leading community mental wellbeing

Queensland Alliance for Mental Health

THE COMMUNITY MENTAL HEALTH WORKFORCE PROJECT

July 2021

Queensland Alliance for Mental Health

Queensland Alliance for Mental Health (QAMH) is the peak body for the community mental health sector in Queensland. We represent more than 100 organisations and stakeholders involved in the delivery of community mental wellbeing services across the state.

Our role is to reform, promote and drive community mental wellbeing service delivery for all Queenslanders, through our influence and collaboration with our members and strategic partners.

At a federal level, we collaborate with Community Mental Health Australia. We work alongside our members to build capacity, and systematically advocate on their behalf on issues that impact their operations and Queensland communities.

QAMH contact details

433 Logan Road
Stones Corner QLD 4120

For any further information please contact:

Jennifer Black
Chief Executive Officer
Email: jblack@qamh.org.au
Tel: (07) 3394 8480

Acknowledgements

We would like to acknowledge the Queensland Government for funding this Project and the members of the Project Reference Group for their support.

We would also like to acknowledge the people who participated in the Project for sharing their experiences, insights, and ideas.

Disclaimer

The views or opinions in this report do not necessarily reflect all the stakeholders that were consulted during the life of the Project.

Every effort has been made to ensure this document is accurate, reliable, and up to date at the time of publication. QAMH does not accept any responsibility for loss caused by reliance on this information and makes no representation or warranty regarding the quality or appropriateness of the data or information.

Availability

The report is available online at www.qamh.org.au

Abbreviations

CALD	Culturally and linguistically diverse
CMO	Community managed organisation
COVID-19	Coronavirus disease of 2019
HR	Human resources
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, or questioning (individual)
NDIS	National Disability Insurance Scheme
PD	Professional development
QAMH	Queensland Alliance for Mental Health
RTO	Registered training organisation
SCHADS Award	The Social, Community, Home Care and Disability Services Industry Award

Table of Contents

Executive summary

Background: Despite the community mental health and wellbeing sector being a crucial part of the mental health service system in Queensland there is a lack of contemporary information regarding the workforce. The coronavirus disease of 2019 (COVID-19) pandemic has recently presented additional demands and challenges for a sector that was already struggling with the changes brought about by the introduction of the National Disability Insurance Scheme (NDIS). The Community Mental Health Workforce Project (the Project) provides a snapshot of the Queensland community mental health and wellbeing workforce in 2021 and an understanding of the key challenge faced by the sector. This review was conducted in collaboration with our members, Community Services Industry Alliance (CSIA) and other related stakeholders. The identification of key areas for consideration will inform future initiatives to ensure the viability and sustainability of the sector.

Methods: The Project was conducted in concurrent stages of separate, but interconnected, research activities.

- **Project Reference Group:** To guide the initiative, a Project Reference Group was formed, which included key representatives from community mental health service providers and the broader sector. The group convened virtually and provided input into the Project methodology, consultation and survey questions, and findings and recommendations.
- **Desktop scan:** A desktop search was conducted utilising major pieces of literature from around Australia, including state and territory community mental health and wellbeing peak bodies' research, academic literature, and publicly available information. The goal of the desktop scan was to map the community mental health and wellness workforce's current and emerging challenges and requirements.
- **Consultation:** Informed by the literature and the Project Reference Group, three sets of questions were developed to collect data specific to the target groups: Service managers, frontline workers and HR managers. Consultations with frontline workers and HR managers were conducted by online surveys. Individual structured interviews were conducted with most service managers, though some participated through focus groups and online surveys.
- **Data analysis:** Quantitative and qualitative data was collected and analysed. A thematic, content analysis approach was used for qualitative data, utilising QSR NVivo software (QSR International, 2020).

Results: Between 9 December 2020 and 31 March 2021 consultation with 50 service managers, 121 frontline workers, and 14 HR managers/officers occurred. Most service managers consulted were from Queensland Alliance for Mental Health (QAMH) member organisations, with some from non-member service providers.

Information was gathered from across Queensland: Over half of the service managers consulted represent organisations that deliver services in Metro Brisbane (North and South). 52% reported their organisation delivers services in regional, rural, or remote regions of Queensland. 60% of participating frontline workers were from Brisbane, nearly a quarter from West Moreton and the Darling Downs and the remaining from Central, North and Regional Queensland.

Participating organisations provide a range of mental health services: Support (group or individual), counselling (group or individual), suicide prevention, accommodation support, homelessness and alcohol and other drugs and peer support were the most cited services provided. Over half of the organisations consulted provide mental health supports and services as their primary function.

Workforce profile survey results

Data from the frontline workers survey revealed the following:

- Most of the workforce is female: 70% frontline workers surveyed were women
- Workers are of an older age demographic: 60% of workers were over 40 years old
- Workers are relatively new to the sector: 55% have been in the sector for less than five years
- The majority were employed on permanent contracts: 63% of workers surveyed held permanent roles (37% full time and 26% part time), 21% were on contracts (12% full time and 9% part time) and 14% of surveyed workers were employed on a casual basis. This trend was also reported by HR managers.
- 6% of participants identified as Aboriginal and/or Torres Strait Islander, while 17% were from culturally and linguistically diverse (CALD) backgrounds.
- 96% of workers held formal qualifications: Vocational qualifications (60%) and/or university qualifications (74%) ranging from Certificate III – Masters' qualifications.

Knowledge gaps and training needs

- Despite the high percentage of staff holding formal qualifications, nearly two thirds of service managers surveyed do not believe that formal qualifications adequately train the workforce. They reported concerns that courses did not provide the opportunity to translate theoretical knowledge into practical experience (e.g., through supervised work placement). Specific workforce knowledge gaps including basic mental health conditions and how best to support people who experience mental illness were identified.

- Other identified training gaps included: Trauma Informed Care, responding to complex /coexisting needs, provision of culturally appropriate services, crisis management, managing risks, establishing professional boundaries, recovery-based practice and leadership and management training.

Career Pathways

- Diverse sector entry and progression pathways were identified.
- The existing lack of consensus on education and skill requirements for specific roles is compounded by diverse role descriptions and position level remuneration.
- Three quarters of frontline workers surveyed believed that career progression opportunities existed within their organisations and advancement to a more senior position can be achieved through either gaining experience or undertaking further training or formal study.

Key Challenges Identified

Contracts

- *Contract lengths* do not support staff being offered permanent positions and contribute to high staff turnover and sector staff attrition.
- *Inadequate funding* inhibits the provision of fair and competitive remuneration of staff, adequate training and supervision and does not cover the costs associated with staff recruitment and onboarding.

The impact of the NDIS: Whilst the NDIS has increased business and employment opportunities, the fee for service model and pricing schedule has seriously impacted the ability to offer secure and satisfactorily remunerated employment and supervision and training opportunities to staff. Training requirements for organisations to comply with standards, understand the pricing model and support frontline workers have been significant and absorbed by services. Frontline workers reported concerns around reduced job security and increased workloads and productivity requirements which have contributed to high stress levels. They also reported significant challenges in supporting clients to navigate access and services in the NDIS.

Recruitment and retention: Managers spoke of burdensome ongoing recruitment and onboarding processes including: competition for competent workers among service providers; personnel churn to government or private sectors due to more appealing work conditions and benefits; a shortage of qualified and experienced candidates applying for jobs; challenges in recruiting and retaining qualified staff with relevant experience – though this problem is more acute in regional and rural areas due to a smaller candidate pool and professional isolation and when recruiting for specialist positions such as those supporting people from CALD, Aboriginal and Torres Strait Islander or LGBTIQ+ backgrounds.

Access to training: Access to training remains a common obstacle for services. Barriers to the provision of staff training include financial costs (direct cost of training and backfilling staff shifts) and the availability of relevant training. The problem is further exacerbated in rural, remote, and very

remote areas where face to face training is particularly scarce in terms of availability. Online training was acknowledged by most service managers as a feasible, accessible and less expensive option.

Work related stress and burnout: Supporting staff wellbeing was considered a priority by Service Managers. Experiences of vicarious trauma, stress and burnout related to the intensity and complexity of the work, high workloads and inadequate support and supervision was reported by frontline workers. According to service managers, the work required of frontline workers, coupled with the increasing casualisation of their roles have both contributed to staff burnout, which in turn exacerbates the issues around the transient nature of the workforce.

Supporting people to navigate the mental health service system: The most common worry expressed by nearly half of responding frontline employees is a lack of, or inadequate, support for clients who are having trouble navigating the mental health service system. This is a particularly concerning issue, as frontline workers are frequently the on-the-ground conduit between clients and services, and they bear the weight of client dissatisfaction and unfavourable outcomes.

The impact of COVID-19: Service providers reported very mixed experiences relating to the impact of COVID-19 on the workforce. Increase in service demands and funding lead to growth in staff numbers for some, whilst other saw a decrease in demand and some staff were made redundant.

Work-related adjustments such as working from home, technology usage, mask wearing, and workload fluctuations increased stress, anxiety, and fatigue levels of the workforce. Professional isolation, lack of interactions with, and support from, colleagues, and concerns about COVID-19 impacted on the mental and social wellbeing of staff. Some workers reported setbacks in their own mental health recovery journey during this period.

Despite the issues and challenges reported, 96% of service managers and 90% of frontline workers would recommend a career within the community mental health and wellbeing sector. 98% of service managers, and 93% of frontline workers reported that they have no plans to leave the sector.

Recommended actions: The Project has provided a snapshot of the profile of the Queensland community mental health and wellbeing workforce and highlighted the significant number of workforce challenges being experienced by the sector. These issues are not unique to Queensland and most have existed in our sector for many years. Some issues have become more prominent with the introduction of the NDIS and the accompanying increase in people working in the sector. Resolving the issues identified will not be a simple process. Action at the Commonwealth, State, service provider and worker level, involving funding, education, and employment institutions is required.

QAMH has identified some actions below that could support the challenges identified in this report to be addressed. These actions were discussed and workshopped at the Project Launch Event on 23 June 2021. Attendees rated workforce challenges as “very important” and “critical” to solve now and agreed that there were feasible solutions available to address them. We look forward to collaborating further with our member organisations to prioritise and facilitate these actions.

Continue to advocate for funding models and contracts that:

- are longer in term (5 years)
- allow for the fair remuneration of the qualified workforce
- include the realistic costs associated with recruitment and onboarding of staff
- include adequate costs associated with staff training and supervision
- include costs to evaluate / demonstrate effectiveness of services
- enable services to be provided to people early in episode
- consider the specific needs of community managed organisation's (CMOs) operating in rural and remote areas and additional costs to provide all the above

Recruitment and retention

- Promotion of the sector as a career of choice**:** identify opportunities to promote the community mental health and wellbeing sector to secondary school students, undergraduates, graduates, and the existing workforce, as an attractive career of choice.
- Challenge stigma and focus on values alignment in promotional activities.
- Explore innovative recruitment and retention approaches further – consider remote supervision, joint appointments, collaborative recruitment, and training.
- Continue to work with CSIA to refine the job matching platform, supporting it's applicability to the community mental health sector and promoting its value.

Qualifications, skill sets and career pathways

- Ensure there are no barriers to accessing entry level qualifications – e.g., Certificate IV Mental Health and Certificate IV in Mental Health Peer Work and explore options to overcome these barriers where they exist.
- Support the ongoing review of vocational qualifications (Cert IV Mental Health, Cert IV Mental Health Peer Work) to ensure they best equip the workforce to perform their roles.
- Define the role and skillsets of the workforce to inform the review of vocational qualifications and development of and further training opportunities. Explore initiatives to enhance capability of service providers to offer quality placement opportunities which will support the transition of knowledge into practice.

Training

Lead sector-wide training initiatives to enhance workforce practice in identified areas of need:

- **Entry level skills** – Mental illness, recovery practice, professional boundaries, NDIS and psychosocial supports.
- **Professional development (PD)** – Trauma informed care, responding to complex and co-existing needs, managing risks, crisis management, provision of culturally appropriate services.
- **Leadership and management training** – to support career progression pathways. Training delivery modes to include face to face and online webinar sessions.

Staff wellbeing

Explore sector wide approaches to supporting staff wellbeing.

Section 1: Background

1.1 The community mental health and wellbeing sector

Community mental health and wellbeing services are crucial in supporting people with mental illness to remain active and connected within their family and community (Department of Health, 2019). Instead of focusing on the symptoms of mental illness alone, these services adopt a holistic approach to facilitate recovery (Jacob, 2015).

Community mental health and wellbeing services:

- Support an individual's emotional, social, occupational, mental, and spiritual needs
- Value the individual's strengths, capacities, aspirations, and goals
- Recognise the individual's rights
- Recognise the individual's lead role in their recovery process
- Acknowledge the value of the community and highlight the contribution of families, social networks, communities, and organisations that surround people with mental illness (Community Mental Health Australia, 2012; Queensland Health, 2015; Thornicroft, 2016)
  Are "best placed to provide essential links for people into the community and between services" (Commonwealth of Australia, 2006, p.288).

