ACIL ALLEN

August 2021

National Mental Health Workforce Strategy

Consultation Draft

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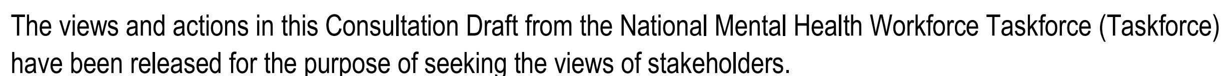

The views and actions in this Consultation Draft from the National Mental Health Workforce Taskforce (Taskforce) have been released for the purpose of seeking the views of stakeholders.

This Consultation Draft does not constitute the final position on these items, which is subject to:

- stakeholder feedback
- further consideration by the Taskforce, and
- consultation with State and Territory Governments.

Please note the actions in this Consultation Draft will inform the final ten year *National Mental Health Workforce Strategy* and do not constitute the Government's position on these items.

Contents

1	This Strategy	1
2	Careers in mental health are, and are recognised as, attractive	7
3	Data underpins workforce planning	11
4	The entire mental health workforce is utilised	14
5	The mental health workforce is appropriately skilled	19
6	The mental health workforce is retained in the sector	25
7	The mental health workforce is distributed to deliver support and treatment when and where consumers need it	30
8	Implementation of the Strategy	35

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This Strategy 1

Problem statement

Across all Australian states and territories, demand for mental health support and treatment has steadily increased over time and outstrips the available supply. The factors constraining the supply of support and treatment to people experiencing suicidality, mental distress and/or ill health are diverse and include the lack of an appropriately skilled workforce able to provide support and treatment when, where and how consumers and carers prefer. Specifically:

— there are shortages of workers across most occupations providing support and treatment to people experiencing suicidality, mental distress and/or ill-health
— the mental health workforce is maldistributed
  – geographically, with more acute shortages in regional and remote locations
  – between service settings such as public, private and community-based (including those providing psychosocial supports) settings
  – within occupations, with some areas of specialisation experiencing more significant shortages than others
— the current mental health workforce is not always appropriately skilled, as not all workers have updated their practice to reflect contemporary approaches that support culturally safe, trauma informed, sustainable, recovery oriented, integrated support and treatment
— not all occupations operate to their full scope of practice, reducing the opportunities afforded to the available workforce, including emerging occupations.

These factors impact on access to and quality of support and treatment available to consumers, carers and their families.

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Background

Commonwealth, state and territory governments recognise the need for generational reform of Australia's mental health system to support improved mental health outcomes across the community. New thinking and innovation are needed to respond to the prevention, intervention and recovery needs of people experiencing suicidality, mental distress and/or ill-health, their carers and families.

Reform of the mental health system aims to create a person-centred system that takes a holistic view of being mentally well and provides people with the right mix of clinical and non-clinical services. This involves redefinition of how we deliver support and treatment and who is best placed to deliver it. It requires recognition of the criticality of the roles played by people who work in mental health settings, other health and social services settings, and in the broader community.

Successful implementation of the reform agenda will depend on the presence of a broadly defined, appropriately skilled workforce, working collaboratively with consumers and carers and one another across occupations, organisations and service settings.

The *National Mental Health Workforce Strategy* (the Strategy) is a ten year plan to grow, strengthen and support an appropriately skilled, flexible mental health workforce, working within a sustainable recovery-oriented, integrated mental health system. The Strategy considers the skills, supply, distribution and structure of a broadly defined mental health workforce, building on the previous ten-year National Mental Health Workforce Strategy (2011).

This Consultation Draft of the Strategy (the Consultation Draft) anticipates and encourages innovation and does not prescribe a model of care, recognising that different models of care are appropriate in different contexts. This depends on what consumers and carers want and locally available workforces. In place of any specific model of care, the Strategy utilises the concept of 'components of care'[1] that may be brought together in different ways to form models of care. There should be clear linkage between components of care, the National Mental Health Service Planning Framework and the various occupational scopes of practice (existing and those yet to be developed).

The Consultation Draft recognises that no single approach to workforce development can be applied to all occupations in all settings, or locations. For example, there are specific challenges for rural and remote locations which impact on the ability to attract, train and retain the mental health workforce that differ from metropolitan settings. It is important that these issues are addressed to support the delivery of the services that local communities need.

The Consultation Draft aims to complement and integrate with other related workforce strategies being developed, rather than duplicating their content. Key examples include the *National Medical Workforce Strategy*, the *Stronger Rural Health Strategy*, the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031* and state and territory mental health workforce strategies.

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Development of the Consultation Draft

The development of this Consultation Draft of the Strategy has been overseen by an independent Taskforce – the National Mental Health Workforce Strategy Taskforce (the Taskforce) – with representatives from the broadly defined mental health workforce and consumers and carers.

The Consultation Draft draws on evidence from a range of sources, including published literature, workforce data analysis, government reports and inquiries, and consultation with carer and consumer representatives, employers in the mental health sector, peak bodies and professional associations, and vocational and higher education providers.

Further detail on the development process is available in the accompanying Background Paper.

The Taskforce is now seeking comments on the Consultation Draft from consumers, carers and the sector more broadly through a public submission process. Following the public consultation process, the Taskforce will deliver its final report to the Australian Government by 30 September 2021. The Department of Health will then work with state and territory governments to ensure a national approach, acknowledging that challenges, priorities, and requirements will differ in each jurisdiction, and collectively seek endorsement of the Strategy under the new Australian Federal Relations Architecture.

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

[1] The National Mental Health Commission's *Vision 2030: Blueprint for Mental Health and Suicide Prevention Consultation Report* outlines components of care, which identify the key supports and clinical interventions required to ensure that every individual can access highly personalised and effective treatment in a timely and coordinated way.

Definition of the mental health workforce

This Consultation Draft 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 Consultation Draft 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) and those working in other health settings who frequently treat, interact with, care and support people experiencing suicidality, mental distress and/or ill-health (for example allied health, general practitioners and nurses).[2]

The Consultation Draft 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.

These workforces overlap 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 Consultation Draft also recognises the critical role that carers, family, friends and important others play in supporting people experiencing suicidality, mental distress and/or ill-health in their recovery.

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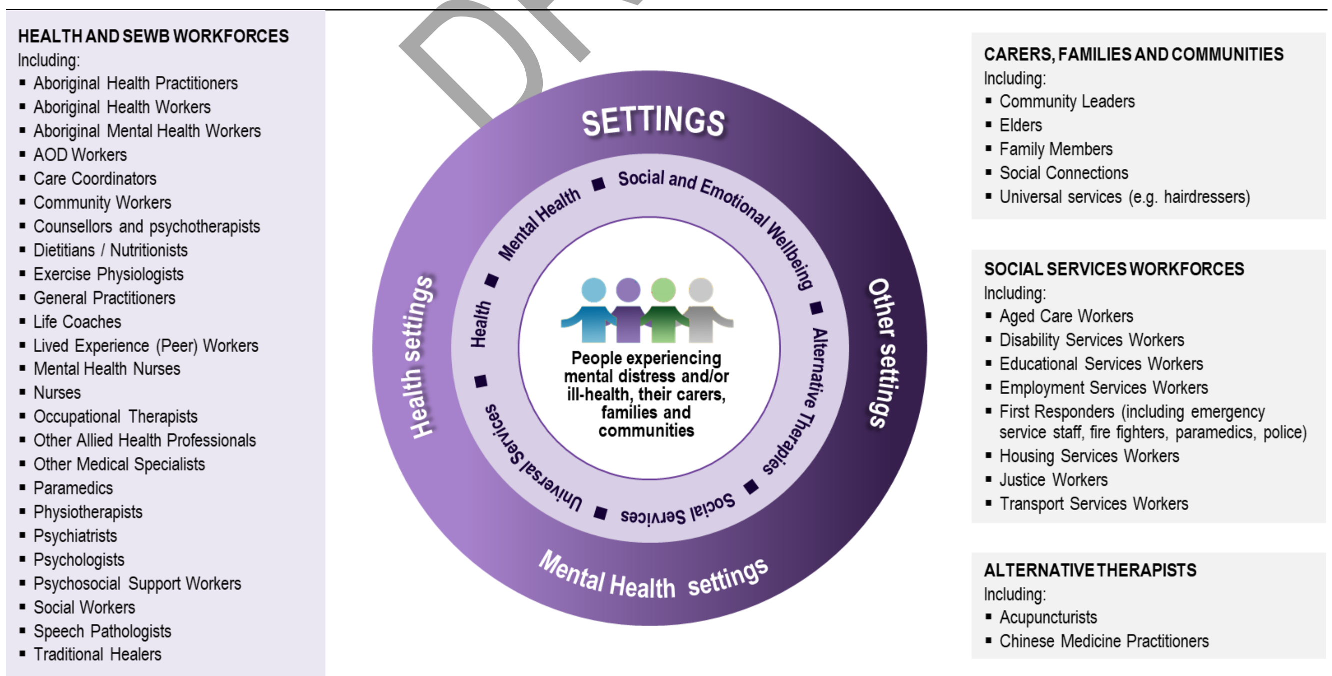
Figure 1.1 Consultation Draft Strategy – Mental health workforce definition



