ACIL ALLEN

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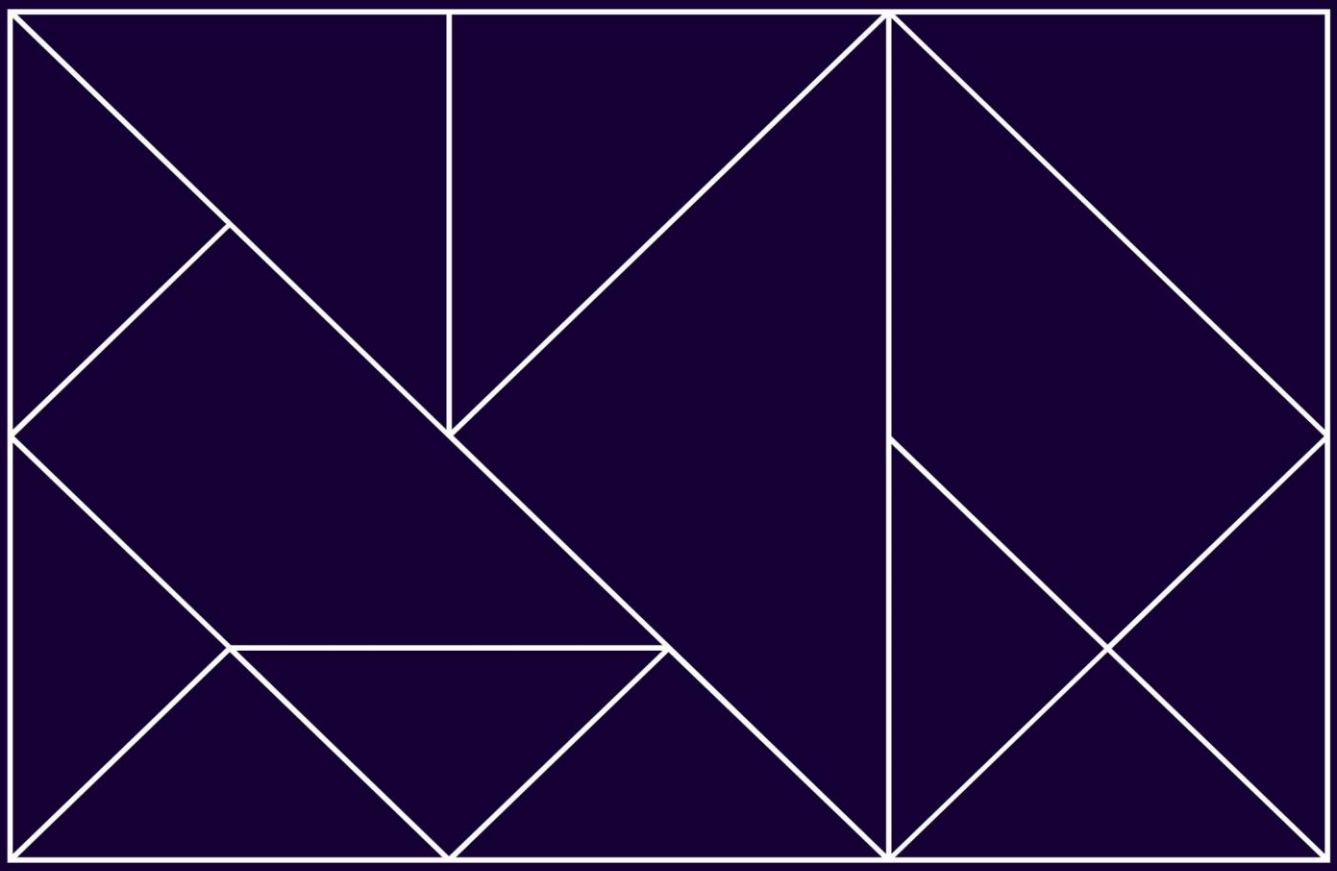
National Mental Health Workforce Strategy

Post Consultation Version



About ACIL Allen

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Contents

Executive summary

Problem statement

Across all Australian states and territories, demand for mental health support and treatment has steadily increased over time and outstrips the available supply. The factors constraining the supply of prevention, support and treatment across the spectrum of intensity are diverse. There is a lack of an appropriately skilled workforce able to deliver mental health promotion activities and provide support and treatment when, where and how consumers and carers[1] prefer across the life course. Specifically:

- there are shortages of workers across most occupations delivering mental health promotion activities and providing support and treatment to people experiencing suicidality, mental distress and/or ill-health
- the mental health workforce is maldistributed
  - geographically, with shortages in metropolitan regions and more acute shortages in regional and remote locations
  - between the public, private and not-for-profit sectors
  - between service settings, which refers to where services are delivered (such as in emergency departments, hospitals and in the community) and service settings that support specific consumer and carer cohorts either at particular stages in their life-course, people with community and cultural needs, people with disability and LGBTIQ+ communities
  - meet the needs of people experiencing specific circumstances such as during the perinatal period or co-occurring alcohol and other drug use and use disorders
  - within occupations, with some areas of specialisation experiencing more significant shortages than others
- the current mental health workforce is not always appropriately skilled and not all workers have been trained in or updated their practice to:
  - reflect contemporary approaches that support trauma informed, sustainable, recovery oriented, and integrated support and treatment
  - respond to peoples' needs across the life course, people with community and cultural needs (including Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people), people with disability, LGBTIQ+ communities
  - meet the needs of people experiencing specific circumstances such as during the perinatal period or issues with alcohol and other drugs

[1] Carers are everyday Australians providing significant emotional, practical and financial support to family members or friends living with mental ill-health.

— not all occupations are operating to their full scope of practice, reducing the opportunities afforded to the available workforce, including emerging occupations.

These factors impact on the access to and quality of suicide prevention and mental health promotion, support and treatment available to consumers, carers and their families.

Background

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

Generational reform

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

A person-centred system

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

Working collaboratively with consumers, families and carers

Successful implementation of the reform agenda will depend on the presence of a broadly defined, appropriately skilled workforce, working collaboratively with consumers, families and carers and with one another across occupations and organisations in multidisciplinary teams to deliver integrated support and treatment. This will build on the strengths of the existing workforce, which includes people and programs working to ensure better mental health promotion, support and treatment for consumers and carers.

Innovation

The Strategy anticipates and encourages innovation and does not prescribe a model of care, recognising that different models of care are appropriate in different contexts. The Strategy recognises the continuum of mental health and wellbeing activities, from mental health promotion and prevention of suicidality, ill health and/or distress, to early intervention, through to support, treatment and recovery. This involves different levels of support and treatment intensity, provided by a wide range of mental health professionals, depending on the severity and complexity of consumer and carer need.

In place of any specific model of care, the Strategy utilises the concept of 'components of care'[2] that may be brought together in different ways to form models of care. There should be clear linkage between components of care, the National Mental Health Service Planning Framework, the various occupational scopes of practice (existing and those yet to be developed) and the education and training required to develop the competences that enable delivery of the components of care.

The Strategy recognises that no single approach to workforce development can be applied to all occupations in all contexts. Each occupation within the broadly defined mental health workforce requires specialist skills and competencies that support the model of care and components of care required in the service setting in which they operate.

There are specific challenges facing each service. For example, the challenges in rural and remote locations differ from metropolitan settings, and those faced by public crisis and emergency settings differ again. All challenges impact on the ability to attract, train and retain the required mental health workforce.

It is important that these issues are addressed to support the delivery of the promotion, prevention, support and treatment that meet the needs of local communities and cohorts with distinct needs, such as children and young people and the elderly.

Related work

The Strategy acknowledges the significant work underway to develop related workforces, including the aged care, disability services and community services workforces, and the associated need to develop a whole-of-government, holistic approach to growing and sustaining these workforces. It aims to complement and integrate with other related strategies that have been developed and are being developed, rather than duplicating their content. Key examples include the National Medical Workforce Strategy, the Stronger Rural Health Strategy, the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021-2031, the forthcoming Suicide

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

Prevention Workforce Strategy and state and territory mental health workforce strategies and initiatives.

Impact of disasters and COVID-19

The Strategy has been developed at a time of significant challenge. Disasters, such as bushfires and the COVID-19 pandemic, have impacted our lives and greatly affected the mental health of many. In turn, this generates an increase in the number of people seeking support. As an example, during the COVID-19 pandemic, there was a 15% increase in the number of Medicare-subsidised mental health services delivered nationally from March to October 2020.[3] The impact was felt particularly in Victoria, with prolonged periods of lockdown contributing to a 31% increase in services accessed between September and October 2020. This highlights the need for the mental health workforce to have sufficient surge capacity to meet sudden, unexpected and significant increases in demand for mental health support and treatment.

Development of the Strategy

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

The Strategy draws on evidence from a range of sources, including published literature, workforce data analysis, government reports and inquiries, and consultation with consumer and carer representatives, employers in the mental health sector, peak bodies and professional associations, and vocational and higher education providers. The Strategy draws heavily on the Productivity Commission's Inquiry into Mental Health (2020).

Further detail on the development process and evidence base is available in the accompanying Background Paper but is not repeated here.

The Taskforce will deliver its version of the Strategy to the Australian Government in late 2021 for consideration.

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

Definition of the mental health workforce

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

Australia's mental health workforce spans the service continuum and includes promotion, prevention, early intervention, support and treatment to support positive mental health and wellbeing. The Strategy recognises that there are:

— people who work exclusively with people experiencing suicidality, mental distress and/or ill-health

— people who work frequently but not exclusively with people experiencing suicidality, mental distress and/or ill-health

— people who are likely to have regular contact with people experiencing suicidality, mental distress and/or ill-health as part of their role.

All of these individuals contribute to the promotion of mental wellbeing and suicide prevention, and require associated knowledge and skills.

Workforces overlap at the individual and occupational level.[4] For example, a nurse may work exclusively in a mental health service, a health service, in a school – or work across all three. This overlap influences the way in which the mental health workforce needs to be considered, trained and developed to address mental health and physical health comorbidities and populations with distinct needs due to their stage of life or circumstances (for example, children and young people, people with disability, or during the peri-natal period).

The Strategy recognises the crucial role played by the volunteer workforce. Volunteers should be valued for their unique contributions and not viewed as a substitute for the paid workforce. The volunteer workforce requires the same supports as the paid workforce, including training, professional development, access to appropriate supervision and debriefing.

[4] The Strategy recognises that people trained in one occupation may work in multiple services. For example, allied health practitioners may work exclusively in mental health settings or in more general health settings, or in both. Some occupations include mental health endorsements in their accreditation arrangements, and some do not.

The Strategy notes the significant overlap between the mental health and suicide prevention workforces with respect to roles, occupations and the required competencies. Suicide prevention competencies are critical to the broadly defined mental health workforce and will be included in the competencies required to deliver the components of care referenced in this Strategy. The National Mental Health Commission is developing a Suicide Prevention Workforce Strategy that will capture specific actions required for the suicide prevention workforce.

The Strategy also recognises the critical role that carers, family, friends and important others play in supporting people experiencing suicidality, mental distress and/or ill-health in their recovery. This group have their own needs, including training and support requirements, and benefit from whole-of-family approaches.

FIGURE ES.1 DEFINITION OF THE MENTAL HEALTH WORKFORCE

The mental health workforce works across promotion, prevention, early intervention, intervention and recovery across the life-course from the early years through to older age, addressing the needs of consumers and carers including community and cultural needs, needs of people with disability, LGBTIQ+ communities and people experiencing specific life circumstances. The mental health workforce works in a range of settings, a range of roles (including academia, clinical, community development, policy, planning and programming), at diverse levels (including leadership and managerial positions) and in paid and unpaid capacities.

