qamh
leading community mental wellbeing

Community Mental Health and Wellbeing Workforce

ISSUES PAPER

February 2023

Queensland Alliance for Mental Health

Acknowledgement of Country

QAMH acknowledges the Traditional Custodians of the land on which we live, learn, and work and recognises their continuing connection to land, waters and community. We pay our respects to them and their cultures; and to Elders past, present and emerging.

Recognition of Lived Experience

QAMH recognises that the Community Mental Health and Wellbeing Sector exists because of people with Lived Experience of mental distress, their families, carers and support people. We acknowledge the expertise and the courage of people with Lived Experience, and we commit to work with and alongside people with Lived Experience in all we do.

Abbreviations

AHPRA	Australian Health Practitioner Regulation Agency
ANZSIC	Australian and New Zealand Standard Industrial Classification
ANZSCO	Australian and New Zealand Standard Classification of Occupations
CALD	Culturally and Linguistically Diverse
DESBT	Department of Employment, Small Business and Training
LGBTIQ+	Lesbian, Gay, Bisexual, Trans and Gender Diverse, Intersex, Queer and Questioning
MHAODB	Mental Health Alcohol and Other Drugs Branch
NMHSPA	National Mental Health and Suicide Prevention Agreement
NMHSPF	National Mental Health Services Planning Framework
PHN	Primary Heath Network
QAMH	Queensland Alliance for Mental Health
RTO	Registered Training Organisation
VET	Vocational Education and Training

Background

Challenges relating to the employment of a suitably qualified and skilled workforce that is sufficient in size to meet demand remains one of the most important issues facing the Community Mental Health and Wellbeing Sector in 2023. Natural disasters, the Covid-19 pandemic, rising cost of living pressures and other socio-economic factors have meant that the demand for community mental health and wellbeing services has grown significantly. Yet the supply of workers to provide these services has not kept pace with the surging demand. As Queensland faces one of the tightest labour markets in recent history with very low unemployment, service providers are struggling to fill workforce gaps.

Importantly, workforce issues go well beyond attraction and retention of workers. The Community Mental Health and Wellbeing Sector needs a workforce that has the right mix of skills and knowledge, achieved through contemporary and high-quality training. It also needs to reflect the diversity that we see in the population of people accessing services, and be informed by people with lived experience. As the yet to be released interim report of the QIMR Berghofer / Griffith University's Systematic Analysis of the Mental Health NGO Sector showed, workforce issues are complex and multifaceted. They include the need to strengthen workforce skills and capabilities, improve workforce conditions so staff feel safe, supported and valued, ensure employment stability, encourage workforce diversity, and enhance career pathways.

Queenslanders are living through a time of major reform in the mental health system. The Productivity Commission's landmark report on mental health in 2020, the National Mental Health and Suicide Prevention Agreement (NMHSPA) and Queensland's Parliamentary Inquiry into the *Opportunities to Improve Mental Health Outcomes for Queenslanders* have led to the sense that we are on the cusp of transformational change. While this is heartening, it is also clear that to be truly effective, these landmark reforms all require a suitably skilled workforce underpinning them.

The yet to be released National Mental Health Workforce Strategy is a key commitment of the NMHSPA. At a state level, the Queensland Government has committed to focussed workforce planning under *Better Care Together* as part of its response to the Parliamentary Inquiry recommendations. In fact, "improving workforce capability and sustainability" has been highlighted as one of the Queensland Government's six key priorities in this document. QAMH would like to ensure that the Community Mental Health and Wellbeing workforce is considered in this strategic planning alongside, and as an equal to, the traditional clinical health professions – doctors, nurses, psychologists, occupational therapists and social workers.

For this purpose, QAMH has collaborated with Queensland Health's Mental Health Alcohol and Other Drugs Strategy and Planning Branch (MHAOD SPB) to develop a workforce strategy specific to our sector. Whilst workforce issues are being experienced across the mental health system, we believe distinctive strategies and actions will be required to address the challenges unique to the community

sector. Complex funding streams, a diversity of qualifications and training pathways, lack of recognition of the sector as a career option, and greater representation of lived experience (peer) workers means that the development of a separate workforce strategy is necessary for the Community Mental Health and Wellbeing Sector.

QAMH has released this Issues Paper to assist individuals and organisations to consider the problems and potential solutions for workforce challenges facing the Community Mental Health and Wellbeing Sector. It is expected this paper will form the basis of our state-wide consultation sessions.

Key Dates

18 November 2022	Draft Issues Paper released
27 January 2023	Closing date for submissions
28 February 2023	Final version of Issues Paper published
March – June 2023 • **14 March: Townsville** • **29 March Bundaberg** • **18 April: Ipswich** • **21 April: Online** • **9 May: Brisbane** • **23 May: Cairns** • **7 June: Mt Isa**	State-wide consultation sessions (online and face-to-face including regional events)
August 2023	Draft Workforce Strategy released
September – November 2023	Feedback on Draft Workforce Strategy
December 2023	Final Workforce Strategy published
February 2024	Action Plan published

Project Scope

The Community Mental Health and Wellbeing Workforce Strategy (the Strategy) will set out a coordinated approach to deliver the diverse, skilled and contemporary workforce required to deliver the reforms occurring in Queensland's mental health system. It will be generated through a collaborative process based on extensive state-wide consultation including online and face-to-face sessions. Engaging the perspectives of service providers, people accessing services, training providers, service partners and other stakeholders will be central to this process.

It will respond to policy directions in *Better Care Together* and a range of recommendations from recent reviews including:

- The Productivity Commission's Mental Health Inquiry Report 2020
- Queensland's Parliamentary Inquiry into the *Opportunities to Improve Mental Health Outcomes for Queenslanders*
- The Final Report from the House of Representatives Select Committee on Mental Health and Suicide Prevention
- The Mental Health Community Support Services Evaluation Report
- Evaluation of National Psychosocial Support Programs: Final Report
- The Community Mental Health Workforce Project
- Interim Report from QIMR Berghofer / Griffith University Systematic Analysis of the Mental Health NGO Sector (yet to be published)

Definitions

Defining the Community Mental Health and Wellbeing workforce is difficult for several reasons – a lack of consensus on terminology, historical lack of awareness of the existence of the sector, people with professional and clinical backgrounds performing non-clinical roles, and the recent introduction of the NDIS which has had the effect of orienting our sector with the disability care sector. Workforce definitions are, of course, much more useful if they align with available data. Unfortunately, most data capturing systems (eg. ANZSCO or NMHSPF) do not explicitly code for our sector and many emerging occupations such as lived experience (peer) workers are not yet captured in the data.

Taking these challenges into consideration, for the purpose of the Strategy, we have defined the Community Mental Health and Wellbeing workforce as: Workers employed by non-governmental,

not-for-profit, community-based organisations who provide non-clinical mental health recovery services in Queensland. They can include recovery support workers, psychosocial support workers, support coordinators, recovery coaches, consumer peer workers, carer peer workers, as well as those at managerial levels within these organisations. While we understand that many NGOs employ staff in clinical and non-clinical roles, we have limited our definition to the non-clinical workforce in this document as we feel this is the cohort missing from current strategies. This will, however, include staff from a variety of vocational and university qualifications (eg. Allied Health) but who are employed in non-clinical roles.