[2] The Consultation Draft recognises that occupations may work across settings. For example, allied health workers may work exclusively in the mental health sector or in health settings. There are also occupations that require mental health endorsements to work in the mental health sector and those that do not.

Aim

The aim of the Consultation Draft Strategy is:

To develop an appropriately skilled mental health workforce of sufficient size that is suitably deployed to help Australians be mentally well by meeting their support and treatment requirements at the time and in the way that best meets their needs.

Suicidality, mental distress and/or ill-health affects people of all ages from all backgrounds in all locations across Australia. Supporting Australians to be mentally well is no longer restricted to supporting those experiencing suicidality, mental distress and/or ill-health, but encompasses prevention and early intervention to promote mental wellbeing and assist people at risk.

Achieving this aim requires the workforce, policy makers, educators and administrators across and beyond the mental health sector to work together, building on the sector's strengths to respond to changing community needs and contemporary ways of working. Through this collaboration, we will achieve a national mental health workforce that is highly skilled, responsive to consumer and carer needs, and delivers support and treatment efficiently with the best use of resources.

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Roles and responsibilities

Achieving the objectives identified in the Consultation Draft of the Strategy requires multiple sectors and stakeholders to work together toward a shared view of mental health system reform. All sectors will need to cooperate to deliver priority action areas from their respective mandates, ensuring that system-wide collaboration helps to expand and improve the broadly defined mental health workforce. This includes:

— *Commonwealth, state and territory governments* – share responsibility for funding public, private and non-government mental health services, delivery of public mental health services (state and territory governments), implementation of prevention and early intervention programs, administration of quality and safety mechanisms, funding and quality assurance of relevant vocational and tertiary education providers.

— *Australian Health Practitioner Regulation Agency (Ahpra) and 15 National Boards* - set standards and policies that all Ahpra registered health practitioners must meet, conducts registration and compliance processes and investigates complaints against Ahpra registered practitioners.

— *Professional peak bodies and colleges* – responsible for defining training and education standards, continuing professional development requirements, administering self-regulated occupational schemes, and representing members.

— *Education providers* – responsible for the developing, designing and delivering education and training programs to appropriately educate and train the mental health workforce.

— *Health and community services providers, including practitioners* – responsible for delivering support and treatment and for the employment, supervision and support to attract and retain the mental health workforce.

Objectives and priority areas for action

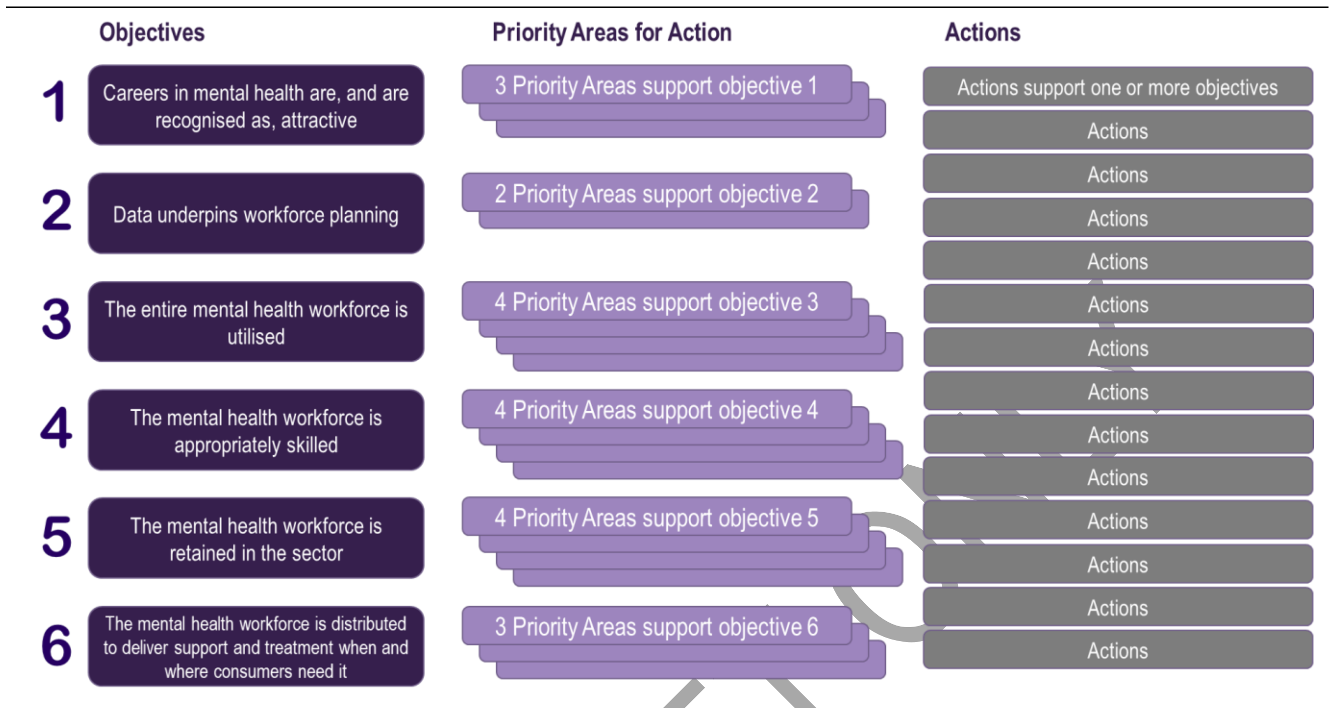
The Consultation Draft Strategy's aim and objectives are conceptualised in Figure 1.2.

Figure 1.2 Consultation Draft Strategy – Aim and objectives

The Consultation Draft identifies priority areas for action (priority areas) and specifies actions that support achievement of the objectives. The priority areas and actions represent an integrated approach to achieving the objectives and include many co-dependencies; therefore, an action may be relevant to more than one priority area and support multiple objectives.

The figure below represents the relationship between the objectives, priority areas and actions.

Figure 1.3 Consultation Draft Strategy – Relationship between objectives, priority areas and actions



Each chapter of this document is aligned to an objective of the Strategy and includes explanation of the priority areas and actions associated with the objective. Where required, additional explanation of actions is provided, such as the occupations where action is required most urgently or the occupations or settings that are most significantly impacted by the issue that the action addresses. Some examples of more detailed implementation activities suggested by the Taskforce and Working Groups are also provided.

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Implementation

In many instances, the actions represent significant bodies of work. The final Strategy will need to be supported by an Implementation plan (or series of plans) that will be developed collaboratively by the Commonwealth, state and territory governments, peak professional bodies and colleges, regulators, and educational institutions to address the objectives of the Strategy.

The implementation plans will assign priority to actions and identify who will lead each activity (for example, those driven centrally by the Commonwealth and those led by individual states and territories). The implementation plan will also include timelines for implementation, governance arrangements, and monitoring and evaluation requirements. The Department of Health will work with state and territory counterparts to develop an appropriate national governance structure to oversee the implementation of the Strategy and ensure its success.

