

**Institute for Social Science Research**

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**Final Report**

**National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries**



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## Acronyms and Abbreviations

AIHW	Australian Institute of Health and Welfare AMHWs Aboriginal Mental Health Workers
AOD	Alcohol and Other Drugs
CSHISC	Community Services and Health Industry Skills Council GPMHSC General Practice Mental Health Standards Collaboration ICT Information and Communication Technologies
LGBTQIA+	Lesbian, Gay/Genderqueer/Genderfluid, Bisexual, Trans, Queer/Questioning, Intersex, Asexual, and all other sexualities, sexes, and genders
NDIS	National Disability Insurance Scheme NMHC National Mental Health Commission
NMHSPF	National Mental Health Services Planning Framework NMHWS National Mental Health Workforce Strategy
MBS	Medicare Benefits Scheme
MHCSS	Mental Health Community Support Services MHPOD Mental Health Professional Online Development PHN Primary Health Network
RACGP	Royal Australian College of General Practitioners RCS Rural Clinical Schools
SMHSOP	Specialist Mental Health Services for Older People

## Main Findings

- The review identified six key workforce challenges: 1. Defining the mental health workforce; 2. Responding to diverse and changing population needs; 3. Mental health workforce shortages; 4. Rural and remote service provision, and how to ensure that the workforce is actively recruited, appropriately trained and supported, retained and incentivised to take up rural and remote work; 5. Responsive and flexible – the mental health workforce needs be agile and adaptive to changing circumstances such as natural disasters and pandemics; 6. Measuring progress – Monitoring and evaluation is key to building an evidence base for the effectiveness of mental health workforce development strategies and initiatives.
- In principle, the mental health workforce plans of all states and territories aim to develop a mental health workforce with the capability and capacity to deliver holistic person-centred, recovery oriented, strengths- based, trauma-informed care that is culturally safe and capable, high quality, sustainable, accessible and equitable. However, currently there is very little publicly

available information reporting the progress on implementation of these strategies nor on the resulting impacts and outcomes from these strategies.

- Developing culturally safe, diverse and inclusive mental health workforces requires: Recruitment of staff from diverse backgrounds across all levels and particularly within peer workforces; Developing place- based workforces; Training of all staff on Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing in practice, LGBTIAQ+ awareness training and other specialist needs training.
- Key issues impacting on the quality, supply, distribution and structure of the mental health workforce include workforce shortages across key provider types, and in rural and remote areas; barriers to attraction and recruitment into mental health careers; and challenges to retention of existing staff. The mental health workforce needs to be developed with the right size, distribution and skill mix to meet consumer needs.
- Building a sustainable mental health workforce relies on a training pipeline that starts early with positive exposure to the range of careers in mental health and continues through the career pathway to ensure the workforce is retained. Particular attention needs to be paid to areas of greatest needs, including rural and remote locations.
- The importance of leadership at all levels is a pervasive theme. Job satisfaction, turnover intention and burnout are major issues for the mental health workforce. However, indications are that these are modifiable with investments in leadership to promote positive workplace cultures and opportunities for professional development and effective supervision.
- **Rural and Remote:** Attracting and retaining a mental health workforce in rural and regional areas involves a delicate balance of structural (e.g. funding cycles), professional (e.g., professional networks; supervision and mentoring) and personal (e.g., housing, schooling, employment opportunities for spouse) factors.
- **Aboriginal and Torres Strait Island Communities:** Aboriginal and Torres Strait Islander leaders and members of the workforce should be supported and valued to be visible and influential across all parts of the Australian mental health system.
- **Peer Workforce and Lived Experience:** There is a clear need to support and develop the peer and lived experience workforce and to ensure their contribution is understood and valued.
- **Education and Training:** Universities and other training and education organisations are key collaborators in the delivery of an effective mental health workforce. Professional development and mentorship should be ongoing and accessible at entry level and throughout all career stages.
- **Interjurisdictional and Intergovernmental:** There is a need for a whole-of-government approach that treats funding agreements and policy strategies affecting mental health as interdependent and mutually reinforcing.

## Executive Summary

This literature review presents an overview of the current policy landscape relating to the Australian mental health workforce and outlines key challenges and best practice approaches for developing an effective mental health workforce. The purpose of the review is to provide relevant information to support the National Mental Health Workforce Strategy Taskforce (the Taskforce) in their role of overseeing the development of the forthcoming National Mental Health Workforce Strategy 2021-2031.

A rapid and targeted review was conducted across a six-week period (16 June - 29 July 2020) and involved close consultation with the Australian Government Department of Health project team and the Taskforce members. Rapid reviews are a form of knowledge synthesis designed to gather and collate information in a rigorous but timely manner. The purpose of a rapid review is to reach an information saturation point across the majority of relevant information sources, as opposed to conducting an exhaustive systematic review of all possible information sources. As such, a rapid review applies a pragmatic approach ensuring collation and synthesis of the most pertinent information to addressing the review questions.

Documents for inclusion in this review were gathered across diverse, complementary information sources. These information sources included:

- Policy documents of national, state and territory jurisdictions including plans, frameworks and strategies relating to the mental health workforce.
- Reviews, enquires, discussion briefs and issue papers relating to the mental health workforce.
- Monitoring and evaluation frameworks and reports, implementation and progress reports on strategies and initiatives relating to the mental health workforce.
- Grey literature and academic peer-reviewed literature on mental health workforce issues and best practice approaches including international sources.

Searches were limited to publicly available sources. Approximately 1,000 potentially relevant information sources were initially identified and screened. This was reduced to approximately 300 documents for review.

The findings of this literature review are structured around the following six review questions:

1. What are the **key workforce challenges** in the mental health workforce in Australia?
2. What are the **commonalities**, graded from most to least prevalent, across the various national and jurisdictional mental health workforce strategies?
3. What principles, actions and mechanisms have been identified to **support an effective mental health workforce** across Australia?
4. What issues have been identified that impact the **quality, supply, distribution and structure** of the mental health workforce?
5. What practical approaches have been recommended to **attract, train and retain** the workforce required to meet the demands of the mental health system in the future?
6. What does the review reveal about the state of the mental health workforce in the following **priority areas**: Rural and Remote, Aboriginal and Torres Strait Islander Communities, Peer Work Force and Lived Experience; Education and Training; and Interjurisdictional and Intergovernmental?

## 1. What are the key workforce challenges in the mental health workforce in Australia?

Six reoccurring challenges were identified. These six challenges do not represent an exhaustive list of the challenges facing the mental health workforce in Australia. Rather they present an overview of the key areas that need to be addressed in order to develop an effective mental health workforce.

- **Challenge 1: Defining the mental health workforce**

The Australian mental health workforce is large, diverse, dynamic, evolving and difficult to define. While mental health workforce definitions are much debated, there is general agreement about specialist, generalist and lived experience as three distinct but inter-related workforces, each of which needs concerted action to develop and support. Useful approaches to defining the mental health workforce can be seen in international examples such as the 'skills level' approach used in Scotland, which also aligns with a stepped care approach to service planning.

- **Challenge 2: Diverse and changing population**

The mental health workforce needs to adapt to the changing needs and expectations of increasingly diverse consumers with increasing complexity and co-occurrence of conditions. This requires training, education, resourcing and capacity building around the delivery of inclusive workforces and culturally safe services. The integration of transdisciplinary perspectives and multidisciplinary teams is also required.

- **Challenge 3: Mental health workforce shortages**

Achieving the right mix and distribution of skills is a challenge, particularly given shortages in new recruits, an ageing workforce and high staff turnover within the mental health workforce.

- **Challenge 4: Rural and remote service provision**

Many of the challenges and issues facing Australia's mental health workforce are intensified in rural and remote contexts. In particular, the shortage of appropriately trained and qualified staff in rural and remote settings is an ongoing, seemingly intractable policy issue. The key issue is how to ensure that the workforce is actively recruited, appropriately trained and supported, retained and incentivised to take up regional and rural work.

- **Challenge 5: Responsive and flexible**

The mental health workforce needs to be agile and adaptive to changing circumstances. Emerging challenges, such as natural disasters and pandemics, can affect the demand and delivery mode of mental health services. Emerging opportunities such as advancing technologies and evolving best practice approaches also need to be capitalised upon.

- **Challenge 6: Measuring progress**

Monitoring and evaluation is key to building an evidence base for the effectiveness of mental health workforce development strategies and initiatives. Monitoring and evaluation sheds light on what works for whom and in what context and as such is a vital tool for ensuring that effort and investment is directed to where it will have the most impact. However, currently there is little publicly available or transparent reporting on the implementation progress and outcomes of mental health workforce strategies. Processes and partnerships need to be established for data collection, management, analysis and reporting that represents the whole mental health workforce.

## 2. What are the commonalities, graded from most to least prevalent, across the various national and jurisdictional mental health workforce strategies?

The Australian mental health workforce policy landscape is diverse and complex. The structure and coverage of mental health workforce policies varies across the different jurisdictions in Australia.

However, despite the nuances across jurisdictions, all mental health workforce plans aim to deliver a workforce that is configured, equipped and enabled to deliver best possible care. Across the various mental health plans there are common core principles and themes that reflect a strong values base that underpin contemporary thinking in mental health care:

- Holistic person-centred care
- Improving quality and safety
- Recovery oriented and strengths-based
- Culturally safe
- Trauma-informed care
- Sustainable, accessible and equitable.

In principle the mental health workforce plans aim to develop a mental health workforce with the capability and capacity to deliver care that is underpinned by the above principles. However, currently there is very little publicly available information reporting on the implementation progress of these strategies nor on their resulting impacts and outcomes.

### **3. What principles, actions and mechanisms have been identified to support an effective mental health workforce across Australia?**

Developing holistic person-centred, recovery oriented, strengths-based and trauma-informed care requires:

- Building knowledge around recovery oriented mental health practice which acknowledges that each individual is an expert of their own life.
- Mechanisms such as consumer, carer and staff feedback loops to build shared understandings of all stakeholder perspectives.
- Co-design processes embedded from project inception and delivered in a genuine and meaningful way by service providers who are adequately supported, trained and resourced to engage in these processes.

Developing culturally safe, diverse and inclusive mental health workforces requires:

- Recruitment of staff from diverse backgrounds across all levels and particularly within peer workforces.
- Developing place-based workforces.
- Training of all staff on Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing in practice, LGBTQIA+ awareness training and other specialist needs training.

Developing a high quality, sustainable, accessible and equitable workforce requires:

- Respectful, mutually beneficial and sustainable partnerships and collaborations across all areas of the mental health workforce.
- Appropriate and responsive education, training, professional development and mentorship throughout all career stages.
- Continuous assessments of progress and outcomes through monitoring and evaluation and adapting and improving strategies where needed.

### **4. What issues have been identified that impact the quality, supply, distribution and structure of the mental health workforce?**

The reviewed literature outlined a range of key issues impacting on the quality, supply, distribution and structure of the mental health workforce, including:

- workforce shortages across key provider types, and in rural and remote areas;
- barriers to attraction and recruitment into mental health careers, including negative perceptions



and a lack of specialisation in mental health in undergraduate programs;

- challenges to retention of existing staff, including issues affecting worker wellbeing (burnout, worker morale, and workplace violence), conditions (particularly in terms of pay and career progression) and negative workplace cultures.

A critical concern that overlaps each of these areas - and one that is prominent in most jurisdictional policies - is ensuring that there are enough people with the right skills in the right places to deliver an effective mental health service system.

#### **5. What practical approaches have been recommended to attract, train and retain the workforce required to meet the demands of the mental health system in the future?**

Some of the key recommendations include:

- Building a sustainable mental health workforce relies on a training pipeline that starts early with positive exposure to the range of careers in mental health and continues through the career pathway to ensure the workforce is retained. Particular attention needs to be paid to areas of greatest needs, including rural and remote locations.
- Building an effective workforce pipeline is essential but will take time. Universities and other training providers are strategic partners at all phases of the mental health career pathway.
- Leadership is vital at all levels. Job satisfaction, turnover intention and burnout are major issues for the mental health workforce. However, indications are that these are modifiable with an investment in leadership and emphasis on positive workplace culture that includes opportunities for professional development and effective supervision.

#### **6. What does the review reveal about the state of the mental health workforce in the following priority areas: Rural and Remote, Aboriginal and Torres Strait Islander Communities, Peer Work Force and Lived Experience; Education and Training; and Interjurisdictional and Intergovernmental?**

The Taskforce have identified five priority areas and developed working groups to examine and report on these areas. This report presents the take-home messages to be considered for a mental health workforce in relation to each of these priority areas. The headline message for each area is presented below, with further detail provided in Section 2.6 of this report.

- **Rural and Remote**

Attracting and retaining a mental health workforce in rural and regional areas involves understanding and addressing a delicate balance of structural, professional and personal factors.

- **Aboriginal and Torres Strait Island Communities**

Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system.

- **Peer Workforce and Lived Experience**

There is a clear need to support and develop the peer and lived experience workforce. Careful attention needs to be given to the valuing and resourcing of this workforce. Training, support and supervision is essential to grow this workforce and to avoid the potential for burnout of community leaders in Aboriginal (and other) communities.

- **Education and Training**

Universities and other training and education organisations are key collaborators in the delivery of an effective mental health workforce. Training, education, professional development and mentorship should start early and be ongoing and accessible at entry level and throughout all career stages.

- **Interjurisdictional and Intergovernmental**

There is a need for a whole-of-government approach that treats funding agreements and policy strategies affecting mental health as interdependent and mutually reinforcing.

## 1. Background

Australia's mental health workforce delivers mental health care, treatment and support across a range of diverse, inter-related services. These services are delivered by a diverse workforce made up of health and social care professionals, including psychiatrists, psychologists, nurses, general practitioners, occupational therapists and social workers, as well as those who may not have a specific mental health role. There is also a growing contribution from the mental health peer workforce and community managed mental health sector and while not always formally recognised, the contribution of families and carers to mental health care cannot be overlooked. Collectively this makes for a diverse and complex landscape of mental health services in Australia.

Effectively meeting the current and future demands of the mental health system relies on attracting, training, supporting and retaining an effective, viable and vibrant mental health workforce. The forthcoming National Mental Health Workforce Strategy 2021-2031 (the Strategy) aims to identify key workforce challenges and actions to support the effective provision of mental health services across Australia.

The Australian Government Department of Health (the Department) and the National Mental Health Commission are currently developing the Strategy, with this development being overseen by the National Mental Health Workforce Strategy Taskforce (the Taskforce). The purpose of this literature review is to provide relevant and fit-for-purpose information to assist the Taskforce in fulfilling their role of overseeing the development of the Strategy.

The forthcoming Strategy will consider the quality, supply, distribution and structure of the mental health workforce. It will identify practical approaches that could be implemented by Australian governments to attract, train and retain the workforce required to meet the demands of the mental health system in the future.

In order to inform the Taskforce, and subsequent Strategy development, this literature review focuses on addressing six overarching review questions:

1. What are the key workforce challenges in the mental health workforce in Australia?
2. What are the commonalities, graded from most to least prevalent, across the various national and jurisdictional mental health workforce strategies?
3. What principles, actions and mechanisms have been identified to support an effective mental health workforce across Australia?
4. What issues have been identified that impact the quality, supply, distribution and structure of the mental health workforce?
5. What practical approaches have been recommended to attract, train and retain the workforce required to meet the demands of the mental health system in the future?
6. What does the review reveal about the state of the mental health workforce in the following priority areas: Rural and Remote, Aboriginal and Torres Strait Islander Communities, Peer Work Force and Lived Experience; Education and Training; and Interjurisdictional and Intergovernmental?

As outlined in review question six, this literature review will pay particular attention to the five priority areas as identified by the Taskforce: Rural and Remote, Aboriginal and Torres Strait Islander Communities, Workforce Training and Education, Peer and Lived Experience and Inter-jurisdictional and Inter-governmental.

This project involved a rapid and targeted review of key policy-relevant literature including published research and reports and unpublished documents and reports (or grey literature). Rapid reviews are a form of knowledge synthesis designed to gather and collate information in a rigorous but timely manner. Details on the review methods are provided in Appendix A. Details on the co-design approach and project governance are provided in [Appendix B](#).

## Language

Words are important, particularly the words we use to describe and discuss mental health and the people who deliver and participate in mental health services. The language used around the mental health workforce is diverse and evolving. The prevailing terms seem to change over time shaped by location, the views of different health and social disciplines and a changing mental health workforce profile. The purpose of this review isn't to critique the use of language concerning the mental health workforce. The terms used throughout this report reflect the predominant terms used in the literature reviewed. However, within the literature there are some discussions about particular terms. Some emerging considerations include:

- **Cultural Safety:** Whilst most literature covering delivery of culturally appropriate care uses the term 'cultural competency', a recent paper by Curtis et al. (2019) recommends the move towards the idea of cultural safety rather than competency. They provide the following definition of cultural safety:
  - *"Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment"* (Curtis et al., 2019, p. 14).
- **Indigenous conceptualisations of mental health:** An Aboriginal perspective takes a holistic, culturally informed view of mental health conceived more broadly as 'social and emotional wellbeing' – a term that is increasingly used in health policy. Social and emotional wellbeing carries a culturally distinct meaning: it connects the health of an Indigenous individual to the health of their family, kin, community, and their connection to country, culture, spirituality and ancestry (Dudgeon et al., 2016). It is a deep-rooted, more collective and holistic concept of health than that used in Western medicine.
- **Peer and lived experience workforce:** In comparison to peer workforce, the term lived experience workforce is understood as a more inclusive term that includes both consumers and carers and families and that encapsulates all types of roles within the mental health workforce, not just direct peer support work roles. The forthcoming national guidelines on lived experience workforce development should be referred to for further consideration on the use of these terms.

Achieving a shared definition and common language for the mental health workforce requires sensitivity to and respect for the different ideas, perspectives and approaches of the mental health sector, including among consumers, carers and families.

## 2. Findings

*Workforce development within the mental health sector should be seen through the lens of significant, overarching reform initiatives – ones that focus on quality improvement, transparency and accountability, and most importantly, the active engagement of consumers and carers in service delivery and service development. Improving service delivery to the people served is always the aim. (Coombs, Burgess, Dickson, & McKay, 2017, p. 313)*

## 2.1. Review Question 1: What are the key workforce challenges in the mental health workforce in Australia?

The mental health workforce faces a variety of challenges, both longstanding and emerging. In the following sections, six of the most prominent workforce challenges are highlighted (section 2.1.1 - 2.1.6). The six key workforce challenges are: 1. defining the mental health workforce; 2. meeting the needs of diverse and changing populations; 3. addressing mental health workforce shortages; 4. providing services in rural and remote areas; 5. being responsive and flexible; and 6. measuring progress and impact.

What is presented here is not an exhaustive list or detailed discussion. Rather it is intended to set the scene by summarising key, reoccurring issues that are consistently highlighted across policy documents, reviews and inquiries and academic and grey literature. New, emerging challenges are likely to arise and other challenges which may not currently be dominant may become so in the future.

In sections 2.2 – 2.6 of this report, each of these six identified challenges are discussed in further detail where through highlighting best practice mental health workforce strategies and initiatives and drawing on the latest findings from research, we set forth opportunities for improvement and enablers for change.

### 2.1.1. Challenge 1: Defining the mental health workforce

#### **The Australian mental health workforce is large, diverse, dynamic, evolving and difficult to define**

In Australia and internationally, there is little consensus on how to define the mental health workforce, nor how best to categorise the provider types and workers it contains. A range of factors, including reforms such as the introduction of the National Disability Insurance Scheme (NDIS), expanding roles for the community sector, advancing technologies, and shifting demands is changing and evolving the profile of the mental health workforce in Australia. Some of these changes are planned policy changes, whilst other changes are the result of unplanned exogenous changes that impact on the mental health workforce profile.

