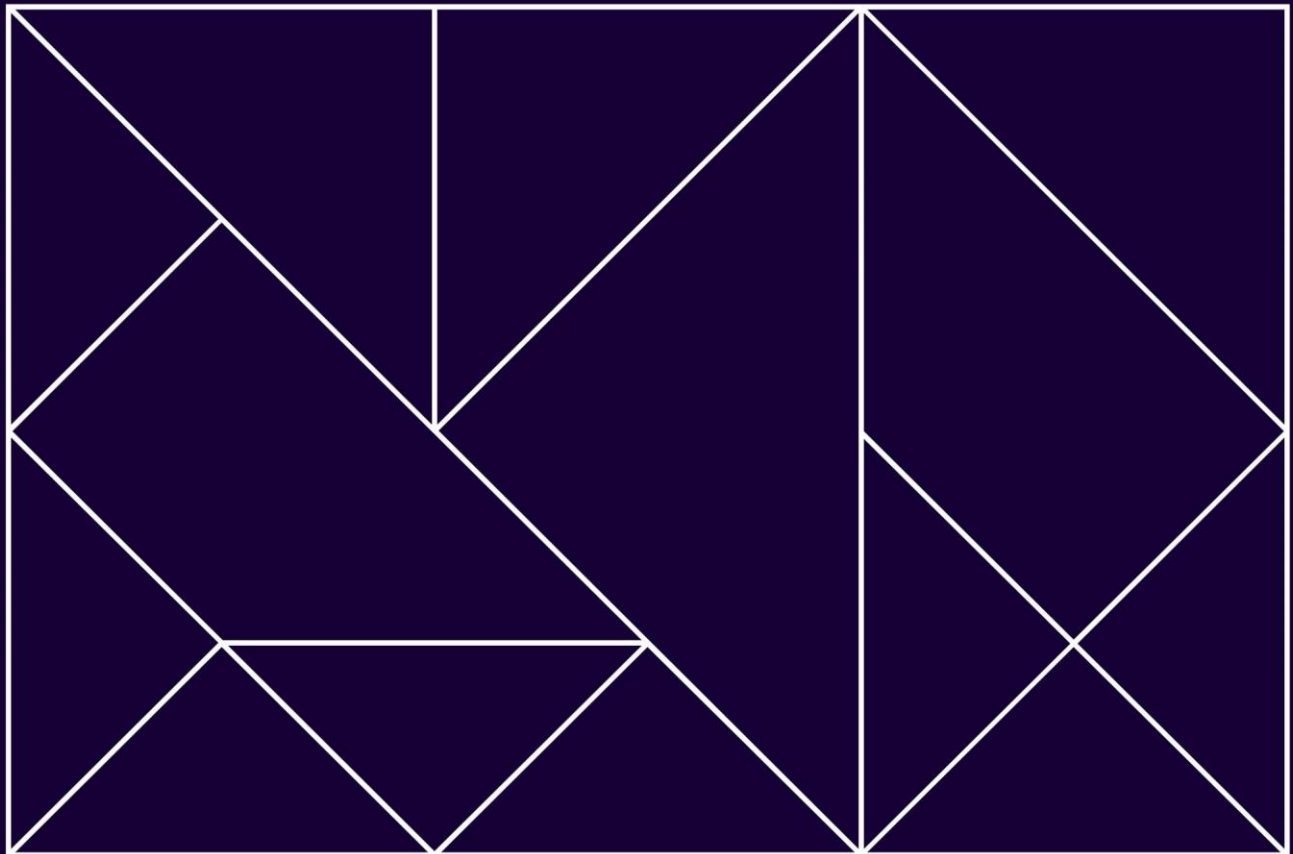


December 2020

Report to Commonwealth Department of Health

# MENTAL HEALTH WORKFORCE – LABOUR MARKET ANALYSIS

Final Report



## **About ACIL Allen**

ACIL Allen is a leading independent economics, policy and strategy advisory firm, dedicated to helping clients solve complex issues.

Our purpose is to help clients make informed decisions about complex economic and public policy issues.

Our vision is to be Australia's most trusted economics, policy and strategy advisory firm. We are committed and passionate about providing rigorous independent advice that contributes to a better world.

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# Executive summary

## Project context

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

The Taskforce endorses service systems and service delivery practices, at organisational and practitioner levels, that provide care to people experiencing mental distress and/or ill-health (consumers), their families and carers that are:

- person-centred, recognising consumers and their carers as partners in planning and decision making
- recovery oriented
- trauma informed
- culturally safe
- place-based
- integrated.

The Taskforce also acknowledges that, over time, consumers require services:

- of varying levels of intensity
- from a wide range of professionals
- in a wide range of service settings.

Consumers should be able to access these services when they need them and in the way that best meets their needs, which may involve accessing services of different levels of intensity at the same time. Consumers should be afforded continuity of care, with a designated lead professional or team responsible for follow-up, monitoring outcomes and keeping people experiencing mental ill-health and their carers connected.

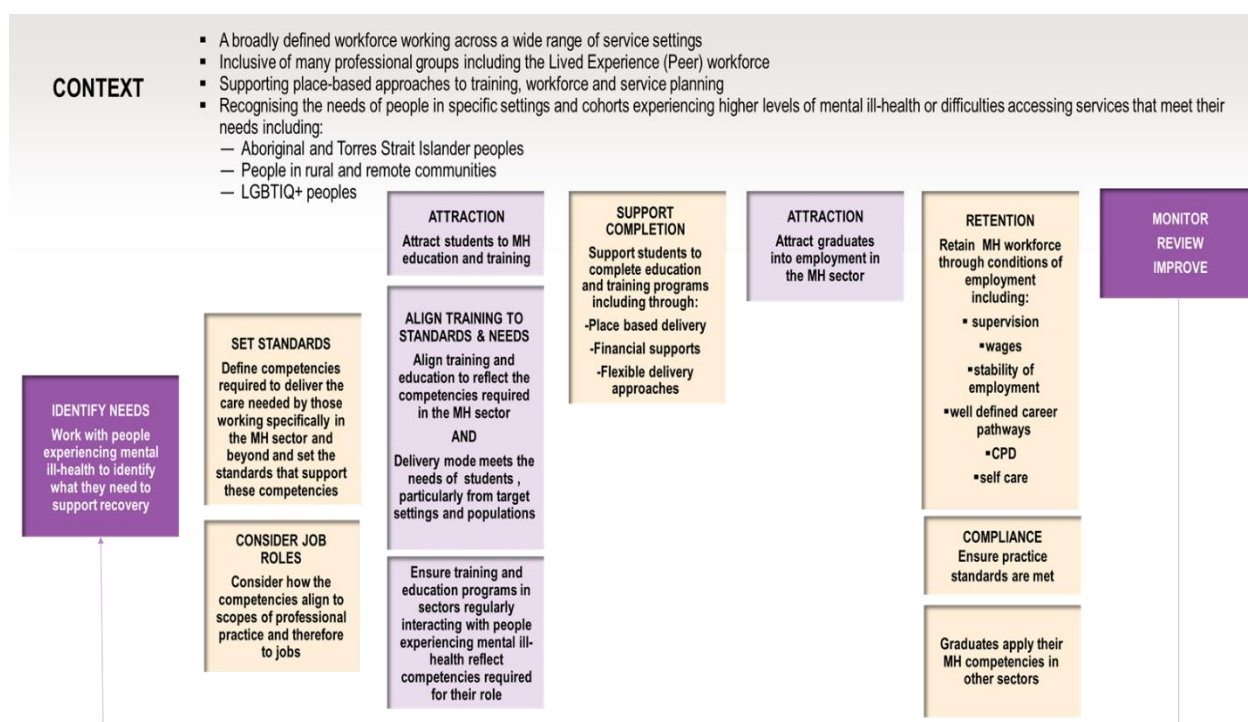
The Strategy aims to provide the workforce required to deliver such care. This is independent from the model of care as the model may vary over time and from place to place, depending on the needs of consumers, carers and local communities. The Strategy

aims to identify approaches that could be implemented by all Australian governments to address current workforce challenges impacting on the effective provision of mental health services.

## National Mental Health Workforce Strategy – Recommendation framework

The Taskforce commenced in early 2020 and has developed the following framework for recommendations, informed by the work of targeted Working Groups focused on specialist areas.<sup>1</sup>

FIGURE ES 1 NATIONAL MENTAL HEALTH WORKFORCE STRATEGY - RECOMMENDATION FRAMEWORK



SOURCE: ACIL ALLEN, 2020.

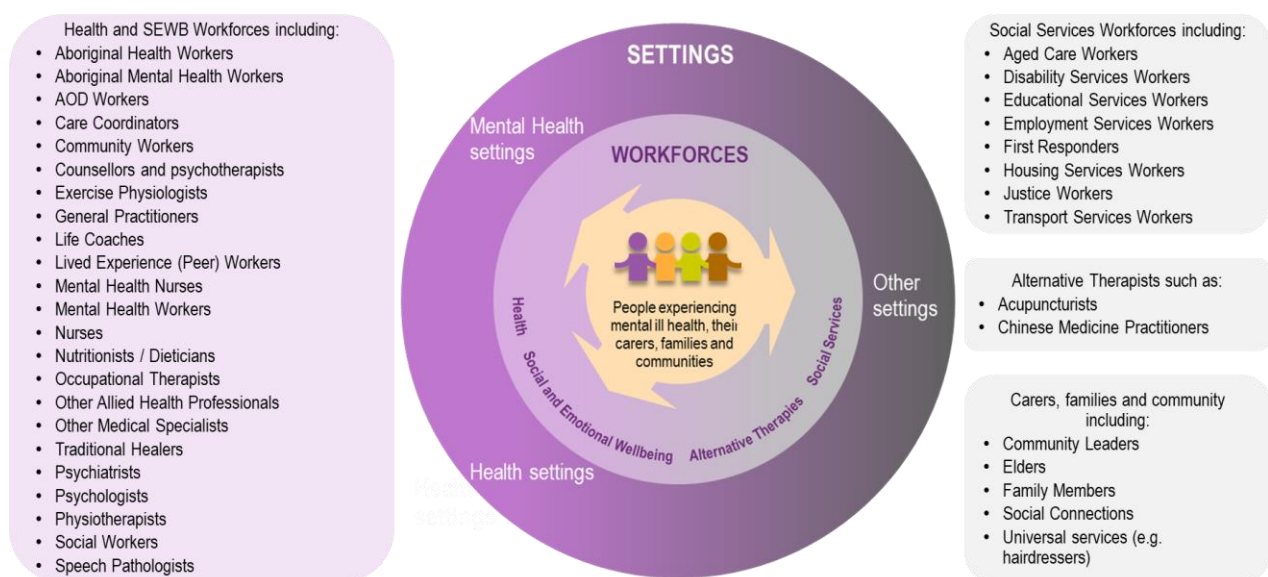
## Workforce definition

The Taskforce has adopted an organising framework premised on social and emotional wellbeing that recognises the indivisible connection between people's physical, social, emotional and cultural wellbeing. This is adapted from the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023.

<sup>1</sup> Including Aboriginal and Torres Strait Islander Communities, Education and Training, Intergovernmental and Interjurisdictional, Lived Experience (Peer) and Rural and Remote.

The organising framework involves a broad definition of the mental health workforce that includes people who interact with and provide support and clinical care to people experiencing mental distress and/or mental ill-health. The workforce is drawn from a wide range of professions and occupations performing an even broader array of roles across different service settings including public, private and community-based organisations. The mental health workforce also includes an informal workforce of family, friends and community members who support people experiencing mental distress and/or ill-health.

**FIGURE ES 2 NATIONAL MENTAL HEALTH WORKFORCE STRATEGY – ORGANISING FRAMEWORK**



SOURCE: NATIONAL MENTAL HEALTH WORKFORCE STRATEGY TASKFORCE, 2020.

## Labour Market Analysis

The Department commissioned ACIL Allen to undertake research to support the development of the Strategy, focusing on the workforce trends for different roles within the mental health workforce.

In addition to summarising workforce trends, the Labour Market Analysis (LMA) addresses the following questions:

- What is the viability of the mental health workforce private practice from an employee, employer and commissioner of services viewpoint?
- What are the pressures and opportunities for the peer mental health workforce?
- What is an appropriate investment in the mental health workforce to meet future demand?

The LMA should be read in conjunction with the Educational Institutes Review (EIR) which provides evidence on current training and education trends for the mental health workforce.

The LMA draws on a mixed-methods approach, which included:

- a document review – examining publicly available documentation on the mental health workforce
- data analysis – analysing publicly available data on workforce demographics and trends to provide an overview of the current state
- targeted consultations – with professional associations, employer representatives and employee representatives to explore workforce challenges.

## **Roles in scope**

This report focuses on the professional and occupational groups whose roles involve working regularly with people who are experiencing mental distress or mental ill-health. The coverage of each of the roles in the report varies in line with the availability of evidence and data relating to workforce trends.

### **LMA – ROLES IN SCOPE**

Aboriginal and Torres Strait Islander Health Worker – included roles:

- Aboriginal and Torres Strait Islander Health Practitioner
- Aboriginal and Torres Strait Islander Health Worker
- Aboriginal and Torres Strait Islander Mental Health Worker.

Counsellor / Psychotherapist– included roles:

- Counsellor
- Psychotherapist.

Dietitian – included role:

- Dietitian.

General Practitioner – included role:

- General Practitioner.

Lived Experience (Peer) Worker – included role:

- Lived Experience (Peer) Worker – Carer
- Lived Experience (Peer) Worker – Consumer.

Mental Health Worker– included roles:

- Alcohol and Other Drug Worker

— Community Worker.

Nurse Enrolled Nurse – included roles:

- Registered Nurse
- Credentialed Mental Health Nurse
- Mental Health Support Worker.

Occupational Therapist – included role:

- Occupational Therapist

Psychiatrist – included role

- Psychiatrist.

Social Worker – included role:

- Social Worker.

Speech Pathologist – included role:

- Speech Pathologist.

### **Public settings**

Public sector mental health settings include psychiatric hospitals, psychiatric units in general hospitals, community residential units and community mental health services. Public hospitals deliver specialised assessment, clinical treatment and rehabilitation for admitted patients with psychiatric, mental or behavioural disorders.

### **Community settings**

Community residential units offer medium- to long-term accommodation, clinical care and rehabilitation services for people with a serious mental illness and psychosocial disability.

Community mental health services provide a range of treatment, disability support and care services for people experiencing less severe forms of mental illness. These services are generally delivered by non-government organisations.

### **Private settings**

Private mental health settings include office-based private practice and in-patient care within private hospitals, including psychiatric hospitals.