There is a growing consensus that services should be in the forefront of communities, connected with primary care, where possible, and practically amalgamated with hospital-based services if appropriate (Rosen et al., 2010). These services are vital for the recovery of people with mental illness (Community Mental Health Australia, 2012). The World Health Organization (2003) and the Productivity Commission (2020) highlight the importance of these services as an alternative to hospital-based care. From a user perspective, these services provide supports to facilitate good mental health within the community (Queensland Health, 2015). Some individuals may benefit from frequent contact and outreach during certain periods in their lives while requiring relatively low levels of support at other times. From a sector perspective, community mental health and wellbeing services are flexible, relatively cost effective and essential to mental health prevention and recovery (Department of Health, 2013). They are distinct from clinical mental health services, alcohol and other drugs services, and other health and community sectors. Many service providers support people with mental illness indirectly through services such as homelessness support, children, youth and family support, alcohol and drug support, employment services, and other health and wellbeing services (Community Mental Health Australia, 2012). These ancillary services support individuals to manage their self-care, improve social and relationship skills and achieve a better quality of life (Thornicroft et al., 2016. Wyngaerden, 2018). From a user perspective, these services provide supports to facilitate good mental health within the community (Queensland Health, 2015). Some individuals may benefit from frequent contact and outreach during certain periods in their lives while requiring relatively low levels of support at other times.

In Australia, community mental health and wellbeing supports, and services are mostly delivered by non-government community managed organisations (CMOs) (Siskind et al., 2012). These services may be provided to individuals or as group programs in the forms of prevention, early intervention, rehabilitation, and psychosocial support in a community setting.

1.2 Changes impacting the sector

Recent reforms and occurrences have presented both challenges and opportunities for the community mental health and wellbeing sector (Victoria State Government, n.d). The National Disability Insurance Scheme (NDIS), introduced in July 2016, transformed the delivery of mental health support services on a national level (Resika et al., 2019). Whilst many people have received life changing supports through the scheme, it has posed specific challenges for the mental health sector and those seeking "Psychosocial Disability" supports. Changes to funding has had negative impacts for workers in terms of their job security and stability, role and workload, and understanding of the NDIS (Cleary et al., 2020; Resika et al., 2019).

As highlighted by the Queensland Mental Health Commission, every part of the community mental health sector's business has been impacted by the NDIS (Queensland Mental Health Commission, 2017). Many CMOs have re-structured their financial and human resources (HR), and customer relationships, to comply with NDIS requirements.

1.3 Limited knowledge regarding the community mental health and wellbeing sector workforce in Queensland

A thorough understanding of the current landscape and trends of the community mental health workforce is vital to identify existing issues, plan for challenges and harness future opportunities. The current limitations on the knowledge of the community mental health and wellbeing sector in Queensland creates difficulties in addressing issues, strategic planning, particularly for the workforce.

The effectiveness of the workforce relies on the number, skills, cultural capability, and availability of workers and how these match the needs of the clients, both geographically and professionally. (Community Mental Health Australia, 2015). The Productivity Commission has also acknowledged the difficulty in encapsulating the role of a community mental health and wellbeing worker (Productivity Commission, 2020).

On a national level, there is a significant gap in knowledge on the community mental health workforce, with no research undertaken to document the status of the sector across Australia. On a jurisdictional level, several states have conducted research into the community mental health and wellbeing workforce.

- NSW gained an understanding of the size, and context of the workforce. The state has also explored the feasibility of enhanced data collection for CMOs in NSW (Ridoutt and Cowles, 2019).
- Victoria analysed the community support service workforce and service providers in the context of the NDIS (Resika et al., 2019).
- Western Australia examined the size, and role of the workforce to identify future needs and issues in the community mental health sector (Western Australia Association for Mental Health, 2017).

Section 2: Methods

2.1 Project aims

The aims of the Community Mental Health Workforce Project (the Project) are to:

- Develop a profile of the community mental health and wellbeing workforce in Queensland.
- Identify existing issues, challenges, and opportunities for the workforce.
- Identify the likely and desirable future needs of the workforce.
- Identify the changing needs of the workforce due to the coronavirus disease of 2019 (COVID-19).
- Identify the key roles, skill sets and associated career pathways.
- Develop an action plan for the workforce.

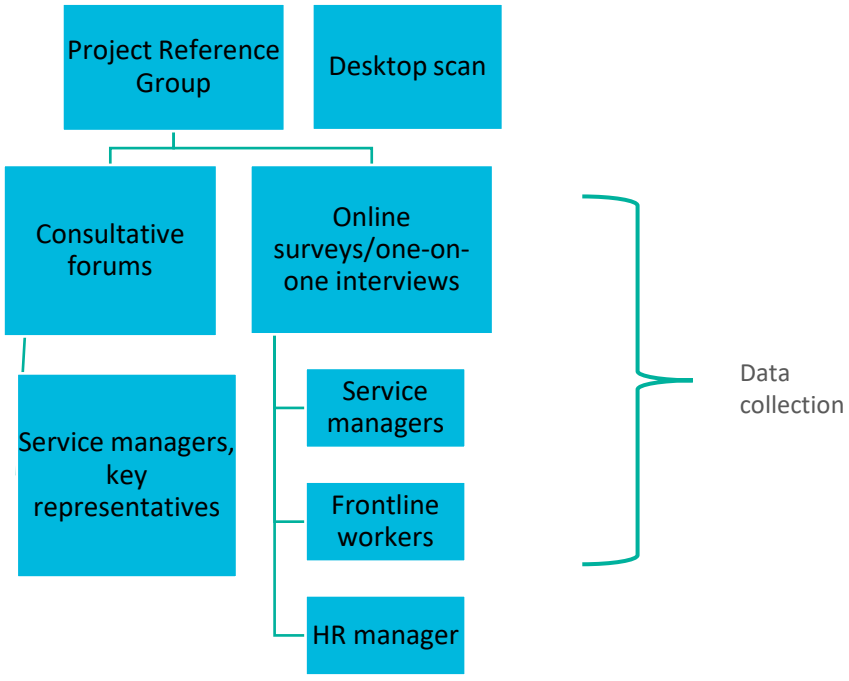
2.2 Project scope

The Project scope includes:

- The community mental health and wellbeing workforce whose primary role involves the provision of non-clinical psychosocial support and services to those living with mental illness in Queensland.
- Consultation and surveys conducted primarily with members of QAMH.
  - To ensure the Project captures a representative profile of the sector, service providers that were not QAMH members may be consulted where they provide supports to a unique population group or rural and remote regions of Queensland.
- Community mental health and wellbeing sector representatives.

2.3 Project design

The Project design consisted of separate, but interconnected, research activities. These were:



2.4 Project Reference Group

A Project Reference Group was established to guide the Project and included key representatives from community mental health service providers and the wider industry. Coupled with the desktop scan, the Project Reference Group provided input to consultation and survey questions. The Project Reference Group met via teleconference to discuss and plan the Project methodology, Project findings and recommendation.

The role of the Reference Group was to:

- Provide guidance, advice, direction, and networking suggestions from the perspective of their organisation.
- Ensure that the views and interests of the community mental health and wellbeing sector are represented.
- Provide access to relevant support from their organisation to meet Project objectives.
- Be reasonably available to attend all meetings and project-related workshops or sending a proxy representative if unavailable.

Members of the Project Reference Group included representatives from:

- Community Services Industry Alliance Limited
- Canefields Clubhouse Beenleigh Inc.
- CheckUP
- Drug ARM
- The Junction Clubhouse Cairns Limited
- Mind Blank Ltd
- NEAMI Limited
- North And West Remote Health Limited
- Queensland Program of Assistance to Survivors of Torture and Trauma Limited
- Stride Mental Health Limited
- Peer support worker representative
- Consumer representative

2.5 Desktop scan

A desktop scan was conducted using key pieces of literature from across Australia including research undertaken by state and territory community mental health and wellbeing peak bodies, academic literature, and information publicly available. The purpose of the desktop scan was to map the existing and emerging needs of the community mental health and wellbeing workforce. Findings from this scan informed the structure and focus of the consultations and surveys with the sector. The key search terms included:

Community mental health, ***or***	Workforce ***and***
Mental health	Development
Wellbeing	Framework
	Gaps
	Training
	Needs

2.6 Sample population

To map the status of the community mental health and wellbeing workforce, a range of perspectives were sought from the sector. Each target group was consulted with a unique set of questions to provide insights into the workforce from the unique perspective of their roles.
The target groups for the Project are:

- Service managers
- Frontline workers
- HR managers

For the purposes of this Project, over 40 service provider organisations were consulted with. They varied greatly in terms of size, and geography, to get as wide and accurate a snapshot from the sector within Queensland as possible.

2.7 Survey design

Three sets of questions were developed to collect data specific to the target groups. Informed by the Desktop Scan (Section 3). The questions were developed in consultation with the Project Reference Group.

2.8 Consultation

Consultations with service managers, frontline workers, and HR managers across Queensland occurred through one-on-one interviews and two focus groups between 9 December 2020 and 31 March 2021.

Service managers

Service managers participated in the Project through focus groups, one-on-one interviews, or via an online survey. Service managers were asked to distribute the surveys to the frontline workers and HR managers within their organisations.

A uniform set of questions was developed with a focus on the following areas of interest:

- Composition of the workforce
- Type of services delivered
- Perceived challenges facing the workforce
- Staff recruitment and retention
- Desirable qualifications/skills and personality attributes of workers
- Education and training priorities and gaps
- Career pathways of workers
- Peer support workers (if relevant)
- Impacts of COVID-19 and implementation of NDIS (if relevant)
- Service delivery and support to specific population groups
- Satisfaction in the sector and work

Frontline workers

Consultations with frontline workers in the community mental health and wellbeing sector were conducted via an online survey. Service managers were asked to send the online survey to relevant frontline workers to obtain a perspective of the workforce from those working on the ground. The questions posed to frontline workers examined:

- Qualifications
- Education and training priorities and gaps
- Perceived challenges facing the community mental health and wellbeing workforce
- Career pathway
- Impacts of COVID-19 and implementation of NDIS (if relevant)
- Satisfaction in the sector and work

HR managers

Consultations with HR managers were conducted via an online survey. The questions for HR managers aimed to collect demographic data of the staff in the service provider organisation. The questions included:

- Role types
- Qualifications
- Employment status
- Staff recruitment and retention information

2.9 Data analysis

A thematic, content analysis approach was used for data analysis. Thematic analysis was a valuable way to summarise, describe and examine the perspectives of the different participant groups to highlight similarities and differences, and to generate unanticipated insights. Responses for quantitative questions on workforce demographics were used to provide an understanding of the size, and staff information, of participating organisations.

QSR NVivo, a qualitative data analysis software, was used to identify and describe common themes, and differences across service provider organisations (QSR International, 2020). Data from each qualitative question was uploaded into NVivo from Survey Monkey and coded thematically. Coding was the assignment of units of meaning to descriptive of inferential research information. Codes (themes) were assigned to blocks of words, phrases or sentences and were then combined to realise the thematic connection between them.

Section 3: Desktop scan

3.1 Challenges of the workforce

Data regarding the Queensland community mental health and wellbeing workforce is limited and dated. The *Productivity Commission Mental Health Inquiry Report* acknowledges a lack of systematic data collection on the community mental health and wellbeing workforce. The lack of understanding about the workforce hinders workforce planning (Productivity Commission, 2020).

There is a lack of data regarding the size and composition of the community mental health and wellbeing workforce on both a national and state level. Numerous sources anticipate growth in the sector and thus, suggest the need to increase in size and diversity skills to meet service demands (Community Mental Health Australia, 2012). Data from the last decade provides a picture of what the workforce was like and allows comparisons to be made to the current sector. National estimates from 2011 suggested that the community mental health workforce was predominantly female with an average age of 42 years old. The research also found that 43% of participants in the sector held a bachelor's degree or higher tertiary qualification while 33% of participants held a mental health-specific qualification (Certificate IV in Mental Health makes up for almost 30% of those with a mental health qualification) (Health Workforce Australia, 2011). A separate 2012 research paper estimated that there needs to be 53.2 full time equivalent community mental health and wellbeing support workers per 100,000 people in Queensland to meet the service needs (Siskind et al., 2012). Without an understanding of the actual number of workers in the current workforce, it is difficult to determine if the needs of Queenslanders are being met.

Limited research, coupled with anecdotal accounts, indicates that the workforce currently experiences a range of internal and external pressures. The challenges facing the community mental health and wellbeing workforce identified through a desktop scan of current literature is summarised below.

3.2 Composition of the workforce

It is difficult to accurately discern the ***number, composition, and characteristics*** of workers in the sector (Productivity Commission, 2020). Relevant data is dated. A review published in 2015 indicated that the majority of the community mental health workforce were female, and over the age of 45. A large portion (40%) of the workforce had less than two years' experience in the sector, with 30% considering leaving the sector in the next 12 months (Foreman et al., 2015).

- There is also a lack of reliable data regarding ***the services provided and resources required*** by the workforce (Department of Health, 2013; Health Workforce Australia, 2011; Wyngaerden, 2018). The challenge to "encapsulate the role of a community mental health and support workers" has been acknowledged by the Productivity Commission (2020, p. 735) The deficit of such data makes assessing the level and nature of skills shortage difficult and hinders workforce planning and development of evidence-based workforce policy (Health Workforce Australia, 2011).

