



Australian Government

National Mental Health Workforce Strategy | 2022–2032



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Acknowledgements

The Australian Government gratefully acknowledges the co-chairs and members of the National Mental Health Workforce Strategy Taskforce (the Taskforce) for their contribution, time and insights in developing the draft Strategy. The Terms of Reference and Membership of the Taskforce are provided at Appendix A.

The Australian Government acknowledges the advice, time and support of the many peak bodies, professional colleges, mental health workers and people with lived or living experiences of mental ill-health and/or suicide including families, carers and kin who contributed to the Strategy through participation in Taskforce Working Groups, Consumer and Carer Roundtables and the public consultation process.

The Australian Government also acknowledges the organisations that supported development of the Strategy: ACIL Allen Consulting which supported the Taskforce to develop the consultation strategy and supporting documents, the University of Queensland which undertook workforce research and analysis, and Mental Health Australia which supported the Consumer and Carer Roundtables.

Also acknowledged is the significant collaboration and input from state and territory governments and the advice from the National Mental Health Commission.

The Australian Government thanks everyone involved for their expert advice and passion for improving Australia's mental health workforce.

Foreword

On behalf of the Australian Government, we are proud to present the 10-year National Mental Health Workforce Strategy 2022–2032. We thank everyone who has contributed to its development, particularly the National Mental Health Workforce Strategy Taskforce and its co-chairs Jennifer Taylor PSM and Thomas Brideson.

Every year, millions of Australians come into contact with the mental health system and almost half of all Australians will experience mental ill-health in their lifetime. The personal toll on the lives of individuals, families and carers is high and the impacts on our community are long lasting. The COVID-19 pandemic, along with drought, bushfire and floods, have heightened distress in our communities, and placed unprecedented demand on already over-stretched mental health services and the workforce that delivers them. These events have also imposed a heavy burden on the health and wellbeing of our frontline workers, who have worked tirelessly to ensure people can continue to receive the care and support they need.

The mental health workforce has a profound impact on the quality, accessibility, effectiveness and sustainability of the mental health system. It is critical to delivering services across primary, acute, aged care, disability and veterans' care. But there are significant shortages of all professions in the mental health workforce. These shortages are getting worse, and they have the potential to curtail the amount and quality of care provided across all settings. Too many people are waiting too long or missing out on vital mental health care, particularly people living in regional, rural and remote areas, and our disadvantaged populations, including First Nations people. We need to ensure our mental health and suicide prevention system is dynamic – just as the needs of individuals, models of care, and technology are dynamic. We need a system that ensures people can access help easily and early before mental health conditions and suicidal distress worsen, and that provides compassionate, person-centred and effective care. Significant and sustained reform is required – and workforce is a key enabler of such reform.

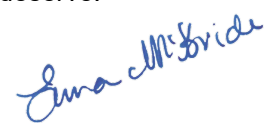
Change must be whole of government and whole of community to make a real difference. At the heart of this change is a highly skilled, diverse, motivated, well-distributed and sustainable mental health workforce that is supported to deliver the services Australians need now and into the future. This is precisely what this National Mental Health Workforce Strategy is designed to do. Crucially, it sets out a clear plan for how governments will work together and in partnership with the sector to attract, train, maximise, support and retain the workforce required to meet current and future demands. Improved collaboration and coordination across governments and sectors, and in partnership with unions and industry, is essential to address workforce issues. The Strategy provides an opportunity to implement immediate actions to alleviate current pressures, as well as set the foundation for longer-term reforms.

Genuine partnership is required to make meaningful reform. Under the National Mental Health and Suicide Prevention Agreement, all governments have agreed to work together to improve and better connect the mental health and suicide prevention system, acknowledging the critical role the workforce plays in achieving this. The Agreement commits all governments to work in partnership to support and enhance the capability of the workforce, to develop this Strategy, and to use it to implement practical changes to grow, upskill and support the workforce.

The importance of mental health care—and a strengthened and appropriately supported workforce to deliver it—cannot be overstated. We pay tribute to, and thank, all mental health workers for their tireless work, their compassion, their commitment and their humanity in helping people with mental ill-health. This Strategy will give this critical workforce the enhanced support they need and deserve.



The Hon Mark Butler MP
Minister for Health and Aged Care



The Hon Emma McBride MP
Assistant Minister for Mental Health and Suicide Prevention
Assistant Minister for Rural and Regional Health

Taskforce co-chairs message

Meeting the mental health and wellbeing needs of Australia's diverse and growing population requires people—people who offer a diverse range of skills, backgrounds and life experiences. The mental health workforce is broad, spanning the health and social service domains in a range of roles and settings, and complemented by family, friends and carers. With growing demand for mental health services and the added workforce pressures from the COVID-19 pandemic, our workforce faces many challenges.

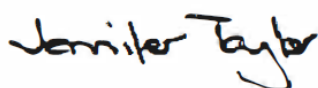
As co-chairs of the National Mental Health Workforce Strategy Taskforce (Taskforce), we are pleased to present the National Mental Health Workforce Strategy (Strategy). The Strategy was developed on the work of the Taskforce, which was informed by five Taskforce Working Groups, two Consumer and Carer Roundtables, public submissions, commissioned research and the knowledge, time and expertise of the Taskforce members. The Strategy was finalised through the subsequent work of the Commonwealth Department of Health and Aged Care in consultation with state and territory governments, the National Mental Health Commission and key stakeholders. We believe the Strategy is inclusive and representative of the diversity of the mental health workforce, yet clearly captures the critical challenges that need to be addressed to enable workforce reform.

We acknowledge the Strategy has been developed at a time of renewed focus on mental health, and considerable change in mental health policy in Australia. The emergence of whole-of-government mental health reforms, and the significant government investment in mental health, have further highlighted the need to design a mental health workforce that can provide Australians with the right care in the right place at the right time, now and into the future.

The Strategy provides a critical opportunity to grow, strengthen and support an appropriately skilled, culturally safe, flexible and innovative mental health workforce, working within a mental health system that is person-centred, sustainable, recovery-oriented, trauma-informed and integrated. The Strategy sets out a clear and actionable high-level plan to attract, train, maximise, support and retain a diverse workforce that can meet the needs of all Australians. To do this, the future workforce needs to be flexible and adaptable, and workers need to feel supported throughout their careers, regardless of experience. Likewise, mental health careers must be promoted as attractive and rewarding, and career pathways and support mechanisms must be enhanced.

We believe the Strategy provides clear direction to achieve these important objectives. We believe the Strategy is ambitious but achievable; comprehensive yet targeted; structured yet adaptable. But challenges will arise along the way. This will require policy makers to engage with and work towards addressing many of the underlying issues and structural barriers that have long confronted the mental health system and its workforce. It will require greater engagement and collaboration across governments, professional organisations, service providers, and people with lived or living experience of mental ill-health and/or suicide including families, carers and kin. However, we believe it is in our best interest to make meaningful and lasting change to the mental health system, which is critical to the wellbeing of all Australians.

We would like to acknowledge and thank the Taskforce members and everyone who contributed to developing the Strategy. We believe it captures the diversity and complexity of the mental health system, while providing clear direction on how we can develop a workforce that has the right capabilities to meet the needs of Australians now and in the future.



Ms Jennifer Taylor PSM
Co-Chair



Mr Thomas Brideson
Co-Chair

Executive Summary

Mental ill-health is one of Australia's most pressing issues. The challenge is complex and impacts all Australians—almost half of us will experience a mental health condition at some point in our lives. As the demand for mental health support and services increases, there is an urgent need to grow and create a well-rounded and responsive mental health system across Australia, that is supported by an appropriately skilled and contemporary workforce to meet the needs of all Australians.

The National Mental Health Workforce Strategy (Strategy) acknowledges the extraordinary efforts of the mental health workforce who work tirelessly to provide services and support to Australians.

The mental health workforce

This Strategy views mental health through a social and emotional wellbeing (SEWB) lens and conceptualises the mental health workforce accordingly, recognising the connection between people's physical, psychological, social, emotional and cultural wellbeing.

The mental health workforce includes people who work exclusively in the mental health sector (for example, First Nations mental health workers, mental health nurses, psychologists and psychiatrists) and those that work 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). In particular, general practice is central to the delivery of mental health care, especially for consumers living in regional, rural and remote areas, often acting as the first entry point to the mental health system.

The workforce also extends to people with lived or living experience of mental ill-health and/or suicide, and those working in other settings who are likely to have regular contact with people experiencing mental distress and/or ill-health and suicidality as part of their role (for example, aged care workers, educators, drug and alcohol workers, and housing and justice services workers). The Lived Experience (Peer) workforce is an integral part of the mental health workforce, with valuable skills and experiences that assist consumers of mental health services and their carers on their recovery journey.

There are several challenges associated with growing and sustaining the mental health workforce in Australia to meet the needs of all Australians. Key challenges include:

- Workforce shortages across occupations and disciplines
- Stigma and negative perceptions associated with working in mental health
- Unclear scopes of practice to establish who is able to perform what service and in which setting, particularly when working in multidisciplinary teams and in emerging workforces
- Limited connection and collaboration across mental health professions and disciplines
- Workforce maldistribution, particularly in regional, rural and remote areas
- Limited availability and use of high-quality data to inform workforce planning, and
- An overarching increasing demand for services.

Policy context and strategy development

The Strategy was developed at a time of considerable change in mental health policy in Australia with several critical reviews undertaken to guide reform, including the Productivity Commission Inquiry Report into Mental Health (2020) and the National Suicide Prevention Adviser's Final Advice (2021). In response, governments are both individually and collectively embarking on activities to transform Australia's mental

health and suicide prevention system. The National Mental Health and Suicide Prevention Agreement, is a significant step towards system reform, committing governments to work in partnership to implement the Strategy, address critical workforce shortages and identify priority areas for action.

The Strategy acknowledges the broad scope of the mental health workforce and the potential to overlap with existing and planned national workforce strategies (for example, for the medical, alcohol and other drugs, suicide prevention and care workforces). To ensure efforts are complementary, implementation of the Strategy will be led by the Australian Government in close collaboration with state and territory governments and key stakeholders.

National Mental Health Workforce Strategy

The Strategy provides a high-level vision and roadmap to build a sustainable workforce that is skilled, well-distributed and supported to deliver mental health treatment, care and support that meets the current and future population needs.

This Strategy acknowledges that social and emotional wellbeing and mental health are closely related. The mental health workforce spans promotion, prevention, early intervention, treatment, and recovery across the life course to address the diverse needs of consumers and carers, and priority populations, including people with disability, First Nations peoples, people from culturally and linguistically diverse (CALD) communities, lesbian, gay, bisexual, trans and gender diverse, intersex, queer and questioning, Sistergirl and Brotherboy (LGBTIQA+SB) communities and people experiencing specific life circumstances. The mental health workforce is spread across health and social service domains in a range of roles, in paid and unpaid capacities, and is complemented by alternative therapies, friends, family and others.

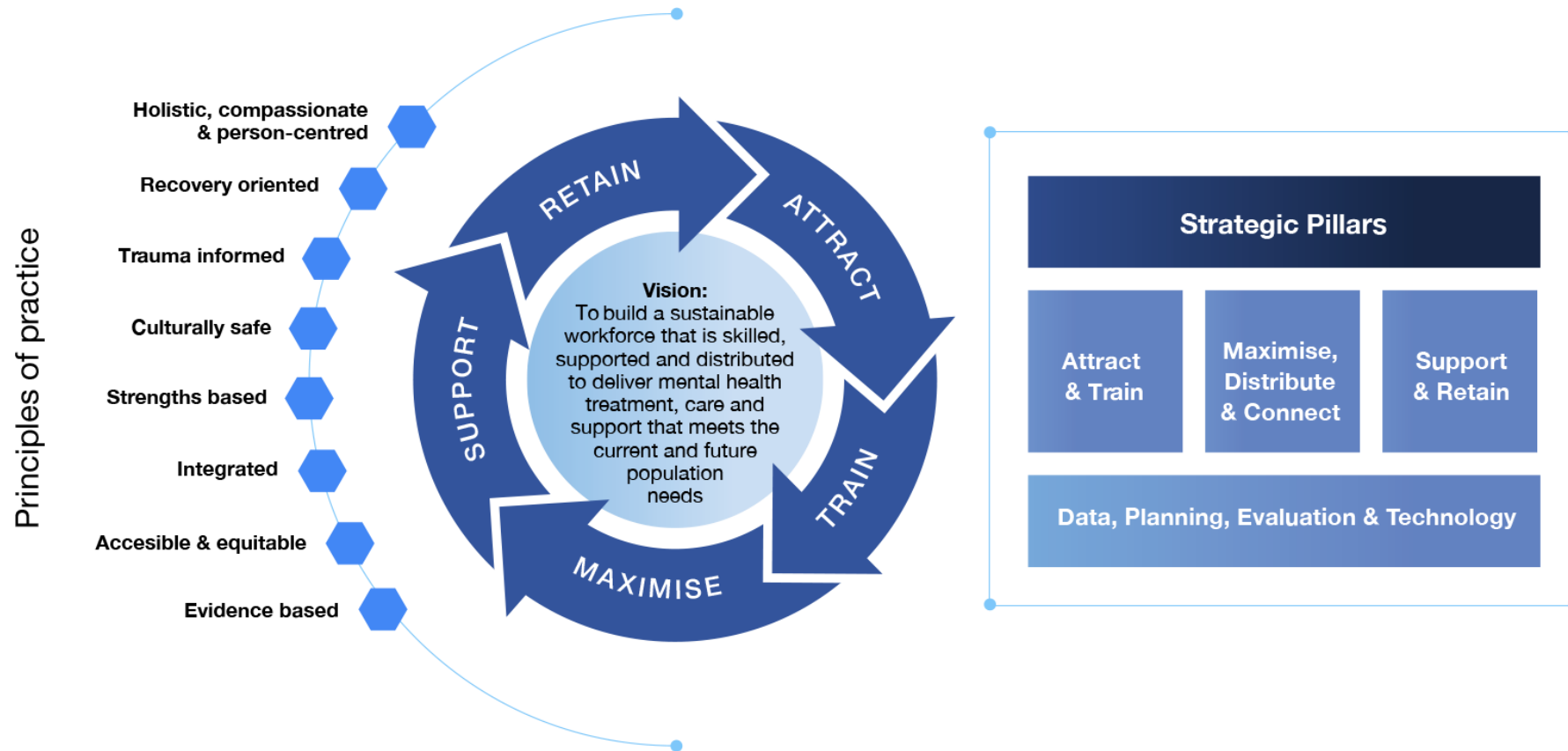
Figure ES-1 presents the framework for the Strategy and outlines the key principles of mental health practice, five goals and four strategic pillars to achieve the Strategy's overarching vision. The framework responds to the key themes emerging from public consultation, broader mental health and suicide prevention reform under way and the direction of other relevant workforce strategies.

The goals of the Strategy are to attract, train, maximise, support and retain an appropriately skilled, motivated and coordinated mental health workforce to meet the evolving needs of the mental health system into the future. These goals are designed to build on the strengths of the existing mental health workforce, integrating core principles of practice, while growing in size and capability over time.

The principles of practice describe a workforce that can meet the needs of people with a lived or living experience of mental ill-health and/or suicide, including families, carers and kin. While the Strategy focuses on actions to build and deliver the required workforce, it acknowledges the ultimate outcome is a workforce that benefits all Australians.

Four strategic pillars provide targeted objectives and prioritise key action areas to achieve the vision of the Strategy. The Strategy recognises that there are linkages between the actions across the strategic pillars, described further below.

Figure ES-1: The National Mental Health Workforce Strategy Framework



Strategic Pillar 1: Attract and Train

The mental health workforce will require growth in capability and capacity to meet future demand. Key considerations relate to the supply of a diverse and appropriately skilled contemporary workforce. Priority areas are to:

- Address critical shortages in the mental health workforce
- Mobilise the broader social and emotional wellbeing and health workforce
- Promote mental health careers as an attractive career choice
- Develop and deliver recruitment and career pathways to attract a suitably skilled and diverse workforce
- Enhance training pathways, access to supervision, and support skills transfer, and
- Strengthen the capability and core competencies of the workforce to recognise and respond to community need.