It is acknowledged that unpaid and informal carers make an important and valuable contribution to recovery, as well as being a valuable part of the care and support landscape. It is fundamentally important that families and unpaid carers, as part of a person's recovery, should be involved in workforce planning and design. However, including unpaid and informal carers as de-facto members of the workforce undermines the legitimate carer role, is exploitative and potentially dangerous.[1] For the purposes of the Strategy, the workforce refers to those workers in paid and formal employment. We appreciate the feedback received during the submission process and recognise that the status and conditions of unpaid carers is an area in need of further work which could be explored separate to the Strategy.

We respect and support Aboriginal and Torres Strait Islander self-determination in the design and delivery of mental health services. We also understand that Aboriginal and Torres Strait Islander people receive care within Aboriginal and Torres Strait Islander Community-Controlled Health Organisations, within mainstream services, or a mixture of both. But irrespective of where care is delivered, it is fundamental that it is culturally safe, inclusive, respectful and responsive. With this in mind, it has been decided that this Strategy will include workforce issues relating to mainstream services that deliver care to Aboriginal and Torres Strait Islander people. Extensive consultation with and inclusion of First Nations people will form part of the Strategy's development.

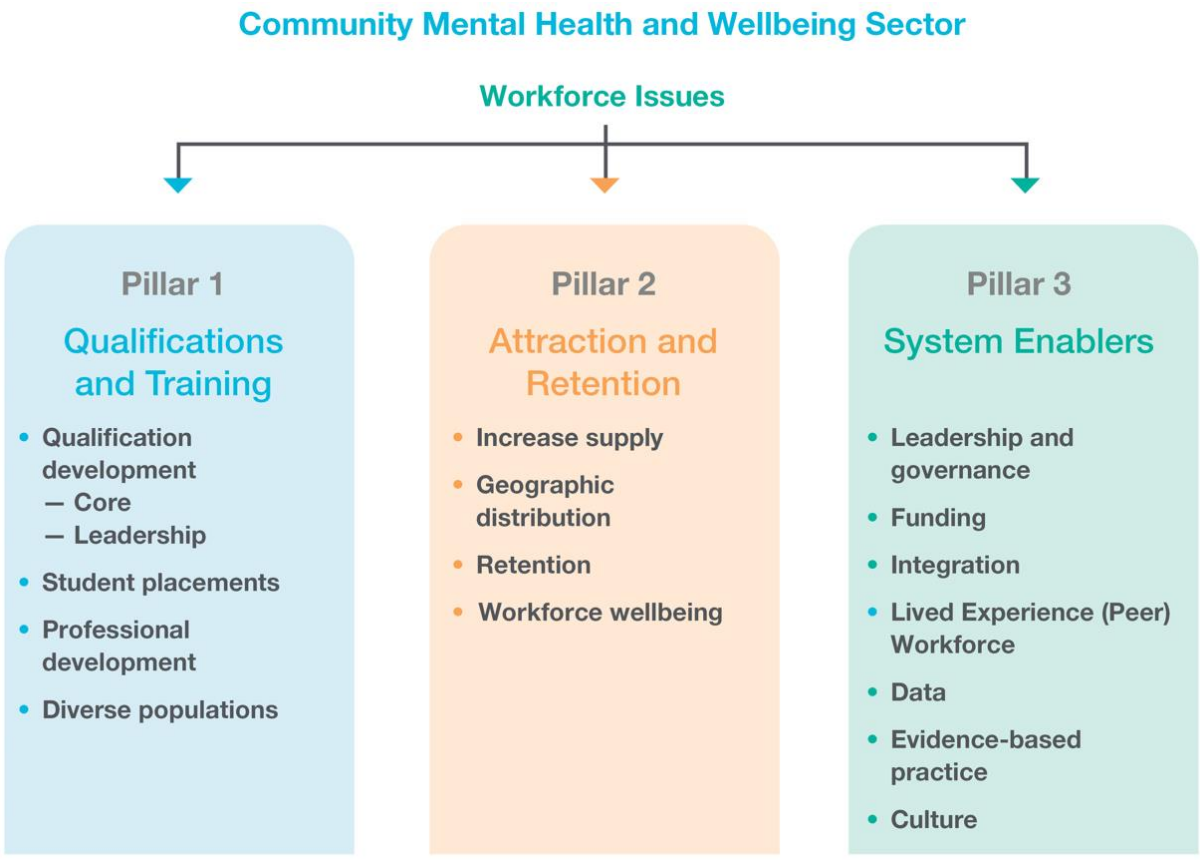
Putting Strategy into Action

QAMH is aware of the sector's disillusionment with the voluminous number of reports, reviews, plans, strategies and inquiries over the past three decades. We have been very vocal about the need to go beyond lengthy discussions to embrace authentic change across the mental health system. This commitment to practical application is reflected in the development of an accompanying Action Plan with key deliverables, assigned responsibilities and set timeframes that will help achieve the Strategy's objectives. The Workforce Strategy and Action Plan will be interdependent documents which will form part of a single overarching framework.

[1] Arafmi Submission to QAMH

Issues

This Issues Paper has been informed by evidence put forward in a number of inquires, reports and reviews, most notably the Productivity Commission's Mental Health Inquiry Report 2020 and Queensland's Parliamentary Inquiry into the *Opportunities to Improve Mental Health Outcomes for Queenslanders*. It is oriented around three key priorities or 'pillars' to guide the design and delivery of workforce reform. It is expected that the Workforce Strategy and accompanying Action Plan will also align with these three pillars.



Pillar 1 – Qualifications and Training

1. Qualification Development

a. Core Qualifications

QAMH's Community Mental Health Workforce Project (2021) found that 96% of surveyed workers held formal qualifications: Vocational qualifications (60%) and/or university qualifications (74%) ranging from Certificate III to Masters qualifications. Concerningly, nearly two thirds of service managers surveyed did not believe that these diverse formal qualifications adequately trained the workforce. Specific knowledge gaps included understanding basic mental health conditions and how best to support people who experience mental illness. Compounding this problem is the increasing complexity of presentations which services are now observing, due in part to the Covid-19 pandemic but also housing instability, cost of living crisis and other socioeconomic factors, which means that there is an ever-widening gap between essential and demonstrable skill sets that workers bring to the sector.[2]

While this diversity of educational pathways undeniably has benefits (eg. people bringing a heterogeneity of professional and educational knowledge to the sector), it also has its drawbacks. For instance, the lack of recognised core qualification for the sector (comparable to the nursing or allied health professions) means that workers don't come with a basic skill set to build upon. In 2022, QAMH developed a micro credential to address this specific gap, but broader strategic planning is required in this area. Without a flagship qualification, it is also difficult to promote the sector as a desirable career pathway to school leavers (see section on Attraction in Pillar 2).

There is a strong argument for standardising core qualifications so that workers have a sound foundational level of knowledge and skills. This would involve reviewing and possibly redesigning the current qualifications (Certificate IV in Mental Health / Peer Work) around an industry-agreed set of core competencies. Embedding "peer led, co-designed and co-delivered training modules"[3] within the Certificate IV curriculum is also something that needs to be further explored. It is anticipated that this process would result in a qualification that is both widely utilised and highly valued within the Community Mental Health and Wellbeing Sector. Importantly, any move to standardise qualifications should not be a barrier to employing people who are the right fit but are yet to attain the qualification. Exploring ways to train these people internally (possibly through a structured traineeship program) will be particularly important for regional and remote communities and is elaborated upon later in this paper.