- The Productivity Commission highlighted the difficulty in the ***quantification and description, and assessment of the extent of formal qualifications***, of the community mental health and wellbeing workforce (Productivity Commission, 2020). This is largely attributed to the lack of consolidated source of data held by the state or Commonwealth governments or in public or private repositories, and no data has been collected at a sufficiently detailed level (Productivity Commission, 2020; State

of Victoria, 2021). The lack of this information hinders the sector's ability to identify potential and actual skill gaps and inform education recommendations and job redesign (National Mental Workforce Planning and Research Collaboration, 2011).

- Data regarding the ***level, and recognition, of training and entry requirements*** of the community mental health and wellbeing workforce remains scarce and anecdotal. A 2019 research on the NSW community mental health and wellbeing sector showed that workers ranged from those with no qualifications to those with undergraduate degrees (Ridoutt et al., 2019). No up-to-date data exists for the Queensland community mental health and wellbeing workforce. The Social, Community, Home Care and Disability Services Industry Award (SCHADS Award) 2010 is commonly used to articulate an employee's job classification, characteristics, responsibilities, and requirements (Fair Work Commission, 2021).

3.3 Staff turnover and casualisation

- The literature indicated that the community mental health and wellbeing sector has a particularly ***high staff turnover rate***, particularly in rural and regional settings (Cleary et al., 2020; Productivity Commission, 2020). Short-term government contracts and funding cycles create a climate of constant uncertainty and change for service providers, thus hindering their ability to offer permanent/long-term contracts (Productivity Commission, 2020). Service providers have cited difficulties in staff recruitment and retention due to the inability to provide job security, leading to high staff turnover. Short-term funding cycles and contracts also negatively impacts service providers' ability to provide services and sustain continued care for, and stable relationships with, people with mental illness (Productivity Commission, 2020).

- This ***attrition*** of the workforce has been attributed to job uncertainty posed the NDIS and short-term government contracts and funding cycles (Productivity Commission, 2020). Other factors contributing include ***low remuneration*** (compared to the public and private sectors), limited training opportunities and career advancement for workers (Cleary et al., 2020). The loss of workers from the sector leads to lower skill and experience levels across the psychosocial support workforce and increasing waiting times and lower quality of care for clients (Community Mental Health Australia, 2018; Productivity Commission, 2020).

- The sector has seen an increase in casual workers (Community Mental Health Australia, 2015; Ridoutt et al., 2019). The ***casualisation*** of the workforce poses an employment concern for staff recruitment and retention. Such short-term employment commitment causes uncertainty and is a barrier to staff development and education (Community Mental Health Australia, 2015). A 2019 NSW research showed that the almost half the workforce was employed on a ***temporary contract or casual basis*** (Ridoutt et al., 2019). Information on the workforce in Queensland appears lacking. Given that nearly half of the Queensland NDIS workforce are casual workers (49.4%), this may provide an inference to the employment status of the community mental health and wellbeing workforce (Workability QLD, 2018).

3.4 Peer support workers

Peer support workers are considered uniquely suited to working with people with mental illness (Sidlauskas, 2017). Able to provide emotional and social support to others with a common experience,

they represent a formative group of workers, and are deemed fundamental in the delivery of recovery-focused mental health services (Northern Territory Mental Health Coalition, 2019). For peer workers, roles and areas of responsibility can often be fluid. Peer workers have reported significant differences between their professional identity, the job description given at the interview, and the reality of their day-to-day responsibilities (Health Workforce Australia, 2014).

- Peer support workers are often ***under-recognised*** and ***under-utilised*** in the sector. Struggles with identity construction, and cultural impediment have been cited as factors undervaluing the importance of peer support workers (Health Workforce Australia, 2014; Vandewalle et al., 2016). In an organisation or healthcare setting, peer support workers are excluded and unappreciated due to a lack of understanding of lived experience work, coupled with ongoing prejudicial attitudes towards mental health diagnosis (Bryne et al., 2017; Jones et al., 2019; Kemp and Henderson, 2015; Sidlauskas, 2017).

- The literature suggests that it is imperative that peer workers be provided with ***ongoing education and professional development (PD)*** (Bryne et al., 2017; Northern Territory Mental Health Coalition, 2019). Inadequate support for workers, both financially and timewise, is deemed as a deterrent towards pursuit of relevant studies and career development pathways (Cleary, 2020). While the nationally accredited Certificate IV in Mental Health Peer Work is often not considered essential, (Bryne et al., 2017; Productivity Commission, 2020), it is commonly seen as the minimum qualification requirement (Queensland Health, 2019). The credibility of peer workers to their non-peer colleagues is bolstered by holding formal qualifications (Northern Territory Mental Health Coalition, 2019).

- Many peer support workers expressed a sense that there is ***limited scope for career advancement***, describing the structure for the peer workforce as flat (Health Workforce Australia, 2014). The capacity to operate within a career structure that offers progression is an important part of further establishing this workforce (Health Workforce Australia, 2014; Northern Territory Mental Health Coalition, 2019). Employment circumstances and outcomes for lived experience labour are extremely changeable and ad hoc. While current national and state standards strongly suggest that lived experience work be developed further, there is currently no accountability or auditing. Moreover, a lack of exposure to, and knowledge of, positions might have an influence on their perceived worth or acceptance. Many people's working circumstances are harmed by the lack of an award wage, a union, or a designated peak organisation. As a result, both lived experience employees and organisations confront difficulties in integrating this still-developing workforce. Due to the stated issues, there is a demand for more formalised frameworks and formalisation of the lived experience workforce to guarantee fairness while yet allowing for crucial flexibility within particular jobs. Whilst organisations such as the Queensland Mental Health Commission have done work outlining frameworks and supports for lived experience workers, more work can be done in implementing and actioning these suggestions and ideas (Byrne et al., 2019).

3.5 COVID-19

COVID-19 has had a detrimental effect all around the world, including in Queensland. While Australia has largely avoided the virus's worst impacts, the effects have been pervasive, ranging from financial stress and loss of income to uncertainty and dread as we adjust to the "new normal". As a result,

people have reported feeling more anxious, panicked, depressed, and angry (Black Dog Institute, 2020).

The Queensland Government implemented several limitations and social (physical) distancing measures in order to try and stop the spread of COVID-19. The restrictions on movement and human contact beyond one's close family significantly hampered one's freedom of movement. People were prohibited from leaving the house except for work, exercise, shopping, or medical reasons, and most public places, including community centres, libraries, and even hospital wards, were closed.

Lockdown was difficult for everyone, but vulnerable populations and individuals who were already at risk for a variety of social and health reasons were particularly impacted by the new situation. People with mental health challenges in the community who rely on a variety of psychosocial supports and services to manage their mental health, assist their recovery, and maintain social networks in their communities are among these categories. To avoid or minimise the harmful impacts of a hard lockdown on persons who were previously known to be vulnerable, health agencies and care providers needed to respond quickly. As a result, all aspects of the mental health service system were obliged to reconsider their old patterns of care, which included drastically lowering face-to-face treatment delivery. To ensure continuity of assistance, services had to respond rapidly to create novel service models. A public health crisis stemming from increased demand for mental health services, combined with service delivery interruptions, necessitated a quick change of service models, forcing both service providers and consumers to adjust to a novel approach.

3.6 NDIS

The implementation of the NDIS presented significant changes and challenges for the community mental health and wellbeing sector in relation to its workforce, funding, service delivery, business model, risk management practices and service delivery (Mendoza, 2013). Prior to the NDIS, State and Territory governments were primarily responsible for the funding of psychosocial support services (Productivity Commission, 2011). In addition to funding, State and Territory governments also delivered and/or managed specialised mental health services that were delivered through CMOs (Productivity Commission, 2011). Since the NDIS, state and territory governments have transferred the funding of some psychosocial support to the NDIS. Most psychosocial support outside the NDIS is now administered by the Primary Health Networks, which commissions but does not provide psychosocial support (Productivity Commission, 2020). "The NDIS is designed to complement other supports, rather than to replace them, which involves complex interface issues that will take time to work out and could lead to gaps in services if governments prematurely withdraw from providing services" (Queensland Productivity Commission, 2020, p.32).

The challenges and changes for the sector arising from the NDIS are summarised below:

- The NDIS has divided the type of work delivered by the community mental health and wellbeing workforce to those who provide *psychosocial recovery support and rehabilitation services* for individuals, and those that provide *core/basic assistance* to consumers individually, or in group setting (Community Mental health Australia, 2018).

- Workers reported changed roles and a reduced scope to perform recovery-oriented work in a disability model. "There is a fundamental disconnect between the psychological sector's recovery focus, and the NDIS goal of managing 'permanent and lifelong impairment" (Rosenberg et al., 2019, p.2).

- The work undertaken by the NDIS has ***moved away from a distinctive mental health focus*** (Community Mental Health Australia, 2015). Staff have also reported concerns that the transition to the NDIS has had negative outcomes for people who access NDIS services resulting in in increased anxiety and stress. People did not trust the NDIS due to systemic flaws and a lack of choice and control over support issues. These issues that arose out of the transition process gave rise to instances of increased friction between people accessing services and those providing the support. (Resika et al., 2019).

- The NDIS has ***increased the competition*** between service providers, where service providers compete on cost, service delivery, and efficiency (Mendoza, 2013).

- Service providers are under pressure to be flexible and responsive. This demand for flexibility has fragmented working hours and created ***financial and employment insecurity for staff***. There is an increase in casual, fixed term employment. It is common for NDIS workers to work for multiple service providers which has implications on the ethical practice, safety and quality of the workforce (e.g., restraint of trade clauses, poaching of clients) (Community Mental Health Australia, 2015).

- Tension has been identified between ***minimum qualifications and/or skills*** required to undertake NDIS psychosocial disability service. Service providers have identified the need to increase the skills of the workforce originally delivering NDIS services to enable their delivery of psychosocial recover-based practice (Community Mental Health Australia, 2015). The Mental Health Community Support Services job roles and classifications do not translate directly to the roles providing psychosocial disability support under the NDIS (Roberts and Fear, 2016).

- The ***lowered NDIS pricing schedule*** limits the time and financial resources allocated for staff induction, training, development, supervision, collaboration, innovation, and routine administration. It was also difficult for providers to accurately recuperate the costs associated with providing reasonable and necessary levels of care as NDIS remuneration does not accurately reflect the different levels of complexity in clients (Community Mental health Australia, 2018).

- Service providers reported ***increased administration and costs*** associated with NDIS reporting, compliance, and data collection. Onerous reporting and contract administration is an issue if the organisation obtains funding from various streams and must fulfil numerous compliance requirements (Productivity Commission, 2020). The increased administration, and less recovery-focused service delivery, further exacerbates the loss of skilled and experienced staff (Community Mental health Australia, 2018).

- The NDIS **stipulates the range of professionals who can provide NDIS support** and coordination of supports (e.g., disability support worker, including mental Health worker, mental health peer worker) (Sidlauskas, 2017). This creates the opportunity for someone with disability qualifications, but no relevant understanding or experience in psychosocial disability or recovery to deliver services under the NDIS for people with psychosocial disability.

- The majority of organisations have committed to recruit workers with a Certificate IV in Mental Health, Certificate IV in Mental Health Peer Work (or equivalent) as a minimum standard to work

in the NDIS. This reflects the sector's determination to ensure the skills of the workforce. However, under the NDIS service providers cite difficulty in finding staff with the right skills for the role. Many organisations have been recruiting staff with no qualifications due to insufficient availability in the labour market of workers with Certificate IV or higher or had to recruit workers with lower skill sets. Service providers also reported having to ***move away from minimum workforce qualifications*** since they cannot afford to pay the salaries required to attract and retain a skilled workforce (Community Mental Health Australia, 2015).

- From a frontline worker's perspective, numerous reports reported ***lower pay rates***, ***job insecurity***, low staff morale, feeling of inadequacy/ineffectiveness, higher workload, and heighted anxiety, stress, dissatisfaction, and emotional load following the implementation of the NDIS. (Community Mental Health Australia, 2015; Resika et al., 2019).

3.7 Vulnerable population groups

The community mental health and wellbeing workforce provides services and support to people from all diverse backgrounds. This includes Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse (CALD) backgrounds, young people, LGBTIQ+ individuals, and those residing in rural, remote, and very remote parts of Queensland. The current scan indicates that there are significant gaps in knowledge on the community mental health and wellbeing workforce in relation to the challenges and issues encountered when supporting these population groups. Literature is abundant on the key issues and barriers faced by mental health professionals when providing services to population groups (Queensland Health, 2016; Cleary et al., 2020) but there is limited data regarding any specific challenges faced by community mental health and wellbeing workers who support and provide services to them.

The desktop scan complements the understanding that there are significant gaps in knowledge on the Queensland community mental health and wellbeing workforce in relation to the definition, composition, and qualification of the workforce.

Section 4: Findings

4.1 Participant demographics

A total of 50 service managers from 43 service providers, 121 frontline workers and 14 HR managers/equivalent were consulted in this Project. For service managers, consultations were conducted via two focus groups, 44 teleconsultations and one face-to-face interview. Two service managers completed the online survey independently. Collectively named service managers, this group of participants consisted of chief executive officers, directors, team leaders and programs managers.

Service managers and organisations

The 50 service managers surveyed represent a good coverage of organisations across the state (Figure 1). Over half of the service managers consulted represent organisations that deliver services in Metro South and Metro North. 52% of service managers reported that their organisation delivers community mental health and wellbeing services to rural, remote and/or very remote regions of Queensland.