Across jurisdictions, the mental health workforce is categorised and defined in a range of ways with policy plans either structured around the various sections of the mental health workforce or with multiple sections of the mental health workforce being addressed by overarching plans.

For example, the NSW Mental Health Workforce Plan 2018-2022 addresses all sections of the mental health workforce defining the mental health workforce as comprising the psychiatry workforce, the mental health nurse workforce, the mental health allied health workforce, the Aboriginal mental health workforce and the mental health peer workforce, as discrete entities (NSW Health, 2018b). Contrastingly, the Victorian Mental Health Workforce Strategy delineates the mental health workforce as the clinical mental health workforce and the mental health community support services (MHCSS) workforce, with separate plans for MHCSS (Victoria's specialist mental health workforce framework Strategic directions 2014–24) (VIC Health, 2014) and peer workforces (Strategy for the consumer mental health workforce in Victoria) (Lived Experience Workforce Strategies Stewardship Group, 2019). According to 'Victoria's specialist mental health workforce framework: Strategic directions 2014–24', the specialist mental health workforce is defined as the people working within Victorian Government funded specialist mental health services (VIC Health, 2014). This workforce encompasses: medical professionals; nurses; allied health professionals; MHCSS staff (including direct-care staff, accommodation and residential support staff, outreach staff, and community development staff), consumer and carer consultants, consumer and carer peer-support workers, Aboriginal workers, a range of support staff (including psychiatric service officers, administrative and clerical officers) and managerial and leadership roles.

The current structuring of policy plans and frameworks across jurisdictions tends to see the mental health workforce broadly operationalised as generalist, specialist, and peer workforces. A basic distinction is frequently made between the specialist (e.g., psychiatrists, psychologists, mental health nurses, occupational therapists and mental health peer workers) and generalist mental health workforce. The specialist workforce has a direct role in providing mental health services, while the generalist workforce includes those who may interact with individuals experiencing mental health issues in a range of settings, such as emergency responders and those who work in corrections, aged care and educational settings. The generalist mental health workforce may be viewed broadly. For example, the Queensland Mental Health Alcohol and Other Drug Workforce Development Framework includes people working in administration, assistant and other clerical-type roles in recognition that people in these roles need to be better equipped to interface with consumers, their families and carers (Queensland Health, 2017c).

Throughout the literature and across all jurisdictions, the peer or lived experience workforce is recognised as a vital component of the mental health workforce. Increasing focus is being placed on the development and support of this workforce, which includes consumer peer workers and carer peer workers who may have either paid or voluntary roles.

The community managed mental health workforce consists of an estimated 800 non-government organisations whose employees provide a diverse range of mental health services (Bateman & Smith, 2011). Currently there are gaps in data on the contribution of community managed sector to mental health service provision, and the size of the community managed mental health sector workforce.

It is important to take a comprehensive approach to defining the mental health workforce to ensure it matches both population demands and mental health system reforms while also understanding the consequences of reforms for the different interconnected workforce sectors.

Developing the capacity of health systems to improve mental health is a global priority and countries throughout the world have focused attention on building the workforce necessary to achieve that goal. Along with this commitment are well recognised challenges and complexities that include the breadth and diversity of the mental health workforce (Walker et al., 2019). Scotland's Knowledge and Skills Framework for Mental Health Improvement, Self-Harm and Suicide Prevention provides an example of an approach to capturing the breadth and complexity of the mental health workforce by categorising the workforce into four levels according to the knowledge and skills required (NHS Education for Scotland, 2019). A focus on skills levels may point to a way of breaking down some of the "professional silos" that can lead to fragmented care. This approach may also contribute to making the most effective use of each discipline's skills. A key starting point for the approach is that contributing to positive mental health is everyone's business: "everyone, in any workplace, workforce or community has the opportunity and ability to positively impact on their own and others' mental health and wellbeing, and contribute to supporting people experiencing mental distress, mental ill health, and preventing self-harm or suicide" (NHS Education for Scotland, 2019, p. 5).

#### **Defining the mental health workforce based on knowledge and skills required**

Scotland's Knowledge and Skills Framework for Mental Health Improvement, Self-Harm and Suicide Prevention provides an example of a broad approach that categorises the workforce into four levels that capture the breadth and complexity of the mental health workforce. Its starting point is that contributing to positive mental health is everyone's business: "everyone, in any workplace, workforce or community has the opportunity and ability to positively impact on their own and others' mental health and wellbeing, and contribute to supporting people experiencing mental distress, mental ill health, and preventing self-harm or suicide" (NHS Education for Scotland, 2019, p. 5).

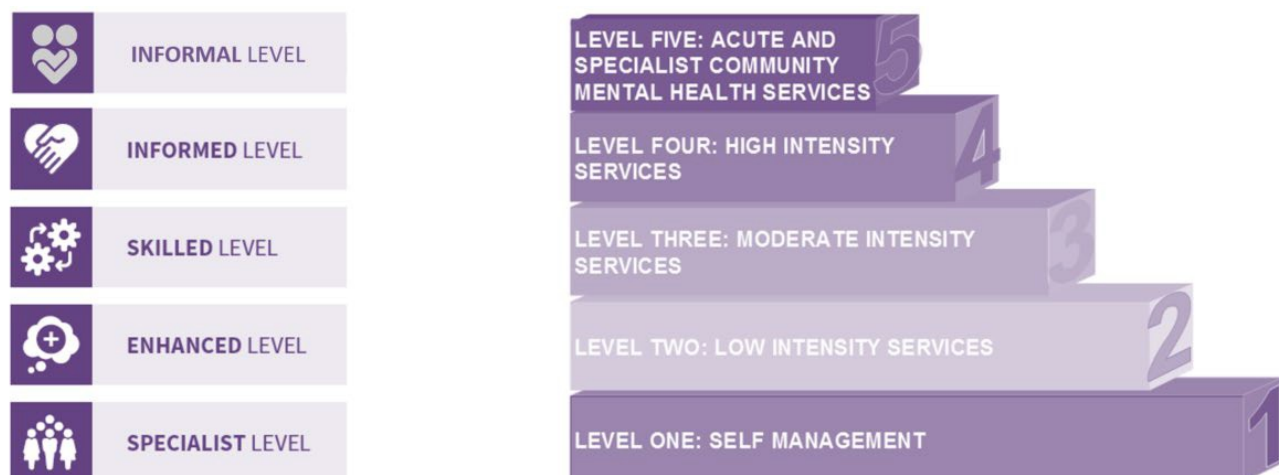
Four levels of the mental health workforce are described according to the knowledge and skills required:

1. **Informed level:** essential knowledge and skills required by all staff working in health and social care to contribute to mental health improvement and the prevention of self-harm and suicide. It also encapsulates most of the wider public health workforce who need to be informed about mental health and wellbeing and be able to respond to someone who is experiencing mental distress, or mental ill health, and who might be at risk of self-harm or suicide.
2. **Skilled level:** knowledge and skills required by ‘non-specialist’ front line staff working in health, social care, and wider public and other services. These workers are likely to have direct and/or substantial contact with people who may be at risk of mental ill health, self-harm or suicide, meaning that they have an important contribution to make in mental health improvement, self-harm and suicide prevention.
3. **Enhanced level:** knowledge and skills required by staff working in health and social care, and wider public services, who have regular and intense contact with people experiencing mental distress, mental ill health, and may be at risk of self-harm or suicide, and whose job role means they can provide direct interventions. The knowledge and skills outlined at this level become increasingly role and context specific.
4. **Specialist level:** knowledge and skills required for staff, who because of their role and/or practice setting, play a specialist role in mental health improvement and the prevention of self-harm or suicide, and includes specialist mental health/public health professionals. The knowledge and skills outlined at this level are role and context specific and should be interpreted in this way.

There also exists a further, often hidden level of the mental health workforce, that of informal carers who provide significant support to family members, friends and others. The estimated annual cost of replacing the support provided by informal carers in Australia with formal services was \$13.2 billion in 2015 (Diminic et al., 2016). Applying the above approach, this level arguably could be thought of as the *Informed informal* level of mental health care.

The above skills-based approach has parallels with a stepped care model (Figure 1). The stepped care model has been part of mental health policy reforms in Australia and other countries, including Canada and the United Kingdom. The stepped care model applies a population-based approach to mental health service planning and provision that ensures a mix of services that matches mental health service need. Here the population is stratified into five groups according to level of mental health service need: well population (mental health promotion and prevention); at risk (early identification services); mild mental illness (low intensity services); moderate mental illness (moderate intensity services); or severe mental illness (specialised services).

Figure 1: Overview of a skills level approach alongside a stepped care approach



NHS Education for Scotland Mental Health Improvement & Suicide Prevention Framework, 2019

National PHN Guidance: Initial Assessment and Referral for Mental Healthcare, Department of Health, 2018

### 2.1.2.Challenge 2: Diverse and changing populations

#### **Increasingly diverse consumers with increasing complexity and co-occurrence of conditions**

The demographic, health and social profile of the Australian population is changing. Key drivers are an ageing population, increases in chronic disease and co- and multi- morbidities and growing social and cultural diversity. Effective service provision and support for people from diverse backgrounds and experiences requires a diverse workforce that includes clinicians, peer workers, allied health, primary health, community support professionals and carers and family. Increasing evidence is available for the benefits of team approaches, including multidisciplinary teams, co-location, virtual teams and tertiary consultation.

Specialisation within diverse, multidisciplinary workforces is also important, particularly when working with diverse backgrounds and experiences. Specialist training may be required to support the mental health workforce in delivering age appropriate and culturally safe services. For example, health professionals and other staff in the mental health, aged care and community support sectors working with older people with mental illness and their carers and families, require specialist training in the mental health of older adults to ensure they are adequately skilled and experienced in addressing the psychological, physiological and social impacts of ageing (Mental Health Commission of NSW, 2017). This needs to be backed up by professional standards and competencies. A major challenge is the recruitment and retention of the workforce with skills and a genuine interest in older people's mental health. Staff turnover and recruitment of suitably qualified and skilled staff is an ongoing problem for specialist services, particularly in residential aged care (King et al., 2012).

Considering diverse settings outside of traditional healthcare settings is also important for delivering appropriate services to diverse consumers. For example, mental health issues amongst young people are increasing, and schools present an important site for working with young people's mental health issues. Staff working in schools require training and support for effectively working with young people experiencing mental health issues.

#### **Understanding and responding to the needs of specific population groups**

Each person has a unique background and experience which may be shaped by social and cultural factors. Understanding these contexts and the complex mental health needs that may arise is critical for inclusive and appropriate care. Priority population groups whose needs may not be well met are widely identified in published literature and reports. Population groups and issues include: young people and adolescents; older people; people with experiences of family violence; perinatal mental health; those affected by suicide, eating disorders, involuntary treatment, incarceration, homelessness, and alcohol and other drug use or dependence; people identifying as LGBTQIA+ or neurodivergent; people with disability; people who are deaf or hard of hearing; veterans; Aboriginal and Torres Strait Islander peoples; and people from culturally and linguistically diverse backgrounds including refugees.

### 2.1.3.Challenge 3: Mental health workforce shortages

#### **Workforce shortages, combined with uneven workforce distribution, exist in the context of increasing demand for services**

According to Australia's Future Health Workforce, there will be nationally an undersupply of 18,500 mental health nurses in 2030 (Health Workforce Australia, 2014). Similar shortages in the face of a growing population and increasing demands are predicted across other sections of the mental health workforce. An ageing workforce combined with high staff turnover, inadequate numbers of new recruits and relatively high rates of attrition among younger workforce members are key drivers of workforce shortages.

An ageing mental health workforce presents a challenge to maintaining and enhancing the provision of appropriate mental health services. In 2017, about 3 in 5 mental health nurses (58%) were aged 45



and over, and one-third (33%) were aged 55 and over (Australian Institute of Health and Welfare, 2018). Other clinical specialities, including psychiatry and psychology, show similar patterns. In 2017, half of psychologists were aged 45 and over, and more than one-quarter were aged 55 and over. While more than 70% of psychiatrists were aged 45 and over, and more than 40% were aged 55 and over. In Queensland, 16% of the clinical mental health workforce is aged over 55 years, presenting a likely risk that a significant proportion of the workforce will retire during the next ten years (Queensland Health, 2017c). As staff retire, this will result in the loss of highly skilled workers and services and drive increased competition for the attraction and retention of experienced workers. The ageing of the workforce is also important in the context of the COVID-19 pandemic, because staff who are over 50 and/or are from an Aboriginal and or Torres Strait Islander background are at high risk of severe infection. Staff who are considered vulnerable may be requested not to work, leading to staff shortages during a time of high demand.

This signals the need for the implementation of strategies aimed at mitigating the impact of an ageing mental health workforce. For example, through ensuring there are mechanisms for succession planning, supporting the needs of ageing workers to remain in the workforce and increasing in the availability of training and education to ensure that there are enough competent workers entering the workforce.

Staff turnover is another driver of mental health workforce shortage. Factors such as over-worked and under-supported workers, stress and burnout and lack of professional development opportunities and career pathways contribute to high staff turnover within mental health services (Productivity Commission, 2019a, 2019b). Similarly, the lack of permanent and full-time positions may be a contributor to high staff turnover, particularly within the mental health community support services sector. A recent survey of community managed organisations that deliver mental health services in New South Wales found that almost half the workforce (49%) was employed on a temporary contract or on a casual (hourly rate of pay) basis, and there was a high level of part time employment (Ridoutt & Cowles, 2019). We discuss workforce shortages and factors impacting on staff turnover in more detail in section 2.4.

#### 2.1.4.Challenge 4: Rural and remote service provision

The tyranny of distance and intensifying of issues create a challenging landscape for mental health service provision

Australia's rural and remote areas face unique challenges when it comes to the provision of high quality, safe, appropriate, culturally competent and accessible mental health services. One of the biggest barriers to accessing mental health services in rural and remote Australia is the 'tyranny of distance' (Senate Community Affairs Committee Secretariat, 2018). The geography of Australia means that many rural and remote communities are thousands of kilometres from their nearest capital city and hundreds of kilometres from a regional centre. Transport options are limited, time consuming and costly.

Telehealth is considered as a potential alternative approach to combating issues of distance and service delivery. However, barriers to telehealth as a viable option include a lack of telecommunications infrastructure, levels of digital literacy and capability on the part of both service users and providers, and funding arrangements.

Issues such as stigma and discrimination towards mental illness and for some a preference of anonymity when accessing services also creates additional barriers to service provision and access. Furthermore, rates of mental ill-health and suicide are disproportionately higher in rural and remote Australia with Australians living in remote areas about twice as likely to die from suicide when compared with Australia overall (Australian Institute of Health and Welfare, 2019b). Recent natural disaster events, including bushfires and droughts, have also significantly affected rural and remote communities. Pandemics such as COVID-19 also substantially impact on service delivery in rural and

remote areas, particularly in areas that rely on 'fly-in-fly-out' workforces.

Within this unique and challenging context of rural and remote locations, there is a fundamental lack of appropriately trained and supported staff to deliver mental health services. Strategies to attract, retain and support the rural mental health workforce are an ongoing priority, including growing of local workforces.

Shortcomings in the delivery of culturally safe mental health services for Aboriginal and Torres Strait Islander peoples are exacerbated in rural and remote areas.

The challenges specific to the rural and remote mental health workforce are discussed in more detail in the sections that follow.

#### 2.1.5. Challenge 5: Responsive and flexible

The mental health workforce needs to be responsive, agile and adaptive to emerging challenges and opportunities

Emerging lived experience mental health workforces, increasing contribution of community based mental health services, evolving best practice approaches and a changing profile of consumers with increasing needs requires a mental health workforce that is responsive, agile and adaptive.

Developing a responsive mental health system and services is a strategic direction of national mental health policy (Department of Health, 2017). This requires supporting and adapting the workforce and responding to changing training and education needs. Some organisational structures may have more barriers to flexibility than others. For example, an Australian study exploring the governmental and community based organisational contexts where peer support mental health services are delivered concluded that in comparison to government organisational context, community based ones were able to be more responsive, mobilise quicker and had greater autonomy to make the organisational shifts required to fully integrate new approaches (Zeng, Chung, & McNamara, 2020). Policy and governance structures within government organisations should be reviewed with the view of embedding processes for rapid response to ensure emerging challenges are addressed and arising opportunities are not missed.

Recent experience with extreme drought and bushfire seasons and ongoing experience with COVID-19 restrictions, further highlights the need for an agile mental health workforce that can respond quickly to changes in the demand and delivery of mental health services. The mental health workforce needs to be responsive to an increasing frequency, duration and impact of emergency situations (e.g. natural disasters, pandemics) (Reifels, Naccarella, Blashki, & Pirkis, 2014), particularly where such events further compound existing mental health inequalities (Dudgeon, Derry, Arabena, et al., 2020).

A recently published Lancet Psychiatry Position Paper (Holmes et al., 2020) sets out a number of responses that are needed to understand and address the immediate and ongoing mental health impacts of COVID-19. Multidisciplinary approaches and novel interventions will be needed to ensure the psychosocial wellbeing of populations including recognition of the disproportionate effects on those most vulnerable. Holmes et al. (2020) maintain that new and effective ways of using technology to remotely deliver mental health services depend on mental health disciplines working together with people with lived experience and in partnership with new disciplines such as digital science, humanities and social science for an interdisciplinary approach to respond to new and complex challenges.

#### 2.1.1 Challenge 6: Measuring progress

**Developing the mental health workforce calls for quantifiable targets and indicators as part of a comprehensive monitoring and evaluation plan**

Some resources on key performance indicators for mental health services already exist. For example,

the Fifth National Mental Health and Suicide Prevention Plan sets out detailed descriptions of proposed indicators in Appendix B, including some relating specifically to the workforce (e.g. 'Proportion of total mental health workforce accounted for by the mental health peer workforce') (Department of Health, 2017). The National Mental Health Service Planning Framework (NMHSPF), which commenced in 2011 under the previous Fourth National Mental Health Plan, also provides a planning framework that 'establishes targets for the mix and level of the full range of mental health services'.

As noted by the National Mental Health Commission (2018), there are barriers to the use of the NMHSPF for service planning, including limitations around rural or Aboriginal and/or Torres Strait Islander populations. There also exists the National Mental Health Performance Framework 2020 (Australian Government, 2020) and the Key Performance Indicators for Australian Public Mental Health Services and accompanying National Health Workforce Data Set. Some of these indicators relate to health and mental health outcomes such as determinants of health (environmental factors, health behaviours, personal biomedical factors, personal history, socioeconomic factors), health status (deaths, health conditions, human function, wellbeing), as well as factors relating to the health system: accessibility, appropriateness, continuity of care, effectiveness, efficiency and sustainability (Australian Government, 2020). Similarly, mental health workforce plans within different jurisdictions often identify key performance indicators and measures of success (NSW Health, 2018b).

