leading community mental wellbeing

Community Mental Health and Wellbeing Sector Workforce Survey 2023

September 2023

Queensland Alliance for Mental Health

Who is QAMH?

The Queensland Alliance for Mental Health (QAMH) is the peak body for the Community Mental Health and Wellbeing Sector and people with experiences of psychosocial disability in Queensland. We represent more than 100 organisations and stakeholders involved in the delivery of community mental health and wellbeing services across the state. Our role is to reform, promote and drive community mental health and wellbeing service delivery for all Queenslanders, through our influence and collaboration with our members and strategic partners. We provide information about services, work to build community awareness, education and training to influence attitudes and remove barriers to inclusion and advise government on issues affecting people with experiences of psychosocial challenges. At a national level, we have a formal collaboration with Community Mental Health Australia and provide input and advice to the work of Mental Health Australia and the National Mental Health Commission where appropriate. Locally, we work alongside our members, government, the Queensland Mental Health Commission and other stakeholders to add value to the sector and act as a strong advocate on issues that impact their operations in Queensland communities.

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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.

Contents

Executive Summary

The Community Mental Health and Wellbeing Sector Workforce Survey 2023 was developed as an online survey tool using the web-platform Survey Monkey. Development of survey questions leveraged recent work completed by Mental Health Coordinating Council and Mental Health Community Coalition ACT. 104 Queensland Community Mental Health and Wellbeing Sector organisations were invited to participate in the survey. Organisations were asked to complete the survey within a six-week time period.

A total of 42 organisations participated in the survey, representing a 40.4 per cent response rate. The survey responses represent organisations providing services across all geographic categories (metropolitan – very remote communities), with over two thirds providing services in metropolitan and regional centres. The survey response is considered representative of the sector with respondents providing a good cross-section of the sector in terms of organisational size. Respondents provided services via diverse funding streams, with 63 per cent of organisations receiving state government funding, 58 per cent receiving funding from the National Disability Insurance Scheme, 50 per cent from Primary Health Networks, 40 per cent from other Commonwealth Government Sources and 38 per cent utilising charitable donations and philanthropy. 139,797 people were supported by responding organisations during 2022-23, with the majority of organisations supporting between 51 – 250 people.

The survey shows that Queensland's Community Mental Health and Wellbeing Sector is a complex and rapidly growing sector that is experiencing significant internal and external pressures. This is due primarily to NDIS expansion. Total sector growth during 2022-2023 was 12.6 per cent (176 workers). The biggest growth was seen in NDIS roles (14.4 per cent) including Mental Health Support Workers and Psychosocial Recovery Coaches. For non-NDIS Roles, the largest increases were in Lived Experience Workers (Carer 208.3 per cent, Consumer 22.9 per cent) and Mental Health Recovery Support Workers 27 per cent). With such high growth, it is not surprising that workforce shortages top the list of workforce concerns, with 57 per cent of organisations citing this as their number one concern.

Overall, the top five workforce issues for respondents were:

- Workforce shortages – 57 per cent
- Inadequate funding – 46 per cent
- Worker wellbeing – 43 per cent
- Insecure contracts – 39 per cent
- Administrative burden of contracts – 36 per cent

More than half of respondents report being “very” or “extremely” concerned about the levels of stress and burnout amongst their staff.

Unsurprisingly, our survey indicates that the workforce is a predominantly female one, comprising 71 per cent female workers. Aboriginal and/or Torres Strait Islander workers make up 3.8 per cent of the workforce, while 13.1 per cent are from Multicultural and Diverse Backgrounds and Connections. Three quarters of organisations have a workplace diversity policy in place and employ strategies such as training, events and targeted recruitment to support worker diversity.

In total, surveyed organisations employed a total of 1,561 FTE positions. This includes 566 FTE NDIS roles, with the two largest categories of NDIS workers represented by Mental Health Support Workers (57.8 per cent) and Support Coordinators (12.7 per cent). It also includes 995 FTE non-NDIS roles comprised mainly of Recovery Support Workers (29.6 per cent) and Peer Workers (8.9 per cent). Of these workers, just over half (54.6 per cent) were employed on a permanent contract, either full-time or part-time. In addition, 25.1 per cent were employed on a fixed-term contract, either full-time or part-time, while 20.3 per cent were employed on a casual basis. In terms of Lived Experience workforce, half of organisations surveyed reported having dedicated Lived Experience leadership roles. Nearly half of organisations report they are actively growing their Lived Experience workforce, and a further 39% plan to do so in the future. Volunteers accounted for an additional 200 workers equating to 28.2 FTE positions. Volunteers in the sector complete a range of tasks and were most commonly responsible for program delivery and support, administration and resources development and peer support.

The sector utilises a range of qualification types. Organisations report that the qualifications they most commonly seek when recruiting are:

- Bachelor degree – 52 per cent (Social Work, Psychology, Counselling, OT)
- Certificate IV Mental Health – 33 per cent
- Certificate IV Mental Health Peer Work – 30 per cent
- No specific qualification – 15 per cent

The survey provided much feedback on the value and delivery of the Certificate IV vocational qualifications, along with recommendations for how these qualifications could be improved. Nearly half of all respondents were “not sure” about whether the Cert IV Mental Health Peer Work equips staff to perform their role. Organisations were more positive about the potential for traineeships, with nearly three quarters of all respondents indicating that they would consider employing a trainee under a new traineeship program if implemented.

Training and development opportunities for staff in the sector are an area of concern, with over half of respondents reporting that they did not believe that staff had adequate access to training and development. Nearly 80 per cent attributed this to lack of funding within their contracts, with 36 per cent citing inadequate time and 29 per cent stating that they believe relevant training was not available. Respondents also provided a wide range of ideas for future training and development areas.

Surveyed organisations report that the most difficult roles to recruit for in the sector include Aboriginal and Torres Strait Islander Mental Health Workers, Counsellors, Mental Health Support Workers and Executive Managers. The most commonly reported reasons for recruitment difficulties were:

- Insufficient numbers of workers with relevant qualifications – 60 per cent
- Inability to offer a competitive salary – 48 per cent
- Difficulty attracting workers to the service location of the position – 44 per cent

Respondents provided ideas to address recruitment challenges including increased contract funding allowing for more attractive working conditions, flexible working arrangements, strengthening training and professional development opportunities and career progression pathways, introducing traineeships and supported entry points.

The findings of this survey paint a useful picture of the Queensland Community Mental Health and Wellbeing Sector workforce. These findings are explored in more detail in this report and will be used to inform the development of the Community Mental Health and Wellbeing Workforce Strategy currently being developed by QAMH and due for completion February 2024.

Background

One of the most persistent problems facing the Community Mental Health and Wellbeing Sector is the lack of available information on workforce numbers, demographics, skills base, educational attainment and geographic distribution. In effect, this renders our sector's workforce – and therefore our sector – invisible.

Unlike other professions within the mental health ecosystem (psychiatrists, psychologists, occupational therapists, social workers and mental health nurses), there is no mechanism to capture data on the Community Mental Health and Wellbeing workforce in either State or Commonwealth systems. Data relevant to our sector is not captured in our national data collections such as Australia and New Zealand Standard Classification of Occupations (ANZSCO) or Australian and New Zealand Standard Industrial Classification (ANZSIC), nor does the National Mental Health Services Planning Framework (NMHSPF) offer a code specifically for community mental health workers. Queensland Health's contractually mandated minimum data sets reported via Mental Health Non-Government Organisation Establishments National Best Endeavours Data Set (MH NGOE NBEDS) are not freely available, nor do they align with workforce data collected by federally funded organisations. Even the National Disability Insurance Agency, which collects vast amounts of information on participants and service providers, does not collate useful information about the Community Mental Health and Wellbeing Sector workforce.

This "invisibility" of our sector and its workforce has significant policy and planning implications, not least that the contributions of the Community Mental Health and Wellbeing Sector are frequently overlooked and undervalued. The absence of comprehensive data and research on the size, nature, and needs of the Community Mental Health and Wellbeing workforce - especially when compared to the information available about the private clinical workforce and the public sector mental health workforce - is a significant barrier to the development of evidence-based policies and initiatives. It also contributes to the relative obscurity and marginalisation of the Community Mental Health and Wellbeing Sector in workforce planning and related government policy processes.