## Key workforce issues

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There are diverse challenges for growing and sustaining the mental health workforce, which impact differently on individual professional and occupational groups and roles within these groups.

Issues in the training pipeline are relatively small. Enrolments in education and training programs that can lead to employment in mental health have been increasing over time and education providers are able to scale delivery to meet demand for courses.<sup>2</sup> Existing workforce shortages are likely to be exacerbated by increasing demand for mental health services, which will necessitate further investment in the training system to support increased supply for most professional and occupational groups.

The more significant challenges relate to attracting graduates to work in the mental health sector and retaining existing employees. Some professional and occupational groups have direct pathways into the mental health sector, which means there are few issues with attraction to employment. This includes Counsellors and Psychotherapists, Lived Experience (Peer) Workers, Psychiatrists, and Psychologists.

For other professional and occupational groups, there are broader career opportunities available. This relates to Aboriginal and Torres Strait Islander Health Workers, Dietitians, General Practitioners (GPs), Nurses, Occupational Therapists, Social Workers and Speech Pathologists. The challenge is to increase the proportion of graduates from these disciplines that see mental health as a sector of choice.

Factors that impede the ability to attract and retain workers in the mental health sector are diverse. Negative workplace cultures with high administrative burdens, stress and burnout can deter employees from entering and staying in public settings. This impacts all professional and occupational groups but has a particular impact on Psychiatrists, who have the option of exiting the public system to move into private practice.

Poor conditions in terms of pay, career progression and employment stability also have a negative impact on workforce attraction and retention. While the characteristics are specific to each professional and occupational group, consultations indicated that all groups were impacted by poor conditions in the mental health sector. This is particularly relevant for vocationally trained roles with no minimum qualifications (including Lived Experience and Mental Health Workers) and those operating in community-based settings where there is a common use of short-term contracts.

Lack of access to quality supervision is another factor which impacts on employee satisfaction and willingness to stay within the mental health sector. All professional and occupational groups identified supervision as a key challenge for retention. For some

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<sup>2</sup> A detailed analysis of course enrolments is provided in the Educational Institute Review Report, presented to the Taskforce on 27 November 2020.

groups (such as Occupational Therapists, Psychologists and Social Workers) the difficulty is in accessing discipline-specific supervision, when care team structures and roles are more generalist in nature. For other groups (such as Lived Experience (Peer) and Mental Health Workers) there is limited access to supervision of any nature within their practice.

While these issues are widely spread across professional and occupational groups, the most significantly impacted cohort is the tertiary qualified workforce that are often employed in generalist roles in the mental health sector. This includes Occupational Therapists, Psychologists and Social Workers who are trained through discipline-specific pathways but often employed in roles where their particular knowledge and skills are not fully utilised. The product of the poor alignment between training and job role exacerbates the lack of career progression, access to supervision and satisfaction.

Systemic underfunding of the mental health system<sup>3</sup> drives many of these issues, creating environments with high workloads and few workforce supports. Public and community-based services are most heavily affected by underfunding, with further constraints facing services in rural and remote contexts. As such, public and community-based services have greater challenges in attracting and retaining high quality workers.

## **Key findings**

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### **Viability of private practice for the mental health workforce**

Increasing the viability of private practice for the mental health workforce has been identified as one possible solution for improving service availability. Currently, employment arrangements for the mental health workforce differ by role and setting. GPs, Clinical and Registered Psychologists, and Psychiatrists operate the majority of mental health private practices, though they sometimes employ Mental Health Nurses, Counsellors and Psychotherapists or other Allied Health Workers to support service delivery.

There are diverse factors that influence the viability of private practice, including the level of awareness of roles, the nature of funding arrangements, and the scale of the market. When combined, these factors limit the viability of private practice for roles including Counsellors and Psychotherapists, Mental Health Nurses, Occupational Therapists and the vocationally trained workforce in particular.

Current Medical Benefits Scheme (MBS) settings do not encourage GPs to specialise in mental health as the rebates for many mental health consultations are less than the rebates for other services, despite the increased time required to deliver them. Reform to MBS rebates could attract more GPs to delivering mental health services, alleviating some of the pressures on the system.

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<sup>3</sup> Productivity Commission, 2020. Pg 1133.

Additionally, offering general practice owners incentives to embed other mental health workers within their medical centres could encourage diversified mental health models. This could follow a similar model to that used by the Australian Government's Workforce Incentive Program which provides financial incentives to support general practices to engage nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals. This approach requires consideration of which professional and occupational groups are best placed to provide mental health support within the general practice environment and may include emerging workforces, such as the Lived Experience (Peer) workforce.

## **Pressures and opportunities for the Lived Experience (Peer) workforce**

Designated Lived Experience (Peer) roles are increasingly recognised as important additions to services offered by the mental health sector. There is a growing policy focus on building awareness of these roles and encouraging their utilisation within a broader range of settings to help diversify the services and supports available to carers and consumers, ultimately improving outcomes. The focus generated by the Productivity Commission presents an important opportunity for the strengthening of the Lived Experience (Peer) workforce.

Consultations identified that there is general support across the mental health workforce for increasing the utilisation and engagement of the Lived Experience (Peer) workforce. Key barriers are the absence of quality/safeguarding processes surrounding the training and practice of Lived Experience (Peer) workers. This means referring professionals have less confidence that high quality services will be consistently delivered by this workforce.

The Productivity Commission explored the benefits of establishing a professional association for Lived Experience (Peer) workers, recommending that the Australian Government provide once-off seed funding to do so. Such an approach would help the Lived Experience (Peer) workforce to establish a robust approach to self-regulation, a necessary step to building awareness of the role and confidence in the broader mental health workforce that Lived Experience (Peer) members will meet appropriate practice standards.

## **Investment in the mental health workforce to meet future demand**

In line with the recognised gaps in services and increasing demand on the mental health sector,<sup>4</sup> the Productivity Commission recognised the need for additional government expenditure and the importance of prioritising efforts.

While it will be necessary to train more workers to meet demand for mental health services over time, the LMA has identified a more immediate need to improve conditions for those who already work in the mental health sector. Many stakeholders reported there being little

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<sup>4</sup> Productivity Commission, 2020. Pg 12.

point training more people to join the sector without addressing the issues that drive current workforce attrition.

Areas for potential intervention span:

- addressing the issues of underfunding within the public and community-based mental health services, which would both increase the retention of the existing workforce through improved employment conditions and help to attract new workers to these settings
- clarifying job roles, career pathways and supervision arrangements for tertiary qualified workers performing non-discipline specific general mental health activities
- extending the funding contracts for community-based services to help support longer-term and sustainable workforce planning and delivery models
- reforming current MBS funding arrangements to enhance the viability of private practice for professional and occupational groups, and to encourage GPs to deliver mental health services.

In addition, it will be necessary to attract greater numbers of students into programs that prepare graduates for employment in mental health. Potential interventions include:

- subsidising education and training programs to attract more students to professions and occupations where there are shortages
- providing greater flexibility to encourage students in rural and remote areas to study mental health-related courses
- providing ‘wrap around’ supports to students from particular cohorts, including Aboriginal and Torres Strait Islander students
- increasing funding to create more training positions (for example, for Psychiatrists).

The opportunities presented below explore possible investment approaches for developing the mental health workforce. The opportunities below are not exhaustive but rather align to the terms of reference for this report.

While it is beyond the scope of this report to quantify the additional funding required to attract sufficient numbers of qualified professionals to meet the mental health needs of the community, in part due to a lack of clarity and agreement on models of care, it is clear that significant additional resourcing is required to do so.

## Opportunities

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There are a range of options that address the issues of alignment between training and work and the impacts of underfunding. The Taskforce’s vision for the mental health workforce will determine which options are most suitable for inclusion in the Strategy.

The options below provide the basis for further discussion and consultation to inform the Strategy's direction and recommendations.

## **Identifying competencies**

Clear articulation of the competencies required to deliver mental health services across the levels of service complexity in a manner that is agnostic of current professional boundaries is an important foundation to better aligning consumer needs, job roles and training needs.

Articulating these competencies, and then identifying the training required to deliver the resultant services safely, provides a strong platform on which to develop more flexible models of care that meet the needs of consumers and reflect local service and workforce availability. It also provides greater opportunity to consider using a mix of vocationally and tertiary qualified workforces.

## **Building capability**

The changing needs and expectations of consumers, their carers and families, alongside the complexity and co-occurrence of conditions, has resulted in capability gaps for both new graduates and the existing workforce. There is a recognised need to build the capability of the existing mental health workforce to improve service outcomes for consumers and carers.

Current competency gaps are relatively consistent across the mental health workforce, as identified by the Productivity Commission's Report on Mental Health, the Royal Commission into Victoria's Mental Health System and broader research base. A key area for improvement is the development of the skills consumers value – including empathy and service navigation abilities. Capabilities in delivering inclusive and culturally safe services including for Aboriginal and Torres Strait Islander peoples, LGBTIQ+ and culturally and linguistically diverse communities, also need to be strengthened.

For the wider definition of the mental health workforce adopted by the Taskforce, general and foundational mental health-related skills are important. This is particularly relevant for those health workforces who may work outside the mental health sector, such as Nurses and medical specialists other than Psychiatrists.

While not in the scope of this report, consultations commonly identified the benefit of providing mental health training and education to the broader workforce as recognised in the Taskforce's agreed definition. This includes early childhood educators, school staff (including non-teaching staff) and those working in the social services sector. This training could cover social and emotional wellbeing, identification of risk factors for mental distress or mental ill-health, and knowledge of referral pathways. The Productivity Commission

recognised the important role of supporting interventions in early childhood and school education as part of a broader prevention approach.<sup>5</sup>

## **Alignment**

Improving the alignment of training and job roles requires a redesign, either of the roles that exist within the mental health sector or the training that individuals undertake to enter the sector.

## **Redesigning roles**

Redesigning roles essentially relates to scope of practice changes, which are often proposed as a strategy to improve supply of the mental health workforce. There are different approaches to changing scope of practice, which include diversifying existing scope, further specialising roles, or substituting one role for another.

Changes to scope of practice have, historically, been limited due to the lack of clarity on the core capabilities shared across different disciplines and the lack of documented scopes of practice for all roles. Any approaches to role redesign would be improved by:

- beginning with an understanding of the needs of people experiencing mental distress and / or mental ill-health and their carers to establish the services they require
- mapping the existing scopes of practice of mental health roles to help understand the level of current capability within the broadly defined mental health workforce
- identifying where roles can be redefined to better match services needed by consumers and carers to the available workforce.

Given the controls for the mental health sector, regulatory and legislative barriers to scope of practice changes would also need to be examined.

## **Redesigning training**

Redesigning some training programs would help to align training with existing job roles and ensure that the potential workforce has a strong understanding of the roles they are entering.

Two possible approaches that could be used to help redesign training include developing new, shorter training pathways and developing new training offerings. Shorter training pathways can reduce the lead-time between training and readiness to deliver services, increasing workforce supply. As an example, the demand for Allied Health services in the mental health sector presents an opportunity for increasing the number of Allied Health Assistants to meet workforce shortages by reducing the existing pressure on Allied Health staff and ensuring they are operating at the top of their scope of practice. Introduction of

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<sup>5</sup> Productivity Commission, 2020. Pg 193.



psychiatry training for GPs (similar to the GP anaesthetist) could assist in addressing the shortage of psychiatrists, particularly in rural areas. Similarly, the Productivity Commission has recommended a direct-entry pathway for Mental Health Nurses.

There are risks in developing shorter training pathways. The approach generally requires reducing course content, which can produce graduates who are able to operate in fewer practice environments. This can exacerbate general workforce shortages and may not align with the mental health needs of consumers who can present in a variety of settings. There is also the need to consider whether this approach reduces the flexibility of the workforce to deliver services in accordance with new models of care.

The second approach is to develop new training offerings. The development of a generalist mental health pathway, with articulation of qualifications from vocational to degree and post graduate levels, is one strategy that could be used to improve retention in the sector. This would help to address issues identified regarding the misalignment between training and roles in the mental health sector, where individuals undertake discipline-specific training to move into generic positions. An example of this is evident in the Mental Health Clinician role common in public settings, where Nurses, Occupational Therapists, Psychologists, Social Workers and Speech Pathologists are seen to bring an interchangeable skill set.

As outlined in the EIR, the majority of university courses are delivered through discipline-specific offerings (for example, nursing, occupational therapy, social work). There are currently few entry level generalist mental health qualifications for the tertiary qualified workforce.

Developing articulated, generalist mental health programs could help to provide a workforce that is prepared for, and interested in, operating in the broader capacity required by the mental health system. Place-based generalist programs could also assist in growing the local workforce and help to address the shortages in regional and remote areas.

## **Conditions**

Improving the conditions for the mental health workforce is essential to improving the attractiveness of the mental health sector, which is currently in strong competition for workers with the disability, aged care and broader health sector. This requires reform to current funding arrangements and the injection of new funds into the sector.

## **Improving remuneration**

The high levels of attrition within the mental health workforce are largely driven by poor workforce conditions, including stress, burnout, occupational violence and low (on average) salaries. One strategy to address this is to improve the awards and funding arrangements to increase the salaries, particularly in the public and community mental health sectors, making work in the mental health sector more attractive. Given the size and

scale of mental health services, this would require significant funding and commitment from Commonwealth, State and Territory Governments.

### **Strengthening flexibility**

Another approach is to improve the flexibility of employment arrangements to enable and encourage professionals to work in both public and private systems. There are concerns about the growing trend for Psychiatrists and Psychologists to work exclusively in private practice. Many medical specialists practice in both public and private health services. This is only feasible if the public health services are sufficiently attractive workplaces, are adequately resourced so practitioners are able to deliver the care that consumers need while protecting their own wellbeing, and employers encourage this approach to employment. Reforming current workplace conditions and improving the availability of flexible working arrangements in the public system may increase the availability of some segments of the workforce to deliver services, improving efficiencies.

### **Redesigned funding model**

Another option would be a more fundamental reform to the funding of mental health services, including services delivered by a wide range of private practitioners, to align more closely with the workforce definition adopted by the Taskforce, which recognises the importance of the non-medical workforce. This could draw on elements of the National Disability Insurance Scheme (NDIS) model, whereby generalist supports are funded and additional funding is provided to engage more specialised providers. The introduction of the NDIS has significantly changed the viability and therefore availability of private practitioners in allied health and disability support (similar to some supports provided in the mental health sector) but brings a need for strong market stewardship to ensure service quality and availability.

