on the use of remote supervision limiting access to potential supervisors who may be based in more metropolitan areas.

Professional development

Current service delivery contracts limit access to continuing professional development (CPD) as they do not include funding for, nor allow providers to release staff for, training and professional development. Access to professional development activities is also challenging in rural and remote locations, where there are few locally based opportunities.

The lack of access to development and upskilling reduces career satisfaction and leads to disengagement. It also impacts on the capability levels of the workforce, with reduced exposure to contemporary practice, reflection and networking opportunities that help to build professional and informed approaches. Without ongoing development, the workforce risks losing the knowledge and skill currency that is essential to ensuring positive outcomes for carers and consumers.

Organisations and peak bodies consulted in the development of this Strategy reported difficulty in accessing information on available professional development opportunities, noting the lack of a consistent and centralised source of high quality training activities that could be recommended for their staff.

Career progression

Access to opportunities for progression in level, role and responsibility is an important contributor to career satisfaction and retentions. The lack of career progression opportunities decreases the attractiveness of employment to some occupations within the mental health sector, their satisfaction at work and consequently the levels of staff retention.

Some occupations have flat, inconsistent or poorly defined career structures within mental health, resulting in limited opportunities for career progression (for example, for Aboriginal and Torres Strait Islander health and mental health workers, lived experience (peer) workers, occupational therapists, and social workers).

The size of service providers, structure of care teams and service delivery models may limit the number of discipline-specific roles into which individuals can progress. This increases the attractiveness of work outside the mental health sector perceived as having greater opportunities for progression.

Job satisfaction

The ability to operate to the optimal scope of practice helps to increase job satisfaction and retain workers within the mental health sector. There are consistent issues with working to top of scope across the workforce, indicative of widespread issues in role design and linked to the earlier point regarding scopes of practice.

For generalist roles, there is often a misalignment between the more specialised pre-service training that graduates have completed and the resultant role which doesn't allow for the application of such expertise. This disconnect between the discipline-specific training and the job roles impedes attraction to and retention in the sector. The most significantly impacted cohort is the tertiary qualified workforce including occupational therapists, psychologists and social workers who are often employed in roles where their particular knowledge and skills are utilised to a very limited extent. The poor alignment between training and job role exacerbates the issues associated with lack of career progression and access to supervision, impacting negatively on job satisfaction.

Employment security

There is a high proportion of short-term contract positions in the mental health sector, particularly in community based mental health services.

This produces employment instability for workers that encourages them to consider seeking alternative employment in other areas of the sector or outside it. In turn, this generates issues for consumers and carers arising from a lack of continuity of care, and creating difficulties for service providers in maintaining high quality workforces.

Workplace culture

A resilient mental health workforce requires a supporting workplace culture, free from burnout, high stress and fatigue.

Workplace culture in the mental health sector is consistently identified as a challenge. Fatigue and burnout were reported to be high through stakeholder consultations as a product of workload levels. These factors contribute to attrition across the board and impact even more strongly on regional and remote workforces where many of the issues discussed previously are exacerbated.

Safety

Workplace violence and harm is significant in mental health settings. Research indicates that there is a higher frequency of exposure to workplace violence in health service settings than in other workplaces, though there is limited data available specifically on mental health service settings.²⁹

The stress of workplace violence, physical and verbal abuse and aggression from patients has a negative impact on the mental health workforce, increasing stress and burnout³⁰, and diminishing the attractiveness of working in the sector.

Ensuring workplace health and safety through appropriate staffing levels, supervisory arrangements and support is an important part of enhancing worker wellbeing.

²⁹ University of Queensland. (2020). Pg 34.

³⁰ University of Queensland. (2020). Pg 4.

Rural and remote contexts

Recruitment into the mental health sector within rural and remote locations poses additional challenges. Though the ideal solution to developing the local workforce is to attract and train local people, place-based approaches are limited due to the attractiveness of the sector and availability of training opportunities.

Failing the development of locally based workforces, the next best option is to attract permanent staff to rural and remote areas in order to provide continuity of care to people experiencing mental distress and/or ill-health. Common practice is to incentivise the use of locums, which impacts negatively on community and outcomes. There is a need to consider flexible service models that build on local service strengths, consider innovative approaches to supervision, and foster specialised generalist models of treatment, care and support.

Service settings

Public and community-based settings have greater difficulty than private services experience attracting and retaining staff in most roles due to a number of factors. Public mental health and community-based services are most heavily affected by systemic underfunding, which creates environments with high workloads and few supports for the workforce.

Poor remuneration and lower wages of workers in the community mental health sector, compared to those performing similar roles in the public or private sector, results in higher staff turnover in this sector. This is exacerbated in rural and remote contexts. Given the forecast increasing reliance on the community sector, there is a need to increase in size and diversify in skills to meet service demand.