[2] Wesley Mission Queensland Submission to QAMH
[3] Wellways and Mind Submission to QAMH

Beyond the Certificate IV qualifications, there are other vocational pathways that could be considered, such as new skill sets or microcredentials which may build towards a recognised qualification over time. QAMH has already collaborated with Workability Queensland (through CSIA) and TAFE Queensland to develop a microcredential specific to the psychosocial workforce, but there is potential for expansion to offer a full suite of similar level qualifications. Beyond the VET sector, we need to consider whether tailored university qualifications have a role for the Community Mental Health and Wellbeing Sector. Anecdotally, service providers have expressed interest in bachelor or graduate certificate/diploma level qualifications being developed specifically for the sector.

An important recent development has been the agreement between the Australian, State and Territory governments to fundamentally reform the Vocational Education and Training (VET) system in Australia. In December 2022, the Australian Government announced that HumanAbility successfully tendered for the Jobs and Skills Council to 'lead and drive' the performance of the VET system in the fields of health and human services, early education, sport and recreation.[4] QAMH hopes that this new system will elevate industry leadership in VET so industry can more effectively address current workforce challenges and shape qualification development, ensuring training is aligned to the skills that are in demand.

Possible Solutions

- Develop a Core Capability Framework which articulates the specific skills, knowledge, behaviors and attitudes for the Community Mental Health and Wellbeing Sector which can guide course content development / revision. This could also be used by organisations to guide reflective practice and support a self-assessment of knowledge gaps to inform continuing professional development requirements. This Core Capability Framework could consider key principles from *The Victorian Mental Health and Wellbeing Workforce Capability Framework*.
- Review and enhance the content, delivery and sector perception of the current Certificate IV in Mental Health / Peer Work, in authentic co-design with Lived Experience, to ensure it is contemporary and aligns with industry needs. This may include, among other things, inclusion of more lecturers who are currently practising to ensure up-to-date content.
- Develop a suite of accredited micro-credentials or skills sets that will enable workers to upskill. Explore how these learning activities could build towards a recognised qualification over time.
- Develop traineeships, in consultation with industry, to align with TAFE qualifications.
- Explore feasibility and appetite for developing new university qualifications specific to the Community Mental Health and Wellbeing Sector.

[4] Stronger, more strategic voice for vocational education and training for health | Australian Healthcare & Hospitals Association (ahha.asn.au)

b. Leadership Qualifications

While core qualifications are an immediate priority, the development of career-progressing qualifications is also essential. There is a current lack of courses targeting senior staff in the Community Mental Health and Wellbeing Sector, a challenge identified in QAMH's Community Mental Health Workforce Project. While those wishing to advance their career often complete generic leadership courses and qualifications (e.g., Diploma of Leadership and Management), it is concerning that there is no sector-specific training in this area. Ability First Australia and the Multicap Group have recently embarked on a project to invest in leadership capability. This resulted in developing a new qualification in collaboration with the University of New England called the Diploma of Disability Leadership. The Community Mental Health and Wellbeing Sector could consider a similar qualification which would help address a training gap and ensure we have strong and effective leadership at all levels of the sector.

Possible Solutions

- Develop a new qualification for those within the sector looking for career progression (eg. Diploma in Community Mental Health Leadership)

2. Student placements

The Community Mental Health Workforce Project found that service managers value the completion of practical placements during formal qualifications. In fact, they felt that the lack of structured placement opportunities in the courses has produced workers who lack the tacit knowledge and practical experience to perform the required work. Embedding more placement and supervision hours into the curriculum was seen as critical to ensuring graduates are equipped with the necessary skills to deliver services with confidence and effectiveness.

However, QAMH understands there are sector-wide barriers to securing placements for people completing Certificate IV in Mental Health / Peer Work.

- Service providers, who are already overwhelmed by heavy workloads and administrative burdens, feel they are unable to take on supervisory roles, especially when there is currently no financial support provided for the additional work required.
- The short duration of placements (currently 80 hours) does not enable students to fully integrate into teams or have deep learning experiences. Also, short placements are onerous for service providers as the labour-intensive onboarding has to occur more frequently.
- Placement coordinators at the Registered Training Organisations (RTOs) are often under-funded, overwhelmed and unable to provide the high level of coordination

required between student, service provider and RTO. This leads to service providers preferentially accepting bachelor students, finding the universities' placement programs easier to work with.

- As opposed to other disciplines such as Allied Health, Nursing or Medicine, where the responsibility for training students on placements is shared between the university and practical supervisor, in the Community Mental Health and Wellbeing Sector this delineation is less clear. Ideally, it would be a dual responsibility, with funding provided for both the RTO and service provider to ensure high quality training and supervision. This would have the additional benefit of bringing RTOs and industry closer together.

We know anecdotally that the resulting lack of available placements leads to students withdrawing from the Certificate IV qualifications. Balancing the need to increase student placement hours in the field, with a hesitancy of service providers to provide the necessary placement opportunities, will be a focus for the Strategy.

Possible Solutions

- Provide traineeships specific to the Community Mental Health and Wellbeing Sector
- Provide funding for both RTOs and service providers to collaboratively deliver training and practice supervision
- Review the length of student placements
- Advocate for better funded placement coordinators at RTOs
- Ongoing government funding for student mentors to coordinate student placement opportunities and offer students support.

3. Professional Development

Access to quality ongoing professional development opportunities is a key ingredient to a contemporary, highly-skilled workforce that is well equipped to meet the needs of people experiencing mental health challenges. This includes training opportunities directed at all job classification levels, from entry to managerial positions. We know that these opportunities not only increase job satisfaction and support wellbeing, but lead to worker retention. Strengthening workplace learning and training opportunities also provides a more immediate solution to knowledge and skills gaps identified in the Core Qualification section earlier, as there will inevitably be a significant time lag for any new qualification development or redesign.[5]

Unfortunately, as demonstrated by QAMH's Community Mental Health Workforce Project, there are systemic barriers to accessing professional development. Providers report that they struggle to provide necessary training to staff due to lack of time and resources – a situation made worse by the introduction of the NDIS with its inadequate fee-for-service model and pricing arrangements which fail to cover costs. Even where organisations support staff to attend training, there is the view that the professional development opportunities on offer are not sufficient to support workers in their current and future roles.

The Workforce Strategy will explore ways to address these challenges, as well as looking at innovative ways to develop staff beyond traditional training. For example, secondments, exchange programs, sabbaticals, coaching, mentoring and reflective practices can all deliver valuable learning experiences.[6] Another option to be explored is whether internal workforce educators should be funded rather than (or in addition to) external training consultants. Embedding educators within organisations has the potential to ensure training material is relevant, contemporary and addressing any specific skills gaps.

Finally, we know from the plethora of inquires, reports and reviews that we need transformational change which redesigns the mental health system. The Productivity Commission's report found that we need a system that focusses on prevention and early intervention, rather than the current reactive, crisis-driven system that is geared towards those with severe and persistent mental illness. QAMH's Wellbeing First report examines this urgent need for change and is a call to fundamentally shift the focus of our sector from managing illness to actively supporting wellbeing. This inevitably will need a workforce with a different skill set. We need a broader conversation about how to widen current scopes of practice that will better support innovative models of care in a transformed mental health system. This Strategy will explore how best to provide contemporary, relevant and high-quality professional development opportunities that fit with this reimagined future.