QAMH has advocated strongly for these issues to be addressed and in 2022, began work in collaboration 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 challenges 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 awareness 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 essential for the Community Mental Health and Wellbeing Sector. This nation-leading work is currently due for completion in February 2024.

The Community Mental Health and Wellbeing Sector Workforce Survey 2023 has been formulated and conducted by QAMH to inform development of the workforce strategy. QAMH intend to complete this process every three years to maintain up-to-date information on our workforce.

Methodology

The Community Mental Health and Wellbeing Sector Workforce Survey 2023 was developed as an online survey tool using the web-platform Survey Monkey. Development of survey questions leveraged recent work completed by the Mental Health Coordinating Council[1] and Mental Health Community Coalition ACT[2] to quantify Community Mental Health and Wellbeing sector workforce data in each respective jurisdiction, New South Wales and the Australian Capital Territory. The survey also drew on New Zealand's four yearly workforce survey, *More than Numbers*[3]. Key survey questions intentionally closely reflect the survey design utilised in NSW and the ACT, in an effort to work towards capturing a national data set.

104 Community Mental Health and Wellbeing Sector organisations were invited to participate in the survey. These organisations, which included QAMH members and non-members, were recruited by approaching QAMH General Members, organisations that receive funding through seven Primary Health Networks in Queensland (as identified via their websites) and NDIS providers of psychosocial supports identified though the NDIA website. Organisations funded through the Mental Health Alcohol and Other Drugs (MHAOD) Branch of Queensland Health were also approached to take part in the workforce survey. All organisations were sent a single Survey Monkey link, so there was only one link per organisation. Organisations were asked to complete the survey within a six-week time period. While participation in the survey was anonymous, QAMH was able to see which organisations had/had not completed the survey.

Findings

A total of 42 organisations participated in the survey, representing a 40.4 per cent response rate. By comparison, the recent ACT Community Mental Health and Wellbeing Sector workforce survey

[1] See Ridoutt, L. and Mental Health Coordinating Council NSW. (2021). *Mental Health Workforce Profile: Community managed organisations mental health workforce report 2021 New South Wales*. MHCC_WorkforceSurvey_2021.pdf

[2] See Ridoutt, L., Curry, R., Prince, S., Dobson, C. and Lawrence, J. (2023). *ACT community-managed mental health workforce profile 2023.* Mental Health Community Coalition ACT, Canberra. https://mhccact.org.au/wp-content/uploads/MHW-2023-Report-v03-WEB.pdf

[3] See Te Pou. (2022). *More than Numbers Workforce Data*. More Than Numbers | Workforce Data | Te Pou

received a 54.5 per cent response rate, which was acknowledged to be particularly high[4]. While Queensland's response rate is lower than expected, the organisations which did participate are considered to provide a useful snapshot of the sector, including a good range of organisation sizes, funding streams and rural/metropolitan representation. Although 42 organisations participated in the survey in total, it should be noted that survey questions weren't compulsory, with respondents having the option to skip questions if they were not relevant, or they were unable to respond to. As such, not all respondents have completed 100 per cent of the survey questions. The total number of respondents is included for each analysis where possible. While using this format served to maximise the survey response rate and reduce the administrative burden for participants, it is acknowledged that this may somewhat negatively impact the validity and generalisability of the results. Where this is believed to be of particular concern, it is noted within this report.

Funding sources

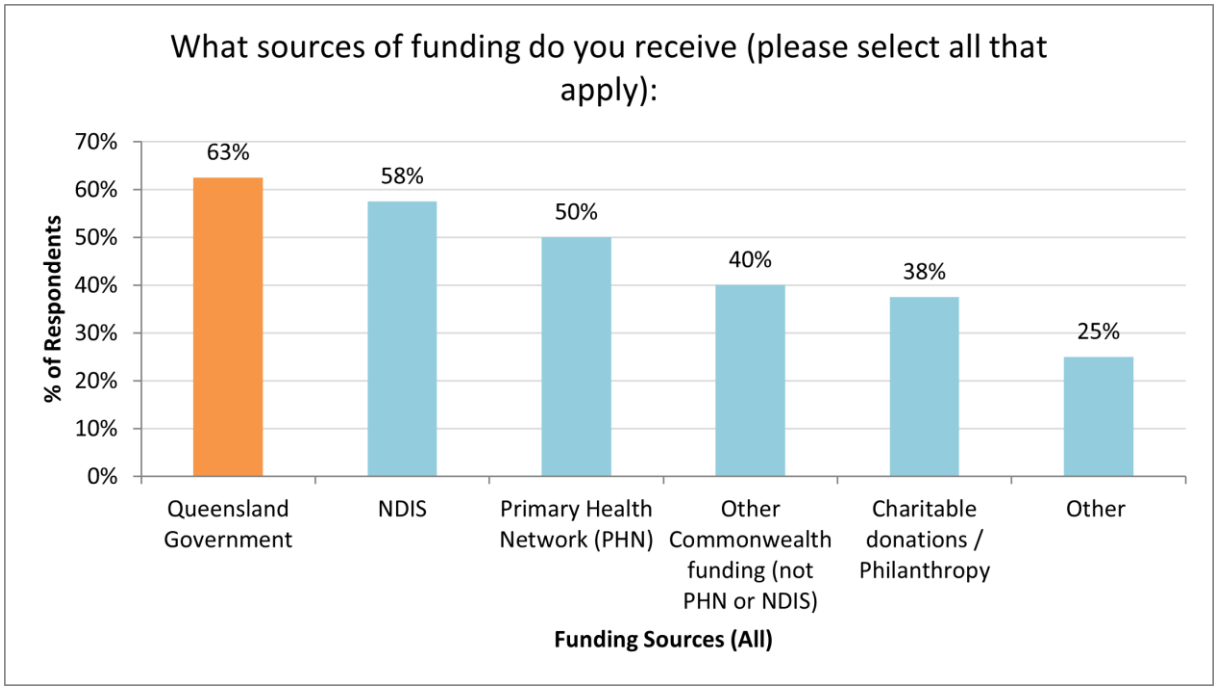
Community Mental Health and Wellbeing organisations utilise funding from a range of sources including State Government funding, Commonwealth funding including NDIS and Primary Health Network (PHN) funding, charitable donations or philanthropy as well as other sources of funding. Each organisation may have more than one funding stream.

Overall, 63 per cent of Community Mental Health and Wellbeing organisations that responded to this survey receive State Government funding, making it the most commonly reported source of funding in the sector. This is almost evenly matched by NDIS funding, which is a key funding source for 58 per cent of Community Mental Health and Wellbeing organisations which responded to this question. Commonwealth funding sources accessed by the sector include Primary Health Network (50 per cent), NDIS (58 per cent) and other commonwealth sources (40 per cent). A further 38 per cent of respondents utilise charitable donations and philanthropy to some extent. Work to establish a deeper understanding of the primary source of funding or amount of funding received from each source would be a useful area for further consultation. Of organisations which receive State Government funding, the top three most commonly reported sources of funding are:

- Queensland Health (84 per cent)
- Department of Children, Youth Justice and Multicultural Affairs (40 per cent)
- Department of Communities, Housing and Digital Economy (32 per cent)

[4] Ridoutt, L., Curry, R., Prince, S., Dobson, C. and Lawrence, J. (2023). *ACT community-managed mental health workforce profile 2023.* Mental Health Community Coalition ACT, Canberra. https://mhccact.org.au/wp-content/uploads/MHW-2023-Report-v03-WEB.pdf

Figure 1: Sources of Funding [40 total responses]