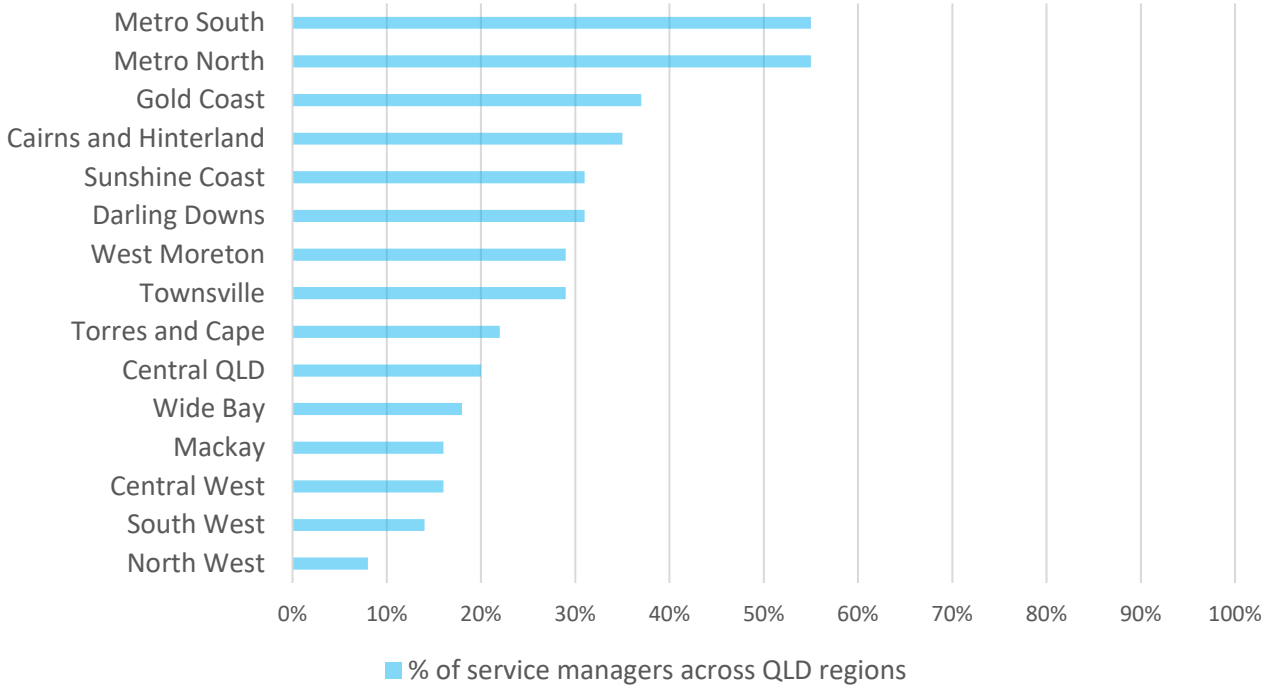


Figure 1. Regions in Queensland serviced by the service providers (organisations) that the service managers represented. Note, service providers may operate in more than one region of Queensland.

Over half of the organisations consulted (57%) provide mental health services and support as their primary function. The service managers come from organisations ranging in size – just over half of those (52%) worked in large organisations that employ over 100 staff and have the ratio of one manager to over 15 staff members (38%). Over 50% of service managers indicated that managers in their organisation manage over 10 staff.

Participating organisations provide a range of mental health services (see Figure 2 below). Support (group or individual), suicide prevention, counselling (group or individual), suicide prevention, accommodation support, homelessness support, alcohol and other drug support were the most cited services provided. Peer support services were provided by 39% of organisations interviewed.

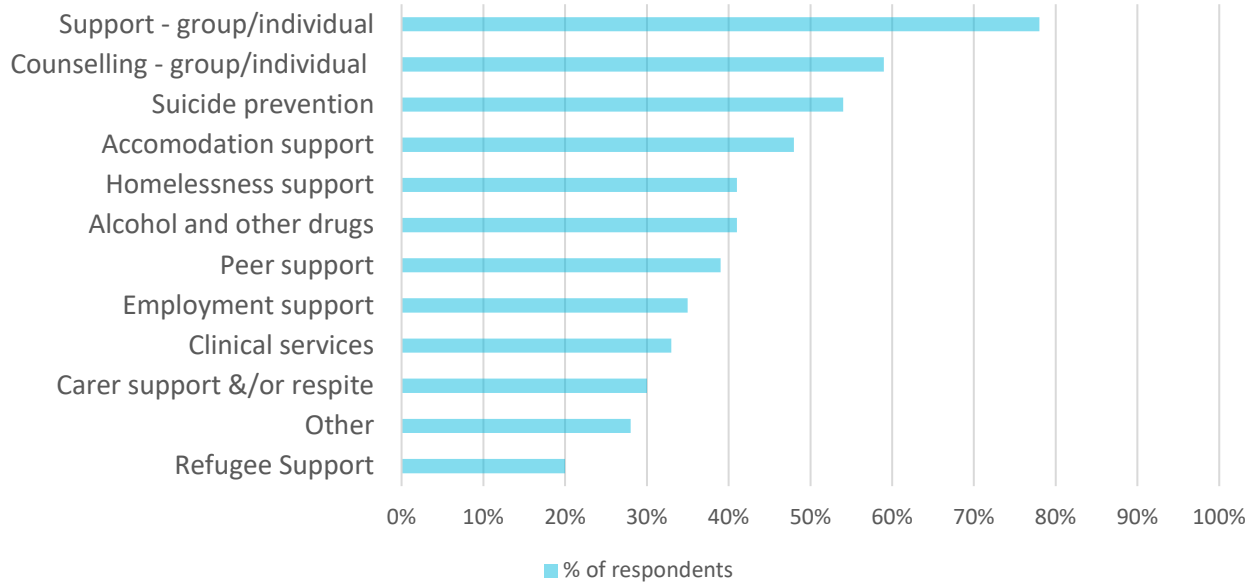


Figure 2. The types of service provided by participating organisations.

Details of frontline workers

Women represented over 70% of the surveyed frontline workers. The age distribution was skewed towards an older age profile in which 60% of the frontline worker participants were over 40 years old. Many workers have not worked long in the sector - 55% of participants have worked less than five years and 21% 6-10 years in the sector. 63% of frontline workers were employed on a permanent basis (full-time or part-time), 21% indicated they were on a full or part time contract, and 14% were employed on a casual basis.

Employment Status	Number	Percentage (%)
Permanent full time	45	37%
Permanent part time	31	26%
Contract full time	15	12%
Contract part time	11	9%
Casual	17	14%
Other	2	2

Table 1. Employment status of frontline workers

Most frontline workers surveyed had job titles of mental health support workers, recovery support workers and support coordinators/facilitators. 20% of workers indicated that their position is a designated lived experience role. Mental health support (group or individual), counselling (group or individual), accommodation support and alcohol and other drugs support were the most common services provided by frontline workers, followed by peer, employment, suicide, and homeless support. The frontline workers surveyed came from all parts of Queensland - over 60% of the frontline workers

who responded work in Brisbane (Metro South and Metro North), followed by the Darling Downs and West Moreton regions (see Figure 3).

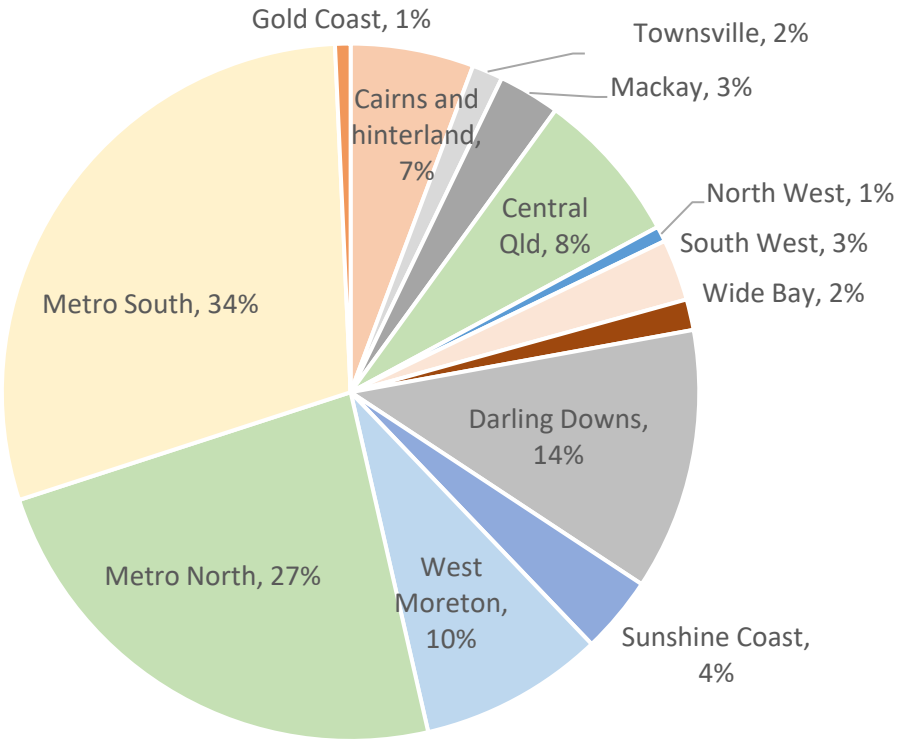


Figure 3. Regions in Queensland frontline workers represent.

Backgrounds

Most service managers surveyed indicated that their organisation has an inclusive workforce and employ individuals from diverse backgrounds, including:

- People from CALD backgrounds
- Aboriginal and Torres Strait Islander
- Lived experience
- Carers with lived experience
- LGBTIQ+

It should be noted that the employment of individuals from the above backgrounds were estimates from service managers. Many indicated that it was hard to know this information accurately as many employees did not disclose their ethnicity, lived experience or sexual preference. This concurs with data from frontline workers. In total, 6% of participants identified as Aboriginal and Torres Strait Islander and 17% were individuals from a CALD background.

Qualifications

Frontline workers surveyed held a breadth of qualifications, ranging from Certificate II to masters' degrees.

Level of qualification		%[1]	Examples of qualification
Vocational Training and Education	**No qualification**	4%	-
	Certificate II	1%	Certificate II in Business
	Certificate III	10%	Certificate III in Individual Support (Disability and Ageing), Certificate III in Community Services
	Certificate IV	18%	Certificate IV in Mental Health, Certificate IV in Mental Health Peer Work
	Diploma	25%	Diploma of Community Services (Alcohol, other drugs and mental health)
	Advanced Diploma	6%	Advanced Diploma of Community Services Management, Advanced Diploma of Family Therapy
University Education	**Bachelor**	33%	Bachelor of Occupational Therapy, Bachelor of Psychology, Bachelor of Behavioural Science (Psychology), Bachelor of Social Work, Bachelor of Counselling
	Bachelor Honours Degree	8%	Bachelor of Psychology (Honours), Bachelor of Social Work (Honours)
	Graduate Certificate	7%	Graduate Certificate in Alcohol and Other Drugs, Graduate Certificate of Therapeutic Child Play
	Graduate Diploma	7%	Graduate Diploma of Counselling, Graduate Diploma of Psychology
	Masters	19%	Master of Social Work, Master of Counselling

Table 2. Qualifications held by frontline workers [1]

Workforce data from HR managers/equivalent

A total of 14 HR managers/equivalent completed the HR survey. Although HR managers reported data from a total of 1,103 employees, low response rates to questions as well as reported "estimates" and "averages" meant that the data was not able to be collated and interpreted accurately. Estimates from HR managers indicated that there are more female staff in the workforce than males, with over 80% of the workforce aged over 35 years old. It was clear that the number of staff employed, and their employment status, differed greatly amongst the organisations. Responses indicated that less than 20% of the workforce were employed on casual contracts, with the remaining staff working in either full or part time roles.

There was an insufficient number of responses to questions related to staff qualifications and award levels to include or interpret any data.

4.2 Workforce challenges

Service managers were first asked to identify **key challenges** affecting the community mental health and wellbeing workforce, and these were subsequently grouped into key themes. The key themes are listed below.

[1] Please note, some participants had more than one level of qualification. This data represents 114 responses.

Key challenges identified by services managers

Training

Access to, and cost of relevant (and ongoing) training was identified as a key challenge for the workforce. Some service managers highlighted organisations lack time, resources (e.g., limited staff) and budget to support staff to complete further training. For services in rural and remote regions, the abovementioned barriers to training were further exacerbated where face-to-face training is often unavailable.

> ***"Need to have training delivered in rural areas (i.e., not send staff to external locations)."***
> [Comment from frontline worker]

With access to appropriate training identified as a clear challenge, many service managers also highlighted concerns that the current workforce has training gaps in relation to providing mental health specific supports and services, including recovery-oriented practice. One service manager suggested the training available is too "dated" to adequately equip staff to perform their work functions. This was echoed by other participants. For example, some service managers reported the workforce lacked knowledge and education on recovery orientated practice in mental health. While other service managers highlighted current education and training lacks focus on professional boundaries.