An alternative approach put forward by the Productivity Commission is the establishment of Regional Commissioning Authorities (RCA) that would pool mental health funds from Commonwealth, State and Territory Governments to commission services within its jurisdiction. Such an approach would streamline funding arrangements, providing clarity on who is responsible for what and helping to address service gaps. In particular, the RCA model would pool mental health, alcohol and other drugs, and psychosocial supports which could help to reduce the current competition for workers across these sectors.



# 1. Current State Assessment

This chapter examines the workforce trends for the mental health workforce, covering demographics, attraction to training, transition to employment and retention.

## 1.1 Workforce demographics

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The Victorian Royal Commission into Victoria's Mental Health System Interim Report recognised 'it is difficult to comprehensively describe the profile of the mental health workforce, largely because there is no consolidated source of data held by the state or Commonwealth governments or in public or private repositories'.<sup>6</sup> The difficulty in describing the mental health workforce also reflects the changing, and broadening, approaches to supporting people experiencing mental distress and/or mental ill-health and their carers, and the workforces involved in providing these services.

This section draws together evidence available through public data, literature and consultation to provide a comparative assessment of the professional and occupational groups in scope for the LMA. It builds on the findings of the University of Queensland's Analysis of national mental health workforce demand and supply: Stage 1 report which identified a moderate under-provision in workforce across nearly all workforce categories (with 86 per cent average percentage NMHSPF target reached)<sup>7</sup> and maldistribution across metropolitan, regional and rural areas.

There is significant variation in demographics across professional and occupational groups. This includes the length of time required to complete entry-level training (ranging from 1 to 11 years). This impacts on the ability to address existing and emerging workforce shortages through the training of new graduates. Groups particularly affected by long training pathways include GPs, Psychiatrists and Clinical Psychologists.

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<sup>6</sup> Victorian Royal Commission, 2019. Pg 132

<sup>7</sup> UQ, 2020. Pg 6. The NMHSPF is a needs-based planning model for Australian mental health services that quantifies community need in and estimates the workforce and other resources required to deliver evidence-based, appropriate mental health care to those populations. It is based on a narrower workforce definition than that adopted by the Taskforce.

Employment arrangements differ across professional and occupational groups. The percentage of the workforce that works part time ranges from 23 to 62 per cent, and the average annual salary varies from \$39,286 to \$181,972. Funding drives employment arrangements. For example, short-term contracts for community-based services impacts on the stability of the workforce employed in this setting. The ability to operate a viable private practice can impact on the possible salary, particularly for Psychiatrists and Psychologists. In addition, the flexibility (or lack thereof) to combine employment in public health services with private practice influences the availability of Psychiatrists to the public system.

### 1.1.1 Summary by role

The table below presents workforce size and current shortages, demographics, employment arrangements, training requirements and salaries for each professional and occupational group. Data gaps are also highlighted. Analysis of the available data indicates that there are key demographics that are shared across the mental health workforce, including a female dominated workforce (with the exception of GPs and Psychiatrists) and an ageing workforce, with significant proportions of workers aged over 45 years old.

FIGURE 1.1 SUMMARY OF WORKFORCE DEMOGRAPHICS

Role	Current size	NMHSFP target	Target reached	Female	Age	Part-time	Hours / week	Training	CPD	Salary
	FTE	2019	Per cent	Per cent	Average	Per cent	Average	Years	Min hours / year	Average
Aboriginal and Torres Strait Islander Health Practitioner	-	-	-	78	45	-	40.5	2	10	\$56,700 *
Aboriginal and Torres Strait Islander Health Worker	53	143	37	76	42	23	36.4	1	N/A	\$49,415
Counsellor	-	-	-	77	45	53	-	3	20	\$48,486
Dietician	-	-	-	95	33	46	-	4	30	\$56,567
General Practitioner	2,671	3,102	85	44	51	24	37.3	8	50	\$128,125
Lived Experience (Peer) Worker	315	1,269	25	77	-	53	-	-	N/A	\$46,600 *
Mental Health Worker	-	-	-	72	-	-	33.6	1	N/A	\$39,286
Nurse (Enrolled)	3,103	1,415	216	90	45	61	31.6	1.5	20	\$47,431
Nurse (Registered)	16,644	19,347	85	88	43	56	33.5	3	20	\$63,518
Occupational Therapist	1,738	2,227	76	91	37	34	33.2	4	20	\$57,981
Psychiatrist	2,861	5,093	56	41	53	15	38.7	11	50	\$181,972
Psychologist	12,981	14,292	88	80	46	45	32.4	6	30	\$70,116
Psychotherapist	-	-	-	81	49	62	-	3	20	\$49,149
Social Worker	2,401	2,079	115	84	42	29	33.0	4	30	\$58,415
Speech Pathologist	-	-	-	93	34	28	-	4	20	\$53,360

Note: \* Where Australian and New Zealand Standard Classification of Occupations (ANZSCO) codes were not available, salary data was sourced from [myskills.gov.au](https://myskills.gov.au) to provide a consistent approach.

SOURCE: ABS CENSUS DATA, 2016; ATO, 2018; DEPARTMENT OF HEALTH 2019A; DEPARTMENT OF JOBS AND SMALL BUSINESS, 2019; UQ, 2020B; MY SKILLS. (N.D.-A); MY SKILLS. (N.D.-B).

## **1.1.2 Workforce demographics by professional and occupational group**

### **Aboriginal and Torres Strait Islander Health Worker**

#### **BOX 1.1 ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER**

**Role:**

Aboriginal and Torres Strait Islander Health Workers provide a range of clinical and primary health care for individuals, families and communities, including in the areas of mental health and alcohol and other drugs (AOD). Clinical hours worked in mental health for Aboriginal and Torres Strait Islander Health Workers is estimated at 12.4 per cent of clinical hours worked, however this may be an underestimation given this workforce adopts a social and emotional wellbeing approach to practice.

**Training requirements:**

Aboriginal and Torres Strait Islander Health Workers and Health Practitioners are two roles with distinct training requirements. Health Workers generally hold a Certificate III qualification in the fields of primary health care or clinical practice, but there is no national requirement to hold this in order to practice. Health Practitioners are registered under the Australian Health Practitioner Regulation Agency (AHPRA) and must have a minimum Certificate IV qualification.

**Employment / funding:**

Most Aboriginal and Torres Strait Islander Health Practitioners (68 per cent) work in Aboriginal Community Controlled Health Services (ACCHS). Funding for ACCHSs is through a mix of block funding from the Australian Government, specific grants for targeted programs (such as child and maternal health), Medicare rebates, and other program funding through PHNs. ACCHSs also receive some grant funding through State and Territory Government programs.

**Current sufficiency of supply:**

There are current shortages of Aboriginal and Torres Strait Islander Health Workers, particularly in urban regions. An ageing workforce is contributing to this shortage. Between 2006 and 2016, there was a decline in the proportion of Health Workers aged under 45 years and an increase in Health Workers aged over 45 years, including a 7.5 per cent increase in Health Workers aged 55 to 64 years.

**Major issues:**

Difficulty accessing and completing training due to limited local availability, limited career progression due to unclear pathways, burnout due to community expectations for 24/7 availability and need.

SOURCE: PC, 2020; SKILLSIQ, 2018; DEPARTMENT OF HEALTH 2017A; WRIGHT, BRISCOE & LOVETT, 2019; UQ, 2020B.

## Counsellor and Psychotherapist

### BOX 1.2 COUNSELLOR AND PSYCHOTHERAPIST

#### Role:

Counsellors and Psychotherapists deliver a range of psychological therapies to consumers to support them in developing self-understanding and to make changes in their lives.

Counsellors and Psychotherapists provide direct face-to-face counselling as well as other therapeutic activities such as intake interviews and liaising with referral agencies.

#### Training requirements:

Counsellors and Psychotherapists registered with the Psychotherapy and Counselling Federation of Australia (PACFA) or the Australian Counselling Association (ACA) must have completed an accredited Diploma, Bachelor or postgraduate qualification. Training takes 4 years on average.

#### Employment / funding:

Counsellors and Psychotherapists work across a range of settings including public, NGO and private settings. While there is no recent data available on workforce breakdown across these settings, research undertaken in 2008 indicated that private practice was the most common work setting for Psychotherapists (83 per cent). Counsellors were more evenly spread across private practice (41 per cent) and NGO and community settings (32 per cent).

#### Current sufficiency of supply:

There is no national standardised data set to determine the current sufficiency of supply. Aggregated data from major counselling and psychotherapy workforce studies indicate that the workforce is distributed widely across Australia, with approximately one third working in regional, rural, and remote areas.

#### Major issues:

Reduced access to government funding compared with psychologists and subsequent impact on role recognition, lack of broader health workforce's understanding of the robustness of registration requirements and consequential underutilisation.

SOURCE: SCHOFIELD, 2008; LEWIS, 2015.

## Dietitian

### BOX 1.3      DIETITIAN

**Role:**

Accredited Practising Dietitians provide consumer-focused, evidence-based nutrition services to address the mental and physical health needs of individuals and population groups.

**Training requirements:**

Dietitians are regulated through Dietitians Australia, as a self-regulating profession. Dietitians must have a bachelor or master's degree in dietetics. Training takes, on average, 4 years to complete.

**Employment / funding:**

There is no recent data available on breakdown on the employment of Dietitians across settings, but they operate predominantly in public and community settings. Public dietetic services are funded through State, Territory and Australian Government programs and Medicare rebates. Only accredited dietitians are eligible for MBS rebates. Items for Accredited Practising Dietitians are not available in the Better Access program.

**Current sufficiency of supply:**

There is no current evidence of a workforce shortage, though Dietitians are maldistributed with regional and rural shortages reported across the country.

**Major issues:**

Access to government funding under the MBS is often limited in a mental health context and referral pathways can be challenging, limited uptake in multidisciplinary teams within public settings due to funding arrangements including under investment in mental health when compared with physical health.

SOURCE: SIOPIS, 2020; VICTORIAN ALLIED HEALTH WORKFORCE RESEARCH PROGRAM, 2018; DIETITIANS AUSTRALIA, 2019.

## General Practitioner

### BOX 1.4 GENERAL PRACTITIONER

#### Role:

General Practitioners (GPs) are often the first point of contact for someone with a mental health issue. GPs have a role in making referrals to specialist mental health services and may provide low-intensity psychological therapies. Clinical hours in mental health for GPs is estimated at 12.4 per cent of clinical hours worked.

#### Training requirements:

GPs are required to undertake extensive training including a bachelor degree and postgraduate degree in medicine, internship and specialist general practice vocational training. The length of training to become a GP is 8 years on average. Accredited mental health training is available for GPs to provide services under the MBS. GPs can undertake two levels of training – the Mental Health Skills (MHS) Training, which allows GPs to undertake mental health assessments, develop and review Mental Health Treatment Plans (MHTP), and Focused Psychological Strategies (FPS) Training, which allows GPs to provide evidence-based FPS as part of an MHTP.

#### Employment / funding:

Most GPs work in the private sector (92 per cent) and more commonly in group practices (88 per cent). Funding for GPs in private practice is fee-for-service (FFS) payments. Most funding comes through private patient fees and the billing of Medicare item numbers.

#### Current sufficiency of supply:

There is a current shortfall of GPs for mental health-related care, however, the supply is not significantly below the National Mental Health Service Planning Framework (NMHSPF) target. The supply of GPs is largely consistent with NMHSPF targets across urban, regional, rural and remote areas, with supply slightly above the NMHSPF target in the most remote areas.

#### Major issues:

Level of MBS funding for mental health items is not commensurate with effort and time, which disincentivises mental health practice.

SOURCE: PC, 2020; AIHW, 2018A; UQ, 2020B.

## Lived Experience (Peer) Worker

### BOX 1.5 LIVED EXPERIENCE (PEER) WORKER

#### Role:

Lived Experience (Peer) Workers are people with a lived experience of mental ill-health or carers of people with mental ill-health. Consumer peer workers apply their personal lived experience of mental illness and recovery in providing emotional and social support to other consumers. Carer peer workers apply their experience from caring and supporting family or friends with mental health issues to supporting other carers and family members.

#### Training requirements:

Peer Workers are employed on the basis of their personal experience. There is currently no mandatory qualification required to be employed as a Lived Experience (Peer) Worker, though there is a nationally recognised Certificate IV in Mental Health Peer Work.

#### Employment / funding:

There is no national data available on the Lived Experience (Peer) workforce. Sources aggregated from research and state and territory data indicate that most work in the NGO sector or public hospitals. Peer Workers are funded by State and Territory Governments. Funding arrangements differ across jurisdictions. In Victoria and Queensland, funding is provided for the employment of peer workers (consumers and carers) in public mental health services. In NSW, peer workers in NGOs are funded through state programs.

#### Current sufficiency of supply:

There is currently a significant shortage of Lived Experience (Peer) Workers. Based on state data, supply reached 25 per cent of the NMHSPF target. This shortfall is slightly greater for carer peer workers. Lived Experience (Peer) Workers are an emerging workforce and expected to grow significantly as the role and value of peer workers is increasingly recognised by others working in the mental health system.

#### Major issues:

Limited recognition of the role and contribution of Lived Experience (Peer) Workers due to the lack of a regulation and consistency in training, difficulties in accessing and completing training.

SOURCE: PC, 2020; UQ, 2020B.



## Mental Health Worker

### BOX 1.6 MENTAL HEALTH WORKER

**Role:**

Mental Health Workers deliver psychosocial support services to assist people with mental health issues, substance abuse and other social problems. Roles vary based on level of experience but generally consist of providing assessments and counselling, developing treatment plans, care coordination and case management, providing referral and linkages to other local community and social services, and monitoring client progress.

**Training requirements:**

There is currently no minimum qualification for Mental Health Workers as the roles are unregulated.

**Employment / funding:**

Mental Health Workers are largely employed in community support services or in specialist public and private mental health services, though there is no national data available on employment conditions. Funding for community mental health services is through Australian Government programs, PHNs and activity-based funding from State and Territory Governments.

**Current sufficiency of supply:**

There is no nationally consistent data available. Recent estimates by the University of Queensland indicate that there is a shortage of Mental Health Workers.

**Major issues:**

Lack of career pathways, poor employment arrangements and supports.

SOURCE: PC 2020; UPSKILLED, N.D.; UQ,2020B.

## Nurse

### BOX 1.7 NURSE

#### Role:

Nurses (including enrolled and registered) comprise the largest segment of the health workforce and perform a wide range of roles, functions and activities for patients seeking physical and mental health care. The workforce also includes credentialled Mental Health Nurses, who have advanced training in mental health. Mental Health Nurses work with the people with a range of mental health disorders and deliver specialised, recovery-oriented, evidence-based care.