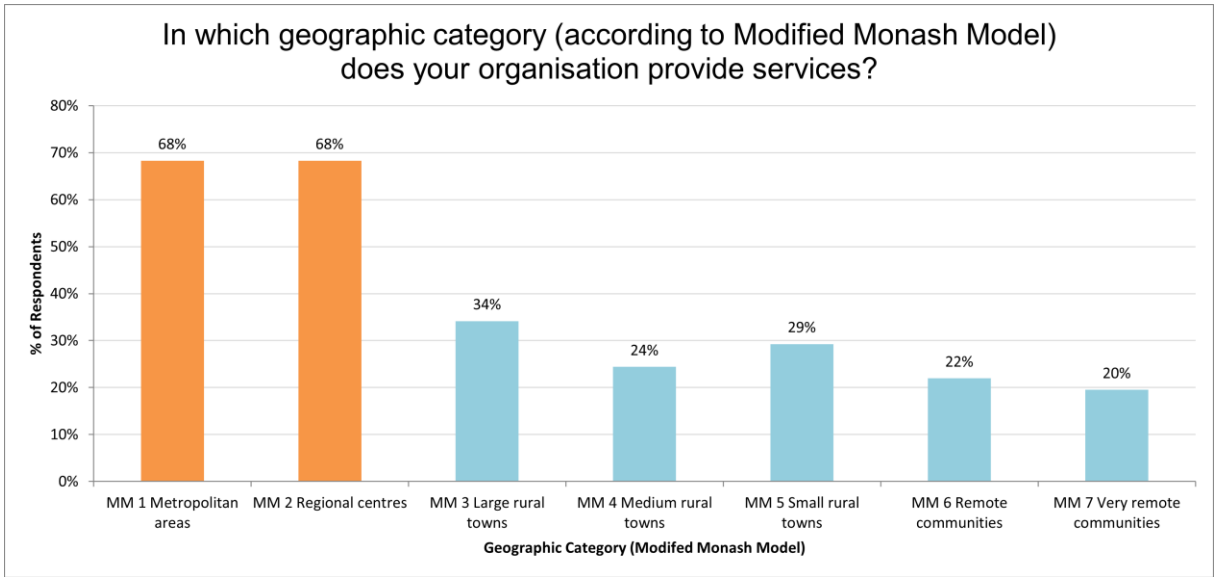


Geographic service area

More than two thirds (68 per cent) of Community Mental Health and Wellbeing organisations which participated in this survey provide services in metropolitan areas such as Brisbane, Gold Coast or Sunshine Coast. A further 68 per cent service large regional centres such as Cairns or Toowoomba that are classified as MM2 areas using the Modified Monash Model 2019 (MMM 2019)[5]. Notably however, a significant proportion of respondents provide services to rural and remote communities with 35 per cent servicing large rural towns (e.g. Maryborough, South Gladstone and Tannum Sands), 24 per cent medium-size rural towns, 29 per cent small rural towns, 22 per cent remote communities and a fifth (20 per cent) of respondents servicing very remote MM7 communities. Figure 2 below shows the percentage of respondents servicing each area classification according to the Modified Monash Model 2019. Please note that percentages add up to more than 100 per cent as respondents were able to select multiple MMM categories if services were provided in more than one category.

[5] Australian Government Department of Health. (2020). *Modified Monash Model – Fact Sheet*. modified-monash-model-fact-sheet.pdf (health.gov.au)

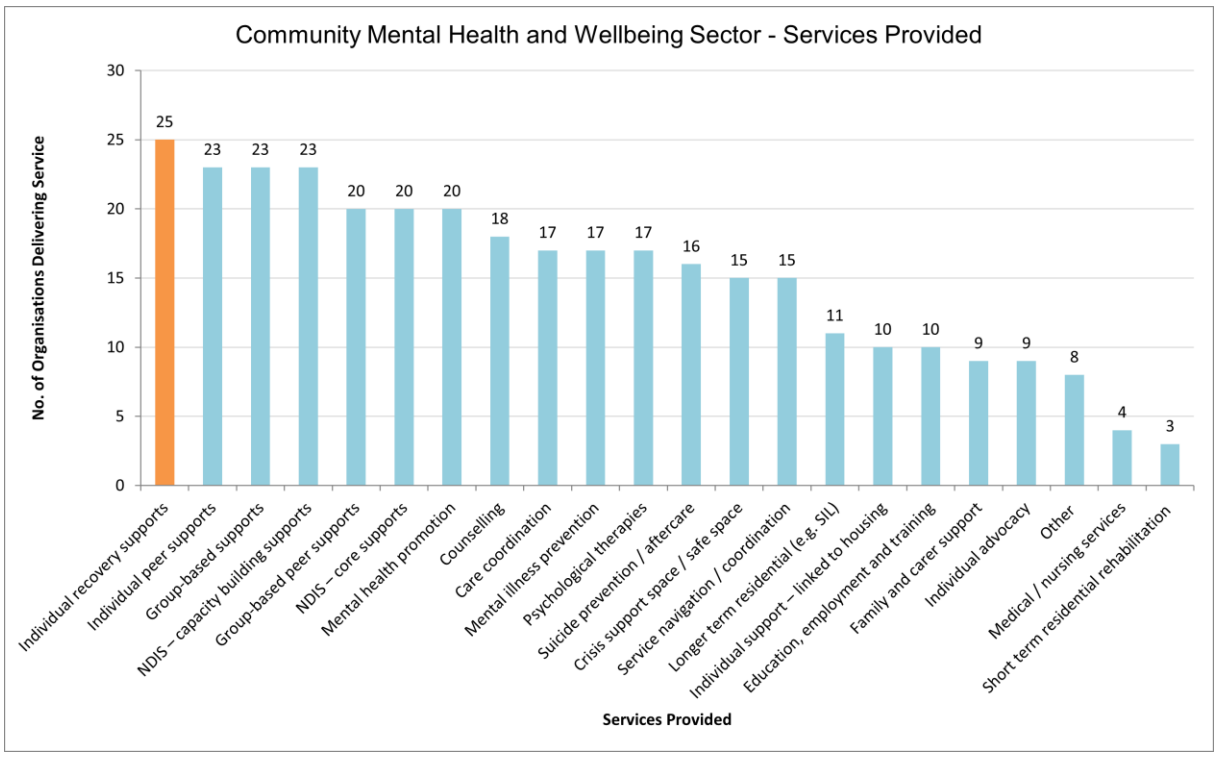
Figure 2: Service Area [41 total responses]



Services provided

Community Mental Health and Wellbeing organisations participating in this survey provide a diverse range of services spanning individual support, group supports, advocacy, family and career support, prevention and mental health promotion to housing and crisis support services. Figure 3 below shows the types of services that organisations deliver. Recovery and peer supports provided on an individual basis were the form of support most commonly provided by organisations, followed closely by NDIS capacity building support and group-based supports. 20 organisations – nearly half of the respondents in this survey - report that they currently provide NDIS Core support.

Figure 3: Services Provided [42 total responses]

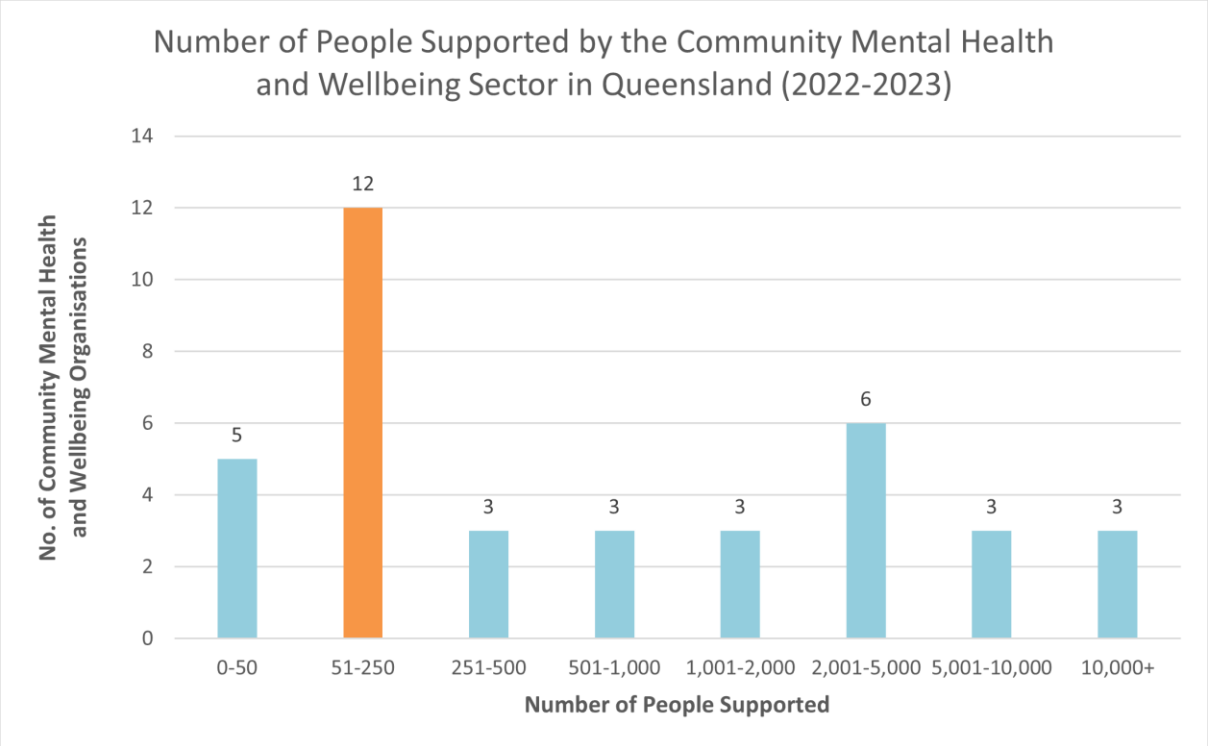


Number of people supported by the sector

Overall, the survey found that the Community Mental Health and Wellbeing Sector organisations which participated in this survey supported a total of 139, 797 people in Queensland during the last financial year 2022-23. While clearly a large number, it must be noted that the amount of time spent supporting people or mode of delivery was not included in survey questions. It is possible that the number includes a large volume of short interactions such as telephone contact.