Difficulty in recruiting and retaining qualified and experienced staff

A shortage in qualified and experienced staff is also an issue raised. The shortage is further intensified by competition for qualified staff between service providers and staff attrition to government or private sectors due to more attractive work conditions and benefits. While there may not be a lack of candidates applying for jobs, the recruitment and retention of qualified staff with the relevant experience is a challenge in both metropolitan and rural areas – although this issue is more significant in rural areas due to a smaller candidate pool and professional isolation. Service managers also noted that there is also a disproportionate over-representation of female staff in the sector.

The workforce contains a large number of casual staff due to the current funding paradigm of the sector. Many service providers are unable to offer permanent roles to staff. This lack of job security has created a workforce that is highly mobile and transient.

Supporting staff wellbeing

Staff wellbeing and mental health are also highlighted in relation to frontline workers' welfare. Vicarious trauma, stress and staff burnout have been associated with the high load and intensity and complexity of the work performed by frontline workers.

Key challenges identified by frontline workers

Difficulty in supporting clients to navigate the mental health service system

Nearly half of frontline workers surveyed expressed concerns and frustrations about the mental health system in general. For example, their clients often do not receive the services they need due to lack of funding, long wait times for services and insufficient community resources (e.g., transport). Some frontline workers also reported difficulty in supporting clients to navigate the mental health sector and had limited appropriate referral pathways (e.g., limited awareness of services available, particularly for CALD communities).

> ***"The need is so huge; our service and other services can only touch the tip of the iceberg."***
> [Comment from frontline worker]

Work related stress

Almost all frontline workers indicated they experienced work-related stress. This was due to a range of reasons including high workloads, under-resourcing in the sector, the challenges of working with clients with complex issues and co-morbidities and dealing with trauma. Many frontline workers highlighted juggling a heavy workload, combined with struggles to meet productivity requirements, impacted on their stress level and ability to maintain a healthy work life balance. This issue directly relates to the references to burnout and vicarious trauma. The demanding nature of the work and complex presentation of clients was reported to have caused vicarious trauma in some staff.

Management support

> ***"Our caseloads are 50% higher working under the NDIS support coordination than what we worked with under the old PHaMs or PIR funding models."***
> [Comment from frontline worker]

Several respondents referred to poor management and organisational constraints, lack of support and loneliness exacerbated by a disconnect between management focussed on achieving KPIs and frontline workers providing support coordination under pressure as factors contributing to stress, exhaustion, and burnout.

The lack of funding for services and supports, staff shortages, and the lack of employment security are also considered challenges facing frontline workers.

Staff recruitment and retention

Service managers were asked about challenges specific to staff recruitment and retention. The shortage of available and appropriate applicants for positions in the sector was reported as the top concern by respondents. This shortage encompasses workers who do not have the required qualifications and those who are deemed not to have sufficient/adequate experiences to work in the sector. The lack of staff with qualification in, or training/experiences specific to, mental health in the sector is a particular concern. The loss of staff to the government or private sectors, worsen staff shortage and augments recruitment challenges. In regional areas, social and professional isolation, less favourable work conditions, travel and personal circumstances further exacerbate the worker shortage compared to metropolitan areas. Service managers also reported difficulty in recruiting male staff.

The shortage of staff exacerbates the recruitment burden for service providers. The administration, labour and cost associated with recruitment and onboarding are significant and impact on the business' bottom line and resource availability. Competition for qualified and experienced staff amongst service providers is common in the sector. Employers are often forced to accept those with less desirable skills and attributes.

Most organisations do not have a preferred or specific training body from which to recruit candidates. However, universities and Registered Training Organisations (RTOs) are named as training bodies from which candidates were often recruited from.

In lieu of qualified, trained and/or experienced staff, many service managers indicate that their organisation provides training opportunities to upskill staff, or encourages and supports them to undertake the relevant training to gain necessary qualification. The need to provide training for staff further adds to recruitment costs.

Many service providers promote their organisational values and offer an attractive work environment, benefits, and arrangements to attract and retain workers as ways to overcome staff shortage and promote recruitment.

Required and desired qualifications and skill sets

Service managers highlighted a range of desired or required qualifications, skills and experiences when recruiting staff. Vocational and university qualifications listed in their responses were similar to many qualifications possessed by frontline workers. An understanding of mental health and recovery or strength-based and/or person-centred practice, lived experience and experience working in the mental health sector are sought after skills and experiences, respectively. Specialised work experience in staff is highly sought after and reflects the niche nature of the work or the specific cultural groups to be supported.

Having the appropriate and relevant skills, experiences and personal attributes is vital to the success of any employee. However, employers look for many qualities in a worker, beyond the technical capacity to complete the required tasks. Both service managers and frontline staff were asked to list skills they deemed relevant or desirable for a frontline worker. General skills, such as good interpersonal and communication skills, are valued by service managers. Cultural understanding and peer support skills are also mentioned. Frontline workers listed universal employable skills - good communication skills, organisation, problem solving abilities etc. Knowledge regarding mental health,

strength-based recovery-oriented practice, local service availability, cultural competency and crisis management are also highly rated.

In relation to personal attributes, service managers place importance on good work ethics when recruiting staff. Desirable personality attributes included empathy, compassion, kindness. Service managers indicate that they often hire staff without the required or desired qualification if the candidates appeared to be a "good fit" for their team/organisation and have the necessary personality attributes/traits. Desirable traits, such as common sense, resourcefulness, respect, resilience, and flexibility further illustrate those employers are seeking an all-round employee with positive personality attributes.

The ability to connect with others is ranked as the most essential personal attribute by frontline staff. Having a non-judgemental attitude, and the ability to build relationships and rapport through good interpersonal skills and friendly demeanour, are also key to forming a successful connection. Lived experience further allows the worker to use his/her own insights and experiences to best help those with mental illness. Personal resilience and calmness are also deemed relevant due to the demanding and complex nature of a frontline worker's job.

A diverse workforce is an important asset to an organisation as it brings together the cultures, strengths, knowledge, skills, and potential of each employee. Most service managers and frontline workers believe that their workplace is a culturally safe environment. Service managers reported numerous ways in which their organisation promoted diversity in staff recruitment. To ensure a diverse workforce, many service providers adopt a range of approaches to urge people from diverse backgrounds to apply for jobs. These include:

- Having an equal employment opportunity recruitment approach.
- Adoption of novel ways to promote job opportunities.
- Development of specific recruitment strategies and plans to attract more Indigenous workers.
- Optimising wordings in job adverts and position descriptions to:
  - Encourage male candidates to apply.
  - Encourage and target people from various backgrounds to apply (e.g., CALD individuals, Aboriginal and Torres Strait Islanders, LGBTIQ+ people, people with certain experiences).
  - Ensure that candidates had a clear understanding of the requirements and duties of the advertised position.
- Ensuring that the workplace is a culturally inclusive workplace.

The need to recruit Aboriginal and Torres Islander workers, or workers with specific experience working with unique population groups (e.g., LGBTIQ+ individuals) is a common theme amongst service managers who report that it is often difficult to recruit such workers.

Multiple approaches are used to facilitate a mentally healthy workplace. Most service managers and frontline workers indicate that their organisation have internal structure in place to ensure and promote the mental wellbeing of staff through the provision and availability of:

- An employee assistance program to provide confidential counselling support and advice to staff when needed.
- Open-door policy to enable staff to have conversations with their managers.
- Regular internal and/or external supervision to provide opportunities for staff to discuss the skill development, strengths, challenges, and professional enhancement.

- PD opportunities to encourage learning and boost self-confidence.
- Use of reflective practices to encourage continual learning.
- Regular team meetings to allow staff to de-brief, discuss work-related challenges and to share experiences with other colleagues.
- Self-care and mental wellbeing training to learn methods to stay mentally healthy, and ways to support wellness.
- Team-building exercises to foster cohesion amongst staff members.
- Flexible work arrangements and extra leave entitlements to optimise staff work life balance, increase productivity, and to increase moral and job satisfaction in the workforce.

Training and education

Despite the majority of the workforce having formal qualifications, 65% of service managers interviewed do not believe that the current education/training courses available are adequately training the workforce. This contrasts with frontline workers surveyed, of whom 81% believe that their training has adequately prepared them for their role.

Almost half of the service managers suggest that current education/training courses are "heavily theory-based" with limited practical training and supervision. Some service managers believe that the lack of structured placement opportunities in the courses has produced workers who lack the tacit knowledge and practical experience/skills to perform the required work. Incorporation of more placement and supervision hours into the curriculum is highlighted as a necessary solution to ensure that graduates are equipped to deliver competent services to clients with confidence and effectiveness.

Service managers reported deficits in knowledge about mental illness, including basic education on common mental health conditions, how to recognise mental health deterioration and ways to best support someone with a mental illness. Training to develop and upskill staff in these areas is required.

Access to training remains a universal challenge for service providers. Associated costs, availability, and access to relevant training are barriers to the provision of training to staff. The lack of face-to-face training opportunities is mentioned by service managers from regional Queensland. Staff-specific issues, such as getting employees to make time for training, keeping them engaged, ensuring knowledge retention, and ensuring accountability further compound the challenge to provide training to staff.

Service managers highlighted the lack of clear training and career pathways, and limited consensus as to what are the basic education and skill requirements for specific roles. Together, these can have negative effects on the capability and quality of workers, and the quality and uniformity of service delivery in the sector. The findings suggest there are many varied training or career pathways for frontline workers. Furthermore, much variation exists for similar roles in relation to role title, skill requirements and educational qualifications.

Training gaps/priorities

Service managers identify a range of training gaps or priorities for staff (Figure 4). These demonstrate the sector's focus on person-centred, trauma informed, recovery-based practice and highlight the

importance for workers to be able to competently manage the complex needs of clients in day-to-day practice.

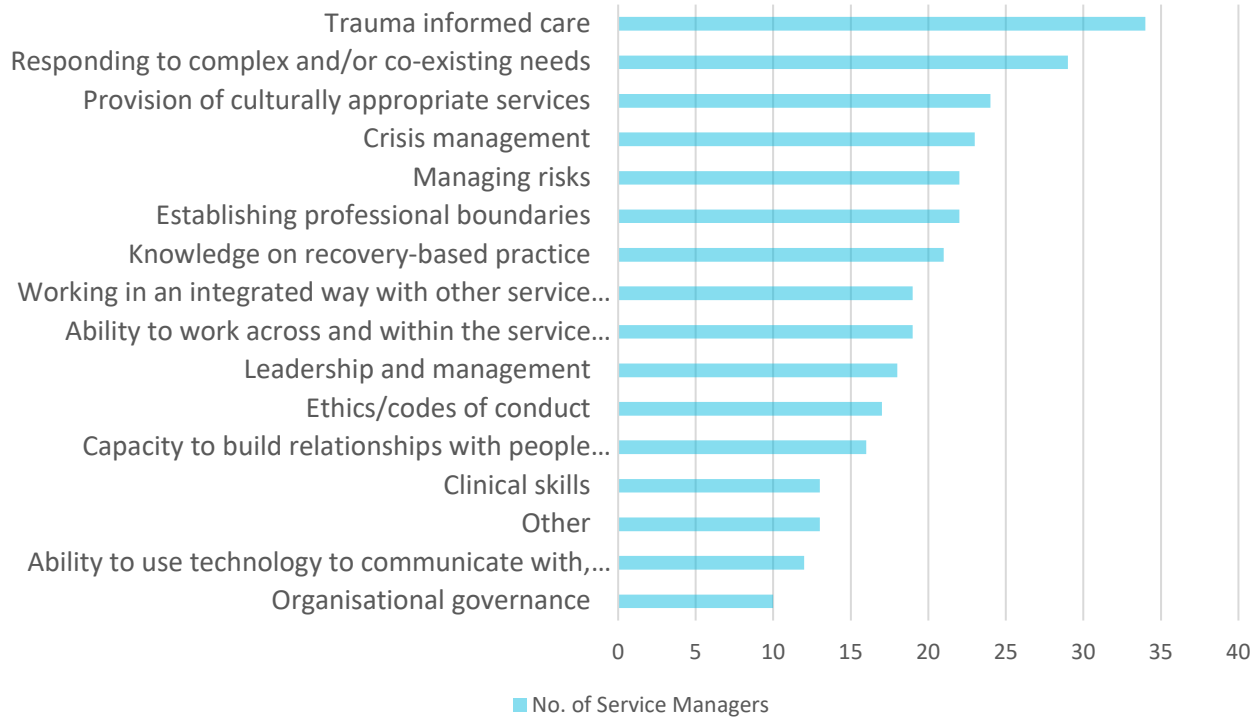


Figure 4. Sector topics identified as training gaps or priorities for staff.

These results from service managers are similar with those of frontline workers who were asked about topics they wish to undertake further education/training on. A total 93% frontline workers indicate interest in undertaking further training and/or education.

Mandatory and additional training

Over 90% of service providers indicated they provide both mandatory and additional training to staff. Service managers indicate that mandatory training consists of workplace induction-related topics, including policies such as bullying and harassment.