SOCIAL & EMOTIONAL WELLBEING & HEALTH

Including but not limited to:
- Aboriginal Health Practitioners
- Aboriginal Health Workers
- Aboriginal Mental Health Workers
- Allied Health Assistants
- Allied Health Practitioners
- AOD Clinicians and Workers
- Care Coordinators
- Community Workers
- Creative Arts Therapists
- Crisis Support Workers
- Counsellors and psychotherapists
- Dentists
- Dietitians / Nutritionists
- Exercise Physiologists
- General Practitioners
- Life Coaches
- Lived Experience (Peer) Workers
- Medical Specialists
- Mental Health Nurses
- Mental Health Promotion Workers
- Midwives
- Nurses (Enrolled, Registered, Practitioners)
- Occupational Therapists
- Paramedics
- Pharmacists
- Physiotherapists
- Physicians
- Psychiatrists
- Psychologists
- Psychosocial Support Workers
- Social Workers
- Speech Pathologists
- Traditional Healers

CARERS, FAMILIES AND COMMUNITIES

Including but not limited to:
- Community leaders
- Elders
- Family members
- Kin
- Social connections
- Universal services (e.g. hairdressers, massage therapists)

SOCIAL SERVICES

Including but not limited to:
- Aged care workers
- Defence Force workers
- Disability services workers
- Educational services workers
- Employment services workers
- First responders (including emergency service staff, fire fighters, paramedics, police)
- Housing services workers
- Justice workers
- Transport services workers

ALTERNATIVE THERAPISTS

Including but not limited to:
- Acupuncturists
- Chinese Medicine Practitioners

Note: Mental Health Nurse refers to Credentialled Mental Health Nurses.

Aim

The aim of the Strategy is:

To develop and retain an appropriately skilled, resourced and sized mental health workforce that is suitably distributed and integrated to help Australians be mentally and physically well by meeting their prevention, support, treatment and recovery requirements at the time and in the way that best meets their needs.

Supporting Australians to be mentally well is no longer restricted to supporting those experiencing suicidality, mental distress and/or ill-health, but encompasses mental health promotion, suicide prevention, early intervention, support and treatment to encourage positive mental health and wellbeing. These issues affect people of all ages from all backgrounds in all locations across Australia.

Objectives and priority areas for action

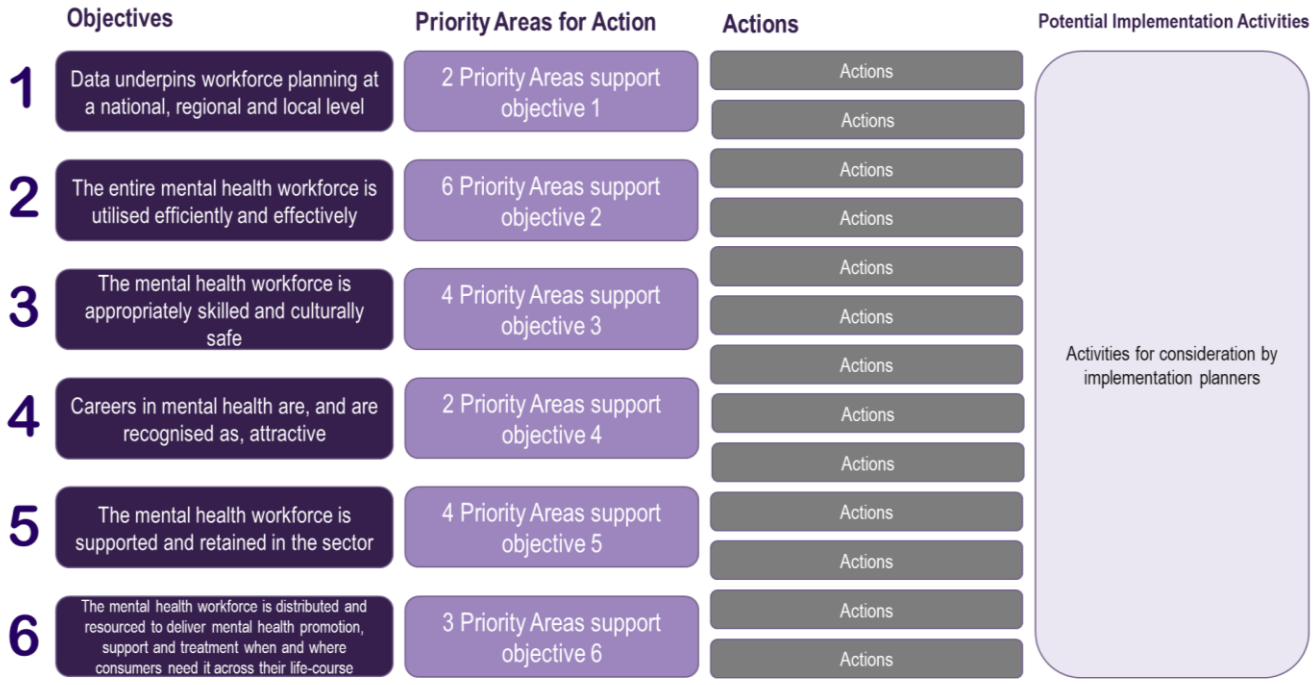
The Strategy's aim and objectives are conceptualised in Figure ES.2. These objectives are designed to recognise, and build on, the strengths of the existing mental health workforce while growing the overall size.

FIGURE ES.2 STRATEGY – AIM AND OBJECTIVES

The Strategy identifies priority areas for action (priority areas) and supporting actions aligned to each objective. The priority areas and actions represent an integrated approach to achieving the objectives and include many co-dependencies; therefore, an action may be relevant to more than one priority area and support multiple objectives.

Potential implementation activities associated with each priority area were suggested to the Taskforce by Working Group members and through consultation processes. These suggestions have been collated and aligned to the objectives, priority areas for action and actions and are provided in Appendix A for information only. The figure below represents the relationship between the objectives, priority areas, actions and potential implementation activities.

FIGURE ES.3 STRATEGY – RELATIONSHIP BETWEEN OBJECTIVES, PRIORITY AREAS, ACTIONS AND POTENTIAL IMPLEMENTATION ACTIVITIES



Each chapter of the Strategy is aligned to an objective and includes explanation of the priority areas and actions associated with the objective.

Implementation

Roles and responsibilities

Achieving the aim of the Strategy requires multiple levels of government, sectors and stakeholders to be proactive and committed to working together toward a shared view of mental health system reform.

The Strategy recognises the need for greater collaboration and coordination within and across levels of government to agree funding, governance and accountability for implementation of reforms. All stakeholders will need to cooperate to deliver priority action areas from their respective mandates, ensuring that system-wide collaboration helps to expand and improve the broadly defined mental health workforce. This includes:

- Commonwealth, state and territory governments – share responsibility for funding public, private and not-for-profit mental health services, delivery of public mental health services (state and territory governments), implementation of prevention and early intervention programs, administration of quality and safety mechanisms, funding and quality assurance of relevant vocational and tertiary education providers. The Commonwealth Government is responsible for the Medicare Benefits Schedule (MBS), a list of health professional services subsidised by the Commonwealth Government, and for determining which occupations can deliver the services that attract these subsidies. This includes the Better Access initiative[5] which provides Medicare rebates to help people access specified mental health services.
- Australian Health Practitioner Regulation Agency (Ahpra) and National Boards – responsible for setting standards and policies that all Ahpra registered health practitioners must meet, conducting registration and compliance processes and investigating complaints against Ahpra registered practitioners.
- Professional peak bodies and colleges, unions, and consumer and carer organisations – responsible for representing and supporting members. Professional peak bodies and colleges also define training and education standards, continuing professional development requirements and administer self-regulated occupational schemes, and share practice expertise.
- Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) – responsible for local health needs assessment, managing the delivery of public hospital services and other community based health services, commissioning primary mental health services, regional planning and coordination.
- Education providers – responsible for the developing, designing and delivering education and training programs, including co-design initiatives involving peak bodies and other relevant groups, to appropriately educate and train the mental health workforce.
- Health and community services providers, including Aboriginal Community Controlled Health Organisations (ACCHOs), and practitioners – responsible for delivering support and treatment, employment, supervision and support to attract and retain the mental health workforce.
- Carers, family, friends and important others – responsible for providing emotional and practical support to a person experiencing suicidality, mental distress and/or ill health to assist in treatment and recovery.

[5] At the time of writing, the Better Access initiative is under review.

Implementation planning

In many instances, implementation of the actions represents significant bodies of work. The Strategy will be supported by an implementation plan (or series of plans) that will be developed collaboratively by the Commonwealth, state and territory governments, peak professional bodies and colleges, regulators, educational institutions, service providers, consumers and carers.

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

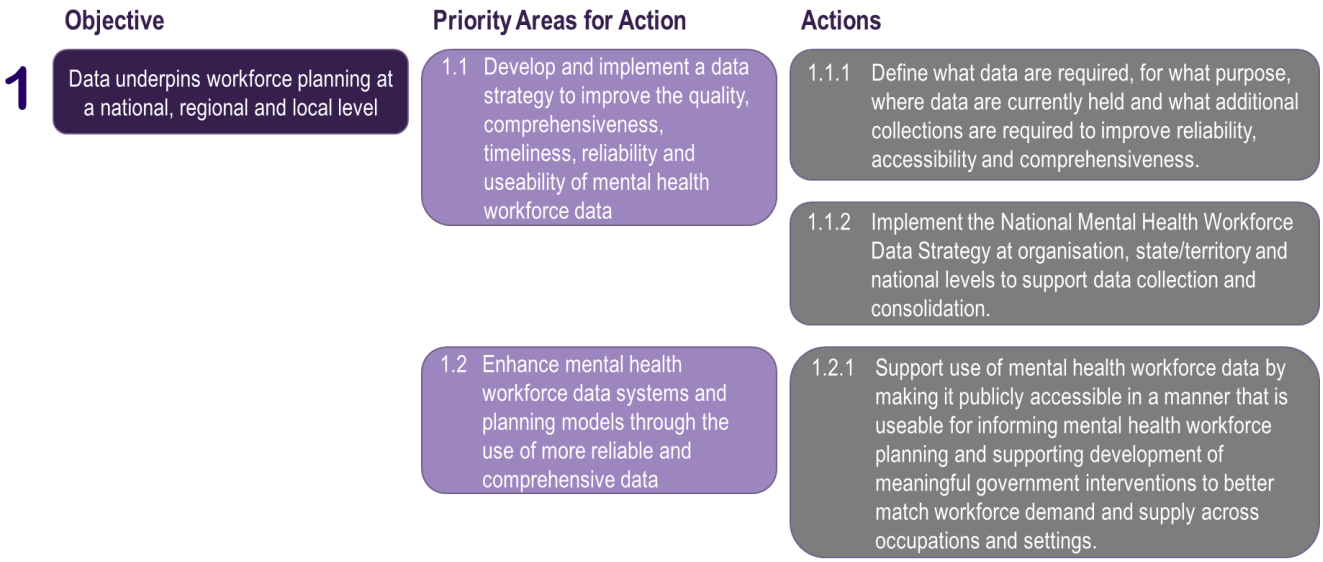
The Strategy includes a broad suite of initiatives that will improve data collection, workforce approaches and consumer outcomes. This will help to provide the basis for government to increase the focus on research and evaluation, from the inception to completion of mental health initiatives.

Further guidance is provided in the final chapter.

1. Data underpins workforce planning at a national, regional and local level

The first objective – Data underpins workforce planning at a national, regional and local level – addresses the need for strategic, future-focused mental health workforce planning to be underpinned by reliable, comprehensive, up-to-date workforce data that is readily accessible. Availability and use of such data will support forecasting and monitoring of strategies that encourage workforce development and growth for both established and emerging occupations.

FIGURE 1.1 OBJECTIVE 1: PRIORITY AREAS AND ACTIONS



Lack of comprehensive data

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

Inconsistent approaches

Current variation in data collection approaches impacts the ability to conduct data-driven workforce planning. A nationally consistent approach to data that adopts a broad definition of the mental health workforce and includes at a minimum people who work in all mental health, social and emotional wellbeing and health settings is required to facilitate improved workforce planning, meaningful intervention and the delivery of support and treatment that better meets the needs of consumers and carers. This will necessitate the development of clear definitions of roles or occupations, the skills and competencies they require, and the settings in which they work.

Disconnected sources

The disjointed nature of data holdings limits the extent to which information is accessible. Access to timely and high quality data about the entire mental health workforce, including data on occupations not regulated through Ahpra, will build a more fulsome understanding of the available workforce by location, occupation and skill set. Information about local service need and scopes of practice including skills and competencies by occupation, combined with improved workforce data, will facilitate better quality, more complete workforce planning that utilises the entire mental health workforce available.