The size of the cohort supported by each organisation varied significantly between organisations, ranging from under 50 to over 10, 000 people. While the majority (12) of Community Mental Health and Wellbeing organisations who responded to this question reported that they supported between 51-250 people during this period, a further 12 organisations (representing approximately a third of organisations which responded to this question) supported 2,000 people or more during 2022-23. Three organisations reported that they supported more than 10,000 people during the last financial year.

Figure 4: Number of People Supported 2022-23 [38 total responses]



Workforce composition and diversity

Table 1: Workforce Composition and Diversity – At a glance

Total number of workers	3072
Number of female workers	2160
Number of male workers	847
Number of workers who identify as gender diverse	65
Percent of workforce who identify as Aboriginal and Torres Strait Islander	3.8%
Percent of workforce who identify as People from Multicultural and Diverse Backgrounds and Connections	13.1%
Percentage of workplaces with a workplace diversity policy	77.1%

Gender

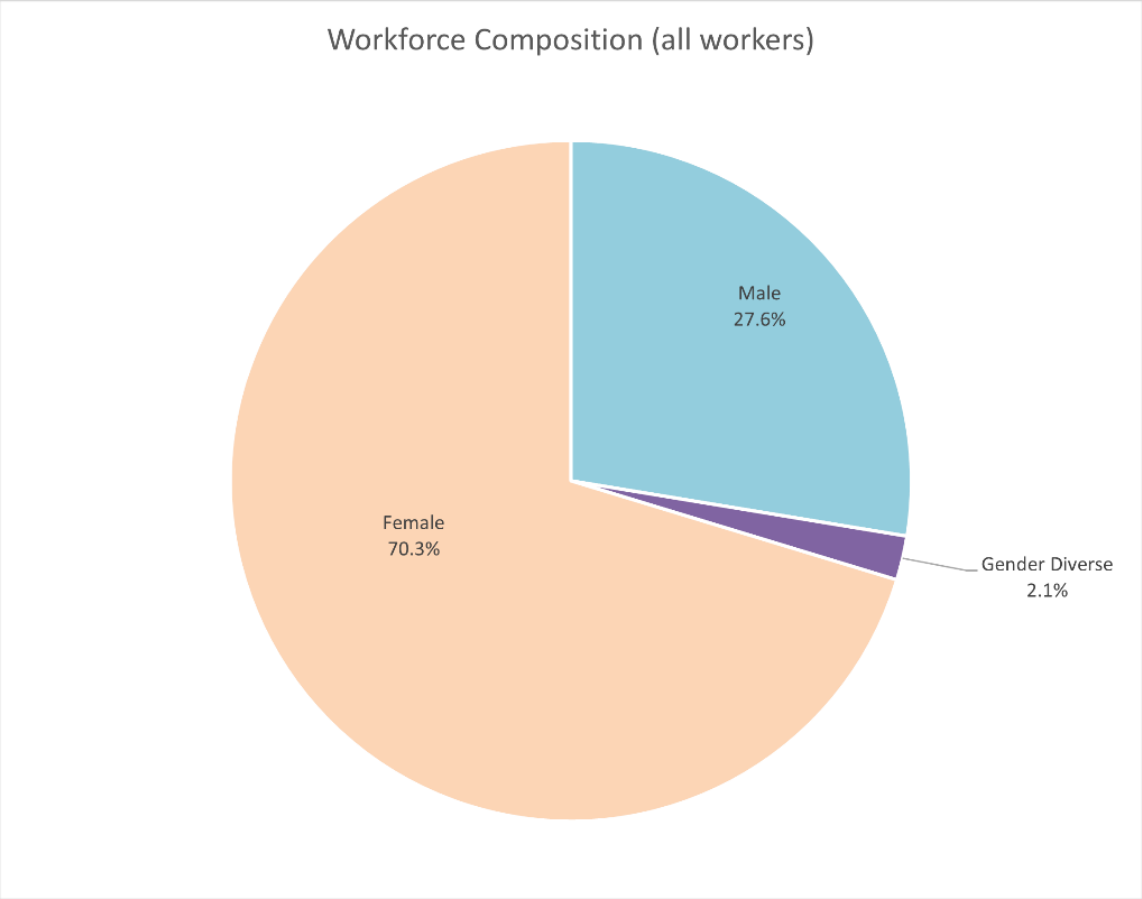
The Community Mental Health and Wellbeing workforce captured via this survey is comprised of approximately 3,072 workers across Queensland. The workforce is predominantly female, with women making up approximately 71 per cent of the workforce (see Figure 5 below). This is lower than the proportion – 85 per cent - of women in Australia's overall welfare workforce in 2020, a figure which has remained relatively consistent since 2010[6]. It is higher than the proportion of women (61 per cent)[7] reported in the ACT Community Mental Health and Wellbeing workforce and similar to the proportion of female workers (72 per cent)[8] reported in NSW. It should be noted that the term "gender diverse" may not properly capture workers who identify as transgender vs cisgender. It is also unclear to what extent organisations capture data on workforce composition and diversity and are therefore able to accurately report this information about their workforce.

[6] Australian Institute of Health and Welfare. (2021). *Welfare Workforce Snapshot*. Welfare workforce - Australian Institute of Health and Welfare (aihw.gov.au)

[7] Ridoutt, L., Curry, R., Prince, S., Dobson, C. and Lawrence, J. (2023). *ACT community-managed mental health workforce profile 2023*. Mental Health Community Coalition ACT, Canberra. https://mhccact.org.au/wp-content/uploads/MHW-2023-Report-v03-WEB.pdf

[8] Ridoutt, L. and Mental Health Coordinating Council NSW. (2021). *Mental Health Workforce Profile: Community managed organisations mental health workforce report 2021 New South Wales.* MHCC_WorkforceSurvey_2021.pdf

Figure 5: Workforce Composition – Gender Diversity [35 total responses]



Cultural diversity

The sector sample has a slightly higher representation of First Nations peoples, with 3.8 per cent of the Community Mental Health and Wellbeing workforce identifying as Aboriginal and Torres Strait Islander, compared with 3.5 per cent of the total Australian workforce[9]. People from Multicultural and Diverse Backgrounds and Connections represent approximately 13.1 per cent of Queensland's Community Mental Health and Wellbeing workforce. While comparisons to Community Mental Health and Wellbeing Sector workforces in ACT and NSW should be treated with caution due to the large number of organisations in both states which reported that they don't collect this data, Table 1 below provides figures reported for each jurisdiction, which can be treated as an indication of workforce diversity. By way of comparison, in the 2021 Australian Census, approximately 22.7 per

[9] Australian Institute of Health and Welfare. (2020). *Aboriginal and Torres Strait Islander Health Performance Framework 2020 Online Data Tables 2.07 Employment.* 2.07 Employment / Data - AIHW Indigenous HPF

cent of Queensland's population identified as being born overseas[10], while 7.49 per cent (measured by headcount) of Queensland's public sector workforce in 2023 identified as People from Multicultural and Diverse Backgrounds and Connections due to speaking a language other than English at home.[11]