While most mental workforce strategies mention the importance of monitoring and evaluating the implementation and impact of the strategy, few have publicly available detailed implementation plans or monitoring and evaluation frameworks. Among the exceptions is the South Australian Mental Health Services Plan 2020-2025 (SA Health, 2019), which sets out measures of success in relation to the stated outcome of a workforce that is supported to provide the best care. These measures include: Increase in new graduates seeking employment in mental health services; Decrease in WorkCover injury claims for psychological distress; and Increase in the number of Aboriginal Mental Health Staff in mental health services. The New South Wales Strategic Framework and Workforce Plan for Mental Health 2018-2022: Implementation Plan is a further exception, however this document includes goals, objectives and actions rather than measures or indicators of progress (NSW Health, 2019). The need for implementation and monitoring and evaluation plans is recognised by the National Mental Health Commission who recommend that the Australian Government produces a clear implementation plan to accompany the development and release of the forthcoming National Mental Health Workforce Strategy (National Mental Health Commission, 2019a).

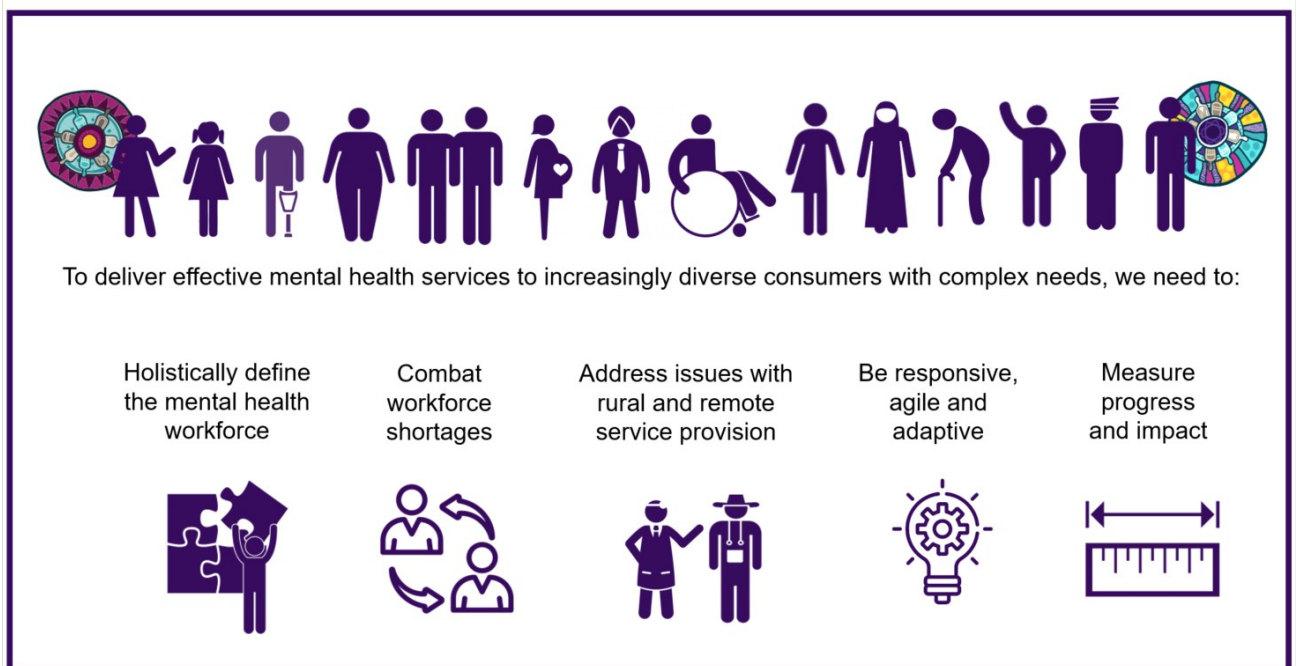
However, despite these existing data collection efforts, a number of reports, including the Royal Commission into Victoria's Mental Health System, cite the absence of a centralised and dynamic approach to workforce data collection and analysis as a key challenge (State of Victoria, 2019). This is concerning as it indicates that current data collection efforts are not achieving full potential and are failing to provide useful information on the progress and outcomes of mental health workforce strategies. It is important to work with the state and territory governments on the development of routinely collected and analysed data on mental health expenditure, workforce and program and service activity, and mental health outcomes. As the mental health workforce diversifies, collection and interpretation of these data will become more complex, particularly when it comes to getting a clear sense of contributions and impacts from community support services, peer mental health workforce and consumers, carers and families.

Efforts will also be needed to establish an 'information literate' mental health workforce who can use contextual data, evidence and performance measures to inform, adapt and improve mental health practice and services (Coombs et al., 2017). Similarly, arrangements and agreements around data sharing that streamlines access but doesn't compromise data quality or security are also required.

While robust data collection and analysis is vital it is also important to be aware of the burden of data collection particularly among mental health workforce staff and consumers. Streamlined, innovative and flexible approaches to data collection and analysis that utilise mixed method approaches and make novel use of existing administrative data and stronger data linkages may help relieve this burden. Partnerships with researchers, another important component of the mental health workforce, should also be considered to facilitate robust data collection, management and analysis.

The six challenges outlined above do not represent an exhaustive list of the challenges facing the mental health workforce in Australia. These six challenges present an overview of the key areas that need to be addressed in order to develop a mental health workforce that provides effective services for increasingly diverse consumers with increasingly complex needs (Figure 2). The following sections (section 2.2 - 2.6) provide more detailed content on how to address these challenges.

Figure 2: Overview of mental health workforce challenges



Motif design by Leigh Harris, Ingeous Studios

**2.2. Review Question 2: What are the commonalities graded, from most to least prevalent, across the various national and jurisdictional mental health workforce strategies?**

This section presents an overview of the commonalities seen across the aims, principles and priority action areas of the mental health workforce strategies of each state and territory. Consideration of the monitoring, evaluation and reporting of the effectiveness of mental health workforce strategies is provided in section 2.2.5.

Mental health policies across jurisdictions are highly consistent in recognising that the effective implementation of any mental health strategy relies on a capable and sustainable workforce that can provide the right care, at the right time, in the right place. For the purposes of this review the most relevant mental health workforce plan from each jurisdiction has been included as the primary source of information with other related workforce or mental health plans referred to as appropriate. Commonalities are graded based on the frequency and depth (most to least prevalent) in which they are covered across the mental health workforce strategies of each jurisdiction.

**2.2.1.A complex policy landscape**

The Australian mental health workforce policy landscape is diverse and complex. The structure and coverage of mental health workforce policies varies across the different jurisdictions in Australia.

Appendix C presents an overview of the mental health workforce policies with specific documents mapped against the various areas relating to the mental health workforce.

The variety in the breadth of policies is somewhat related to the challenge of defining the mental health workforce (section 2.1.1). Different jurisdictions define and categorise the mental health workforce in different ways. Some jurisdictions have developed individual policies specific to each area of the mental health workforce (e.g. Victoria and Queensland) whereas other jurisdictions have one policy covering many aspects of the mental health workforce (e.g. New South Wales). Not all jurisdictions have a current mental health workforce strategy. For example, Western Australia's Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2018 – 2025 is still in development and only the consultation draft is available for inclusion in this review (Mental Health Commission, 2018).

In Tasmania the Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020) is specific to the suicide prevention workforce and not the mental health workforce more broadly (Department of Health and Human Services, 2016). Finally, there is a health service plan currently being developed in the Australian Capital Territory, but there isn't a current mental health workforce plan available for inclusion in this review. There is an ACT Mental Health Services Plan 2009 – 2014 (ACT Health, 2009) which is referred to where appropriate but is not analysed alongside the more current mental health workforce strategies.

Where states and territories have both a health workforce plan and mental health workforce plan, these plans tend to exist somewhat independently of each other with little cross reference. Interestingly, the underpinning policies of these plans and drivers for their development can also be different. For example, in Queensland, the mental health workforce plan was developed in response to Priority 2 of 'Connecting care to recovery 2016- 2021: A plan for Queensland's State-funded mental health alcohol and other drug services' (Queensland Health, 2017c), whereas the health workforce plan was developed in response to the 'My health, Queensland's future: Advancing health 2026' policy (Queensland Health, 2017a). It would be beneficial to have explicit communication on how all the varied plans and policies relating to the mental health workforce interact and support one another. This would help streamline effort and increase collaboration across the various health workforces.

Interestingly, some mental health workforce plans also include the alcohol and other drugs workforce (QLD, WA), despite these workforces having separate strategies at the national level and within other jurisdictions (e.g. VIC).

National mental health peer workforce guidelines are currently in development. However, Queensland, Victoria, Western Australia and Tasmania have already developed strategies and frameworks for the peer mental health workforce:

- *Strategy for the Consumer Mental Health Workforce in Victoria* (Lived Experience Workforce Strategies Stewardship Group, 2019)
- *Peer Workforce Development Strategy* (Mental Health Council of Tasmania, 2019)
- *A Peer Work Strategic Framework for the Mental Health and Alcohol and Other Drug Sectors in Western Australia* (Western Australian Association for Mental Health, 2014)
- *Queensland Framework for the Development of the Mental Health Lived Experience Workforce* (Queensland Mental Health Commission, 2019).

While most mental health workforce plans tend to be developed by the relevant department of health, mental health peer workforce plans tend to be developed by mental health councils or commissions.

The 2011 National Mental Health Workforce Strategy was explicitly mentioned as an overarching or supporting strategy in the following mental health workforce plans:

- Victoria’s Specialist Mental Health Workforce Framework Strategic Directions 2014–2024 (VIC Health, 2014)
- South Australian Mental Health Nursing Workforce Strategy 2020-2030 (SA Health, 2020)
- Western Australia’s Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018- 2025 (consultation draft) (Western Australian Association for Mental Health, 2014)
- Queensland’s Mental Health Alcohol and Other Drugs Workforce Development Framework 2016- 2021 (Queensland Health, 2017c)
- Living Well: A Strategic Plan for Mental Health in NSW (2014) (NSW Mental Health Commission, 2014)

### 2.2.2. Policy aims and objectives

The 2011 National Mental Health Workforce Strategy sets the aim to “develop and support a well-led, high performing and sustainable mental health workforce delivering quality recovery-focused mental health services”. This vision is reflected in the visions set out in the mental health workforce plans of different jurisdictions. For example, the vision of the South Australian Mental Health Services Plan 2020-2025 is to commission “mental health services of the highest quality, that are effective and safe, uphold human rights, enhance wellbeing and support people to fully participate and thrive in their chosen community.”

Similarly, the Queensland mental health workforce plan envisions that the mental health workforce is “designed, strengthened, connected and enabled to provide responsive, high quality, recovery-focused services.” In Victoria and New South Wales, the mental health workforce plans don’t state unique visions but rather support the visions stated in the relevant mental health plans. The following table outlines the mental health workforce visions for each state and territory.

Table 1: Overview of visions stated within mental health workforce strategies

Vision	Policy
Our mental health alcohol and other drugs workforce is designed, strengthened, connected and enabled to provide responsive, high quality, recovery-focused services.	Queensland Mental Health Alcohol and Other Drug Workforce Development Framework 2016-2021 (Queensland Health, 2017c)
The South Australian Department for Health and Wellbeing will commission mental health services of the highest quality, that are effective and safe, uphold human rights, enhance wellbeing and support people to fully participate and thrive in their chosen community.	South Australia Mental Health Services Plan 2020-2025 (SA Health, 2019)
The Northern Territory’s vision is to promote, protect and enhance the mental health of all Territorians across all stages of life.	Northern Territory Mental Health Service Strategic Plan 2015 – 2021 (NT Health, 2015)
To guide the growth and development of an appropriately qualified and skilled workforce that will deliver individualised, high quality mental health and alcohol and other drugs services and programs for the Western Australian community.	Western Australia Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2018 – 2025 (consultation draft) (Mental Health Commission, 2018)

Vision	Policy
The Framework and Workforce Plan support achievement of the vision outlined in Living Well, that: "The people of NSW have the best opportunity for good mental health and wellbeing and to live well in their community and on their own terms"	New South Wales Strategic Framework and Workforce Plan for Mental Health 2018-2022 (NSW Health, 2018b)
All Victorians experience their best possible health, including mental health	Victoria 10-Year Mental Health Plan – Mental Health Workforce Strategy (VIC Health, 2016)
Support priority workforces and groups to provide effective and compassionate care and support to people experiencing suicidal thoughts and behaviours.	Tasmania Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020) (Department of Health and Human Services, 2016)

### 2.2.3. Policy principles

While each policy has its own set of values and principles that reflect some variations in approach, priorities and range of services delivered, there are common core themes. The following table outlines the key principles mentioned and identifies which jurisdiction's mental health workforce plans have explicitly included each principle.

Table 2 presents the principles that were identified in the policy documents according to the number of jurisdictions citing each principle, with the principles ranked from most to least common. The number of principles contained in the strategies ranged from three (QLD, NSW, SA) to 12 (VIC).

Table 2. Principles identified in the reviewed mental health workforce plans graded from most to least common

Principle	Description	Plans explicitly mentioning this principle
<b>Holistic person-centred care</b>	People with lived experience and service users are engaged as valued partners in guiding workforce design, planning, development and evaluation. The rights and dignity of individuals and their families and carers are respected and upheld. The workforce is supported to recognise and be inclusive of the views, needs and strengths of people from diverse social, cultural and spiritual backgrounds.	QLD, NSW, NT, VIC, WA, SA

Principle	Description	Plans explicitly mentioning this principle
<b>Continuously improving the quality and safety of care</b>	<p>Workforce planning and development is motivated by a commitment to continuously improve service delivery outcomes for individuals, families, carers and the broader community with the ultimate aim to provide high quality and evidence-based care.</p> <p>Treatment and care is informed by innovation, research and the application of best practice. The workforce applies the highest ethical service and professional standards and participates in ongoing professional development to apply knowledge consistent with professional and organisational practice standards.</p>	QLD, NSW, NT, SA
<b>Recovery-oriented and strengths based</b>	<p>Sometimes included as part of the person-centred care principle (NSW, QLD) or as a standalone principle (NT, VIC, WA). Services will support people to use and build on their personal strengths, resourcefulness and resilience, and be responsive to their unique circumstances, needs and preferences to set them on their recovery journey.</p>	QLD, NSW, NT, VIC, WA
<b>Sustainable, accessible and equitable</b>	<p>Services will provide equitable access in ways that are easy to navigate and accessible early in life, early in episode and early in the illness.</p>	QLD, NSW, NT, VIC
<b>Connected, coordinated and collaborative care</b>	<p>Services will be provided in a collaborative and coordinated way that acknowledges and is responsive to the range of needs that people experiencing mental illness may have, as well as the range of service sectors that can be involved in responding to these needs appropriately.</p>	VIC, NSW, SA
<b>Culturally safe and appropriate care</b>	<p>Cultural safety means providing services that are: 'safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening' (Williams, 1999). Services and programs are planned and delivered in ways that recognise and respect differences in culture and values within diverse populations.</p>	NT, VIC, WA



Principle	Description	Plans explicitly mentioning this principle
<b>Partnering with consumers, carers, families and communities</b>	<p>Consumers and carers are partners in planning and decision-making in the service system across the continuum from their own care and local service delivery to system-wide policy and planning.</p> <p>Consumers are at the centre of their own care and decision making. Their families, carers and support people can contribute a significant role in treatment, care planning and decision making to support the person's recovery from mental illness.</p>	NT, VIC, WA
<b>Trauma informed</b>	<p>The impact of traumatic experiences on people who access health and human services can be profound and can vary considerably from person to person. Service delivery will be provided in a way that is informed by the impact of trauma on the lives of people requiring mental health treatment and care.</p>	VIC, WA, NSW
<b>Responsive to multiple and complex needs</b>	<p>People accessing specialist mental health services often have complex needs and are often disadvantaged by a range of factors such as poor physical health, poverty, family violence, substance use, disability, family rejection and social isolation. Services will be provided in a way that acknowledges and responds to the diversity of life events that people experience.</p>	VIC
<b>Age appropriate and developmentally focused</b>	<p>Services will be provided in a way that ensures appropriate and focused responses that address people's experiences of mental illness across the lifespan, from infancy and childhood through to old age.</p>	VIC
<b>Rights based</b>	<p>Services are required by law to respect the human rights of individuals, including consumers, family members, carers and service staff. Wherever possible, individuals will be involved in decision making processes that affect them, including the development of mental health service policies and practice change.</p>	VIC

Principle	Description	Plans explicitly mentioning this principle
<b>Workforce planning and development occurs across the service spectrum.</b>	The service spectrum ranges from mental health promotion and primary prevention through to treatment, including national, state-wide, community-based and acute hospital-based services. Workforce planning and development is important to address the requirements of the workforce across this service spectrum, particularly the community and prevention sectors, which are currently well below the optimal level. To be effective, it is important that workforce development and planning is addressed at an individual, organisational and systemic level.	WA
<b>All workers, including clinicians, are offered the opportunity to be involved in addressing workforce planning and development issues</b>	Providing avenues and opportunities for all workers to contribute to workforce planning and development decisions is essential. Mental health and alcohol and other drugs workers, including clinicians, have a wealth of knowledge and expertise that can aid in determining how to improve services for consumers, families and carers, as well as better support the workforce.	WA
<b>Workforce configuration is flexible and responsive</b>	Models of service and population demographics change over time so it is important the workforce remain flexible and responsive to these changes. New evidence and emerging trends continue to inform the provision of prevention strategies through to treatment services and therefore, the staff types, skills and competencies required to deliver services must be able to adapt.	WA
<b>Changes within the workforce are sustainable</b>	Sustainability as it relates to the workforce involves a requirement to develop the workforce in a way that can be maintained on an ongoing basis, whilst continually improving worker wellbeing and providing high quality, safe and accessible services. It is essential the configuration of the workforce provides value for money, whilst prioritising safety and quality. Workforce sustainability requires a focus on workload and worker wellbeing, thereby reducing staff turnover and retaining the skills of the workforce.	WA

### 2.2.4. Priority Areas

Each mental health workforce plan has its own focus areas or priority domains. However, there are commonalities across the different jurisdictions. Table 3 presents the priority action areas for each state and territory.

Within the broader literature, place-based recruitment and retention is identified as a priority area for developing effective mental health workforces, particularly within rural and remote areas. However, within the mental health workforce strategies of states and territories, place-based approaches were rarely explicitly mentioned with the exception of Victoria's specialist mental health workforce framework Strategic directions 2014–24 which includes a strategy to 'Support and strengthen existing and new place-based recruitment and retention initiatives to attract people into mental health careers in rural and regional areas'.