The public / private divide also impacts heavily on psychiatry and psychology, with great difficulty attracting these workforces into public contexts. Private settings are seen to offer higher potential incomes, increased prestige, a lower acuity of patients, and improved safety for practitioners. Collectively, these improved conditions are also seen to improve the wellbeing of the psychiatry and psychology workforce.

5.6 Deployment

Rural and remote training availability

The limited availability of locally-based vocational and tertiary courses in rural and remote areas affects the attraction of students living in these areas to health and mental health-related study.

People living in regional and remote areas are increasingly moving to metropolitan locations to study and are more likely to cite financial and fee difficulties as their reason for not completing due to the stress of supporting life away from home.³¹

The value of online delivery of education in improving accessibility is well recognised, in part due to the COVID-19 pandemic. While there is broad support for increased blended delivery through online platforms, there is a need for appropriate compliance mechanisms to ensure that quality is maintained. Similarly, while distance education options are increasingly available, difficulty accessing quality placements with appropriate supervisory arrangements in rural and remote locations impacts the attractiveness of these options for many students.

³¹ Grattan Institute. (2018). Background Paper No. 2018-08. University attrition: what helps and what hinders university completion?

Aboriginal and Torres Strait Islander communities

Aboriginal and Torres Strait Islander peoples are under-represented within the mental health workforce, both in designated roles and more broadly across the sector. Despite growth in absolute numbers, there has been no real improvement in the proportion of Aboriginal and Torres Strait Islander peoples in the total health workforce.

The lack of locally-based courses impacts significantly on Aboriginal and Torres Strait Islander communities who face compounding barriers to accessing entry-level training, including the need to spend time away from community, increased travel costs and difficulties managing study with cultural obligations. Aboriginal and Torres Strait Islander students have a higher risk of non-completion, compared with non-Indigenous students.³²

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³² Grattan Institute. (2018). Mapping Australian higher education.

Occupation-specific issues

6

Outside the issues common across the mental health workforce, there are particular or unique challenges for some occupations. This chapter outlines the most significant issues as identified through the literature review, data analysis and consultations undertaken by the Taskforce to date.

6.1.1 Aboriginal and Torres Strait Islander health practitioners, workers and mental health workers

The issues discussed in chapter 5 are compounded for Aboriginal and Torres Strait Islander health practitioners, workers and mental health workers. While there are registration processes that provide consistency in training and qualifications for practitioners, the limited role recognition and inconsistency in roles across organisations or jurisdictions creates further challenges in attracting Aboriginal and Torres Strait Islander health workers to mental health.

Having a more developed and standardised system of roles and levels could provide the sector with common expectations. However, it would need to address the current variation in function across service providers and jurisdictions. This would require collaboration from a peak body perspective, but also at the local level within individual organisations responsible for the design of positions.

6.1.2 Allied Health (Occupational therapists, dietitians and speech pathologists)

Allied Health workers are often recruited into generalist positions within the mental health sector (namely, generic mental health practitioner roles rather than discipline-specific roles). This is driven in part by the need for organisations to advertise generalist roles, even when there are specific disciplines required, in order to attract workers to fill positions in the mental health sector – a problem that is exacerbated in rural and remote areas. This reduces the attractiveness of the sector in the first instance.

A further driver is the limited awareness in the mental health sector of the role and contribution of dietitians, occupational therapists, social workers and speech pathologists to mental health service delivery, which reduces the number of specialist job opportunities available. Both issues mean that once in generalist roles, there are few opportunities for allied health staff to apply discipline-specific skills which increases attrition.

Unique issues relating to the sustainability of the profession have emerged for counsellors and psychotherapists. The vast majority of this workforce are in private practice where they are remunerated directly by clients, occasionally utilising private health insurance. Since the introduction of Better Access in 2006 referrals from GPs have shifted to psychologists to ensure maximum rebate for clients. This has reduced private practice sustainability for counsellors.

6.1.3 General practice

GPs have a central role in the mental health system, often operating as the first point of call for people experiencing mental distress and/or ill-health.

Despite this, there is minimal mental health training in the qualification process. Though there are credentialled training modules to access MBS items, uptake is relatively limited due to the lack of a financial incentive to deliver mental health related services when compared with broader health MBS items.

The Productivity Commission recognised the particular, role of GPs in regional and remote areas as key providers of mental health services and the need for more tailored or specialised mental health training for those operating in these areas.

6.1.4 Lived experience (Peer) practice

Lived Experience (Peer) roles are increasingly recognised as important additions to services offered by the mental health sector.

There are particular challenges in attracting the Lived Experience (Peer) workforce into training, including the lack of visible career pathways, absence of minimum mandated qualifications, level of available qualifications (with the entry point generally at Certificate IV level), costs to undertake training, and systemic barriers that prevent participation in training (for example, the access to Centrelink entitlements).