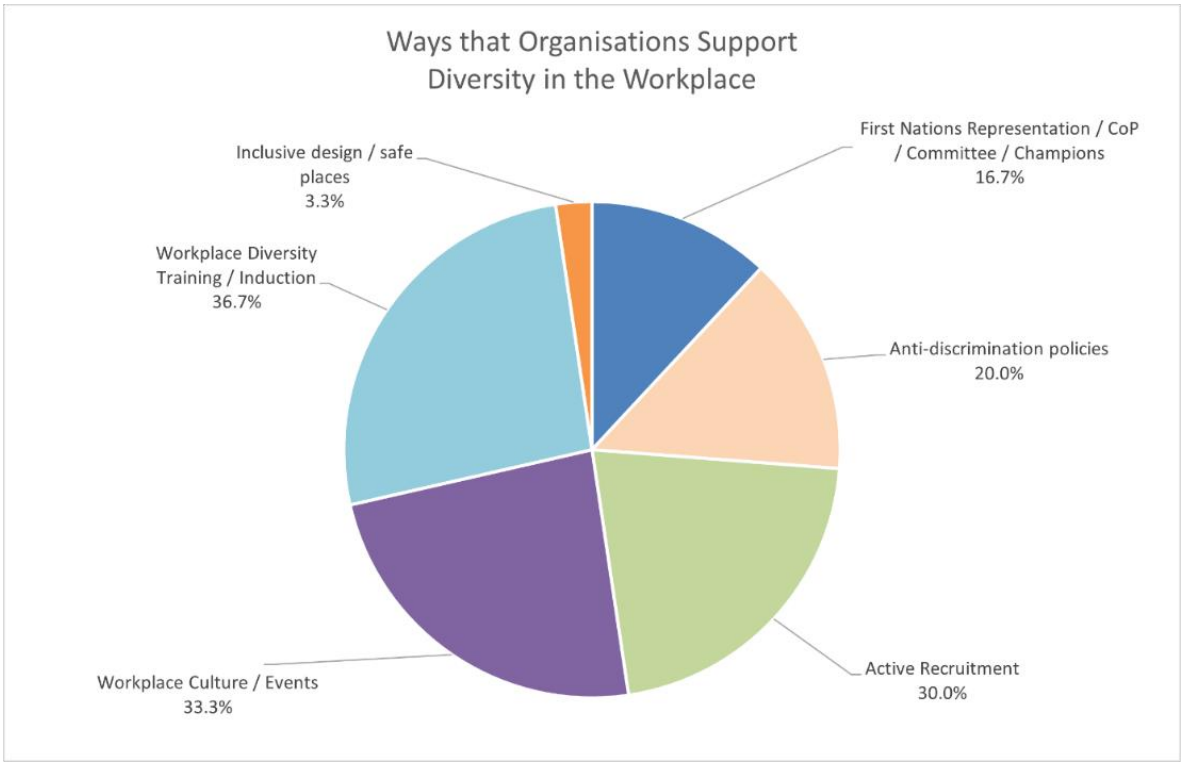
Table 2: Community Mental Health and Wellbeing Sector Workforce Diversity by Jurisdiction

Community Mental Health and Wellbeing Workforce Jurisdiction	Multicultural and Diverse Backgrounds and Connections (Workforce %)	Aboriginal and Torres Strait Islander (Workforce %)
Queensland	13.1%	3.8%
Australian Capital Territory (2023 data[12])	15.1%	1.5%
New South Wales (2021 data[13])	7.4%	3%

The top three ways that organisations report that they support workplace diversity in their workplace (see Figure 7 below) are workplace training and induction processes, workplace culture and events; and active recruitment. More than three quarters (77.1 per cent) of organisations report that they have a workplace diversity policy in place.

[10] Australian Bureau of Statistics. (2022). *Cultural Diversity of Australia.* Cultural diversity of Australia | Australian Bureau of Statistics (abs.gov.au)
[11] Public Sector Commission. (2023). *Queensland Public Sector Workforce Profile*. Queensland public sector workforce profile March 2023 (forgov.qld.gov.au)
[12] Ridoutt, L., Curry, R., Prince, S., Dobson, C. and Lawrence, J. (2023). *ACT community-managed mental health workforce profile 2023.* Mental Health Community Coalition ACT, Canberra. https://mhccact.org.au/wp-content/uploads/MHW-2023-Report-v03-WEB.pdf
[13] Ridoutt, L. and Mental Health Coordinating Council NSW. (2021). *Mental Health Workforce Profile: Community managed organisations mental health workforce report 2021 New South Wales*. MHCC_WorkforceSurvey_2021.pdf

Figure 6: Ways that Organisations Support Workplace Diversity [30 total responses]



Examples of the various ways that organisations report that they support diversity in the workplace included:

"We have a First Nations Caucus where First Nations employees come together to discuss their employment experience. We have lived experience and peer identified roles across our programs – reflecting the communities we work with." – Community Mental Health and Wellbeing Sector organisation

"We actively encourage diversity through training programs, we have a diversity committee leading change within the organisation, we promote diversity in recruitment and governance." – Community Mental Health and Wellbeing Sector organisation

"Equal opportunity for all employees, including identifying and creating opportunities for employment that are equitable and accessible to people from disadvantaged backgrounds. In recognition of distinct cultural rights of Aboriginal and Torres Strait Islander Peoples, we develop plans and programs in partnership with local Elders and their communities to increase access to workplace opportunities for Aboriginal and Torres Strait Islander Peoples. Provide reasonable adjustments in the workplace. Training for all employees and others in accordance

with diversity and inclusion policy." – Community Mental Health and Wellbeing Sector organisation

"Aboriginal and/or Torres Strait Islander recruitment and retention strategy, RAP group, Aboriginal and/or Torres Strait Islander Advisory group, cultural safety training, ATSI senior managers and Board members etc." – Community Mental Health and Wellbeing Sector organisation

"1. Celebrate a variety of cultural events. 2. Make food from a variety of cultures. Encourage staff to share their cultural recipes. 3. Social media campaigns - interviews with staff and members to celebrate and learn about diversity. 4. Policies 5. Training - including compulsory training LGBTQI and multicultural for all staff. 6. Flags hanging in the Clubhouse - LGBTQI, Aboriginal and different countries 7. Commenced developing a RAP 8. Culture - a culture where everyone is included." – Community Mental Health and Wellbeing Sector organisation