#### Training requirements:

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

#### Employment / funding:

Enrolled Nurses are evenly split across the public sector and private sector (49 per cent each) with a small proportion working across both (2 per cent). The majority (62 per cent) of registered nurses work in the public sector. The most common work setting for enrolled and registered nurses is hospital (47 and 64 per cent, respectively). Funding arrangements for each of these settings are diverse and include State, Territory and Australian Government funding (activity-based and block), private insurance funds and individual out-of-pocket expenses.

#### Current sufficiency of supply:

The supply of Enrolled Nurses in mental health is above the NMHSPF target, however, there is a current shortage of Registered Nurses. There are shortages across all relevant service sectors, with the largest deficit evident in bed-based services, and maldistribution by geographic location. While NMHSPF targets are being met in urban regions, there are significant deficits in Registered Nurses in more rural areas.

#### Major issues:

More diverse career pathways outside the mental health sector, occupational safety issues and poor workplace culture, need for uplift in mental health capability for all nurses.

SOURCE: PC, 2020; ACHMHN, 2019; DEPARTMENT OF HEALTH 2019B; DEPARTMENT OF HEALTH 2019C; DEPARTMENT OF HEALTH 2017B; DEPARTMENT OF HEALTH 2019C; UQ, 2020B.

## Occupational Therapist

### BOX 1.8 OCCUPATIONAL THERAPIST

#### Role:

Occupational Therapists (OTs) provide behaviourally-oriented, goal-directed services to assist people with daily living and work skills. There are specialised Mental Health Occupational Therapists, who assist people who are struggling with mental distress and/or mental health illness. However, there is limited data available on the size and conditions of this specific segment of the workforce.

#### Training requirements:

OTs registered with the Occupational Therapy Board of Australia must complete a minimum bachelor degree (4 years). Undergraduate degrees include a focus on mental health and students can undertake mental health clinical placements throughout their course. Mental Health Occupational Therapists (accredited by Occupational Therapy Australia) are not required to complete any additional training, unless delivering services under the Better Access program.

#### Employment / funding:

The workforce is split across the public and private sector, with a small proportion working across both. Most OTs work in hospitals (20 per cent) and community health care services (16 per cent). Public occupational therapy services are funded through State and Territory Government or Australian Government programs and Medicare rebates. Items for Occupational Therapist are available in the Better Access program. Funding for community mental health services is through Australian Government programs and PHNs and activity-based funding from State and Territory Governments.

#### Current sufficiency of supply:

There is a shortfall of OTs providing mental health care based on NMHSPF targets. OTs are distributed across regional, rural and remote areas and the workforce is relatively young (average age of 37 years). Key issues with supply of OTs providing mental health care relate to attraction to employment (discussed in the following section).

#### Major issues:

Mismatch between discipline-specific training and generalist mental health roles, lack of career progress and supervision, significant competition from the disability sector with perceived better conditions.

SOURCE: PC, 2020; DEPARTMENT OF HEALTH, 2017D; UQ, 2020B; VICTORIAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2018A.

## Psychiatrist

### BOX 1.9 PSYCHIATRIST

#### Role:

Psychiatrists are medical practitioners specialising in the diagnosis and management of mental illness who generally treat people with more severe forms of mental illness. Psychiatrists are trained to assess both the mental and physical aspects of psychological problems. They use a variety of treatments, including psychotherapy, psychosocial interventions, prescribing medications and other treatments depending on the needs of the patient.

#### Training requirements:

Psychiatrists undertake advanced training in mental health including a bachelor degree and postgraduate degree in medicine, followed by specialist training in psychiatry with the Royal Australian and New Zealand College of Psychiatrists (RANZCP). The RANZCP Fellowship Program involves rotations to expose trainees to different specialties. The training pathways takes a minimum of 11 years to complete.

#### Employment / funding:

The most common work settings are hospital (29 per cent), followed by solo private practice (23 per cent). Public hospital psychiatry services are joint funded by State, Territory and Australian under an activity-based or block funding model. Private hospital psychiatry services are funded by private health insurance funds, individual out-of-pocket expenses and Australian, State and Territory Governments through private health rebates and the Department of Veterans' Affairs. Funding for Psychiatrists in private practice is fee-for-service payments through private patient fees and the billing of Medicare item numbers.

#### Current sufficiency of supply:

There is a current shortage of Psychiatrists, particularly in sub-specialities, such as child and adolescent, community liaison, forensic, psychotherapy, and addiction, as well as specific settings, such as inpatient units and emergency departments. An ageing workforce and time lag to increase supply due to length of training are contributing to the shortage and there remains a significant reliance on overseas-trained psychiatrists to meet demand. In 2015, 41 per cent of new fellows obtained their specialist qualification outside of Australia.

#### Major issues:

Underinvestment in public mental health system discourages employment in public settings, inflexible work arrangements disincentivises cross-setting practice.

SOURCE: PC, 2020; AIHW, 2018B; RANZCP, 2017; STATE OF VICTORIA, 2019; DEPARTMENT OF HEALTH, 2016A; UQ, 2020B.

## Psychologist

### BOX 1.10 PSYCHOLOGIST

**Role:**

Psychologists provide assessment, diagnosis and treatment to people experiencing mental ill-health. They use evidence-based therapies and evidence-based therapy relationships to assist clients to resolve mental health disorders or psychological problems.

**Training requirements:**

The minimum training requirements are a Bachelor of Psychology or degree with a major in psychology and a fourth-year Honours or post-graduate diploma. There are three training pathways which lead to general registration. Provisional psychologists can take the higher degree pathway, which involves an additional postgraduate qualification, or the internship pathway, either an additional year of study and one-year internship (5+1 pathway) or two-year internship program (4+2 pathway). Clinical Psychologists and Counselling Psychologists endorsed by the Psychology Board of Australia under AHPRA requires an additional two years of supervised experience in the relevant area of practice.

**Employment / funding:**

Most psychologists work in solo private practice (19 per cent) or group private practice (17 per cent). There has been an increasing trend toward the private sector. Funding for Psychologists in private practice is fee-for-service payments through private patient fees and the billing of Medicare item numbers under the Better Access program.

**Current sufficiency of supply:**

The supply of Psychologists is moderately below NMHSPF targets. There are shortages by service sector, with deficits in clinical ambulatory services, and maldistribution by geographic location, with deficits in rural and remote areas. Distribution across the public and private sector is a key concern.

**Major issues:**

Conversion of psychology students to registered Psychologists is low, poor workplace cultures and lack of career progression, limited flexibility in employment arrangements.

SOURCE: PC, 2020; DEPARTMENT OF HEALTH, 2017E; UQ, 2020B; APS, 2019.

## Social Worker

### BOX 1.11 SOCIAL WORKER

**Role:**

Social Workers assist people in dealing with personal and social issues through counselling support and community engagement. Accredited Mental Health Social Workers are recognised providers through the Better Access to Mental Health Care program. They deliver clinical social work services and utilise a range of evidence-based strategies, including Cognitive Behavioural Therapy (CBT) and other interventions, to assist people with mental health disorders.

**Training requirements:**

Social Workers must complete a minimum Bachelor of Social Work, generally 4 years. They are self-regulated and accredited by the Australian Association of Social Workers (AASW). Mental Health Social Workers must have received at least two years post-qualifying supervision in a mental health field and meet continuing professional development (CPD) requirements.

**Employment / funding:**

As Social Workers are not AHPRA-registered, there is no national consistent dataset available on employment arrangements. Sources aggregated from research and state/territory data indicate that most work on a full-time basis, with less than one-third working part-time (29 per cent). The most common settings for Social Workers are hospital and community health settings. Social work services are funded through State and Territory Government and Australian Government programs and the MBS. Only Accredited Mental Health Social Workers are eligible for MBS funding. MBS items are available in the Better Access program. Other funding sources include the NDIS and the Department of Veterans' Affairs.

**Current sufficiency of supply:**

The supply of Social Workers in specialist mental health services is above the NMHSPF target.

**Major issues:**

Poor workplace cultures, high level of burnout, mismatch between specialist training and generalist roles.

SOURCE: PC, 2020; AASW, 2020; AASW, N.D.; URBIS, 2018; VICTORIAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2018C; UQ, 2020B.

## Speech Pathologist

### BOX 1.12 SPEECH PATHOLOGIST

**Role:**

Speech Pathologists are university trained allied health professionals with expertise in the assessment and treatment of communication and/or swallowing difficulties. Speech Pathologists play an important role in early identification and assessment for populations at risk of communication and swallowing difficulties that are associated with mental ill-health.

**Training requirements:**

Speech Pathology are self-regulated profession through Speech Pathology Australia and certified practicing members must complete a minimum bachelor degree. The length of training is 4 years.

**Employment / funding:**

Speech Pathologists work across a range of settings. The most common are private clinics, community health services and schools. There is no national data available on workforce distribution. Funding for Speech Pathologist in private practice is FFS payments through private patient fees. Items for Speech Pathologists are not available in the Better Access program. Community mental health services are funded through Australian Government programs and PHNs and activity-based funding from State and Territory Governments.

**Current sufficiency of supply:**

There is no current shortage of Speech Pathologists, though maldistribution has created shortages in regional and remote areas. There is emerging evidence that the market is tightening as demand grows (for example, through the NDIS).

**Major issues:**

Limited recognition of the role of speech pathology in mental health services, limited access to discipline-specific supervision, lack of career progression within mental health settings.

SOURCE: SPEECH PATHOLOGY AUSTRALIA, 2020.

## 1.2 Workforce challenges

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There are diverse challenges for growing and sustaining the mental health workforce which impact on professional and occupational groups in different ways. This section outlines the common trends across attraction to training, capability, attraction to employment and retention drawn from the literature, Productivity Commission Report into Mental Health, Taskforce and Working Group meetings and consultations.

### **1.2.1 Attraction to training**

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Enrolments in education and training programs that can lead to employment in mental health have been increasing over time.<sup>8</sup> Despite the growth, existing workforce shortages are likely to be exacerbated by increasing demand for mental health services.

The limited availability of courses in regional and remote areas affects the attraction of students living in these areas to mental health-related study. While there have been some improvements (for example, through the increased health offerings of regional universities), most courses are still based in metropolitan locations which can create financial and personal barriers to training participation. While relevant to all professional and occupational groups, this particularly impacts Aboriginal and Torres Strait Islander Health Workers who have additional barriers to travelling off country for study including connecting with community while they are away.

The limited awareness of career opportunities and associated training pathways impacts the ability to attract sufficient students into training for some professional and occupational groups. The impacts differ depending on roles and service providers, including Aboriginal and Torres Strait Islander Health Workers, Lived Experience (Peer) Workers and Mental Health Workers. Some providers may not specify minimum qualifications for employees or not distinguish remuneration between those that do and do not hold qualifications, which means there is limited incentive to participate in formal training.

The cost of training, particularly in the vocational training sector, can impede participation. This relates to course fees, the potential lost income from taking time off to study and costs of living away from home where this is relevant. This impacts broadly on students from low socio-economic status and on students studying for particular roles (including Lived Experience (Peer) and Aboriginal and Torres Strait Islander Health Workers).

The Federal Government's reform to higher education funding may present a barrier to future enrolments for Counsellors/Psychotherapists as it will increase the fees paid by students. The reforms increase the cost of a year of study and will be impacted by the units chosen by the student. Two Professional Pathways have been created for Social Work and Psychology that include students in youth work, counselling and community work. Based on the units chosen by the student, the cost of a year of study will change from \$6,804 to either \$7,950 (if from a Professional Pathway) or \$14,500 (if not from a Professional Pathway). No data are available on the impact of these reforms as they are still to take effect.

When compared with the other segments of the mental health workforce pipeline (discussed below), the challenges associated with attraction to training impact most significantly on people living in rural and remote areas, Aboriginal and Torres Strait Islander peoples and the

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<sup>8</sup> A detailed analysis of course enrolments is provided in the Educational Institute Review Report, presented to the Taskforce on 27 November 2020.



potential Lived Experience (Peer) workforce. Challenges associated with attraction to training for others are not significantly impacting the future supply of the mental health workforce.

### **1.2.2 Competency**

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The changing needs and expectations of consumers, their carers and families, alongside the complexity and co-occurrence of conditions, has resulted in capability gaps for both new graduates and the existing workforce. As an indicator, the Mental Health Complaints Commissioner reported that complaints about staff behaviour, competence and professional conduct constituted one of the most common complaints raised in 2017–18 (22 per cent of complaints).

Capability needs are relatively consistent across the mental health workforce, as identified by the Productivity Commission's Report on Mental Health, the Royal Commission into Victoria's Mental Health System and broader research base. A key area for improvement is the development of the skills consumers value – including empathy and service navigation abilities.

Capabilities in delivering inclusive and culturally safe services including for Aboriginal and Torres Strait Islander peoples, LGBTIQ+ and culturally and linguistically diverse communities, need to be strengthened. The workforce's lack of capability in delivering inclusive and culturally safe practice is an impediment to service access for individuals and their families.

For the wider definition of the mental health workforce adopted by the Taskforce, general and foundational mental health related skills are important. This is particularly relevant for those health workforces who may work in outside the mental health sector, such as Nurses and medical specialists other than Psychiatrists.

### **1.2.3 Attraction to employment and retention**

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Some professional / occupational groups have direct pathways into the mental health sector, which means there are few issues with attraction to employment. This includes Counsellors and Psychotherapists, Lived Experience (Peer) Workers, Psychiatrists, and Psychologists.

For other professional / occupational groups, there are broad career opportunities available and graduates do not always pursue employment in the mental health sector. This relates to Aboriginal and Torres Strait Islander Health Workers, Dietitians, GPs, Mental Health Workers, Nurses, Occupational Therapists, Social Workers and Speech Pathologists, although noting that Aboriginal and Torres Strait Islander Health Workers adopt a social and emotional wellbeing approach to practice which includes aspects of mental health. The ability to grow these workforces is dependent, in part, on encouraging more graduates to see mental health as a sector of choice.

The most significant challenges to maintaining and growing the mental health workforce relate to the ability to attract and retain high quality workers in the mental health sector. There are inconsistent data available on the current retention rates of the mental health workforce, which makes it difficult to quantify the scale of the issue, however there are consistent issues that drive poor retention across the mental health workforce.

Negative perceptions of the mental health sector begin through poor quality placements in pre-service training, which can discourage graduates from applying for mental health positions. Placements are often in high-stress areas, particularly in public settings, where underfunding impacts on the service setting, breadth of services provided and on staffing levels, including the ability to provide students with adequate supervision or support for a quality experience.