The most cited additional training offered by providers includes Mental Health First Aid (MHFA), suicide prevention, cardiopulmonary resuscitation and first aid, and note taking. Specific to the work of the frontline worker, training is generally on the following topics:

- Trauma informed care
- Food hygiene and safety
- Infection control
- Cultural and/or gender awareness, diversity, and inclusion
- Organisational compliance and leadership
- Conflict resolution and risk management
- Medication management
- Privacy and confidentiality

- Staff wellbeing
- Alcohol and other drugs

In addition to basic workplace induction training, service managers suggested the provision of additional training was primarily required to upskill staff and support PD. Many service managers emphasised the need for ongoing PD and learning to ensure services reflect best practice and are responsive to local needs. Service managers also suggested additional training was required to support frontline workers to meet the complex and varying needs of clients. One service manager stated, "to ensure competency across complex issues", while another service manager said: "to ensure staff can provide personalised patient-centred care to clients." Other key reasons for the provision of additional training include: risk mitigation, to maintain registration and accreditation and ensure safety, and quality of services.

Provision of training and PD opportunities

The provision of training and PD opportunities are ways to better staff. Training is centred around knowledge, skills, ability, and behaviours needed to competently perform a job, whereas PD allows staff to excel in areas beyond status quo. The provision of training and PD staff is key to advancement of retention of staff. Cost and time are the most fundamental impediments hindering the delivery of PD to staff.

Service managers identify that staff training or PD is an expensive exercise. Training costs, wages and productivity loss present financial obstacles for organisations wishing to provide professional opportunities or training to staff. As such, difficult decisions on which staff can and cannot go to training or PDs must be made. Furthermore, the need and cost associated with backfilling staff (to fill the position of the staff who is at training) presents an additional rostering dilemma. This is an issue as not all service providers have the HR to backfill staff attending training or undertaking PD opportunities. The lack of funding also acts as a monetary barrier to provide training and PD. Time for staff to undertake training or PD equates to time taken away from service delivery and productivity. It is often difficult for time-poor staff to undertake training or PD.

Service managers indicate that for training or PD to be of benefit, these must be relevant to the staff's scope of practice, and of sufficient technical quality. Training or PD that does not fulfil these requirements are a drain on time and money. Additionally, there are some staff who are disinterested and unwilling to engage unless training or PD is compulsory.

Over 87% of frontline workers (n = 95) claim that their organisation provides PD opportunities to staff. Funding and resource constraints are the main reason why organisations do not provide PD opportunities (15%). Most workers agree that the PD opportunities offered are relevant to their role. Less than 10% of workers indicate that they can choose their own training/PD opportunity. In total, 13% of workers considered the provision of supervision as an opportunity to foster PD. Other common PD opportunities include vocational qualifications (e.g., Certificate III in Community Services, Certificate IV in Mental Health), MHFA and topics relating to mental health, and alcohol and drugs. Leadership/management training and cultural competence were also mentioned.

The use of online platforms for training

Over 87% of service managers acknowledged that online training is a feasible, and often cheaper and more accessible, option to provide training and PD to staff. Face-to-face training or PD remains highly regarded. While popular, some service managers highlighted that certain topic (those that requires human interactions), if delivered online, may have less favourable learning outcomes than face-to-face training. A small proportion (13%) of service managers felt online training was not a feasible option for their staff and raised concerns on the suitability of online training as it allows for distractions and interruptions, lacks the ability for staff and trainer to build rapport conducive to learning, and may not be a beneficial learning method for all staff.

Career pathways of the workforce

Service managers identify numerous pathways for frontline workers to enter the community mental health and wellbeing sector. These include:

- From other community mental health and wellbeing service providers
- People studying towards relevant or related qualifications
- Placement students and graduates from university or RTOs

Most service managers state that frontline workers generally undertake further study to progress professionally.

Career advancement is important to staff engagement, satisfaction, productivity, and retention. Professional progression helps foster a culture of knowledge-sharing and allow for role gaps to be filled internally. The most common career advancement pathway for frontline workers is to become a team leader, support coordinator or manager. Other advancement options include advancement in the same role (i.e., support worker to senior support worker, facilitator to group facilitator, practitioner to advanced/senior practitioner) and further study to complete a qualification. Some service managers indicated that there is limited opportunity to progress or advance due to the size or flat organisational structure of the service provider.

Nearly 60% of service managers believe that frontline workers seek management roles. They report that management and leadership courses and qualifications (e.g., Diploma of Leadership and Management) are commonly undertaken to build leadership skills and are seen as a one of the prerequisites to career advancement. This correlates with responses from frontline workers in which two-thirds of workers claim they are interested in seeking advancement prospects. These include the progression/advancement to a management, supervisory or coordination role, support coordinator, supervisor, or manager. Internal horizontal career moves, such as transfer to another role or team, is also common.

Three quarters of frontline workers surveyed believe that career progression opportunities exist in their organisation. These include the progression/advancement to a management, supervisory or coordination role, such as team leader, support coordinator, supervisor, or manager. Internal horizontal career moves (e.g., transfer to another role, team, or program) is also common. These are seen as an avenue to upskill and gain the experiences and knowledge required to progress their career path in the future. However, many noted that any advancement or horizontal career moves is limited to funding and position availability within the organisation. Only a quarter of service managers indicate that their organisation provides in-house training on management/leadership skills.

Peer support workers

Half of the service managers surveyed indicated their organisations employs peer workers.

Recruitment

The majority of the organisations who employ peer support workers reported having recruitment strategies in place specific to these workers. In addition to conventional recruitment methods, organisations will advertise positions in the peer support community (e.g., the Peer Participation in Mental Health Services network) and involve a peer support worker coordinator or consumer representative in the recruitment process.

Qualification

Vocational qualifications are the most common qualifications peer support workers hold. Certificate IV in Mental Health, Certificate IV in Mental Health Peer Work are the most common qualifications, while related qualifications in Individual Support and Community Services were also mentioned. Given the role of a peer support worker, lived experience is a requirement for the position. Experiences working in the mental health or related fields is also highly regarded.

More than half (57%) of service managers indicated that the abovementioned qualification(s) do not adequately equip peer support workers in their role. Service managers that provided further explanation suggested ongoing PD opportunities, support, mentorship and supervision were required.

Career advancement

The majority (70%) of service managers[2] believe that peer support workers seek career advancement. Progression to a higher-ranking position is a common career advancement pathway (for example, senior peer support worker, team leader or manager). However, career advancement can also take other forms. This may include further training or study towards a higher qualification or seeking more secure employment, such as changing to a role that does not require a lived experience (e.g., counsellor, youth worker) or more permanent work status (many peer support workers are employed on a casual basis).

COVID-19

Service providers were asked to describe the impacts of COVID-19 on their workforce. Experiences of service delivery changes were different amongst service providers – some experienced an increase in service demands and funding and had growth in staff numbers, while others saw a decrease in client demands and had to make staff redundant.

To comply with COVID-19 restrictions, many organisations asked staff to work from home and changed rostering/staffing and service delivery practices (e.g., rotating teams on site) to ensure staff safety. All service providers adopted, or increased their use of, technology and online platforms to engage and support clients using video meetings/chats, telehealth, and other telecommunication channels. Responses are mixed regarding the use of technology to deliver support and services – some clients liked the convenience and autonomy, while others were negatively impacted with the reduction of

[2] This question had a 46% response rate.

worker-client contact and struggled with the decrease in face-to-face service delivery. Some service providers found it challenging to procure and assemble equipment for staff, and in some client's cases, to use technology to connect.

Service managers reported that the changes incurred by COVID-19 have had both professional, social, and personal impacts on staff. Work-related adjustments such as working from home, technology usage, mask wearing, and workload fluctuations have increased stress, anxiety, and fatigue levels. Professional isolation, lack of interactions with, and support from, colleagues, and concerns about COVID-19 impacted on the mental and social wellbeing of staff. Some workers reported setbacks in their own mental health recovery journey during this period.

To operate, service providers were required to have a COVID-Safe plan and ensure that staff have had relevant training. Service managers highlight that their organisation provided in-house COVID-19 related training or have had staff complete government training on COVID-19. All the COVID-19 related training needs identified by service managers reflect the reality of the pandemic, government requirements and the use of technology to support clients. These include:

- Training on COVID-safe practices, including basic hygiene and record management training.
- Training on workplace health and safety.
- Use of technology (e.g., online meeting platforms, telehealth, teleconsultation) to engage with and support clients.
- Ways to ensure and promote staff and clients' mental and physical health during COVID-19 (e.g., resilience training, education on COVID-19 to eradicate misunderstanding and misinformation).

COVID-19 requirements and changes to service delivery have direct impacts on the day-to-day work of frontline workers. When asked whether COVID-19 has instigated additional training needs, 102 workers provided responses. While 70% of workers did not identify any COVID-19 related training needs, infection control and the delivery of services and support, and engagement of clients, using telehealth technology are identified as areas requiring further training due to COVID-19 by the remaining 30% of frontline worker participants.

NDIS

The majority of service managers surveyed work in organisations that provide services under the NDIS, with just over one third of frontline respondents indicating that they work in NDIS services. Service managers agree that the implementation of the NDIS has increased business and employment opportunities in the sector while half of the frontline workers believe that their work has been impacted by the implementation of the NDIS.

Funding

The NDIS fee-for-service funding model differs greatly from the previous block funding model and negatively impacts the viability of the sector. Service managers reported low NDIS profit margins, and difficulty in establishing cost parameters for particular care functions or services due to inadequacies in the NDIS pricing model. It is often challenging for a service provider to predict work, forecast income and manage staff (e.g., rostering, employment) due to the inability to predict client demand and service requirements as clients can cancel their support or usage of a service provider at a relatively short notice. In addition, workers' wages and work conditions are not adequately covered under the

current NDIS pricing schedule due to the disconnection between the NDIS price guide and the SCHADS Award. These limitations have shaped the sector such that the majority of NDIS frontline workers employed on a casual basis have a poor work-life balance. Coupled with the increased workload associated with NDIS administration, burnout, stress, and other negative psychological impacts, this has resulted with in uncertain work conditions and high work intensity.

Service managers indicate that the absence of institutional support, coupled with the fee-for-service funding structure, limits the ability of service providers to deliver non-NDIS funded services or activities (e.g., conduct staff meetings and supervision, undertake business administration, provide staff training) that are not directly related to service provision, or do not provide financial reimbursement/assistance for organisations to undertake costly administrative activities associated with the operation of the NDIS (e.g., NDIS accreditation). Many organisations have incurred substantial costs and overheads in order to meet NDIS accreditation requirements.

Exactly 50% of frontline workers surveyed state that the NDIS has had an impact on their role and work. Frontline workers expressed concerns that the new funding system has resulted in reduced job security as organisations are forced to reduce costs (e.g., shifting to more casual employment), and workloads have increased by as much as 50%, impacting on service outcomes.

Understanding and navigation of the NDIS

Both service managers and frontline workers highlighted the need for more training to better enable workers and their clients to navigate the NDIS system and improve service delivery, for example: These include:

- Training on NDIS operation, structure, funding model, price schedule and administration.
- Understanding of “choice and control” as specified under the NDIS and what this means for both clients and service providers.
- Ways to comply with NDIS requirements and financial administration (e.g., bookkeeping skills).
- Skills to empower and support clients to continually gain independence and prowess, under the NDIS capacity building model.
- Understanding of mental health (e.g., mental health conditions, ways to support people with mental illness) and other disability-specific skills to work with individuals with disability, and their family/carers.
- Support coordination skills.

HR

Service managers reported a lack, and related recruitment and retention challenges, of qualified and experience staff to work in the NDIS. Budgetary constraints have hindered service providers’ ability to provide training, support, and supervision to staff and this further exacerbates staff attrition, and increases workforce shortages. Due to this shortage, many service providers must undergo the resource and labour-intensive exercise of constant staff recruitment. The poaching of experienced staff by competing service providers is not uncommon, as is the recruitment of staff with no/limited qualification/experiences to deliver services under the NDIS.

Client support

Frontline workers indicated that one of their biggest challenges relates to their ability to support clients with their NDIS applications and assessments. In many instances, both workers and clients have poor understanding of the NDIS, limiting their ability to successfully navigate the system. The time and effort taken to assist clients with their NDIS applications is an added constraint on their work. The overall pressures on workers to maintain high client numbers was another issue of concern as it meant they had less time to support clients towards recovery.

> ***"I feel more pressured to just keep a client "happy" rather than do meaningful work in a recovery model. There is pressure to keep people on the books so they can be billed than build a client's independence, so they don't need the organisation."***
> [Comment from frontline worker]

Working with different client population groups

The service providers consulted in this Project provided community mental health and wellbeing services to a broad range of population groups. These included:

- Aboriginal and Torres Strait Islander individuals.
- People from CALD backgrounds.
- Young people (15 to 24 years old).
- Older people (>65 years old)
- LGBTIQ+ individuals.
- People with co-existing alcohol and other drugs concerns.
- People living in rural and remote areas.

Some service providers also worked in niche areas, such as perinatal mental health, people <15 years old, temporary visa holders, refugees, and people living in institutions.

Service managers indicate that it was often difficult to recruit workers to appropriately support the abovementioned population groups. Given the complexity and differences that exist between and within CALD communities, it is hard to find a CALD worker who can work across multiple cultural groups.
Stigma, and the lack of cultural sensitivity, are challenges when working with people. Stigma of clients against staff from certain cultures, and vice versa, prevents the effective delivery of services and supports. This is further worsened by the lack of cultural awareness amongst staff, and limited

available training and resources, to allow the delivery of culturally appropriate services to those who need it.