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[5] Purpose at Work Submission to QAMH
[6] Purpose at Work Submission to QAMH

Possible Solutions

- Establish a central 'repository' or database to coordinate learning and professional development activities across the whole sector to increase awareness of relevant training available
- Increase availability of professional development for those entering managerial / supervisory roles
- Integrate lived experience expertise in the design and delivery of professional development opportunities
- Consider embedding, at an organisational level, professional development opportunities beyond traditional training (eg. Secondments, exchange programs, sabbaticals, coaching, mentoring and reflective practices)
- Consider funding internal workforce educators to coordinate professional development opportunities
- Explore ways to provide contemporary training opportunities which best equip the workforce to operate in a reformed mental health system of the future

4. Diverse Populations

It is important that the Community Mental Health and Wellbeing workforce is suitably diverse to reflect the community it supports. This diversity relates to gender, sexuality, culture, language, religion and age. People with lived experience of mental health challenges tell us that a diverse workforce is an essential ingredient to delivering an inclusive service. Particularly for maringinalised communities, having mental health workers from a similar background can enhance their recovery journey.

There are a number of specific population groups that experience mental distress at higher levels than the broader population and yet face the structural barrier of having very few services that specifically cater for their needs.

a. Aboriginal and Torres Strait Islander Peoples

We know that Aboriginal and Torres Strait Islander peoples are often over-represented in mental health statistics. 31 per cent of Aboriginal and Torres Strait Islander adults had high to very high levels of psychological distress in 2018-19 compared to 13 per cent of non-Indigenous Australians.[7] The suicide rate in Aboriginal and Torres Strait

[7] Australia. Australian Institute of Health and Welfare and National Indigenous Australians Agency. (2020). *Aboriginal and Torres Strait Islander Health Performance Framework: Summary Report*. Aboriginal and Torres Strait Islander Health Performance Framework (HPF) - AIHW Indigenous HPF

Islander peoples is twice that of the non-Indigenous population, and suicide occurs at much younger ages. Suicide is the number one cause of death for Aboriginal and Torres Strait Islander Queenslanders aged 15-35 years.[8]

A fundamental step towards improving these outcomes is to address the many barriers Aboriginal and Torres Strait Islander people face in accessing and receiving supports. One of these barriers is a misalignment of mainstream services with Aboriginal and Torres Strait Islander people and cultures. Concerningly, Aboriginal and Torres Strait Islander peoples report that they are often treated poorly in mental health systems which are not delivering culturally appropriate models of care. In developing this Strategy, it is timely to reflect on how the Community Mental Health and Wellbeing Sector can improve the cultural safety and responsiveness of our mainstream services.

This needs to be developed in close partnership with our First Nations communities and align with government policy, such as those represented in *Better Care Together*, Closing the Gap, and the Gayaa Dhuwi (Proud Spirit) Declaration Implementation Plan (once finalised).

As Australia embarks on a journey to recognise Aboriginal and Torres Strait Islander peoples in our Constitution with a referendum on a Voice to Parliament in 2023, it is timely to consider how non-indigenous Australians can learn from this ancient and enduring culture. QAMH's Wellbeing First report advocates for a shift in focus from managing illness to actively supporting wellbeing, which we define as a combination of a person's emotional, psychological and social health factors that is strongly linked to life satisfaction, self-acceptance and a sense of belonging to a community. The social and emotional wellbeing approach that Aboriginal and Torres Strait Islander communities take, with its focus on a multi-dimensional concept of mental health, encompassing connection to Country, culture, spirituality, ancestry, family and communities, aligns with the Wellbeing First model. For example, yarning circles and Indigenous programs that focus on the interconnectedness of culture, identity and wellbeing echo our view that human distress does not always need a medical response and that there are life-changing benefits to connecting people with their community.

While we fully support Aboriginal and Torres Strait Islander peoples in their self-determination and establishment of community-controlled support services, we are also hopeful that there may be many opportunities for the mainstream services' workforce to learn from these ancient cultures and this will form part of the Strategy's consultations.

[8] Queensland. Queensland Mental Health Commission. (2019). Every Life: The Queensland Suicide Prevention Plan 2019-2029, p9.

Possible Solutions

- Increase Aboriginal and Torres Strait Islander representation in the Community Mental Health and Wellbeing workforce in all locations across Queensland
- Work with First Nations communities to ensure mainstream services are delivered in a culturally safe manner by:
    - Development of new microcredentials specifically addressing cultural safety, intergenerational trauma, the historical legacy of colonialism, racism and its roots, and Social and Emotional Wellbeing
    - Strengthening the core content in the current Certificate IV in Mental Health / Peer Work to reflect the above (noting that this may result in a longer course duration)
    - Development of specific educational pathways that allow for sub-specialisation within existing courses
- Explore learning opportunities for cross-cultural sharing to enhance conventional 'status quo' models of mental health

b. CALD

Similarly, Culturally and Linguistically Diverse (CALD) communities face unique challenges that put them at an increased risk of developing mental illness. Displacement, family separation, past exposure to trauma and torture, prolonged detention and social isolation can negatively impact mental health and wellbeing. We also know that people from CALD communities are often reluctant to seek help because of language barriers, a lack of culturally sensitive and inclusive service providers, and perceived discrimination by mainstream services.

The Queensland Government has accepted the Mental Health Select Committee's recommendation that CALD services are reviewed, and opportunities for improvement and expansion across the state are identified. *Better Care Together* refers to "increasing the specialist multicultural workforce across MHAOD services to improve culturally safe and quality treatment, care and support for people from CALD backgrounds". These major reforms aimed at improving services to CALD populations are necessarily going to require an expanded workforce equipped with the necessary skills. In this Strategy QAMH will explore opportunities for ensuring the Community Mental Health and Wellbeing workforce is adequately scaled and suitably qualified to implement these policies.

Possible Solutions

- Embed CALD content in all courses
- Develop CALD specific electives or sub-specialisations within educational pathways
- Consider developing targeted traineeships for CALD communities

c. LGBTIQ+

While many lesbian, gay, bisexual, transgender, intersex, queer people and other sexuality and gender diverse (LGBTIQ+) people live healthy and happy lives, research has demonstrated that a disproportionate number experience poorer mental health outcomes than the community average.

- LGBTIQ+ people are two and a half more times likely to have been diagnosed or treated for a mental health condition in the past 12 months
- Young LGBTIQ+ people are three times more likely to self-harm and twice as likely to contemplate suicide
- Transgender people aged 14-25 are fifteen times more likely to attempt suicide that the general population[9]

Despite these sobering statistics, in Queensland there are only limited services offering programs specific to LGBTIQ+ people. The Queensland Government has agreed to the Mental Health Select Committee's recommendation that opportunities for improvement are identified and specific services are either expanded or established across the state. These reforms will require a suitable skilled workforce underpinning them.