The lack of progression opportunities decreases the attractiveness of the mental health sector, satisfaction at work and retention. For some professional / occupational groups, the limited opportunities in mental health services are driven by the lack of consistent or well defined career structures (for example, for Aboriginal and Torres Strait Islander Health Workers, Occupational Therapists, Social Workers and Lived Experience (Peer) Workers). For other groups, the structure of care teams and service delivery limits the number of discipline-specific roles that an individual can move into. This increases the attractiveness of work outside the mental health sector where there are greater perceived opportunities.

Workplace culture in the mental health sector is consistently identified as a challenge across roles. Fatigue and burnout are high as a product of the high workload generated through current funding insufficiency, which results in increased administrative burdens and long work hours. These factors contribute to attrition and impact more strongly on regional and remote workforces.

Current service delivery contracts limit access to CPD as they do not include funding, nor allow providers' time to release staff for training and professional development. The lack of access to development and upskilling reduces career satisfaction and leads to disengagement.

Conditions vary considerably across roles in the sector in terms of remuneration and employment stability. This is a function of industrial awards, the structure of pay rates set by State and Territory governments, and the impact of MBS payments. Stakeholders consistently referred to the competition for employees between community mental health providers, public mental health providers and Primary Health Networks (PHNs) reflecting the different pay scales that apply to each.<sup>9</sup> Employee feedback often indicates that remuneration does not align with the requirements of the role which can lead to high attrition rates.

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<sup>9</sup> For example, health professionals with a three year degree under the Victorian Public Service Enterprise Agreement will be paid a minimum of \$70,791 annually. By contrast, health professionals with a three year degree employed under the Health Professionals and Support Services Award 2020 will be paid a minimum of \$956.20 a week (which equates to approximately \$50,000 a year).

Insecurity of work is a further concern. Community-based mental health service providers commonly use one-year employment contracts as a consequence of the short-term contracts through which they are funded. This creates employment uncertainty and reduces the attractiveness of employment in the mental health sector when other service settings offer employment in less stressful and more stable contexts (such as program delivery roles in the public service).

The lack of access to quality supervision impacts on employee satisfaction and willingness to stay within the mental health sector. All professional and occupational groups identified supervision as a key challenge for retention. For some groups (such as Occupational Therapists, Psychologists and Social Workers) there is difficulty accessing discipline-specific supervision, when care team structures and roles are generalist in nature. For other groups (such as Lived Experience (Peer) and Mental Health Workers) there is limited access to supervision of any nature within their practice.

## 2. Opportunities

### 2.1 Addressing the issues

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The Productivity Commission's Report into Mental Health identified that 'workforce planning should be driven by what consumers and carers want, and what governments and providers can realistically deliver in the mental healthcare system, not just by correcting mismatches and shortages through recruitment and retention.'<sup>10</sup> This highlights the need for consideration of different approaches to addressing workforce challenges in addition to attracting more people into training to increase the supply of potential workers.

While there are many issues facing the mental health workforce that need to be addressed, two central issues underpin many of the concerns:

- Misalignment between training and roles, driven by service needs – there is a strong disconnect between the discipline-specific training for some graduates moving into the mental health sector and the resultant roles which are generic in nature. This significantly impedes attraction and retention in the sector. The most significantly impacted cohort is the tertiary qualified workforce including Occupational Therapists, Psychologists and Social Workers who are often employed in roles whereby their particular knowledge and skills are not utilised. The poor alignment between training and role exacerbates the lack of career progression, access to supervision and satisfaction.
- Systemic underfunding of mental health services – the challenges discussed in section 2.2 regarding conditions, supervision and access to CPD stem largely from the systemic underfunding of the mental health system which creates environments with high workloads and few supports for the workforce. Public mental health and community-based services are most heavily affected by underfunding, which is exacerbated in rural and remote contexts. As such, public and community-based services have greater challenges in attracting and retaining high quality workers.

There are a range of options that address the issues of alignment between training and work and the impacts of underfunding. The Taskforce's vision for the mental health workforce will determine which options are most suitable for inclusion in the Strategy.

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<sup>10</sup> Productivity Commission, 2020. Pg 706

The options below provide the basis for further discussion and consultation to inform the Strategy's direction and recommendations. These opportunities reflect possible areas of investment to support development of the mental health workforce required to meet the needs of people experiencing mental distress and mental ill-health, their families and carers. Each option in isolation will not address the full breadth of issues raised.

## **2.2 Improving alignment**

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Improving the alignment of training and roles requires a redesign, either of the roles that exist within the mental health sector or the training that individuals undertake to enter the sector.

### **Redesigning roles**

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Redesigning roles essentially relates to scope of practice changes, which are often proposed as a strategy to improve supply of the mental health workforce. There are different approaches to changing scope of practice:

- diversification, in which the existing scope of practice is changed (generally through expansion)
- specialisation, where roles become more focused in their scope of practice
- substitution, referring to the use of one role in place of another.

There are limitations on scope of practice changes. For many mental health services, the required skills are highly specialised and only align with a single or small number of roles. For example, specialised psychiatric treatment is delivered by Psychiatrists and peer support is provided by the Lived Experience (Peer) workforce. This restricts the possible contexts for diversification. Specialisation has a longer lead time, requiring consultation with professional associations and education providers, to develop programs and build timelines – and, in some models, can further extend the lag between training and workforce availability. Substitution requires cultural change within service providers to build the comfort in using non-traditional service models.

Diversification generally involves expanding the scope (and consequently the training) of workforce roles to widen their possible scope of practice. This is often used to increase the possible services that can be provided by a particular role, maximising their utility. Diversifying the scope of practice of disciplines such as psychology or social work could increase the supply of workers who have relevant foundations but lack the specialised capabilities to provide a broader range of services.

Specialisation involves the development of more tailored capabilities within a workforce role. This is generally employed to help target the utilisation of a given role, particularly in highly technical or focused areas. As an example, the suggestion from the Productivity Commission to introduce an undergraduate mental health nurse pathway would support specialisation

within training and education pathways, developing a more specialised cohort of nursing graduates.

Substitution involves identifying roles that have relevant capabilities, developed through quality programs, that could be used to deliver mental health services in place of another role.

Consultations indicated that substitution is already occurring in practice to some extent, though this could be strengthened by clearer articulation of the scope of practice of each role to improve confidence in the appropriateness of the substitution.

The Productivity Commission has identified that there is scope to substitute Aboriginal Health Workers, Mental Health Workers and Lived Experience (Peer) Workers in place of roles with higher salaries through expanding block grants to community providers. The benefits identified included the faster training pathways, local availability and increased likelihood of cultural competence.

A further example of substitution relates to care coordination functions. Care coordination is essential to both meeting the needs of consumers and delivering efficient services, and the role requires capability in case management and knowledge of referral pathways to services. Currently this role can be filled by a number of positions, depending on the particular service model used by the provider. Consultations identified that while a broad range of qualified workers can operate in the role, an increased use of Nurses in this role could help to address many of the factors currently driving attrition.

#### BOX 2.1      OPTIONS FOR ROLE RE-DESIGN

Changes to scope of practice have, historically, been limited due to the lack of clarity on the core capabilities shared across different disciplines and the lack of documented scopes of practice for all roles. Any approaches to diversification, specialisation or substitution would be improved by:

- beginning with an understanding of the needs of people experiencing mental distress and / or mental ill-health and the carers, to establish the services they require
- mapping the existing scope of practice of mental health roles to help understand the level of current capability within the broadly defined mental health workforce to ensure high quality service delivery
- identifying where roles can be redefined to better match services needed by consumers and carers to the available workforce.

Given the controls for the mental health sector, regulatory and legislative barriers to scope of practice changes would also need to be examined.

## **2.2.1 Role of Lived Experience (Peer) Workers**

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Designated Lived Experience (Peer) roles are emerging as important additions to services offered by the mental health sector. There is an increasing policy focus on strengthening the position within the broader workforce. The Productivity Commission identified a number of pressures facing the Lived Experience (Peer) workforce, including:

- role confusion – limited understanding of the role, scope of practice and the best way to operate in an interdisciplinary team
- limited perception of value – scepticism about the skills, qualifications and contribution of the role in the mental health sector
- re-traumatisation – high risk of workplace harm through vicarious trauma and re-traumatisation as a product of the lack of value
- opportunities for career development – unclear career pathways, access to discipline-specific supervision and tailored professional development.
- underdeveloped system of qualifications – current education and training opportunities are limited to a Certificate IV in Mental Health Peer Work and a nationally recognised skill set (though no delivery has occurred to date).<sup>11</sup>

Consultations identified that there is general support across the mental health workforce for increasing the utilisation and engagement of the Lived Experience (Peer) workforce. A key barrier to expansion is the lack of quality and safeguards surrounding the training of individual workers. Psychiatrist and GP representatives consulted noted the need for a mechanism to provide confidence that Lived Experience (Peer) workers had the required knowledge, skills and attitudes to operate effectively and appropriately within a mental health environment.

### **BOX 2.2 OPTIONS FOR THE LIVED EXPERIENCE (PEER) WORKERS**

The Productivity Commission explored the benefits of establishing a professional association for Lived Experience (Peer) workers, recommending that the Australian Government provide once-off seed funding to do so. Such an approach would help the Lived Experience (Peer) workforce to begin self-regulating, a necessary step to building awareness of the role and confidence in the broader mental health workforce that Lived Experience (Peer) members will meet appropriate practice standards.

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<sup>11</sup> Productivity Commission, 2020. Pg 728.



## **2.2.2 Redesigning training**

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Redesigning some training programs would help to align training with the job roles that exist, ensuring the potential workforce has a strong understanding of the roles they are entering.

### **Training pathways**

An alternative approach to addressing workforce shortages is to develop new, shorter training pathways. This can reduce the lead-time between training and readiness to deliver services, increasing workforce supply.

As an example, the demand for Allied Health services in the mental health sector presents an opportunity for increasing the training of Allied Health Assistants. Allied Health training in the higher education sector requires a long lead time to build skills which impacts the ability to build workforce supply<sup>12</sup>. By contrast, Allied Health Assistants can be trained in a shorter period of time to help address workforce shortages, particularly in non-metropolitan locations. The disability sector has recently been exploring this model, increasing the use of Allied Health Assistants under other allied health workers. A systematic review of studies on the use of AHAs found improved clinical outcomes, increased patient satisfaction, higher-level services, and more available time for allied health professionals to concentrate on patients with complex needs.<sup>13</sup> Introduction of psychiatry training for GPs (similar to the GP anaesthetist) could assist in addressing the shortage of psychiatrists, particularly in rural areas.

The Productivity Commission has identified similar opportunities for Mental Health Nurses. The proposed recommendations highlighted the opportunity to develop a three-year direct-entry (undergraduate) degree in mental health nursing, similar to the option already available to midwives, to reduce the current training time while developing the specialised skills held by Mental Health Nurses. This approach does not have universal support, the countervailing argument being that all nurses require increased knowledge of mental health regardless of setting (unlike midwifery).

There are risks in developing shorter training pathways. The approach generally requires reducing course content which can produce graduates who are able to operate in fewer practice environments. This can exacerbate general workforce shortages and may not align with the mental health needs of consumers who can present in a variety of settings.

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<sup>12</sup> Windsor & Associates, 2017.

<sup>13</sup> Lizarondo L, Kumar S, Hyde L, Skidmore D. Allied health assistants and what they do: A systematic review of the literature. *J Multidiscip Healthc.* 2010;3:143-153. Published 2010 Aug 19. doi:10.2147/JMDH.S12106.



## Training offerings

The mismatch between discipline-specific training and the need for generalist functions within the mental health workforce is a key factor driving high rates of attrition. The development of a generalist mental health pathway is one strategy that could be used to improve occupational linkages.

As outlined in the Education Institutes Review, the majority of university courses are delivered through discipline-specific offerings (for example, nursing, occupational therapy, social work). There are currently few generalist mental health qualifications for the tertiary qualified workforce at an entry-level. Those that are available include:

- the Bachelor of Health Science (Mental Health) at Charles Sturt University, which prepares Aboriginal and Torres Strait Islander students to operate as mental health professionals across community, health and mental healthcare services. This degree combines online study with residential schools over three years, with qualified exit points available annually.
- the Bachelor of Community Mental Health, Alcohol and Other Drugs at Chisolm Institute, which aims to develop the skills to provide non-clinical services to specialists such as psychiatrists, nurses and social workers. This degree is only available face-to-face as a three year program.

There is a wider range of post-graduate generalist mental health qualifications available, including the Master of Mental Health Practice (Griffith University), Graduate Certificate to Master of Mental Health (Australian Catholic University) and the Applied Mental Health Studies program at the Health Education and Training Institute (HETI). These qualifications are generally designed to help graduates specialise in mental health or to develop more practical experience for working in the mental health sector.

Developing generalist mental health programs, with articulation from vocation to undergraduate and postgraduate levels, could help to provide a workforce that is prepared for, and interested in, operating in the broader capacity required by the mental health system. Place based generalist programs could also help to assist in growing the local workforce, helping to address the shortages in regional and remote areas.

**BOX 2.3      OPTIONS FOR TRAINING RE-DESIGN**

The development of new training pathways could help to increase supply of potential workers in the short-term, addressing current and emerging shortages. The Productivity Commission highlighted Mental Health Nurses as one option and there are likely other roles that could benefit from similar adaptations. The key consideration for the Taskforce is to identify which roles the training pathways would link to, in order to ensure that adapted training pathways do not replicate current issues of misalignment and attrition.

The re-design of training to develop a generalist tertiary qualified mental health program, designed to produce workers that meet the requirements of generic positions in the mental health sector, could help to improve the alignment of expectations and the work environment. Pathways could be established to allow progression into areas of specialisation (for example, occupational therapy or psychology). This option would benefit from further consultation with employers to determine whether such an approach would be desirable in the current context.

## **2.3      Improving conditions**

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Improving the conditions for the mental health workforce requires reform to current funding arrangements and the injection of additional resourcing into the sector.

### **2.3.1      Improving remuneration and flexibility**

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The high levels of attrition within the mental health workforce are largely driven by poor workforce conditions, including stress, burnout, occupational violence and low (on average) salaries. One strategy to address this is to improve the awards and funding arrangements to increase the salaries, particularly in the public and community mental health sectors, making work in the mental health sector more attractive. Given the size and scale of mental health services, this would require significant funding and commitment from Federal, State and Territory governments.

Another approach is to improve the flexibility of employment arrangements to enable and encourage professionals to work in both public and private systems. There are concerns about the growing trends for Psychiatrists and Clinical Psychologists to work exclusively in private practice. Many medical specialists practice in both public and private health services. This is only feasible if the public health services are sufficiently attractive workplaces and in particular are adequately resourced so practitioners are able to deliver the care that consumers need while protecting their own wellbeing, and employers encourage this approach to employment. Consultations identified a number of factors that are contributing to this shift, including the:

- level of autonomy available in private practice, which allows individuals to direct own operations

- lack of work / life balance in the public sector, where shortages can make it difficult to access leave
- limited availability of opportunities to work in both public and private practice in the mental health sector, with few opportunities for part-time arrangements.