Further guidance is provided in Chapter 8.

2 Careers in mental health are, and are recognised as, attractive

The first objective – ***Careers in mental health are, and are recognised as, attractive*** – addresses the need for the mental health sector to offer attractive career options for people from a wide range of occupations, and to ensure there are high levels of awareness of these careers.

Building the mental health workforce begins with increasing the visibility and attractiveness of careers in mental health. This requires:

— a coordinated effort to raise awareness of the career opportunities that the mental health sector provides
— addressing the stigma associated with working in mental health
— increasing awareness of the training pathways that lead to careers in mental health
— addressing the factors that decrease the attractiveness of working in the mental health sector.

This chapter addresses the first three issues, while the attractiveness of working in the mental health sector is discussed in chapter 6 *Retaining the mental health workforce.*

There is limited awareness of the career opportunities that the mental health sector affords across a wide range of occupations, and this impacts on the number of students expressing enrolling in some of the requisite training programs. This applies to entire programs of study that focus on mental health, and programs of study that include elective units in mental health. It is relevant to occupations that work exclusively in mental health (for example, mental health nurses) and occupations that *may* work in mental health (such as nurses). While this may change to some extent as a result of recent government announcements of significant investment in the sector, concerted effort is required to lift the profile of the career opportunities available.

Coupled with the limited awareness of career opportunities are widespread negative perceptions of working in mental health. These negative perceptions further reduce the demand for requisite mental health-specific education and training, particularly within courses where graduates have the option to pursue a career across multiple settings, not just mental health (for example, dietitians and occupational therapists).

There is a need to market mental health as an attractive career choice to secondary school students, undergraduates, graduates and the existing health workforce to help build demand for associated training programs, including mental health components within broader programs.

Increasing exposure to mental health workplaces in pre-service education and training would help alleviate misconceptions about careers in mental health. The quality and variety of placements is an important factor in breaking down this stigma. 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 or when experiences are confined to acute mental health care settings.

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Priority areas and actions

Figure 2.1 Objective 1: Priority areas and actions

Objective	Priority Areas for Action	Actions
1 Careers in mental health are, and are recognised as, attractive	1.1 Increase the attractiveness of careers in mental health	1.1.1 Increase the attractiveness of careers in mental health by addressing priority areas for actions 3.3, 4.3, 5.1, 5.2, 5.3, 5.4 (see relevant chapters).
	1.2 Increase the awareness of pathways into and within mental health	1.2.1 Increase the awareness of pathways into, and within, the mental health workforce for both vocationally and higher education trained occupations including across work settings.
	1.3 Address the stigma and negative perceptions associated with working in mental health	1.3.1 Create positive perceptions of working in mental health by improving the pre-service or post-graduate placement experience of trainees.
		1.3.2 Ensure mental health trainees undertake clinical placements and internships across a more representative mix of settings, including community, private and public settings.

Explanation

PRIORITY AREA 1.1 –
Increase the attractiveness of careers in mental health

Increasing the attractiveness of a career in mental health will require action across a number of the objectives outlined in this Strategy to ensure that mental health is seen as a skilled, safe and rewarding career. The actions that support priority areas 3.3, 4.3, 5.1, 5.2, 5.3, 5.4 also support increasing the attractiveness of careers in mental health.

PRIORITY AREA 1.2 –
Increase the awareness of pathways into and within mental health

Awareness of pathways into, and within, the mental health workforce needs to increase to support attraction of larger numbers of workers into the sector. This applies to vocationally and higher education trained occupations across work settings (e.g., public, private, community settings, in regional and remote locations) and roles.

The table below identifies the occupations and settings where urgent attention is required in the short term (within the next 12 months) to address critical shortages being experienced, and occupations where action is required over the next 12–24 months.

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Action 1.2.1 – Increase the awareness of pathways into, and within, the mental health workforce for both vocationally and higher education trained occupations including across work settings.		
Occupations for immediate action (<12 months)	**All settings**	**Specific settings / roles**
Aboriginal and Torres Strait Islander Health Practitioners	✓	
Aboriginal and Torres Strait Islander Health Workers	✓	
Aboriginal and Torres Strait Islander Mental Health Workers	✓	
Lived Experience (Peer) Workforce	✓	Consumer and Carer roles
Psychosocial Support Workers	✓	
Psychiatrists	✓	Public, rural and remote Child and adolescent, forensic and addiction
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Mental Health Nurses	✓	Rural and remote
Registered Nurses	✓	Rural and remote

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PRIORITY AREA 1.3 –
Address the stigma and negative perceptions associated with working in mental health

Addressing the stigma and negative perceptions that people may associate with working in mental health or with specific settings is important to increase the numbers of workers considering careers in mental health. This is relevant for those occupations where other areas of specialisation are available (for example, occupational therapists and medical practitioners), where some settings may be considered more (or less) attractive, and in some geographic locations.

Action 1.3.1 – Create positive perceptions of working in mental health by improving the pre-service or post-graduate placement experience of trainees.		
Occupations for immediate action (<12 months)	**All settings**	**Specific settings**
General Practitioners	✓	
Psychiatrists[3]	✓	
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Mental Health Nurses	✓	
Medical Practitioners	✓	
Occupational Therapists	✓	
Psychologists		Rural and remote
Registered Nurses	✓	
Social Workers	✓	

[3] There are existing initiatives to help improve the attractiveness of psychiatry, including RANZCP's Psychiatry Interest Forum (PIF) which aims to help address the current and projected shortfall in trained psychiatrists.

The availability, quality and range of settings in which clinical placements and internships are undertaken are important in providing trainees with positive experiences of the mental health sector, leading to greater numbers of students / trainees / interns who are likely to consider careers in mental health.

Action 1.3.2 – Ensure mental health trainees undertake clinical placements and internships across a more representative mix of settings, including community, private and public settings.		
Occupations for immediate action (<12 months)	**All settings**	**Specific settings**
General Practitioners	✓	Community and private
Psychiatrists	✓	Community and private
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Counsellors and Psychotherapists	✓	Public
Mental Health Nurses	✓	Community and private
Medical Practitioners	✓	Community and private
Occupational Therapists	✓	
Psychologists	✓	Rural and remote
Registered Nurses	✓	Community and private
Social Workers	✓	

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Possible implementation activities

The table below includes potential implementation activities that address the priority actions. They were identified by Taskforce and Working Group members and are offered as examples of activities that may be captured in future implementation plans.

Priority area	Example implementation activity
1.2	– Develop student placements, internships and student employment opportunities to increase exposure to potential future careers in mental health.
1.3	– Implement a nationally coordinated campaign that promotes mental health as a career.

3 Data underpins workforce planning

The second objective – ***Data underpins workforce planning*** – addresses the need for strategic, future-focused mental health workforce planning to be underpinned by reliable, comprehensive workforce data. Availability and use of such data will support forecasting and monitoring of strategies that encourage workforce development and growth.

There is an acknowledged lack of comprehensive mental health workforce data which impedes workforce planning. This is particularly apparent for occupations that are not regulated under Ahpra and for the community managed sector where nationally consistent data regarding workforce size, education levels and composition by occupation are not available.

A nationally consistent approach to data that adopts a broad definition of the mental health workforce and includes at a minimum people who work in all mental health, social and emotional wellbeing and health settings is required to facilitate improved workforce planning, meaningful intervention and the delivery of support and treatment that better meets the needs of consumers and carers.

Access to better data about the entire mental health workforce, including data on occupations not regulated through Ahpra, will build a more fulsome understanding of the available workforce by location, occupation and skill set. Information about local service need (see chapter 7) and scopes of practice including skills and competencies by occupation (see chapter 4) combined with improved workforce data will facilitate better quality, more complete workforce planning that utilises the entire mental health workforce available.

In turn, this will inform better targeted interventions to address shortages – either through increasing the number of workers in particular occupations, utilising an available workforce to its full scope of practice or supporting the transferability of skills.