Possible Solutions

- Embed LGBTIQ+ content in all courses
- Develop LGBTIQ+ specific electives or sub-specialisations within educational pathways
- Incentivise student placements at LGBTIQ+ organisations

[9] LGBTIQ+ Health Australia. (2021). *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTIQ+ People*. The 2021 update - LGBTIQ+ Health Australia

Pillar 2 - Attraction and Retention

1. Increase Supply

The Community Mental Health and Wellbeing Sector is facing a looming labour shortage, the causes of which are complex and multi-faceted. Natural disasters, the Covid-19 pandemic, rising cost of living pressures and other socio-economic factors have meant that the demand for mental health services has grown significantly. Mental Health Australia's recent *Report to the Nation*, prepared in collaboration with Ipsos Public Affairs, showed that 53% of Australians have needed mental health support over the past three months.[10] Other recent reports, such as the *National Study of Mental Health and Wellbeing*, have showed that particular populations such as young women and LGBTIQ+ communities, are experiencing distress at alarming rates.[11] We also know that "the demand for mental health care is expected to grow considerably over the next ten years"[12] which will overwhelm an already struggling system. Attracting more workers to the sector is vital to ensuring the increasing number of Queenslanders who require mental health supports are able to access them.

In addition, the introduction and expansion of the NDIS has seen massive changes in the mental health landscape. The last few years have seen a significant rise in the number of people with psychosocial disability receiving funded packages. In June 2022, there were 10,741 participants with psychosocial disability in Queensland, an increase of over 15 per cent in the preceding 12 months. Services have expanded or set up new models of care, and new organizations have entered the sector in response to these tectonic shifts.

The Community Mental Health and Wellbeing workforce also needs to grow substantially – and in a planned way – to deliver on the Parliamentary Inquiry's recommendations. Many of the reforms will require specific changes to frontline service delivery, such as increased community alternatives to emergency departments, LGBTIQ+ and CALD services, and suicide prevention and aftercare services. An expansion of the lived experience (peer) workforce is also a key recommendation. To deliver on these, a pipeline must be built to grow the workforce.

[10] Ipsos Public Affairs. (2022). *Report to the Nation*. mental_health_australia_2022_report_to_the_nation.pdf (mhaustralia.org)
[11] Australia. Australian Bureau of Statistics. (2022). *National Study of Mental Health and Wellbeing*. National Study of Mental Health and Wellbeing, 2020-21 | Australian Bureau of Statistics (abs.gov.au)
[12] ACIL Allen. (2021). National Mental Health Workforce Strategy: Background Paper.

Unfortunately, the sector faces numerous challenges in recruitment:

- Poor recognition of the sector: The Community Mental Health and Wellbeing Sector has historically suffered from lack of recognition. This may partly be due to what the Productivity Commission refers to as "a culture of superiority that places clinicians and clinical interventions above other service providers."[13] Competing with clinical professions for workers has been a constant challenge, and the sector has been traditionally poor at promoting itself as a viable alternative.
- Competition with clinical workforce salaries: Many providers employ staff with clinical backgrounds, however they find it difficult to compete with salaries offered to clinical staff in the Hospital and Health Services. This is particularly true for the lived experience (peer) workforce, where salaries don't recognise the valuable expertise they provide.
- New contracts from funding bodies requiring an over-reliance on nursing staff (where psychosocial workers could also be employed for a portion of the roles) with nursing staff not always having training in mental health focused 'recovery-values', wanting to work in community-managed settings or take a pay decrease and reduced career prospects.[14]
- Lack of recognised entry pathways: There is a lack of awareness of formal training pathways available to students and those wanting a change of career to help them enter the Community Mental Health and Wellbeing Sector (eg. Certificate IV in Mental Health / Peer Work). Combating this challenge may involve developing new entry pathways such as traineeships which can combine on-the-job and off-the-job learning and allow participants to be paid while doing it.
- Stigma and discrimination: We know there are negative perceptions associated with working in community mental health, with the sector seen as less prestigious and poorly renumerated compared to other areas of the mental health system, and health more generally.
- Difficulty recruiting people with recovery-focused ethos whose core values align with the sector.

The Strategy will explore ways to address these challenges and help meet labour demand so that the Community Mental Health and Wellbeing Sector is seen as an attractive, rewarding, and highly valued career pathway.

[13] Australia. Productivity Commission. (2020). Mental Health Inquiry Report, 1(95), p8.
[14] NEAMI Submission to QAMH

Possible Solutions

- Develop a state-wide campaign to increase awareness of the value of the Community Mental Health and Wellbeing Sector, highlighting success stories and promoting job opportunities within the sector
- Enhance school-to-work transitions by creating clear pathways for young people leaving school (eg. traineeships, better quality career information and advice)
- Enhance/promote change-of-career pathways, with consideration given to targeting specific populations (Aboriginal and Torres Strait Islander peoples, CALD and LGBTIQ+)
- Develop an online tool for potential workers to self-assess suitability and the skills required to work in the sector (as an important first step in a career pathway).
- Review the Certificate IV in Mental Health and Certificate IV Peer Work to ensure they are well-respected and valued entry pathways into the workforce which are both contemporary and in alignment with industry needs
- Work with Queensland Health to address stigma and discrimination facing the Community Mental Health and Wellbeing Sector, as part of their state-wide stigma reduction strategy
- Funding bodies to commit to flexible funding arrangements in terms of contractually required staffing roles

2. Geographic Distribution

Queensland's unique geography, including vast distances and areas of remoteness, have impacted the mental health landscape. Servicing all corners of our disparate state to ensure that remoteness is not a barrier to accessing care is a constant challenge. While telehealth and fly-in fly-out services can provide some benefit, they are not the whole solution. We need to ensure that people in remote regions are still able to access affordable, face-to-face services.

While there are state-wide community mental health workforce shortages, it is clear that the gaps are significantly larger in rural and remote locations. QAMH members in rural and remote areas report struggling to fill vacancies and provide supportive workplaces for staff and adequate supervision to trainees. The development of these thin markets has meant that people with mental health challenges living in these areas miss out entirely on critical supports and a lack of choice and control, a fundamental principle of the NDIS.

Unlike other parts of the mental health system, there are no current policies or programs to incentivise the community mental health workforce to service rural and remote areas of need. While *Better Care Together* admittedly refers to "embedding locally sustainable lived

experience (peer) support in rural and remote HHS regions", all other references to enhancement of rural and remote services focus on the clinical professions. It is clear that we need strategies to support local communities to grow their own workforces. The Strategy will explore opportunities to use data to identify geographic maldistribution and workforce shortages in the Community Mental Health and Wellbeing Sector, and implement policies and programs to address these inequities.

Possible Solutions

- Fund traineeships for the Certificate IV qualifications under the User Choice Program so that communities can 'grow their own' workforces, by providing opportunities for people to participate in self-paced online learning while being employed by local service providers.
- Government funding to incentivise regional, rural and remote pathways for the Community Mental Health and Wellbeing workforce beyond just lived experience (peer) workers. This may include financial incentives to cover relocation costs, integration supports for workers and their families, or other benefits.

3. Retention

High workforce retention is crucial for service continuity and reducing the high cost of recruiting, onboarding and training replacement workers. It is well documented that the Community Mental Health and Wellbeing Sector experiences a high staff turnover rate within organisations and high attrition from the sector. There are many reasons for this:

- Limited ongoing professional development and career advancement opportunities (see Pillar 1)
- Short-term government contracts and funding cycles create a climate of constant uncertainty, hindering service providers' ability to offer permanent/long-term contracts
- Multiple funding streams contributing to instability
- The introduction of the NDIS leading to casualisation of the workforce. 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
- Loss of NDIS support staff who establish themselves as non-registered sole traders providing support work independently (and often taking participants with them)
- Low remuneration compared to the public and private sectors. The following table compares hourly pay rates between Queensland Health and the NGO Sector (as employed

under the Social, Community, Home Care and Disability Services Industry Award), demonstrating that Queensland Health is generally able to offer more competitive pay rates, especially for the allied health professions.