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

Priority areas and actions

PRIORITY AREA 1.1 – Develop and implement a data strategy to improve the quality, comprehensiveness, timeliness, reliability and useability of mental health workforce data:

- Action 1.1.1 – Define what data are required, for what purpose, where data are currently held and what additional collections are required to improve reliability, accessibility and comprehensiveness
- Action 1.1.2 – Implement the National Mental Health Workforce Data Strategy at organisation, state/territory and national levels to support data collection and consolidation

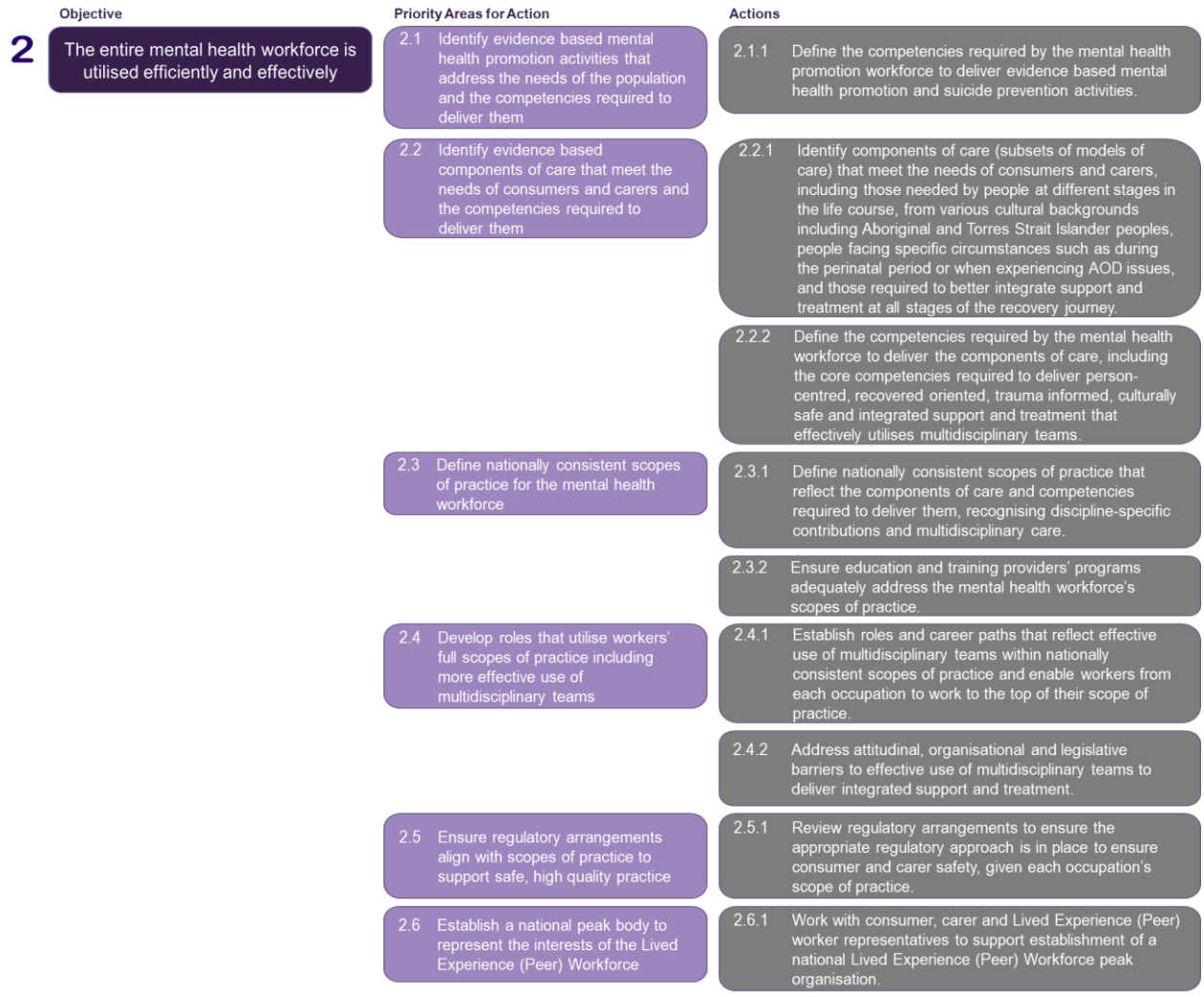
PRIORITY AREA 1.2 – Enhance mental health workforce data systems and planning models through the use of more reliable and comprehensive data:

— Action 1.2.1 – Support use of mental health workforce data by making it publicly accessible in a manner that is useable for informing mental health workforce planning and supporting development of meaningful government interventions to better match workforce demand and supply across occupations and settings

2. The entire mental health workforce is utilised efficiently and effectively

The second objective – The entire mental health workforce is utilised efficiently and effectively – is critical to ensuring that mental health promotion activities are conducted by those best-placed to do so, and that people experiencing suicidality, mental distress and/or ill-health and their carers are able to access safe, high quality support and treatment, delivered by skilled workers from a broad range of occupations in diverse service settings, when and where they are needed.

FIGURE 2.1 OBJECTIVE 2: PRIORITY AREAS AND ACTIONS



Recognition of the broadly defined workforce

Population, consumer and carer needs are more likely to be met if the entire mental health workforce is appropriately utilised. This requires recognition of the broadly defined workforce, and appropriate definition of the requisite knowledge and skills. Improving this includes better articulation of mental health promotion activity, identifying the workforces that are best placed to perform these activities and providing them with the requisite knowledge and skills. When mental health support and treatment is required, it requires workers performing roles that reflect their full scope of practice, more frequent and effective adoption of multidisciplinary team-based approaches and provision of better integrated support and treatment.

Need for common components of care and competencies

Clear articulation of the '*components of care*' that address consumer and carer needs, including those related to sustainable recovery, is required. So too is the identification of the competencies required to deliver the components of care, and specification of the occupations that are trained to perform these competencies.

The competencies that enable the workforce to deliver the components of care need to reflect consumer and carer needs across the life-course including those of children, young people, adults, and older people. Components of care and related competencies are also required to meet the needs of consumers from different cultures and backgrounds, including Aboriginal and Torres Strait Islander peoples and LGBTIQ+, and people experiencing specific circumstances such as during the perinatal period or issues with alcohol and other drugs. The competencies include cultural knowledge and support and must be developed across all occupations that comprise the mental health workforce.

The competencies that enable the workforce to deliver the components of care include core competencies common across occupations, such as person-centred support and treatment – recognising consumers and carers as partners in planning and decision making, recovery oriented, trauma informed, and culturally safe. These core competencies are critical to providing the integrated support and treatment that consumers and carers need, genuinely drawing on the strengths of a multidisciplinary workforce.

Inconsistencies across occupations

There is significant variation in the knowledge, skills and behaviours of the mental health workforce both within and between occupations. Variation between occupations is expected and appropriate, however it is not nationally consistent. The variation within occupations is caused by many factors including changes in education and training practices and requirements over time, which occupations are supported through government incentives in

training and delivery of care, varying investment in and regulatory requirements for continuing professional development, differing work practices and roles between settings, and unclear scopes of practices for some occupations.

Varied availability of scopes of practice

There are few nationally consistent, clearly documented scopes of practice across the occupations in the mental health sector which creates confusion about who is able to undertake what tasks in which settings. While some occupations have documented and national scopes of practice, many other occupations do not – particularly emerging and self-regulated occupations and in the broader social and emotional wellbeing workforce.

This lack of clarity and consistency raises barriers to the appropriate utilisation of some occupations within the mental health sector. It also creates challenges for multidisciplinary team care models, with limited clarity on how scopes of practice can be utilised to their fullest extent.

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

Definition of clear scopes of practice will mean the broadly defined mental health workforce is better able to respond to unexpected, sudden increases in demand for mental health services as there will be a much clearer view of which occupations are trained to provide which components of care and can therefore be called on when required. The need for a surge capacity has been highlighted by the increased mental health concerns associated with recent bushfires and experiences arising from the COVID 19 pandemic.

Contemporary regulation requirements

The quality of care and safety of service delivery for consumers is underpinned by effective regulatory arrangements. The current arrangements for regulating the occupations in the mental health workforce have evolved over time. Some occupations have long-established, mature regulatory schemes[6]. There is a need to ensure that the appropriate regulatory

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

arrangements are in place for emerging occupations and occupations that may be able to contribute more fully.

The adoption of a social and emotional wellbeing approach to mental health, and the broader definition of the mental health workforce, means it is timely to review the occupational regulatory arrangements that monitor and support safe practice by the occupations that comprise the mental health workforce. The revision of regulatory arrangements should be conducted in light of the revised / reconfirmed scopes of practice. The appropriate regulatory approach for each occupation should build on the work of *the Independent Review of the National Registration and Accreditation Scheme for health professions,* 2014 and the *Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for Health Professionals*, 2018.

Occupational regulation is a mechanism for protecting the community by requiring that prescribed professional practice standards are met and should not be viewed through the lens of gaining access to funding arrangements. The Strategy acknowledges the criticality of adequate funding to meeting the mental health needs of the community, consumers and carers. This is partially managed through the MBS, including through the Better Access Program, which is currently being reviewed and is therefore beyond the scope of this Strategy.

Much of the work required to implement the actions described below will require involvement of the peak organisations that represent the mental health workforce. Most of these occupations currently have peak organisations that represent the interests of members. Notably, the Lived Experience (Peer) Workforce does not and establishment of such a body is recommended to support development of this important part of the mental health workforce.

Alignment of job roles with training

Job roles within the mental health sector need to utilise the full scope of practice of each occupation. This requires a move away from generic job roles to those that recognise the discipline-specific training of occupations. This not only helps to address the impact of workforce shortages on consumer and carer access to support and treatment, but also provides more challenging and rewarding career paths which increase retention.

Priority areas and actions

PRIORITY AREA 2.1 – Identify evidence based mental health promotion activities that address the needs of the population and the competencies required to deliver them:

— Action 2.1.1 – Define the competencies required by the mental health promotion workforce to deliver evidence based mental health promotion and suicide prevention activities.

PRIORITY AREA 2.2 – Identify evidence based components of care that meet the needs of consumers and carers and the competencies required to deliver them:

— Action 2.2.1 – Identify components of care (subsets of models of care) that meet the needs of consumers and carers, including those needed by people at different stages in the life course, from various cultural backgrounds including Aboriginal and Torres Strait Islander peoples, people facing specific circumstances such as during the perinatal period or when experiencing AOD issues, and those required to better integrate support and treatment at all stages of the recovery journey

— Action 2.2.2 – Define the competencies required by the mental health workforce to deliver the components of care, including the core competencies required to deliver person-centred, recovered oriented, trauma informed, culturally safe and integrated support and treatment that effectively utilises multidisciplinary teams.

PRIORITY AREA 2.3 – Define nationally consistent scopes of practice for the mental health workforce:

— Action 2.3.1 – Define nationally consistent scopes of practice that reflect the components of care and competencies required to deliver them, recognising discipline-specific contributions and multidisciplinary care

— Action 2.3.2 – Ensure education and training providers' programs adequately address the mental health workforce's scopes of practice.

PRIORITY AREA 2.4 – Develop roles that utilise workers' full scopes of practice including more effective use of multidisciplinary teams:

— Action 2.4.1 – Establish roles and career paths that reflect effective use of multidisciplinary teams within nationally consistent scopes of practice and enable workers from each occupation to work to the top of their scope of practice

— Action 2.4.2 – Address attitudinal, organisational and legislative barriers to effective use of multidisciplinary teams to deliver integrated support and treatment.

PRIORITY AREA 2.5 – Ensure regulatory arrangements align with scopes of practice to support safe, high quality practice:

- Action 2.5.1 – Review regulatory arrangements to ensure the appropriate regulatory approach is in place to ensure consumer and carer safety, given each occupation's scope of practice.