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Priority areas and actions

Figure 3.1 Objective 2: Priority areas and actions

Objective	Priority Areas for Action	Actions
2 Data underpins workforce planning	2.1 Develop and implement a data strategy to improve the reliability and comprehensiveness of mental health workforce data	2.1.1 Define what data are required, for what purpose, where data are currently held and what additional collections are required to improve reliability, accessibility and comprehensiveness.
		2.1.2 Implement the National Mental Health Workforce Data Strategy at organisation, state/territory and national levels to support data collection and consolidation.
	2.2 Enhance mental health workforce data systems and planning models through the use of more reliable data	2.2.1 Utilise the improved data and make it publicly accessible to inform mental health workforce planning and support development of meaningful government interventions to better match workforce demand and supply across occupations and settings.

Explanation

PRIORITY AREA 2.1 –

Develop and implement a data strategy to improve the comprehensiveness and reliability of mental health workforce data

There is a clear need for more comprehensive and reliable data on the mental health workforce to inform better workforce planning and targeting of initiatives to address imbalances in demand for and supply of the workforce. The following actions will support the development and implementation of a national mental health workforce strategy.

Action 2.1.1 –

Define what data are required, for what purpose, where data are currently held and what additional collections are required to improve reliability, accessibility and comprehensiveness.

Action 2.1.2 –

Implement the National Mental Health Workforce Data Strategy at organisation, state/territory and national levels to support data collection and consolidation.

PRIORITY AREA 2.2 –

Enhance mental health workforce data systems and planning models through the use of more reliable data

Once developed and implemented, the National Mental Health Workforce Data Strategy (priority area 2.1) will enable development of enhanced workforce data systems and planning models. These systems and models will improve the quality of outputs, such as the occupations, settings, locations and extent of workforce shortages or over supply. This will facilitate better targeting of initiatives to address workforce imbalances.

Action 2.2.1 –

Utilise the improved data and make it publicly accessible to inform mental health workforce planning and support development of meaningful government interventions to better match workforce demand and supply across occupations and settings.

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Possible implementation activities

The table below includes potential implementation activities that address the priority areas. They were identified by Taskforce and Working Group members and are offered as examples of activities that may be captured in future implementation plans.

Priority area	Example implementation activity
2.1	– Enable data sharing across jurisdictions, peak professional bodies and colleges and education providers to support visibility of training pipeline data.
2.1	– Where possible, link workforce data to service quality and safety data including consumer and carer outcome data.
2.2	– Review the National Mental Health Service Planning Framework to ensure relevance across states and territories.

A suggested set of occupations for inclusion in the first iteration of a National Mental Health Workforce Data Strategy is outlined below.

Suggested occupations for inclusion in the first iteration of a National Mental Health Data Strategy	Current workforce data sources
Aboriginal and Torres Strait Islander Health Practitioners	National Board supported by Ahpra
Aboriginal and Torres Strait Islander Health Workers	-
Aboriginal and Torres Strait Islander 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 Credentialled by 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

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The entire mental health workforce is utilised 4

The third objective – ***The entire mental health workforce is utilised*** – is critical to ensuring people experiencing suicidality, mental distress and/or ill-health and their carers are able to access safe, high quality support and treatment, delivered by skilled workers from a broad range of occupations in diverse service settings, when and where they are needed.

Consumer and carer needs are more likely to be met if the entire mental health workforce is appropriately utilised, which includes workers performing roles that reflect their full scope of practice, and more frequent adoption of multidisciplinary team-based approaches. Clear articulation of the '*components of care*' that address consumer and carer needs including needs that support sustainable recovery is required, including the competencies required to deliver the components of care and specification of the occupations that are trained to perform these competencies.

There is significant variation in the knowledge, skills and behaviours of the mental health workforce both within and between occupations. Variation between occupations is expected and appropriate, however it is not nationally consistent. The variation within occupations is caused by many factors including changes in education and training practices and requirements over time, which occupations are supported through government incentives in training and delivery of care, varying investment in and regulatory requirement for continuing professional development, differing work practices and roles between settings, and unclear scopes of practices for some occupations.

There are few nationally consistent, clearly documented scopes of practice across the occupations in the mental health sector which creates confusion about who is able to undertake what tasks in which settings. While some occupations (such as general practitioners, nurses and psychiatrists) have documented and national scopes of practice, many other occupations do not – particularly emerging and self-regulated occupations and in the broader social and emotional wellbeing workforce. This lack of clarity and consistency raises barriers to the appropriate utilisation of some occupations within the mental health sector. It also creates challenges for multidisciplinary team care models, with limited clarity on how scopes of practice can be utilised to their fullest extent.

The quality of care and safety of service delivery for consumers is underpinned by effective regulatory arrangements. The current arrangements for regulating the occupations in the mental health workforce have evolved over time. Some occupations have long-established, mature regulatory schemes (such as general practitioners, nurses, psychiatrists and psychologists)[4]. There is a need to ensure that the appropriate regulatory arrangements are in place for emerging occupations and occupations that may be able to contribute more fully.

Definition of clear scopes of practice that reflect the components of care will mean the broadly defined mental health workforce is better able to respond to unexpected, sudden increases in demand for mental health services as there will be a much clearer view of which occupations are trained to provide which components of care and can therefore be called on when required. The

[4] The Australian Health Practitioners Registration Agency (Ahpra) regulates a range of occupations including Aboriginal and Torres Strait Islander Health Practitioners, Medical Practitioners, Nurses, Occupational Therapists, and Psychologists. These arrangements include codes of conduct, ethics, continuing professional development and registration components.

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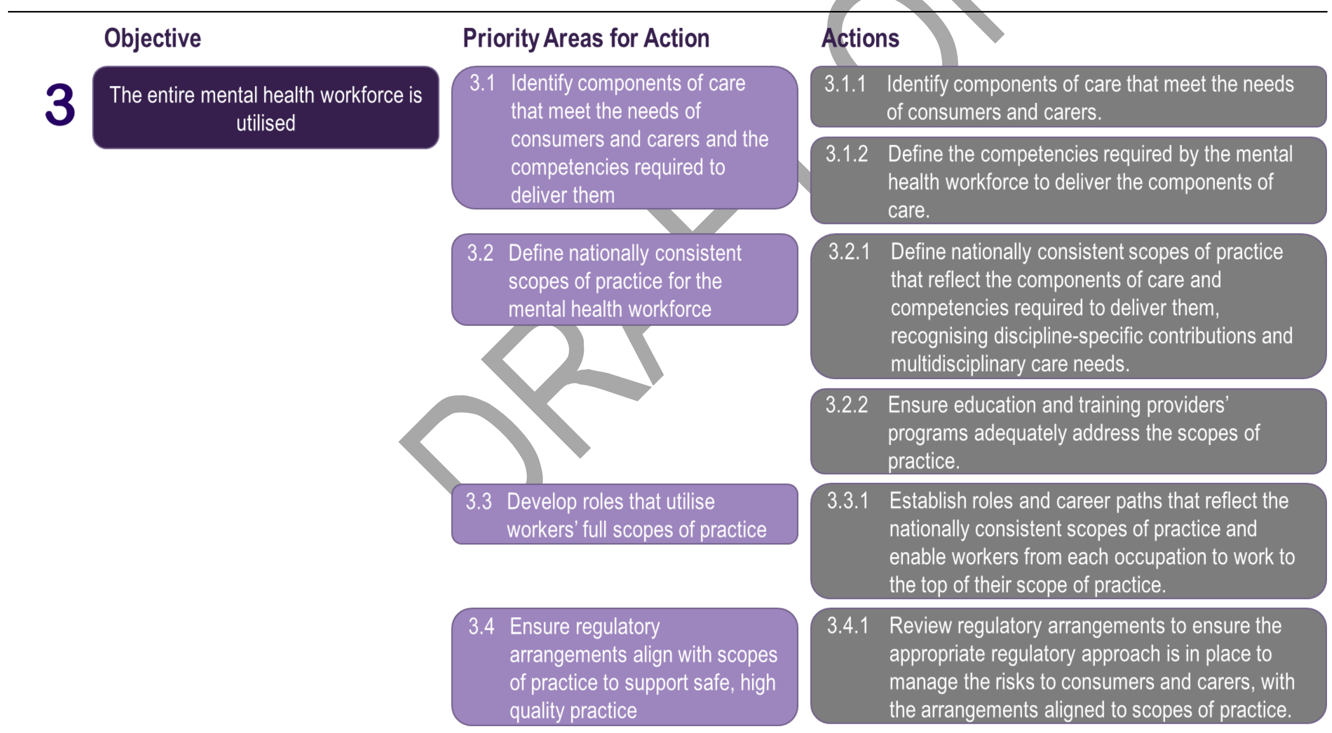
need for a surge capacity has been highlighted by the increased mental health concerns associated with recent bushfires and experiences arising from the COVID 19 pandemic.