Table 1: Comparative hourly rate of Queensland Health and Community NGO employees

Employed by Queensland Health	Permanent Hourly rate	Employed by Community NGO	Permanent Hourly rate
N/A	-	Support Worker (SCHADS Level 2)	$30.46 – $33.23
Support Workers (OO Level 3-4)	$30.54 - $36.31	Recovery Support Worker (SCHADS Level 3 – 4)	$34.04 - $42.25
Peer Worker (AO Level 3-4)	$34.66 - $45.30	Peer Worker (SCHADS Level 3 – 4)	$34.04 - $42.25
Allied Health (Social Worker, OT Psychologist) (HP Level 3 – 4)	$39.21 - $62.43	Allied Health (Social Worker, Psychologist, OT) (SCHADS Level 6-7)	$49.07 – $ 55.29

Sources:

1) Queensland Government. (2022). *Queensland Health Wage Rates*. Queensland Health wage rates | Queensland Health

2) Australian Government. (2022). *Pay Guide: Social, Community, Home Care and Disability Services Industry Award [MA000100]*. Pay guides - Fair Work Ombudsman

Possible Solutions

- Develop ongoing professional development opportunities – see Pillar 1
- Develop leadership capability to better support workforces and lead change
- Develop clearly defined career-progressing pathways and provide appropriate support to access these opportunities
- Governments at all levels commit to five yearly funding cycles, with renewal processes occurring with adequate lead time
- The Australian Government to review the NDIS pricing arrangements to ensure line items are adequate to cover service provider costs, including supervision and training of staff, and support workforce development
- Consider strategies to ensure competitive wages

4. Workforce Wellbeing

We know that workforce wellbeing is integral to retaining workers in the Community Mental Health and Wellbeing Sector. The evidence put to Queensland's Parliamentary Inquiry showed that stress and burnout were key challenges affecting retention of staff. Multiple factors contribute to this: Increased demand for mental health supports, the intensity and complexity of the work, casualisation of the workforce, experiences of vicarious trauma, workplace abuse and aggression, and inadequate training, support and ongoing supervision. These issues were also illuminated in QAMH's 2021 Community Mental Health Workforce Project.

QAMH welcomed the Queensland Government's acceptance of the Mental Health Select Committee's recommendation that the government "develop and implement strategies to foster a supportive and safe workplace culture". We also note that *Better Care Together* has committed to "implementing strategies to support staff health and wellbeing" and this will involve "developing training about strategies to support and improve mental health and wellbeing of the MHAOD workforce including adequate security, physical safety, stigma reduction, stress mitigation measures and support services." The introduction of the *Managing the Risk of Psychosocial Hazards at Work Code of Practice 2022* is also a welcome development and will require training and resources to enable organisations to comply. QAMH's Workforce Strategy will further explore these issues through a community mental health lens specific to our sector.

A potential solution that needs further exploration lies in the National Lived Experience (Peer) Workforce Development Guidelines. Supporting organisations to implement these guidelines would enhance worker wellbeing and positively distinguish the Community Mental Health and

Wellbeing Sector as an employer of choice.[15] These guidelines provide a roadmap for embedding equality, mutality, self-determination, co-production and authenticity into workplace culture and practices. Indeed, recovery and lived experience values and principles have as much relevance for the development and support of the entire mental health workforce as they do for the lived experience workforce.[16]

Possible Solutions

- Support the safety and wellbeing of workers through wellbeing monitoring programs and embedding additional supports to prevent fatigue, stress and burnout
- Present or profile the work already being done in the sector on worker wellbeing
- Establish Communities of Practice across the sector to foster a culture of collaboration and support
- Support organisations to implement the guidelines and principles in the National Lived Experience (Peer) Workforce Development Guidelines
- Invest in professional developmental opportunities for leaders with a focus on positive workplace culture

[15] Purpose at Work Submission to QAMH

[16] Walker, L., Perkins, R., and Repper, J. (2014), "Creating a recovery focused workforce:supporting staff wellbeing and valuing the expertise of lived experience", *Mental Health and Social Inclusion*, Vol. 18 No 3, pp 133-141.

Pillar 3 – System Enablers

1. Leadership and Governance

Recent reports and inquiries, including the NMHSPA and Queensland's Parliamentary Inquiry, have argued strongly in favour of joint regional planning where Primary Health Networks, Hospital and Health Services, consumers and carers work together to determine local needs, identify gaps and duplication, and design and fund services in response to the needs of local communities. Encouragingly, the state and federal governments have agreed to work together in the first 12 months of the NMHSPA to develop national guidelines on minimal standards for regional planning and commissioning.

While this approach to service delivery is welcomed by QAMH, we feel a similar level of collaboration is required for workforce planning. Currently, there is no overarching governance structure that is responsible for workforce planning and development of the Community Mental Health and Wellbeing Sector. This failure to regulate the sector has had some undesirable consequences, such as:

- There is no systematic, sector-wide approach to data collection that properly informs workforce policy
- The number, type and delivery of vocational qualifications are not adjusted according to the needs of the sector
- There is no system-wide approach to content review of applicable vocational qualifications and ongoing professional development opportunities to ensure they remain contemporary and align with industry needs

While QAMH, with its limited resources, has provided ad hoc projects and discrete data collection, a stronger governance structure which includes the PHNs, Queensland Health, DESBT, NGOs, educational providers and lived experience voices is required for sector-wide oversight of workforce planning and development. We understand that recently Industry Clusters have been established at a federal level to lead the Vocational Education and Training (VET) system to meet the evolving skills and training needs of industry. It is possible that these new arrangements may address some of these challenges.

Possible Solutions

- Ensure the Community Mental Health and Wellbeing Sector is represented in workforce planning strategic discussions, especially in relation to HumanAbility as the new Jobs and Skills Council
- Develop stronger relationships between VET sector and Community Mental Health and Wellbeing Sector to ensure educational offerings align with industry need

2. Funding

Much of QAMH's advocacy work has focused on the terms of Commonwealth and state contracts. In our representations to governments, we have consistently called for extending the length of the funding cycle to a minimum of five years and renewal processes to occur with adequate lead time. While we understand this may not be feasible for new programs or pilots where funding bodies need to see evidence of a program's efficacy before investing further, it should be routine procedure for established programs with a robust evidence base.[17] The relationships between contract length, sustainable service delivery and workforce attraction are interconnected. Without longer funding cycles, community mental health organisations will continue to be plagued by high staff turnover, lack of permanent employees and an inability to execute longer term planning and workforce development. It also means that organisations are unable to invest in continuous improvement including risk management, better governance structures and staff training and development. Rather, "the way community-based mental health is funded maintains the status quo."[18] We also need to acknowledge that this has "significant mental health impacts on staff who manage a great deal of uncertainty until the end of a contract, not knowing if they will continue to be employed".[19]

The Productivity Commission's report, the House of Representatives Select Committee's final report, and the Inquiry into the *Opportunities to Improve Mental Health Outcomes for Queenslanders* all recommended that funding transition to five yearly cycles for reasons outlined above. The Queensland Government has supported in principle the Inquiry's second recommendation to apply five-yearly funding cycles to state-funded services, saying it will investigate whether it is "appropriate and feasible" to transition. Federally, there have been discouragingly few signs that contract length will be extended beyond the current 1-3 yearly cycles.