Reforming current workplace conditions and improving the availability of flexible working arrangements in the public system may increase the availability of some segments of the workforce to deliver services, improving efficiencies. Encouraging more opportunities to work in both public and private settings can also help to address some issues driving attrition, including professional satisfaction, career opportunities and access to professional development.

### **2.3.2 Improving viability of private practice**

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Increasing private practice service delivery has been identified as one possible solution for improving service availability. As described above, employment arrangements for the mental health workforce differ by role and setting. GPs, Clinical Psychologists, and Psychiatrists operate the majority of mental health private practices, though they sometimes employ Mental Health Nurses, Counsellors and Psychotherapists or other Allied Health Workers to support service delivery.

There are diverse factors that influence the viability of private practice, including the level of awareness of roles, the nature of funding arrangements, and the scale of the market. Each of these factors, and the roles impacted, are explored below.

#### **Funding**

Federal and State or Territory funding is the central driver for the viability of private practice. Current MBS funding discourages mental health specialisations for GPs. Below outlines the current fee structure for a selection of items which indicates that the fee for a physical health consultation often equals or exceeds the value of mental health consultations which are more complex and often time consuming.

#### **EXTRACT OF MBS ITEMS:**

##### **ITEM 36**

Professional attendance by a general practitioner (not being a service to which any other item in this table applies) lasting at least 20 minutes, including any of the following that are clinically relevant:

- a) taking a detailed patient history;
- b) performing a clinical examination;
- c) arranging any necessary investigation;
- d) implementing a management plan;

e) providing appropriate preventive health care;

in relation to 1 or more health-related issues, with appropriate documentation.

Fee: \$75.05

#### **ITEM 279**

Professional attendance by a medical practitioner in relation to a mental disorder and of at least 20 minutes in duration, involving taking relevant history and identifying the presenting problem (to the extent not previously recorded), providing treatment and advice and, if appropriate, referral for other services or treatments, and documenting the outcomes of the consultation.

Fee: \$59.20

#### **ITEM 281**

Professional attendance by a medical practitioner (who has undertaken mental health skills training) of at least 20 minutes but less than 40 minutes in duration for the preparation of a GP mental health treatment plan for a patient.

Fee: \$75.10

#### **ITEM 283**

Professional attendance at consulting rooms by a medical practitioner, for providing focussed psychological strategies for assessed mental disorders by a medical practitioner registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service, and lasting at least 30 minutes, but less than 40 minutes

Fee: \$76.50

SOURCE: [HTTP://WWW.MBSONLINE.GOV.AU/](http://www.mbsonline.gov.au/)

Other government funding arrangements influence the amount that can be charged for a given service, and who is able to deliver it. Examples include Better Access, state and territory funding for support for traffic accidents, workforce compensation, and victims of crime-related services, and program-based initiatives (such as disaster and emergency relief). This impacts on the viability of private practice for:

- Counsellors and Psychotherapists
- Mental Health Nurses
- Occupational Therapists with a mental health specialisation.

As an example of the positive impact funding can have on the viability of private practice, the inclusion of Psychologists, Accredited Mental Health Social Workers and Mental Health Occupational Therapists under Better Access has helped increase the number of approved

providers by improving the viability – through both the availability of an MBS rebate, increased awareness of the role and demand for services.<sup>14</sup> This also had impacts for improved access, particularly in markets where there had historically been limited mental health service provision. The success of this initiative has been greater for those groups that are more commonly associated with the mental health sector (such as Psychologists) where other groups indicated there were still some challenges in operating in private practice due to the limited consumer awareness of their contribution.

## Understanding of roles

For private practice to be viable, there needs to be an understanding of the scope of practice of a given workforce among both other health service providers and consumers and their carers.

Other health service providers need to understand the training, skills and quality of services offered by a given role in the mental health sector in order to have confidence in referring patients on. To help support this awareness, the Commonwealth Government funded the Mental Health Professionals Network to improve interdisciplinary mental health practice. It is also important that consumers share this awareness, either to seek help from the provider type or feel comfortable in referring on.

The lack of understanding impacts on the viability of private practice both as a sole trader or working within a private practice for the following roles:

- Aboriginal Health Workers
- Counsellors and Psychotherapists
- Lived Experience (Peer) Workers
- Mental Health Nurses
- Occupational Therapists with a mental health specialisation
- Social Workers.

One approach to help build the understanding of other roles over time would be to incentivise general practice owners to embed other mental health workers in their medical centres. This could follow a similar model to that used by the Australian Government's Workforce Incentive Program which provides financial incentives to support general practices to engage nurses, Aboriginal and Torres Strait Islander Health Practitioners and Health Workers, and eligible allied health professionals. This approach would require consideration of which professional and occupational groups were best placed to provide mental health support within the general practice environment, which may involve expanding to include the Lived Experience (Peer) workforce.

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<sup>14</sup> <https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-ba-eval-dsum-toc~mental-ba-eval-dsum-8~mental-ba-eval-dsum-8-1>

## Thin markets

The size of the market for service delivery further compounds the above barriers to the viability of private practice. As an example, operating in rural and remote contexts involves greater travel costs, lower service demands and increased need for collaboration with providers to support effective service coordination. Current funding arrangements do not account for these components, which makes the business models used in metropolitan regions less viable in regional and rural contexts. As a consequence, those who do operate in these settings often have to diversify their model (for example, through the use of a hub and spoke model connecting from regional centres rather than local delivery).

Another model being explored in thin markets is technology-led delivery. The use of telehealth through COVID has highlighted the feasibility of such models, should MBS funding continue to be available. This would improve the financial viability. The disability sector has also explored the use of digital platforms (for example, through Mable and Higher Up) as mechanisms to support local community-based commissioning approaches, though there is limited evidence of yet on the long-term viability or client outcomes.

### 2.3.3 Redesigned funding model

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Another option would be a more fundamental reform to the funding of mental health services, including services delivered by a wide range of private practitioners, to align more closely with the workforce definition adopted by the Taskforce, recognising the importance of the non-medical workforce. This could draw on elements of the NDIS model, whereby generalist supports are funded and additional funding is provided to engage more specialised providers. The introduction of the NDIS has significantly change the availability of private practitioners in allied health and disability support (similar to some supports provided in the mental health sector) but brings a need for strong market stewardship to ensure service quality and availability.

An alternative approach put forward by the Productivity Commission is the establishment of Regional Commissioning Authorities (RCA) that would pool mental health funds from Commonwealth, State and Territory Governments to commission services within its jurisdiction. Such an approach would streamline funding arrangements, providing clarity on who is responsible for what and helping to address service gaps. In particular, the RCA model would pool mental health, alcohol and other drugs, and psychosocial supports which could help to reduce the current competition for workers across these sectors.

While it is beyond the scope of this report to quantify the additional funding required to adequately attract sufficient numbers of qualified professionals to meet the mental health needs of the community, it is clear that significant additional resourcing is required to do so.

**BOX 2.4      OPTIONS – IMPROVING CONDITIONS**

Increased funding for the mental health system more broadly could improve remuneration and conditions, including workload, access to supports and supervision. Given the size and scale of mental health services, this would require significant funding and commitment from Federal, State and Territory governments.

Changing the MBS fees for mental health-related items could improve the viability of private practice, particularly for GPs. Expanding use of MBS items to appropriate professional and occupational groups could similarly increase workforce supply and improve the ability to access services.

A more fundamental reform option is an extension of the funding model, similar to the NDIS, that enables more efficient use of the available workforce and encourages other groups (such as Occupational Therapists) to move into private practice.

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# Appendices



# A Workforce Profiles

This appendix provides an overview of each of the workforce roles that fall within the scope of the LMA. The purpose of the profiles is to provide a consistent approach to describing and assessing each role, in order to best understand where there are common issues (impacting across the mental health workforce) and specific issues (impacting particular roles).

The profiles provide an assessment of the current:

- state of the workforce (demographics, registration requirements, employment arrangements, settings and remuneration)
- issues facing the workforce (supply and demand, attraction to training, skill needs, attraction to employment and retention).

The profiles have been developed through a document and literature review, collating the current evidence base on workforce issues facing the mental health sector. The review focused on information produced in the last five years to ensure a contemporary reflection of the system. Where relevant, data have also been drawn from aggregate sources on employment outcomes and arrangements (for example, [myskills.edu.gov.au](http://myskills.edu.gov.au)). The following roles are covered in the remainder of this appendix:

## WORKFORCE PROFILES:

- Aboriginal and Torres Strait Islander Health Worker – includes Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander Health Worker; Aboriginal and Torres Strait Islander Mental Health Worker
- Counsellor / Psychotherapist – includes Counsellor; Psychotherapist
- Dietitian – includes Dietitian
- General Practitioner – includes General Practitioner
- Lived Experience (Peer) – includes Lived Experience (Peer) Worker – Carer; Lived Experience (Peer) Worker – Consumer
- Nurse – includes Enrolled Nurse; Registered Nurse; Mental Health Nurse
- Occupational Therapist – includes Occupational Therapist
- Psychiatrist – includes Psychiatrist
- Psychologist – includes Clinical Psychologist; Counselling Psychologist; Psychologist
- Social Worker – includes Social Worker
- Speech Pathologist – includes Speech Pathologist

## **A.1 Aboriginal and Torres Strait Islander Health Worker**

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### WORKFORCE PROFILE – ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER

#### Demographic – Aboriginal and Torres Strait Islander Health Worker:

- Average age of Aboriginal and Torres Strait Islander Health Workers is 42 years.
- More than three quarters (76 per cent) are female.
- Most are located in the NSW (55 per cent), Queensland (15 per cent) and the NT (14 per cent).

#### Demographic – Aboriginal and Torres Strait Islander Health Practitioner:

- Average age of Aboriginal and Torres Strait Islander Health Practitioners is 45 years.
- More than three quarters (78 per cent) are female.
- Most are located in the NT (26 per cent), NSW (23 per cent), WA (20 per cent) and Queensland (18 per cent).

#### Registration requirements – Aboriginal and Torres Strait Islander Health Worker:

- Aboriginal and Torres Strait Islander Health Workers are unregistered.

#### Registration requirements – Aboriginal and Torres Strait Islander Health Practitioner:

- Regulated by: AHPRA – Aboriginal and Torres Strait Islander Health Practice Board of Australia
- Entry-level qualification: Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care Practice
- Average cost: \$5,925
- Length of training: Up to 2 years
- CPD requirements: 60 hours over three years, minimum of 10 hours annually

#### Employment arrangements – Aboriginal and Torres Strait Islander Health Worker:

- 23 per cent work on a part-time basis.
- Average of 36.4 hours per week.

#### Employment arrangements – Aboriginal and Torres Strait Islander Health Practitioner:

- Average of 40.5 hours per week, with an average of 32.9 clinical hours.

Settings – Aboriginal and Torres Strait Islander Health Worker:

- The most common work setting is Aboriginal Community Controlled Health Services.

Settings – Aboriginal and Torres Strait Islander Health Practitioner:

- Just under one-third (31 per cent) work in the public sector. A small proportion work across both.
- Most Health Practitioners (68 per cent) work in Aboriginal Community Controlled Health Services.

Remuneration – Aboriginal and Torres Strait Islander Health Worker:

- Average salary \$49,415

Remuneration – Aboriginal and Torres Strait Islander Health Practitioner:

- Average salary \$56,700

## CURRENT WORKFORCE ISSUES

Supply and demand:

- Current shortage of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners. The total number increased by 25 per cent from 2006 to 2016 but this was not commensurate with general population growth.
- Supply increased in Queensland and New South Wales from 2006 to 2016 but declined in the NT, South Australia, Victoria and Western Australia.

Attraction to training:

- Program enrolments in Aboriginal and Torres Strait Islander Health Worker-related qualifications have increased each year between 2015 and 2018.
- Barriers to training include cost and time required to complete the minimum qualification.
- For people in regional and remote areas, additional barriers include travel and time away from family and community.

Skill needs:

- Selection criteria most requested by employers in the sector are Aboriginal and/or Torres Strait Islander descent and communication skills according to the job vacancy data.
- Current gap in language, literacy and numeracy skills, with many students below the level required to complete the minimum qualification.
- Aboriginal and Torres Strait Islander Health Workers and Health Practitioners may have an increasing role in identifying and responding to family violence. Greater workforce training and development in family violence is required.

**Attraction to employment:**

- Lack of nationally consistent career structure. The absence of a robust career structure is shifting the workforce towards job opportunities outside the health sector, where there are perceived greater career progression opportunities.

**Retention:**

- Factors impacting on job satisfaction and retention include low pay rates, mismatch between clinical responsibilities and training, lack of mentors and coaches, burnout, limited career and professional development opportunities, and lack of understanding of the role and capabilities of Aboriginal and Torres Strait Islander Health Workers leading to difficulties with integration into broader teams and organisations.

SOURCE: ABS CENSUS DATA, 2016; ATSIHBA, 2020; AHPRA, 2013; AISC, 2020; ATO, 2018; UQ, 2020A; DEPARTMENT OF HEALTH, 2019A; DEPARTMENT OF HEALTH, 2017A; HEALTH WORKFORCE AUSTRALIA, 2014A; MY SKILLS, N.D.-A; PC, 2020; SKILLSIQ, 2019; SKILLSIQ, 2018; WRIGHT, BRISCOE, & LOVETT, 2019; UQ, 2020B.

## **A.2 Counsellor and Psychotherapist**

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### **WORKFORCE PROFILE – COUNSELLOR AND PSYCHOTHERAPIST**

**Demographics:**

- Average age of Dietitians is 33 years.
- Most (95 per cent) are female.
- Most are located in NSW (33 per cent), Victoria (26 per cent) and Queensland (21 per cent).

**Registration requirements:**

Self-regulated by: Dietitians Association of Australia / Dietetic Credentialing Council

- Entry-level qualification: Bachelor or masters degree in dietetics
- Average cost: Data not available
- Length of training: 4 years
- CPD requirements: 30 hours annually.

**Settings:**

- No recent data available on workforce breakdown across settings, but predominantly in public and community settings.
- 2017 Victorian survey reported public, private and not-for-profit and sectors, with the majority employed in the hospital inpatient setting.

Remuneration:

- Average salary \$56,567

## CURRENT WORKFORCE ISSUES

Supply and demand: No data available on supply and demand issues.