Table 3: Priority areas of mental health workforce strategies

Priority area	Mental Health Workforce Plan
Designing the workforce Core knowledge and skills for the workforce A flexible workforce operating at its optimal scope of practice Recruiting and retaining the workforce Enabling the workforce Flexible workforce practices Building the future workforce through workforce planning Strengthening the workforce Education, training and professional development pathways Developing the future leaders of the workforce Culturally safe care A well and safe workforce Keeping connected Ability to effectively partner with other care providers and an individual's family and carer(s) Equipping the broader workforce with the necessary skills	Queensland Mental Health Alcohol and Other Drug Workforce Development Framework 2016-2021 (Queensland Health, 2017c)
Community alternatives: timely access to community-based care earlier in the course of illness and early in episode Human rights: ensuring human rights are respected, protected, and fulfilled, with a reduction in coercion Peer workforce: peer workers will be incorporated as an integral component of mental health service delivery Effective Suicide Prevention: commitment to a Towards Zero Suicide initiative within our tertiary mental health services Access to therapies: Providing greater access to a range of evidence-based therapies Equity of access to services: ensuring people in South Australia have equitable access to services wherever they live, including people in rural and remote communities	South Australia Mental Health Services Plan 2020-2025 (SA Health, 2019)
Shaping our mental health system for the future	Northern Territory

Priority area	Mental Health Workforce Plan
Embedding person, family and community-centred practice in the NT mental health system Promotion, prevention and early intervention Enabling participation and Engagement Developing our mental health Workforce Using knowledge to drive quality and innovation	Mental Health Service Strategic Plan 2015 – 2021 (NT Health, 2019)
Support the current and future workforce to deliver high-quality, modern, culturally appropriate and secure, services and programs. Ensure the specialist workforce is adequately configured and supported to meet the requirements of the Western Australian community. Promote innovation in service delivery and encourage the uptake of best practice and evidence-informed practices, including the integration of services and delivery of holistic, whole-of-person support. Support relevant generalist health and human service agencies and staff to deliver appropriate mental health and AOD services. Improve workforce data collection and continually monitor and evaluate workforce data to enable effective planning and development activity	Western Australia Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2018 – 2025 (consultation draft) (Mental Health Commission, 2019)
Strengthening mental health leadership Strengthening the psychiatry workforce Increasing access to allied health Developing emerging workforces Workforce planning Workforce development Supporting capacity in partner workforces	New South Wales Mental Health Workforce Plan 2018-2022 (NSW Health, 2018b)
Workforce availability and skill: Right person, right place, right skill Worker safety and satisfaction Workforce integration Co-design and co-delivery with consumers and carers Workforce innovation	Victoria 10-Year Mental Health Plan – Mental Health Workforce Strategy (VIC Health, 2016)
Priority areas structured around the different workforces and groups with people at risk of suicide	Tasmania Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020) (Department of Health and Human Services, 2016)

### 2.2.5. Monitoring and evaluation

Monitoring and evaluation is key to building an evidence base for the effectiveness of mental health workforce development strategies and initiatives. Monitoring and evaluation sheds light on what works for whom and in what context and as such is a vital tool for ensuring that effort and investment is directed to where it will have the most impact.

The mental health workforce strategies of all jurisdictions mention the importance of monitoring and evaluation, although the level of detail varies. For example, the South Australian mental health services plan outlines 11 mental health service outcomes and accompanying actions and measures and sets a commitment for the plan to be evaluated at three time points (SA Health, 2019). Conversely, other plans just include a brief section mentioning proposed plans for developing a

monitoring and evaluation framework but lack any firm detail on how this will be done.

Some jurisdictions have developed tools and frameworks to support monitoring and evaluation efforts. For example, the New South Wales Health Analytics Framework outlines a five-year vision for analytics in NSW Health, although there isn't much detail specific to mental health (NSW Health, 2016). Similarly, the South Australian Performance Accountabilities Framework sets out the framework within which the South Australian Department of Health and Wellbeing monitors and assesses the performance of public sector health services in South Australia (SA Health, 2019).

While there are high level plans for monitoring and evaluation outlined within most mental health workforce plans, overall there is limited publicly available information on details of how monitoring and evaluation efforts will be carried out and reported upon. In summary:

- Very few jurisdictions have publicly available Implementation Plans to accompany the mental health workforce strategy. See the NSW Strategic Framework and Workforce Plan for Mental Health 2018 – 2022: Implementation Plan for an example of an implementation plan (NSW Health, 2019).
- No publicly available Evaluation Frameworks were identified. Evaluation Frameworks are important for providing clear communication and consistent messaging on the program logic (theory of change) underpinning the intended outcomes of strategies and initiatives. Evaluation Frameworks also help identify the appropriate indicators for the process evaluation (was the strategy implemented as intended and was it implemented well) and outcome evaluation (has the strategy achieved the intended results) as well as outline the governance arrangements and roles and responsibilities of relevant stakeholders in data collection, management, analysis and reporting.
- No jurisdiction has publicly available, transparent reporting (online dashboards or regular progress reports). This is the case for both reporting on implementation progress of the strategy and on the impacts or outcomes of the strategy.

Some examples of outcome monitoring, both for the workforce and for developing culturally responsiveness, are available from other countries. The *New Zealand Mental Health and Addiction Workforce Action Plan 2017-2021* places a major emphasis on building a culturally responsive workforce (NZ Ministry of Health, 2018). The overall vision of the Action Plan is "The overall outcome of the Action Plan is that New Zealanders experience joined-up care from an integrated, competent, capable, high-quality and motivated workforce focused on improving health and wellbeing." (p. viii). This vision is underpinned by four priority areas:

1. A workforce that is focused on people and improved outcomes.
2. A workforce that is integrated and connected across the continuum.
3. A workforce that is competent and capable.
4. A workforce that is the right size and skill mix.

Also included in the Action Plan is 'a commitment to improve outcomes for Māori and other groups where disparity is evident'. The Action Plan 'aims to build a workforce that is culturally responsive to all New Zealanders and reflects the population it serves' (NZ Ministry of Health, 2018).

The New Zealand Mental Health and Addiction Workforce Action Plan 2017-2021 links with the 'Ala Mo'ui: Pathways to Pacific health and wellbeing 2014-2018 (NZ Ministry of Health, 2014), which is a four-year plan that provides an outcomes framework for delivering high-quality health services to Pacific peoples.

The four priority outcome areas for the *Ala Mo'ui* are that:

- systems and services meet the needs of Pacific peoples

- more services are delivered locally in the community and in primary care
- Pacific peoples are better supported to be healthy
- Pacific peoples experience improved determinants of health.

The New Zealand Ministry of Health also released regular progress reports on the implementation of Ala Mo'ui against these priority outcome areas (NZ Ministry of Health, 2016). This provides an international example of embedding cultural responsiveness and outcome monitoring into policy.

With the increasing diversity and complexity of the mental health workforce, it is important that monitoring and evaluation efforts account for the contribution and impact of all sectors, otherwise it may not be possible to capture the whole picture and assess the real impact of the mental health workforce. Such reporting will require transdisciplinary and mixed methods research approaches with collaboration and data and skill sharing needed across different government departments and tiers as well as across organisations and sectors.

### **2.3. Review Question 3: What principles, actions and mechanisms have been identified to support an effective mental health workforce across Australia?**

There are nuances and unique characteristics to the mental health workforce strategies of each jurisdiction (Section 2.2.3). However, an overarching theme across the workforce strategies of all jurisdictions is the emphasis on developing a mental health workforce with the capability and capacity to deliver high quality holistic person-centred care. Contemporary best practice features care that is recovery oriented, strengths-based, trauma-informed and culturally safe and is sustainable, accessible and equitable. The following sections outline some of the key actions and mechanisms that have been identified for enabling the development of such a mental health workforce.

#### **2.3.1. Actions for a workforce that delivers holistic person-centred, recovery oriented, strengths-based and trauma-informed care**

Stepped care is a measure introduced as part of the Australian Government's mental health reform agenda to improve service delivery across the spectrum of mental health care need. The stepped care model involves a population-based planning approach: "an evidence-based, staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs" (Australian Government Department of Health, 2016, p. 2). Primary Health Networks (PHNs) have a central role in ensuring that the regional planning and commissioning of mental health services corresponds to a stepped care model where availability of services exists across the spectrum of need ranging from whole of population needs for mental health promotion and prevention, through to those with severe, persistent and complex conditions.

Stepped care is a person-centred approach that aims to ensure access to the right level of mental health services at the right time. Lower intensity steps are widely available to promote early support and an emphasis on prevention. Key principles that underpin the stepped care approach are: Person-centred (recovery oriented); effective (evidence-based); flexible (spectrum of services); efficient (lowest cost service according to individual's need); timely (access to services); coordinated (integration of services across the spectrum) (Australian Government Department of Health, 2019).

Recovery-oriented mental health practice and meaningful engagement and partnerships with consumers, carers and families are central to contemporary mental health care and the delivery of a holistic model of mental health care and these principles are endorsed widely (Department of Health, 2013a). These approaches acknowledge that living with, managing and recovery from mental illness are personal, transformational and incremental processes, where persons are viewed as active agents of growth rather than passive recipients of care (Zeng et al., 2020). Some workforce strategies have explicit objectives to 'enable the delivery of contemporary and evidenced informed care that is co-designed with consumers and carers with lived experience' (SA Health, 2020) and to 'embed

person, family and community-centred practice in the mental health system’ (NT Health, 2019).

Enablers of these objectives include a workforce that supports recovery oriented mental health practice which acknowledges that each individual is an expert in their own life. Mechanisms such as consumer, carer and staff feedback loops to build shared understandings of all stakeholder perspectives, training and capacity building resources on mental health co-design processes and supporting collaboration and partnership skills training can all help develop the mental health workforce in achieving holistic person-centred, recovery oriented and strengths-based care.

Embedding holistic person-centred and recovery-oriented approaches within mental health workforces depends upon these approaches also being integrated within the training and education of all mental health professions, particularly at the undergraduate level. Further information on developing the mental health workforce through education and training is provided in section 2.5.

Co-design processes are an effective approach to achieving person-centred care, however genuine co-design needs to be considered and embedded from project inception, needs to be delivered in a genuine and meaningful way by service providers who are adequately supported (training and capacity building, time and resources) and needs to be continually reviewed and adapted to ensure the co-design process is effective in achieving its intended outcomes.

### 2.3.2. Actions for culturally safe, diverse and inclusive mental health workforces

As outlined in Challenge 2, the mental health workforce needs to be supported in meeting the needs of increasingly diverse consumers with an increasing complexity and co-occurrence of conditions. Access to ongoing training — that may include free access to online tools and resources — may be one way to support the mental health workforce in acquiring specialised skills and knowledge for delivering appropriate services to consumers from diverse backgrounds and experiences.

For example, the free e-learning tool ‘Intellectual disability mental health e-Learning’ ([www.idhealtheducation.edu.au](http://www.idhealtheducation.edu.au)) provides extra training for the health and disability workforce, carers and family, so they can provide expert care to people with intellectual disability and mental illness. Similarly, the NSW Ministry of Health’s Specialist Mental Health Services for Older People (SMHSOP) benchmarking initiative aims to benchmark mental health services for older people against evidence-based principles, practices and outcome targets as way of promoting and supporting quality improvement (Ministry of Health, 2018; NSW Health, 2018a). Building awareness and knowledge of diverse consumer needs should also occur during undergraduate studies of mental health professionals.

The advice set out in the Gayaa Dhuwi (Proud Spirit) Declaration should be followed, particularly as it relates to increasing the presence and leadership of Aboriginal and Torres Strait Islander people within the mental health workforce. For example, ‘Aboriginal and Torres Strait Islander leaders should be supported and valued to be visible and influential across all parts of the Australian mental health system’ (National Aboriginal and Torres Strait Islander Leadership in Mental Health, 2015). Non-Indigenous mental health workers should receive training and awareness raising on the Aboriginal and Torres Strait Islander concepts of social and emotional wellbeing, mental health and healing in practice.

Inclusion of consumers from diverse backgrounds as part of the mental health peer workforce may help introduce specialised experience and skills within the mental health workforce. Evidence suggests that youth peer workers may be particularly beneficial in addressing the low rates of help seeking behaviour among young people who need it most (Ivancic, Perrens, Fildes, Perry, & Christensen, 2014). Peer mental health youth workers are particularly important in the context of Indigenous youth mental health (Dudgeon et al., 2016).

The Queensland Framework for the Development of the Mental Health Lived Experience Workforce (2019) outlines a number of emerging best practice strategies for ensuring diversity and inclusion

within the mental health peer workforce. These best practice strategies include preparing the existing workforce and workplace through education and communication and making reasonable adjustments to work premises, schedules and equipment. Acknowledging cultural understandings and practices, values, holidays and celebrations, creating and publicising inclusive policies (e.g. LGBTQIA+ friendly policies) and establishing mentoring and support networks, can all help support mental health workers from diverse backgrounds.

**Case Study: The Older Persons Peer Support Program, NSW**

Support from an individual who understands what it is to live with a mental illness in older age is highly valuable to older people experiencing mental illness (Mental Health Commission of NSW, 2017). Peer worker models in older people's mental health can help support an effective mental health workforce. While there are logistical challenges with such models, the NSW, Central Coast Primary Care employs older peer workers, in either paid or volunteer roles, to support consumers of the Older People's Mental Health Service.



**Case Study: Alive and Kicking Goals!, WA**

Through use of football and peer education this program aims to improve mental health among Indigenous youth. It is community-developed and led and was built on the popularity of football and the peer relationships that can develop from playing the game. Volunteer youth leaders, who are well-respected sportsmen, undertake training to become peer educators. They educate young people in communities about mental health and lifestyle and demonstrate that seeking help is not a sign of weakness.

**2.3.3. Actions for a high quality, sustainable, accessible and equitable workforce**

A sustainable mental health workforce requires attention to funding, partnerships and worker attraction, training and retention. Many of the actions suggested here require structural support within organisations, along with appropriate resourcing, to accompany policy actions.

As the composition of the mental health workforce continues to change and diversify, the need for sustainable partnerships and collaborations becomes of upmost importance. Respectful, mutually beneficial and sustainable partnerships and collaborations across all areas of the mental health workforce are needed to maintain and enhance the quality of services. Working relationships across service providers can be improved through innovative models of care where possible (e.g. co-location of services), and strengthening processes such as joint-training, information sharing, shared data collection and evaluation and joint case conferencing to ensure the successful implementation of models of care.

Appropriate and responsive education, training and professional development is essential to the ongoing improvement and sustainability of the mental health workforce. Supporting early career workers through mentorship and structured on-the-job supervision is required and capacity for senior workers to deliver this early career support should be appropriately planned and resourced. Cross-discipline mentorship is a potentially useful approach for building transdisciplinary perspectives and understandings on mental health services. Similarly, access to cultural mentors as a support for mental health workers could help build inclusive and equitable service provision. There needs to be ongoing review and embedding of mechanisms for the development and provision of training programs and education that responds to emerging technologies and research findings and evolving health systems and that is accessible and inclusive for culturally diverse workers and those in rural and remote areas.

Place-based approaches to developing the mental health workforce may help ensure long-term accessibility and sustainability of services, particularly in rural and remote areas and during events such as pandemics which can disrupt the accessibility of services. It is critical to support and appropriately utilise the existing local workforce, and to create and grow a longer-term, place-based, multidisciplinary Indigenous social and emotional wellbeing workforce (Dudgeon, Derry, & Wright, 2020).

As highlighted in Challenge 3, an ageing mental health workforce poses a challenge to mental health workforce sustainability. Workforce plans should integrate succession planning to provide strategic leadership continuity, operational effectiveness and improved quality of care. Similarly, the development of new roles and work design and flexible employment models may also offer opportunities for the retention of older workers with valuable knowledge and skills.

As outlined in section 2.2.5, monitoring and evaluation is essential to understanding how effective mental health strategies are in providing high-quality services that provide positive mental health outcomes. Indicators on the quality, accessibility and sustainability of mental health services and the intended mental health outcomes should be collected, analysed and reported on to ensure ongoing quality and improvement of the mental health workforce.

## 2.4. Review Question 4: What issues have been identified that impact the quality, supply, distribution and structure of the mental health workforce?

The reviewed literature outlined a range of key issues impacting on the quality, supply, distribution and structure of the mental health workforce. A critical concern that overlaps each of these areas - and one that is prominent in most jurisdictional policies - is ensuring that there are enough people with the right skills in the right places to deliver an effective mental health service system. Currently large gaps exist in the types of services available to consumers, and there are gaps in the distribution of services.

As outlined in section 2.1, some of the key challenges facing the mental health sector in Australia revolve around the shortages in the mental health workforce more generally, and amongst specific provider types (e.g. mental health nurses), in specific settings (e.g., rural and remote areas), and for specific population groups (e.g., younger and older age groups; Aboriginal and Torres Strait Islander peoples). Numerous reviews, inquiries and reports on the state of the mental health sector in Australia highlight these areas of shortage and uneven distribution and their consequences for the provision of mental health services that are consistent with the defining principles of contemporary best practice care (Health Performance Council, 2013; Productivity Commission, 2019a, 2019b; Senate Community Affairs Committee Secretariat, 2018; State of Victoria, 2019).

The section below outlines the key issues impacting on the quality, supply, distribution and structure of the mental health workforce, and in the subsequent section 2.5 we address practical approaches to address some of these issues.

### 2.4.1. Quality

A capable and well-equipped mental health workforce is essential to delivering quality services. Appropriate education and training, standards, guidelines and regulations for professional practice provide a solid foundation for a quality mental health service system. Currently there are a number of issues affecting the quality of the mental health service system in Australia; at the core of it, the key issue is achieving the right mix of training, accreditation and qualification requirements for different types of providers in the mental health service system. This is particularly important for peer workforces and non-clinical workforces where guidelines, standards and accreditation systems may not be as developed. Some of the key issues for consideration in regard to the quality of the mental health workforce include:

- The need for training of the mental health workforce to ensure that the voices of consumers are incorporated into service design and delivery.
- Need for leadership at all levels, and leadership at the national level through coordination and monitoring to ensure the quality of services (National Mental Health Commission, 2019b; Productivity Commission, 2019a, 2019b).
- Lack of appropriately trained staff and services for people with co-morbidities, particularly in rural and regional areas (Productivity Commission, 2019a, 2019b).
- Under-utilisation of effective approaches such as multi-disciplinary teams and collaborative care for people with complex needs.
- Continuous professional development requirements are important but there is patchy implementation and access to organisational resources to support this for many staff, and in some cases results in personal cost to staff (for example, in terms of money and time).

### 2.4.2. Supply

There are a number of challenges with the supply of the mental health workforce, particularly around staff shortages across some key provider types. For example, although they make up the largest segment of the clinical mental health workforce, there is a shortage of mental health nurses to meet demand (Productivity Commission, 2019a, 2019b). Similarly, there is also a shortage of

psychiatrists, particularly in rural and regional areas in Australia (Productivity Commission, 2019a, 2019b).

Challenges to the supply of the mental health workforce in Australia revolve around the ability to attract people to the qualification and training pathways that enable them to work in the mental health sector, the ability to retain people working in the sector as well as issues of staff turnover. High staff turnover, and poor retention in the mental health workforce results in a lack of continuity of services for clients, costs to employers, and a higher burden for remaining staff members. Negative workplace cultures, stigma, stress, and burnout can result in high turnover and poor retention (Productivity Commission, 2019a, 2019b).

Some of the key issues negatively impacting on attraction and recruitment of mental health workers include:

1. Negative perceptions of mental health and mental health specialisations as a career choice.
2. Perception of poor conditions in the sector.
3. Inadequate remuneration in some sectors.
4. Lack of specialisation in mental health at the undergraduate level in some university degrees (e.g. Nursing undergraduate degrees are generalist only and there is no specialisation in mental health).
5. Clinical placements in high stress settings, such as inpatient units, discourage students from seeking a mental health career.

Addressing issues that negatively impact on retention of the mental health workforce will require focused effort in the areas of mental health worker wellbeing, mental health worker conditions and worksatisfaction.

Recent surveys of mental health professionals in Australia (Scanlan, Meredith, & Poulsen, 2013) and the United States (Yanchus, Periard, & Osatuke, 2017) highlight the close relationship between job satisfaction, turnover intention and burnout. The importance of fostering positive workplace cultures and the provision of supervisory support are strongly indicated. In the United States, a large study of more than 200,000 mental health nurses, social workers, psychologists and psychiatrists concluded that culture change initiatives focused on psychological safety and workplace civility were necessary (Yanchus et al., 2017). This in turn requires attention to leadership support and role modelling of these organisational expectations.

Findings from Australia reflect similar themes. A survey of 277 mental health personnel from a large government-funded mental service in New South Wales and comprising 21 inpatient units and multiple community teams found that feedback, rewards and recognition were related to positive employee outcomes (Scanlan et al., 2013). The role of leadership styles in improving job satisfaction and reducing burnout was emphasised.