Possible Solutions

- Governments at all levels commit to five yearly funding cycles, with renewal processes occurring with adequate lead time

[17] NEAMI Submission to QAMH
[18] NEAMI Submission to QAMH
[19] Wesley Mission Queensland Submission to QAMH

3. Integration

One of the major recommendations from the Productivity Commission's Inquiry into Mental Health was to "improve coordination and integration" to better promote recovery.[20] This relates to both within the sector and also at the interface between clinical and non-clinical services. The Community Mental Health and Wellbeing workforce "often operates in partnership with clinical services to deliver integrated clinical and non-clinical mental health and wellbeing support" and the Strategy should consider arrangements which support an integrated approach.[21]

The current fiscal landscape, which is based on grant funding through Queensland Health and PHNs or individual fee-for-service funding through the NDIS and Medicare, encourages services to operate as silos. This is not in the best interests of people experiencing mental distress and is an abrupt change from the pre-NDIS environment where services operated more collaboratively in networks of community-based care. Prior to the NDIS, through programs such as Partners in Recovery (PIR) and Personal Helpers and Mentors (PHaMS), service providers would refer people to each other's programs, draw on each other's strengths and knowledge, and work together to provide the best outcomes for people in distress.

The Strategy will explore ways to return to this environment of collaboration and integration within the mental health landscape. While much of this fragmentation has arisen because of diverse funding streams, we believe there are ways to foster cooperation and collaborative care at a grassroots level.

Possible Solutions

- Supporting increased local collaboration through the development of workforce initiatives such as shared recruitment processes, induction training, secondments, exchange programs, sabbaticals, coaching, mentoring and reflective practices

[20] Australia. Productivity Commission. (2020). Mental Health Inquiry Report, 1(95), p63.
[21] Wellways and Mind Submission to QAMH

4. Lived Experience (Peer) Workforce

People with lived experience bring unique knowledge, insights and expertise which makes them an essential component of a thriving mental health workforce. They represent a paradigm shift from pathologising mental illness through the biomedical model of care to a trauma-based, recovery-oriented way of empowering people to realise their full potential. Their core value and competency stems from their lived/living experience of mental health challenges or supporting someone close to them, and their emphasis on hope, empowerment, self-management and social inclusion has the capacity to improve outcomes for people with mental health challenges and their families, friends and carers. Recent years have seen an embracing of this workforce as a central component in any future mental health landscape in Queensland, with *Better Care Together* committing to "embedding lived experience (peer) workers in services to inform service delivery, drive person-centred care and support shared decision making".

While the inherent value of the lived experience (peer) workforce is indisputable, it is clear that there are a range of factors to be addressed in order to successfully grow, integrate and sustain this workforce. The National Lived Experience (Peer) Workforce Development Guidelines and Queensland's Framework for the Development of the Mental Health Lived Experience Workforce have extensively explored these challenges and will heavily inform the Strategy.

Central is the need to support development of the lived experience (peer) workforce by agreeing on skill sets or core capabilities that equip workers to perform their roles safely and effectively. While lived experience of mental ill-health, service use and recovery is the essential ingredient to the lived experience (peer) workforce, peer workers, like workers in all occupations, need quality training and professional development in order to be effective in their roles. The requisite knowledge and skills include topics as diverse as delivering trauma informed care, recovery-based practice, responding to complex/coexisting needs, provision of culturally appropriate services, crisis management, managing risk, relevant legislation and establishing professional boundaries.

The Certificate IV in Mental Health Peer Work was developed in 2012, touted as the nationally recognised qualification for peer workers. The 12-month course is offered at five RTOs in Queensland and offers participants the opportunity to build on their lived experience of mental health conditions as either a consumer or carer. The blend of theory, practical coursework and discussions with other peer workers allows exploration of recovery-oriented and trauma-informed care, dealing with loss and grief and navigating the mental health system.

However, the rollout of the Certificate IV in Mental Health Peer Work has not been without its challenges. In 2021, Queensland Lived Experience Workforce Network (QLEWN), Brisbane North Peer Participation in Mental Health Services Network and QAMH organised a Peer Workforce Survey to explore the availability and quality of training in Queensland for the

emerging peer workforce. The results confirmed what was anecdotally known. Concerns were raised around the content and delivery of the Certificate IV in Mental Health Peer Work, as well as a perceived lack of academic support and difficulty securing student placements. QAMH's Peer Workforce Student Mentoring Program was implemented in direct response to these findings.

Importantly, challenges with training the lived experience (peer) workforce are not limited to the Certificate IV in Mental Health Peer Work. Outside this foundational course there are very limited peer work-specific training opportunities available for ongoing professional development. The survey found that most organisations (83%) felt the training and/or professional development opportunities available were not sufficient to support peer workers in their role. Ensuring the lived experience (peer) workforce has access to relevant and contemporary training for ongoing professional development will be a focus of the Strategy.

Other challenges facing the lived experience (peer) workforce which will be explored in the Strategy include:

- How we can appropriately renumerate lived experience (peer) workers, who often come to the role with a range of skill sets and qualifications in addition to the expertise that is gained through their experience, and often share their knowledge at great personal and professional risk.[22]
- How to ensure organisations are adequately resourced to support and supervise lived experience (peer) workers in the workplace
- How to enhance lived experience leadership through appropriate professional development
- How to redesign commissioning processes to increase the number of people with lived experience working in a diverse range of roles including leadership, advocacy and research.

Indeed, the system needs to be "reconfigured at the foundations to elevate and centre lived experience knowledge and work. They need to move beyond removing stigma and discrimination to a sector that recognizes lived experience as a respected form of knowledge."[23]

Finally, it is crucial that the wider (non-lived experience) workforce develop an understanding of the inherent value lived experience (peer) workers bring to organisations. The National Lived Experience (Peer) Workforce Development Guidelines discuss this need to "invest in whole-of-sector education on the uniqueness and value" of this workforce. A culture of respect

[22] NEAMI Submission to QAMH
[23] NEAMI Submission to QAMH

and acceptance needs to be achieved, along with a "move away from the us versus them dialogue that continues to influence discussions around Lived Experience and clinical workforces".[24] This will include, among other things, addressing the stigma and misconceptions about mental illness which still permeate workplaces and limit people's ability to disclose lived experience of mental health challenges. It will also look at how to ensure the lived experience (peer) workforce is wholly valued for their learned experience – not just their lived experience.[25] Designing ways to ensure 'organisational readiness' to embrace the lived experience workforce will form a key part of the Strategy. This could involve funded organisational support to be able to implement the National Lived Experience (Peer) Workforce Development Guidelines as "even the most motivated organisations need tailored supports to be able to transform into a genuinely enabling environment."[26]

[24] Wesley Mission Queensland Submission to QAMH
[25] NEAMI Submission to QAMH
[26] Purpose at Work Submission to QAMH