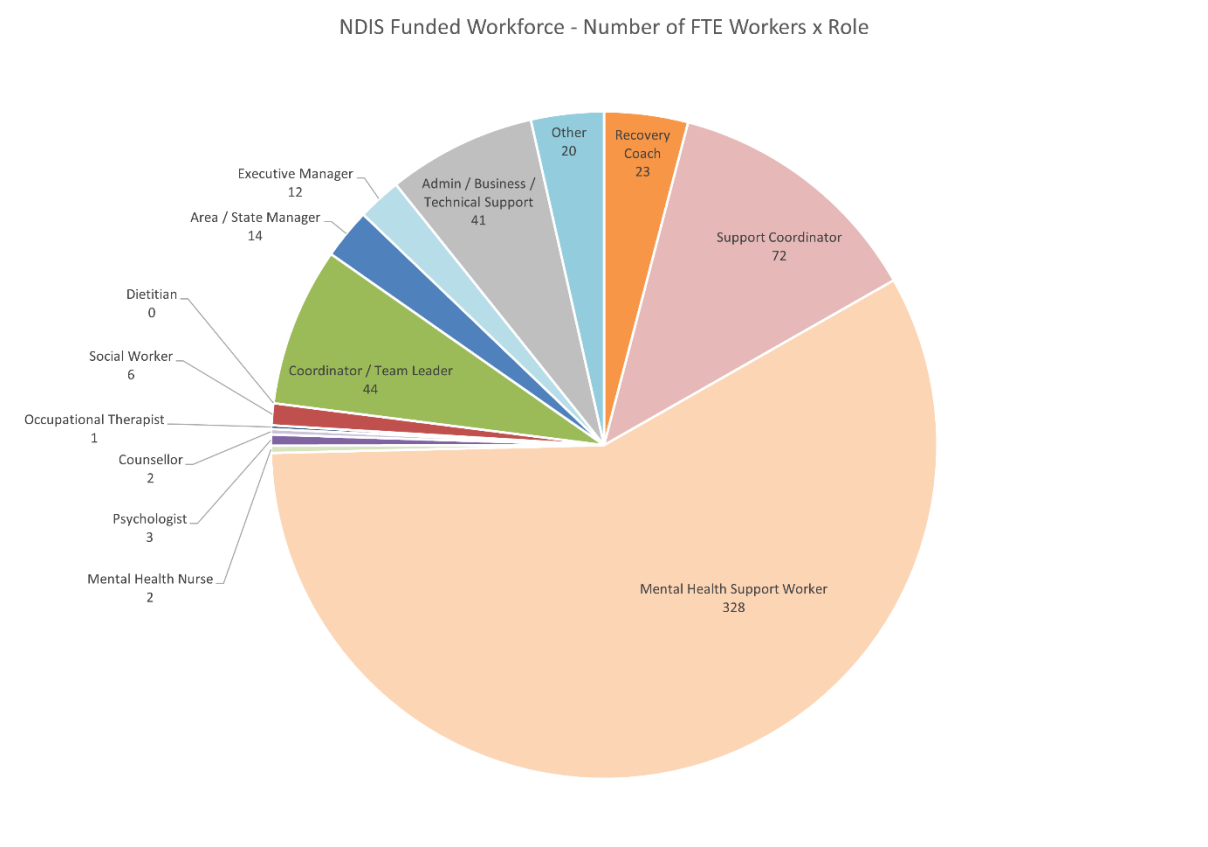
NDIS vs non-NDIS workforce composition

Overall, 36.3 per cent of current Full Time Equivalent (FTE) positions within the Community Mental Health and Wellbeing Sector organisations surveyed are employed in an NDIS role, while 63.7 per cent of current FTE positions are employed in non-NDIS roles.

NDIS workforce

Within organisations responding to this survey, a total of 566 FTE positions are employed by the sector in NDIS roles. The overwhelming majority of these positions are Mental Health Support Workers, comprising 57.8 per cent of the NDIS workforce, or 328 FTE positions. The next largest proportions of workers are Support Coordinators (12.7 per cent), Administration, Business and Technical Support (7.2 per cent) and Coordinators or Team Leaders (7.7 per cent). Psychosocial Recovery Coaches comprise just 4.1 per cent of the NDIS workforce, while clinical and Allied Health roles are also minimally represented at 2.4 per cent of the total NDIS workforce.

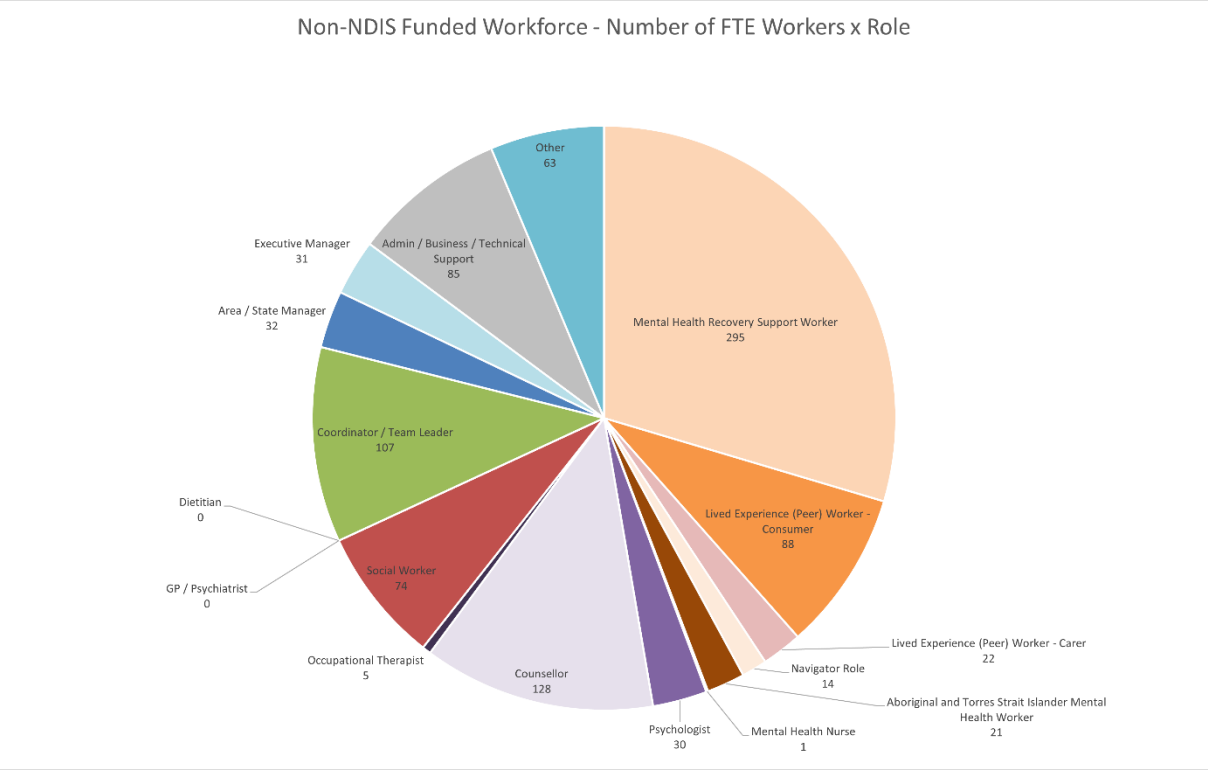
Figure 7: NDIS Workforce - FTE Roles [15 total responses]



Non-NDIS workforce

The non-NDIS funded Community Mental Health and Wellbeing workforce represented by organisations responding to this survey is made up of around 995 FTE positions. By comparison, the non-NDIS workforce consists of a more diverse range of roles. Figure nine below shows the composition of the non-NDIS funded workforce. Again, Mental Health Recovery Support Workers comprise the largest proportion of the non-NDIS workforce at 29.6 per cent, followed by Counsellors (12.8 per cent), Coordinators / Team Leaders (10.8 per cent), Lived Experience (Peer) Worker – Consumers (8.9 per cent) and Administration, Business Support and Technical roles (8.5 per cent). While Mental Health Recovery Support Workers make up a smaller proportion of the non-NDIS workforce compared to the NDIS workforce (57.8 per cent), when considered together with Lived Experience (Peer) Workers, the proportion is approximately 38.5 per cent. It is worth noting that a number of respondents stated that they don't believe that Lived Experience (Peer) roles should be considered separately to the category of "Mental Health Support Worker".

Figure 8: Non-NDIS Workforce - FTE Roles [21 total responses]



Attraction and Retention

To get an idea of what is happening in terms of attraction and retention within the Community Mental Health and Wellbeing workforce organisations which participated in this survey, the survey also looked at how many FTE positions were recruited, compared to how many resigned for each role type between June 2022 and May 2023. This period represents nearly a complete financial year. Overall, the results paint an interesting picture of a highly diverse workforce that is growing in some areas and shrinking in others. However, in total, the sector's paid workforce has grown by approximately 12.6 per cent, from 1,385 to 1,561 FTE positions during this period. While the headcount growth for the sector should be expected to be much higher, this still represents significant annual growth, nearly double the findings for the Community Mental Health and Wellbeing workforce in New South Wales, which reported annual FTE growth of just over 6 per cent since 2019[14]. While it is encouraging to see this increase, it must be noted that the overall numbers are still small (ie. the workforce growth is from a small base). It is also potentially a result of short-term funding boosts (eg. Covid-19 grants) or one-off investments (eg. Head to Health). These figures need to be reviewed over a number of years to gain a better understanding of long-term workforce trends.

In comparison to general employment growth in Queensland, it is even higher. For Queensland, the year-average employment growth is forecast to reach 2.75 per cent in 2022-23, before easing to 1.5 per cent in 2023-24[15]. Results for the Queensland Community Mental Health and Wellbeing NDIS funded and non-NDIS funded workforce are presented below.

NDIS Funded Workforce

The NDIS funded workforce showed the strongest growth overall, with the total NDIS workforce increasing by 14.4 per cent during 2022-23. The highest FTE increases were seen in the numbers of Psychosocial Recovery Coaches and Mental Health Support Workers employed. Mental Health Support Workers in particular recorded exceptional growth, with the FTE workforce more than tripling to record an increase of approximately 213 per cent. Table 3 below indicates the workforce change reported by organisations for each NDIS role type. However, these results are drawn from responses to two survey questions and should be interpreted with some caution particularly where the numbers involved are very low due to possible difference in the organisations which responded to each question. For this reason, we are unable to extrapolate any meaningful or useful workforce data about clinical and allied health professions such as occupational therapists and counsellors.