Notably, a survey of peer workers in mental health services in New South Wales suggested that peer workers experienced levels of satisfaction and burnout similar to those of mental health professionals generally (Scanlan et al., 2020). This study highlighted the importance of efforts directed at integration and acceptance of the peer workforce, including greater understanding and recognition of their contribution. Ensuring the availability of senior peer workers to provide supervision, leadership and systemic advocacy was recommended (Scanlan et al., 2020).

Ensuring workplace health and safety is an important part of enhancing worker wellbeing. Research indicates that there is a higher frequency of exposure to workplace violence in health service settings than in other workplaces. There are few studies in the Australian context that attempt to quantify the frequency and consequences of violence in mental health services. One study by Tonso et al. (2016) of workplace violence in Victorian mental health services found that there is a high level of violence against staff, and that this has major implications for staff wellbeing, with one-in-three employees who were exposed to violence reporting psychological distress.

The above issues are likely to be magnified for the Aboriginal mental health workforce working in rural and remote contexts. To investigate factors affecting job satisfaction and retention of Aboriginal Mental Health Workers (AMHWs), Cosgrave, Maple, and Hussain (2018) interviewed AMHWs who worked in New South Wales in rural and remote community mental health services. The authors identified three aspects negatively impacting on job satisfaction of AMHWs: 1) difficulties being accepted into the team and organisation; 2) culturally specific work challenges including assumptions that Aboriginal clients would always want to see an Aboriginal worker; and 3) professional differences and inequality, particularly in terms of remuneration and career building.

Lai, Taylor, Haigh, and Thompson (2018) systematically reviewed the literature on enablers and barriers to retention of Indigenous Australians in the health workforce, breaking these factors into structural, system, organisational and individual factors that affect retention. They found that the following barriers to retention across a number of studies:

- i. structural: racism
- ii. system: limited organisation funding and inadequate remuneration; limited career pathways
- iii. organisational: heavy workloads and demands; lack of support from management and lack of mentoring; lack of professional development opportunities
- iv. individual: proximity to community.

There are also supply issues in the community mental health sector, where there is particularly high staff turnover. Given an increasing reliance on the community mental health sector, this sector needs to increase in size and diversify in skills to meet service demand. The community mental health workforce has been identified as particularly vulnerable (Western Australian Association for Mental Health, 2017), largely due to issues with funding, contracting and procurement of community-based services. In particular, there is inadequate funding in contracts to allow for adequate training and ongoing workforce development activities. Poor remuneration and lower wages of workers in the community mental health sector, compared to those performing similar roles in the public sector, results in high staff turnover in this sector.

#### 2.4.3. Distribution and Structure

As already highlighted, the distribution of the mental health workforce is uneven and regional, rural and remote areas in Australia are under-served. Growth corridor areas, for example in greater Melbourne, can also experience difficulties in accessing mental health services. There is also imbalance between staff in the private and public sectors. In addition, some of the workforce types with lower numbers of workers, for example psychiatry, have particularly uneven distributions with most of the workforce clustered around urban centres.

The Australian Institute of Health and Welfare (AIHW) releases the 'Mental Health Services in Australia', which provides a picture of mental health in Australia, including data on the mental health workforce (Australian Institute of Health and Welfare, 2019a). The most recent report provides the following snapshot of the mental health workforce in 2018 (Australian Institute of Health and Welfare, 2019a):

- Mental Health Nursing: Nationally there were 87.8 full-time-equivalent (FTE) mental health nurses per 100,000 population working in Australia in 2018 (AIHW, 2020). The majority of nurses reported their principal role to be a clinical one (93.7%), followed by administration (3.4%), and teacher or educator (2.0%).
- Psychiatrists: Nationally, there were 13.3 FTE psychiatrists per 100,000 population working in Australia in 2018. The majority of FTE psychiatrists (93.2%) were employed in a clinical role, followed by administrator (3.7%), researcher (1.5%), teacher or educator (1.0%) and then other (0.6%). The most common work setting for psychiatrists was hospital (28.6%), followed by solo

private practice (22.8%), and community mental health service (19.4%).’

- Psychologists: Nationally, there were 92.3 FT psychologists per 100,000 population working in 2018, with some variation between jurisdictions. The majority (88.1%) of FTE psychologists reported their principal role at work to be clinician, followed by administrator (4.6%) and researcher (3.5%). The most common work setting for psychologists was solo private practice (18.8%), followed by group private practice (17.1%) and school (10.8%).

Whilst acknowledging that other professionals provide mental health related care, the AIHW limit workforce data to mental health nurses, psychiatrists, and psychologists. The AIHW does provide information relevant to other sectors across their datasets. The following provides a brief overview of the distribution of other sectors of the mental health workforce in Australia:

- GPs: According to the Bettering the Evaluation and Care of Health (BEACH) survey of general practice, around 12.4% of all GP encounters were mental health-related in 2015–16, representing an increase from 10.8% in 2007–08 (Australian Institute of Health and Welfare, 2019a).
- Peer workforce: Of the 170 state and territory specialised mental health service organisations in 2016–17, 76 organisations (44.7%) employed mental health consumer workers and 46 organisations (27.1%) employed mental health carer workers (Australian Institute of Health and Welfare, 2019).
- Community mental health care services: 9.5 million community mental health care service contacts were provided to approximately 435,000 patients in 2017–18. Aboriginal and Torres Strait Islander patients received community mental health care services at approximately 3 times the rate of non-Indigenous patients (53.8 compared to 16.1 per 1,000 population) in 2017–18.
- Counsellors and psychotherapists are not currently included as part of the mental health workforce in ongoing data collection.

Definitional challenges have implications for gaining a clear and agreed understanding of the mental health workforce. Many others in a wide range of roles make direct and indirect contributions in the field of mental health. In many instances, including those providing informal and/or unpaid care, teachers, first responders, aged care workers and numerous others, there is little ongoing data collection to quantify their largely hidden contributions.

The distribution and development of mental health services needs to be planned and delivered in response to population need. Achieving the right mix and distribution of mental health skills to meet population needs now and in the future is a complex task. Improving workers’ competencies, redefining roles and functions and using more innovative team structures may contribute towards a better mix of skills and a better workforce distribution (Health Workforce Australia, 2011). It is important to plan for the development of a mental health workforce that has the size, skill mix and distribution to meet projected population growth, consumer needs and preferences, and changing service models (Victoria Health, 2014). A capability-based approach to education, training and workforce development offers a potential solution to shortages and uneven distribution in the health workforce. It creates a common platform for access to and mobility across different health careers. It also supports more integrated work practices across disciplines and sectors (Health Workforce Australia, 2011).

Many mental health workforce strategies set out objectives for delivering connected and coordinated services (e.g. New South Wales). Services need to be integrated across health, mental health, social and community streams, inpatient and community-based settings, and the life course, according to need. The way that Australian health care is funded and provided across settings is complex. This contributes to challenges for consumers, carers and service providers in navigating the system. Differences in governance and responsibility, data and information sharing and the physical location of services can make referral and transition periods particularly challenging (NSW Health,

2018b).

Various factors will continue to shape the structure of the mental health workforce. For example, policy changes pursued by governments have affected the nature and structure of mental health care work. In particular, the NDIS represented a significant policy and funding model change that had major ramifications for the community managed mental health sector (Community Mental Health Australia, 2015). Similarly, introductions of the stepped care approach, has had significant impacts on workforce structure. The inclusion or otherwise of different provider types in the Medicare Benefits Scheme (MBS), such as the Better Access Initiative, also shapes the distribution and structure of the workforce. For example, registered counsellors and psychotherapists do not currently have access to the MBS, and there have been recommendations made to include their services to help address workforce shortages and waiting times (Australian Register of Counsellors and Psychotherapists, 2019). Other professions, including psychologists and general practitioners, and corresponding single practitioner (rather than team-based approaches), have expanded markedly in response to the Better Access Initiative (Rosenberg & Hickie, 2020).

## **2.5. Review Question 5: What practical approaches have been recommended to attract, train and retain the workforce required to meet the demands of the mental health system in the future?**

The information presented in this section is closely related to that presented in section 2.4, which outlined the issues affecting the quality, supply, distribution and structure of the mental health workforce. Following on from the preceding section, this section focuses in more detail on best practice recommendations and practical approaches to attract, recruit, train, support and retain the mental health workforce in order to address the issues identified in Section 2.4.

### **2.12 Workforce Attraction and Recruitment**

Attracting people to a career in mental health is the first step in ensuring an effective pipeline of talent to address existing shortages and projected need in the mental health workforce. The education and training sector is a key partner in delivering on any objective to enhance attraction and recruitment for mental health careers.

Practical approaches for attracting and recruiting an effective mental health workforce include incentive programs, programs to enhance the intention to pursue a career in mental health career at the secondary level and in university settings, awareness raising initiatives that market mental health services as an attractive career choice, and addressing stigma and misconceptions associated with the mental health workforce.

Actions and objectives on workforce recruitment are outlined in the mental health workforce strategies of all jurisdictions. For example, the NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 aims to improve recruitment through development of a Mental Health Attraction Campaign that includes a focus on value-based recruiting. Strengthening linkages within and between rural and metropolitan services and professionals to facilitate opportunities for secondments, professional development and service collaboration is also identified as key approach to recruitment (NSW Health, 2018b). Similarly, the Queensland mental health workforce development framework outlines strategies to develop and promote career pathways to maximise recruitment and retention through optimal development, leadership and remuneration opportunities, including consideration of regional and remote settings and Aboriginal and Torres Strait Islander workers.

There is also a need to market mental health services as an attractive career choice, for secondary school students, undergraduates, graduates and the existing health workforce. This marketing needs to be tailored to identified workforce shortages and needs across disciplines and geographical locations. The success of such marketing approaches will be dependent upon effort spent in addressing the current stigma that has been shown to be associated with working in mental health and reducing negative perceptions of mental health as a career option (Productivity Commission, 2019a, 2019b). This may be helped by increasing exposure to mental health workplaces during the

training and education of students in the health disciplines. Placements, graduate programs and flexible employment arrangements for students would address any misconceptions about mental health careers and help services to develop pathways into mental health careers. Building awareness around mental health and advocating mental health careers should occur as early as possible. A good example of this is the recent offering of psychology as a senior secondary course in secondary school in some states and territories in Australia.

Recruitment within rural and remote locations poses additional challenges. Across various parts of the health workforce, having a rural background and positive rural training experiences are closely associated with the intention to work rurally (Cosgrave, Malatzky, & Gillespie, 2019; Kondalsamy-Chennakesavan et al., 2015). The Rural Clinical Schools Program and the Rural Health Multidisciplinary Training Program aim to ensure a well distributed health workforce by supporting rural training experiences (McGirr et al., 2019). Combined data from 12 Rural Clinical Schools (RCS) provided evidence of a positive impact on rural health workforce distribution with RCS graduates significantly more likely to be working rurally five years post-graduation (McGirr et al., 2019). As the authors note, this is a long-range strategy, with a further five to ten years required to see this early graduate cohort become a more senior and a vocationally qualified rural workforce.

The recruitment strategies identified in rural and remote health workforce strategies also hold relevance for the mental health workforce. In Queensland, workforce attraction initiatives for rural and remote areas are now based on 'pull' approaches to encourage staff to move to locations rather than 'pushing' them. One such initiative is the partnership between university rural schools and Queensland Health. University Departments of Rural Health (UDRH) attract young students and graduates to remote areas of the state. This collaboration between Queensland Health and the UDRH provides increased support, and the opportunity to have broad clinical experiences and research opportunities that would not usually be offered in urban settings (Queensland Health, 2017b). The development of territory or state-wide talent pools and marketing campaigns with appropriate orientation and on-boarding programs are critical to recruitment success in rural and remote locations. When considering approaches to attracting potential employees to rural and remote areas it is important to also consider other individual drivers of potential employees and their families, including living amenities, partner employment opportunities and education for children.

The Productivity Commission Draft Report (2019a) makes the following relevant recommendations with regard to workforce recruitment:

- Set targets to attract and retain workers and establish a system to monitor and report progress in achieving the targets.
- Reduce negative attitudes surrounding mental health careers, for example by offering more internships in mental health settings other than inpatient settings.
- Making rural and remote locations more attractive for health professionals, including expanding the availability of locums for workers when they are on leave or undertaking professional development.

#### **Case Study: The Gippsland Mental Health Vacation School Program**

The Gippsland Mental Health Vacation School program was an initiative designed to expose pre-registration allied health and nursing students from urban areas to rural mental health employment and career opportunities. The intervention consisted of a five-day 'Vacation School' which invited allied health and nursing students to a five-day orientation to mental health service employment and career opportunities in Gippsland, a regional area of Victoria. Keith Sutton and colleagues have published a series of papers detailing the results of the brief intervention (Sutton, Maybery, & Moore, 2012; Sutton, Patrick, Maybery, & Eaton, 2016; Sutton, Maybery, & Moore, 2011; Sutton, Maybery, & Patrick, 2015; Willems, Sutton, & Maybery, 2015). These studies of the intervention

found that post-programme, there was a positive change in participants' interest and attitudes to working in a rural setting. These effects diminished over time, indicating that appropriate timing of this style of program in a student's university career is crucial.

### 2.1.3 Workforce Training

Workforce training is a key part of ensuring a quality workforce and an effective service system that responds to the needs of consumers.

The endorsement and application of evidence-based approaches by staff is predicted by knowledge, attitudes and skills, thus making training programs for staff a key means of ensuring an effective mental health service system (Smith & Jury, 2017). There are a broad range of training programs to enhance the knowledge, attitudes, and skills of staff in the mental health workforce. Training can increase positive attitudes towards and deployment of evidence-based approaches.

Jackson-Blott, Hare, Davies, and Morgan (2019) performed a narrative review of recovery-oriented training programs for mental health staff. The 17 included studies were of variable methodological quality and covered a diverse range of training programs, making it difficult to draw conclusions, however the authors indicate that experiential learning and the involvement of service users in training programs can have benefits. The evidence from the review suggested that recovery training has the potential to improve recovery-consistent knowledge, attitudes and competencies of mental health workers. They found limited evidence for any effect on service user or service-level outcomes.

The National Practice Standards for the Mental Health Workforce (2013b) aim to complement discipline- specific practice standards or competencies of the professions of nursing, occupational therapy, psychiatry, psychology and social work. From these practice standards the Mental Health Professional Online Development (MHPOD) Portal was developed. As such, MHPOD was originally designed for nurses, social workers, occupational therapists, psychiatrists and psychologists working in mental health in Australia, particularly those in their first two years of practice in Australian clinical mental health services. While this remains the case, this online portal may also be of use for general practitioners (GPs), consumer workers, carer workers, Aboriginal health workers, and other allied health workers will also find it useful. However, it would be of benefit to enhance such online training and development tools to be more relevant to and inclusive of all members of the increasingly diverse mental health workforce.

Specialist training of clinicians in the early detection, care and treatment of mental health disorders is central to providing effective early intervention. This includes skill and knowledge areas not previously included in training curricula (e.g. hope, stigma, values, sexual health) (Stavely, Hughes, Pennell, & McGorry, 2013). Given that general practitioners (GPs) are at the frontline of the mental health workforce, it is vital that they are equipped to detect, diagnose and respond to mental health problems. The Mental health training standards 2020–22: A guide for training providers was prepared by the General Practice Mental Health Standards Collaboration (GPMHSC) (General Practice Mental Health Standards Collaboration, 2020). The GPMHSC is a multidisciplinary body managed by The Royal Australian College of General Practitioners (RACGP) and is responsible for establishing standards of education and training for the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (MBS) Better Access Initiative. GPs who complete specific skills training are eligible to access MBS item numbers to support their delivery of mental health care under the Better Access Initiative. The National Rural Generalist Pathway is a further approach to addressing rural service shortages and strengthening primary care. The aim is to enable doctors in rural areas to extend their scope of practice to meet community needs, including in mental health care. The intent is to establish a framework for professional qualifications and remuneration that develops and supports doctors to meet the needs of local communities.

The Productivity Commission Draft Report (2019a) makes the following relevant recommendations



with regard to workforce training:

- Increase number of mental health nurses through development of a three-year direct entry undergraduate degree and recognising specialist mental health qualifications as part of nurse registration.
- Increase the number of trained psychiatrists by raising training placements and available supervisors
- Strengthening the peer workforce through a more comprehensive system of training, work standards, an organisation to represent this workforce, and a program to build support for the value of peer workers among other health professions.
- Better workforce planning by governments to align service provider skills, availability and location with demand.
- Encouraging more GPs in rural and remote areas to undertake advanced specialist training in mental health.
- Incorporating best-practice approaches to managing medication side effects in continuing professional development requirements for GPs and psychiatrists.

#### Case Study: Psychogeriatric SOS (services on screen)

This innovative e-health solution is designed to address major workforce shortages in relation to providing quality mental health care for older people in rural and remote settings (Burke, Burke, & Huber, 2015). Established at St Vincent's Hospital in Sydney, the clinician-to-clinician services include information, discussion, advice, education, supervision, clinical case review, or multidisciplinary case-conferencing. The service also incorporates specialist supervision for mental health professionals. The model enables local clinicians in under-resourced rural and remote settings to provide services with the guidance of support of a highly specialised team and has the potential to be translated to address other population mental health needs (Bartram & Chodos, 2018).

Further evidence of successful innovations in older people's mental health services in rural areas is provided by Jackson, Roberts, and McKay (2019) who highlight the importance of investing in local service leaders, joint planning and local implementation that is supported by regular evaluation to ensure acceptability and efficacy for older people as populations change. Again, these broad principles are likely to be transferable to other areas of need.

#### Development of a culturally safe workforce

As outlined in Challenge 2, the workforce needs to develop the relevant knowledge, skills and experience to deliver culturally safe and appropriate services to consumers from diverse backgrounds and experiences. Appropriate training of staff is key to achieving this. Professional education, training and development for all health and mental health workers should strongly emphasise Aboriginal perspectives on health and wellbeing (Curtis et al., 2019).

In a recent review of articles on cultural competency and cultural safety, Curtis et al. (2019) recommend the following as core principles of cultural safety:

- Be clearly focused on achieving health equity, with measurable progress towards this endpoint.
- Be centred on clarified concepts of cultural safety and critical consciousness rather than narrow based notions of cultural competency.
- Be focused on the application of cultural safety within a healthcare systemic/organizational context in addition to the individual health provider-patient interface.
- Focus on cultural safety activities that extend beyond acquiring knowledge about 'other cultures' and developing appropriate skills and attitudes and move to interventions that acknowledge and address biases and stereotypes.
- Promote the framing of cultural safety as requiring a focus on power relationships and inequities within health care interactions that reflect historical and social dynamics.

- Not be limited to formal training curricula but be aligned across all training/practice environments, systems, structures, and policies (Curtis et al., 2019, p. 14).

Furthermore, they outline the following steps that should be taken by policymakers to take a comprehensive approach to cultural safety:

- Mandate evidence of engagement and transformation in cultural safety activities as a part of vocational training and professional development.
- Include evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and ongoing certification.
- Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes).
- Require ongoing cultural safety training and performance monitoring for staff, supervisors, and assessors (not just one-off training).
- Acknowledge that cultural safety is an independent requirement that relates to, but is not restricted to, expectations for competency in ethnic or Indigenous health (Curtis et al., 2019, pp. 14-15).

Additional findings on practical approaches to delivering a culturally safe workforce are also provided in section 2.3.2.