Attraction to training: No data available on issues with attraction to training.

Skill needs: More opportunities are needed for student Dietitians to experience mental health practice in entry-level training.

Attraction to employment: Limited positions for Dietitians in mental health settings due to the lack of understanding of the role and its contribution.

Retention: Limited access to CPD and discipline-specific support while in employment.

SOURCE: ARCAP, 2019; ATO, 2018; AUSTRALIAN COLLEGE OF APPLIED PSYCHOLOGY, N.D.; DEPARTMENT OF JOBS AND SMALL BUSINESS, 2019; LEWIS, 2015; JOB OUTLOOK, N.D.-A; JOB OUTLOOK, N.D.-C; PACFA, 2020; PACFA, 2018; SCHOFIELD, 2008; SCHOFIELD & ROEDEL, 2012.

## A.3 Dietitian

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### WORKFORCE PROFILE – DIETITIAN

Demographics:

- Average age of Dietitians is 33 years.
- Most (95 per cent) are female.
- Most are located in NSW (33 per cent), Victoria (26 per cent) and Queensland (21 per cent).

Registration requirements:

- Self-regulated by: Dietitians Association of Australia / Dietetic Credentialing Council
- Entry-level qualification: Bachelor or masters degree in dietetics
- Average cost: Data not available
- Length of training: 4 years
- CPD requirements: 30 hours annually.

Employment arrangements:

- Just under half (46 per cent) work on a part-time basis.

**Settings:**

- No recent data available on workforce breakdown across settings, but predominantly in public and community settings.
- 2017 Victorian survey reported public, private and not-for-profit and sectors, with the majority employed in the hospital inpatient setting

**Remuneration:**

- Average salary \$56,567

**CURRENT WORKFORCE ISSUES**

Supply and demand: No data available on supply and demand issues.

Attraction to training: No data available on issues with attraction to training.

Skill needs: More opportunities are needed for student Dietitians to experience mental health practice in entry-level training.

Attraction to employment: Limited positions for Dietitians in mental health settings due to the lack of understanding of the role and its contribution.

Retention: Limited access to CPD and discipline-specific support while in employment.

SOURCE: ABS CENSUS DATA, 2016; DIETITIANS ASSOCIATION OF AUSTRALIA, 2019; JOB OUTLOOK, N.D.-B.

## **A.4 General Practitioner**

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**WORKFORCE PROFILE – GENERAL PRACTITIONER****Demographics:**

- Average age of general practitioners (GPs) is 51 years.
- More than half (56 per cent) are male.
- Most are located in NSW (29 per cent), Victoria (25 per cent) and Queensland (22 per cent).
- Aboriginal and Torres Strait Islander people account for 0.4 per cent of the workforce.

**Registration requirements:**

- Regulated by: AHPRA – Medical Board of Australia
- Entry-level qualification: Bachelor degree in medicine and postgraduate degree in medicine, followed by an internship in a hospital and specialist general practice vocational training

- Average cost: Data not available
- Length of training: 8 years
- CPD requirements: Set by the relevant specialist medical college

#### Employment arrangements:

- Approximately one-quarter work on a part-time basis (24 per cent).
- Average of 37.3 hours per week.
- GPs in solo practices and hospitals are more likely to work full-time compared to larger group practices, where part-time options are more available.

#### Settings:

- GPs work mostly in the private sector (92 per cent) compared to the public sector. General practitioners are more likely to work in group practices (88 per cent) than in solo practices (12 per cent).

#### Remuneration:

- Average income \$128,125
- Earnings depend on a number of factors including practice costs and the structure of the practice, ratio of private billing and bulk billing, the percentage of billings earned and involvement in after hours.

### CURRENT WORKFORCE ISSUES

#### Supply and demand:

- Current shortage of GPs in mental health care, however, it is not significantly below the National Mental Health Service Planning Framework (NMHSPF) targets.
- Distribution across urban, regional, rural and remote areas is largely consistent with NMHSPF targets. Supply is slightly above the NMHSPF target in the most remote areas.

#### Attraction to training:

- No data available on issues with attraction to training.

#### Skill needs:

- Key knowledge and skill gaps include ability to identify, conduct assessments, manage and refer appropriately patients, knowledge of the role of clinical pharmacology, management of mental health medications and skills in establishing and working within mental health teams.
- GPs in rural and remote areas require skills in FPS given the limited availability of specialist mental health workforce.



**Attraction to employment:**

- Higher earnings for other medical specialists is likely contributing to the decline in medical graduates choosing general practice as a career.
- GPs can achieve two levels of accredited training correlating with specific sets of MBS item numbers – Mental Health Skills (MHS) Training and Focused Psychological Strategies (FPS) Training. The uptake of MHS has been successful (91 per cent of GPs) but uptake of FPS has been low (3 per cent). The comparative value of rebates for FPS do not reflect the level of ongoing training requirement and is a disincentive for GPs.

**Retention:**

- Factors that influence job satisfaction and retention include remuneration, recognition and hours of work.
- Current rebates do not reflect the challenges and work undertaken to deliver FPS services and higher rebates for physical illness lead to attrition of GPs offering FPS services.
- In 2016, 300 GPs either nominated to be deregistered or did not meet CPD requirements to continue as an FPS provider.

SOURCE: AIHW, 2018; AIHW, 2016; ATO, 2018; DEPARTMENT OF HEALTH, 2019A; DEPARTMENT OF HEALTH, 2018A; DEPARTMENT OF JOBS AND SMALL BUSINESS, 2019; UQ, 2020B; GPMHSC, 2020; GPMHSC, 2019; MEDICAL BOARD, 2020; MEDICAL RECRUITMENT, N.D., ORYGEN, 2020; PC, 2020; RIDOUTT, PILBEAM & PERKINS, 2014; RACGP, 2012.

## **A.5 Lived Experience (Peer) Worker**

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### **WORKFORCE PROFILE – LIVED EXPERIENCE (PEER) WORKER**

**Demographics:**

- The most common age group for Lived Experience (Peer) Workers is 50 to 54 years.
- Most (77 per cent) are female.
- Most are employed in Victoria (28 per cent), NSW (23 per cent) and Queensland (14 per cent).

**Registration requirements:**

- No registration requirements.

**Employment arrangements:**

- Most work on a part-time basis (53 per cent).

**Settings:**

- Approximately half work in the NGO sector, followed by public hospitals. Few work in private hospitals or Aboriginal Community Controlled health organisation or services.

**Remuneration:**

- Average salary \$46,000

**CURRENT WORKFORCE ISSUES****Supply and demand:**

- No national standardised data set on the Lived Experience (Peer) Workforce. Based on aggregated, publicly available data, estimates suggest there is a current shortage.
- The number of Lived Experience (Peer) Workers to meet demand is unknown given the current and planned expansion of the workforce.

**Attraction to training:**

- No mandatory qualification required to be employed as a Lived Experience (Peer) Worker.
- Currently only one specialised qualification (Certificate IV in Mental Health Peer Work).
- Barriers to training include cost, difficulty with assessments, and personal reasons, such as illness.

**Skill needs:**

- Inconsistent training contributing to difficulties around unclear and inconsistent role definitions.
- Shared experience, compassion, empathy and hope are central to the role and although 'lived experience' cannot be taught, applying it in challenging and complex environments necessitates training.

**Attraction to employment:**

- Low salary, limited training and development opportunities, lack of career progression are deterrents from attraction to employment.

**Retention:**

- Issues with retention include gaps in leadership and supervisory skills for supporting Lived Experience (Peer) Workers, feeling isolated in their role and lack of opportunities for career progression.
- For some Lived Experience (Peer) Workers, their 'career' finishes when they have reached a certain point in their recovery pathway.

SOURCE: UQ, 2020A; COMMUNITY MENTAL HEALTH AUSTRALIA, 2015; UQ, 2020B; HEALTH WORKFORCE AUSTRALIA, 2014B; MCMAHON, 2019: PC, 2020; MY SKILLS, N.D.-B; RIDOUTT, PILBEAM & PERKINS, 2014; STATE OF VICTORIA, 2019.

## **A.6 Mental Health Worker**

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### **WORKFORCE PROFILE – MENTAL HEALTH WORKER**

#### **Demographics:**

- Predominantly female (72 per cent).
- Registration requirements: Mental Health Workers are unregistered.

#### **Employment arrangements:**

- Generally employed on short-term contracts or casual basis.
- Average of 33.6 hours per week.

#### **Settings:**

- Mental Health Workers are largely employed in community support services or in specialist public and private mental health services.

#### **Remuneration:**

- Average salary \$39,386

### **CURRENT WORKFORCE ISSUES**

#### **Supply and demand:**

- No national standardised data set on vocationally qualified Mental Health Workers. In New South Wales, there is a deficit in vocationally qualified Mental Health Workers (34 per cent).

#### **Attraction to training:**

- No reported issues with attraction to training.

#### **Skill needs:**

- Developing recovery plans with clients and mental health relapse prevention and self-care are key skills required for undertaking work in NGO services.
- Mental health relapse prevention and self-care is identified as an area for further training.
- Workforce skills shortages exist in key areas, such as youth mental health.

- Barriers to workforce development include inability to backfill staff when undertaking training, difficulty in accessing training and lack of budget.

Attraction to employment:

- No reported issues with attraction to employment.

Retention:

- Workplace stress and burnout, short-term contracts, inadequate funding for training and development, poor remuneration and lower wages compared to the public sector contributes to turnover in the community health sector.
- Casualisation of the workforce and reduced opportunities for highly paid roles under the NDIS, could see a loss of highly skilled, experienced and qualified Mental Health Workers from the sector.

SOURCE: ATO, 2018; UQ, 2020A; COMMUNITY MENTAL HEALTH AUSTRALIA, 2015; UQ, 2020B; PC, 2020; RIDOUTT 2014; WAAMH, 2017.

## **A.7 Nurse**

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### **WORKFORCE PROFILE – ENROLLED NURSE**

Demographics:

- The average age of Enrolled Nurses is 45 years.
- 90 per cent are female.
- Most are located in Victoria (32 per cent) followed by Queensland (21 per cent) and NSW (21 per cent).
- Aboriginal and Torres Strait Islander people account for 2.6 per cent of the workforce.

Registration requirements:

- Regulated by: AHPRA – Nursing and Midwifery Board
- Entry-level qualification: Diploma of Nursing
- Average cost: \$21,000
- Length of training: 18 months
- CPD requirements: Minimum of 20 hours per registration period.

Employment arrangements:

- 61 per cent work on a part-time basis.
- Average of 31.6 hours worked per week, with an average of 29.7 clinical hours.

**Settings:**

- Enrolled Nurses are evenly split across the public sector (49 per cent) and private sector (49 per cent) with a small proportion working across both (2 per cent).
- Most common work settings are hospital (47 per cent) and residential health care facilities (29 per cent).

**Remuneration:**

- Average salary \$47,431

**WORKFORCE PROFILE – REGISTERED NURSE****Demographics:**

- The average age of Registered Nurses is 43 years.
- 88 per cent are female.
- Most are located in NSW (28 per cent), Victoria (25 per cent) and Queensland (20 per cent).
- Aboriginal and Torres Strait Islander people account for 1.0 per cent of the workforce

**Registration requirements:**

- . Regulated by: AHPRA - Nursing and Midwifery Board
- Entry-level qualification: Bachelor of Nursing
- Average cost: \$30,000
- Length of training: 3 years (plus an additional year for a credentialled Mental Health Nurses)
- CPD requirements: Minimum of 20 hours per registration period, 10 additional hours for scheduled medicines endorsement

**Employment arrangements:**

- 56 per cent work on a part-time basis.
- Average of 33.5 hours worked per week, with an average of 28.7 clinical hours.

**Settings:**

- 62 per cent of Registered Nurses work in the public sector compared to 35 per cent in the private sector and 3 per cent work in both.
- Hospital (64 per cent) is the most common work setting, followed by residential health care facilities (10 per cent) and community health care service (8 per cent).

**Remuneration:**

- Average salary \$63,518.

## CURRENT WORKFORCE ISSUES

### Supply and demand:

- Current shortage of Registered Nurses. NMHSPF targets are being met in urban regions, however, there are significant deficits in more rural areas. No shortage of Enrolled Nurses.
- Employment of Mental Health Nurses has been static since 2013 at roughly 85 FTE per 100,000 population. Both public and private health services recruit overseas-trained Mental Health Nurses to fill gaps.

### Attraction to training:

- The number of students commencing a general nursing course leading to initial registration increased by 20.7 per cent from 2015 to 2018.
- Credentialed Mental Health Nurses must complete an additional graduate diploma or masters degree. The cost of training can be a barrier and lack of increase in remuneration can limit attraction.

### Skill needs:

- Nurses working in mental health settings do not always have the right skills to support people experiencing mental ill-health. In 2017, close to 85 per cent did not have a specialist mental health qualification.
- Current training standards for general nurses include mental health within units on broader subjects.
- There is growing need for more nurses and midwives with both AOD and mental health experience.

### Attraction to employment:

- Clinical placements have historically been in the stressful settings, particularly inpatient units, which discourage students from specialising in mental health.
- Stigma, unsupportive workplace cultures, occupational violence, and options for career advancement are deterrents to nurses choosing a career in mental health.

### Retention:

- Attrition is driven in large part by workplace stressors, including verbal and physical aggression, and fatigue.

SOURCE: ANMF, 2020; ANMF, 2019; ATO, 2018; UQ, 2020A; DEPARTMENT OF HEALTH, 2019A; DEPARTMENT OF HEALTH, 2019B; DEPARTMENT OF HEALTH, 2019C; DEPARTMENT OF HEALTH, 2019D; DEPARTMENT OF HEALTH, 2017B; DEPARTMENT OF HEALTH, 2017C; DEPARTMENT OF JOBS AND SMALL BUSINESS, 2019; UQ, 2020B; MY SKILLS, N.D.-C; NURSING AND MIDWIFERY BOARD, 2020; PC, 2020; RIDOUTT, PILBEAM & PERKINS, 2014; STATE OF VICTORIA, 2019.

## **A.8 Occupational Therapist**

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### WORKFORCE PROFILE – OCCUPATIONAL THERAPIST

#### Demographics:

- Average age of Occupational Therapists (OTs) is 37 years.
- Most (91 per cent) are female.
- Most are located in NSW (28 per cent), Victoria (26 per cent) and Queensland (20 per cent).
- Aboriginal and Torres Strait Islander people account for 0.5 per cent of the workforce.