Strategic Pillar 2: Maximise, Distribute and Connect

The mental health workforce will require coordination to meet the needs of Australians at different stages across the life course and in a range of settings. Key considerations relate to the scope of practice, coordination of care, and distribution of the workforce, and opportunities to build a workforce that recognises and best utilises the skills and strengths of all workers. Priority areas are to:

- Enable the workforce to expand and work to the top of their scope and enhance regulatory arrangements to strengthen the safety and quality of care
- Strengthen coordinated care, collaboration and multidisciplinary ways of working within and between the mental health, wider health and social service workforces
- Provide evidence-based guidance to underpin workforce planning and the management of demand and surge capacity
- Address workforce supply in rural and remote areas, and
- Address workforce distribution across settings and between public, private and not-for-profit sectors.

Strategic Pillar 3: Support and Retain

There is a need to support the mental health workforce and systematically address key issues that impact workforce retention. The provision of supportive, safe and rewarding experiences responds to attraction and retention challenges. Priority areas are to:

- Support workplaces to create mentally healthy workplaces and adopt positive workplace cultures
- Implement evidence driven strategies to prevent and address worker stress and burnout
- Increase access to, and use of, continuing professional development across all career stages
- Increase supervision and mentoring across all career stages, including current and emerging leaders, and
- Adopt funding models and arrangements that drive quality of care and promote retention.

Strategic Pillar 4: Data, Planning, Evaluation and Technology

The mental health workforce will require a range of supporting structures to deliver services that meet the needs of the population across service settings. These include access to and use of high-quality data, workforce planning, monitoring and evaluation, and digital technology. Priority areas are to:

- Collaborate with consumers, carers and service providers in planning, monitoring and evaluation processes
- Use data to support workforce and service planning, including demand and surge management
- Improve data governance, quality, collection and utilisation, including addressing data gaps
- Evaluate workforce initiatives and monitor outcomes to drive continuous improvement, and
- Improve access to digital technology and support greater digital inclusion.

Implementation

Implementation of the Strategy will be shared. The Australian Government has established a national governance mechanism to oversee implementation of the Strategy and support collaboration between governments, regulators, peak bodies, professional colleges, training and education providers, and consumers and carers: the Mental Health Workforce Working Group (Working Group).

The Implementation Roadmap identifies short, medium and long-term priorities and actions to guide implementation activities. This will be supported by a series of Implementation Plans that outline targeted activities for priority professions, occupational groups and cross cutting issues facing the mental health workforce. These Implementation Plans will be progressively developed under the oversight of the national Working Group.

Part A — Development of the National Mental Health Workforce Strategy

Introduction

Mental health in Australia

Almost half of all Australians (45.5%) aged over 16 years will experience mental ill-health in their lifetime and one in five (20.0%) in any given year.ⁱ

Supporting Australians to be mentally well encompasses support for those experiencing suicidality, mental distress and/or ill-health, along with prevention, early intervention and wellbeing promotion. Mental ill-health affects people of all ages from all backgrounds and locations across Australia, often linked to experiences of disadvantage, trauma and other social issues. Risk factors can include genetics, disability, homelessness, 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).ⁱⁱ

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%), substance use disorders (5.1%) and eating disorders (estimated between 4 and 16%).ⁱⁱⁱ These conditions can often occur in combination, including comorbidly with physical health conditions such as cancer and chronic pain.^{iv} The severity of these conditions varies greatly, with most people with mental ill-health experiencing mild (9% of the population) or moderate (5%) symptoms, with a smaller proportion experiencing severe mental ill-health (3%). There is also a significant proportion of people at risk of mental ill-health presenting with emerging symptoms (23%).ⁱ 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 more than one third of deaths for people aged 15–24 years.^v

Mental ill-health has a significant economic and social impact in Australia. The economic cost of mental ill-health and suicide in Australia is estimated to be \$43 billion to \$70 billion (2018–19), and diminished health and reduced life expectancy for those with mental ill-health, self-inflicted injury and/or who die by suicide is estimated to cost approximately \$151 billion.ⁱⁱ People who live with mental illness are also more likely to experience a range of adverse social, economic and health outcomes.^{iv} Some of the social impacts of mental illness may include direct and indirect caring duties, social isolation, absenteeism and presenteeism, as well as potentially reduced opportunities in one's career.

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 and evidence-based online treatment. Support and treatment of varying intensity may be accessed simultaneously, in line with individualised needs. 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.^{vi}

The health workforce, including mental health workers, are at heightened risk of experiencing stress, burnout, and the development of mental illness than the general population due to the demanding nature of their work.ⁱ Increased personal risk, trauma exposure, and physical demands are among the primary factors which negatively affect the mental health and wellbeing of the health workforce. The COVID-19 pandemic has further exacerbated existing mental health issues within the sector, with healthcare workers showing significant symptoms of moderate-severe level depression (21%), anxiety (20%) and post-traumatic stress disorder (29%).^{vii} Providing mental health support reduces the risk of burnout, absenteeism, workforce attrition and ongoing mental health issues such as post-traumatic stress disorder.

Impact of COVID-19

The prevalence of mental health difficulties experienced in the population increased during the COVID-19 pandemic, further exacerbating the impacts of mental health on economic and social outcomes. Studies

undertaken during the pandemic reported that up to 78% of people experienced worsening of their mental health conditions since the COVID-19 outbreak. Of these, 50% reported elevated levels of psychological distress, depression and anxiety.^{viii} In response, there has been a strong uptake of mental health services and governments have increased funding for mental health services to respond to the mental health impacts of the pandemic.

The COVID-19 pandemic has brought both challenges and opportunities for the mental health system and its workforce. Increasing service demand and heavier workloads have taken a toll on the health workforce, including the mental health workforce. Conversely, the swift adoption of digital technologies and the mobilisation of the broader health workforce highlight the opportunity for innovation in health service delivery and models and provide important lessons for implementation of the Strategy.

The mental health workforce

This Strategy views mental health through a social and emotional wellbeing (SEWB) lens and conceptualises the mental health workforce accordingly, recognising the connection between people's physical, psychological, social, emotional and cultural wellbeing (See Figure 1).

The mental health workforce spans promotion, prevention, early intervention, treatment and recovery across the life course to address the needs of consumers and their families, carers and kin. The mental health workforce includes people who work exclusively in the mental health sector (for example, First Nations mental health workers, mental health nurses, psychologists and psychiatrists) and those that work 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). In particular, general practice is central to the delivery of mental health care, especially for consumers living in regional, rural and remote areas, often acting as the first entry point to the mental health system.

The workforce also extends to people with lived or living experience of mental ill-health and/or suicide and those working in other settings who are likely to have regular contact with people experiencing mental distress and/or ill-health and suicidality as part of their role (for example, aged care workers, educators, drug and alcohol workers, and housing and justice services workers). The Lived Experience (Peer) workforce is an integral part of the mental health workforce, with valuable skills and experiences that assist consumers of mental health services and their families, carers and kin, on their recovery journey.

This Strategy also recognises the important role of diverse, emerging and self-regulated workforces and their capability and capacity to deliver mental health treatment, care and support.

The way the workforce describes itself is diverse, covering a variety of knowledge, skills and ways of working with consumers, carers, families, and supporters.^{ix} This diversity of workforce skills and experiences influences the way in which the mental health workforce needs to be developed and supported.

Figure 1: The mental health workforce through a social and emotional wellbeing lens



Identified challenges facing the mental health workforce

The challenges associated with growing and sustaining the mental health workforce impact professional and occupational groups differently. Identified mental health workforce challenges are explored in each of the Strategic Pillars and include:

- **Workforce shortages across most occupations** providing support and treatment.
- **Not all occupations are operating to their full scope of practice**, that is, the utilisation of the full range of skills that a professional has been trained in and is competent to perform. Those trained through discipline-specific pathways are often employed in roles where they are not fully utilised to the top of their scope, exacerbating a lack of career satisfaction.
- **Workforce competencies do not always reflect contemporary approaches**, such as providing care that aligns with multidisciplinary care and principles of practice (trauma-informed, holistic, person-centred, strengths-based); and the ability to deliver services via digital and telehealth channels.
- The **mental health workforce is maldistributed**: geographically, with shortages in metropolitan regions and more acute shortages in regional, rural and remote locations; between the public, private and not-for-profit sectors; between service settings; within capacity against need and within specialisations.
- **Negative workplace cultures** with high administrative burdens, stress and burnout with inadequate workforce support, employment instability, and a lack of career progression. While these issues are widely spread across professional and occupational groups, the most significantly impacted group is the tertiary qualified workforce.
- **A lack of data driven system planning** contributes to many of the identified challenges in attracting and retaining mental health workers.
- **Sustainability of the current model**, with the possibility of facing an increasing number of emergencies in the future, such as pandemics and climate emergencies.

Workforce supply and demand snapshot

In 2020, the University of Queensland was commissioned to undertake an analysis of mental health workforce demand from the National Mental Health Service Planning Framework (NMHSPF) versus workforce supply to inform the development of the National Mental Health Workforce Strategy.

The NMHSPF is a needs-based planning model for Australian mental health services. It quantifies the total mental health need in the community, and then estimates the workforce and other resources required to deliver evidence-based, appropriate mental health care to those populations. The analysis was limited to the workforce providing services for people with mental health problems that are within the planning/funding scope of the NMHSPF (mental health system).

Workforce supply was estimated using health services administrative data and the National Health Workforce Data Set. In some instances, full-time equivalent (FTE) staff were estimated based on available service activity data and NMHSPF assumptions about working hours.

Key findings

There is currently a 32% shortfall in mental health workers when compared to the 2019 NMHSPF target, and this shortfall is expected to grow to 42% by 2030 if current shortages are not addressed (Figure 2). The NMHSPF predicts a need for 74,252 FTE mental health staff nationally in 2019, growing to 87,645 FTE by 2030.

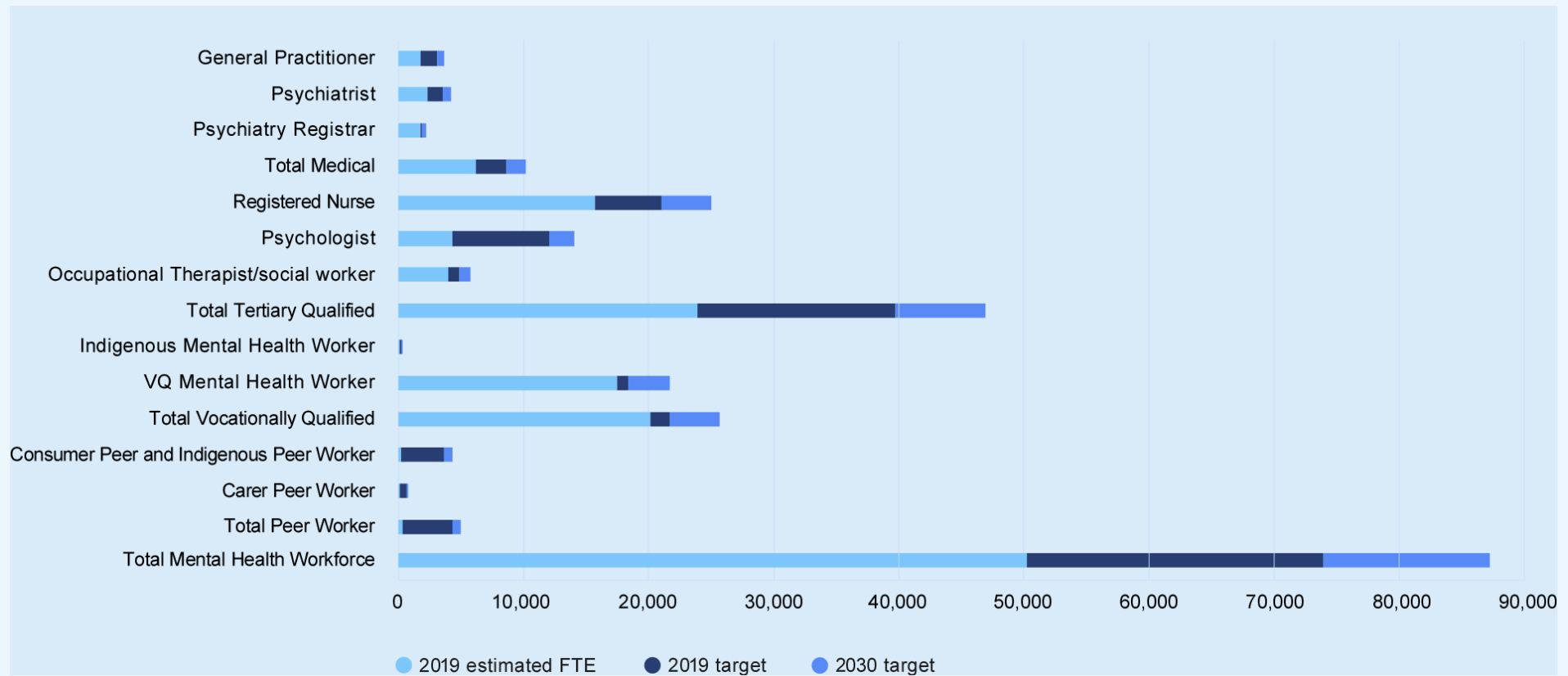
There is a moderate under-provision in FTE across nearly all mental health workforce categories, with the largest relative gaps identified for: consumer and carer peer workers (5% and 14% of the NMHSPF target respectively); psychologists (35% of the NMHSPF target); and Indigenous mental health workers (37% of the NMHSPF target) (Figure 2). Across all provider types, greater gaps in workforce supply were generally evident for consumers aged 65+ years, followed by those aged 0–17 years.

For consumers aged 18–64 years, workforce supply consistently reached a higher proportion of the NMHSPF targets.

The availability of mental health staff is generally lower in more remote areas compared to more populous regions. There were significant shortfalls in psychiatrists and psychologists in the primary care sector across all Modified Monash Model (MMM) regions, with deficits more pronounced in rural regions (MMM6–7).

The analysis identified several data gaps, including a paucity of data on non-AHPRA regulated professions and on full workforce delivering psychosocial support services. Hence the results were limited by available data.

Figure 2: Estimated 2019 FTE compared with NMHSPF 2019 and 2030 targets by workforce type*



Source: Commercial in Confidence - University of Queensland (2021). Analysis of national mental health workforce demand and supply. Final report

Notes:

- * Some workforce types within categories have been combined (such as Occupational Therapist and Social Worker, and Consumer Peer and Indigenous Peer Worker) due to the existence of gaps in FTE 2019 data which do not allow for separate analysis of each workforce type
- * Enrolled nurse and Other Medical officer workforce types have been excluded from the graph due to current FTE 2019 estimates exceeding NMHSPF 2030 target
- * Data is not available or complete for all workforce types (e.g. low intensity workers, other tertiary qualified and Indigenous mental health clinician). Categories may underestimate the total FTE

Strategic policy context and direction for mental health reform

Mental health reform and policy context

The Strategy was developed at a time of considerable change in mental health policy in Australia. Several critical reviews were undertaken to guide reform, starting with the Productivity Commission Inquiry Report into Mental Health (2020) and the National Suicide Prevention Adviser's Final Advice (2021).

The Productivity Commission highlighted service gaps and opportunities for change and presented a long-term plan for the sustainable reform of Australia's mental health system. The National Suicide Prevention Adviser highlighted the need for system reforms to be informed by people with lived experience of mental ill-health and suicide, including as family members, carers and kin. Both reports offered a series of recommendations to create a person-centred mental health system, focusing on prevention, early intervention and improving people's experience within and beyond the mental health service system. Recommendations also included supporting the mental health system with a skilled and sustainable workforce along with strong governance structures to drive a whole-of-government approach.

The subsequent recommendations made by the Royal Commission into Victoria's Mental Health System (2021) (Royal Commission) and the House of Representatives Select Committee on Mental Health and Suicide Prevention (2021) further highlighted the need for a person-centred mental health system supported by a skilled and sustainable workforce and good governance.

In response to these inquiries, governments have both individually and collectively embarked on activities to transform Australia's mental health and suicide prevention system. For example, in 2021 the Australian Government invested \$2.3 billion in the National Mental Health and Suicide Prevention Plan to lead landmark reform, including a commitment to work with state and territory governments on a new National Agreement; and the Victorian Government announced its commitment to implementing all 65 of the Royal Commission's recommendations to improve the mental healthcare system and achieve better outcomes for Victorians.