The adoption of a social and emotional wellbeing approach to mental health, and the broader definition of the mental health workforce, means it is timely to define the components of care that are required to meet the support and treatment needs of consumers and carers, specify the education and training required to deliver the components of care, clarify the scopes of practice for each occupational group and review the occupational regulatory arrangements that monitor and support safe practice.

Progression of these priority actions should build on the work of the Independent Review of the National Registration and Accreditation Scheme for health professions, 2014 and the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professionals, 2018.

Priority areas and actions

Figure 4.1 Objective 3: priority areas and actions



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Explanation

The priority areas and actions identified below represent significant programs of work. They are inter-related and should be viewed as a holistic, integrated approach to identifying:

- the components of care (subsets of models of care) consumers and carers want and need
- the knowledge, skills and competencies required to deliver them
- which occupations are appropriately trained and qualified to perform the components of care
- the job roles and career paths that support delivery of the components of care
- the appropriate occupational regulatory schemes to support consumer and carer safety.

PRIORITY AREA 3.1 –

Identify components of care that meet the needs of consumers and carers and the competencies required to deliver them

Utilisation of the entire mental health workforce requires clarity on the components of care that meet the needs of consumers and carers and the competencies required to deliver them safely.

Action 3.1.1 –

Identify components of care (subsets of models of care) that meet the needs of consumers and carers.

Action 3.1.2 –

Define the competencies required by the mental health workforce to deliver the components of care.

PRIORITY AREA 3.2 –

Define nationally consistent scopes of practice for the mental health workforce

For safe, appropriate delivery of support and treatment, it is necessary to understand which occupations have the knowledge and competencies to provide these components of care, acquired through completing education, training and practical experience. The occupations' scopes of practice should reflect the components of care and the education, training and experience required.

Action 3.2.1 –

Define nationally consistent scopes of practice that reflect the components of care and competencies required, recognising discipline-specific contributions and multidisciplinary care.

Occupations – Scope should be confirmed	Occupations – Scope should be developed
Aboriginal and Torres Strait Islander Health Practitioners	Aboriginal and Torres Strait Islander Health Workers
Counsellors and psychotherapists	Aboriginal and Torres Strait Islander Mental Health Workers
Dietitians	Exercise Physiologists
Enrolled Nurses	Lived Experience (Peer) Workers
General Practitioners	Paramedics
Mental Health Nurses	Psychosocial Support Workers
Nurse Practitioners	
Occupational Therapists	
Other Allied Health Workers	
Physiotherapists	
Psychiatrists	
Psychologists and Endorsed Psychologists	
Registered Nurses	
Social Workers	
Speech Pathologists	

Action 3.2.2 –

Ensure education and training providers' programs adequately address the mental health workforce's scopes of practice.

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PRIORITY AREA 3.3 –
Develop roles that utilise workers' full scopes of practice

Job roles within the mental health sector need to utilise the full scope of practice of each occupation. This not only helps to the address the impact of workforce shortages on consumers' and carers' access to support and treatment, but also provides more challenging and rewarding career paths which increase retention.

Action 3.3.1 -
Establish roles and career paths that reflect the nationally consistent scopes of practice and enable workers from each occupation to work to the top of their scope of practice.

Occupations where career paths are established	Occupations where career paths can be strengthened
Counsellors and psychotherapists Dietitians Enrolled Nurses Exercise Physiologists Nurse Practitioners Psychiatrists Psychologists and Endorsed Psychologists	Aboriginal and Torres Strait Islander Health Practitioners Aboriginal and Torres Strait Islander Health Workers Aboriginal and Torres Strait Islander Mental Health Workers General Practitioners Lived Experience (Peer) Workers Mental Health Nurses Occupational Therapists Paramedics Psychosocial Support Workers Registered Nurses Social Workers Speech Pathologists

PRIORITY AREA 3.4 –

Ensure regulatory arrangements align with scopes of practice to support safe, high quality practice

Occupational regulation arrangements need to reflect the risk to the community posed by those who practice specific occupations. Amongst other things, appropriate regulatory arrangements must reflect the scopes of practice of each occupation, the extent of continuing professional development required for ongoing safe, contemporary practice and changes in community expectations and standards.

Action 3.4.1 –

Review regulatory arrangements to ensure the appropriate regulatory approach is in place to manage the risks to consumers and carers, with the arrangements aligned to scopes of practice.

Occupations where arrangements need to be confirmed	Occupations where arrangements need to be reviewed
Dietitians	Aboriginal and Torres Strait Islander Health Practitioners
Enrolled Nurses	Aboriginal and Torres Strait Islander Health Workers
Exercise Physiologists	Aboriginal and Torres Strait Islander Mental Health Workers
General Practitioners	Counsellors and psychotherapists
Mental Health Nurses	Lived Experience (Peer) Workers
Nurse Practitioners	Psychosocial Support Workers
Occupational Therapists	
Psychiatrists	
Psychologists	
Registered Nurses	
Social Workers	
Speech Pathologists	

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Possible implementation activities

The table below includes potential implementation activities that address the priority areas. They were identified by Taskforce and Working Group members and are offered as examples of activities that may be captured in future implementation plans.

Priority area	Example implementation activity
3.2	– Develop a national governance process to oversee the review of scopes of practice, ensuring a mutually consistent approach across the mental health sector.
	– Establish a nationally co-ordinated committee with representatives of broadly defined mental health workforce to drive improved consistency of training.

The mental health workforce is appropriately skilled 5

Objective 4 – ***The mental health workforce is appropriately skilled*** – recognises that training and education provides one of the foundations on which a high quality mental health workforce is based. This applies to:

— pre-service programs that prepare people to enter the workforce, and

— in-service professional development activities that build the skills required for contemporary practice.

The delivery of pre-service and in-service programs and activities requires that educators and trainers are appropriately qualified, experienced and able to support learners to develop skills. It also necessitates access to supervisors of sufficient quality and quantity to oversee trainees.

There is a need to ensure that people working in mental health settings, other social services and health settings and the broader workforce have the contemporary skills to support sustainable, recovery oriented, trauma informed, person-centred and culturally safe support and treatment to assist consumers in their recovery journey. Staff in frontline, managerial and executive roles across organisations also require mental health skills appropriate to their positions.

Training and education programs should build the skills and knowledge that graduates need to work to the full occupational scopes of practice described in the previous chapter. This requires close interaction between education and training providers, regulators, national occupational boards, medical colleges, occupations' peak organisations, and Aboriginal and Torres Strait Islander organisations.

Close interaction between education and training providers and health and mental health services is also required to ensure that students completing training participate in placements that are of high-quality, are of appropriate duration so students experience consumers progressing in their recovery, have appropriate supervision, are in a variety of service settings and are safe.