"Can be stigma against staff who are, or who supports CALD & LGBTIQ, from clients who are not from these groups."
[Comment from service manager]

Satisfaction in the community mental health and wellbeing sector

This section examines the reasons why service managers and frontline workers choose to work in the field. A total of 46 service managers and 102 frontline workers responded to this section. For both groups, the main reasons include wanting to help (e.g., make a difference/difference) those who are vulnerable and/or in need, lived experience and an interest/passion in the sector. Other motives listed by the two groups vary. Service managers' report study and/or experience in the mental health field and a desire for social justice and advocacy while frontline workers highlight enjoyment of working with people and wishing to make a positive difference as other reasons why they are working in the sector.

Both groups were asked what they enjoy the most, and wish to change, about their jobs to shed light on the positives and negatives of working in the industry. The attributes deemed most enjoyable compliment the abovementioned motivators of working in the sector. For service managers, the ability to work collaboratively, and making a positive difference in the lives of others are highly ranked as the most enjoyed attributes. This followed by other features include personal growth, the ability to grow the team, job autonomy and variety ("every day is different"). Frontline workers report attributes that relate more closely with their interactions with clients, such as supporting the achievement of constructive results for the people they work with. This includes accomplishing positive outcomes, people realising their goal(s), or seeing the person they support recover, change or grow in the support journey.

Service managers are further asked about what they would like to change about their job or sector. An increase in funding, resources and training for workers coupled with higher remuneration, were cited most. Better organisational structure and processes, improved HR management, reduced workload and less NDIS-led focus on productivity/output are also features that require further optimisation.

Overall, 96% of service managers and 90% of frontline workers would recommend the community mental health and wellbeing sector to others. The rewarding and meaningful nature of the work was the most cited reason and reflects the above-mentioned motivators for both groups choosing to work in the sector. Service managers also added that the sector is more suited to those with the right values and passion (i.e., wanting to make a difference).

Nearly all of the participating service managers (98%), and frontline workers (93%), do not have plans to leave the sector in the near future. Poor job satisfaction, lack of employer support and the lack of career pathways are the cited as core reasons why some people may leave. Only a small number (n =

12) of the frontline workers surveyed indicated that they plan to leave the sector in the next 12 months, citing reasons such as wishing to pursue private work/explore other career pathways, racism/injustice, poor job satisfaction, limited career progression opportunities and the inability to assist clients as needed.

Section 5: Discussion and recommended actions

5.1 The community mental health and wellbeing workforce profile in Queensland

The information collected in this Project provides a snapshot of the Queensland community mental health and wellbeing workforce in relation to their age, years of experience in the sector, educational backgrounds, contracted engagement, and the types of services they are delivering.

Our Project data indicates that the Queensland community mental health and wellbeing workforce are mostly female (70%), of an older age demographic (60% over 40 years old) and relatively new to the sector (55% > 5 years). The surveyed workforce is highly qualified, with 60% holding vocational qualifications and 74% university qualifications - some holding multiple qualifications. The wide range of qualifications held - from Certificate III to master's qualifications reflects the diversity in the workforce and roles and services provided by the community mental health and wellbeing sector in Queensland.

Just over half of participating organisations indicated they provided mental health supports and services as their primary function. Most frontline workers worked as mental health support workers, recovery support workers and support coordinators/facilitators. 20% of the workers indicated that their position is a designated lived experience role. Mental health support (group or individual), counselling (group or individual), suicide prevention, accommodation support and alcohol and other drugs support were the most common services provided by frontline workers, followed by peer, employment, suicide, and homeless support.

These Project findings mostly complement those recently conducted in other states and territories. A NSW survey reported a similarly high percentage of female staff, high proportion of staff with tertiary and vocational qualifications and limited experience in the sector (Ridoutt and Cowles, 2019) However, the age distribution of the frontline workers who participated in the Queensland consultations was older than those found in NSW where two-thirds of the workforce were under 45 years of age (Ridoutt and Cowles, 2019). Western Australia also reports a diverse and highly qualified workforce, the majority of whom hold vocational or university qualifications (Penter et al., 2017).

The Queensland consultation indicates that people are highly satisfied with the work they do. Workers discuss the rewarding and meaningful nature of the work, as reasons that over 93% of respondents would recommend working in the sector to others and state they not have any plans to leave in the near future.

Services managers and frontline workers both referred to the existence of a large casual workforce in the Queensland sector. Lack of employment security was cited as a product of short-term funding contracts and the NDIS fee-for service financial model. This commentary matches some of the current literature which evidences a highly casualised workforce with high staff turnover rates.

Our Project data indicated that 63% of the surveyed workforce held permanent positions (full time and part time), 21% were employed on temporary contracts and 14% were casual workers. Recent NSW data on the workforce shows that over half of the NSW workforce are employed on a permanent basis (Ridoutt and Cowles, 2019).

Despite people expressing high levels of satisfaction in the work they do and describing no plans to exit their positions in the short term, the data collected suggests that workers are not remaining long in their roles. Over half of all workers surveyed indicated they were new to the sector, indicating a high staff turnover. Short term funding cycles, comparatively low remuneration, and limited training and supervision opportunities all contribute to staff attrition and the need for ongoing burdensome recruitment and onboarding processes.

5.2 Existing issues, challenges and opportunities

The key challenges relating to the workforce that were identified in Queensland generally reflect those referenced in the available literature. These include:

Workload, stress, and burnout

Work in disability and aged care, as well as the wider community services industry, is characterised by high levels of occupational stress. Despite the fact that the health and community services industry employ just about 10% of the Australian workforce, it has the highest rate of workers compensation claims for psychological distress, accounting for 20% of all claims (Cortis et al., 2013).

A significant number of frontline workers surveyed for this Project, discussed issues of workloads, stress, vicarious trauma, and burnout. High workloads, under-resourcing in the sector, the challenges of working with clients with complex disorders and co-morbidities and dealing with trauma were reported. Juggling a heavy workload whilst struggling to achieve productivity goals, according to many frontline workers, has been detrimental to their stress levels and capacity to maintain a healthy work-life balance. This issue is compounded by what frontline workers describe as inadequate support and supervision (impeded by inadequate funding contracts) and lack of employment security.

This issue of high stress levels is one well known to service managers who rated supporting staff wellbeing as one of the top challenges they face. Organisations identified multiple approaches to supporting mentally health workplaces and managing workplace stress. These included: Employee assistance programs; training on self-care and mental wellbeing; development opportunities to increase skills and confidence in roles; encouraging reflective practice; regular team meetings and team building activities; flexible work arrangements and leave entitlements. Further investigation of this issue is warranted given the scale of the issues reported.

Recruitment and retention of qualified and experienced staff

A shortage of experienced and qualified staff remains the biggest issue for service providers when recruiting. Unfavourable sector-wide work conditions related to low remuneration and employment instability means that qualified/experience staff often leave the sector to work in government or private domains. High staff turnover and low retention result in a loss of service continuity, greater expenses for employers, and an increased workload for remaining employees (Cleary et al., 2020).

More than just increasing efforts and resources to enhance recruitment and retention is required. Strategies to address the professional and socio-economic factors involved in staying, or leaving, the job and sector must also be addressed to enhance recruitment and curb attrition. Proper address of the factors mentioned by participants in this Project including better pay, contract stability, training and PD opportunities and clear career pathways will ensure that the workforce is retained and incentivised to take up, and continue, to work in the sector. In rural and regional areas, focus also

needs to be on addressing “personal” factors to attract new workers. “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” (Cleary et al., 2020, p.46).

Quantitatively, attracting more people to a career in the community mental health and wellbeing sector is a logical step in ensuring an increase in recruits for the sector. From an entry level, the promotion of the community mental health and wellbeing sector to secondary school students, undergraduates, graduates, and the existing workforce, as an attractive career choice is a practical way to increase sector exposure (Cleary et al., 2020). This marketing should be tailored to local needs and aimed to address the current, or potential, workforce shortage to encourage people to pursue a career in the relevant/needed fields. The availability of incentive programs and education subsidies will also play an important part in attracting interested individuals to undertake the relevant education (e.g., increase in student intake, placement, and graduate programs) to enter, and the existing workforce to partake additional trainings in, the workforce (Cleary et al., 2020).

Knowledge gaps and training needs

Vocational (e.g., Certificate IV in Mental Health, Certificate IV in Mental Health Peer Work) and tertiary qualifications (e.g., Bachelor of Human Services, Social Work and Psychology) are highly valued in the Sector. However, despite 96%of workers surveyed holding formal vocational and university qualifications, one of the largest challenges identified by mangers was their lack of mental health specific knowledge and practical experiences. Basic education on mental health conditions and how best to support people who experience mental illness was reported as essential workforce knowledge but lacking in those entering the community mental health and wellbeing workforce.

Specific training needs and gaps were clearly identified as part of this Project. Topics including recovery oriented practice, trauma informed care, responding to complex and co-existing needs, managing risks, crisis management and the provision of culturally appropriate services were the most often identified by respondents. Leadership and management training was flagged as desirable by frontline workers for whom career progression was most achieved through advancement to a coordinator or team manager role. Some frontline staff also reported poor management support and practices in their organisations as one that they found very challenging.

NDIS

The impacts of the NDIS on the community mental health and wellbeing workforce have been substantial. Much commentary already exists about the impact on the sector. In this Project, managers and frontline workers discussed the very real impact it had for them. Most of the issues and challenges identified by them are either directly attributed to or compounded by the introduction of the Scheme.

Whilst the implementation of the NDIS has increased business and employment opportunities in the sector, the fee for service model has seriously impacted the ability of service providers to offer secure and satisfactorily remunerated employment. The Pricing Schedule is not adequate to provide suitable working conditions, including supervision and training, and has created a shift to casual employment. Workloads for staff have increased significantly. The sector discusses a “divide” that exists between its NDIS services and workforce, and services that are funded through other sources. They see the

disability model of the NDIS as completely different (and even at odds with) the recovery, independence, and wellbeing focused models they provide outside of the scheme.

The NDIS created significant training requirements for organisations to comply with standards and understand the pricing and service model along with training frontline workers. Staff being recruited from the disability sector and those with generic disability qualifications (e.g., Certificate III Individual Support) require training to understand the specific needs of people receiving psychosocial supports. It is also not uncommon to recruit staff to work in the NDIS with no formal qualifications, particularly in rural and remote regions where there is a lack of qualified applicants. Service providers have weathered the costs of this training. Service managers believe that the constant changes to, and the complexity of, the Scheme makes it difficult for both staff and clients to navigate and use effectively. Frontline workers indicated that one of their biggest challenge relates to their ability to support clients with their NDIS applications and assessments. In many instances, both workers and clients have poor understanding of the NDIS, limiting their ability to successfully navigate the system.

5.3 The impact of COVID-19 on the workforce

Service Providers reported very mixed experiences relating to the impact of COVID-19 on the workforce. Increase in service demands and funding lead to growth in staff numbers for some, whilst other saw a decrease in demand and some staff were made redundant.

Work-related adjustments such as working from home, technology usage, mask wearing, and workload fluctuations increased stress, anxiety, and fatigue levels of the workforce. Professional isolation, lack of interactions with, and support from, colleagues, and concerns about COVID-19 impacted on the mental and social wellbeing of staff. Some workers reported setbacks in their own mental health recovery journey during this period.

Whilst the anticipated workforce surge did not eventuate, QAMH worked with CSIA to review and refine their job matching platform to support its applicability and usefulness to community mental health and wellbeing providers. Discussions between QAMH and CSIA project teams on sector specific roles and qualifications ensured applicants could be more successfully matched with providers seeking new workers. All participating managers indicated that they were not aware of the Job Matching platform, so CSIA were invited to present at a QAMH Members Forum. QAMH has also promoted the platform in their newsletters to members and via Social Media posts.

5.4 Training and career pathways

People enter the community mental health and wellbeing sector following completion of a wide range of vocational or university qualifications and there is consensus that further study and experience can lead to career progression, either within the organisation (as a more senior worker or manager) or with another community provider. Progression may be limited by the size or flat organisational structure in the organisation, though three quarters of frontline workers surveyed indicated that career progressions was possible within their own organisation. Horizontal career moves also support the development of new skills and experiences. Training supports promotion to leadership and management roles, but only 25% of the services participated provided these opportunities to workers “in-house”.

Diversity in the qualifications, experience and roles within the workforce community mental health and wellbeing sector in Queensland, indicates the need for multiple training pathways. The sector faces the challenge of retaining a workforce in an environment where occupations, workplaces and the skills associated with them, are continually being transformed. Diverse and flexible pathways for skills formation, development and progression are vitally important for industry to be able to develop and maintain a skilled and adaptable workforce.

5.5 Recommendations

This Project has provided a snapshot of the profile of the Queensland community mental health and wellbeing workforce and highlighted the significant number of workforce challenges being experienced by the sector. These issues are not unique to Queensland and most have existed in our sector for many years. Some issues have become more prominent with the introduction of the NDIS and the accompanying increase in people working in the sector. Resolving the issues identified will not be a simple process. Action at the federal, state, service provider and worker level, involving funding, education, and employment institutions is required.

QAMH has identified some actions below that could support the challenges identified in this report to be addressed. These actions were discussed and workshopped at the Project Launch Event on June 23, 2021. Attendees rated workforce challenges as "very important" and "critical" to solve now and agreed that there were feasible solutions available to address these. Work with the QLD sector and commissioning bodies to enable more detailed and regular collection of workforce data in the future. This will allow the examination of workforce trends and provide the ability to review the effectiveness of initiatives actioned as a result of data collected.