Since then, the National Mental Health and Suicide Prevention Agreement (National Agreement) has come into effect with parties agreeing to work in partnership to implement the Strategy, address critical workforce shortages and identify priority areas for action. In addition, the National Agreement reaffirms governments' commitment to the principles of Equally Well – the National Consensus Statement for improving the physical health and wellbeing of people living with mental illness in Australia.

Alignment with broader mental health workforce strategies

The Strategy acknowledges the mental health workforce is broad, works across a variety of settings, can be characterised by speciality or subspecialty, and competes with the broader health workforce in the labour market. The mental health workforce also shares similar workforce challenges being experienced in the aged care, disability, veterans' services, and community services sectors.

As such, the Strategy recognises the potential overlap with existing and planned national workforce strategies, such as the National Medical Workforce Strategy, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan, the National Alcohol and Other Drugs Workforce Development Strategy, the National Strategy for the Care and Support Economy, and the Suicide Prevention Workforce Strategy, in addition to state and territory-based workforce strategies. Implementation of this Strategy will be cognisant of these overlaps and will be guided by collaboration across portfolios and between governments, consumers and carers, peak bodies and professional colleges.

Development of the Strategy

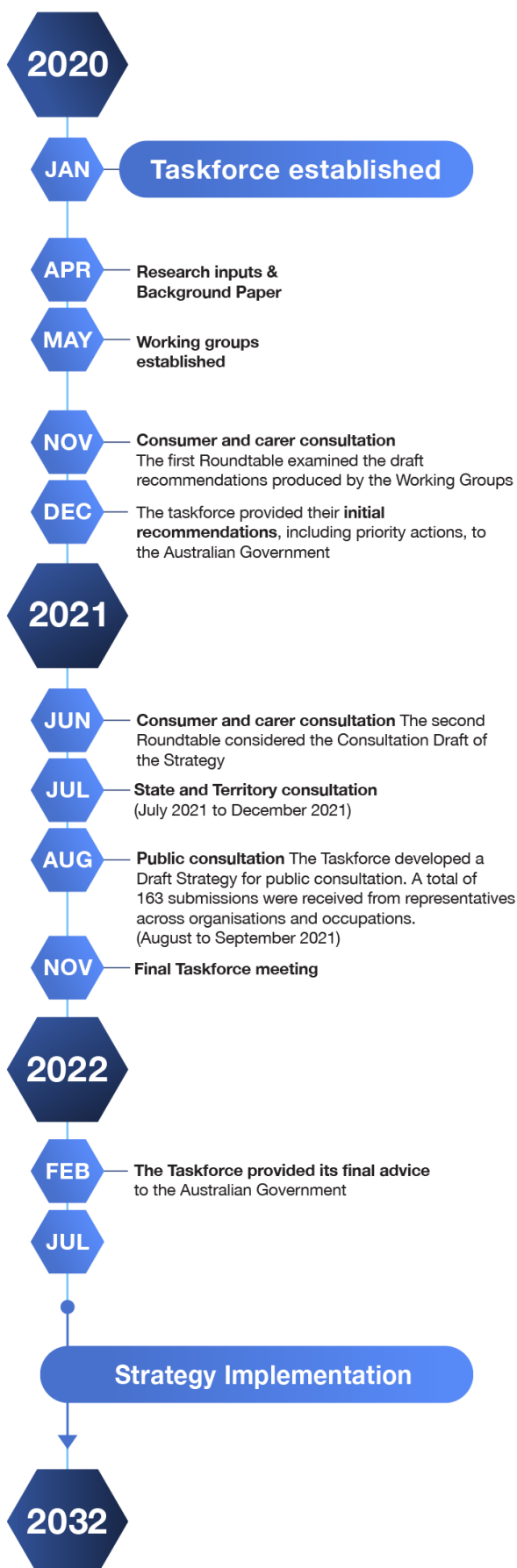
The Strategy has been informed by advice from the independent National Mental Health Workforce Strategy Taskforce (Taskforce), state and territory governments, and public consultation with consumer and carer representatives, employers in the mental health sector, peak bodies and professional associations, and vocational and higher education providers.

The Taskforce was established to provide independent advice and included representatives from the mental health workforce, consumers and carers, industry and peak bodies. Appendix A provides the Taskforce Terms of Reference and Membership. To form its advice, the Taskforce drew on evidence from a range of sources, including published literature, workforce data analysis, government reports and inquiries. Working Groups were established to examine in greater detail the priority areas of rural and remote workforce and service delivery; First Nations communities; workforce training and education; peer and lived experience; and inter-jurisdictional and inter-governmental workforce policies and strategies.

To further support the work of the Taskforce, the Department of Health and Aged Care commissioned the following research:

- 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.
- An analysis of national mental health workforce supply and demand to better understand current and future mental health workforce supply and demand.
- A labour market analysis to review workforce trends for different occupations within the mental health workforce.
- An education institutes review to examine current trends in enrolments and completion, and the capability of providers to scale up delivery.

Figure 3: Development of the Mental Health Workforce Strategy timeline



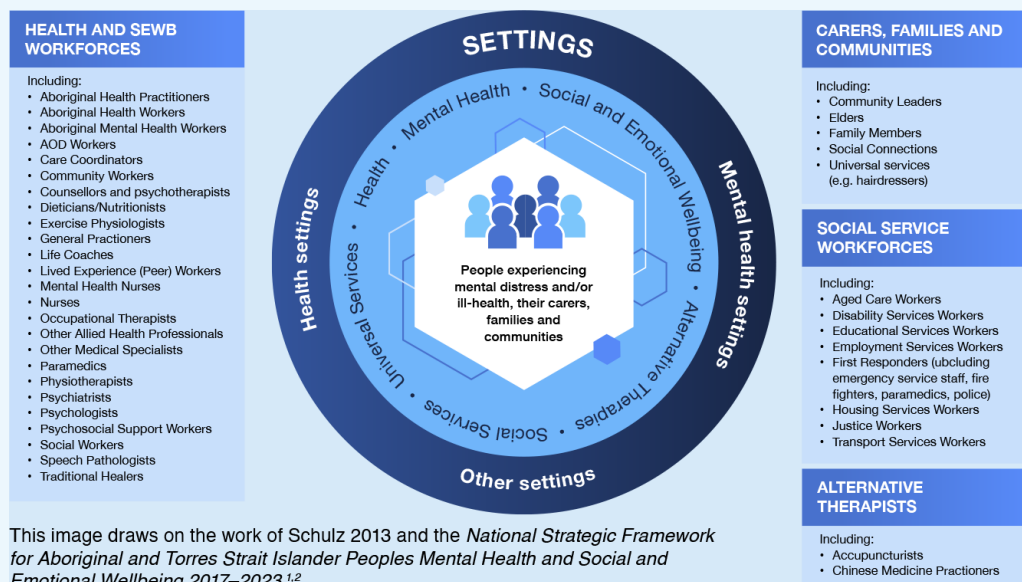
The National Mental Health Workforce Strategy Taskforce

In preparing our advice, the Taskforce viewed mental health through a social and emotional wellbeing (SEWB) lens and recognised the indivisible connection between people’s physical, psychological, social, emotional and cultural wellbeing, noting the mental health workforce is spread across health and social service domains in a range of roles, in paid and unpaid capacities, and is complemented by alternative therapies, friends, family and others. The image below provides an example of the vast number of professions that have a role in the mental health workforce through a SEWB lens, noting this is not an exhaustive list and that many more professions also contribute to supporting the mental health of consumers.

We recognised the need for a mental health workforce which spans promotion, prevention, early intervention, treatment and recovery across the life course to respond to the needs of consumers and carers, and priority populations, including people with disability, First Nations peoples, people from CALD communities, people who identify as LGBTIQ+SB, and people experiencing specific life circumstances.

We also highlight:

- The important role of the diverse, emerging and self-regulated workforce and their capability and capacity to deliver mental health treatment, care and support for all Australians in need.
- The contribution the Lived Experience (Peer) workforce makes in providing mental health care and treatment, and the significant potential of this workforce that can be achieved through enabling greater participation.
- The valuable role played by the volunteer workforce and the need for it to be supported in the same way as the paid workforce.
- The significant overlap between the mental health and suicide prevention workforces with respect to roles, occupations, and the required competencies.
- The contribution that people working in service roles outside of the health and community sector who are likely to have regular contact with people experiencing suicidality, mental distress and/or ill-health and the role they play in suicide prevention and early intervention.

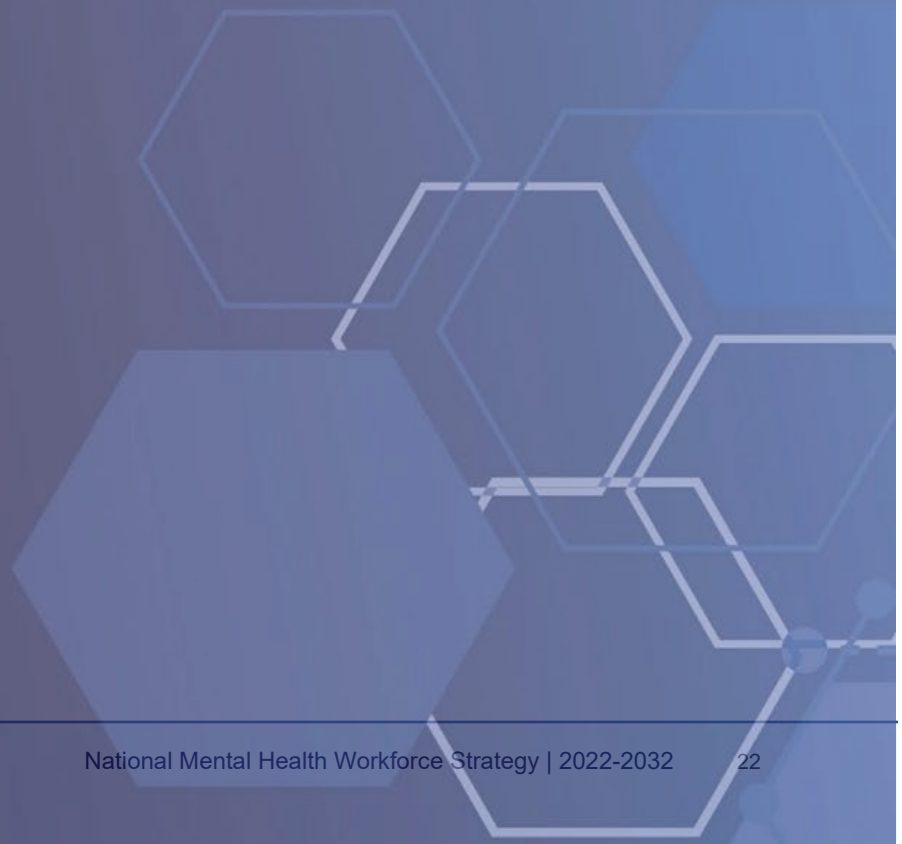


This image draws on the work of Schulz 2013 and the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017–2023*.^{1,2}

1 Schultz C. Maintaining Strong Being: A new theory of resilience grounded in the lived experiences and knowledge's of Aboriginal and Torres Strait Islander Confirmation paper [dissertation]. Gold Coast Qld: Griffith University 2013.

2 Commonwealth of Australia 2017. *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*. Canberra: Department of the Prime Minister and Cabinet.

Part B — National Mental Health Workforce Strategy



Vision, goals, principles and framework

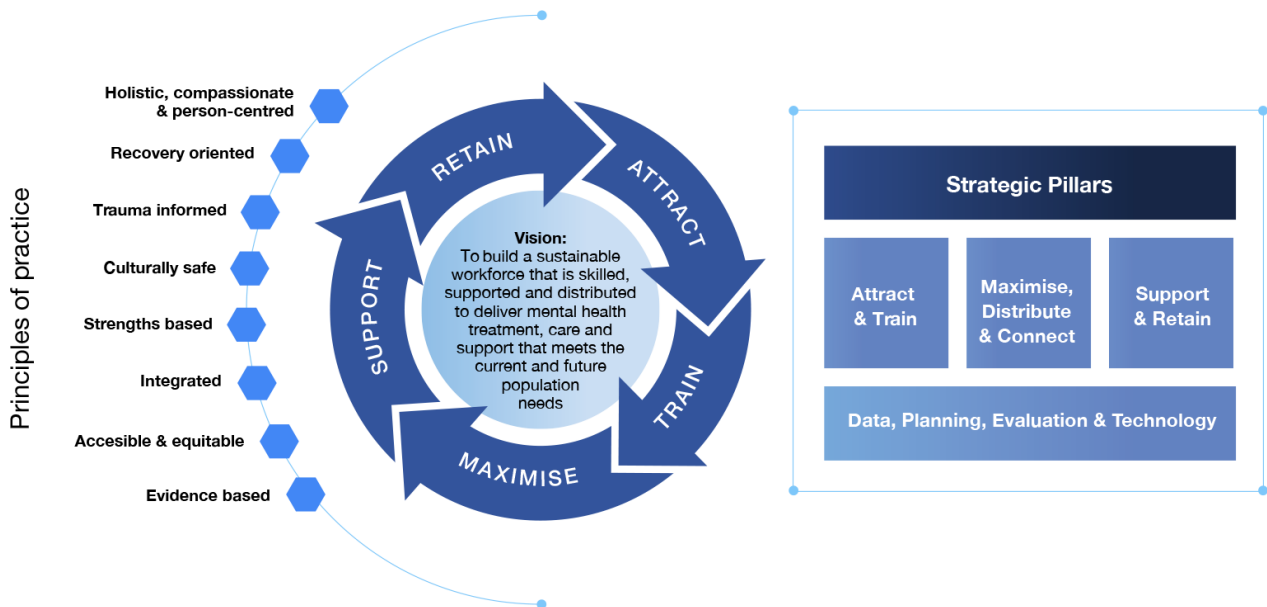
Vision

The ten-year National Mental Health Workforce Strategy (Strategy) provides a vision and roadmap to build a sustainable workforce that is skilled, distributed and supported to deliver mental health treatment, care and support that meets the current and future population needs.

This Strategy acknowledges that social and emotional wellbeing and mental health are closely related. The mental health workforce spans promotion, prevention, early intervention, treatment, and recovery across the life course to address the needs of consumers and carers, and priority populations, including people with disability, First Nations people, people from CALD communities, LGBTIQ+SB communities and people experiencing specific life circumstances. The mental health workforce is spread across health and social service domains in a range of roles, in paid and unpaid capacities, and is complemented by alternative therapies, friends, family and important others.

Noting the shared responsibility in this space, implementation will be shared by governments, regulators, professional colleges, education providers, peak bodies and the sector more broadly, and will complement other workforce strategies.

Figure 4: The National Mental Health Workforce Strategy Framework



Principles of practice

To meet current and future population needs, the Strategy supports the workforce (regardless of discipline, setting or role) to deliver mental health treatment, care and support in accordance with the following principles of practice:

- **Holistic, compassionate and person-centred.** The needs and goals of consumers and carers are placed at the centre. To create a person-centred system that takes a holistic view of being mentally well and provides people with the right mix of mental health initiatives and clinical and non-clinical services to address mental and physical health needs.
- **Recovery oriented.** Consumers and their carers and families are supported to actively lead their recovery journey. Consumers will be empowered to retain hope, understanding of one's abilities

and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self.

- **Trauma-informed.** Services are delivered in a way that is informed by the impact of trauma on the people seeking mental health care. Care is based on the understanding that trauma is defined by the impact an experience has had on a person, rather than the experience itself.
- **Culturally Safe.** Care is safe for all cultural, sexual and gender identities. The workforce has an understanding of diverse cultures within Australia, are actively mindful and respectful of this difference and are trained to deliver care according to these differences.
- **Strengths-based.** People are supported to use and build on their unique strengths and resources. The workforce will acknowledge and positively reinforce people's strengths and capacity for personal recovery and reflect a strengths focus in attitude, language and actions.
- **Integrated.** Mental health services are connected across the wider health and social services sectors. Integrated care is seamless, effective and efficient across primary, community and hospital settings.
- **Accessible and equitable.** Services respond to the diversity of needs at different stages in the life course, minimising barriers for vulnerable communities. Care is responsive and respectful with a focus on service accessibility and equity for all people.
- **Evidence-based.** Data and evidence underpin service and workforce design, delivery and evaluation. Evidence based forecasting, monitoring and planning of strategies to encourage workforce development and growth for both established and emerging workforces.