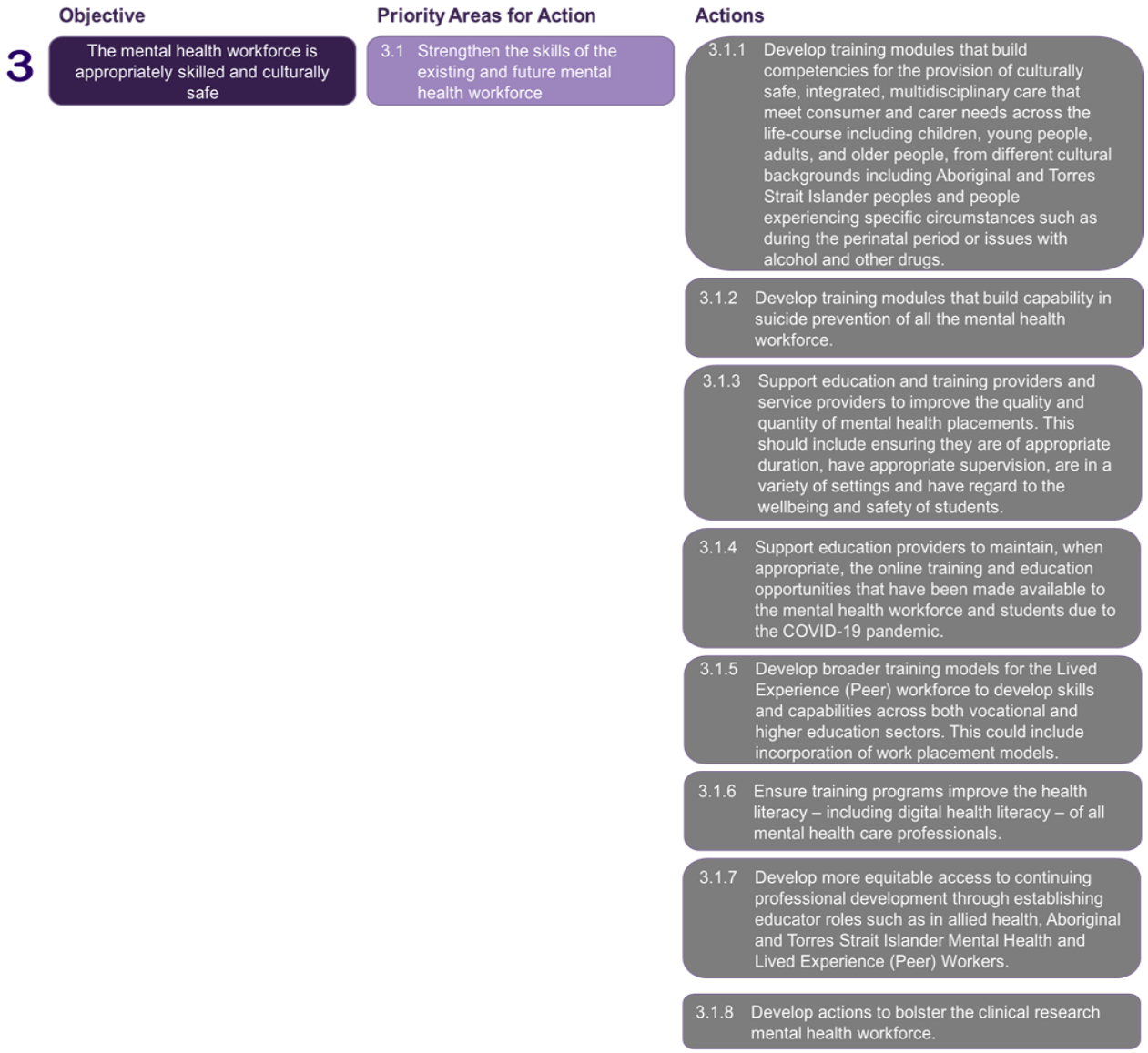
PRIORITY AREA 2.6 – Establish a national peak body to represent the interests of the Lived Experience (Peer) Workforce:

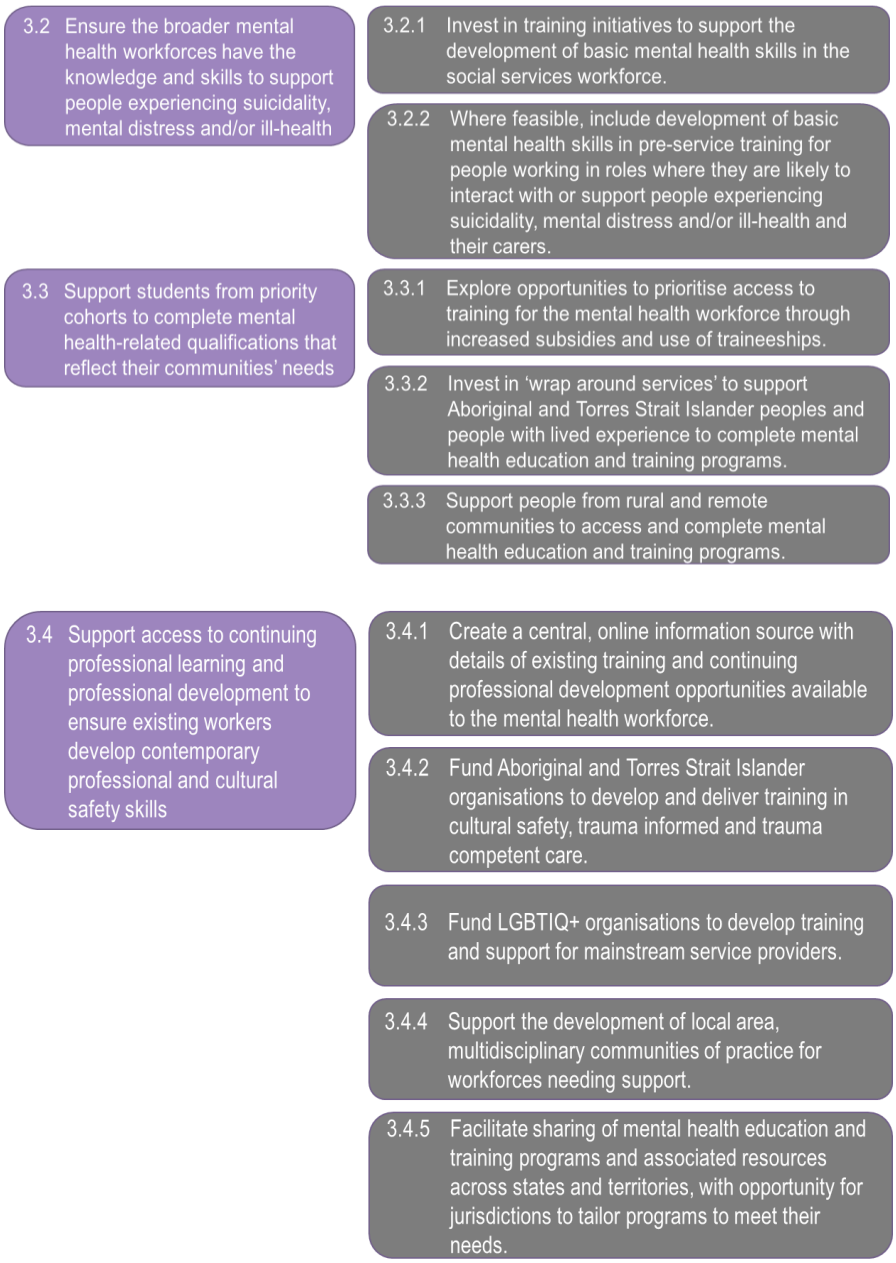
- Action 2.6.1 – Work with consumer, carer and Lived Experience (Peer) worker representatives to support establishment of a national Lived Experience (Peer) Workforce peak organisation

3. The mental health workforce is appropriately skilled and culturally safe

Objective 3 – The mental health workforce is appropriately skilled and culturally safe – recognises that training and education provides one of the foundations on which a high quality mental health workforce is based.

FIGURE 3.1 OBJECTIVE 3: PRIORITY AREAS AND ACTIONS





Quality training experiences

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

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

Contemporary skills

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

Education and training providers also need to consider the skills that the workforce will require to deliver the mental health promotion activities, support and treatment now and in the future.

Training and education programs should improve the health literacy – including digital health literacy – of all mental health care professionals and build the skills and knowledge that graduates need to work to the full occupational scopes of practice described in the previous chapter. This requires close interaction between education and training providers, regulators, national occupational boards, medical colleges, occupation and sector peak organisations, and Aboriginal and Torres Strait Islander organisations.

Priority areas and actions

PRIORITY AREA 3.1 – Strengthen the skills of the existing and future mental health workforce:

- Action 3.1.1 – Develop training modules that build competencies for the provision of culturally safe, integrated, multidisciplinary care that meet consumer and carer needs across the life-course including children, young people, adults, and older people, from different cultural backgrounds including Aboriginal and Torres Strait Islander peoples and people experiencing specific circumstances such as during the perinatal period or co-occurring alcohol and other drug use and use disorders
- Action 3.1.2 – Develop training modules that build capability in suicide prevention of all the mental health workforce
- Action 3.1.3 – Support education and training providers and service providers to improve the quality and quantity of mental health placements. This should include ensuring they are of appropriate duration, have appropriate supervision, are in a variety of settings and have regard to the wellbeing and safety of students
- Action 3.1.4 – Support education providers to maintain, when appropriate, the online training and education opportunities that have been made available to the mental health workforce and students due to the COVID-19 pandemic

- Action 3.1.5 – Develop broader training models for the Lived Experience (Peer) workforce to develop skills and capabilities across both vocational and higher education sectors. This could include incorporation of work placement models
- Action 3.1.6 – Ensure training programs improve the health literacy – including digital health literacy – of all mental health care professionals
- Action 3.1.7 – Develop more equitable access to continuing professional development through establishing educator roles such as in allied health, Aboriginal and Torres Strait Islander Mental Health and Lived Experience (Peer) Workers
- Action 3.1.8 – Develop actions to bolster the clinical research mental health workforce.

PRIORITY AREA 3.2 – Ensure the broader workforces have the knowledge and skills to support people experiencing suicidality, mental distress and/or ill-health:

- Action 3.2.1 – Invest in training initiatives to support the development of basic mental health skills in the social services workforce
- Action 3.2.2 – Where feasible, include development of basic mental health skills in pre-service training for people working in roles where they are likely to interact with or support people experiencing suicidality, mental distress and/or ill-health and their carers.

PRIORITY AREA 3.3 – Support students from priority cohorts to complete mental health-related qualifications that reflect their communities' needs:

- Action 3.3.1 – Explore opportunities to prioritise access to training for the mental health workforce through increased subsidies and use of traineeships
- Action 3.3.2 – Invest in 'wrap around services' to support Aboriginal and Torres Strait Islander peoples and people with lived experience to complete mental health education and training programs
- Action 3.3.3 – Support people from rural and remote communities to access and complete mental health education and training programs.

PRIORITY AREA 3.4 – Support access to continuing professional learning and professional development to ensure existing workers develop contemporary professional and cultural safety skills:

- Action 3.4.1 – Create a central, online information source with details of existing training and continuing professional development opportunities available to the mental health workforce
- Action 3.4.2 – Fund Aboriginal and Torres Strait Islander organisations to develop and deliver training in cultural safety, trauma informed and trauma competent care
- Action 3.4.3 – Fund LGBTIQ+ organisations to develop training and support for mainstream service providers
- Action 3.4.4 – Support the development of local area, multidisciplinary communities of practice for workforces needing support