The skills, capabilities, scope of practice and values which underpin the Lived Experience (Peer) workforce need to be clearly defined and recognised nationally. As an emerging workforce, the role of peer workers also needs definition. Once the foundations for supporting this emerging workforce are in place, appropriate training needs to be designed that is aligned to the skills required and accessible to the potential workforce.

This creates additional challenges in terms of access to appropriate professional development, supervision and progression. Retention is an issue, with some experienced workers continuing careers outside of the designated roles due to the lack of opportunity to progress to. This result in loss of expertise and candidates to provide supervision and/or training for new entrants.

There are different approaches underway to address these issues. At a national level, the National Mental Health Commission is currently developing the Peer Workforce Development Guidelines.

6.1.5 Psychiatry

Many states and territories experience difficulty attracting sufficient numbers of medical graduates to psychiatry training pathways. These shortages are exacerbated significantly in regional and remote areas.

Attraction of medical graduates to psychiatry training is affected by attitudes and perceptions of working in the mental health system. These perceptions are influenced by placement experiences during pre-service medical training and as junior medical officers.

Placements often occur in public mental health settings which often involve high stress, in-patient settings with exposure to the most unwell patients, where supervision and support is limited due to understaffing, physical settings can be rundown and seen as unsafe and exposure to patient recovery is limited, which reduces the proportion of graduates who go on to specialise in psychiatry. In addition, there are limitations on the number of psychiatry training places available due to state / territory government funding arrangements and the RANZCP's requirements.

6.1.6 Psychology

Unlike some other occupations in the mental health sector, psychology programs often have a high level of applications for the number of places available. This is relevant for both undergraduate level courses and postgraduate qualifications, which are a requirement to become either an endorsed or clinical psychologist.

Post-graduate psychology qualifications are resource intensive to deliver due to the supervision ratios established by the Australian Psychology Accreditation Council. These programs predominantly consist of Commonwealth Supported Places, though there are shifts toward introducing full fee positions to help meet demand. When combined, these two factors mean that psychology programs are often operated at a loss. Though there is strong demand for places, universities are generally unwilling to scale up delivery due to the financial implications. Other contributing factors are access to qualified supervisors and access to placements, challenges shared with other mental health related occupations.

DRAFT ONLY

Taskforce Terms of Reference

A

Purpose of the National Mental Health Workforce Strategy Taskforce

The Taskforce's purpose is to oversee the development of a ten year National Mental Health Workforce Strategy.

It will advise the Commonwealth Department of Health and the National Mental Health Commission, who are jointly developing the Strategy.

Terms of Reference for the National Mental Health Workforce Strategy Taskforce

The Taskforce will examine:

- Defining the mental health workforce, with respect to both settings and professions.
- Sustainability, supply, distribution and retention issues for the mental health workforce.
- The scopes of practice and structure of the mental health workforce across the service continuum.
- The training, support and the wellbeing of the mental health workforce, in the light of contemporary priorities such as suicide prevention and recovery-oriented care.
- The workforce's capability in providing telephone-based and digital services.
- The adequacy of data to inform workforce planning and development.
- Any matters reasonably relevant to the issues above, as determined by co-Chairs.

The Taskforce will:

- Recommend practical approaches that governments and other stakeholders can take to strengthen the workforce.
- Consider how to build a workforce that recognises and best utilises the skills and strengths of all workers, including peer workers, disability support workers, alcohol and other drug workers and carers.
- Develop advice that will clarify and enhance the role of various segments of the emerging workforce including but not limited to the peer workforce and Aboriginal and Torres Strait Islander health practitioners, health workers and mental health workers.
- Provide recommendations to improve the capability of, and support to, professions that provide support to people with mental illness as a secondary role such as first responders, educators, justice system staff and health professionals.
- Consider the application of trauma-informed care and practice at the organisational and individual practitioner level within mental health services.
- Address the need to build and retain a culturally responsive mental health workforce for populations whose health needs may not be met by mainstream services including Aboriginal

and Torres Strait Islander peoples, culturally and linguistically diverse communities and lesbian, gay, bisexual, trans, and/or intersex (LGBTI+) people and communities.

- Work in the context of current mental health and broader government policy settings of relevance to the workforce. Alignment with The Fifth National Mental Health and Suicide Prevention Plan is essential.
- Have regard to other workforce reports, strategies and inquiries, including jurisdictional mental health workforce strategies, in development or being implemented.
- Consider appropriate access to the mental health workforce for the specific needs of regional, rural, remote and very remote communities.
- Set targets to attract and retain workers, and establish a system to monitor and report progress in achieving targets.
- Provide recommendations on how to strengthen data on the mental health workforce.