Intended goals

This Strategy aims to **attract, train, maximise, support and retain** an appropriately skilled, motivated and coordinated mental health workforce to meet the evolving needs of the mental health system into the future. It is intended to provide practical guidance and a roadmap on how to achieve this.

These goals are designed to build on the strengths of the existing mental health workforce while growing its overall size and capability and are guided by core principles of practice.

Strategic pillars

Four strategic pillars provide targeted objectives and prioritise key action areas to achieve the vision of the Strategy: Attract and Train; Maximise, Distribute and Connect; Support and Retain; Data, Planning, Evaluation and Technology. The Strategy recognises there are linkages between the actions across the strategic pillars. Each strategic pillar is outlined in detail in the following sections.

Strategic Pillar 1: Attract and Train

The national mental health workforce will require growth in capability and capacity to meet future demand and address maldistribution. Key considerations relate to the supply of a diverse and appropriately skilled contemporary workforce. The growth of the mental health workforce is supported by a training and education system that is accessible and equips people with the skills and knowledge they need to perform their role in the mental health workforce across various settings.

Attracting individuals to the mental health sector is critical to growing a diverse and skilled workforce that meets the mental health and wellbeing needs of consumers and society more broadly. There are several challenges that may discourage individuals from seeking careers in the mental health sector. These include stigma and negative perceptions associated with working in mental health; negative experiences for early career professionals; and a lack of transparent career pathways across the mental health workforce, particularly in emerging professions and disciplines.

Stigma and negative perceptions associated with mental health careers reduce the attractiveness of the sector for prospective individuals. Key factors contributing to negative perceptions include the underfunded mental health services; employee stress, fatigue and burnout; quality of workplace conditions, such as insecure employment and remuneration; and workplace safety.

Negative placement and training experiences for early career professionals, such as students and new graduates, is identified as a significant barrier which discourages careers in mental health. This is particularly evident in acute public and community-based settings, with individuals expressing insufficient funding and resources, overwork, and lack of adequate support and supervision at this critical early stage as key deterrents to ongoing participation in the sector. Further, there are difficulties in recruiting and retaining academic and clinical staff needed to support quality delivery of placements. Limited availability of staff presents challenges to supporting training at a vocational level and providing discipline-specific supervision. These impacts are exacerbated in rural and remote service settings. Providing prospective students and early career professionals positive exposure to mental health workplaces (both in pre- and post-graduate placement situations) is critical to alleviate the negative perceptions and encourage individuals to consider entering the sector.

There is a lack of transparent career pathways across the mental health sector, impacting the perception of mental health as a viable career option for individuals. These are particularly pronounced in the Lived Experience (Peer) workforce, SEWB workforce, emerging and self-regulated workforce, and First Nations workforce, where recognition (both formal and informal) and ongoing training opportunities are limited. For individuals in rural and remote locations, a lack of local education and training options may inhibit participation in the sector. Opportunities exist to address these challenges and deterrents to promote mental health as an attractive, rewarding, and highly valued sector, which is critically important to society now and into the future. Key opportunities are described in the sections below.

Address critical shortages in the mental health workforce

Opportunities to further grow and support several workforce professions and disciplines have been identified. These include:

- The mental health medical, nursing and allied health workforces.** The Productivity Commission identified critical shortages in several professions, including psychiatry, psychology, mental health nursing, and other relevant allied health professions.ⁱ Through the National Agreement, governments have identified that these professions require immediate action to address critical shortages and promote multidisciplinary care. In implementing the Strategy, the Australian Government will work with state and territory governments, peak bodies and professional colleges to explore opportunities to improve training and registration pathways.

There is opportunity to increase the supply of the workforce through increasing access to clinical supervision and quality mental health placements and traineeships. Reviewing the supply of mental health training placements and encouraging the mental health and education sectors to support placements will also reduce bottlenecks in the training pipeline. There is also opportunity to raise awareness of training pathways to encourage students, graduates and existing clinicians to choose careers in mental health.

- The Lived Experience (Peer) workforce.** The Lived Experience (Peer) workforce is increasingly recognised as a valued component of the mental health sector. There is opportunity to encourage greater participation of the Lived Experience (Peer) workforce, and a need to enhance pathways to promote career development and growth, including structures to support mandatory ongoing supervision and mentoring. For the Lived Experience (Peer) workforce, access to training opportunities may be improved by providing differing entry points (including Certificate II, higher level qualifications such as Certificate IV and Bachelor and Postgraduate qualifications) to provide the broadest opportunity possible for prospective workers and improving affordability of training programs. Greater consistency in education and training standards is also needed to upskill the Lived Experience (Peer) workforce and provide confidence in the level of skills held by these workers across the sector. Further, people with lived or living experience of mental ill-health and/or suicide should be partners in the design and delivery of training programs for the workforce. The *Lived Experience (Peer) Workforce Development Guidelines* note that a ‘thriving mental health Lived Experience (Peer) workforce is a vital component of quality, recovery-focused mental health services’ and that a national peak organisation could support the development of professional leadership for both the consumer and carer Lived Experience workforces at national and state levels.^x There is opportunity to embed Lived Experience (Peer) workforce across different roles (e.g. leadership) and to increase organisational readiness for a Lived Experience (Peer) workforce.
- First Nations mental health workforce.** In alignment with the National Agreement on Closing the Gap priority reforms, there is an opportunity to increase the representation of First Nations people within the mental health workforce, including in higher paid roles. Identified opportunities include clearly defining career pathways; providing appropriate support for career progression; providing mental health traineeships or training programs; enabling a culturally safe work environment; promoting inclusion in multidisciplinary teams and recognising and valuing the broad array of skills including cultural knowledge that First Nations workers bring to their positions. Consideration must be given to the availability of locally based education and training programs to improve access to entry level training and address barriers such as needing to spend time away from community.^{xi}
- Emerging and self-regulated workforces.** There are emerging and self-regulated workforces for which a lack of documented and nationally consistent scopes of practice, and varied levels of regulation, prohibit opportunities to fully participate in the broader mental health workforce. Further support of these workforces may grow the capacity and capability of the overall mental health workforce and promote employment of contemporary workforce models.

	Actions
1.1.1	Address critical medical, nursing and allied health workforce shortages with an initial focus on priority professions as agreed in the National Agreement—psychiatry, psychology, mental health nursing, and other relevant allied health professions
1.1.2	Examine innovative service delivery models to support increased engagement of the Lived Experience (Peer) and First Nations workforces in different contexts

	Actions
1.1.3	Establish educator roles to support the further development of the Lived Experience (Peer) Workforce and First Nations mental health workforce
1.1.4	Collaborate with consumer, carer and Lived Experience (Peer) worker representatives to support establishment of a national Lived Experience (Peer) workforce peak organisation
1.1.5	Develop broader training models for the Lived Experience (Peer) workforce to develop skills and capabilities
1.1.6	Create incentives for employers to increase the numbers of designated Lived Experience (Peer) employees across all organisational levels
1.1.7	Support First Nations people and people with lived experience to complete mental health education and training programs with 'wrap around services'
1.1.8	Support First Nations organisations to develop and deliver training in cultural safety, trauma informed and trauma competent care
1.1.9	Define the competencies required by emerging and self-regulated workforces to deliver evidence-based suicide prevention, mental health promotion, treatment, support and care

Mobilise the broader social and emotional wellbeing and health workforce

Population, consumer and carer needs are more likely to be met if the entire mental health workforce is appropriately utilised. This requires recognition of the broadly defined workforce, such as the SEWB workforce, and appropriate definition of the requisite knowledge and skills. When mental health support and treatment is required, it requires workers performing roles that reflect their full scope of practice, more frequent and effective adoption of multidisciplinary team-based approaches and provision of better integrated support and treatment.

The SEWB workforce will play an important role in the delivery of new service models in an evolving system. It will be important to consider how this workforce can be integrated into existing systems and how new skills can help serve population needs. This includes the definition of scopes of practice and the recognition of qualifications to support mobilisation of the SEWB workforce.

	Actions
1.2.1	Review and clearly define the scopes of practice of the broader social and emotional wellbeing and health workforce
1.2.2	Support service models that enable integration of the social and emotional wellbeing and health workforce into existing service systems

Promote mental health careers as an attractive career choice

A key lever for attracting, growing and retaining a suitably skilled workforce is awareness and clarity of mental health career opportunities and education and training pathways. There is an opportunity to work with industry and education providers to increase the awareness of the opportunities that the mental health sector affords. This applies equally across work settings, locations and for populations that are currently underrepresented, including First Nations people, people with disability, people from CALD backgrounds, and LGBTIQ+SB communities.

There is a need for greater transparency and clarity on career pathways across the system and opportunities for progression. For students, this includes providing greater clarity on what is required to progress in the workforce, prerequisites for career advancement, and how long this will take. For existing workers, it is important to have clearly defined pathways to upskill and further or diversify career opportunities. This includes providing alternative training pathways such as developing new, shorter training pathways to uplift existing mental health skills, reducing the lead time between training and readiness to deliver services.

Mental health stigma and negative perceptions associated with working in mental health careers can be a significant barrier to participating in employment. There is an opportunity to address stigma and promote mental health careers as rewarding and attractive through targeted campaigns in the broader community, ensuring that the community values and respects the mental health workforce. For the workforce, increasing positive exposure to mental health workplaces in pre-service education and training would help alleviate negative perceptions about careers in mental health.

	Actions
1.3.1	Raise the awareness of pathways into, and within, the mental health workforce for both vocational and higher education trained occupations including across work settings
1.3.2	Address stigma and negative perceptions associated with working in mental health
1.3.3	Create positive perceptions of working in mental health by improving the pre-service and/or postgraduate placement experience of students and trainees

Develop and deliver recruitment and career pathways to attract a suitably skilled and diverse workforce

Greater visibility and clarity of career pathways is needed in the mental health sector, particularly for school leavers, adult learners and those in vocationally trained roles to be able to attract, foster and develop a suitably skilled and diverse workforce that meets the needs of the communities they serve. Additionally, inclusivity of workforce policies and settings should be addressed to improve the representation of diverse groups, including CALD communities, First Nations people, LGBTIQ+SB people and people with disability, to better meet the needs of the Australian population. The Strategy acknowledges that inclusive practice and recruitment are key areas of focus in strategies such as *Australia’s Disability Strategy 2021–2031* and the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031*.

Opportunities to attract and grow a contemporary mental health workforce across Australia include:

- Graduate health professionals.** There is a need to attract health graduates to work in the mental health sector as well as the public health services.¹ Opportunities exist to improve the flexibility of career pathways, in line with other health professions, by providing graduates greater choice and clear avenues for pursuing training (and retraining) in specialties within mental health.

This is particularly important given the competition in the labour market for health professions that can select specialised pathways. There is a key opportunity to support the higher education sector and vocational training sector to promote mental health careers as an attractive career choice and opportunity to support people and the community.^{xii}

- **Home grown professionals.** People originating from rural and remote areas often have a preference to undertake training and employment in their own (or comparable) communities, where community linkages exist. Focusing on developing, growing and sustaining the regional, rural and remote mental health workforce through providing localised education, training, and placement opportunities for students could support increased uptake of training opportunities.
- **Overseas trained professionals.** The recruitment of overseas trained professionals is a part of Australia’s strategy to grow the health workforce, including the mental health workforce and in rural and remote settings. Advantages of skilled migration include reducing the time taken to grow the workforce, introducing diversity of backgrounds and expertise, and reduced training time and costs.³ Strengthening and streamlining recruitment pathways, particularly in rural and remote locations, endorsed or in partnership with professional associations can support the successful attraction of overseas professionals and increase the number of specialised practitioners to meet the existing and future demand in Australia. Skilled migrants can be supported as they transition to Australia by providing enhanced education and social support, including relocation and settlement support.
- **Existing skilled professionals.** There are diverse groups of workers who are not currently engaged in the mental health sector but would join the mental health workforce if career pathways enabled recognition of capabilities and provided opportunities to gain the additional competencies required. Well-structured and connected pathways that support transition through career stages may enhance retention of this workforce.

	Actions
1.4.1	Collaborate with the education sector to strengthen recruitment pathways
1.4.2	Recruit people from regional, rural and remote communities to access and complete mental health education and training programs
1.4.3	Strengthen recruitment and integration support pathways for overseas trained health professionals
1.4.4	Develop and implement mental health career pathways within and between mental health and health service settings

Enhance training pathways, access to supervision, and support skills transfer

Enrolments in mental health related education and training programs have increased over time, with education providers scaling delivery to meet demand for courses. Further investment is required to support increased access to training pathways for most groups within the mental health sector. Opportunities include improving awareness of existing mental health related training programs; enhancing collaboration across jurisdictions; improving program affordability; promoting community-based entry level support roles; improving access outside metropolitan areas, including through virtual delivery methods; and investment in appropriate digital infrastructure.^{xii} Such training programs may support entry level

³ Noting that in the time of writing this Strategy the COVID-19 pandemic has impacted skilled migration.

training, upskilling and reskilling. Improved access to education and training will enable the workforce to provide contemporary, recovery-focused services to meet consumer and carer needs across the life course, for specific population groups and people experiencing specific circumstances (for example, people with disability, veterans and their families, or during the perinatal period).

There is an opportunity for governments and health and tertiary education sectors to work together to enhance training and development requirements. Greater collaboration can better identify workforce training requirements based on consumer needs and ensure that an appropriate volume of training positions and clinical supervision structures are in place to support a growing and evolving workforce to meet current and future demand.

Implementing quality training pathways also requires close interaction between education and training providers and mental health and suicide prevention services to facilitate access to supervision and placements of appropriate duration and across a range of settings and areas.

The broader health workforce, for example, nurses (including midwives and nurse practitioners), pharmacists, paediatricians, geriatricians, and First Nations health workers and practitioners, may also provide opportunistic mental health care to patients. Training initiatives to support skills transfer, strengthen partnerships, and build career pathways may further increase the capability and capacity of the mental health workforce.

There exist a range of social and community service occupations that deliver mental health services to Australians. For example, alcohol and other drug workers, family and domestic violence workers, homelessness workers and disability case managers commonly deliver mental health support for consumers. There is opportunity to upskill the social services workforce and people working in roles where they are likely to support people experiencing suicidality, mental distress and/or ill-health and their carers (such as first responders and justice system staff) in basic mental health skills.

Further, there is a need for shorter programs to address current barriers around length, cost and accessibility of training, such as offering individuals more direct pathways to obtain mental health specialisation within defined occupations and disciplines. Micro-credentialing is a training model that allows students to undertake study in buildable blocks which can be easier to complete than a full-length qualification and provide more flexibility for employers. The development of micro-credentials needs to be supported by employers and professional associations to ensure the skills developed align to key areas of need, with viable funding arrangements for education and training providers to enable training delivery.

There is also an opportunity to encourage and support students and non-mental health practitioners to undertake training in mental health, including through developing alternative training modules and reviewing funding arrangements.

	Actions
1.5.1	Develop training modules that build competencies for the provision of culturally safe, integrated and multidisciplinary care
1.5.2	Develop training modules that build capability in suicide prevention of all the mental health workforce
1.5.3	Increase the supply of education and training programs for both vocational and higher education trained occupations, including programs outside of metropolitan areas

	Actions
1.5.4	Identify opportunities to prioritise access to training for the mental health workforce through increased subsidies and use of placements and traineeships
1.5.5	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
1.5.6	Support education providers to maintain, when appropriate, a combination of onsite and remote training and education opportunities
1.5.7	Ensure mental health students and trainees undertake mental health placements and internships across a more representative mix of settings, including clinical and non-clinical settings
1.5.8	Support the development of basic mental health skills in the social and community services workforce and professions
1.5.9	Support the development of basic mental health skills in the broader health workforce
1.5.10	Review funding arrangements for education and training providers to enable delivery of micro-credentialing course work

Strengthen the capability and core competencies of the workforce to recognise and respond to community need

The workforce requires the knowledge, skills and experience to deliver appropriate services based on consumers' diverse backgrounds, demographics and experiences, and which meet community needs and preferences. Opportunities exist to clearly articulate the components of care that address consumer and carer needs, including those related to sustainable recovery, identify competencies required to deliver the components of care, and specify the occupations that are trained to perform these competencies.