#### **Development of peer and lived experience workforce**

A recent survey of community managed organisations that deliver mental health services in New South Wales found that the emerging peer workforce appeared to generally have a lower level of nationally recognised qualification compared to the Mental Health Support Worker workforce (Ridoutt & Cowles, 2019).

Barriers to training and development for the peer workforce need to be addressed. For example, attaining a Certificate IV in Mental Health Peer Work can be expensive and difficult for many lived experience workers without support from funders/employers. This can limit access to lived experience roles. Gaps in leadership and supervisory skills for supporting peer workers (and incorporating consumer views and people with lived experience into the organisation's governance and operations) have also been identified (Northern Territory Mental Health Commission, 2019).

The Queensland Framework for the Development of the Mental Health Lived Experience Workforce outlines some best practice strategies to addressing these barriers (Queensland Mental Health Commission, 2019):

- Credentialing policies for organisations and funders to provide opportunities for scholarships/paid accreditation as part of roles.
- Provision of lived experience traineeships as a form of on-the-job training.
- Ensure professional development funds allow lived experience access to conferences including local, state and national opportunities.
- Develop ongoing mentoring and formal networks to allow resource sharing and assistance between organisations with a priority on lived experience employment.

The development of a national member-based organisation for all peer workers has also been proposed. The Private Mental Health Consumer Carer Network completed a report entitled 'Towards Professionalisation: A Project to undertake a feasibility study into the establishment of a member based organisation for the peer workforce in Australia' (National Mental Health Commission, 2019c). The report makes a series of recommendations to progress action towards a national peer workforce organisation, including a series of recommendations for future work for the National Mental Health Commission.

A number of these recommendations are relevant to training and development of the peer workforce,

including: increase the roll out and uptake of the Certificate IV in Mental Health Peer Work CHC43515 national qualification; introduce this qualification into the training sector in the Northern Territory; and push for other professional development related to peer work such as 'Intentional Peer Support' (ISP), introductory courses, traineeships, or scholarships (National Mental Health Commission, 2019c, p. 7). Online resources such as the Peer Work Hub ([peerworkhub.com.au](http://peerworkhub.com.au)) may also be useful tools for supporting peer workforce development.

#### Case Study: Mental Health Service, Gold Coast, QLD

All members of the Consumer, Carer and Family Participation Team were supported financially and in worktime to complete Certificate IV Mental Health Peer Work training. The training was also made available to other peer workers, advocates, representatives and interested persons with lived experience on the Gold Coast. The Mental Health Service not only allowed their Consumer, Carer and Family Participation Team members significant scope in their roles to support other students, they also fully funded a formal graduation ceremony for all students and their families, friends and supporters.

### 2.14 Workforce Retention

There are a number of practical approaches that can address the issues that negatively impact on retention of the mental health workforce. Broadly, these approaches can be grouped into the following categories: mental health worker wellbeing, mental health worker conditions and work satisfaction and include approaches such as worker health and wellbeing programs, leadership and succession planning, and consumer, family, carer and supporter participation.

Ensuring workplace health and safety is an important part of enhancing worker wellbeing. Research indicates that there is a higher frequency of exposure to workplace violence in health service settings than in other workplaces. We could locate few examples of violence reduction programs in the mental health sector, nor evaluations of these programs. There is also little ongoing data collection on factors relevant to mental health worker wellbeing such as the experience of workplace violence (Tonso et al., 2016). The ongoing collection and analysis of data on mental health worker wellbeing and working conditions is key to informing successful programs, as is ongoing evaluation of programs that are implemented to improve workers' wellbeing.

A barrier to worker retention is the high proportion of short-term contract positions which are particularly common within community based mental health services. It is important to advocate for and where possible, provide longer-term service contracts and funding periods to support the recruitment and retention of a suitably qualified and experienced workforce (Productivity Commission, 2019b).

Working in mental health offers both challenges and benefits, and with the right support can be exceptionally satisfying personally and professionally. Programs to enhance the retention of staff in the mental health workforce concentrate on enhancing resiliency, developing professional identity and enhancing practice (Ashby, Ryan, Gray, & James, 2013). In addition "strategies that encourage reflection on the theoretical knowledge underpinning practice can sustain resilience" (Ashby et al., 2013, p. 110). Several methods have been proposed to increase professional resilience and work satisfaction:

- Clinical supervision, mentoring, professional development pathways and opportunities
- Flexible employment arrangements
- Leadership and workplace culture.

Professional resilience programs have attracted increasing attention in the published literature. A review of resilience and strategies to strengthen resilience among mental health nurses stressed the need for a multi-faceted approach that calls for a combination of strategies at the individual, work unit and organisational levels (Foster et al., 2019). Again, highlighted is the importance of leadership

to promote safe and flexible working arrangements that include opportunities for professional development.

Evidence suggests that when it comes to leadership in the healthcare sector, organisations are shifting away from a top-down, autocratic leadership style ('heroic' leadership) to a style that emphasises distributed and collaborative leadership ('engaging' leadership) (Fitzgerald & Galyer, 2007).

In a systematic review of enablers and barriers to retention of Indigenous Australians in the health workforce, Lai et al. (2018) found that "retention of Indigenous health professionals will be improved through building supportive and culturally safe workplaces; clearly documenting and communicating roles, scope of practice and responsibilities; and ensuring that employees are appropriately supported and remunerated" (p. 1).

Buykx, Humphreys, Wakerman, and Pashen (2010) reviewed the effective retention incentives for health workers in rural and remote area and proposed a framework to address factors known to contribute to avoidable turnover in rural and remote areas (Table 4). The components relate to staffing, infrastructure, remuneration, workplace organisation, professional environment, and social, family and community support.

Table 4: Rural and remote health workforce framework, Buykx et al. (2010, p. 106)

<p><b>1. Maintaining an adequate and stable staffing</b></p>	<p>Appropriate recruitment – selecting the right person Adequate relief/avoiding burnout Mandated service/visa waiver</p>
<p><b>2. Providing appropriate and adequate infrastructure</b></p>	<p>Ready access to good quality Information and Communication Technologies (ICT) and technical support Ready access to vehicle Adequate housing Air conditioning</p>
<p><b>3. Maintaining realistic and competitive remuneration</b></p>	<p>Packaging benefits Retention bonuses</p>
<p><b>4. Fostering an effective and sustainable workplace organisation</b></p>	<p>Good communication Leadership management role Employee induction and orientation Leadership Successful organisations reflect vision and strategic leadership Management and supervision</p>

<b>1. Maintaining an adequate and stable staffing</b>	Appropriate recruitment – selecting the right person Adequate relief/avoiding burnout Mandated service/visa waiver
<b>5. Shaping the professional environment that recognises and rewards individuals making a significant contribution to patient care</b>	Preceptor/mentor ship program Collegial support and supervision A supportive and harmonious workplace increases professional satisfaction Continuing Professional Development (CPD) and conference opportunities Engaging in research and scholarships for academic pursuits Enhances opportunities for professional satisfaction and career advancement Degree of autonomy Opportunity for promotion and career pathway within organisation/service
<b>6. Ensuring social, family and community support</b>	Child care and family support

A broad problem observed across much of the literature on programs to enhance attraction, recruitment and retention of the mental health workforce is the lack of systematic, rigorous and ongoing evaluation of these strategies. Buykx et al. (2010) noted a lack of evaluation studies of retention programs in rural and remote settings in Australia and recommend rigorous evaluation of these programs. Lai et al. (2018) also made the point that there was an absence of intervention studies of retention strategies for Indigenous Australians in the health workforce, meaning that individual interventions need to be more rigorously evaluated and published. There are piecemeal evaluations of particular approaches but a lack of connection between broad overarching policy strategies and/or outcomes in terms of workforce outcomes.

## 2.6. Review Question 6: What does the review reveal about the state of the mental health workforce in the following priority areas: Rural and Remote, Aboriginal and Torres Strait Islander Communities, Peer Work Force and Lived Experience; Education and Training; and Interjurisdictional and Intergovernmental?

### 2.6.1. Rural and Remote

*“Attracting and training a capable, sufficient and sustainable mental health workforce to serve rural and remote Australia will be challenging” (Senate Community Affairs Committee Secretariat, 2018)*

It is clear that the provision of effective mental health services in rural and remote areas is a persistent and escalating challenge. Many of the challenges and issues facing the mental health workforce in Australia are intensified in rural and remote contexts (Senate Community Affairs Committee Secretariat, 2018).

In particular, the shortage of appropriately trained and qualified staff in rural and remote settings is an ongoing, seemingly intractable policy problem. The key issue is how to ensure that the workforce is actively recruited, appropriately trained and supported, retained and incentivised to take up regional and rural work.

The literature review has identified the following points to note when considering the challenges of mental health service provision in rural and remote areas:

- Attracting and retaining a mental health workforce in rural and regional areas involves a delicate

balance of structural (e.g. funding cycles), professional (e.g., professional networks; supervision and mentoring) and personal (e.g., housing, schooling, and employment opportunities for spouse) factors.

- Recruitment that uses ‘pull’ and value-based approaches may be most effective in attracting mental health workers to rural and remote areas.
- The education and training sector is a key partner in delivering on any objective to enhance attraction and recruitment in mental health careers in rural and remote areas. Positive rural and remote work experiences early and throughout a candidate’s education and training are important for encouraging subsequent careers in rural and remote areas. Work placements within mental health services in rural and remote areas are key to this but they need to be timed appropriately within the study program to optimise the outcomes. Establishing education and training centres within rural and remote areas is also useful (e.g. University Departments of Rural Health or Rural Clinical Schools). Better alignment of training and education timeframes with recruitment and job demand cycles will help ensure that qualified graduates are available at the right times.
- Supporting mental health workers through access to peer support hubs and professional development networks. For example, knowledge sharing and supervision through using innovative eHealth solutions (e.g. Psychogeriatric SOS program).
- Support and strengthen existing and new place-based recruitment and retention initiatives to attract local people into mental health careers in rural and regional areas. Growing local workforces will ensure sustainability of service provision particularly during disruptive events (e.g. COVID-19 restrictions) which may prevent the supply of a fly-in-fly-out workforce.
- There is a heavy reliance on community mental health services in Australia’s rural communities (Cosgrave, Hussain, & Maple, 2015), however, this sector is particularly affected by issues of long- term unfilled positions, high staff turnover, poor job satisfaction and worker burnout, and these issues are magnified in a rural and regional setting. Policy should be developed to address these issues of avoidable staff turnover; in particular funding and contracting arrangements with the community sector should be reformed to encourage longer contracting cycles, to enhance job security and satisfaction (Cosgrave et al., 2015; Productivity Commission, 2019a, 2019b).
- External events such as natural disasters (e.g. drought, bushfires), health pandemics (e.g. COVID-19) and economic recessions may disproportionately impact the mental health of rural and remote. Mental health services will need to be responsive to these changes in service demands and delivery modes.
- Telehealth approaches may help combat challenges with distance and service access but this needs to be supported by telecommunications infrastructure, funding arrangements and building levels of digital literacy and capability on the part of both service users and providers.
- There is a need to address stigma around mental health which is more pronounced in rural and remote communities as well as address misconceptions around the status and image of mental health careers in rural and remote areas.

In a review of Australian national and state and territory mental health plans and strategies, Roberts and Maylea (2019) observed that while rural mental health workforce issues were covered in national plans, they received very little attention in state and territory plans; thus a national mental health workforce strategy can serve the purpose of providing leadership in this area and providing a roadmap for the states and territories to develop their own rural mental health workforce plans.

### 2.15 Aboriginal and Torres Strait Islander Communities

*“Without a concerted effort by all stakeholders involved, the lack of cultural competency of the workforce will continue to cause these services to fail, which in turn has devastating effects on the health of individual Aboriginal and Torres Strait Islander persons, and more broadly on the entire communities in which they live.” (Senate Community Affairs Committee Secretariat, 2018: p154).*

A lack of Aboriginal and Torres Strait Islander mental health service providers and culturally safe services is one of the main drivers for poor access to services and poorer mental health of Aboriginal and Torres Strait Islander people.

Across all jurisdictions there is a recognition that Aboriginal and Torres Strait Islander people are under-represented within the mental health workforce. A number of mental health workforce plans aim to address this through setting targets to increase the number of Aboriginal mental health workers. NSW has set a target of one Aboriginal mental health worker for every 1000 Aboriginal people (NSW Department of Health, 2007). Australia seeks to double the participation of Aboriginal people in the South Australian public sector, spread across all classifications, to 2% (SA Health, 2017). Queensland has set the target of Aboriginal and Torres Strait Islander people representing 3% of the Queensland Health workforce by the end of 2022 (Queensland Health, 2016).

The literature review has identified the following points to note when considering the mental health workforce and Aboriginal and Torres Strait Islander Communities:

- Health workforce plans need to improve the capability and capacity of the Aboriginal and Torres Strait Islander workforce by providing a clear career structure and enhanced leadership and dedicated training and professional development opportunities.
- Collaborating with the education and training sector to address access barriers and increase the representation of Aboriginal and Torres Strait Islander students within health training and courses. Scholarships, access to cultural mentors and supervisors and inclusive education environments can assist with this.
- Retention of Aboriginal and Torres Strait Islander people within the mental health workforce will be aided by supportive and culturally safe workplaces; clearly documenting and communicating roles, scope of practice and responsibilities; and ensuring that employees are appropriately supported and remunerated (Lai et al, 2018).
- The Senate report on the Accessibility and Quality of Mental Health Services in Rural and Remote Australia specifically noted the importance of appropriate cultural training for the non-Aboriginal mental health workforce to ensure culturally safe service provision and the need for Aboriginal and non-Aboriginal workforces to work together.
- The mental health workforce needs to be prepared to respond to the increasing mental health impacts of prolonged and more frequent extreme events (e.g. more intense bushfire and drought seasons, emerging pandemics) among Aboriginal and Torres Strait Islander communities where such events will further compound existing mental health inequalities. As local health services evolve in response to COVID-19, it is critical to recognise, utilise, and support the existing skills, capacity, and full potential of the Aboriginal and Torres Strait Islander health workforce, especially those with expertise in mental health and social and emotional wellbeing, and to enable this workforce to grow.
- In addition to the local workforce, Aboriginal and Torres Strait Islander researchers and research organisations are a vital part of the health workforce involved in the pandemic mental health response and related research and evaluation (Dudgeon et al., 2020). The mental health workforce needs to ensure that culturally safe services are accessible and sufficiently resourced to support the psychosocial recovery from COVID-19 lockdown, restricted practices, and the inevitable economic recession to follow (Dudgeon et al., 2020).
- The advice set out in the Gayaa Dhuwi (Proud Spirit) Declaration should be followed, particularly as it relates to increasing the presence and leadership of Aboriginal and Torres Strait Islander people within the mental health workforce.

## 2.16 Peer Workforce and Lived Experience

The role of the peer workforce is strongly supported throughout policy documents and the published literature. The value of peer workforce is clear, particularly in contributing to a recovery-oriented approach that is central to best practice in contemporary mental health care (Gillard et al., 2015).

The literature review has identified the following points to note when considering the peer and lived experience workforce:

- There is a clear need to support and develop the peer and lived experience workforce. This includes the development of training, standards, and representation (Productivity Commission, 2019a).
- Developing the peer workforce comes with complexities and notes of caution. Specific issues identified include the potential for burnout of community leaders in Aboriginal (and other) communities if not appropriately supported; the need for adequate resourcing, including financial support and training.
- Executive/senior management commitment and action is critical to the success of lived experience roles (Byrne, Roennfeldt, & O'Shea, 2017).
- The National Mental Health Commission are currently creating lived experience workforce development guidelines which are being developed in collaboration with consumers, carers and lived experience workers. Once available, these guidelines should be closely referred to when developing the forthcoming national mental health workforce strategy. In the interim, lived experience workforce guidelines already developed in Queensland, Victoria, Western Australia and Tasmania can provide guidance.
- Lived experience workers should be supported to access relevant training and professional development opportunities from entry level and across all career stages. For example, addressing funding and time barriers to obtaining Certificate IV in Mental Health Peer Work and other relevant qualifications. Similarly, leadership and mentorship across all levels will help support lived experience workers.
- Lived experience workers will benefit from access to peer support hubs and professional networks. For example, the Centre of Excellence in Peer Support (Australia) provides a centralised specialist clearinghouse and online resource centre that aims to support best practice for mental health peer support. In the United States, Peers for Progress aims to develop the evidence base for peer support and promote peer support programs throughout the world.
- There is a need to embed co-design approaches with consumers and carers from the beginning and to ensure adequate capacity to deliver and assess effectiveness of co-design approaches (e.g. appropriately trained and resourced staff, monitoring and evaluation processes).

### 2.1.7 Education and Training

The importance of training, education and ongoing professional development is highlighted across the policies of all jurisdictions and is a key recommendation within the academic literature. Building a mental health workforce that is equipped to provide high quality care requires a longitudinal view that begins with attracting and recruiting workers and continues with multi-faceted approaches to support and retain those workers across their career.

The literature review has identified the following points to note when considering the education and training of the mental health workforce:

- Universities and a range of other training providers are key strategic partners for workforce attraction and recruitment, as well as ongoing workforce development, providing education and training of the future workforce and upskilling and professional development opportunities for the current workforce.
- Removing structural and other barriers to ongoing professional development is a key challenge that needs to be addressed.
- Establishing training centres and creating positive training experiences in non-metropolitan areas is an important step in developing rural and remote workforce (McGirr et al., 2019; Senate Community Affairs Committee Secretariat, 2018).
- The lived experience workforce needs to be adequately supported, both financially and time



wise, to pursue relevant studies and career development pathways. Mentorship and peer support networks are also key to ongoing professional development and support for the peer workforce. Free access to online e-learning portals such as the Peer Work Hub are useful, particularly for rural and remote workforces. Training resources need to be accessible to people from diverse backgrounds and experiences (e.g. accessible to workers with diverse needs).

- The organisations delivering mental health services should set explicit objectives and strategies that support leadership, mentorship and hands-on supervisory support for mental health workers, particularly new entrants.

### 2.1.8 Interjurisdictional and Intergovernmental

The different roles and responsibilities of state and territory governments and the Australian government create some challenges and opportunities in moving forward with a national mental health workforce strategy. This is not just an issue for the mental health workforce, but for the health sector more broadly. Two key issues are policy integration and the impact of funding arrangements on service availability.

#### 1. Policy integration

A key task is to actively pursue a whole-of-government approach that treats these agreements and strategies affecting mental health as interdependent and mutually reinforcing rather than as stand-alone policies (Productivity Commission, 2019). A whole-of-government approach is vital in such a broad-ranging area as the mental health workforce, which cuts across current departmental and ministerial responsibilities (for example, health, housing, education, disability, social services, the labour market, and rural economic

development). The Productivity Commission of Inquiry (2019) draft report observes that there is poor integration between the National Mental Health Strategy and other relevant national strategies that affect mental health (for example, the National Disability Agreement). The report highlights that there has been gaps in strategic planning, notably the lack of a contemporary national mental health workforce strategy, which the Australian Government is currently addressing. The Productivity Commission report also notes that the National Mental Health Strategy needs to be supported by enabling strategies such as those covering workforce, data and program evaluation, and that the strategy should also include links to other supporting strategies.

Many of the reviewed documents note that a national approach to workforce development is necessary to develop a systematic, integrated approach to the mental health workforce. The Orygen Youth Mental Health Workforce Reform Report recommends that a National Centre should be established to develop and coordinate training and workforce development for youth mental health workers, consumers and the community. This is a recommendation that could be applied more broadly, through the establishment of a National Centre for the Mental Health, with specialisations, or a network of National Centres for particular subspecialisations for the mental health workforce.