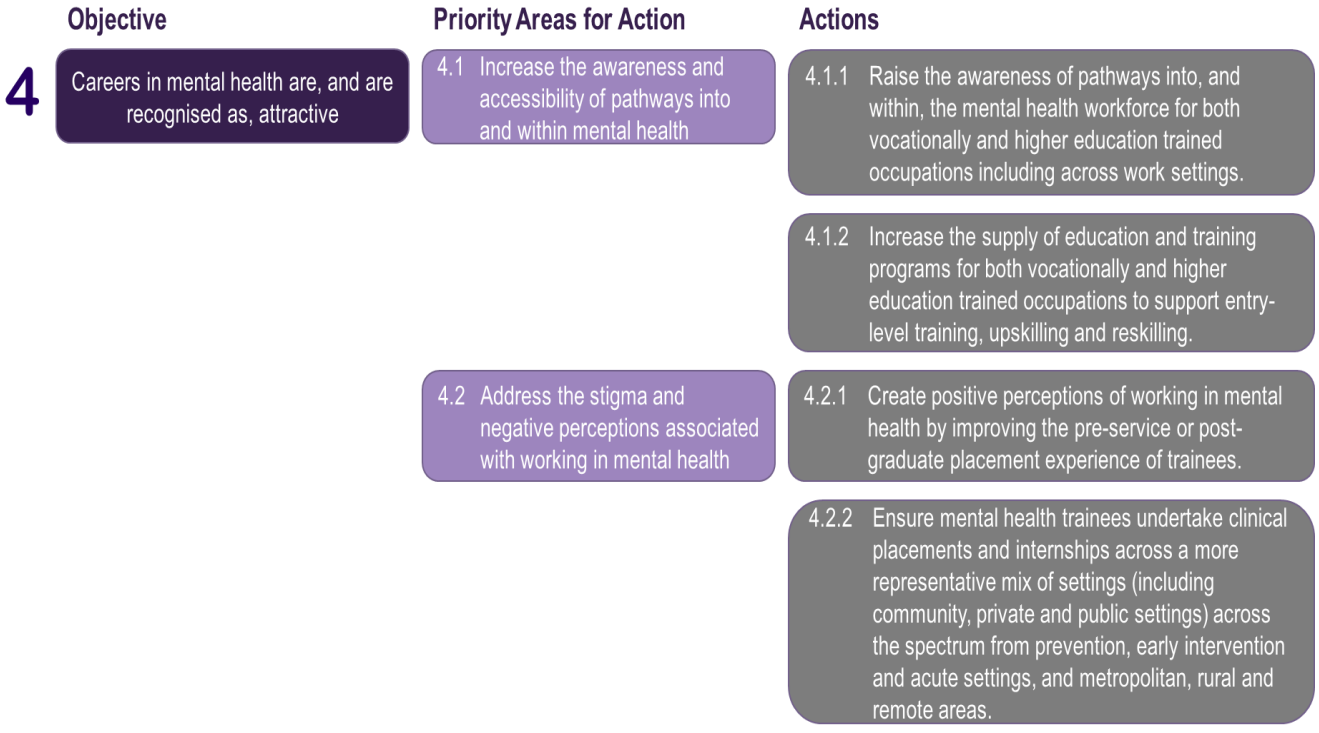
— Action 3.4.5 – Facilitate sharing of mental health education and training programs and associated resources across states and territories, with opportunity for jurisdictions to tailor programs to meet their needs.

4. Careers in mental health are, and are recognised as, attractive

The fourth objective – Careers in mental health are, and are recognised as, attractive – addresses the need for the mental health sector to offer attractive career options to the broadly defined workforce, ensure there are high levels of awareness of these careers and that there is appropriate access to high quality training.

There is a clear need to improve attraction to the workforce across the occupations providing mental health promotion, prevention, early intervention, support and treatment across the life-course, including children, young people, adults, and older people, and for specific circumstances such as during the perinatal period or issues with alcohol and other drugs.

FIGURE 4.1 OBJECTIVE 4: PRIORITY AREAS AND ACTIONS



Limited awareness of pathways

There is limited awareness of the career opportunities that the mental health sector affords and this impacts on the number of students enrolling in some training programs. This applies to entire programs of study that focus on mental health, and programs of study that include elective units in mental health. It is relevant to occupations that work exclusively in mental health (for example, mental health nurses) and occupations that *may* work in mental health (such as nurses).

This issue applies to vocationally and higher education trained occupations, across work settings, locations and for populations that are currently underrepresented (such as Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, and LGBTIQ+ communities).

While this may change to some extent as a result of recent government announcements of significant investment in the sector, concerted effort is required to lift the profile of the career opportunities available. There is a need to market mental health as an attractive career choice to secondary school students, undergraduates, graduates and the existing health workforce to help build demand for training programs, including mental health components within broader programs.

Stigma and negative perceptions

Stigma and negative perceptions associated with working in mental health further reduces the demand for mental health-specific education and training, particularly within courses where graduates have the option to pursue a career in other sectors. There is a need to address the stigma associated with mental health careers, ensuring that the community values and respects the mental health workforce.

Increasing positive exposure to mental health workplaces in pre-service education and training would help alleviate negative perceptions about careers in mental health. The availability, quality and range of settings in which placements and internships are undertaken are important in providing trainees with positive experiences of the mental health sector. Positive placement experiences lead to greater numbers of students, trainees and interns who are likely to consider careers in mental health.

Priority areas and actions

PRIORITY AREA 4.1 – Increase the awareness and accessibility of pathways into and within mental health:

- Action 4.1.1 – Raise the awareness of pathways into, and within, the mental health workforce for both vocationally and higher education trained occupations including across work settings
- Action 4.1.2– Increase the supply of education and training programs for both vocationally and higher education trained occupations to support entry-level training, upskilling and reskilling.

PRIORITY AREA 4.2 – Address the stigma and negative perceptions associated with working in mental health:

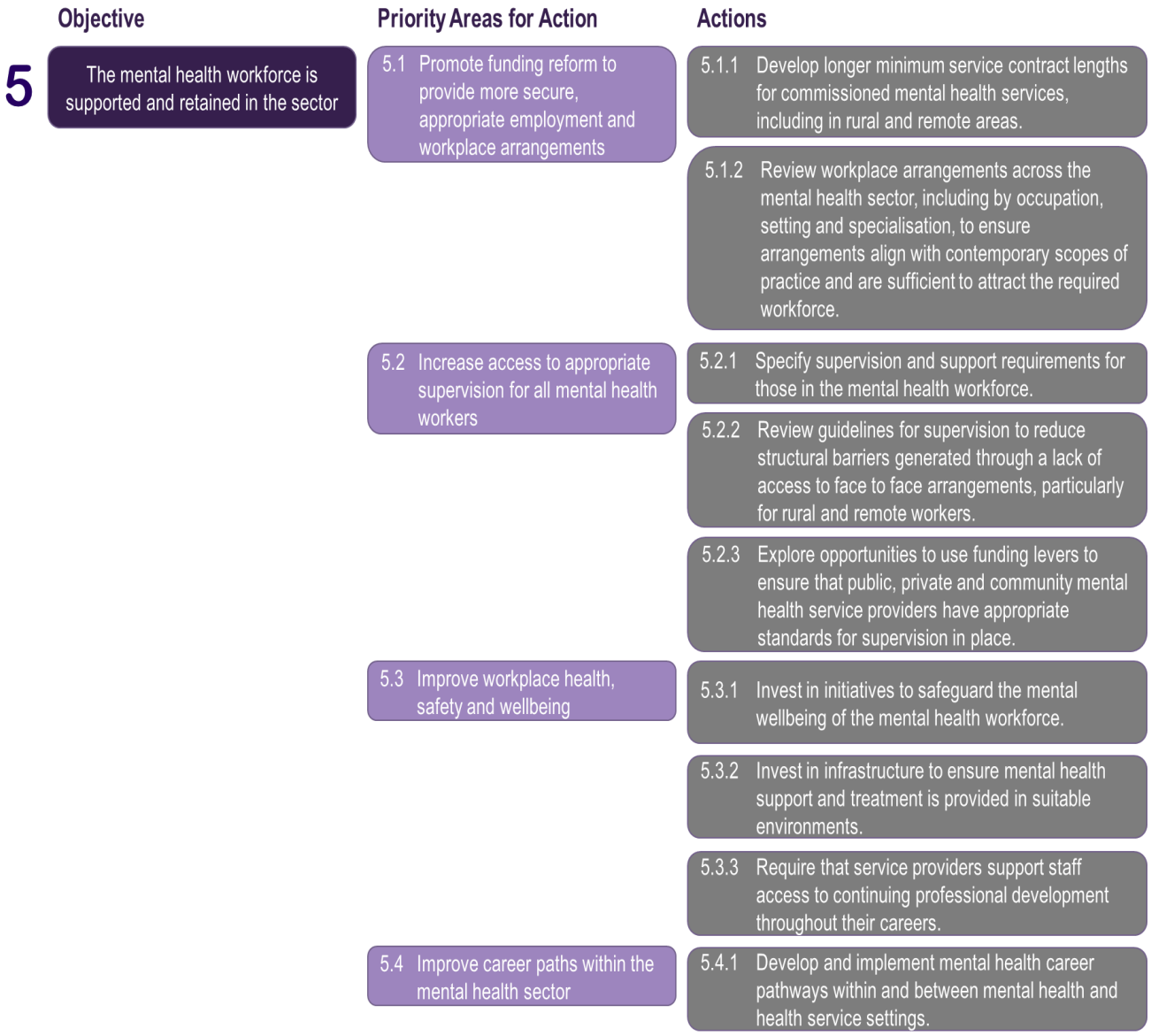
- Action 4.2.1 – Create positive perceptions of working in mental health by improving the pre-service and/or post-graduate placement experience of trainees
- Action 4.2.2 – Ensure mental health trainees undertake clinical placements and internships across a more representative mix of settings, across the spectrum from prevention, early intervention and acute settings, and metropolitan, rural and remote areas.

5. The mental health workforce is supported and retained in the sector

Objective 5 – The mental health workforce is supported and retained in the sector – addresses key issues that impact on the attrition of qualified and experienced workers in the mental health sector. This chapter addresses the attractiveness of working in the mental health sector and is closely linked to Objective 4 Careers in mental health are, and are recognised as, attractive.

There are incomplete data on the retention rates of the mental health workforce which makes it difficult to quantify the scale of the issue for some occupations, and there would be benefit in conducting additional research on attrition. While individuals may leave the workforce for personal reasons, there are consistent workplace issues that drive poor retention across the mental health workforce.

FIGURE 5.1 OBJECTIVE 5: PRIORITY AREAS AND ACTIONS



Insecure employment

The lack of employment security, often a product of short term funding contracts that are prevalent in the community mental health sector, impacts on both the attraction and retention of workers. Those who have the option of working in sectors where employment is more secure may choose to do so, reducing the availability of mental health support and treatment. There is a need to transition to longer term employment arrangements, and permanent positions where possible, to retain experienced workers.

Workplace arrangements

Workplace arrangements including supervision arrangements (addressed separately) differ significantly across occupations, employers and service settings. Access to supervision (addressed below), continuing professional development (CPD) can be limited due to current service delivery contracts which do not include funding for CPD or backfill. Exposure to successful outcomes for consumers, carers and their families plays an important role in workforce retention but varies across settings.

Remuneration levels, relativities within and between occupations and across service settings influence staff retention and cause concern to many working in mental health. The Strategy stresses the importance of these issues and encourages all governments to be mindful of how progress may be made, noting that addressing these matters is beyond the scope of this Strategy.

Supervision

Where there is a lack of access to quality supervision, employee satisfaction and willingness to stay within the mental health sector are negatively impacted. There is a close relationship between having appropriate, high quality professional supervision from experienced professionals and retention. Addressing issues related to supervision will require collaboration across governments, peak bodies, employers and colleges.

Safety and wellbeing

Workplace health, safety and wellbeing is integral to retaining workers in the mental health sector. There is a need to recognise that working in the sector can involve challenges that mean employers need to take additional action to support their workforces.

There is a need for appropriate investment in both workforce size and quality of infrastructure to facilitate appropriate support and treatment. These issues are not experienced universally across service settings, nor are they unique to the mental health sector, but do need to be addressed to improve retention. High levels of fatigue and burnout can result from workload levels and the stress of workplace violence, abuse and aggression. Unsuitable physical infrastructure can limit the quality of support and treatment that can be provided, particularly in rural communities.

Limited opportunities for progression

Workforce retention within any sector is dependent, in part, on the availability of opportunities for workers to grow, progress and advance their careers. Progression can include clinical, policy and program, management and research roles. The lack of attractive and transparent career paths in mental health is more acute for some occupations and in some settings, which can impact on career satisfaction and retentions.

Priority areas and actions

PRIORITY AREA 5.1 – Promote funding reform to provide more secure, appropriate employment and workplace arrangements:

- Action 5.1.1 – Develop longer minimum service contract lengths for commissioned mental health services, including in rural and remote areas
- Action 5.1.2 – Review workplace arrangements across the mental health sector, including by occupation, setting and specialisation, to ensure they align with contemporary scopes of practice and are sufficient to attract the required workforce.

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

- Action 5.2.1 – Specify supervision and support requirements for those in the mental health workforce
- Action 5.2.2 – Review guidelines for supervision to reduce structural barriers generated through a lack of access to face to face arrangements, particularly for rural and remote workers
- Action 5.2.3 – Explore opportunities to use funding levers to ensure that community, public and private mental health service providers have appropriate standards for supervision in place.