The mental health workforce needs to be enabled to deliver the components of care that reflect consumer and carer needs across the life course including those of children and young people, adults and older people, and to respond to the physical health of people with mental ill-health consistent with Equally Well—the National Consensus Statement.

The competencies that enable the workforce to deliver the components of care include core competencies common across occupations, such as person-centred support and treatment. Opportunities exist to develop a set of core competencies and skills for specific qualifications that are portable across occupations and sectors with notable skill overlap. This 'skills passport' would enable professionals to seamlessly move between similar roles and sectors (such as aged care, alcohol and other drugs and disability), providing professionals additional career progression opportunities and expanding the flexibility of the workforce to meet areas of identified need.

There is an identified connection between mental health and substance use, and a need to build the capacity of the mental health workforce to identify and respond to co-occurring mental ill-health and

alcohol and other drug addiction to support the long-term recovery of consumers. There is opportunity to improve service delivery and integration through improving competencies and cross-skilling both the mental health and alcohol and other drugs sector.

A diverse workforce is better able to advocate for and meet the needs of diverse patients and communities. There is opportunity to develop First Nations, CALD, LGBTQIA+SB and disability-led initiatives to support inclusion in the mental health workforce. Additionally, professional education and training should be enhanced to ensure that treatment and care meets the needs of consumers from diverse cultures and backgrounds and circumstances, including people with disability, First Nations people, people who identify as LGBTQIA+SB, veterans and their families and CALD communities.

It is important to acknowledge that cultural safety is an independent requirement that relates to, but is not restricted to, expectations for competency in CALD communities and in First Nations health.^{xiii} Strengthening cultural competencies of the workforce in both urban and remote settings is possible through both vocational training as well as continuing professional development (CPD). Ongoing cultural safety training and performance monitoring for staff, supervisors, and assessors, opposed to one-off training, promotes continual learning and development and will raise awareness of the different models of intervention and appropriateness for best practice quality care.

	Actions
1.6.1	Identify components of care (subsets of models of care) that meet the needs of consumers and carers and develop cultural safety education and training for all mental health workforces
1.6.2	Support the mental health workforce to upskill in and respond to co-occurring alcohol and other drug addiction
1.6.3	Support the alcohol and other drug workforce to upskill in and respond to co-occurring mental ill-health
1.6.4	Support First Nations, CALD, LGBTQIA+SB and disability led initiatives to grow and develop the mental health workforce to meet the needs of their patients and communities
1.6.5	Support higher education providers to embed the Aboriginal and Torres Strait Islander Health Curriculum Framework into higher education curricula for a broad range of undergraduate and graduate courses and health social service career pathways

Strategic Pillar 2: Maximise, Distribute and Connect

To meet the needs of Australians at different stages across the life course and in a range of settings, the mental health workforce will work to the full breadth and top of their scope of practice and adopt multidisciplinary ways of working and collaborate regularly within and between the mental health and wider health and social services workforces. Key considerations relate to the scope of practice, coordination of care, workforce distribution, and opportunities to build a workforce that recognises and best utilises the skills and strengths of all workers.

A well-functioning mental health system is dependent upon high quality workers with the right skills in the right places.¹ This involves aligning the skills, availability, and location of mental health professionals with the needs of consumers.

There are considerable imbalances in the current distribution of the mental health workforce across workforce settings and occupations, locations, and between the public and private sectors. Workforce distribution challenges are particularly acute in regional, rural and remote areas, where availability of and access to certain professions and services is limited. Additionally, the general preference of individuals to favour employment in private over public sector settings, due to perceived greater employment and career opportunities, has led to evident imbalances between these sectors.

It is widely acknowledged that multidisciplinary approaches are key to delivering optimal mental health treatment and support. However, there is limited connection and collaboration across mental health professions and disciplines in the delivery of services. Contributing factors include a general lack of understanding about the transferability of roles, skills and qualifications, unclear scopes of practice across occupations and service settings, and variations in regulation and legislation across settings.

Achieving the right mix and distribution of mental health skills to meet population needs now and in the future is a complex task. Strengthening competencies, redefining roles and functions, and embedding more innovative team structures will drive increased skill mix and a better workforce distribution. Following this, the integration of new and emerging workforces into the existing system will be a key focus.

Key opportunities to maximise, distribute and connect the workforce are described in the sections below.

Enable the workforce to expand and work to the top of their scope and enhance regulatory arrangements to strengthen the safety and quality of care

Nationally consistent and clear scopes of practice and working to the top of scope is important to enhance opportunities and capacity to utilise the mental health workforce to its full potential and maximise multidisciplinary practice. This may require broader review of models of care and team structures, particularly in community mental health services. Clear scopes of practice will also support a professional identity for workers within multidisciplinary teams.

There is opportunity to better use and integrate the self-regulating and emerging workforces in the mental health system by developing or clarifying scopes of practice and improving regulation. Nationally consistent, clearly documented scopes of practice across occupations in the mental health workforce and between jurisdictions are critical in ensuring that the workforce understands who is able to perform what service and in which setting, particularly when working in multidisciplinary teams. This may be especially important for emerging workforces where currently there is limited understanding of their knowledge, skills and possible role, for example, care navigation or service navigation.

There is also an opportunity to support general practitioners and other referring practitioners to consider and use a wider range of mental health services and providers when referring patients for treatment or support. For example, patients with milder conditions may be referred to low intensity community-based services or digital supports, thereby helping to ensure the clinical workforce is not diverted away from treating those with more moderate, severe or complex needs.

The quality of care and safety of service delivery for consumers is underpinned by effective regulatory arrangements. Occupational regulation is a mechanism for protecting the community by requiring that prescribed professional practice standards are met. The current arrangements for regulating the occupations in the mental health workforce have evolved over time with mature regulatory schemes for some occupations. There is a need to ensure that the appropriate regulatory arrangements are in place for emerging workforces and occupations that may be able to further contribute to mental health treatment, care and support. Consistency in regulation across occupations can help utilise the workforce optimally (related to scopes of practice) and ensure consumer safety and quality of care.

The appropriate regulatory approach for each occupation 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*.

	Actions
2.1.1	Develop and refine nationally consistent scopes of practice across occupations and between jurisdictions that reflect the components of care and competencies required to deliver them, recognising discipline-specific contributions and multidisciplinary care
2.1.2	Review regulatory arrangements to ensure the appropriate approach is in place to ensure consumer and carer safety, given each occupation's scope of practice
2.1.3	Establish roles and career paths that reflect effective use of multidisciplinary teams within nationally consistent scopes of practice and enable workers from each occupation to work to the top of their scope of practice
2.1.4	Create incentives for service providers to use service delivery models that utilise the competencies of all workforces to their full scopes of practice

Strengthen coordinated care, collaboration and multidisciplinary ways of working within and between the mental health, wider health and social service workforces

Wrap-around service delivery models or models that adopt a person-centred approach where services are “wrapped around” the person and their family and carers have demonstrated the potential to improve health outcomes, particularly in regional, rural and remote areas. Service delivery coordination should be responsive to local needs and strengthen the capacity in mental health support services. Attention needs to be given to building an integrated workforce across many sectors, with greater collaboration and integration of the health and social services workforces. Integrated care pathways across the aged care, disability, alcohol and other drug and primary and tertiary health care settings can minimise barriers to service and prevent individuals falling through gaps between multiple sectors and services. This requires coordination of the workforces.

Working together in partnership across disciplines supports a coordinated approach to respond to new and complex challenges.^{xiv} For example, supporting general practitioners to seek timely advice from

psychiatrists when managing complex patients on diagnosis, treatment, and medication safety, minimising the need to refer to specialist care, and therefore alleviating wait lists and potential out of pocket costs for the consumer.

A range of attitudinal, organisational and legislative barriers must be addressed to enable multidisciplinary teams to deliver integrated support and treatment. Investment into multidisciplinary teams supports improved mental health outcomes, utilises the workforce to their full scope, and facilitates sharing of knowledge and best practice. These are opportunities to incentivise multidisciplinary teams and working with colleagues across professions, for example, through enhanced funding arrangements through the Medicare Benefits Schedule.

There is also a need for disciplines to better understand how their scope of practice contributes to the overall work of the mental health workforce. This lack of understanding currently contributes to the siloed culture of mental health care and inversely, genuine integration and collaboration depends on mutual understanding and appreciation of the role of everyone involved. Further work will be required to integrate new and emerging workforces into the existing system. This will require, at a minimum, promotion of how these workers best work together and how to connect services.

	Actions
2.2.1	Address attitudinal, organisational and legislative barriers to effective use of multidisciplinary teams
2.2.2	Integrate the workforce and care pathways across the aged care, disability, alcohol and other drug and primary and tertiary health care settings

Provide evidence-based guidance to underpin workforce planning and the management of demand and surge capacity

Delivering appropriate evidence-based mental health interventions is critical to maximising workforce capacity, particularly within the context of increasing service demand and identified workforce shortages. Tailored workforce planning approaches require local community context, with opportunities to build on existing service strengths and capacity in the design of local workforce plans.

Opportunities exist to better utilise the vocationally trained workforce to support the transition of workers with comparable skills and experience to areas experiencing high demand and/or workforce shortages. This may include leveraging existing initiatives, including the Allied Health Rural Generalist Pathway, and Advanced Specialist Rural Generalist training for General Practitioners. By leveraging skills across health sectors and disciplines and recognising prior experience in the design of training and qualifications, the workforce is better positioned to respond to the changing needs of regions and consumers more broadly.

Innovative approaches may be employed to manage workforce surge requirements and immediately mobilise and allocate professionals to areas of need. This may include leveraging strategies employed during Australia’s response to the COVID-19 pandemic including the rapid mobilisation of non-practising and retired health practitioners, and exploring alternative service models, such as hub and spoke models of care, particularly in rural, regional and remote areas. Consideration must also be given to the role of technology to improve access to specialist mental health services in primary care, such as telehealth services and e-mental health programs, while also acknowledging current limitations and the preference of some individuals for face-to-face mental health services.

	Actions
2.3.1	Detail guidance to support system and local workforce planning, acknowledging best practice to reflect local context in the planning approach
2.3.2	Provide planning guidance to respond to high demand, surge requirements, and workforce shortages

Address workforce supply in rural and remote areas

The diversity of rural and remote areas across Australia and variations in supply and demand of skills mean that it is challenging to apply a universal workforce approach in all environments. Often there is a lack of interest from potential recruits in moving to these locations due to limited professional development, training, and career progression opportunities along with the change in lifestyle.

Operating in rural and remote contexts requires a specialised skill set which is often under recognised. This includes understanding the unique context of mental ill-health presentations, more targeted collaboration and communication capabilities, telehealth delivery and outreach services. There is opportunity to raise awareness of rural and remote mental health practise as an area of speciality and the value and benefits of working in rural and remote areas, and to clearly define how to become a rural practitioner.

The accessibility and availability of placement opportunities, including access to infrastructure in rural and remote areas, may be limited, presenting difficulties to attract and train an appropriately skilled workforce that can respond to local needs. Opportunities to attract people to rural and remote settings and retain them include supporting the education sector to expand workforce training and placement opportunities in regional, rural and remote communities; ensuring the rural and remote workforce is provided with timely and quality clinical supervision and support, particularly as they respond to complex, critical and severe mental illness; and putting in place infrastructure and community supports to encourage people to stay in the community.

	Actions
2.4.1	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
2.4.2	Incentivise the use of place-based approaches to training and professional development to help attract and retain workforce in rural and remote areas
2.4.3	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
2.4.4	Support initiatives to grow local mental health workforces, particularly in rural and remote settings. This includes expanding training and placement opportunities in regional, rural and remote areas to encourage students to undertake education and training, and remain in communities for employment
2.4.5	Develop a training and retention strategy for the rural and remote mental health workforce

Address workforce distribution across settings and between public, private and not-for-profit sectors

The mental health workforce is unevenly distributed across workforce settings and types and between the public, private and not-for-profit sectors. Workforce imbalances may be compounded in certain circumstances when professionals in short supply are concentrated in particular locations. This has consequences for the provision of mental health services that are consistent with the defining principles of best practice care and Australians' expectation of quality service.^{i,ix}

There are several opportunities to address workforce distribution across settings and between the public and private sectors.

- Improving the competitiveness and attractiveness of the public sector for health professionals.** There is a need to retain a strong and experienced public sector workforce to be able to provide accessible and affordable mental health services to individuals, regardless of their circumstance. Some health professionals (such as medicine) may view the private sector more favourably than the public sector due to preferable working conditions, more defined career pathways and training opportunities, and support structures. However, this is not representative of all health professions and occupations, such as for nursing, where public sector working conditions are more favourable to private settings. Opportunities exist to improve the competitiveness of the public sector to recruit and maintain an experienced public sector workforce, particularly in rural and remote locations. This includes facilitating and formalising career pathways; providing funded training and upskilling opportunities for staff regardless of level or position; improving working conditions, both monetary (remuneration) and non-monetary (flexible working arrangements, mentorship and leadership opportunities); assistance and outreach programs in rural and remote settings; and ensuring a more balanced resourcing profile across staffing levels. Other opportunities exist in improving the flexibility of employment arrangements to enable and encourage professionals to work in both public and private systems.
- Ensuring barriers and incentives are explored and considered for all mental health occupations.** While some challenges are shared across occupations (such as access to supervision and workforce shortages), it is important to recognise the distinct nature and challenges experienced by each mental health occupation, and the need to design targeted responses to address identified barriers.
- Adopting a capability-based approach to education, training and workforce development.** There is an opportunity to review current education, training, and workforce settings to identify where core competencies, capabilities and skills can be shared or created across and within disciplines to support a more mobile, adaptable and integrated workforce. Adopting a capability-based approach to education, training and workforce development may contribute to a better skill mix in addressing imbalances in workforce distribution, while helping to deliver services in response to changing population needs and consumer preferences.

	Actions
2.5.1	Improve the attractiveness of the public sector for health professionals through enhanced career pathways, training opportunities and working conditions
2.5.2	Review current education, training and workforce settings to identify where core competencies, capabilities and skills can be shared or created across and within disciplines

Strategic Pillar 3: Support and Retain

There is a need to support the mental health workforce and systematically address key issues that impact workforce retention. This requires the provision of supportive, safe and rewarding experiences and access to supervision, professional development and evidence-based approaches for self-care and harm minimisation.

Workplace health, safety and wellbeing is integral to retaining workers in the mental health sector. There is a need to recognise that working in the sector can involve challenges that mean employers need to take additional action to support their workforces. High levels of fatigue and burnout can result from workload levels and the stress of workplace violence, abuse and aggression. Unsuitable physical infrastructure, such as inaccessible buildings and locations, can limit the quality of support and treatment that can be provided, particularly in rural communities. There is a need for appropriate investment in both workforce size and quality of infrastructure to facilitate appropriate support and treatment.

There is an opportunity to create positive cultures through reducing administrative burdens, addressing causes of stress and burnout and improving employment stability and remuneration. Lack of access to quality supervision is another factor which impacts on employee satisfaction and willingness to stay within the mental health sector. Aligning remuneration to roles and responsibilities within and between occupations and across service settings can strengthen transparency and positively influence staff retention across the sector. An increase in remuneration would improve recruitment and retention and remunerate people adequately for the work they do.

Targeted collaboration and coordination across the mental health sector stakeholders, such as governments, peak bodies, employers, and the education and training sector, is required to increase access to continuous professional development, supervision and mentorship throughout all career stages.

Each of these components are further outlined below.

Support workplaces to create mentally healthy workplaces and adopt positive workplace cultures

Mental health workplaces with positive cultures both support worker wellbeing and enhance consumer health outcomes.^{xv} Positive workforce cultures also drive a more sustainable, efficient and cost-effective health system through increased workforce satisfaction, retention, reduced personal leave and reduced stigma about working in mental health careers.^{xvi}

The National Mental Health Commission's *Blueprint for Mentally Healthy Workplaces* outlines the core pillars and principles underpinning a nationally consistent approach to mentally healthy workplaces:^{xvii}

- **Protect.** Identify and manage work-related risks to mental health.
- **Respond.** Build capability to identify and respond to support people experiencing mental ill-health or distress.
- **Promote.** Recognise and enhance the positive aspects of work that contribute to good mental health.