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Priority areas and actions

Figure 5.1 Objective 4: Priority areas and actions

Objective	Priority Areas for Action	Actions
4 The mental health workforce is appropriately skilled	4.1 Strengthen the skills of the existing and future mental health workforce	4.1.1 Develop training modules that build skills for the provision of integrated and multi-disciplinary care.
		4.1.2 Support education and training providers and service providers to improve the quality and quantity of mental health placements. This should include ensuring they are of appropriate duration, have appropriate supervision, are in a variety of settings and have regard to the wellbeing and safety of students.
		4.1.3 Support education providers to maintain, when appropriate, the online training and education opportunities that have been made available to the mental health workforce and students due to the COVID-19 pandemic.
		4.1.4 Develop broader training models for the Lived Experience (Peer) workforce to develop skills and capabilities across both vocational and higher education sectors. This could include incorporation of work placement models.
	4.2 Ensure the broader mental health workforces have the knowledge and skills to support people experiencing suicidality, mental distress and/or ill-health	4.2.1 Invest in training initiatives to support the development of basic mental health skills in the social services and workforce.
		4.2.2 Where feasible, include development of basic mental health skills in pre-service training for people working in roles where they are likely to treat, interact with or support people experiencing suicidality, mental distress and/or ill-health.
	4.3 Support students from priority cohorts to complete mental health-related qualifications that reflect their communities' needs	4.3.1 Explore opportunities to prioritise access to training for the mental health workforce through increased subsidies and use of traineeships.
		4.3.2 Invest in 'wrap around services' to support Aboriginal and Torres Strait Islander peoples and people with lived experience to complete mental health education and training programs.
		4.3.3 Support people from rural and remote communities to access and complete mental health education and training programs.
	4.4 Support access to continuing professional learning and professional development to ensure existing workers develop contemporary skills	4.4.1 Create a central, online information source with details of existing training and continuing professional development opportunities available to the mental health workforce.
		4.4.2 Fund Aboriginal and Torres Strait Islander organisations to develop and deliver training in cultural safety, trauma informed and trauma competent care.

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Explanation

PRIORITY AREA 4.1 –
Strengthen the skills of the existing and future mental health workforce

The following actions support the strengthening of the skills of the existing mental health workforce and those that will be trained in the future. They acknowledge the importance of building skills that help people from all occupations to work in ways that provide consumers and carers with integrated, multi-disciplinary care.

This priority area also recognises the importance of providing students / trainees / interns with high quality training, including mental health placements across a range of settings and locations to support skill development and increase the likelihood that they will pursue careers in mental health. This increases the workforce and potentially the availability of support and treatment.

Action 4.1.1 –
Develop training modules that build skills for the provision of integrated and multi-disciplinary care.

Action 4.1.2 –
Support education and training providers and service providers to improve the quality and quantity of mental health placements. This should include ensuring they are of appropriate duration, have appropriate supervision, are in a variety of settings and have regard to the wellbeing and safety of students.

Occupations for immediate action (<12 months)	All settings	Specific settings / roles
Mental Health Nurses	✓	Community and private
Psychologists	✓	Community and private Rural and remote Endorsed Psychologists
Psychiatrists	✓	Community and private Child and youth, addiction and older persons
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Counsellors and Psychotherapists	✓	
Occupational Therapists	✓	
Registered Nurses	✓	Rural and remote
Social Workers	✓	

Action 4.1.3 –
Support education providers to maintain, when appropriate, the online training and education opportunities that have been made available to the mental health workforce and students due to the COVID-19 pandemic.

Action 4.1.4 –
Develop broader training models for the Lived Experience (Peer) workforce to develop skills and capabilities across both vocational and higher education sectors. This could include incorporation of work placement models.

PRIORITY AREA 4.2 –

Ensure the broader mental health workforces have the knowledge and skills to support people experiencing suicidality, mental distress and/or ill-health

This priority action acknowledges the role of the broader workforce in supporting people experiencing suicidality, mental distress and/or ill-health.

Action 4.2.1 – **Invest in training initiatives to support the development of basic mental health skills in the social services and workforce.**	
Key occupations impacted	Aged Care Workers Disability Services Workers Educational Services Workers Employment Services Workers First Responders (including emergency services, fire fighters, paramedics, police) Housing Services Workers Justice Workers Transport Services Workers

Action 4.2.2 – **Where feasible, include development of basic mental health skills in pre-service training for people working in roles where they are likely to treat, interact with or support people experiencing suicidality, mental distress and/or ill-health.**	
Key occupations impacted	Allied Health Workers General Practitioners Medical Practitioners (excluding Psychiatrists) Nurses Paramedics

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PRIORITY AREA 4.3 –

Support students from priority cohorts to complete mental health-related qualifications that reflect their communities' needs

This priority area acknowledges that some cohorts in society are under-represented in the mental health workforce and may need additional support to access and complete the education and training required to work in the mental health sector.

Action 4.3.1 –

Explore opportunities to prioritise access to training for the mental health workforce through increased subsidies and use of traineeships.

Occupations for immediate action (<6 months)	All settings	Specific settings / roles
Aboriginal and Torres Strait Islander Health Workers	✓	
Aboriginal and Torres Strait Islander Mental Health Workers	✓	
Lived Experience (Peer) Workers	✓	
Psychologists (including Endorsed Psychologists)	✓	
Psychosocial Support Workers	✓	

Action 4.3.2 –

Invest in 'wrap around services' to support Aboriginal and Torres Strait Islander peoples and people with lived experience to complete mental health education and training programs.

Action 4.3.3 –

Support people from rural and remote communities to access and complete mental health education and training programs.

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PRIORITY AREA 4.4 –
Support access to continuing professional learning and professional development to ensure existing workers develop contemporary skills

This priority area addresses the need for existing workers in the mental health sector to update their skills to reflect contemporary practice.

Action 4.4.1 –
Create a central, online information source with details of existing training and continuing professional development opportunities available to the mental health workforce.

Action 4.4.2 –
Fund Aboriginal and Torres Strait Islander organisations to develop and deliver training in cultural safety, trauma informed and trauma competent care.

Action 4.4.3 –
Support the development of local area, multidisciplinary communities of practice for workforces needing support.

Occupations for immediate action (<6 months)	All settings	Specific settings / roles
Lived Experience (Peer) Workers	✓	
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Allied Health Workers	✓	Mental health settings
Psychosocial Support Workers	✓	
Social Workers	✓	

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Possible implementation activities

The table below includes potential implementation activities that address the priority areas. They were identified by Taskforce and Working Group members and are offered as examples of activities that may be captured in future implementation plans.

Priority area	Example implementation activity
4.1	– Develop peer led, co-designed and co-delivered training modules that focus on the Lived Experience (Peer) role, scope and knowledge.
	– Support universities to embed the Aboriginal and Torres Strait Islander and Torres Strait Islander Health Curriculum Framework into higher education health curricula.
	– Include specific, contextualised Lived Experience modules within the Certificate IV in Training and Assessment to support appropriate training of Lived Experience (Peer) educators.
	– Invest in the development of GP psychiatry career pathways, similar to the model used for GP obstetrics and GP anaesthetics. This would require the establishment of comparable remuneration structures to support uptake.
4.3	– Expand scholarship programs for Aboriginal and Torres Islander Mental Health Workers and Mental Health Nurses.

The mental health workforce is retained in the sector 6

Objective 5 – ***The mental health workforce is retained in the sector*** – addresses some of the issues that are causing a shortage of workers across the mental health sector.

The impact of insufficient staff numbers and high staff turnover results in a lack of continuity of support and treatment for consumers and carers, a higher burden for remaining staff members and increased costs to employers. This chapter addresses the attractiveness of working in the mental health sector and is closely linked to chapter 2 *Careers in mental health are, and are recognised as, attractive.*

There are incomplete data on the current retention rates of the mental health workforce which makes it difficult to quantify the scale of the issue for some occupations, however there are consistent issues that drive poor retention across the mental health workforce. These include:

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

— where there is a lack of access to quality supervision, it impacts on employee satisfaction and willingness to stay within the mental health sector.

— current service delivery contracts can limit access to continuing professional development (CPD) as they do not include funding for CPD or backfill for providers to release staff to attend training

— insecurity of employment associated with short term contracts and low levels of remuneration can impact both the attraction and retention of the workforce.

— access to opportunities for progression in level, role and responsibility is an important contributor to career satisfaction and retentions but varies across occupations.