#### 2. Funding arrangements

The differing responsibilities for funding of mental health services is another key intergovernmental issue. The WADoH Sustainable Health Review notes that the WA mental health system is “funding-centred, rather than people-centred”, and this criticism can also apply to other jurisdictions. The confusion in funding arrangements between the Australian Government and State and Territory Governments mean that the needs of some people are not effectively addressed within the current service system.

The Australian Government funds primary mental health care, whilst the State and Territory Governments provide specialised mental health care in public hospital and community settings. As noted by the Productivity Commission, these arrangements for mental health care funding have created service gaps particularly for people whose needs are too acute for primary mental health

care but not acute enough for the public hospital system. The Productivity Commission Draft Report (2019a) notes that there are two key factors behind these gaps:

*“First, the relevant government roles and responsibilities are unclear. Second, State and Territory Governments face incentives to direct resources towards acute care instead of providing more care in the community.”*

A third area of service funding is the Commonwealth funding provided to Primary Health Networks (PHNs), who then commission community-level mental health services. A related issue is the boundaries between the public and private care system, which impedes integrated and effective care. To address this issue, the Draft Recommendations of the Productivity Commission report centre around structural reform that affords greater regional control and responsibility for mental health funding.

### 3. Considerations and conclusions

Developing a sustainable mental health workforce that provides effective services to consumers with increasingly complex and diverse needs requires an agreed holistic definition and understanding of the mental health workforce. There is clear need for strategies to combat workforce shortages and address disparities in rural and remote service provision.

Critically important are processes for building, supporting and enabling responsive and flexible workforces together with mechanisms for measuring progress and impact. As for any effective workforce strategy, there is a need to set targets and establish a system to track implementation and progress.

The issue of leadership at all levels is an overarching theme in relation to the mental health workforce. Investing in leadership is an important step in creating positive workplace cultures and enabling high quality staff to flourish in their roles. This applies equally to the specialist and peer workforces.

Mental health workforce strategies should be linked with broader workforce strategies and those from other sectors. Workforce strategies to address attraction, recruitment and training have clear connections with education strategies (for example, qualification and accreditation frameworks).

Attracting, recruiting and retaining a local workforce is critical for addressing community challenges and strengthening communities, particularly in regional areas. Although frequently raised in published literature and reports, our observation was that place-based workforce strategies were less often explicit in current policy documents. This may be an issue for further consideration.

The community mental health sector has long played a vital role in the mental health workforce. The ongoing sustainability of the community sector needs consideration in light of specific funding challenges and the implications that follow in relation to security of staff contracts and service continuity.

Contemporary best practice across the mental health workforce strategies emphasise care that is recovery oriented, strengths-based, trauma-informed and culturally safe and is sustainable, accessible and equitable. Mental health workforce strategies need to be designed to enable service delivery against these principles and values. These features of best practice need to be well reflected in the recruitment, training, development and retention of the workforce that is expected to deliver such practice.

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## Appendix A: Methods

This project was structured around five stages (Table 1) delivered across six weeks (16 June – 29 July). Each of the five project stages are discussed in further detail below.

Table 5: Overview of project stages.

#	STAGE DESCRIPTION	KEY ACTIVITIES
1	Inception, planning and design	Project inception meeting. Co-develop a search protocol (i.e. key terms, screening period, and inclusion criteria). Deliver a Project Plan and Risk Management Plan.
2	Identification and review of literature	Across five targeted review activities we: Implemented the co-developed search strategy (i.e. identify literature meeting the inclusion criteria for review). Identified, collated and screened relevant literature (i.e. from key scholarly databases and priority grey literature sources). Reviewed selected documents and extract key data (i.e. using data extraction templates with data categories aligned with project questions).
3	Synthesis	Synthesised the literature across the five review activities using a structured method to answer the key project questions.
4	Draft report and feedback	Developed a draft report informed by the synthesis of the literature, delivered a presentation to the Taskforce and sought feedback from the Taskforce and the Department on the report.
5	Final report	Produced the final report and supplied to the Department (this document).

### Stage 1 Inception, planning and design

The Project inception meeting occurred on 18 June 2020. The ISSR Review Team met with the Department and Taskforce Co-chairs to clarify key questions about the project and how to best meet the information needs of the Department and Taskforce.

The Search Strategy guiding this literature review and project plan was developed in consultation with the Department, Taskforce Co-Chairs and UQ Advisory Group.

### Stage 2 Identification and review of literature

To address the priority areas and key questions, this literature review applied a pragmatic and consultative approach that used multiple review methods and drew upon diverse, complementary sources of information, for example, academic literature, grey literature including policy, reviews and reports, stakeholder consultation and international evidence from countries with comparable health systems. The literature review was structured around five key review components:

1. Review all current mental health workforce strategies across all Australian jurisdictions.

2. Identify and review current and recent past mental health reviews and inquiries.
3. Review academic databases and grey literature for best practice in international mental health workforce strategies.
4. Identify and review evaluation reports on existing mental health workforce strategies.
5. Identify and review peer reviewed literature on mental health workforce issues.

Each of these review components is discussed in further detail below. Each review component was structured around addressing the key questions guiding the literature review (Table 1).

Table A-1: How each review component assists in addressing project questions.

Key project questions	Review Components				
	1. Review jurisdictional MH workforce strategies	2. Review current and past MH inquiries and reviews	3. Review best practice in MH workforce strategies	4. Identify and review evaluation reports of workforce strategies	5. Review peer-reviewed literature on MH workforce issues
<b>What are the key workforce challenges in the mental health workforce in Australia?</b>	✓	✓			✓
<b>What are the commonalities graded, from most to least prevalent, across the various national and jurisdictional mental health workforce strategies?</b>	✓				
<b>What principles, actions and mechanisms have been identified to support an effective mental health workforce across Australia?</b>	✓	✓	✓	✓	
<b>What issues have been identified that impact the quality, supply, distribution and structure of the mental health workforce?</b>			✓	✓	✓
<b>What practical approaches have been recommended to attract, train and retain the workforce required to meet the demands of the</b>		✓	✓	✓	✓

Key project questions	Review Components				
	1. Review jurisdictional MH workforce strategies	2. Review current and past MH inquiries and reviews	3. Review best practice in MH workforce strategies	4. Identify and review evaluation reports of workforce strategies	5. Review peer-reviewed literature on MH workforce issues
<b>mental health system in the future?</b>					
<b>What does the review reveal about the state of the mental health workforce in the following priority areas: Rural and Remote, Aboriginal and Torres Strait Islander Communities, Peer Work Force and Lived Experience; Education and Training; and Interjurisdictional and Intergovernmental?</b>	✓	✓	✓	✓	✓

**Key:** MH = mental health

### **Review all current mental health workforce strategies across all Australian jurisdictions**

The first review component involved a policy audit and mapping of existing mental health workforce strategies across all jurisdictions in Australia. Core documents to be included were identified through a combination of systematic searching, and consultation with the Department, Taskforce, and the UQ Advisory Group. Consultation with the Department and Taskforce led to identification of the following key documents for consideration within the review:

- National Mental Health Strategic Framework
- National Mental Health Service Planning Framework (toolkit)
- National Medical Workforce Strategy (in development)
- National Mental Health Workforce Plan 2011
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023
- The National Mental Health and Wellbeing Pandemic Response Plan 2020
- National Mental Health Commission's Peer Workforce Development Guidelines (in development)
- Orygen's National Youth Mental Health Workforce Strategy 2016-2020

We also conducted a systematic online review of publicly available documents from Australian jurisdictions (Commonwealth and states and territories). Using a combination of key words relevant to the review, we employed a systematic search strategy to rapidly identify relevant current strategies from Australian Government Department websites and other relevant websites such as the websites of Mental Health Commissions and Productivity Commissions. The results of all

searches were recorded and managed to ensure transparent reporting and justification for the identification, selection and inclusion of documents within the literature review. An overview of the search methods used in this review component is presented in the following table.

Table A-2: Overview of the search methods used to review all current mental health workforce strategies across all Australian jurisdictions.

Aim	<i>Review all current mental health workforce strategies across all Australian jurisdictions</i>
<b>Inclusion criteria</b>	<p>Limited to the Australian context.</p> <p>Looking only at current strategies and documents identified through consultation with the Department and Taskforce.</p>
<b>Method</b>	<p><b>Desktop search of all relevant Australian Government department websites (Commonwealth, states and territories), for example:</b></p> <ul style="list-style-type: none"> <li>• <b>State and territory health department websites as well as other relevant state departments</b></li> <li>• <b>Commonwealth agency websites (e.g. Australian Institute of Health and Welfare)</b></li> <li>• <b>COAG Health Council</b> (<a href="http://coaghealthcouncil.gov.au/">http://coaghealthcouncil.gov.au/</a>)</li> <li>• <b>National Mental Health Commission</b> (<a href="https://www.mentalhealthcommission.gov.au/">https://www.mentalhealthcommission.gov.au/</a>)</li> <li>• <b>Queensland Mental Health Commission</b> (<a href="https://www.qmhc.qld.gov.au/">https://www.qmhc.qld.gov.au/</a>)</li> <li>• <b>Mental Health Commission of New South Wales</b> (<a href="https://nswmentalhealthcommission.com.au/">https://nswmentalhealthcommission.com.au/</a>)</li> <li>• <b>SA Mental Health Commission</b> (<a href="https://samentalhealthcommission.com.au/">https://samentalhealthcommission.com.au/</a>)</li> <li>• <b>Western Australia Mental Health Commission</b> (<a href="https://www.mhc.wa.gov.au/">https://www.mhc.wa.gov.au/</a>)</li> <li>• <b>Tasmanian Government Department of Health and Human Services</b> (<a href="https://www.health.tas.gov.au/">https://www.health.tas.gov.au/</a> )</li> <li>• <b>Victorian Government Department of Health</b> (<a href="https://www2.health.vic.gov.au/">https://www2.health.vic.gov.au/</a>)</li> <li>• <b>Australian Capital Territory Health</b> (<a href="https://health.act.gov.au/">https://health.act.gov.au/</a> )</li> <li>• <b>Northern Territory Health</b> (<a href="https://health.nt.gov.au/">https://health.nt.gov.au/</a>)</li> </ul> <p>Other core documents containing strategies relevant to informing the mental health workforce strategy were identified through reading references and linked policies mentioned in selected strategies. We complemented searches of government websites with a targeted Google search using keywords to ensure comprehensive coverage of relevant strategies.</p> <p>We also reviewed related selected workforce strategies identified through stakeholder consultation:</p> <ul style="list-style-type: none"> <li>• <b>National Medical Workforce Strategy (in development)</b></li> </ul>

Aim	<i>Review all current mental health workforce strategies across all Australian jurisdictions</i>
	<ul style="list-style-type: none"> <li>National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (2016-2023).</li> </ul> <p>We also identified and collect state and territory equivalents of these policies, where available.</p>

### Identify and review current and recent past mental health reviews and inquiries

Focusing on the Australian context, we conducted a targeted review of current and recent inquiries and reviews of mental health service provision to identify workforce issues. Consultation with the Department and Taskforce led to the identification of the following documents for consideration within this review component:

- Productivity Commission Mental Health Draft Report October 2019
- National Mental Health Commission’s Vision 2030 Consultation Paper
- Senate report on the Accessibility and Quality of Mental Health Services in Rural and Remote Australia December 2018
- Royal Commission into Victoria’s mental health system (Interim Report November 2019)
- The National Mental Health Commission’s Report *Contributing Lives* Review (2014) and the Government Response (2015).

We used a systematic approach to search Australian parliamentary websites for relevant current and recent past mental health reviews and inquiries. We limited the time period for included inquiries and reviews to the past six years. Relevant inquiry and review reports were analysed according to the key project questions (e.g. to identify mental health workforce issues in rural and remote areas, among others). An overview of the search methods used in this review component is presented in the following table.

Table A-3: Overview of the search methods used to identify and review current and recent past mental health reviews and inquiries.

Aim	Identify and review current and recent past mental health reviews and inquiries
Inclusion criteria	<p>Limited to the Australian context.</p> <p>To ensure currency, all searches were limited to reviews in the past six years (2014-2020).</p>

Aim	Identify and review current and recent past mental health reviews and inquiries
Method	<p>Desktop search of all relevant government department websites and state commission websites, for example:</p> <p>Parliament of Australia website (<a href="http://www.aph.gov.au/">http://www.aph.gov.au/</a>)</p> <p>Parliament of Victoria (<a href="https://www.parliament.vic.gov.au/">https://www.parliament.vic.gov.au/</a>)</p> <p>South Australian Parliament (<a href="https://www.parliament.sa.gov.au/">https://www.parliament.sa.gov.au/</a>)</p> <p>Western Australian Parliament (<a href="https://www.parliament.wa.gov.au/">https://www.parliament.wa.gov.au/</a>)</p> <p>Queensland Parliament (<a href="https://www.parliament.qld.gov.au/">https://www.parliament.qld.gov.au/</a>)</p> <p>Tasmanian Parliament (<a href="https://www.parliament.tas.gov.au/">https://www.parliament.tas.gov.au/</a>)</p> <p>New South Wales Parliament (<a href="https://www.parliament.nsw.gov.au/Pages/home.aspx">https://www.parliament.nsw.gov.au/Pages/home.aspx</a>)</p> <p>Northern Territory Parliament (<a href="https://parliament.nt.gov.au/">https://parliament.nt.gov.au/</a>)</p> <p>Australian Capital Territory Legislative Assembly (<a href="https://www.parliament.act.gov.au/">https://www.parliament.act.gov.au/</a>)</p> <p>Where relevant we searched the websites of mental health peak bodies in Australia to identify reports and resources that may contain useful mental health workforce information. For example, the Mental Health Council of Tasmania has developed a suite of resources on peer workforce development.</p> <p>To ensure comprehensive coverage of key documents, desktop searches were supplemented through reviewing reference lists of key documents and through consultation with the Department, Taskforce and UQ Advisory Group.</p>

### Review academic databases and grey literature for best practice international mental health workforce strategies

We conducted a rapid review of best practice in mental health workforce strategies both within Australia and internationally. We searched academic databases and selected grey literature sources. Where recent, high quality reviews were available, we drew on these, updating as appropriate with relevant subsequently- published studies.

For the grey literature, we searched websites of key organisations such as national and state mental health commissions (e.g. Mental Health Commission of Canada), departments of health and relevant professional organisations (e.g. Royal Australian New Zealand College of Psychiatrists; Australian Psychological Society). An overview of the search methods used in this review component is presented in the following table.

Table A-4: Overview of the search methods used to review academic databases and grey literature for best practice international mental health workforce strategies.

Aim	Review academic databases and grey literature for best practice international mental health workforce strategies
Inclusion criteria	<p>For this review, 'best practice' was defined as one for which there is good quality evidence or is considered to be a good foundation for practice.</p> <p>Eligibility Criteria:</p> <p>To ensure currency, all searches were limited to literature published since 2010. This date was chosen to align with the date of the last National Mental Health Workforce Plan which was released in 2011.</p> <p>Full text available and available in English.</p>



Aim	Review academic databases and grey literature for best practice international mental health workforce strategies
Method	<p>We searched academic and grey literature sources systematically using a combination of keywords. Search results were compiled, organised and screened using Covidence (an online platform for shared management and screening of documents).</p> <p>Our searches focused on best practice in the priority areas identified by the Taskforce (Rural and Remote; Aboriginal and Torres Strait Islanders; Workforce Education and Training; Peer and Lived Experience; Inter-jurisdictional and Inter- governmental). Review component 3 and 5 used the same search strategy and keywords, but results will be screened from two sets of inclusion criteria, with review component 5 focusing on workforce issues and only searching peer- reviewed literature. The search terms used for this review component (Component</p> <p>also included additional search terms related to 'best practice' to ensure that we identified a broad scope of sources that detail best practice in mental health workforce strategies.</p> <p>The search strategy in this review component comprised two sub-searches, as follows:</p> <ul style="list-style-type: none"> <li>• <i>Peer reviewed literature search:</i> Search key scholarly databases for relevant academic literature, including but not limited to: Web of Science, Scopus, JSTOR, Australian Public Affairs Full Text (APA-FT), PubMed, Medline, Science Direct, PsycINFO, Australian Indigenous HealthInfoNet and the Cochrane Database of Systematic Reviews. Review of reference lists of key articles, and cited reference searching for key articles to look for more recent sources citing key articles.</li> </ul>

Aim	Review academic databases and grey literature for best practice international mental health workforce strategies
	<ul style="list-style-type: none"> <li>• <i>Grey literature search:</i> Open Grey, Social Science Research Network,, APO (Analysis &amp; Policy Observatory [<a href="https://apo.org.au">https://apo.org.au</a>]) – searched via Informat database called <i>Policy</i> – and Google Scholar. Websites of relevant Australian peak bodies and NGOs (e.g. Mental Health Council of Australia and Beyond Blue). International evidence from grey literature was identified through desktop searches of websites of mental health commissions and government health departments at national and jurisdictional levels:               <ul style="list-style-type: none"> <li>– Canada_ <a href="https://www.mentalhealthcommission.ca/">https://www.mentalhealthcommission.ca/</a></li> <li>– France</li> <li>– United Kingdom_ <a href="https://www.mwcscot.org.uk/">https://www.mwcscot.org.uk/</a> <a href="https://www.england.nhs.uk/">https://www.england.nhs.uk/</a> <a href="https://www.health-ni.gov.uk/">https://www.health-ni.gov.uk/</a> <a href="https://www.wales.nhs.uk/">https://www.wales.nhs.uk/</a></li> <li>– New Zealand_ <a href="https://www.health.govt.nz/">https://www.health.govt.nz/</a></li> <li>– International Initiative for Mental Health Leadership</li> <li>– <a href="http://www.iimhl.com/">http://www.iimhl.com/</a></li> <li>– World Federation for Mental Health</li> <li>– <a href="http://www.wfmh.org/">http://www.wfmh.org/</a></li> </ul> </li> </ul>

Review components 3 and 5 used the same search strategy, however for component 3 there was one set of additional search terms to ensure that we identified a broad set of results relating to ‘best practice’ in workforce strategy development. Table A-2 and Table A-3 presents the search terms that were used across the components.

Table A-5. Search terms for Components 3 and 5.

Priority areas		AND	MH Workforce terms	AND	Location
Rural and remote	rural* OR “non-urban” OR region* OR remote OR village OR settlement OR town OR “non-metropolitan” OR “non- CMA” OR “non-census metropolitan”	AND	“Mental health workforce**”	AND	Australia OR New Zealand OR NZ OR Canada OR United Kingdom OR UK OR England OR Scotland OR Wales OR Northern Ireland France
Aboriginal and Torres Strait Islanders	“Traditional Owner**” OR “Indigenous” OR “Aborigin**” OR “Torres Strait Islander**” OR				

Priority areas		AND	MH Workforce terms	AND	Location
	"native Australian*" OR "Māori " OR "Pacific Islander" OR "First Nation*" OR "First People" OR Inuit*				
Workforce Education and Training	Workforce OR quality OR training OR education				
Peer and Lived Experience	"peer work*" OR consumer OR "lived experienc*"				
Inter-jurisdictional and Inter-governmental	Inter-jurisdictional OR inter-governmental				

Table A-6. Review component 3: Additional search terms.