The Blueprint acknowledges that organisations and businesses have legal obligations related to work health and safety that include psychological health, and details aspects of the above pillars, including:

- Psychosocial hazard identification and management
- Resilience training to support mental health during high-pressure situations

- Creating environments where people feel safe to raise concerns at work
- Strategies to address stigma within organisations
- Promoting help seeking and pathways to treatment
- Opportunities for personal and professional development
- Recognising and rewarding positive behaviours
- Opportunities for people to shape their work
- Connecting to meaning and purpose.

Further consideration must also be given to the safety of the physical environment in which the mental health workforce delivers treatment, care and support, and the need for a shift in the culture. Workplaces should also be supported and encouraged to employ a diverse mental health workforce, including provision of flexible working arrangements that support inclusion.

	Action
3.1.1	Develop initiatives to safeguard the wellbeing of the mental health workforce
3.1.2	Identify opportunities to invest in infrastructure to ensure mental health support and treatment is provided in environments which promote safety and wellbeing of workers
3.1.3	Promote the need to develop a culture of collaboration, trust, learning and accountability, and a platform where culture, values and attitudes are overtly prioritised in policies across all workforces and workplaces

Implement evidence-driven strategies to prevent and address worker stress and burnout

The mental health workforce’s exposure to multiple stressors and high-pressure environments can contribute to negative workplace culture in some services, particularly in the public sector. Stressors can include high workloads, overwork and stress from workplace shortages; resource limitations; fear of making clinical errors; and exposure to violence. Worker stress and burnout is a major driver of the attrition of the mental health workforce. Reported rates of burnout have increased across the sector during the COVID-19 pandemic.^{ix} Workplaces need to be equipped to better understand and recognise the factors driving stress and burnout, so that appropriate action can be taken to address these issues.

Increasing workloads, rapidly changing work environments, geographical isolation, insufficient practical support, inadequate operational guidance and lack of management conditions are some of the commonly cited reasons for workplace burnout, particularly among first responders and frontline workers. This was especially emphasised during the COVID-19 pandemic.^{xviii, xix} There is opportunity to support the workforce by building emerging and robust evidence into practice. For example, emerging practices such as Just and Restorative culture will be needed to build and sustain workforce resilience, support recovery and enable workplaces to better mitigate and manage events.

	Actions
3.2.1	Adopt evidence-based practice to promote self-care and manage incidents and recovery, and implement communities of practice to share insights and lessons learnt
3.2.2	Implement training and professional practices that support recognition and management of stress and burnout
3.2.3	Strengthen processes to consistently and regularly review workloads, assess risks and develop solutions

Increase access to, and use of, continuing professional development across all career stages

There is a close relationship between professionals having access to appropriate, high-quality support and their willingness to remain in the mental health workforce.^{xx} Continuous Professional Development (CPD), both formal and informal, will help the mental health workforce to maintain and enhance their skills and knowledge, as well as ensure consumers receive contemporary evidence-based treatment.

Current CPD arrangements are inconsistent across occupations, employers and service settings. Consideration must be given to mechanisms to enhance the commitment from providers to support workers to engage in CPD, including for professions that do not have CPD requirements associated with the maintenance of registration or practice. This requires the development of both occupation specific and general mental health workforce CPD, and mechanisms to support funding of training and supernumerary positions, including time away from practise required for CPD. Further, educator roles in allied health professions, First Nations mental health and Lived Experience (Peer) workers may drive equitable access to CPD for currently under-served groups.

The Mental Health Professional Online Development (MHPOD) learning portal is an evidence-based online learning resource for people working in or connected to mental health service delivery. Currently, there are more than 100 hours of material across 74 topics, written and produced in Australia. The topics range from recovery to legislation and dual disability. Each topic includes an overview, activity, in-practice section, and resources such as checklists, templates, or links to further information. The content of MHPOD is linked to the National Practice Standards for the Mental Health Workforce.^{xxi} There is further opportunity to build on MHPOD to centralise details of existing training and CPD opportunities available to the mental health workforce.

	Action
3.3.1	Encourage service providers to support staff access to continuing professional development throughout their careers
3.3.2	Develop equitable access to continuing professional development through establishing educator roles such as in allied health professions, First Nations mental health and Lived Experience (Peer) workers
3.3.3	Build on existing initiatives like MHPOD to centralise details of existing training and continuing professional development opportunities available to the mental health workforce on an ongoing basis

Increase supervision and mentoring across all career stages, including current and emerging leaders

While supervision is particularly important for the development of students and early-career professionals, it is also critical to the ongoing development of the mental health workforce, across all levels and in all roles. This includes the provision of supportive environments in which to practise new skills. Current barriers to accessing quality supervision vary across mental health occupations and professions. Some of these barriers include supervisors having insufficient time to devote to supporting students in their placements due to balancing increasing service delivery demands with supervisory commitments; understaffing; restrictions on the use of remote supervision for regional and rural students which limit access to supervisors located in metropolitan areas; and difficulties accessing discipline-specific supervision when roles are generalist or practises are emerging in nature, such as the Lived Experience (Peer) workforce. Opportunities exist to address current barriers and increase the number of supervisors across the mental health sector through targeted interventions. These include supporting supervisors to continue accessing training and professional development; ensuring career pathways are transparent and recognise the value and importance of experience in providing supervision to early career professionals; and increasing funding and incentives to increase the availability of discipline specific supervision. Additionally, it is necessary to review supervision guidelines and specify support requirements to drive consistent access to supervision. This requires consideration of opportunities to increase access for regional, rural and remote workers.

Access to formal mentoring across all career stages provides a mechanism to strengthen career pathways and support retention of the mental health workforce. For future leaders, formal career pathways and defined role structures that balance professionals' practice or clinical workload with supervisory and leadership commitments will support development of leadership capability and capacity.

	Action
3.4.1	Review guidelines for supervision and specify support requirements for those in the mental health workforce, with consideration of access barriers for regional, rural and remote workers
3.4.2	Strengthen access to formal mentoring across all career stages, including approaches to foster future leaders

Adopt funding models and arrangements that drive quality of care and promote retention

Several key considerations relate to the use of funding reform to support workforce retention, including:

- **Employment stability.** The length of funding contracts and service delivery funding eligibility impacts on workforce attraction and retention. Short term funding contracts that inhibit the ability for providers to support full time and secure employment arrangements are prevalent in the community mental health sector.^{xii} There is a need for longer term funding contracts to provide certainty to providers to plan for an ongoing workforce and offer employment security through longer term employment arrangements, and where possible permanent positions.
- **Support for ongoing learning.** There may be opportunities to embed funding in service contracts to support CPD of workers throughout their careers.
- **Regional, rural and remote incentives.** There are opportunities to implement approaches to build, retain and incentivise mental health professionals to provide services in regional, rural and remote areas settings through funding levers. Consideration must also be given to incentivising

and improving rural traineeships and placements, including access to supervision and support, to improve placement experiences of students and trainees, and increase the likelihood of maintaining careers in these settings.

- Multidisciplinary service models.** Collaborative arrangements are important in providing multidisciplinary service models that are able to maximise the use of different workforce roles. There is a need to introduce incentives including enhanced payment structures to facilitate increased communication between professions and across disciplines.

	Action
3.5.1	Develop longer minimum service contract lengths for commissioned mental health services, including in rural and remote areas
3.5.2	Identify opportunities to embed funding in service contracts to support continued professional development, and incentives to build and retain the regional, rural and remote workforce
3.5.3	Identify funding arrangements to encourage greater collaboration across the mental health sector, including by occupation, setting and specialisation

Strategic Pillar 4: Data, Planning, Evaluation and Technology

The mental health workforce will require a range of supporting structures to deliver services that meet the needs of the population across service settings. These include access to and use of high-quality data, workforce planning, monitoring and evaluation, and digital technology.

Data, planning, evaluation and technology are key supporting structures to develop and utilise a mental health workforce that is enabled to meet the needs of the communities they serve. Currently, several barriers exist across these supporting structures.

There is a current lack of comprehensive, high quality, and up to date data available for the mental health sector from the number of skilled professionals and occupations and the mental health care support provided by the broader health workforce, through to current and forecast service demand. This impedes the ability to make informed, evidence-based workforce planning decisions in responding to immediate and future workforce shortages. It also limits the ability to design targeted policy interventions at national, regional and local levels that address forecasted service demand and workforce needs. Additionally, available mental health datasets are typically unintegrated, and may be inaccessible to certain stakeholders, limiting the ability to derive meaningful insights to inform workforce planning and service development. Data limitations are particularly evident for emerging and under-recognised sections of the workforce, such as SEWB, First Nations and Lived Experience (Peer) workforces.

The evaluation and monitoring of workforce initiatives is critical in ensuring they are relevant and continue to meet community needs and program objectives. However, workforce development initiatives and outcomes are not reviewed consistently, limiting the ability to understand and apply meaningful insights and lessons learned from previous programs to inform the development of future interventions. Additionally, there is a lack of consistent evaluative measures to determine what is and is not effective in which service settings.

The delivery of mental health services using digital technology is currently limited to specific circumstances and service settings, limiting the flexibility of the workforce to adapt and offer blended care models to meet growing service demand. Current factors cited by stakeholders include a lack of digital literacy, unavailability of digital infrastructure and resources, and preferences for face-to-face services. These barriers are present for both the workforce and consumers alike. There is a need to focus on upskilling the workforce in the use and adoption of digital technologies, both available (telehealth) and emerging technologies, to offer more blended care models and respond to service demand and consumer expectations of service delivery.

Key opportunities for improving support structures are described below.

Collaborate with consumers, carers and service providers in planning, monitoring and evaluation processes

Mental health workforce planning must be coordinated, collaborative, and reflect the diverse perspectives of consumers, carers and service providers in its design and implementation.

Engagement and co-design with consumers, carers and service providers is crucial to ensure mental health services meet population needs and guide the development of the mental health workforce. Opportunities exist to better coordinate national and local planning processes, recognising and prioritising the local context and perspectives of community members. Both top-down and bottom-up planning

approaches are needed to enable a shared understanding of training and development requirements, workforce needs and supports available across settings.

There is a need to focus on engaging emerging workforce groups in workforce development to ensure planning and services are inclusive and culturally safe. For example, engagement and collaboration with the Lived Experience (Peer) workforce will be important in developing tailored training and professional development requirements that recognise this group’s unique and growing contribution to the mental health workforce.

Opportunities also exist to increase engagement and collaboration with First Nations Elders, traditional healers and First Nations mental health workers in workforce planning processes and service design to ensure services are culturally safe.

	Actions
4.1.1	Collaborate with consumers, carers and service providers in planning, monitoring and evaluation processes
4.1.2	Identify opportunities to better engage the Lived Experience (Peer) workforce and First Nations people in workforce planning to ensure services are inclusive and culturally safe

Use data to support workforce and service planning, including demand and surge management

The use of data in workforce planning is key to enable evidence-based, targeted and appropriate responses to workforce needs.^{xxii} Data must be comprehensive, up to date, and integrated across all aspects of the mental health workforce lifecycle—from training through to service demand—to highlight workforce requirements and future opportunities. This will enable better understanding and planning of workforce opportunities, and can inform the design of targeted policy responses, such as addressing future workforce needs through interventions in the education and training sector.

Opportunities exist to review the structure and scope of current data collection approaches to ensure data can provide the insights required to inform current and future workforce responses. For example, data should be able to enable appropriate analysis to understand the availability of skills and interventions compared to the service context. Opportunities for combining existing data collection methods and tools with alternative methods should be investigated to enable a comprehensive view, and to more accurately forecast mental health workforce needs.

There is a need to review data access requirements and coordinate data collection activities across government departments and jurisdictions (such as investigating the use of universal data sets) to address known data gaps and variations. Consideration must also be given to expanding access to other sector stakeholders (such as to community-controlled services) to enable proactive planning and service design in identifying future workforce needs, including for early intervention. Expertise across the Australian Government and state and territory government agencies should be leveraged to enable a comprehensive view of workforce requirements, and to ensure that data and forecasts account for workforce demand in other care sectors, such as disability and aged care. This will enable utilisation of multidisciplinary skills across disciplines and service settings.

	Action
4.2.1	Review data collection approaches to ensure data can appropriately inform mental health workforce planning, and identify the need for new data collection approaches, tools and methods
4.2.2	Support the use of mental health workforce data by making it publicly accessible in a manner that is useful for informing mental health workforce planning and support development of meaningful government interventions to better match workforce demand and supply across occupations and settings

Improve data governance, quality, collection and utilisation, including addressing data gaps

A nationally consistent approach to data is imperative to facilitate improved workforce planning and the delivery of mental health services that meet the needs of consumers and carers. There is opportunity within the system to enhance comprehensive data collection. This includes creating a nationally consistent approach that adopts a broad definition of the mental health workforce that includes people who work in health and social service settings; increasing access to timely and high quality data about the entire mental health workforce, including data on occupations not regulated through the Australian Health Practitioner Regulation Agency (AHPRA); and collecting and utilising information about local service need and scopes of practice including skills and competencies by occupation. These strategies in turn will inform evidence-based interventions to address workforce gaps and shortages, whether it is by increasing the number of workers in particular occupations, utilising an existing workforce to its full scope of practice, or supporting skills transfer.

Improved data collection is also necessary to better understand the pipeline from education into employment. In turn, this will inform curricula design and incentives to increase enrolment rates to match workforce shortages. Data collection should include student enrolments and mental health course completion, graduate employment roles, service context of placements, and data on private practice, including the mix with public practice, to better understand levels of dual practice.

Data collection efforts will become more complex as the mental health workforce becomes more diverse. Organisations will need to be supported through streamlined, innovative and flexible approaches to data collection and analysis to minimise the burden of data collection as well as to get a clear sense of contributions and impacts from different workforce types including Lived Experience (Peer) workforce, SEWB workforce, and new and emerging workforces.^{xiv} Similarly, it is necessary to enhance and in some cases enable data sharing capabilities so that organisations and stakeholders can access data in a streamlined way, without compromising on data quality or security.

	Action
4.3.1	Define what data is required, for what purpose, where data is currently held and what additional collections are required to improve reliability, accessibility and comprehensiveness
4.3.2	Support data collection and consolidation at organisation, state and territory and national levels

Evaluate workforce initiatives and monitor outcomes to drive continuous improvement

Workforce development initiatives must be regularly monitored and evaluated to ensure they are effective, relevant and continue to achieve intended outcomes. Monitoring and evaluation also drive continuous learning to be applied in future policy responses and service design and provide an evidence base to support decision making and direct investment to areas where it is likely to have the greatest impact.

There is a need to strengthen monitoring and evaluation of mental health workforce initiatives to determine what is and is not effective across settings. Opportunities exist to build monitoring and evaluation into the design of workforce initiatives to measure impact and drive continuous improvement. Additionally, innovative approaches to monitoring, evaluating and researching emerging workforces (for example, Lived Experience and SEWB workforces) should be adopted to build the evidence base, and recognise the diversity and growing contribution of these workforces.

Existing governance structures, roles and reporting functions should be reviewed to drive accountability in monitoring and evaluation. Opportunities exist to embed monitoring and evaluation in national plans and agreements, providing individual and collective accountability against outcomes. This will require an agreed set of indicators or measures that can be tracked over time. Oversight and coordination roles within the Australian Government and state and territory governments should be reviewed and/or established, tasked with monitoring and reporting on workforce data to determine the extent to which services are meeting needs, both at the service and geographical level. Further, there is an opportunity to establish reporting processes from the Australian Government and state and territory governments to monitor, evaluate and drive accountability for the implementation and outcomes of the National Mental Health Workforce Strategy.

	Actions
4.4.1	Build monitoring and evaluation into the design of mental health workforce initiatives, including initiatives relating to Lived Experience (Peer), First Nations, SEWB and emerging workforces to enable ongoing evaluation and continuous improvement practices
4.4.2	Define roles and responsibilities for the ongoing management of monitoring and evaluation activities, including reporting on outcomes

Improve access to digital technology and support greater digital inclusion

The mental health workforce will need to be flexible and able to adapt to the changes in industry and needs of the population overtime. Delivering telehealth, utilising digital technology and delivering digital mental health are becoming increasingly important. There is a need to enhance the digital literacy of the workforce to support the delivery of digital mental health services. Education on digital mental health service delivery should be at the centre of training programs and resources provided to mental health professionals, including Lived Experience (Peer) workers, emerging workforces and the SEWB workforce. Encouraging greater adoption of digital mental health services may also require improvements to technology and infrastructure so that all workforces have equal access, including those in regional, rural and remote areas.