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[14] Ridoutt, L. and Mental Health Coordinating Council NSW. (2021). *Mental Health Workforce Profile: Community managed organisations mental health workforce report 2021 New South Wales*. MHCC_WorkforceSurvey_2021.pdf

[15] The Queensland Cabinet and Ministerial Directory. (2022). *2022-23 Queensland Budget Update*. 2022-2023 Queensland Budget Update - Ministerial Media Statements

Interestingly, the results show that growth is not consistent across all role types, with other key NDIS roles – Support Coordinators and Team Leaders – recording negative growth. The Support Coordination workforce barely changed, recording -0.3 per cent growth. This lack of growth in the Support Coordination workforce may in part reflect the NDIS shift towards the specialised Psychosocial Recovery Coach role and increasing uptake of this support in plans for psychosocial disability. Concerningly, despite the significant growth of the sector's overall NDIS workforce, the number of FTE Team Leader positions were found to decrease by 7.4 per cent. This could point to a worrying trend of difficulty retaining higher level positions within the Community Mental Health and Wellbeing Sector, as workers seek higher paid roles, as well as the challenge in coverage the costs of support and supervision into the NDIS fee for service model.

Table 3: FTE Workforce Change - NDIS Funded Workforce [18 total responses]

Role (NDIS Funded)	Original Workforce Jun 2022 (FTE positions)	Current Workforce May 2023 (FTE positions)	% Increase
Psychosocial Recovery Coach	13	23	76.9%
Mental Health Support Worker	23	72	213.0%
Support Coordinator	328.6	327.6	-0.3%
Mental Health Nurse	2	2	0.0%
Psychologist*	1	2	100.0%
Counsellor*	0.5	1.5	200.0%
Occupational Therapist*	Invalid result	Invalid result	Invalid result
Social Worker	4	6	50.0%
Dietitian	0	0	0.0%
Team Leader	47.1	43.6	-7.4%
Area / State Manager	12.8	13.8	7.8%
Executive Manager	12	12	0.0%
Admin / Business / Technical Support	37.3	40.8	9.4%
Other	14	20	42.9%
Total	**494.3**	**565.3**	**14.4%**

* Indicates these results should be treated with caution, due to low numbers involved.

Non-NDIS Funded Workforce

While not quite as strong as the growth of the NDIS funded workforce, the non-NDIS funded workforce still demonstrated an impressive increase in the number of FTE positions it employs, recording total growth of 11.7 per cent during the period June 2022 – May 2023. Here, the strongest statistically significant growth was recorded in direct service delivery roles including Mental Health Recovery Support Workers (27.0 per cent) and Lived Experience (Peer) Workers – Consumer (22.9 per cent). While Lived Experience (Peer) Workers – Carer (208.3 per cent increase) also showed very

high growth, this result should be interpreted with some caution due to the low numbers involved. If all three roles are considered together as Mental Support Workers, the reported workforce grew from approximately 311 FTE positions to 405 FTE positions between June 2022 – May 2023, representing a 30.3 per cent increase. Social Workers also demonstrated strong growth at 15.5 per cent.

Reflecting trends for leadership positions in the NDIS funded workforce, higher level non-NDIS roles including Coordinator / Team Leader, Area State Manager and Executive Manager all recorded negative growth during the survey period. These findings align with concerns regarding the difficulty in recruiting for these roles reported in the next section of this report. Interestingly, clinical roles of GP and Psychiatrist are not represented in the survey findings at all, indicating that these roles are not relevant to the Community Mental Health and Wellbeing Workforce in Queensland.

Table 4: FTE Workforce Change – non-NDIS Funded Workforce [24 total responses]

Role (non-NDIS Funded)	Original Workforce Jun 2022 (FTE positions)	Current Workforce May 2023 (FTE positions)	% Increase
Mental Health Recovery Support Worker	231.8	294.5	27.0%
Lived Experience (Peer) Worker - Consumer	71.7	88.1	22.9%
Lived Experience (Peer) Worker – Carer*	7.2	22.2	208.3%
Navigator Role	14	14	0.0%
Aboriginal and Torres Strait Islander Mental Health Worker	21	21	0.0%
Mental Health Nurse*	Invalid result	Invalid result	Invalid result
Psychologist	29.9	29.9	0.0%
Counsellor	125.8	127.8	1.6%
Occupational Therapist*	3.8	4.8	26.3%
Social Worker	64.4	74.4	15.5%
GP	0	0	0.0%
Psychiatrist	0	0	0.0%
Dietitian	0	0	0.0%
Coordinator / Team Leader	112.4	107.4	-4.5%
Area / State Manager	33.5	31.5	-6.0%
Executive Manager	31.7	30.7	-3.1%
Admin / Business / Technical Support	82.8	84.8	2.4%
Other	61.8	62.8	1.6%
Total	**890.8**	**994.9**	**11.7%**

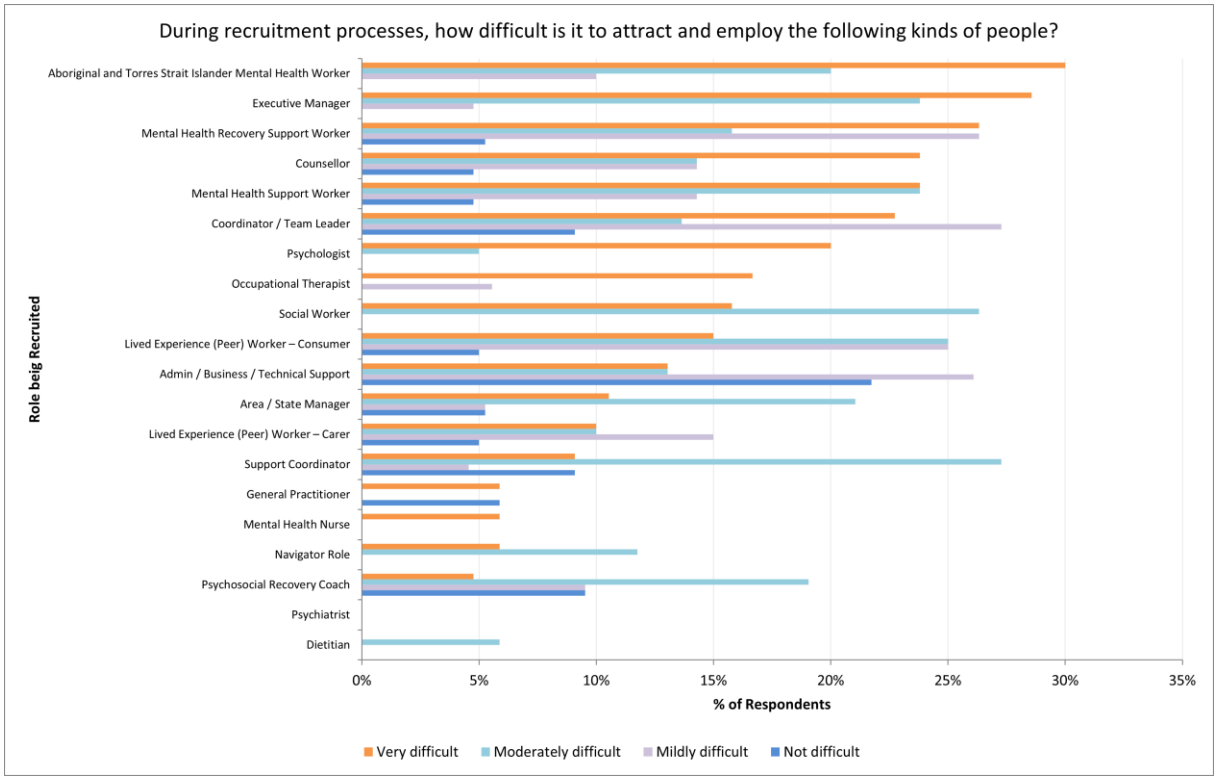
* Indicates these results should be treated with caution, due to low numbers involved.

Recruitment difficulty

Queensland Community Mental Health and Wellbeing organisations reported that the most difficult roles to recruit for are Aboriginal and Torres Strait Islander Mental Health Workers, Counsellors, Mental Health Support Workers (NDIS and non-NDIS funded roles) and Executive Managers. The majority of respondents indicated that it was “very difficult” or “moderately difficult” to attract and employ suitable individuals for these types of roles.