Best practice	MH Workforce terms	Location
	"Mental health workforce*"	Australia OR New Zealand OR Canada OR United Kingdom OR UK OR England OR Scotland OR Wales OR Northern Ireland France

### 3.1.1. List of Relevant Websites for Grey Literature Searches

- Mental Health Council Australia (<https://mhaustralia.org/>)
- Mental Health Coordinating Council NSW (<https://www.mhcc.org.au/>)
- Being (<http://being.org.au/>)
- Mental Health Community Coalition of ACT (<http://www.mhccact.org.au/cms/index.php>)
- ACT Mental Health Consumer Network (<http://www.actmhcn.org.au/>)
- Mental Health Council of Tasmania (<https://mhct.org/>)
- NT Mental Health Coalition (NTMHC) (<https://www.ntmhc.org.au/>)
- QLD Alliance for Mental Health (<http://www.qldalliance.org.au/>)
- Mental Health Coalition of South Australia (<http://mhcsa.org.au/>)
- Psychiatric Disability Services of Victoria (<http://www.vicserv.org.au/>)
- Victorian Mental Illness Awareness Council (<http://vmiac.org.au/>)

- Western Australian Association for Mental Health (<http://www.waamh.org.au/>)
- Consumers of Mental Health WA (<http://www.comhwa.org.au/>)
- ACOSS (<https://www.acoss.org.au/>) and state/territory organisations
- Mental Health Carers Australia (<http://www.mentalhealthcarersaustralia.org.au/>)
- Beyond Blue (<https://beyondblue.org.au/>)
- Embrace website: <https://embracementalhealth.org.au/>
- Private Mental Health Consumer Carer Network (<http://www.pmhccn.com.au/>)
- Orygen (<https://www.orygen.org.au/>)
- Gayaa Dhuwi (Proud Spirit) Australia (<https://www.gayaadhuwi.org.au/>)
- Australian Indigenous Healthinfonet (<https://healthinfonet.ecu.edu.au/>)

### Identify and review evaluation reports on existing mental health workforce strategies

We will use a systematic search strategy to rapidly identify evaluations of workforce strategies across all jurisdictions in Australia. We will conduct a desktop search of all Australian Government Department websites to identify relevant evaluation, progress and annual reports that provide insight on the barriers and enablers to effective mental health workforce strategies. We will also search selected websites of mental health peak bodies and non-government organisations, such as the Mental Health Council of Australia and Beyond Blue. Inclusion of evaluation reports will be based on relevance to informing what works for whom in mental health workforce strategies. Not all evaluation reports are publicly available and we will work with the Department and Taskforce to gain access to relevant evaluation reports where feasible. Consultation with the Department and Taskforce has led to identification of the following key document for consideration within this review component:

- National Mental Health Commission’s National Report 2019

Aim	Identify and review evaluation reports on existing mental health workforce strategies
Inclusion criteria	<p>Australian context only.</p> <p>We only included evaluations reports from within the last 10 years, because the National Mental Health Workforce Plan was released in 2011.</p> <p>Evaluations reports have to be publically available or accessible through the Department and Taskforce.</p>
Method	<p>In addition to the websites identified in review component 1, we reviewed the websites of relevant peak bodies and non-government organisations.</p> <p>Google and Google Scholar searches were performed to ensure that any relevant evaluations of existing mental health workforce strategies are included. The search terms included: (1) “mental health workforce” (2) strategy OR policy OR framework (3) evaluation OR review. For these searches, the first 10 pages of results were reviewed and relevant websites were manually checked.</p>

### Identify and review peer reviewed literature on mental health workforce issues

This review component used the same search strategy and search terms identified in review component 3 but was confined to peer-reviewed literature identified through searches of academic databases.

Aim	Identify and review peer reviewed literature on mental health workforce issues
<b>Inclusion criteria</b>	Peer-reviewed literature published since 2010. Studies in countries with comparable mental health systems and written in English. Full-text available.
<b>Method</b>	<p>We will also perform a rapid review of peer-reviewed literature on mental health workforce issues using a systematic search method via combinations of keywords. We will use the search strategy identified in review component 3, but only focus on peer-reviewed literature in academic databases. Please see Appendix C for our search terms. As per review component 3, our searches will be limited to articles published since 2010.</p> <p>Building on the findings from the other four review components, we will perform a targeted search specific to identifying mental health workforce issues. We will search the reference lists of documents identified through the other review components (e.g. Component 3) and conduct additional targeted searches of selected academic databases outlined in Component 3 using keyword search terms specific to the five mental health workforce priority areas. Where recent, high quality reviews are available, we will draw on these, updating as appropriate with relevant subsequently-published studies. We will also do cited reference searching to identify articles that have cited key articles.</p> <p>Results were screened focussing on articles published on mental health workforce issues.</p>

The qualitative data analysis software package NVivo was used to identify, extract and organise key information from the selected documents. Within top level codes (referred to as parent codes in NVivo) we used a number of sub-codes (referred to as child codes in NVivo). The following table presents the codes that was used within each Review Component. The first column of the following table presents the top level codes and the second column, where applicable, presents the sub-codes. Within each reviewed document only the content that is relevant to the mental health workforce will be coded. In addition to the pre-identified codes we included an 'other' code within each component to capture any important information or themes that did not fit within the pre-identified codes.

Table A-7: Coding protocol for data extraction.

Code	Sub-Code	What to include in this code
<b>Aim/s</b>	<input type="checkbox"/> Overall aim/purpose/vision <input type="checkbox"/> Specific goals/objectives/priority areas	Code content describing the aim/s of the policy or plan as well as specific priority areas/domains and high level goals/objectives.
<b>Values and/or guiding principles</b>	n/a	Code any content describing the underpinning principles or values of the plan.
<b>Actions</b>	n/a	Code any content that states described specific actions for how the goals/objectives will be achieved.
<b>Monitoring, evaluation and reporting</b>	<input type="checkbox"/> Challenges and issues/barriers <input type="checkbox"/> Approaches/enablers	Code any content describing how the plans will carry out monitoring evaluation and reporting.
<b>Key performance indicators</b>	<input type="checkbox"/> Process indicators <input type="checkbox"/> Outcome indicators <input type="checkbox"/> Gaps/limitations	Code any content that describes how that will track progress on implementing these outcomes (process indicators) and how they will measure the impact of these actions (outcome indicators). If not clear what exactly is being measured just code at the top level of 'key performance indicators'. Also note any mention of gaps or limitations with data and monitoring.
<b>Linked policies</b>	<input type="checkbox"/> 2011 National Mental Health Workforce Strategy	Where a plan mentions alignment/links to other policies capture this information with the parent code and use the sub-code where there is specific mention of the 2011 National Mental Health Workforce Strategy.
<b>Aboriginal and Torres Strait Islander Communities</b>	<input type="checkbox"/> <b>Challenges and issues/barriers</b> <input type="checkbox"/> <b>Recommendations and best practice/enablers</b>	<b>Code any content specific to mental health workforce challenges or recommendations relating to ATSI communities.</b>
<b>Rural and Remote</b>	<input type="checkbox"/> Challenges and issues/barriers <input type="checkbox"/> Recommendations and best practice/enablers	Code any mental health workforce challenges or best practice specific to rural and remote Australia.

Code	Sub-Code	What to include in this code
<b>Workforce Training and Education</b>	<input type="checkbox"/> Challenges and issues/barriers <input type="checkbox"/> Recommendations and best practice/enablers	Code any mental health workforce challenges or best practice specific to Workforce Training and Education.
<b>Peer and Lived Experience</b>	<input type="checkbox"/> Challenges and issues/barriers <input type="checkbox"/> Recommendations and best practice/enablers	Code any mental health workforce challenges or best practice specific to Peer and Lived Experience.
<b>Inter-jurisdictional and Inter-governmental</b>	<input type="checkbox"/> Challenges and issues/barriers <input type="checkbox"/> Recommendations and best practice/enablers	Code any mental health workforce challenges or best practice specific to Inter-jurisdictional and Inter-governmental.
<b>Workforce attraction and retention</b>	<input type="checkbox"/> Challenges and issues/barriers <input type="checkbox"/> Recommendations and best practice/enablers	Code any mental health workforce challenges or best practice specific to workforce attraction and retention.
<b>Workforce structure</b>	<input type="checkbox"/> Challenges and issues/barriers <input type="checkbox"/> Recommendations and best practice/enablers	At the parent level, code content that describes the current status of the health workforce (e.g. distribution of MH professions) and at the child level code specific challenges (e.g. ageing workforce) and enablers associated with current health workforce status.
<b>Future considerations</b>	<input type="checkbox"/> Emerging challenges <input type="checkbox"/> Emerging opportunities	Code any content that discusses horizon scanning of potential future challenges and opportunities.
<b>Workforce definitions</b>	n/a	Code any content that attempts to define the mental health workforce.
<b>Other</b>	<input type="checkbox"/> <b>Challenges and issues/barriers</b> <input type="checkbox"/> <b>Recommendations and best practice/enablers</b>	<b>The purpose of this code is to pick up on any themes that don't fit within the other pre-identified codes.</b>

### 3.1.2. Review Management

All review activities will be supported by the literature review databases, software and platforms accessible by UQ. For management of identified documents, we used:

- Reference management software Endnote to combine database searches, remove duplicates, to assist with the screening process, and for storing the full-texts of relevant documents.
- A shared, secure drive for all study documents (e.g. data extraction sheets, summary tables and draft reports).
- NVivo 12 (qualitative research software) for data extraction on the identified documents.
- Online software Covidence for Review components 3 and 5 for streamlining evidence screening and synthesis. Figure A-1 below presents the PRISMA statement from Covidence for the search results and screening process for Review components 3 and 5.

Table A-8: Overview of number of documents identified screened.

	Number of websites/databases searched	Number of documents retrieved	Final number of selected documents after screening
RC1	20	85	76
RC2	42	28	21
RC3 (peer-reviewed literature)	8	386	117 <sup>a</sup>
RC3 (grey literature)	3 databases/28 websites	71	34
RC4	28	45	21
RC5	8	386 <sup>a</sup>	117 <sup>a</sup>

<sup>a</sup>Screening was combined for components 3 and 5 in Covidence. See Figure A-1 below.



Figure A-1. PRISMA Diagram of Screening Process for Research Components 3 and 5.



### 3.1.3. Stage 3 Synthesis

We developed data extraction templates that collated relevant information around key aspects of the mental health workforce, for example, quality of the workforce; attraction, training and retention of the workforce; workforce support; workforce development issues and best practice in workforce development strategies.

Framework analysis is a qualitative data analysis method that offers a structured but flexible approach that is ideally suited to addressing policy-related questions. All the information collated in the data extraction templates will be synthesised using framework analysis to identify themes in the literature relevant to the project questions and priority areas; Rural and Remote, Aboriginal and Torres Strait Islander Communities, Workforce Training and Education, Peer and Lived Experience and Inter-jurisdictional and Inter-governmental. Preliminary findings from the synthesis were presented in a progress report delivered to the Department in Week 4.

### 3.1.4. Stage 4 Draft Report

We sought feedback from the Department and the Taskforce chairs regarding the most useful presentation for the draft report and final report during our progress report meeting on the 8<sup>th</sup> July 2020 (see Appendix B for details of our co-design approach). The intention was to present the final report in a way that is useful and appropriate to the diverse audience of the Taskforce. During this meeting, it was decided that the most useful structure for the report would be according to the six review questions that were set for the literature review project, and as such the draft report was structured around answering those six review questions.

We delivered the draft report to the Department of Health on 17<sup>th</sup> July 2020, and sought feedback for incorporation before the delivery of the final report on the 29<sup>th</sup> of July 2020. We then delivered a presentation to the Taskforce and members of the Department on the 24<sup>th</sup> of July 2020, where we sought feedback on aspects of the literature review report for incorporation into the final report.

### Stage 5 Final Report

Comments from consultation with the Department and members of the Taskforce on the draft report have been taken into consideration into the final report (this document).

## Appendix B: Co-Design Approach and Governance

This literature review was developed through a collaborative, co-design approach with close and ongoing consultation occurring between the ISSR review team, the UQ Advisory Group, the Department of Health (the Department) Project Team and the Taskforce. An overview of the key personnel in each of these collaborating groups is provided in Figure B-1.

The Taskforce is co-chaired by Jennifer Taylor PSM and Thomas Brideson. Both Taskforce Co-chairs will represent the Taskforce in this project. The Taskforce includes member representatives from across the mental health sector, including professional, peak and peer groups, consumers and carers, Commonwealth, States and Territories, Aboriginal and Torres Strait Islander reference groups, education and economics. A list of current Taskforce members is provided in Table B-1.

A series of meetings occurred through-out the process with the purpose of reviewing progress and setting the direction going forward. An overview of these meetings is provided in Table B-2.

Figure B-1: Overview of key personnel involved the project.

<b>National Mental Health Workforce Strategy Literature Review Project Team</b>				
<b>UQ Advisory Group</b>	Core ISSR Review Team		Department of Health Project Team	NMHWS Taskforce
	Lead: Fran Boyle			
<b>Simon Smith Caroline Salom Yaqoot Fatima</b>	Co-Lead: Anne Cleary	Co-Lead: Natalie Thomas	Paul Cutting Jo Schell Patrick Smith Nathan Borg	Jennifer Taylor Tom Brideson Other members
	Information Scientist: Jane Moore			
	Research Assistant			

Table B-1: National Mental Health Workforce Strategy Taskforce Membership.

<b>Name</b>	<b>Position</b>
<b>Jennifer Taylor PSM</b>	Co-Chair
<b>Thomas Brideson</b>	Co-Chair
<b>Mark Roddam</b>	Commonwealth Department of Health
<b>Lyndall Soper</b>	National Mental Health Commission
<b>Michael Tam</b>	Royal Australian College of General Practitioners
<b>John Allan</b>	Royal Australian and New Zealand College of Psychiatrists
<b>Stephen Jackson</b>	Australian College of Mental Health Nurses
<b>Ros Knight</b>	Australian Psychological Society
<b>Leanne Beagley</b>	Mental Health Australia
<b>Bill Gye</b>	Community Mental Health Australia
<b>Margaret Doherty</b>	Peer Workforce representative
<b>Le Smith</b>	Northern Territory Primary Health Network
<b>Gabrielle O'Kane</b>	National Rural Health Alliance
<b>Faye McMillan</b>	Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group representative
<b>Peter Heggie</b>	Carer representative
<b>Heather Nowak</b>	Consumer representative
<b>Jeff Borland</b>	Labour Market expert
<b>Genevieve Pepin</b>	Australian Council of Deans of Health Sciences
<b>John Brayley</b>	Mental Health Principal Committee
<b>Tricia O'Riordan</b>	Mental Health Principal Committee

<b>Date</b>	<b>Meeting Purpose</b>
<b>18 June 2020</b>	Project Inception meeting
<b>24 June 2020</b>	Review Project Plan
<b>08 July 2020</b>	Review Progress Report and set direction for draft report
<b>20 July 2020</b>	Review draft report
<b>24 July 2020</b>	Present draft report to the Taskforce

## Appendix C: Mapping of Mental Health Workforce Policy Landscape

	Work Policies							Mental Health
	Health			Lived experience	Aboriginal and Torres Strait Islander	Rural and Remote		Main plan
	General	Mental Health	Other	Mental Health	General	Health	Health	
<b>AUS</b>	National Medical Workforce Strategy Scoping Framework July 2019 (in development)	National Mental Health Workforce Strategy 2011 and National Youth Mental Health Workforce Strategy 2016 – 2020	National Alcohol and Other Drug Workforce Development Strategy 2015-2018	National Peer Workforce Development Guidelines (in development)	Commonwealth Aboriginal and Torres Strait Islander Workforce Strategy 2020-2024	Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2026	National Strategic Framework for Rural and Remote Health 2011	The Fifth National Mental Health and Suicide Prevention Plan 2017
<b>QLD</b>	Advancing health service delivery through workforce: A Strategy for Queensland 2017–2026 and Medical Practitioner Workforce Plan for Queensland and Queensland Health Workforce Diversity and Inclusion Strategy 2017 – 2022 and Business Planning Framework: a tool for nursing and midwifery workload	Mental Health Alcohol and Other Drugs Workforce Development Framework 2016-2021	Optimising the allied health workforce for best care and best value - A 10-year Strategy 2019- 2029	Queensland Framework for the Development of the Mental Health Lived Experience Workforce. 2019	Moving Ahead A strategic approach to increasing the participation of Aboriginal people and Torres Strait Islander people in Queensland's Economy 2016–2022	Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026	Advancing rural and remote service delivery through workforce: A strategy for Queensland 2017–2020	Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan 2018-2023

	Work Policies							Mental Health
	management 5th Edition 2016							
<b>NSW</b>	Health Professionals Workforce Plan 2012-2022	NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022(including Implementation Plan)			The NSW public sector Aboriginal employment strategy NSW Working together for a better future 2019–2025	Good Health - Great Jobs Aboriginal Workforce Strategic Framework 2016-2020	NSW Rural Health Plan: Towards 2021	Living Well: A Strategic Plan for Mental Health in NSW 2014-2024
<b>VIC</b>	2020 Health and human services	Workforce Strategy 2016 – Victoria’s 10 Year Mental Health Plan	Victoria’s specialist mental health workforce framework Strategic directions 2014-2024	Strategy for the Consumer Mental Health Workforce in Victoria Centre For Mental Health Learning Victoria 2019	Aboriginal employment Strategy 2016–2021	Koolin Balit Aboriginal health workforce plan 2014-2017	Rural Workforce Agency Victoria Annual Reports	Victoria’s 10 Year Mental Health Plan 2015
<b>TAS</b>	Strategic Framework for Health Workforce 2013–2018	Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020)	n/a	Peer Workforce Development Strategy- Mental Health Council of Tasmania November 2019	Tasmanian State Service Aboriginal Employment Strategy to 2022	n/a	n/a	Rethink Mental Health – Better Mental Health and Wellbeing A long-term plan for mental health in Tasmania 2015-2025

	Work Policies							Mental Health
<b>SA</b>	n/a	Mental Health Nursing Workforce Strategy 2020-2030	SA HEALTH Clinical Governance Framework for Allied Health Professionals 2018	n/a – but advocated for in the MH plan	Aboriginal Workforce Strategy 2018 – 2022	SA Health Aboriginal Workforce Framework 2017-2022	SA Rural Medical Workforce Plan 2019–2024	South Australian Mental Health Strategic Plan 2017–2022
<b>WA</b>	n/a	Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2018-2025 Consultation Draft		A Peer Work Strategic Framework for the Mental Health and Alcohol and Other Drug Sectors in WA October 2014	Aboriginal Employment Strategy 2011 – 2015 Building a diverse public sector workforce	WA Health Aboriginal Workforce Strategy 2014–2024	Rural Health West Strategic Plan 2018 - 2021	Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025 (Plan Update 2018 (Plan Update 2018))
<b>ACT</b>	Territory-wide Health Service Plan–in development	n/a	n/a	n/a	n/a	n/a	n/a	Office for Mental Health and Wellbeing Work Plan 2019–2021
<b>NT</b>	Northern Territory Health Workforce Strategy 2019 - 2022	NT Mental Health Service Strategic Plan 2015-2021	n/a	n/a	Aboriginal Employment and Career Development Strategy 2015–2020	Northern Territory Health Aboriginal Cultural Security Framework 2016 to 2026	n/a	Northern Territory Mental Health Strategic Plan 2019 to 2025

Note: The ‘other’ column refers to health workforces outside of traditional medical professions. This column encompasses areas such as Allied Health workforces, Specialist mental health workforces and Mental Health Community Support Service workforces.



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