The mental health workforce will, overtime, need the skills and confidence to keep up with changing consumer preferences. This includes the ability to provide blended models of care, where online treatment is combined with face-to-face treatment. There is a need to increase understanding and awareness of digital mental health services to build workforce trust and confidence to adopt and integrate digitally enabled models of care into existing treatment pathways. This includes awareness of the full

breadth of available digital mental health services, different treatment modalities and access channels, and acceptability and efficiency of digital services and blended models of care for the general population and specific groups. Equally, it is important that health professionals are educated on how to manage consumer privacy and confidentiality when using digital services.

Integration between digital platforms and information systems has clear benefits including the reduced need for consumers to repeat their medical history, transfer of data and information and less duplication. There is an opportunity to increase interoperability of digital platforms and information systems that comply with the Digital Service Standard. Strategies include facilitating greater sharing of research, data and information across services providers to reduce time taken to find information, and adopting funding models and incentives that encourage interoperability.

	Actions
4.5.1	Ensure training programs improve the health literacy, including digital health literacy, of all mental health care professionals
4.5.2	Develop and implement training programs to raise awareness of digital mental health services and guidance on best practice adoption of digital services and blended models of care
4.5.3	Implement the national digital mental health framework and clearly define practice guidelines relating to digital mental health service delivery, including safety and quality parameters for service users and providers
4.5.4	Identify opportunities to invest in technology and new services to enhance interoperability and greater sector collaboration

Implementation and measuring success

Governance

Implementation of the Strategy will be shared. The Strategy recognises the need for greater collaboration and coordination within and across levels of government to agree funding, monitoring and accountability for implementation. Action will be guided by this Strategy, the National Agreement and other key reports guiding mental health and suicide prevention system reform (Appendix B).

Under this Strategy, the Australian Government will continue to lead and coordinate activities to further grow and develop the mental health workforce. However, everyone has a role to play. Governments, regulators, peak bodies, professional colleges, training and education providers, and consumers and carers must work together to realise the Strategy's vision and goals.

The Australian Government has established a national governance structure to support strategic collaboration on the Strategy's implementation and provide implementation oversight, including monitoring and evaluation – the Mental Health Workforce Working Group (Working Group). The Working Group will be made up of representatives from all governments and those with a lived or living experience, who will be responsible for taking forward workforce actions under the National Agreement. The Working Group will accommodate the establishment of working groups targeted at priority areas for action, and

will work closely with representatives from the mental health sector as needed to progress its work.

Through the National Agreement, the mental health workforce is identified as a national priority. Parties have agreed to work in partnership to implement the Strategy, and have identified psychiatry, psychology, mental health nursing, First Nations mental health and suicide prevention workers, Lived Experience (Peer) workers, and other relevant allied health workers as professions requiring immediate action

Roles and responsibilities

The key roles and responsibilities include:

- **Commonwealth, state and territory governments** – all Australian governments have a shared responsibility to ensure equitable access to effective mental health and suicide prevention services for all Australians. The National Agreement describes the roles and responsibilities of all governments, both individual and shared, to ensure a sustainable, sufficient and appropriately skilled supply of mental health workers.
- **Education providers** – are responsible for developing, designing and delivering education and training programs, including co-design initiatives involving peak bodies and other relevant groups, to appropriately educate and train the mental health workforce.
- **Australian Health Practitioner Regulation Agency (AHPRA) and National Boards** – are responsible for setting standards and policies that all AHPRA-registered health practitioners must meet.
- **Professional peak bodies, colleges and unions** – are responsible for representing and supporting members. Professional peak bodies and colleges also define training and education

standards, continuing professional development requirements and administer self-regulated occupational schemes, and share practice expertise.

- **Health and community service providers, including Aboriginal Community Controlled Health Organisations (ACCHOs), and practitioners** – are responsible for delivering support and treatment, employment, supervision and support to attract and retain the mental health workforce.
- **Consumer and carer organisations** – represent people with lived experience of mental ill-health or suicide and are critical to ensure the needs and preferences of consumers and carers are central to actions taken to grow and support the mental health workforce.

Implementation Roadmap

The Implementation Roadmap is intended to be a guide and identifies short, medium and long-term priorities and actions to guide implementation activities (see Table 1). It also identifies stakeholders that have a role in the delivery of each action underpinning key priority areas, including the Australian Government, state and territory governments, training and education providers, peak bodies and professional colleges, and service providers and workplaces.

Implementation plans will:

- be progressively developed under the oversight of the national governance mechanism and in line with the Strategic Pillars outlined in this Strategy
- be guided by the Implementation Roadmap and actions identified in this Strategy, ensuring actions complement other national workforce strategies where relevant
- be developed for priority professions as identified in the National Agreement
- provide an avenue to coordinate, target and partner on initiatives, maximising the benefit of collective efforts and investment
- consider the evidence-base available or needed for activities/interventions in producing the outcomes required to meet the goals of the Strategy
- identify who will lead each activity (for example, those driven centrally by the Australian Government and those led by individual states and territories)
- embed monitoring and evaluation requirements
- help guide future investment in the mental health workforce.

Monitoring and evaluation

The overall success of the Strategy in achieving its vision and goals will be measured against two overarching indicators:

- Growth and distribution of the mental health workforce, and
- Satisfaction and wellbeing of the workforce.

The overarching indicators will guide monitoring and evaluation and provide a nationally consistent way to report against progress of the Strategy. The Australian Government will work with state and territory governments and other key stakeholders such as regulators, peak bodies, professional colleges, training and education providers, and consumers and carers to identify appropriate data sources and metrics to measure these indicators, including a range of quantitative and qualitative mechanisms. These may include the following:

- Evaluation of each implementation action plan to enable incremental measures of progress and identify areas of strength and areas where more work needs to be done to achieve the goals of the Strategy
- Defining and assessing progress against targets and key performance indicators
- Regular snapshots which provide point-in-time assessments of the mental health workforce and re-baselining the demand and supply models to revise future forecasts
- Regular assessment of the impacts of new policy on the demand and supply of the mental health workforce
- In-depth evaluation of major initiatives or reforms, particularly where the cost of implementation is high, or the activity is particularly sensitive or untested
- A mid-term review and an overall evaluation of the Strategy in its final year.

Table 1: Implementation Roadmap

Priority areas	Timeline	Actions	Australian Government	States and Territories	Training and Education Providers	Peak Bodies/Colleges	Service Providers / Workplaces
Strategic Pillar 1: Attract and Train							
Address critical shortages in the mental health workforce	1–2 years	Address critical medical, nursing and allied workforce shortages with an initial focus on priority professions as agreed in the National Agreement – psychiatry, psychology, mental health nursing, and other relevant allied health professions	✓	✓	✓	✓	
	1–2 years	Examine innovative service delivery models that support increased engagement of the Lived Experience (Peer) and First Nations workforces in different contexts	✓	✓		✓	
	3–5 years	Establish educator roles to support the further development of the Lived Experience (Peer) Workforce and First Nations mental health workforce	✓	✓	✓		✓
	3–5 years	Support First Nations organisations to develop and deliver training in cultural safety, trauma informed and trauma competent care	✓	✓	✓		✓
	3–5 years	Collaborate with consumer, carer and Lived Experience (Peer) worker representatives to support establishment of a national Lived Experience (Peer) workforce peak organisation	✓	✓		✓	
	3–5 years	Develop broader training models for the Lived Experience (Peer) workforce to develop skills and capabilities			✓		
	3–5 years	Create incentives for employers to increase the numbers of designated Lived Experience (Peer) employees across all organisational levels	✓	✓			✓
	3–5 years	Support First Nations people and people with lived experience to complete mental health education and training programs with 'wrap around services'	✓	✓	✓		
	3–5 years	Define the competencies required by emerging and self-regulated workforces to deliver evidence-based suicide prevention, mental health promotion, treatment, support and care	✓	✓			
	Mobilise the broader social and emotional wellbeing and health workforce	3–5 years	Review and clearly define the scopes of practice of the broader social and emotional wellbeing and health workforce	✓	✓		✓

Priority areas	Timeline	Actions	Australian Government	States and Territories	Training and Education Providers	Peak Bodies/Colleges	Service Providers / Workplaces
	3–5 years	Support service models that enable integration of the social and emotional wellbeing and health workforce into existing service systems	✓	✓			✓
Promote mental health careers as an attractive career choice	1–2 years	Raise the awareness of pathways into, and within, the mental health workforce for both vocational and higher education trained occupations including across work settings	✓	✓	✓		✓
	1–2 years	Address stigma and negative perceptions associated with working in mental health	✓	✓		✓	✓
	1–2 years	Create positive perceptions of working in mental health by improving the pre-service and/or postgraduate placement experience of students and trainees	✓	✓	✓		✓
Develop and deliver recruitment and career pathways to attract a suitably skilled and diverse workforce	1–2 years	Develop and implement mental health career pathways within and between mental health and health service settings	✓	✓	✓	✓	✓
	3–5 years	Collaborate with the education sector to strengthen recruitment pathways	✓	✓	✓		✓
	3–5 years	Recruit people from regional, rural and remote communities to access and complete mental health education and training programs			✓		✓
	6–10 years	Strengthen recruitment and integration support pathways for overseas trained health professionals	✓				✓
Enhance training pathways, access to supervision, and support skills transfer	1–2 years	Identify opportunities to prioritise access to training for the mental health workforce through increased subsidies and use of placements and traineeships	✓	✓	✓		
	1–2 years	Support the development of basic mental health skills in the broader health workforce	✓	✓	✓		✓
	1–2 years	Support the development of basic mental health skills in the social and community services workforce and professions	✓	✓	✓		✓
	3–5 years	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	✓	✓	✓		✓
	3–5 years	Ensure mental health students and trainees undertake mental health placements and internships across a more representative mix of settings, including clinical and non-clinical settings	✓	✓			✓
	3–5 years	Increase the supply of education and training programs for both vocational and higher education trained occupations, including programs outside metropolitan areas	✓		✓		
	3–5 years	Develop training modules that build competencies for the provision of culturally safe, integrated and			✓		

Priority areas	Timeline	Actions	Australian Government	States and Territories	Training and Education Providers	Peak Bodies/Colleges	Service Providers / Workplaces
		multidisciplinary care					
	3–5 years	Develop training modules that build capability in suicide prevention of all the mental health workforce			✓		
	3–5 years	Support education providers to maintain, when appropriate, a combination of onsite and remote training and education opportunities	✓	✓	✓		
	3–5 years	Review funding arrangements for education and training providers to enable delivery of micro-credentialing course work	✓	✓	✓		
Strengthen the capability and core competencies of the workforce to recognise and respond to community need	1–2 years	Support the mental health workforce to upskill in and respond to co-occurring alcohol and other drug addiction.	✓	✓	✓	✓	✓
	1–2 years	Support the alcohol and other drug workforce to upskill in and respond to co-occurring mental ill-health	✓	✓	✓	✓	✓
	3–5 years	Identify components of care (subsets of models of care) that meet the needs of consumers and carers and develop cultural safety education and training for all mental health workforces			✓	✓	
	3–5 years	Support First Nations, CALD, LGBTQIA+SB and disability led initiatives to grow and develop the mental health workforce to meet the needs of their patients and communities	✓	✓		✓	
	6–10 years	Support higher education providers to embed the Aboriginal and Torres Strait Islander Health Curriculum Framework into higher education curricula for a broad range of undergraduate and graduate courses and health social service career pathways	✓	✓	✓		
Strategic Pillar 2: Maximise, Distribute and Connect							
Enable the workforce to expand and work to the top of their scope and enhance regulatory arrangements to strengthen the safety and quality of care	3–5 years	Develop and refine nationally consistent scopes of practice across occupations and between jurisdictions that reflect the components of care and competencies required to deliver them, recognising discipline—specific contributions and multidisciplinary care	✓	✓		✓	
	3–5 years	Review regulatory arrangements to ensure the appropriate approach is in place to ensure consumer and carer safety, given each occupation’s scope of practice	✓	✓			
	3–5 years	Create incentives for service providers to use service delivery models that utilise the competencies of all workforces to their full scopes of practice	✓	✓			
	6–10 years	Establish roles and career paths that reflect effective use of multidisciplinary teams within nationally consistent scopes of practice and enable workers from each occupation to work to the top of their scope of practice	✓	✓		✓	

Priority areas	Timeline	Actions	Australian Government	States and Territories	Training and Education Providers	Peak Bodies/Colleges	Service Providers / Workplaces
Strengthen coordinated care, collaboration and multidisciplinary ways of working within and between the mental health, wider health and social service workforces	3–5 years	Address attitudinal, organisational and legislative barriers to effective use of multidisciplinary teams	✓	✓			✓
	6–10 years	Integrate the workforce and care pathways across the aged care, disability, alcohol and other drug and primary and tertiary health care settings	✓	✓			✓
Provide evidence-based guidance to underpin workforce planning and the management of demand and surge capacity	3–5 years	Detail guidance to support system and local workforce planning, acknowledging best practice to reflect local context in the planning approach	✓	✓			
	3–5 years	Provide planning guidance to respond to high demand, surge requirements, and workforce shortages	✓	✓			
Address workforce supply in rural and remote areas	1–2 years	Support initiatives to grow local mental health workforces, particularly in rural and remote settings. This includes expanding training and placement opportunities in regional, rural and remote areas to encourage students to undertake education and training, and remain in communities for employment	✓	✓	✓		
	1–2 years	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	✓	✓	✓		
	3–5 years	Develop a training and retention strategy for the rural and remote mental health workforce	✓		✓		
	3–5 years	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	✓	✓	✓		
	3–5 years	Incentivise the use of place-based approaches to training and professional development to help attract and retain workforce in rural and remote areas	✓	✓	✓		
Address workforce distribution across settings and between	3–5 years	Review current education, training, and workforce settings to identify where core competencies, capabilities and skills can be shared or created across and within disciplines	✓		✓		✓
	3–5 years	Improve the attractiveness of the public sector for health professionals through enhanced career pathways, training opportunities and working conditions	✓	✓		✓	✓
Strategic Pillar 3: Support and Retain							
Support workplaces to create mentally healthy workplaces and adopt positive workplace cultures	1–2 years	Develop initiatives to safeguard the wellbeing of the mental health workforce	✓	✓			✓

	Timeline	Actions	Australian Government	States and Territories	Training and Education Providers	Peak Bodies/Colleges	Service Providers / Workplaces
	3–5 years	Promote the need to develop a culture of collaboration, trust, learning and accountability, and a platform where culture, values and attitudes are overtly prioritised in policies across all workforces and workplaces	✓	✓		✓	✓
	3–5 years	Identify opportunities to invest in infrastructure to ensure mental health support and treatment is provided in environments which promote safety and wellbeing of workers	✓	✓			✓
Implement evidence-driven strategies to prevent and address worker stress and	1–2 years	Adopt evidence-based practice to promote self-care and manage incidents and recovery, and implement communities of practice to share insights and lessons learnt	✓	✓			✓
	1–2 years	Strengthen processes to consistently and regularly review workloads, assess risks and develop solutions					✓
	3–5 years	Implement training and professional practices that support recognition and management of stress and burnout					✓
Increase access to, and use of, continuing professional development across all career stages	1–2 years	Encourage service providers to support staff access to continuing professional development throughout their careers	✓	✓	✓		✓
	1–2 years	Build on existing initiatives like the Mental Health Professional Online Development (MHPD) to centralise details of existing training and continuing professional development opportunities available to the mental health workforce on an ongoing basis	✓	✓	✓		
	3–5 years	Develop equitable access to continuing professional development through establishing educator roles such as in allied health professions, First Nations mental health and Lived Experience (Peer) workers			✓		✓
Increase supervision and mentoring across all career stages, including current and emerging leaders	1–2 years	Review guidelines for supervision and specify support requirements for those in the mental health workforce, with consideration of access barriers for regional, rural and remote workers	✓		✓	✓	✓
	1–2 years	Strengthen access to formal mentoring across all career stages, including approaches to foster future leaders				✓	✓
Adopt funding models and arrangements that drive quality of care and promote retention	1–2 years	Develop longer minimum service contract lengths for commissioned mental health services, including in rural and remote areas	✓	✓			
	3–5 years	Identify opportunities to embed funding in service contracts to support continued professional development, and incentives to build and retain the regional, rural and remote workforce	✓	✓			
	6–10 years	Identify funding arrangements to encourage greater collaboration across the mental health sector, including by occupation, setting and specialisation	✓	✓			
Strategic Pillar 4: Data, Planning, Evaluation and Technology							