Possible Solutions

- Agree on the defined core capabilities (skills, knowledge, attitudes and behaviours) required for lived experience (peer) workers and ensure qualifications and training are built around this definition
- Review and re-design the Certificate IV in Mental Health Peer Work to ensure it remains relevant and up-to-date
- Develop traineeships or 'Peer Work Internships' that align with TAFE qualifications, combine time at work with formal training and acknowledge that sometimes employing the right people is more important than having the qualifications at the time of employment
- Offer peer mentoring programs for students completing the Certificate IV
- Develop a training package / microcredential for peer workers to be delivered on induction
- Develop training opportunities to support leadership skills in lived experience (peer) work
- Raise awareness and understanding of peer work within organisations and across the community to change attitudes, reduce stigma and better understand the value it brings to the mental health system
- Ensure appropriate HR policies and procedures are in place to support the wellbeing of lived experience (peer) workers, including access to peer supervision and mentoring
- Establish peak body resources for the lived experience (peer) workforce to support the needs of this emerging workforce
- Funding for organisations to access support to implement the National Lived Experience (Peer) Workforce Development Guidelines
- Explore options for ensuring the industrial award adequately reflects the knowledge and experience of lived experience (peer) workers
- Consider options for weaving lived experience quotas through the commissioning process

5. Data

One of the most pressing problems facing the Community Mental Health and Wellbeing Sector is the lack of available information on workforce numbers, demographics, skill base, educational attainment and geographic distribution. At present, access to workforce data is limited for most mental health occupations not regulated by the Australian Health Practitioner Regulation Agency (AHPRA). It is not captured in our national data collections such as ANZSIC or ANZSOC and the National Mental Health Services Planning Framework (NMHSPF) does not code specifically for community mental health workers. Queensland Health's contractually mandated minimum data sets are not widely accessible. Even the National Disability Insurance Agency, which collects vast amounts of information on participants and service providers, does not collate useful information on the Community Mental Health and Wellbeing workforce. QAMH conducted a Workforce Project in 2021 which provided some invaluable insights, however was limited in size and provided only a snapshot of the entire state-wide workforce. Without dedicated resources and strategies for capturing this essential data, it is very difficult to implement sector-wide workforce planning and development initiatives.

The challenge of capturing workforce data was explored at length in the Productivity Commission's Report. It is also one of the major commitments made in the NMHSPA, where Part 7 commits to state and federal governments collaborating "to build the data and systems needed to understand and improve mental health and suicide prevention workforce planning".

We need to build a rigorous evidence base to plan, project and respond to future demands on the Community Mental Health and Wellbeing Sector. There needs to be a systematic and comprehensive approach to workforce data collection, with results shared with the sector. The Strategy will explore opportunities to improve workforce data capture in order to better inform policy decisions and whole-of-sector reform.

Possible Solutions

- Initiate a regular 'Census' for the Community Mental Health and Wellbeing Workforce, asking services to provide total numbers of FTE staff (actual and vacancy) to capture basic workforce numbers
- Initiate more comprehensive data collection such as New Zealand's four-yearly More Than Numbers Workforce survey or Victoria's newly introduced workforce personnel survey, asking service providers more detailed questions about workforce composition, qualifications, staff turnover, funding etc
- Liaise with Queensland Health to utilise the National Best Endeavour Data Set (NGOE NBEDS)
- Optimise use of the NMHSPF, including more accurately coding for the Community Mental Health and Wellbeing workforce
- Facilitate greater transparency and sharing of data, in contrast to the current NMHSPF which has strictly controlled access. This will enable service providers to make informed decisions about service expansion and staffing arrangements, particularly in thin markets

6. Evidence-based Practice

There is a need for a stronger commitment to capturing outcomes. Currently, evaluation of programs and services either occurs in an ad hoc and siloed fashion without a systemic view to informing larger policy and investment decisions, or simply not at all. Aligning with commitments made under the NMHSPA, it is essential work is done on developing an evaluation framework that is system-wide, co-designed with people with lived experience and used to drive evidence-informed policy. Such a framework would allow comparison of outcomes achieved by the Community Mental Health and Wellbeing workforce with other areas of the mental health system, and support policy makers in directing resources across the entire system. The evidence could inform commissioning processes and ongoing decision making about policies and investment.

The development of an evaluation framework must consider what outcomes are important to people with lived experience. It must move beyond capturing numbers of presentations and throughput, or clinical endpoints which focus on mental illness as opposed to mental wellbeing. Rather, it should incorporate holistic, person-centric, psychosocial measures across multiple life domains. Some alternative indicators to consider which better capture mental wellbeing data include:

- Mental Health Australia's Report to the Nation: This online questionnaire was designed by Ipsos, in collaboration with Mental Health Australia, and includes measures such as self-rated mental health over past three months, if they felt life has been filled with interesting/enjoyable things, if they felt part of a community, whether they needed mental health support.
- Mental Wellbeing Index — Smiling Mind: This survey, designed by Smiling Mind and KPMG, uses data collected over a two-year period from more than 225,000 Australians. The index is released quarterly. It looks at six everyday mental wellbeing domains including emotional awareness, focus and concentration, emotional regulation, relationships and social connections, sleep and stress.
- Harvard Flourishing Measure: These 12 items assess various domains of flourishing or human well-being in the following domains - Happiness and Life Satisfaction, Mental and Physical Health, Meaning and Purpose, Character and Virtue, and Close Social Relationships.

Possible Solutions

- Establish an evaluation framework for capturing and reporting on outcome measures, in accordance with commitments made under the NMHSPA
- Include harmonized data reporting requirements in service delivery contracts
- Establish a central repository of harmonised data which is broadly available for research and service delivery planning
- Ensure any evaluation framework is capturing what is important to people with lived experience

7. Culture

In our submission to the Parliamentary Inquiry, QAMH argued that the mental health system's culture was the 'elephant in the room' when examining past failures to embrace reform. A power imbalance is experienced by different services in the mental health ecosystem, stemming from entrenched beliefs about what different parts of the system can and should contribute. For the Community Mental Health and Wellbeing Sector, there are low expectations from other elements of the system of its professionalism and ability to manage risk and support complexity. This is due to its evolution and limited resources, and despite the many positive, life-saving outcomes being achieved by our sector. Indeed, "the sector works within an evidence-based framework with workers expected to understand and apply complex practice principles including trauma-informed approaches, socio-emotional wellbeing principles, understanding the impact of intersectionality and so

on. Yet community-based mental health is not afforded the same investment or respect as work undertaken in the traditional health or clinical sectors…."[27]

QAMH believes that a fundamental cultural shift is needed where the Community Mental Health and Wellbeing workforce is seen as a central component of the mental health landscape and afforded the same consideration as the rest of the mental health system, in terms of consultation, resourcing and decision-making processes. This can be reflected in a myriad of ways, including being specifically referred to in the National Mental Health Workforce Strategy (along with GPs, nurses, psychiatrists, psychologists and social workers), having strong representation at federal and state workforce discussions and establishing more direct lines of communication between the sector and decision makers.

Possible Solutions

- Ensure Community Mental Health and Wellbeing Sector in included in appropriate system-wide governance structures
- Ensure the Community Mental Health and Wellbeing Sector is explicitly planned for in the National Mental Health Workforce Strategy

[27] NEAMI Submission to QAMH