PRIORITY AREA 5.3 – Improve workplace health, safety and wellbeing:

- Action 5.3.1 – Invest in initiatives to safeguard the mental wellbeing of the mental health workforce
- Action 5.3.2 – Invest in infrastructure to ensure mental health support and treatment is provided in suitable environments
- Action 5.3.3 – Require that service providers support staff access to continuing professional development throughout their careers.

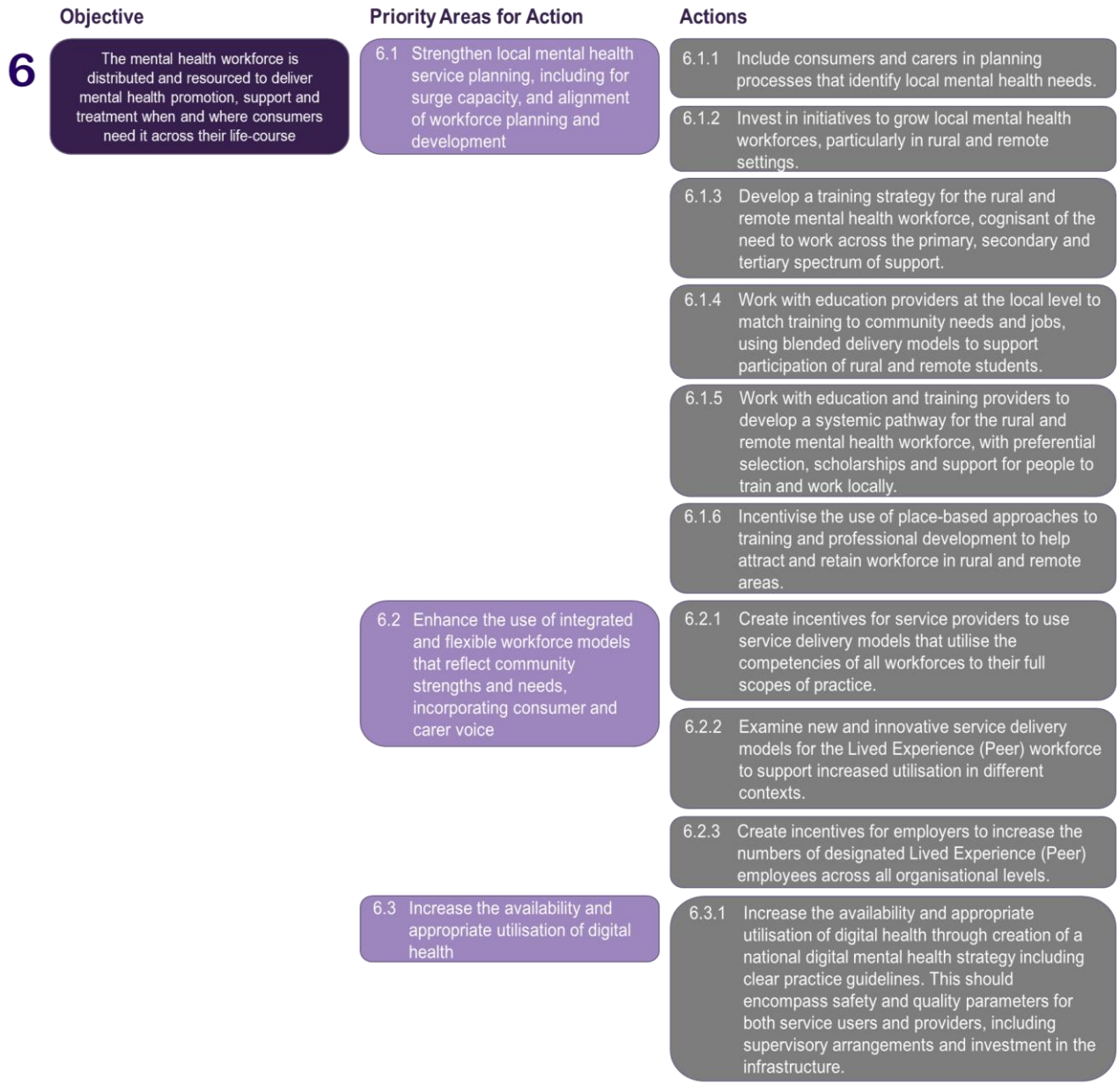
PRIORITY AREA 5.4 – Improve career paths within the mental health sector:

— Action 5.4.1 – Develop and implement mental health career pathways within and between mental health and health service settings.

6. The mental health workforce is distributed and resourced to deliver mental health promotion, support and treatment when and where consumers need it across their life course

Objective 6 – The mental health workforce is distributed and resourced to deliver mental health promotion, support and treatment when and where consumers need it across their life-course – involves addressing a number of key challenges.

FIGURE 6.1 OBJECTIVE 6: PRIORITY AREAS AND ACTIONS



Improving the voice of consumers and carers

The extent to which national planning processes are linked to local planning is limited. There is a recognised need for locally-led processes that prioritise the perspective of consumers and carers, contributing understanding of local issues, to ensure all needs are identified and suitable strategies. There requires a shared understanding of training pipelines, workforce needs and supports across system stakeholders to support both ground-up and top-down planning approaches.

Rural and remote challenges

Staffing mental health services in rural and remote locations poses specific challenges. Though the ideal solution to developing the local workforce is to attract and train local people, place-based approaches are limited due to the attractiveness of the sector and availability of locally based training opportunities. Initiatives that make better use of the vocationally trained workforce, including Allied Health Assistants, provide ways to address some workforce shortages, as do the Allied Health Rural Generalist Pathway, and Advanced Specialist Rural Generalist training for General Practitioners.

While the Strategy does not identify specific models of care, it does recognise that different approaches are needed in different contexts. Flexible service models that address consumer and carer needs by building on local service strengths and available workforce, provide innovative approaches to supervision, and foster specialised generalist models of support and treatment are needed, particularly in rural and remote areas.

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

Priority areas and actions

PRIORITY AREA 6.1 – Strengthen evidence based local mental health service planning, including for surge capacity, and alignment of workforce planning and development:

- Action 6.1.1 – Include consumers and carers in planning processes that identify local mental health needs
- Action 6.1.2 – Invest in initiatives to grow local mental health workforces, particularly in rural and remote settings
- Action 6.1.3 – Develop a training strategy for the rural and remote mental health workforce, cognisant of the need to work across the primary, secondary and tertiary spectrum of support
- Action 6.1.4 – Work with education providers at the local level to match training to community needs and jobs, using blended delivery models to support participation of rural and remote students.
- Action 6.1.5 – Work with education and training providers to develop a systemic pathway for the rural and remote mental health workforce, with preferential selection, scholarships and support for people to train and work locally.

— Action 6.1.6 – Incentivise the use of place-based approaches to training and professional development to help attract and retain workforce in rural and remote areas.

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

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

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

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

PRIORITY AREA 6.3 – Increase the availability and appropriate utilisation of digital health

— Action 6.3.1 – Increase the availability and appropriate utilisation of digital health through creation of a national digital mental health strategy including clear practice guidelines. This should encompass safety and quality parameters for both service users and providers, including supervisory arrangements and investment in the infrastructure.

7. Implementation of the Strategy

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

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

An implementation plan (or series of plans) will be developed collaboratively by the Commonwealth, state and territory governments, peak professional bodies and colleges, regulators, educational institutions, service providers, consumers and carers to address the objectives of the Strategy.

The implementation plans will:

— assign priorities to actions
— identify who will lead each activity (for example, those driven centrally by the Commonwealth and those led by individual states and territories)
— consider local consumer and carer needs and issues across locations and settings
— include timelines for implementation
— address governance arrangements
— embed monitoring and evaluation requirements.

The Commonwealth Department of Health will work also with state and territory counterparts to develop an appropriate national governance structure to oversee the implementation of the Strategy and ensure its success.

Appendix A:
Summary of Priority Areas, Actions and Potential Implementation Examples

Where required, additional explanation of actions is provided, such as the occupations where action is required most urgently or the occupations or settings that are most significantly impacted by the issue that the action addresses.

Objective 1 – Data underpins workforce planning at a national, regional and local level

PRIORITY AREA 1.1 – Develop and implement a data strategy to improve the quality, comprehensiveness, timeliness, reliability and useability of mental health workforce data

Action 1.1.1

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

Detail: Occupations for inclusion in the first iteration of a National Mental Health Data Strategy: Aboriginal and Torres Strait Islander Health Practitioners; Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; Alcohol and Other Drug Workers; Counsellors and psychotherapists; Creative Arts Therapists; Dietitians ; Enrolled Nurses; Exercise Physiologists; General Practitioners (including Rural Generalists); Lived Experience (Peer) Workers; Mental Health Nurses; Nurse Practitioners; Occupational Therapists; Paediatricians; Pharmacists; Psychiatrists; Psychologists; Psychosocial Support Workers; Physiotherapists; Registered Nurses; Social Workers; Speech Pathologists.

Action 1.1.2

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

Detail: N/A

Potential implementation examples:

- Identify early opportunities to improve data collection, monitoring and sharing while the National Mental Health Workforce Data Strategy is being developed.
- Support education and training providers and professional bodies and colleges to capture data on student enrolments and completions to provide visibility of training pipelines.
- Enable data sharing across jurisdictions, health services (including ACCOs), peak professional bodies and colleges and education providers to support understanding of possible workforce supply.
- Where possible, link workforce data to service quality and safety data including consumer and carer outcome data. This could include accessible data that helps to improve understanding of the factors that contribute to quality care.
- Embed the ABS 2020 Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables to enable usable and comparable data which accurately captures LGBTIQ+ people.
- Develop a National Allied Health Data Strategy which includes building a geospatial Allied Health Minimum Dataset that incorporates comprehensive rural and remote allied health workforce data.

PRIORITY AREA 1.2 – Enhance mental health workforce data systems and planning models through the use of more reliable and comprehensive data

Action 1.2.1

Support use of mental health workforce data by making it publicly accessible in a manner that is useable for informing inform mental health workforce planning and support development of meaningful government interventions to better match workforce demand and supply across occupations and settings.

Detail: N/A

Potential implementation examples:

- Review the National Mental Health Service Planning Framework to ensure relevance and accessibility across states and territories and inclusion of rural, remote and vulnerable populations.
- Provide funding to facilitate collection of data on community-based workforces, including psychosocial and Lived Experience (Peer) workforces.

Objective 2 – The entire mental health workforce is utilised efficiently and effectively

PRIORITY AREA 2.1 – Identify evidence based mental health promotion activities that address the needs of the population and the competencies required to deliver them

Action 2.1.1

Define the competencies required by the mental health promotion workforce to deliver evidence based mental health promotion and suicide prevention activities.

Detail: N/A

Potential implementation examples: N/A

PRIORITY AREA 2.2 – Identify evidence based components of care that meet the needs of consumers and carers and the competencies required to deliver them

Action 2.2.1

Identify components of care (subsets of models of care) that meet the needs of consumers and carers, including those needed by people at different stages in the life course, from various cultural backgrounds including Aboriginal and Torres Strait Islander peoples, people facing specific circumstances such as during the perinatal period or when experiencing AOD issues, and those required to better integrate support and treatment at all stages of the recovery journey

Detail: N/A

Potential implementation examples:

— Develop a shared language to support implementation of the common core competencies required to deliver preventative mental health activities and mental health support and treatment, recognising the need for specialised competencies.

Action 2.2.2

Define the competencies required by the mental health workforce to deliver the components of care, including the core competencies required to deliver person-centred, recovered oriented, trauma informed, culturally safe and integrated support and treatment that effectively utilises multidisciplinary teams

Detail: N/A

Potential implementation examples:

— Develop a shared language to support implementation of the common core competencies required to deliver preventative mental health activities and mental health support and treatment, recognising the need for specialised competencies.

— Map proposed scopes of roles against the National Mental Health Core Capabilities to inform both the above and consideration of appropriate role scopes.