#### Registration requirements:

- Regulated by: AHPRA – Occupational Therapy Board of Australia
- Entry-level qualification: Bachelor of Occupational Therapy or bachelors degree with a major in occupational therapy
- Average cost: \$29,000
- Length of training: 4 years
- CPD requirements: Minimum of 20 hours annually, minimum of five hours in an interactive setting with other practitioners

#### Employment arrangements:

- Approximately one-third work on a part-time basis (34 per cent).
- Average of 33.2 hours per week.
- OTs working in community drug and alcohol services have the highest average weekly hours (37.2 hours) and those in solo private practice have the lowest (29.2 hours).

#### Settings:

- Approximately half (47 per cent) work only in the public sector and the other half only in the private sector, with a small proportion working across both.
- Most common work settings are hospital (20 per cent) and community health care service (16 per cent).

#### Remuneration:

- Average salary \$57,981



## CURRENT WORKFORCE ISSUES

### Supply and demand:

- Current shortage of OTs. Distributed by service sector, there is a deficit in bed-based services but no shortage in clinical ambulatory services or psychosocial support services.

### Attraction to training:

- No reported issues with attraction to training.

### Skill needs:

- Areas for further development include assessment, engaging challenging patients (low motivation, disruptive, abusive, inappropriate behaviour), self-management, and professional self-care and resilience.

### Attraction to employment:

- Number of applicants applying for junior positions is high. Recruiting to intermediate and senior positions is more difficult.
- Attraction to the sector is limited due to lack of understanding of the role of OTs in mental health and poor recognition for the discipline, in terms of Medicare rebates.
- OTs are increasingly being employed in generic roles, such as case managers or care coordinators. Less attraction to generic roles due to loss of discipline-specific service delivery.

### Retention:

- Factors impacting on job satisfaction and retention include making a difference to clients, working in a supportive team, being encouraged and supported to continue learning, and rewards, in terms of recognition.
- Lack of access to supervision and lack of opportunities for career progression negatively impact on retention. There are a limited number of grade 4 positions in mental health available.

SOURCE: ATO, 2018; DEPARTMENT OF HEALTH, 2019A; DEPARTMENT OF HEALTH, 2017D; DEPARTMENT OF JOBS AND SMALL BUSINESS, 2019; UQ, 2020B; FINKELSTEIN, 2020; NWMH, 2019; SCANLAN ET AL., 2016; SCANLAN ET AL., 2013; STATE OF VICTORIA, 2019; VICTORIAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2018A.

## **A.9 Psychiatrist**

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### WORKFORCE PROFILE – PSYCHIATRIST

#### Demographics:

- Average age of Psychiatrists is 53 years.
- 59 per cent are male.
- Most are located in NSW (29 per cent), Victoria (28 per cent) and Queensland (20 per cent).

#### Registration requirements:

- Regulated by: AHPRA – Medical Board of Australia
- Entry-level qualification: Bachelors degree in medicine and postgraduate degree in medicine, followed by specialist training in psychiatry with the Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Average cost: Data not available
- Length of training: 11 years
- CPD requirements: Minimum of 50 hours annually that includes a Professional Development Plan, at least 10 hours of peer reviewed activities, at least 25 hours of self-guided learning, and at least 5 hours of practice development, quality improvement and review

#### Employment arrangements:

- The vast majority work on a full-time basis, with only 15 per cent working on a part-time basis.
- Average of 38.7 hours per week, with an average of 32.4 clinical hours.

#### Settings:

- The most common work settings are hospital (29 per cent), followed by solo private practice (23 per cent), and community mental health service (19 per cent).

#### Remuneration:

- Average income \$181,972

## CURRENT WORKFORCE ISSUES

### Supply and demand:

- Current shortage of Psychiatrists. Significant shortages in sub-specialities (child and adolescent, community liaison, forensic, psychotherapy, and addiction) and specific settings (inpatient units and ED).
- Length of training creates a time lag to increase supply. Australia has relied heavily on attracting overseas-trained psychiatrists, particularly to fill senior registrar positions.
- RANZCP introduced a competency-based training program to reduce bottleneck in trainees progressing from basic to advanced training. Expected to substantially reduce shortfall in Psychiatrists by 2025.
- Maldistribution by geographic location (86 per cent in major cities in 2018) and by areas of socio-economic disadvantage.

### Attraction to training:

- Number of applicants applying for the RANZCP training program has increased. Likely reasons are the greater number of local medical graduates and increased interest in psychiatry training.
- No formal cap on training places. Constraints include supply of suitable applicants and availability of supervisors.
- Junior Medical Officers (JMOs) can be discouraged from specialising in psychiatry because training placements are often in the stressful settings, particularly inpatient units.
- Lack of incentives to train in sub-specialities due to number of positions available and lack of academic appointments.

### Skill needs:

- Need for Psychiatrists to upskill in e-mental health tools and growing areas of need, such as addiction.
- Continuing professional development requirements for managing the side effects of medication prescribed to treat mental illness.

### Attraction to employment:

- Recruitment to inpatient units is difficult. There is a misconception that only the public sector treats acute patients.
- Recruitment becomes more difficult by geographic remoteness.
- A key disincentive to attracting metropolitan-based consultant Psychiatrists in private practice to rural areas is the disparity in income. This includes telepsychiatry which can be higher for some MBS items than face-to-face delivery.

**Retention:**

- Retaining consultant Psychiatrists in the public sector is an issue.
- Between 2011 and 2014, the proportion of Psychiatrists working in both the public and private sectors declined from 43 to 31 per cent and the proportion working solely in private practice increased from 34 to 45 per cent.
- Reasons include overwork and stress due to under-resourcing, lack of financial rewards, increasing red tape, bureaucracy, and paperwork, insufficient administrative support, and occupational aggression.

SOURCE: AIHW, 2018B; ATO, 2018; DEPARTMENT OF HEALTH, 2019E; DEPARTMENT OF HEALTH, 2016A; DEPARTMENT OF HEALTH, 2016B; DEPARTMENT OF JOBS AND SMALL BUSINESS, 2019; MEADOWS ET AL., 2015; MEDICAL BOARD, 2020; MOORE, SUTTON & MAYBERY, 2010; NEWTON ET AL., 2019; PC, 2020; RANZCP, 2020A; RANZCP, 2020B; RANZCP, 2017; RANZCP, N.D.; STATE OF VICTORIA, 2019.

## **A.10 Psychologist**

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### **WORKFORCE PROFILE – PSYCHOLOGIST**

**Demographics:**

- Average age of Psychologists is 46 years.
- 80 per cent are female.
- Most are located in NSW (33 per cent), Victoria (28 per cent) and Queensland (18 per cent).
- Aboriginal and Torres Strait Islander people account for 0.7 per cent of the workforce.

**Registration requirements:**

- Regulated by: AHPRA – Psychology Board of Australia
- Entry-level qualification: Bachelor of Psychology or bachelors degree with a major in psychology, Honours year or post-graduate diploma followed by:
  - a) two-year postgraduate qualification (higher degree pathway)
  - b) two-year internship (4+2 pathway)
  - c) an additional year of study and one-year internship (5+1 pathway).
- Average cost: Data not available
- Length of training: 6 years (plus an additional 2 years for endorsement as a Clinical Psychologist)
- CPD requirements: Develop a learning plan based on objective self-assessment, 10 hours peer consultation activities and 20 hours of other CPD activities annually

**Employment arrangements:**

- 45 per cent work on a part-time basis.
- Average of 32.4 hours per week, with an average of 23.8 clinical hours.

**Settings:**

- The most common work settings are solo private practice (19 per cent), followed by group private practice (17 per cent) and schools (11 per cent).

**Remuneration:**

- Average salary \$70,116
- Earnings depend on a number of factors including years of experience and endorsement as a Clinical Psychologist.

**CURRENT WORKFORCE ISSUES****Supply and demand:**

- There is a moderate undersupply of Psychologists based on NMHSPF targets. Shortage in clinical ambulatory services and maldistribution by geographic location, with deficits in rural and remote areas.

**Attraction to training:**

- Significant increase in the number of people studying psychology at university over the past decade, but no commensurate growth in registered psychologists. This is often attributed to the limited availability of supervised internships.
- The bottleneck associated with internships will to some extent be addressed by phasing out the 4+2 pathway.
- The two-tiered rebate system under MBS is an incentive to undertake the post-graduate clinical psychology pathway. However, it is seen as inequitable by some practising psychologists that have difficulty accessing clinical endorsement due to the cost of training.

**Skill needs:**

- No data available on skill gaps.
- Attraction to employment:
- Difficulties in attracting Grade 3 and Grade 4 Psychologists into public mental health services.
- Difficulties in attracting Psychologists to rural and remote areas given the limited incentives for rural practice, such as scholarships, rural placements and supported internships, and registrar opportunities.

**Retention:**

- The high cost and time to train as a Psychologist may reduce the attrition rate from the profession.
- Public mental health services have difficulty retaining experienced Psychologists. Between 2014 and 2017, the proportion of Psychologists working in a private practice setting in their principal role increased from 36.8 to 40.2 per cent.
- Reasons include workload, staffing levels and loss of clinical time to a burdensome administrative.

SOURCE: AIHW, 2018B; APS, 2019; ATO, 2018; DEPARTMENT OF HEALTH, 2019A; DEPARTMENT OF HEALTH, 2017E; DEPARTMENT OF JOBS AND SMALL BUSINESS, 2019; UQ, 2020B; PC, 2020; PSYCHOLOGY BOARD OF AUSTRALIA, 2020; STATE OF VICTORIA, 2019; VICTORIAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2018B; VICTORIAN PSYCHOLOGISTS ASSOCIATION INC, 2019.

## **A.11 Social Worker**

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### **WORKFORCE PROFILE – SOCIAL WORKER**

**Demographics:**

- Average age of Social Workers is 42 years.
- 84 per cent are female.
- Most are located in Victoria (29 per cent) and NSW (29 per cent), followed by Queensland (17 per cent).
- Aboriginal and Torres Strait Islander people account for 3.2 per cent of the workforce.

**Registration requirements:**

- Self-regulated by: Australian Association of Social Workers
- Entry-level qualification: Bachelor of Social Work
- Average cost: Data not available
- Length of training: 4 years (plus 2 years' experience in a mental health setting for Mental Health Social Workers)
- CPD requirements: 30 hours annually that includes 10 hours of supervision, 15 hours on skills and knowledge and 5 hours on maintaining and developing the professional identity of social work
- For an accredited Mental Health Social Worker, 20 hours must be linked to the mental health field of practice and 10 hours must be linked to FPS

#### Employment arrangements:

- Approximately one-third work on a part-time basis (29 per cent). Few work on weekends, nights or shift work.
- Average of 33.0 hours per week in Victoria.

#### Settings:

- The most common work settings are hospital (54 and 50 per cent in Victoria and NSW respectively) and community health settings (24 and 21 per cent in Victoria and NSW respectively).

#### Remuneration:

- Average salary \$58,415

### CURRENT WORKFORCE ISSUES

#### Supply and demand:

- No national standardised data set on the social work workforce. Based on aggregated, publicly available data, there is no current shortage of Social Workers.
- Social Workers at the intermediate grades are most in demand, particularly those with skills and experience in mental health or domestic and family violence.

#### Attraction to training:

- No current issues with attraction to training.

#### Skill needs:

- No significant skill gaps for accredited Mental Health Social Workers.
- Areas for further development include understanding the hospital and health environment, family violence knowledge and experience and alcohol and other drugs.

#### Attraction to employment:

- Barriers to workforce attraction include lack of career pathways, low pay levels in the community sector and short-term contracts and funding constraints.
- In particular, there are difficulties attracting staff to rural and remote areas.

#### Retention:

- Barriers to retention include high workloads, burnout, lack of career progression opportunities, poor workplace culture or leadership and lack of adequate supervision and support.

- Career structures do not reward clinical expertise or specialty. There is a bottleneck at grade 2 due to lack of available positions, particularly in regional and rural areas and in the community sector.

SOURCE: AASW, 2020; ATO, 2018; JOB OUTLOOK, N.D.-E; DEPARTMENT OF JOBS AND SMALL BUSINESS, 2019; UQ, 2020B; NATSILMH, IAHA & AIPA, 2019; STATE OF VICTORIA, 2019; URBIS, 2018; VICTORIAN DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2018C.

## **A.12 Speech Pathologist**

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### WORKFORCE PROFILE – SPEECH PATHOLOGIST

#### Demographics:

- Average age of Speech Pathologists is 34 years.
- Most (93 per cent) are female.
- Most are located in NSW (30 per cent), Victoria (27 per cent) and Queensland (20 per cent).

#### Registration requirements:

- Self-regulated by: Speech Pathology Australia
- Entry-level qualification: Bachelor or masters of Speech Pathology
- Average cost: \$28,000
- Length of training: 4 years
- CPD requirements: Minimum of 20 points annually

#### Employment arrangements:

- 28 per cent work on a part-time basis.

#### Settings:

- Data not available.

#### Remuneration:

- Average salary \$53,360



## CURRENT WORKFORCE ISSUES

### Supply and demand:

- No current shortage of Speech Pathologists, though maldistribution has created shortages in regional and remote areas. Some evidence that the market is tightening as demand grows (for example, through the NDIS).

### Attraction to training:

- No current issues with attraction to training.

### Skill needs:

- Entry-level training could increase focus on interrelationship between mental health and communication and swallowing, and the role of speech pathology in prevention/early intervention of mental health problems.
- Attraction to employment:
- Limited roles available due to the lack of recognition of Speech Pathologists in mental health settings. Driven by the current lack of access to funding, such as the MBS rebate restrictions.

### Retention:

- Lack of support and training opportunities (including funding for access).
- Increasing use in generalist mental health roles, rather than discipline-specific positions.

SOURCE: ATO CENSUS DATA, 2016; DEPARTMENT OF JOBS AND SMALL BUSINESS, 2019; JOB OUTLOOK, N.D.-E; SPEECH PATHOLOGY AUSTRALIA, 2019

## B Consultation Schedule

The list below outlines the individuals and organisations consulted through the development of the Labour Market Analysis report. ACIL Allen would like to thank them for their time and contribution to this important research.

- AMA Council of Rural Doctors
- Australian College of Mental Health Nurses
- Australian College of Nursing
- Australian Psychological Society
- Australian Register of Counsellors and Psychotherapists
- Deputy Chief Medical Officer for Mental Health
- Flourish Australia (Community based employer)
- Jeff Borland, Labour Market Economist
- LGBTI Health Alliance
- Lifeline
- Melbourne Disability Institute
- National Aboriginal and Torres Strait Islander Health Worker Association
- National Aboriginal Community Controlled Health Organisation
- National Rural Health Alliance
- Occupational Therapy Australia
- Royal Australian College of General Practitioners
- Royal Australian and New Zealand College of Psychiatrists

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