Operation of the National Mental Health Workforce Strategy Taskforce

The Taskforce will be co-chaired by Jennifer Taylor PSM and Thomas Brideson. Membership of the Taskforce will be settled by the Minister for Health, in consultation with co-Chairs. Members will be drawn from the following professional groups:

- Professional and occupational peak bodies
- Provider peak bodies and representatives
- Consumers and Carers
- State/territory representation
- Education sector representation
- Aboriginal and Torres Strait Islander sector representation
- Economics representatives

The Taskforce is expected to meet approximately nine times between January 2020 and June 2021. The Taskforce will provide initial recommendations to the Government by December 2020. A final report will be provided to Government by June 2021 prior to endorsement by the Australian Health Minister's Advisory Council.

The Taskforce, in consultation with the Department of Health, has the capacity to commission and consult experts, and engage in broad stakeholder and community consultation.

The Department of Health will provide the Secretariat for the Taskforce.

Working Group membership

B

Aboriginal and Torres Strait Islander Communities

- Thomas Brideson, Taskforce Co-Chair (Chair)
- Dr Joe Tighe, Close the Gap Steering Committee
- Dr Siva Balaratnasingam, RANZCP
- Donna Murray, National Health Leadership Forum Representative
- Dawn Casey, NACCHO
- Anna-Louise Kimpton, NACCHO (Proxy)
- Jess Styles, NACCHO (Proxy)
- Harry Lovelock, Mental Health Australia
- Brenda Graham, National Indigenous Australians Agency
- Emily Jones, National Indigenous Australians Agency
- Louise Cooke, National Indigenous Australians Agency
- Carolyn Bourke, Department of Education, Skills and Employment
- Patrick Smith, Department of Health
- Elizabeth Brown, Mental Health Consumer Representative
- Rosalyn Havard, Mental Health Carer Representative

Education and Training

- Jennifer Taylor, Taskforce Co-Chair (Chair)
- Rachel Bowes, Lifeline
- Dr Jeff Borland, Labour Market Economist
- Maria Brett, Psychotherapy and Counselling Federation of Australia
- Dr Sidney Cabral, Royal Australian and New Zealand College of Psychiatrists
- Peter Heggie, Carer Representative
- Heather Nowak, Consumer Representative
- A/Prof. Genevieve Pepin, Australian Council of Deans of Health Sciences
- Martin Paul, Commonwealth Department of Education Skills and Employment
- Dr Morton Rawlin, Royal Australian College of General Practitioners
- Stephen Jackson, Australian College of Mental Health Nurses

Intergovernmental and Interjurisdictional Issues

- Jennifer Taylor, Taskforce Co-chair (Chair)
- Bill Gye, Community Mental Health Australia
- Ros Knight, Australian Psychological Society
- John Brayley, Chief Psychiatrist SA
- Tricia O'Riordan, NSW Health
- Jason Davies-Kildea, Beyond Blue
- Esmeralda Rocha, Department of Prime Minister and Cabinet
- Gina Andrews, Department of Prime Minister and Cabinet
- Moira Campbell, Department of Veterans' Affairs
- Noel Muller, Consumer representative
- Eileen McDonald, Carer representative

Lived Experience (Peer) Workforce

- Margaret Doherty, Mental Health Advisory Council Western Australia (Co-Chair)
- Peter Heggie, NSW Health (Co-Chair)
- Anne Barbara, Carer representative
- Catherine Brown, National Mental Health Commission
- Louise Byrne, RMIT
- Vanessa Corunna, Curtin University
- Shauna Gaebler, Consumers of Mental Health Western Australia
- Lisa Goldrick, Federal Department of Defence
- Tim Heffernan, National Mental Health Peer Workforce Development Guidelines
- Stephanie Hodson, Federal Department of Veterans' Affairs
- Roderick McKay, RANZGP
- Heather Nowak, South Australian Mental Health Commission
- Carli Sheers, consumer proxy
- Lisa Sweeney, SANE
- Lorelle Zemunik, Mental Health Victoria

Rural and Remote

- Leanne Beagley, Mental Health Australia (Chair)
- Sophie Dodd, Beyond Blue
- Jack Heath, SANE
- Anna Brooks, Lifeline Australia
- Umit Agis, NSW Health
- Prof Russell Roberts, Charles Sturt University
- Dr Mathew Coleman, RANZCP
- A/Prof Ruth Stewart, National Rural Health Commissioner
- Dot Wright, Department of Infrastructure, Transport, Regional Development and Communication
- Le Smith, NT PHN
- Gabrielle O’Kane, National Rural Health Alliance
- Joe Hooper, Rural and Remote Mental Health
- Michelle Clewett, Department of Education, Skills and Employment
- Ingrid Hatfield, Mental Health Australia
- Elizabeth Brown, Mental Health Consumer representative
- Yvonne Quadros, Mental Health Carer representative

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