There is a need for appropriate investment in both workforce availability and quality infrastructure to facilitate appropriate support and treatment. Fatigue and burnout were reported to be high through stakeholder consultations as a product of workload levels and the stress of workplace violence, physical / verbal abuse and aggression from patients. Unsuitable physical infrastructure can limit the way in which support and treatment are provided, particularly in rural communities, while also impacting on incidences of violence. 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.

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Priority areas and actions

Figure 6.1 Objective 5: Priority areas and actions

Objective	Priority Areas for Action	Actions
5 The mental health workforce is retained in the sector	5.1 Promote funding reform to provide more secure employment arrangements	5.1.1 Develop longer minimum service contract lengths for commissioned mental health services, including in rural and remote areas.
	5.2 Increase access to appropriate supervision for all mental health workers	5.2.1 Specify supervision and support requirements for those in the mental health workforce.
		5.2.2 Review guidelines for supervision to reduce structural barriers generated through a lack of access to face to face arrangements.
		5.2.3 Explore opportunities to use funding levers to ensure that public and private mental health service providers have appropriate standards for supervision in place.
	5.3 Improve workplace health, safety and wellbeing	5.3.1 Invest in infrastructure to ensure mental health support and treatment is provided in suitable environment.
		5.3.2 Encourage service providers to adopt innovative approaches to service delivery that meet consumer and carer needs.
		5.3.3 Require that service providers support staff access to continuing professional development.
	5.4 Improve career paths within the mental health sector	5.4.1 Develop and implement mental health career pathways within and between mental health and health service settings.

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Explanation

PRIORITY AREA 5.1 –
Promote funding reform to provide more secure employment arrangements

This priority area addresses the issues caused by employment insecurity experienced by some occupations in the mental health sector. The lack of employment security means that workers who have the option of working in more secure sectors will do so, impacting negatively on the availability of mental health support and treatment.

Action 5.1.1 –
Develop longer minimum service contract lengths for commissioned mental health services, including in rural and remote areas.

Occupations for immediate action (<6 months)	All settings	Specific settings
Allied Health Workers		Public and community
Lived Experience (Peer) Workers		Public and community
Psychosocial Support Workers		Public and community
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Psychologists		Public and community
Social Workers		Public and community

PRIORITY AREA 5.2 –
Increase access to appropriate supervision for all mental health workers

This priority area recognises the importance of having appropriate, high quality professional supervision to retention of workers in the mental health sector.

Action 5.2.1 –
Specify supervision and support requirements for those in the mental health workforce.

Occupations for immediate action (<6 months)	All settings	Specific settings
Aboriginal and Torres Strait Islander Health Practitioners	✓	
Occupational Therapists	✓	
Psychologists	✓	Rural and remote
Speech Pathologists	✓	
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Dietitians	✓	
General Practitioners	✓	
Nurses	✓	
Paramedics	✓	

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Action 5.2.2 –
Review guidelines for supervision to reduce structural barriers generated through a lack of access to face to face arrangements

Action 5.2.3 –
Explore opportunities to use funding levers to ensure that public and private mental health service providers have appropriate standards for supervision in place.

Occupations for immediate action (<12 months)	All settings	Specific settings
Lived Experience (Peer) Workers	✓	
Occupational Therapists		Discipline-specific supervision in mental health
Psychosocial Support Workers	✓	
Psychologists		Supervision for Endorsed Psychologists
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Dietitians		Discipline-specific supervision in mental health
Social Workers	✓	Discipline-specific supervision in mental health

PRIORITY AREA 5.3 –
Improve workplace health, safety and wellbeing

This priority area emphasises the importance of workplace health, safety and wellbeing to retaining workers in the mental health sector. It recognises that working in the sector can involve challenges that mean employers need to take additional action to support their workforces.

Action 5.3.1 – Invest in infrastructure to ensure mental health support and treatment is provided in suitable environment.	
Key occupations impacted	This priority action relates to all occupations working in public and community settings, with significant impacts on emergency departments and psychiatrists.

Action 5.3.2 – Encourage service providers to adopt innovative approaches to service delivery that meet consumer and carer needs.	
Key occupations impacted	This priority action impacts on all occupations, with significant impacts for Aboriginal and Torres Strait Islander Mental Health Workers, Lived Experience (Peer) Workers and Counsellors/psychotherapists.

Action 5.3.3 –
Require that service providers support staff access to continuing professional development.[5]

Occupations for immediate action (<12 months)	All settings	Specific settings
Aboriginal and Torres Strait Islander Health Workers	✓	Public and community Rural and remote
Aboriginal and Torres Strait Islander Mental Health Workers	✓	Public and community Rural and remote
Lived Experience (Peer) Workers	✓	
Psychologists	✓	Public and community Rural and remote
Psychosocial Support Workers	✓	
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Counsellors and psychotherapists		
Psychiatrists	✓	Public and community Rural and remote
Social Workers		

[5] It is recognised that regulatory arrangements mandate the completion of CPD for some occupations. Consultation feedback indicated that workers experienced difficulty accessing time or support to complete their mandatory CPD requirements.

PRIORITY AREA 5.4 –
Improve career paths within the mental health sector

Workforce retention within any sector is dependent, in part, on the availability of opportunities for workers to grow, progress and advance their careers. The lack of attractive career paths in mental health is more acute for some occupations and in some settings.

Action 5.4.1 –
Develop and implement mental health career pathways within and between mental health and health service settings.[6]

Occupations for immediate action (<6 months)	All settings	Specific settings/roles
Aboriginal and Torres Strait Islander Health Practitioners	✓	
Aboriginal and Torres Strait Islander Health Workers	✓	
Aboriginal and Torres Strait Islander Mental Health Workers	✓	
General Practitioner		Mental-health specific
Lived Experience (Peer) Workers	✓	
Occupational Therapists		Mental-health specific
Psychiatrists		Public-private
Psychosocial Support Workers	✓	
Occupations for further action (12-24 months)	**All settings**	**Specific settings/roles**
Counsellors and psychotherapists		Public settings
Mental Health Nurses	✓	
Social Workers	✓	
Speech Pathologists	✓	

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Possible implementation activities

The table below includes potential implementation activities that address the priority areas. They were identified by Taskforce and Working Group members and are offered as examples of activities that may be captured in future implementation plans.

Priority area	Example implementation activity
5.1	– Align government funding across sectors relevant to the mental health workforce to improve consistency of salaries.
5.4	– Create a framework to provide guidance for employers on reasonable workplace adjustments for Lived Experience (Peer) workforces to improve career opportunities.

[6] This priority action interfaces with 3.3.1.

The mental health workforce is distributed to deliver support and treatment when and where consumers need it

7

Objective 7 – ***The mental health workforce is distributed to deliver support and treatment when and where consumers need it*** – involves addressing a number of key challenges that impact on the availability of support and treatment.

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 needs are identified and suitable strategies. There is a need to develop a shared understanding of training pipelines, workforce needs and supports across system stakeholders to support both ground-up and top-down planning approaches.

Staffing mental health services in rural and remote locations poses specific 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 locally based training opportunities. The priorities in this chapter are closely linked to those in the preceding chapters.

Different models of care are adopted in different contexts, in line with the local characteristics, community needs and workforce availability. 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 support and treatment.