Priority areas	Timeline	Actions	Australian Government	States and Territories	Training and Education Providers	Peak Bodies/Colleges	Service Providers / Workplaces
Collaborate with consumers, carers and service providers in planning, monitoring and evaluation processes	1–2 years	Collaborate with consumers, carers and service providers in planning, monitoring and evaluation processes	✓	✓		✓	✓
	3–5 years	Identify opportunities to better engage the Lived Experience (Peer) workforce and First Nations people in workforce planning to ensure services are inclusive and culturally safe	✓	✓		✓	✓
Use data to support workforce and service planning, including demand and surge management	3–5 years	Review data collection approaches to ensure data can appropriately inform mental health workforce planning, and identify the need for new data collection approaches, tools and methods	✓	✓		✓	✓
	3–5 years	Support the use of mental health workforce data by making it publicly accessible in a manner that is useful for informing mental health workforce planning and support development of meaningful government interventions to better match workforce demand and supply across occupations and settings	✓	✓			
Improve data governance, quality, collection and utilisation, including addressing data gaps	1–2 years	Define what data is required, for what purpose, where data is currently held and what additional collections are required to improve reliability, accessibility and comprehensiveness	✓	✓			
	3–5 years	Support data collection and consolidation at organisation, state/territory and national levels	✓	✓			
Evaluate workforce initiatives and monitor outcomes to drive continuous improvement	1–2 years	Define roles and responsibilities for the ongoing management of monitoring and evaluation activities, including reporting on outcomes	✓	✓			
	3–5 years	Build monitoring and evaluation into the design of mental health workforce initiatives, including initiatives relating to Lived Experience (Peer), First Nations, SEWB and emerging workforces to enable ongoing evaluation and continuous improvement practices	✓	✓			✓
Improve access to digital technology and support greater digital inclusion	3–5 years	Identify opportunities to invest in technology and new services to enhance interoperability and greater sector collaboration	✓	✓			
	3–5 years	Ensure training programs improve the health literacy, including digital health literacy, of all mental health care professionals	✓		✓		
	3–5 years	Develop and implement training programs to raise awareness of digital mental health services and guidance on best practice adoption of digital services and blended models of care	✓		✓		✓
	3–5 years	Implement the national digital mental health framework and clearly define practice guidelines relating to digital mental health service delivery, including safety and quality parameters for service users and providers	✓				

Appendix A. Taskforce Terms of Reference and Membership

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 Australian Government 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 First Nations 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 First Nations people, CALD communities and LGBTIQ+SB 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, and
- Provide recommendations on how to strengthen data on the mental health workforce.

Taskforce membership

Role/Organisation	Member/s
Co-Chair	Jennifer Taylor PSM
Co-Chair	Thomas Brideson
Australian Government Department of Health	Mark Roddam
National Mental Health Commission	Christine Morgan / Lydall Soper
Royal Australian College of General Practitioners	Michael Tam / Morton Rawlin
Royal Australian and New Zealand College of Psychiatrists	John Allan
Australian College of Mental Health Nurses	Stephen Jackson
Australian Psychological Society	Ros Knight / Tamara Cavenett
Mental Health Australia	Harry Lovelock / Leanne Beagley
Community Mental Health Australia	Bill Gye
Peer workforce representative	Margaret Doherty
Northern Territory Primary Health Network	Le Smith
National Rural Health Alliance	Gabrielle O'Kane
Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project	Faye McMillan
Carer representative	Peter Heggie
Consumer representative	Heather Nowak
Labour market expert	Jeff Borland
Australian Council of Deans of Health Sciences	Genevieve Pepin
Chief Psychiatrist, South Australia Department of Health and Wellbeing	John Brayley
NSW Ministry of Health	Tricia O'Riordan
Australian Register of Counsellors and Psychotherapists	Di Stow

Appendix B. Policy Context

Mental Health and Suicide Prevention Strategies and Plans

- ***The Fifth National Mental Health and Suicide Prevention Plan*** (2017) which commits all governments to integrated mental health and suicide prevention action to 2022.
- ***Vision 2030 Blueprint*** (2019) which shapes a national direction for mental health and wellbeing through a unified system that takes a whole-of-community, whole-of-life and person-centred approach to mental health.
- ***The National Mental Health and Suicide Prevention Plan*** (2021) is the Australian Government's commitment to mental health reform and responds to recommendations from the Productivity Commission Inquiry Report on Mental Health and the National Suicide Prevention Adviser's Final Advice, as well as the Royal Commission into Victoria's Mental Health System.
- **The National Mental Health and Suicide Prevention Agreement (National Agreement)** (2022) provides a platform for all governments to work together to build a better mental health and suicide prevention system for all Australians.

Guiding Mental Health and Suicide Prevention System Reform

- ***Productivity Commission Inquiry Report on Mental Health*** (2020) which examined 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.
- ***National Suicide Prevention Adviser's Final Advice*** (2021) which recommends all governments commit to prioritising evidence based and compassion-focused workforce development to drive cultural change in and improve the capacity and capability of all (formal and informal) workforces involved in suicide prevention.
- ***Royal Commission into Victoria's Mental Health System - Final Report*** (2021) which highlights existing service gaps, fragmentation and disconnects between part of the system, and stigma and discrimination that impact people's ability to access the right care at the right time.
- ***House of Representatives Select Committee on Mental Health and Suicide Prevention - Final Report*** (2021) which highlights how mental health care could be better delivered, funded and recognised in Australia. It presents the recommendations of an inquiry into the mental health system and its workforce, in light of the 2019 bushfires and the COVID-19 pandemic.

Appendix C. List of actions by strategic pillar

Strategic pillar 1: Attract and Train	
Priority Area	Actions
<i>Address critical shortages in the mental health workforce</i>	<ul style="list-style-type: none"> • Address critical medical, nursing and allied health workforce shortages with an initial focus on priority professions as agreed in the National Agreement— psychiatry, psychology, mental health nursing, and other relevant allied health professions • Examine innovative service delivery models to support increased engagement of the Lived Experience (Peer) and First Nations workforces in different contexts • Establish educator roles to support the further development of the Lived Experience (Peer) Workforce and First Nations mental health workforce • Collaborate with consumer, carer and Lived Experience (Peer) worker representatives to support establishment of a national Lived Experience (Peer) workforce peak organisation • Develop broader training models for the Lived Experience (Peer) workforce to develop skills and capabilities • Create incentives for employers to increase the numbers of designated Lived Experience (Peer) employees across all organisational levels • Support First Nations people and people with lived experience to complete mental health education and training programs with ‘wrap around services’ • Support First Nations organisations to develop and deliver training in cultural safety, trauma informed and trauma competent care • Define the competencies required by emerging and self-regulated workforces to deliver evidence-based suicide prevention, mental health promotion, treatment, support and care
<i>Mobilise the broader social and emotional wellbeing and health workforce</i>	<ul style="list-style-type: none"> • Review and clearly define the scopes of practice of the broader social and emotional wellbeing and health workforce • Support service models that enable integration of the social and emotional wellbeing and health workforce into existing service systems

Strategic pillar 1: Attract and Train	
Priority Area	Actions
<i>Promote mental health careers as an attractive career choice</i>	<ul style="list-style-type: none"> ● Raise the awareness of pathways into, and within, the mental health workforce for both vocational and higher education trained occupations including across work settings ● Address stigma and negative perceptions associated with working in mental health ● Create positive perceptions of working in mental health by improving the pre-service and/or postgraduate placement experience of students and trainees
<i>Develop and deliver recruitment and career pathways to attract a suitably skilled and diverse workforce</i>	<ul style="list-style-type: none"> ● Collaborate with the education sector to strengthen recruitment pathways ● Recruit people from regional, rural and remote communities to access and complete mental health education and training programs ● Strengthen recruitment and integration support pathways for overseas trained health professionals ● Develop and implement mental health career pathways within and between mental health and health service settings
<i>Enhance training pathways, access to supervision, and support skills transfer</i>	<ul style="list-style-type: none"> ● Develop training modules that build competencies for the provision of culturally safe, integrated and multidisciplinary care ● Develop training modules that build capability in suicide prevention of all the mental health workforce ● Increase the supply of education and training programs for both vocational and higher education trained occupations, including programs outside of metropolitan areas ● Identify opportunities to prioritise access to training for the mental health workforce through increased subsidies and use of placements and traineeships ● 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 ● Support education providers to maintain, when appropriate, a combination of onsite and remote training and education opportunities ● Ensure mental health students and trainees undertake mental health placements and internships across a more representative mix of settings, including clinical and non-clinical settings

Strategic pillar 1: Attract and Train	
Priority Area	Actions
	<ul style="list-style-type: none"> • Support the development of basic mental health skills in the social and community services workforce and professions • Support the development of basic mental health skills in the broader health workforce • Review funding arrangements for education and training providers to enable delivery of micro-credentialing course work
<i>Strengthen the capability and core competencies of the workforce to recognise and respond to community need</i>	<ul style="list-style-type: none"> • Identify components of care (subsets of models of care) that meet the needs of consumers and carers and develop cultural safety education and training for all mental health workforces • Support the mental health workforce to upskill in and respond to co-occurring alcohol and other drug addiction • Support the alcohol and other drug workforce to upskill in and respond to co-occurring mental ill-health • Support First Nations, CALD, LGBTQIA+SB and disability led initiatives to grow and develop the mental health workforce to meet the needs of their patients and communities • Support higher education providers to embed the Aboriginal and Torres Strait Islander Health Curriculum Framework into higher education curricula for a broad range of under-graduate and graduate courses and health social service career pathways

Strategic pillar 2: Maximise, Distribute and Connect	
Priority area	Actions
Enable the workforce to expand and work to the top of their scope and enhance regulatory arrangements to strengthen the safety and quality of care	<ul style="list-style-type: none"> • Develop and refine nationally consistent scopes of practice across occupations and between jurisdictions that reflect the components of care and competencies required to deliver them, recognising discipline-specific contributions and multidisciplinary care • Review regulatory arrangements to ensure the appropriate approach is in place to ensure consumer and carer safety, given each occupation's scope of practice • Establish roles and career paths that reflect effective use of multidisciplinary teams within nationally consistent scopes of practice and enable workers from each occupation to work to the top of their

Strategic pillar 2: Maximise, Distribute and Connect	
Priority area	Actions
	<p>scope of practice</p> <ul style="list-style-type: none"> ● Create incentives for service providers to use service delivery models that utilise the competencies of all workforces to their full scopes of practice
Strengthen coordinated care, collaboration and multidisciplinary ways of working within and between the mental health, wider health and social service workforces	<ul style="list-style-type: none"> ● Address attitudinal, organisational and legislative barriers to effective use of multidisciplinary teams ● Integrate the workforce and care pathways across the aged care, disability, alcohol and other drug and primary and tertiary health care settings
Provide evidence-based guidance to underpin workforce planning and the management of demand and surge capacity	<ul style="list-style-type: none"> ● Detail guidance to support system and local workforce planning, acknowledging best practice to reflect local context in the planning approach ● Provide planning guidance to respond to high demand, surge requirements, and workforce shortages
Address workforce supply in rural and remote areas	<ul style="list-style-type: none"> ● 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 ● Incentivise the use of place-based approaches to training and professional development to help attract and retain workforce in rural and remote areas ● 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 ● Support initiatives to grow local mental health workforces, particularly in rural and remote settings. This includes expanding training and placement opportunities in regional, rural and remote areas to encourage students to undertake education and training, and remain in communities for employment ● Develop a training and retention strategy for the rural and remote mental health workforce
Address workforce distribution across settings and between public, private and not-for-profit sectors	<ul style="list-style-type: none"> ● Improve the attractiveness of the public sector for health professionals through enhanced career pathways, training opportunities and working conditions ● Review current education, training and workforce settings to identify where core competencies, capabilities and skills can be shared or created across and within disciplines

Strategic Pillar 3: Support and Retain	
Priority area	Actions
Support workplaces to create mentally healthy workplaces and adopt positive workplace cultures	<ul style="list-style-type: none"> • Develop initiatives to safeguard the wellbeing of the mental health workforce • Identify opportunities to invest in infrastructure to ensure mental health support and treatment is provided in environments which promote safety and wellbeing of workers • Promote the need to develop a culture of collaboration, trust, learning and accountability, and a platform where culture, values and attitudes are overtly prioritised in policies across all workforces and workplaces
Implement evidence-driven strategies to prevent and address worker stress and burnout	<ul style="list-style-type: none"> • Adopt evidence-based practice to promote self-care and manage incidents and recovery, and implement communities of practice to share insights and lessons learnt • Implement training and professional practices that support recognition and management of stress and burnout • Strengthen processes to consistently and regularly review workloads, assess risks and develop solutions
Increase access to, and use of, continuing professional development across all career stages	<ul style="list-style-type: none"> • Encourage service providers to support staff access to continuing professional development throughout their careers • Develop equitable access to continuing professional development through establishing educator roles such as in allied health professions, First Nations mental health and Lived Experience (Peer) workers • Build on existing initiatives like the Mental Health Professional Online Development (MHPOD) to centralise details of existing training and continuing professional development opportunities available to the mental health workforce on an ongoing basis
Increase supervision and mentoring across all career stages, including current and emerging leaders	<ul style="list-style-type: none"> • Review guidelines for supervision and specify support requirements for those in the mental health workforce, with consideration of access barriers for regional, rural and remote workers • Strengthen access to formal mentoring across all career stages, including approaches to foster future leaders

Strategic Pillar 3: Support and Retain	
Priority area	Actions
Adopt funding models and arrangements that drive quality of care and promote retention	<ul style="list-style-type: none"> • Develop longer minimum service contract lengths for commissioned mental health services, including in rural and remote areas • Identify opportunities to embed funding in service contracts to support continued professional development, and incentives to build and retain the regional, rural and remote workforce • Identify funding arrangements to encourage greater collaboration across the mental health sector, including by occupation, setting and specialisation

Strategic Pillar 4: Data, Planning, Evaluation and Technology	
Priority area	Actions
Collaborate with consumers, carers and service providers in planning, monitoring and evaluation processes	<ul style="list-style-type: none"> • Collaborate with consumers, carers and service providers in planning, monitoring and evaluation processes • Identify opportunities to better engage the Lived Experience (Peer) workforce and First Nations people in workforce planning to ensure services are inclusive and culturally safe
Use data to support workforce and service planning, including demand and surge management	<ul style="list-style-type: none"> • Review data collection approaches to ensure data can appropriately inform mental health workforce planning, and identify the need for new data collection approaches, tools and methods • Support the use of mental health workforce data by making it publicly accessible in a manner that is useful for informing mental health workforce planning and support development of meaningful government interventions to better match workforce demand and supply across occupations and settings
Improve data governance, quality, collection and utilisation, including addressing data gaps	<ul style="list-style-type: none"> • Define what data is required, for what purpose, where data is currently held and what additional collections are required to improve reliability, accessibility and comprehensiveness • Support data collection and consolidation at organisation, state and territory and national levels

Strategic Pillar 4: Data, Planning, Evaluation and Technology	
Priority area	Actions
Evaluate workforce initiatives and monitor outcomes to drive continuous improvement	<ul style="list-style-type: none"> ● Build monitoring and evaluation into the design of mental health workforce initiatives, including initiatives relating to Lived Experience (Peer), First Nations, SEWB and emerging workforces to enable ongoing evaluation and continuous improvement practices ● Define roles and responsibilities for the ongoing management of monitoring and evaluation activities, including reporting on outcomes
Improve access to digital technology and support greater digital inclusion	<ul style="list-style-type: none"> ● Ensure training programs improve the health literacy, including digital health literacy, of all mental health care professionals ● Develop and implement training programs to raise awareness of digital mental health services and guidance on best practice adoption of digital services and blended models of care ● Implement the national digital mental health framework and clearly define practice guidelines relating to digital mental health service delivery, including safety and quality parameters for service users and providers ● Identify opportunities to invest in technology and new services to enhance interoperability and greater sector collaboration

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