We look forward to collaborating further with our member organisations to prioritise and facilitate these actions.

1. **Continue to advocate for funding models and contracts** that:
   - are Longer in term (5 years)
   - allow for the fair remuneration of the qualified workforce
   - include the realistic costs associated with recruitment and onboarding of staff
   - include adequate costs associated with staff training and supervision
   - include costs to evaluate / demonstrate effectiveness of services
   - enable services to be provided to people early in episode
   - consider the specific needs of CMO's operating in rural and remote areas and additional costs to provide all of the above

2. **Recruitment and retention**
   - Promotion of the sector as a career of choice**:** Identify opportunities to promote of the community mental health and wellbeing sector to secondary school students, undergraduates, graduates, and the existing workforce, as an attractive career of choice
   - Challenge Stigma and focus on values alignment in promotional activities.
   - Explore innovative recruitment and retention approaches further – consider remote supervision, joint appointments, collaborative recruitment and training.
   - **Continue to work with CSIA to refine the job matching platform, supporting its applicability to the community mental health sector and promoting its value**

3. **Qualifications**
   - Ensure there are no barriers to accessing entry level qualifications – e.g. Certificate IV Mental Health and Certificate IV in Mental Health Peer Work and explore options to overcome these barriers where they exist.
   - Support the ongoing review of vocational qualifications (Cert IV Mental Health, Cert IV Mental Health Peer Work) to ensure they best equip the workforce to perform their roles
   - Define the role and skillsets of the workforce to inform the review of vocational qualifications and development of and further training opportunities
   - Explore initiatives to enhance capability of service providers to offer quality placement opportunities which will support the transition of knowledge into practice

4. **Training:**

Lead Sector wide training initiatives to enhance workforce practice in identified areas of need:

- **Entry level Practice Skills** – Mental Illness, Recovery Practice, Professional Boundaries, NDIS and psychosocial supports
- **PD** – Trauma Informed Care, responding to complex and co-existing needs, managing risks, crisis management, provision of culturally appropriate services,
- **Leadership and Management training** – to support Career Progression Pathways

Training delivery modes to include face to face and online webinar sessions

5. **Staff wellbeing:**

Explore sector wide approaches to supporting staff wellbeing

5.6 Limitations

The data captured in this Project is intended to a high-level snapshot of the Queensland community mental health and wellbeing sector. There are several limitations associated with this Project. Firstly, the scope of this Project was limited to member organisations of QAMH. Across Queensland, a total of 39 QAMH member organisations were consulted with and constituted over 56% QAMH members at the time of the Project. Four non-member organisations participated in the Project thanks to volunteering, or because they could provide unique insights into certain client populations (9%). Based on the number of organisations consulted, the data may not be a true representation of the sector and results should be interpreted as generalisations.

Secondly, an employer (service provider) survey represented the most viable option to collect workforce data in the sector due to the absence of a more comprehensive and routinely collected data set. The use of an employer survey is a common, yet imperfect, method to undertake workforce research as its accuracy is highly dependent on population sampling. Over the course of the Project, multiple attempts were made to maximise the response rate through promotion of the Project and surveys through QAMH's communication channels, namely members forums, websites, and electronic newsletters.

Thirdly, the nature of these surveys is self-reported data. Participants were able to choose which questions they wish to complete as none of the questions were compulsory for survey completion.

Due to this, there was different response rates across the questions, and the data collected may not be representative of all participants. Furthermore, varied interpretation of questions and data items could lead to incorrect and/or inconsistent answers amongst participants. This is particularly relevant with the data collected from frontline workers and HR managers as they completed their respective online surveys independently. The flawed answering from the HR managers' survey is testament to this.

References

Australian Institute of Health and Welfare. (2018). *Health and Welfare Expenditure Glossary.* *https://www.aihw.gov.au/reports-data/health-welfare-overview/health-welfare-expenditure/glossary*

Andresen, R., Oades, L., & Caputi, P. (2003). The experience of recovery from schizophrenia: Towards an empirically validated stage model. *The Australian and New Zealand Journal of Psychiatry*, *37*(5), 586–594. https://doi.org/10.1046/j.1440-1614.2003.01234.x

Black Dog Institute. (2020). *Mental Health Ramifications of COVID-19: The Australian context.* http://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/20200319_covid19-evidence-and-reccomendations.pdf

Bryne, L., Roennfeldt, H., & O'Shea, P. (2017). *Identifying barriers to change: The lived experience worker as a valued member of the mental health team.* Queensland Mental Health Commission. https://www.mhcsa.org.au/wp-content/uploads/2018/12/Identifying-barriers-to-change-final-report.pdf

Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L. (2019). *Queensland Framework for the Development of the Mental Health Lived Experience Workforce.* Queensland Government: Brisbane https://www.qmhc.qld.gov.au/sites/default/files/qmhc_lived_experience_workforce_framework_web.pdf

Cleary, A., Thomas, N., & Boyle, F. (2020). *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*. The University of Queensland. https://www1.health.gov.au/internet/main/publishing.nsf/Content/529E1CB9E69E34C9CA25857300087D51/$File/NMHWS%20-%20Literature%20review.pdf

Commonwealth of Australia. (2006). A national approach to mental health: From crisis to community. Select Committee on Mental Health. https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/index

Community Mental Health Australia. (2012). *Taking our place: Working together to improve mental health in the community*. https://cmha.org.au/wp-content/uploads/2017/05/cmha-taking-our-place.pdf

Community Mental Health Australia. (2015). *Developing the workforce*. https://cmha.org.au/wp-content/uploads/2017/04/ndis_workforce_report.pdf

Community Mental Health Australia. (2018). *Continuity of support* [Position statement] https://cmha.org.au/wp-content/uploads/2017/04/CMHA-Coninuity-of-support-position-statement-2018.pdf

Department of Health. (2007). *What is mental illness?* *https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-w-whatmen-toc~mental-pubs-w-whatmen-what#:~:text=A%20mental%20illness%20is%20a,and%20interacts%20with%20other%20people*

Department of Health. (2013). *A national framework for recovery-oriented mental health services: Guide for practitioners and providers.* Australian Health Ministers' Advisory Council. https://www.health.gov.au/sites/default/files/documents/2021/04/a-national-framework-for-recovery-oriented-mental-health-services-guide-for-practitioners-and-providers.pdf

Department of Health. (2019). *Head to health: Connecting with community.* https://headtohealth.gov.au/meaningful-life/connectedness/community

Fair Work Commission. (2021). *Social, community, home care and disability services industry award 2010.* https://www.fwc.gov.au/documents/documents/modern_awards/award/ma000100/default.htm

Foreman, E., Perry, C., & Wheeler, A. (2015). Higher education scholarships: A review of their impact on workplace retention and career progression. *Open Review of Educational Research*, *2*(1), 155–166. https://doi.org/10.1080/23265507.2015.1056220.

Gold Coast PHN. (2020). *Comprehensive non-clinical support services*. https://gcphn.org.au/patient-care/mental-health/non-clinical-support-services/

Health Workforce Australia. (2011, May). *Mental health non-government organisation workforce project* [Final report]. National Health Workforce Planning & Research Collaboration. https://www.voced.edu.au/content/ngv%3A53788

Health Workforce Queensland. (2014). *Health workforce needs assessment summary report.* http://www.mhcsa.org.au/wp-content/uploads/2018/12/HWA-Mental-health-Peer-Workforce-Study.pdf

Jacob, K. S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. *Indian Journal of Psychological Medicine*, *37*(2), 117–119. https://doi.org/10.4103/0253-7176.155605

Jones, N., Niu, G., Thomas, M., Riano, N. S., Hinshaw, S. P., & Mangurian, C. (2019). Peer specialists in community mental health: Ongoing challenges of inclusion. *Psychiatric Services, 70*, 1172–1175. https://doi.org/10.1176/appi.ps.201800552

Kemp, V., & Henderson, A. (2015). Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal, 35*(4), 337–340. https://doi.org/10.2975/35.4.2012.337.340

Mendoza, J. (2013, December 2–3). *The NDIS and mental health: Is this* really *such a great idea?* Integrating mental health and the National Disability Insurance Scheme conference. https://waamh.org.au/assets/documents/reports/resources/connetica-integrating-mental-health-and-ndis.pdf

Penter, C., McKinney, B., & Jones, M. (2017, July). *Workforce development in community mental health* [Project report]. Western Australian Association for Mental Health. https://waamh.org.au/assets/documents/sector-development/waamh-workforce-development-report.pdf

Productivity Commission. (2011). *Disability care and support* [Disability Commission Inquiry Report No. 54]. https://www.pc.gov.au/inquiries/completed/disability-support/report

Productivity Commission. (2020). *Mental health* [Productivity Commission Inquiry Report No. 95]. https://www.pc.gov.au/inquiries/completed/mental-health/report

QSR International. (2020). *QSR: NVIVO Version 10*. https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home/

Queensland Government. (2019a). *Caring for somebody with a mental illness*. https://www.qld.gov.au/health/mental-health/carers

Queensland Health. (2015). Connecting care to recovery 2016-2021: A plan for Queensland's state-funded mental health, alcohol and other drug services. https://www.health.qld.gov.au/__data/assets/pdf_file/0020/465131/connecting-care.pdf

Queensland Mental Health Commission. (2017, November 20). *NDIS: Where to from here?* https://www.qmhc.qld.gov.au/media-events/news/ndis-where-to-from-here

Queensland Productivity Commission. (2020). *Inquiry into the National Disability* Insurance Scheme market in Queensland. https://qpc.blob.core.windows.net/wordpress/2020/11/NDIS-market-in-Queensland-draft-report.pdf

Resika, K. C., Mallyon, A., & Petrakis, M. (2019). Community mental health staff perspectives of the impacts of transition to the National Disability Insurance Scheme (NDIS) on consumers, carers and workforce in Victoria. *Australian Journal of Community Work*, *1*, 1–14. https://www.acwa.org.au/wp-content/uploads/2021/01/AJCW-2019-2020-KC-Mallyon-Petrakis.pdf

Ridoutt, L., & Cowles, C. (2019). *The NSW CMO mental health workforce: Findings from the 2019 MHCC workforce survey* [Final report]. NSW Mental Health Coordinating Council. https://www.mhcc.org.au/wp-content/uploads/2020/01/WorkforceSurvey2020.pdf

Roberts, D., & Fear, J. (2016, April). *Psychosocial supports design project [Final Report].* National Disability Insurance Agency and Mental Health Australia. https://mhaustralia.org/sites/default/files/docs/psychosocial_supports_design_project_final_-_july_2016.pdf

Rosen, A., Gurr, R., Fanning, P. (2010). The future of community-centred health services in Australia: Lessons from the mental health sector. *Australian Health Review, 34*(1), 106–115. https://doi.org/10.1071/AH09741

Rosenberg, S., Redmond, C., Boyer, P., Gleeson, P., & Russell, P. (2019). Culture clash? Recovery in mental health under Australia's national disability insurance scheme: A case study. *Public Health Research & Practice, 29*(4), e:29011902. https://doi.org/10.17061/phrp29011902.

Sidlauskas, R. (2017, October). *Workforce training & development analysis report: Exploring the needs of the Victorian community mental health workforce training & development analysis* [Final report]. Psychiatric Disability Services of Victoria. https://www.mhvic.org.au/images/documents/Vicserv_Workforce_Analysis_Report_FINAL.pdf

Siskind, D., Harris, M., Buckingham, B., Pirkis, J., & Whiteford, H. (2012). Planning estimates for the mental health community support sector. *Australian and New Zealand Journal of Psychiatry, 46*(6), 569–580. https://doi.org/10.1177/0004867412443058

State of Victoria. (2021). *Royal commission into Victoria's mental health system: Final report: Summary and recommendations*. https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf

Thornicroft, G., Deb, T., & Henderson, C. (2016). Community mental health care worldwide: Current status and further developments. *World Psychiatry*, *15*(3), 276–286. https://doi.org/10.1002/wps.20349

Vandewalle, J., Debyser, B., Beeckman, D., Vandecasteele, T., Van Hecke, A., & Verhaeghe, S. (2016). Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. *International Journal of Nursing Studies*, *60*, 234–250. https://doi.org/10.1016/j.ijnurstu.2016.04.018

WorkAbility Qld. (2018). *Queensland workforce profile*. https://workabilityqld.org.au/wp-content/uploads/2021/03/WorkAbility-Qld-Queensland-Workforce-Profile.pdf

World Health Organization. (2003). *Organization of services for mental health: Mental health policy, plans and programs* [Mental health policy and service guidance package, updated Version 2].

https://www.afro.who.int/sites/default/files/2017-06/MNH%20Policy%20and%20plans_essential%20package.pdf

Wyngaerden, F. (2018). *Community mental health: Theory, practices and perspective*. The Government of the Grand Duchy of Luxembourg, Ministry of Foreign and European Affairs. https://d3n8a8pro7vhmx.cloudfront.net/handicapinternational/pages/3998/attachments/original/1536674568/Community_mental_health_-_theory__practices__and_perspectives_-_May_2018.pdf?1536674568