PRIORITY AREA 2.3 – Define nationally consistent scopes of practice for the mental health workforce

Action 2.3.1

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

Occupations where scope should be confirmed: Aboriginal and Torres Strait Islander Health Practitioners; Counsellors and psychotherapists; Dietitians; Enrolled Nurses; Emergency Department Medical Officers; Exercise Physiologists; General Practitioners; General Practitioners with Advanced Specialist training in Mental Health; General Practitioners with Advanced Specialist training as Rural Generalists; Mental Health Nurses; Nurse Practitioners; Occupational Therapists; Other Allied Health Workers; Paediatricians; Paramedics; Pharmacists; Physiotherapists; Psychiatrists; Psychologists and Endorsed Psychologists; Registered Nurses; Registrars; Social Workers; Speech Pathologists.

Occupations where scope should be developed: Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; Alcohol and Other Drug Workers; Allied Health Assistants; Creative Art Therapists; Exercise Physiologists; First Responders (Emergency Services); Lived Experience (Peer) Workers; Paramedics; Psychosocial Support Workers.

Potential implementation examples:

— Develop a national governance process that is inclusive of the broadly defined mental health workforce to oversee the review of scopes of practice and authorities for referral, ensuring a mutually consistent approach across the mental health sector.

— Establish a nationally coordinated committee with representatives of broadly defined mental health workforce to drive improved consistency of training, including for the workforces delivering preventative mental health activities.

— Introduce a staged process requiring mandatory qualifications for specialist psychosocial support staff, including recognition of prior learning, to ensure that the expansion of these services does not result in a reduction in service quality.

— Support development of vocational and higher education training experiences that are co-designed and co-produced with consumers and carers.

— Map proposed scopes of roles against the National Mental Health Core Capabilities to inform both the competencies and appropriate role scopes.

Action 2.3.2

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

Detail: N/A

Potential implementation examples:

— Develop a national governance process that is inclusive of the broadly defined mental health workforce to oversee the review of scopes of practice and authorities for referral, ensuring a mutually consistent approach across the mental health sector.

— Establish a nationally coordinated committee with representatives of broadly defined mental health workforce to drive improved consistency of training, including for the workforces delivering preventative mental health activities.

— Introduce a staged process requiring mandatory qualifications for specialist psychosocial support staff, including recognition of prior learning, to ensure that the expansion of these services does not result in a reduction in service quality.

— Support development of vocational and higher education training experiences that are co-designed and co-produced with consumers and carers.

— Map proposed scopes of roles against the National Mental Health Core Capabilities to inform both the competencies and appropriate role scopes.

PRIORITY AREA 2.4 – Develop roles that utilise workers' full scopes of practice including more effective use of multidisciplinary teams

Action 2.4.1

Establish roles and career paths that reflect effective use of multidisciplinary teams within nationally consistent scopes of practice and enable workers from each occupation to work to the top of their scope of practice.

Occupations where career paths are established: Counsellors and psychotherapists; Emergency Department Medical Officers; Enrolled Nurses; Exercise Physiologists; Nurse Practitioners; Paediatricians; Paramedics; Pharmacists; Physiotherapists; Psychiatrists; Psychologists and Endorsed Psychologists; Registrars.

Occupations where career paths can be strengthened: Aboriginal and Torres Strait Islander Health Practitioners; Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; Alcohol and Other Drug Workers; Allied Health Assistants; Creative Art Therapists; Dietitians; General Practitioners; General Practitioners with Advanced Specialist training in Mental Health; General Practitioners with Advanced

Specialist training as Rural Generalists; Lived Experience (Peer) Workers; Mental Health Nurses; Occupational Therapists; Paramedics; Psychosocial Support Workers; Registered Nurses; Social Workers; Speech Pathologists.

Potential implementation examples:

— Develop training frameworks that encompass vocational and higher education programs to enable students and professionals to understand how their occupations contribute to multidisciplinary team approaches.
— Develop an education campaign regarding the usefulness of multidisciplinary teams and the role of other occupations in preventing mental ill health.
— Provide incentives (such as time, information systems, financial systems and funding) to support the mental health workforce to function collaboratively and innovatively between occupations, providers and sectors, including through the use of digital health.
— Transition away from the use of generic job roles and teams towards multidisciplinary teams, including development of clinical leaders, educator roles across all occupations, and changes to management and professional governance structures in some areas.

Action 2.4.2

Address attitudinal, organisational and legislative barriers to effective use of multidisciplinary teams to deliver integrated support and treatment.

Detail: N/A

Potential implementation examples:

— Develop training frameworks that encompass vocational and higher education programs to enable students and professionals to understand how their occupations contribute to multidisciplinary team approaches.
— Develop an education campaign regarding the usefulness of multidisciplinary teams and the role of other occupations in preventing mental ill health.
— Provide incentives (such as time, information systems, financial systems and funding) to support the mental health workforce to function collaboratively and innovatively between occupations, providers and sectors, including through the use of digital health.
— Transition away from the use of generic job roles and teams towards multidisciplinary teams, including development of clinical leaders, educator roles across all occupations, and changes to management and professional governance structures in some areas.

PRIORITY AREA 2.5

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

Action 2.5.1

Review regulatory arrangements to ensure the appropriate regulatory approach is in place to ensure consumer and carer safety, given each occupation's scope of practice.

Occupations where regulation need to be confirmed: Dietitians; Emergency Department specialist and non-specialist health professionals; Enrolled Nurses; Exercise Physiologists; General Practitioners; General Practitioners with Advanced Specialist training in Mental Health; General Practitioners with Advanced Specialist training as Rural Generalists; Mental Health Nurses; Nurse Practitioners; Occupational Therapists; Paramedics; Pharmacists; Physiotherapists; Psychiatrists; Psychologists; Registered Nurses; Registrars; Social Workers; Speech Pathologists.

Occupations where regulation needs to be reviewed: Aboriginal and Torres Strait Islander Health Practitioners; Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; Alcohol and Other Drug Workers; Allied Health Assistants; Counsellors and Psychotherapists; Creative Art Therapists; Lived Experience (Peer) Workers; Psychosocial Support Workers.

Potential implementation examples: Include capture of information on areas of accreditation in regulatory processes.

PRIORITY AREA 2.6

Establish a national peak body to represent the interests of the Lived Experience (Peer) Workforce.

Action 2.6.1

Work with consumer, carer and Lived Experience (Peer) worker representatives to support establishment of a national Lived Experience (Peer) Workforce peak organisation.

Detail: N/A

Potential implementation examples: N/A

Objective 3 - The mental health workforce is appropriately skilled and culturally safe

PRIORITY AREA 3.1

Strengthen the skills of the existing and future mental health workforce

Action 3.1.1

Develop training modules that build competencies for the provision of culturally safe, integrated, multidisciplinary care that meet consumer and carer needs across the life-course including children, young people, adults, and older people, from different cultural backgrounds including Aboriginal and Torres Strait Islander peoples and people experiencing specific circumstances such as during the perinatal period or issues with alcohol and other drugs.

Action 3.1.2

Develop training modules that build capability in suicide prevention of all the mental health workforce.

Action 3.1.3

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

Occupations for immediate action (<12 months): Mental Health Nurses (Endorsed Psychologists; Psychologists (particularly in community and private settings, rural and remote locations); Psychiatrists (particularly in community and private settings, and specialisations in children and youth, addiction, and older persons); Nurse Practitioners.

Occupations for further action (12-24 months): Counsellors and Psychotherapists; Dietitians; Lived Experience (Peer) Workers, Occupational Therapists; Registered Nurses (particularly in rural and remote locations); Social Workers.

Action 3.1.4

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

Action 3.1.5

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

Action 3.1.6

Ensure training programs improve the health literacy – including digital health literacy – of all mental health care professionals.

Action 3.1.7

Develop more equitable access to continuing professional development through establishing educator roles such as in allied health, Aboriginal and Torres Strait Islander Mental Health and Lived Experience (Peer) Workers.

Action 3.1.8

Develop actions to bolster the clinical research mental health workforce.

Potential implementation examples

- Develop guidelines for the inclusion of training in competencies (identified in Priority Action Areas 3.2 and 3.3) for all mental health workforce occupations.
- Review existing training modules for the provision of integrated and multi-disciplinary care and where there are gaps develop new modules.
- Develop specialisation streams within mental health training programs, for example youth, aged care, co-morbidities with AOD, LGBTQI+
- Develop peer led, co-designed and co-delivered training modules that focus on the Lived Experience (Peer) role, scope and knowledge.
- Support universities to embed the Aboriginal and Torres Strait Islander and Torres Strait Islander Health Curriculum Framework into higher education health curricula.
- Include specific, contextualised Lived Experience modules within the Certificate IV in Training and Assessment to support appropriate training of Lived Experience (Peer) educators.
- Invest in the development of GP psychiatry career pathways, similar to the model used for GP obstetrics and GP anaesthetics. This would require the establishment of comparable remuneration structures to support uptake.
- Develop evidence-based national guidelines for the mental health workforce that focus on the identification and management of co-occurring AOD use and use disorders.
- Develop Rural Generalist Psychiatry Career pathways.

PRIORITY AREA 3.2 – Ensure the broader workforces have the knowledge and skills to support people experiencing suicidality, mental distress and/or ill-health

Action 3.2.1

Invest in training initiatives to support the development of basic mental health skills in the social services workforce.

Key occupations impacted: Aged Care Workers; Allied Health Assistants; Disability Services Workers; Educational Services Workers; Employment Services Workers; First Responders

(including emergency services, fire fighters, paramedics, police); Housing Services Workers; Justice Workers; Transport Services Workers.

Action 3.2.1

Invest in training initiatives to support the development of basic mental health skills in the social services workforce.

Key occupations impacted: Aged Care Workers; Allied Health Assistants; Disability Services Workers; Educational Services Workers; Employment Services Workers; First Responders (including emergency services, fire fighters, paramedics, police); Housing Services Workers; Justice Workers; Transport Services Workers.

Action 3.2.2

Where feasible, include development of basic mental health skills in pre-service training for people working in roles where they are likely to interact with or support people experiencing suicidality, mental distress and/or ill-health and their carers.

Key occupations impacted: Alcohol and Other Drug Workers; Allied Health Practitioners (including Assistants); Emergency Service Workers; Enrolled Nurses; General Practitioners; Medical Practitioners (excluding Psychiatrists); Midwives; Nurse Practitioners; Paramedics; Pharmacists; Police; Registered Nurses.

Potential implementation examples

— Utilise existing suicide prevention frameworks (e.g., Suicide Prevention Australia) as a basis for training the broader workforce.

— All medical students be provided with access to high quality education and training in mental health, and for clinical placements across a range of settings and locations.

PRIORITY AREA 3.3 – Support students from priority cohorts to complete mental health-related qualifications that reflect their communities' needs

Action 3.3.1

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

Occupations for immediate action (<12 months): Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; Lived Experience (Peer) Workers; Allied Health Assistants (particularly for rural and remote locations); Mental Health Nurses (particularly for rural and remote locations); Paediatricians; Psychologists (including Endorsed Psychologists); Psychosocial Support Workers.

Action 3.3.2

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

Action 3.3.3

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

Potential implementation examples

- Expand scholarship programs for Aboriginal and Torres Strait Islander Mental Health Workers and Mental Health Nurses.
- Provide mentoring and culturally safe support mechanisms for Aboriginal and Torres Strait Islander students.
- Provide place-based education and digital training delivery options (see Action 6.1.5).
- Provide mental health bonded scholarships (or waiver of HELP fees) for nursing and allied health undergraduate courses to build workforce capacity (1-3 year service requirements) including for people from Aboriginal and Torres Strait Islander and culturally diverse backgrounds.
- Expand the provision of Commonwealth-funded places for postgraduate, allied health and mental health-related Certificate IV courses.
- Develop bridging modules for micro-credentialing for health workers from migrant communities.
- Develop bridging modules for micro-credentialing for health workers from migrant communities.

PRIORITY AREA 3.4 – Support access to continuing professional learning and professional development to ensure existing workers develop contemporary professional and cultural safety skills

Action 3.4.1

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

Action 3.4.2

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

Action 3.4.3

Fund LGBTIQ+ organisations to develop training and support for mainstream service providers.

Action 3.4.4

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

Occupations for immediate action (<12 months): Lived Experience (Peer) Workers.

Occupations for further action (12-24 months): Alcohol and Other Drug Workers; Allied Health Workers (particularly for mental health settings); Psychosocial Support Workers; Registered Nurses (including practice nurses) (particularly in rural and remote locations); Social Workers.

Action 3.4.5

Facilitate sharing of mental health education and training programs and associated resources across states and territories, with opportunity for jurisdictions to tailor programs to meet their needs.