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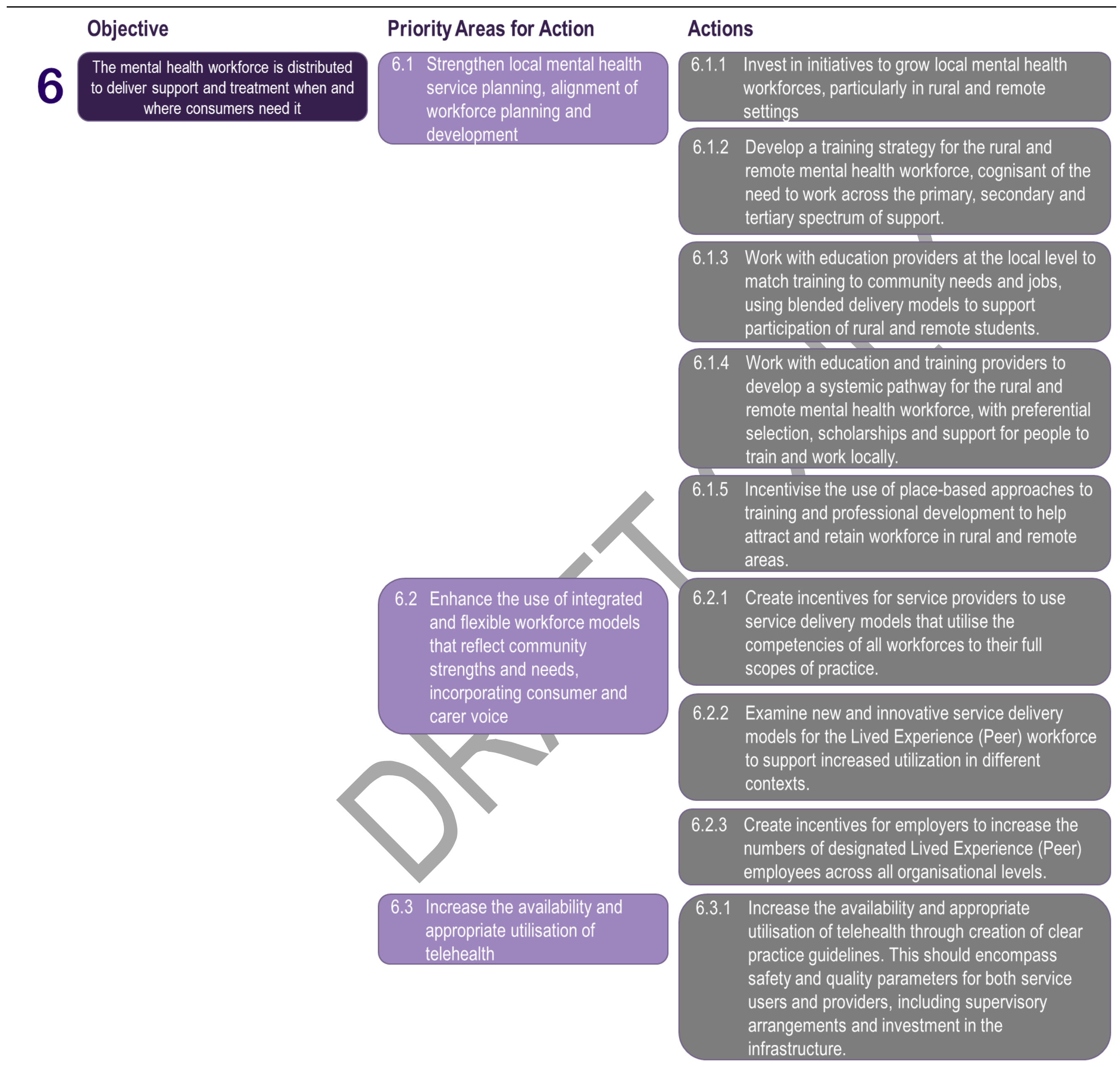
Priority areas and actions

Figure 7.1 Objective 6: Priority areas and actions



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Explanation

The following priority areas stress the criticality of linking mental health workforce planning to the needs of consumers and carers at the local level through local mental health service planning. This is increasingly important in areas where workforce shortages are more acute such as rural and remote locations. An integrated, coordinated planning approach is needed that starts with consumer and carer needs, builds on existing local capacity and extends investment in and support of local people, utilising technology where it is helpful to do so.

PRIORITY AREA 6.1 –
Strengthen local mental health service planning, alignment of workforce planning and development

Action 6.1.1 –
Invest in initiatives to grow local mental health workforces, particularly in rural and remote settings.

Occupations for immediate action (<12 months)	All settings	Specific settings
Aboriginal and Torres Strait Islander Health Practitioners	✓	Rural and remote
Aboriginal and Torres Strait Islander Health Workers	✓	Rural and remote
Aboriginal and Torres Strait Islander Mental Health Workers	✓	Rural and remote
Counsellors and psychotherapists	✓	Rural and remote
Lived Experience (Peer) Workforce	✓	Rural and remote
Psychologists	✓	Rural and remote
Psychosocial Support Workers	✓	Rural and remote

Action 6.1.2 –
Develop a training strategy for the rural and remote mental health workforce, cognisant of the need to work across the primary, secondary and tertiary spectrum of support.

Action 6.1.3 –
Work with education providers at the local level to match training to community needs and jobs, using blended delivery models to support participation of rural and remote students.

Action 6.1.4 –
Work with education and training providers to develop a systemic pathway for the rural and remote mental health workforce, with preferential selection, scholarships and support for people to train and work locally.

Action 6.1.5 –
Incentivise the use of place-based approaches to training and professional development to help attract and retain workforce in rural and remote areas.

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PRIORITY AREA 6.2 –
Enhance the use of integrated and flexible workforce models that reflect community strengths and needs, incorporating consumer and carer voice

Action 6.2.1 –
Create incentives for service providers to use service delivery models that utilise the competencies of all workforces to their full scopes of practice.

Occupations for immediate action (<6 months)	All settings	Specific settings
Aboriginal and Torres Strait Islander Health Practitioners	✓	
Aboriginal and Torres Strait Islander Health Workers	✓	
Aboriginal and Torres Strait Islander Mental Health Workers	✓	
Lived Experience (Peer) Workforce	✓	
Psychosocial Support Workers	✓	
Occupations for further action (12-24 months)	**All settings**	**Specific settings**
Counsellors and psychotherapists	✓	
Psychologists	✓	

Action 6.2.2 –
Examine new and innovative service delivery models for the Lived Experience (Peer) workforce to support increased utilization in different contexts

Action 6.2.3 –
Create incentives for employers to increase the numbers of designated Lived Experience (Peer) employees across all organisational levels

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PRIORITY AREA 6.2 –
Increase the availability and appropriate utilisation of telehealth

Action 6.3.1 – Increase the availability and appropriate utilisation of telehealth through creation of clear practice guidelines. This should encompass safety and quality parameters for both service users and providers, including supervisory arrangements and investment in the infrastructure.	
Key occupations impacted	General Practitioners Occupational Therapists Psychiatrists Psychologists Social Workers Speech Pathologists

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Possible implementation activities

The table below includes potential implementation activities that address the priority area. They were identified by Taskforce and Working Group members and are offered as examples of activities that may be captured in future implementation plans.

Priority area	Example implementation activity
6.2	– Ensure that all service level agreements for provision of mental health services include specific funding for designated Lived Experience (Peer) roles.

Implementation of the Strategy 8

In early 2020, the development of the Strategy commenced with the intention that the Taskforce would provide its final report to Government prior to endorsement by the Australian Health Ministers' Advisory Council (AHMAC), a subcommittee of the Council of Australian Governments (COAG). In May 2020, the National Cabinet agreed to the cessation of the Council of Australian Governments (COAG); therefore, endorsement of the final Strategy by all governments will now be sought under the new Australian Federal Relations Architecture.

Following the public consultation process, the Taskforce will deliver its final report to the Australian Government by 30 September 2021. The Department of Health will then work with state and territory governments to ensure a national approach, acknowledging that challenges, priorities, and requirements will differ in each jurisdiction, and collectively seek endorsement of the Strategy under the new Australian Federal Relations Architecture.

An Implementation plan (or series of plans) will be developed collaboratively by the Commonwealth, state and territory governments, peak professional bodies and colleges, regulators, and educational institutions to address the objectives of the Strategy. The implementation plans will assign priorities to actions, identify who will lead each activity (for example, those driven centrally by the Commonwealth and those led by individual states and territories). The implementation plan will also include timelines for implementation, governance arrangements, and monitoring and evaluation requirements. The Department of Health will work also with state and territory counterparts to develop an appropriate national governance structure to oversee the implementation of the Strategy and ensure its success.

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