Objective 4 - Careers in mental health are, and are recognised as, attractive

PRIORITY AREA 4.1 – Increase the awareness and accessibility of pathways into and within mental health

Action 4.1.1

Raise the awareness of pathways into, and within, the mental health workforce for both vocationally and higher education trained occupations including across work settings.

Occupations for immediate action (<12 months): Aboriginal and Torres Strait Islander Health Practitioners; Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; Allied Health Practitioners, Lived Experience (Peer) Workforce (for both consumer and carer roles); Psychosocial Support Workers; Psychiatrists (particularly in public health services, rural and remote locations, and specialisations in child and youth, forensic, old age and addiction).

Occupations for further action (12-24 months): Allied Health Assistants; Exercise Physiologists; Mental Health Nurses (particularly in rural and remote locations); Nurse

Practitioners; Occupational Therapists; Registered Nurses (particularly in rural and remote locations).

Action 4.1.2

Increase the supply of education and training programs for both vocationally and higher education trained occupations to support entry-level training, upskilling and reskilling.

Key occupations impacted: Aboriginal and Torres Strait Islander Health Practitioners; Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; Clinical Psychologists; Lived Experience (Peer) Workers.

Potential implementation examples

- Develop career education and school-based programs to help increase awareness of pathways into the mental health workforce prior to completion of secondary school.
- Provide funding incentives for vocational and higher education providers to offer a range of mental health-related programs, including cadetships, traineeships and micro credentials.
- Subsidise training positions for Aboriginal and Torres Strait Islander students, students with lived experience, LGBTIQ+ students, culturally and linguistically diverse students, and students from rural and remote areas to attract individuals to entry level training.
- Provide funding for student placements, internships and student employment opportunities to increase exposure to potential future careers in mental health, particularly for public settings and rural and remote students.
- Leverage employment programs to facilitate pathways into mental health careers for jobseekers.

PRIORITY AREA 4.2 – Address the stigma and negative perceptions associated with working in mental health

Action 4.2.1

Create positive perceptions of working in mental health by improving the pre-service and/or post-graduate placement experience of trainees.

Occupations for immediate action (<12 months): General Practitioners; Lived Experience (Peer) Workers; Psychosocial Support Workers; Psychiatrists.

Occupations for further action (12-24 months): Dietitians; Exercise Physiologists; Mental Health Nurses; Medical Practitioners; Nurse Practitioners; Occupational Therapists; Pediatricians; Psychologists; Registered Nurses; Social Workers.

Action 4.2.2

Ensure mental health trainees undertake clinical placements and internships across a more representative mix of settings, across the spectrum from prevention, early intervention and acute settings, and metropolitan, rural and remote areas.

Occupations for immediate action (<12 months): General Practitioners (particularly in community and private practice settings); Lived Experience (Peer) Workers, Psychiatrists (particularly in community settings including private practices).

Occupations for further action (12-24 months): Counsellors and Psychotherapists (particularly in public health and mental health services); Creative Arts Therapists; Dietitians; Exercise Physiologists; Mental Health Nurses (particularly in community and private settings); Medical Practitioners (particularly in community and private settings); Occupational Therapists; Psychologists (particularly in community and private settings); Physiotherapists, Registered Nurses (particularly in settings outside public hospitals); Social Workers.

Potential implementation examples

— Implement a nationally coordinated campaign that promotes mental health as a rewarding, respected and valued career, to be developed in collaboration with peak bodies.

— Develop a culturally appropriate awareness campaign in consultation with Aboriginal and Torres Strait Islander peoples that targets increasing the Aboriginal and Torres Strait Islander mental health workforce and promotes Aboriginal and Torres Strait Islander leadership.

— Promote volunteering opportunities in the mental health sector to help increase exposure and provide positive experiences for the possible workforce.

— Develop guidelines for supervision arrangements of student placements to improve the quality of student experiences.

Objective 5 - The mental health workforce is supported and retained in the sector

PRIORITY AREA 5.1

Promote funding reform to provide more secure, appropriate employment and workplace arrangements.

Action 5.1.1

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

Occupations for immediate action (<12 months): AOD Workers; Allied Health Practitioners; General Practitioners (particularly in rural and remote locations); Lived Experience (Peer) Workers; Psychosocial Support Workers.

Occupations for further action (12-24 months): Dietitians; Nurse Practitioners; Psychologists (particularly in settings beyond private practice); Social Workers.

Potential implementation examples: Align government funding across sectors relevant to the mental health workforce to improve consistency of salaries.

Action 5.1.2

Review workplace arrangements across the mental health sector, including by occupation, setting and specialisation, to ensure arrangements align with contemporary scopes of practice and are sufficient to attract the required workforce.

Detail: N/A

Potential implementation examples: Align government funding across sectors relevant to the mental health workforce to improve consistency of salaries.

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

Action 5.2.1

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

Occupations for immediate action (<12 months): Aboriginal and Torres Strait Islander Health Practitioners and Mental Health Workers; General Practitioners; Occupational Therapists; Psychologists; Psychosocial Support Workers; Social Workers; Speech Pathologists.

Occupations for further action (12-24 months): AOD Workers; Dietitians; Exercise Physiologists; Nurses; Paramedics.

Action 5.2.2

Review guidelines for supervision to reduce structural barriers generated through a lack of access to face to face arrangements, particularly for rural and remote workers.

Detail: N/A

Action 5.2.3

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

Occupations for immediate action (<12 months): Lived Experience (Peer) Workers; Occupational Therapists (discipline specific supervision in mental health); Psychosocial Support Workers; Psychologists (supervision for Endorsed Psychologists).

Occupations for further action (12-24 months): AOD Workers; Dietitians (discipline specific supervision in mental health); Exercise Physiologists; Social Workers (discipline specific supervision in mental health).

Potential implementation examples

- Provide funding to support peer, cultural and clinical supervision for Aboriginal and Torres Strait Islander Mental Health Workers and Lived Experience (Peer) workers.
- Support the mental health workforce to access remote supervision, through incentivised funding arrangements or adjustments to current guidelines and requirements, particularly for rural and remote workforces.
- Fund initiatives that improve supervision through partnerships, for example between education and training providers and health services.
- Improve consistency of clinical and professional governance for each occupation, including defining minimum levels of supervision for each occupation.

PRIORITY AREA 5.3 – Improve workplace health, safety and wellbeing

Action 5.3.1

Invest in initiatives to safeguard the mental wellbeing of the mental health workforce.

Detail: N/A

Action 5.3.2

Invest in infrastructure to ensure mental health support and treatment is provided in suitable environments.

Detail: N/A

Action 5.3.3

Require that service providers support staff access to continuing professional development throughout their careers.

Occupations for immediate action (<12 months): Aboriginal and Torres Strait Islander Health Workers (across all settings and in rural and remote locations); Aboriginal and Torres Strait Islander Mental Health Workers (across all settings, and in rural and remote locations); Lived Experience (Peer) Workers; Psychologists (across all settings, and in rural and remote locations); Psychosocial Support Workers.

Occupations for further action (12-24 months): AOD workers; Counsellors and psychotherapists; Dietitians; General Practitioners (including Rural Generalists); Psychiatrists (across all settings, and in rural and remote locations); Social Workers.

Potential implementation examples

— Providing funding to support accessible and affordable CPD for the mental health workforce, particularly for those in rural and remote areas.

— Fund initiatives to support mentally health workplaces, for example business and educators, and stigma reduction initiatives for help seeking behaviour.

— Fund initiatives to improve the cultural safety of organisations working in the mental health sector.

— Provide support to health services to build organisational readiness for the integration of lived experience roles in the provision of mental health services.

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

Action 5.4.1

Develop and implement mental health career pathways within and between mental health and health service settings.

Occupations for immediate action (<12 months): Aboriginal and Torres Strait Islander Health Practitioners; Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; General Practitioner; Lived Experience (Peer) Workers; Occupational Therapists; Psychiatrists; Psychosocial Support Workers.

Occupations for further action (12-24 months): AOD Workers; Clinical Psychologists; Counsellors and psychotherapists; Dietitians; Exercise Physiologists; Mental Health Nurses; Mental Health Promotion Workers; Social Workers; Speech Pathologists.

Potential implementation examples:

— Create a framework to provide guidance for employers on reasonable workplace adjustments for Lived Experience (Peer) workforces to improve career opportunities.

— Develop CPD programs that include applied learning in public sector organisations for private practitioners, and private practices for practitioners employed by public services, to facilitate skill-sharing and mixed practice career pathways.

Objective 6 – The mental health workforce is distributed and resourced to deliver mental health promotion, support and treatment when and where consumers need it across their life-course

PRIORITY AREA 6.1 – Strengthen evidence based local mental health service planning, including for surge capacity, alignment of workforce planning and development

Action 6.1.1

Include consumers and carers in planning processes that identify local mental health needs.

Detail: N/A

Action 6.1.2

Invest in initiatives to grow local mental health workforces, particularly in rural and remote settings

Occupations for immediate action (<12 months): Aboriginal and Torres Strait Islander Health Practitioners; Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; Counsellors and psychotherapists; Lived Experience (Peer) Workers; Psychologists; Psychosocial Support Workers.

Action 6.1.3

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

Details: N/A

Action 6.1.4

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

Details: N/A

Action 6.1.5

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

Details: N/A

Action 6.1.6

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

Details: N/A

Potential implementation examples

- Provide incentives such as housing assistance, paid conferencing and flexible work hours to overcome professional, financial and personal barriers to attracting and retaining mental health workers in rural communities.
- Provide funding to Aboriginal Controlled Health Services to develop the Aboriginal and Torres Strait Islander mental health workforce and enable their participation in cultural activities within their communities.
- Expand the Rural Generalist pathways for General Practitioners and Allied Health professionals.
- Improve support for newly graduated nurses and midwives in rural and remote health facilities to aid retention.
- Assist rural and remote nurse and midwife managers in their role as preceptors of beginning registered practitioners.
- Consider a program similar to the grants provided under the Rural Health Multidisciplinary Training program to support student training in aged care settings, to increase student exposure to particular cohorts and settings.
- Invest in increased accreditation of rural and remote facilities to allow more opportunities for psychiatry trainees to train rurally.
- Expand the Rural Health Multidisciplinary Training Program supports health students to undertake rural training.
- Consider developing a program involving psychologists to boost care in rural areas that is similar to that launched by RACGPs and Australian College of Rural and Remote Medicine.

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

Action 6.2.1

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

Occupations for immediate action (<12 months): Aboriginal and Torres Strait Islander Health Practitioners; Aboriginal and Torres Strait Islander Health Workers; Aboriginal and Torres Strait Islander Mental Health Workers; Lived Experience (Peer) Workforce; Psychosocial Support Workers.

Occupations for further action (12-24 months): Allied Health Assistants; Counsellors and psychotherapists; Exercise Physiologists; Mental Health Nurse Practitioners; Occupational Therapists; Psychologists

Action 6.2.2

Examine new and innovative service delivery models for the Lived Experience (Peer) workforce to support increased utilisation in different contexts.

Details: N/A

Action 6.2.3

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

Details: N/A

Potential implementation examples

- Ensure that all service level agreements for provision of mental health services include specific funding for designated Lived Experience (Peer) roles.
- Consider placing Aboriginal Mental Health Workers in Emergency Settings as part of a flexible workforce model to meet community needs.
- Consider investment in evidence-based nursing programs, integrated in GP clinics, with funded increased support by psychiatrists and mental health nurses
- Consider new funding to support trials of innovative service delivery models that promote workforce optimisation including services that may be more effective for specific cohorts such as LGBTQIA+ people.

PRIORITY AREA 6.3 – Increase the availability and appropriate utilisation of digital health

Action 6.3.1

Increase the availability and appropriate utilisation of digital health through creation of a national digital mental health strategy including clear practice guidelines. This should encompass safety and quality parameters for both service users and providers, including supervisory arrangements and investment in the infrastructure.

Key occupations impacted: Alcohol and Other Drug Workers; General Practitioners; Occupational Therapists; Mental Health Nurse Practitioners; Midwives; Nurse Practitioners; Registered Nurses; Psychiatrists; Psychologists; Psychosocial Support Workers; Social Workers; Speech Pathologists.

Potential implementation examples: N/A

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