By contrast, Social Workers, Lived Experience (Peer) Workers – Consumer, Area / State Managers, Support Coordinators and Psychosocial Recovery Coaches were generally considered moderately difficult roles to recruit. Administration, Business and Technical Support roles were reported to be the easiest roles to recruit. Coordinators / Team Leaders showed mixed results with a similar number of respondents (23 per cent) indicating that these roles were “very difficult” to recruit and 27 per cent indicating that these roles are “mildly difficult” to recruit. This is an interesting finding when considered in the context of the shrinking size of this occupation group within both the NDIS and non-NDIS funded workforces.

Figure 9: Recruitment Difficulty - All Roles [28 total responses]



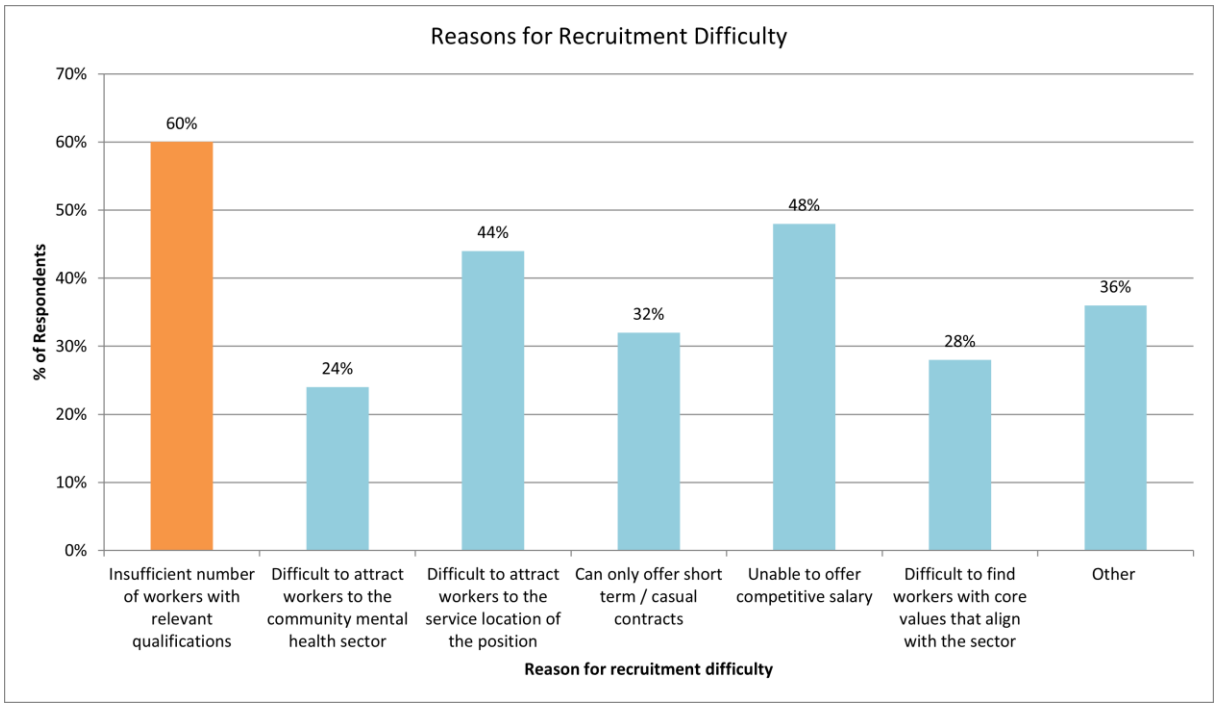
For roles that were identified above as difficult to attract and employ suitable candidates, the most commonly reported reasons for recruitment difficulty were:

- Insufficient numbers of workers with relevant qualifications (60 per cent)

- Inability to offer a competitive salary (48 per cent)
- Difficulty attracting workers to the service location of the position (44 per cent)

Figure 11 shows reasons for recruitment difficulty reported by Community Mental Health and Wellbeing organisations. Respondents also identified that the reasons for recruitment difficulty vary depending on the role, and that it can be difficult to balance equally important recruitment priorities, for example skills and qualifications together with lived experience values and perspectives. These additional responses were captured in the "other" category.

Figure 10: Reasons for Recruitment Difficulty - All Roles [25 total responses]



To address these barriers to employment, organisations suggested innovative practices and ideas, including:

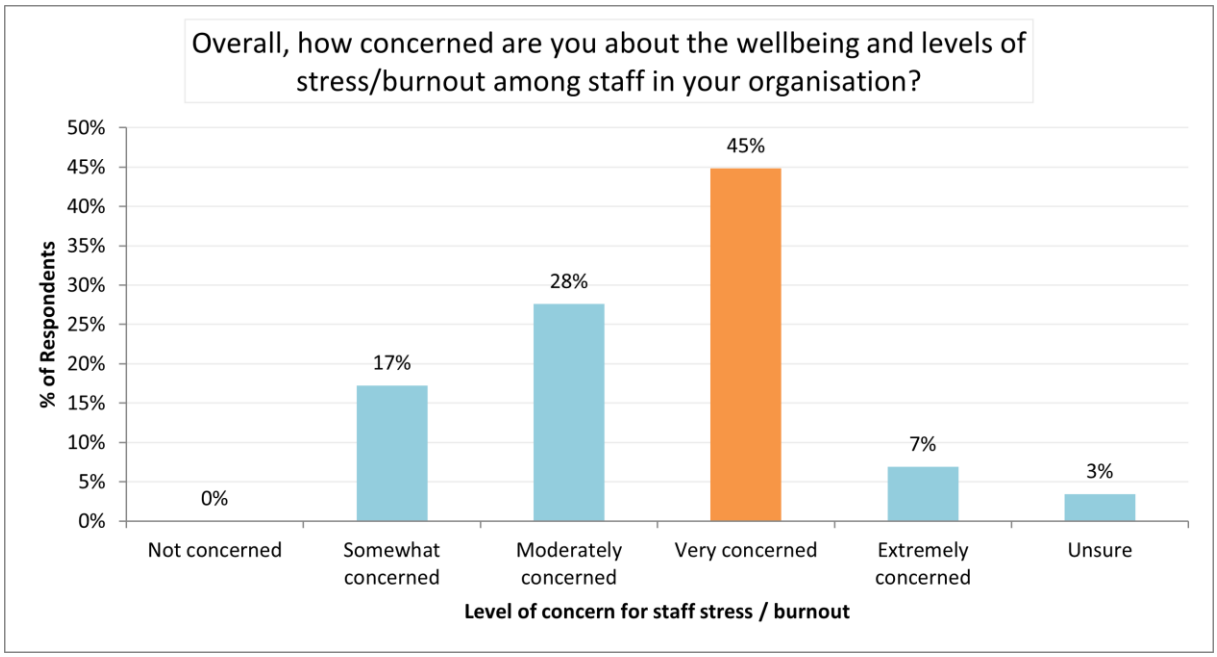
- Introducing advanced practitioner levels and improving internal leadership skills development to develop more pathways for internal advancement;
- Maintaining and improving healthy organisational cultures in order to attract staff whose values align with organisations in the Community Mental Health and Wellbeing Sector;
- Increasing funding to the non-government sector to allow for more attractive/competitive salary packaging;
- Increasing pay and working conditions, for example competitive wages, full-time permanent positions, flexible working conditions, reimbursement of work expenses (e.g. kms for car use), providing paid monthly external supervision to staff;

- Strengthening the capacity of organisations to deliver in house training, career progression, and workforce development framework;
- Providing internships;
- Creating partnerships and working with a DES provider/s to train people to be support workers and provide genuine, intensive training and long-term incentives to remain employed in role.
- Limiting NDIS psychosocial disability support workforce to registered providers only;
- Developing co-employment opportunities with Government (for example, job sharing so staff can experience government and non-government roles)
- Building group support responses that tackle social isolation as a key component of psychosocial challenges;
- Introducing a Flexible Work in Work out model of care;
- Supporting the personal development of those working in the sector to challenge their prejudices and build their maturity, in order to make the sector a more attractive place to work; and
- Introducing traineeships and supported entry points.

Worker wellbeing

It is well recognised that staff working in psychosocial support roles and mental health organisations face a greater risk of psychosocial hazards in the workplace. The difficulty in attracting and employing workers for difficult to fill vacancies can further increase the pressure on existing staff and amplifying the risk to their wellbeing. Overall, more than half (52 per cent) of respondents report that they are "very concerned" or "extremely concerned" with the levels of stress and burnout among staff in their organisation.

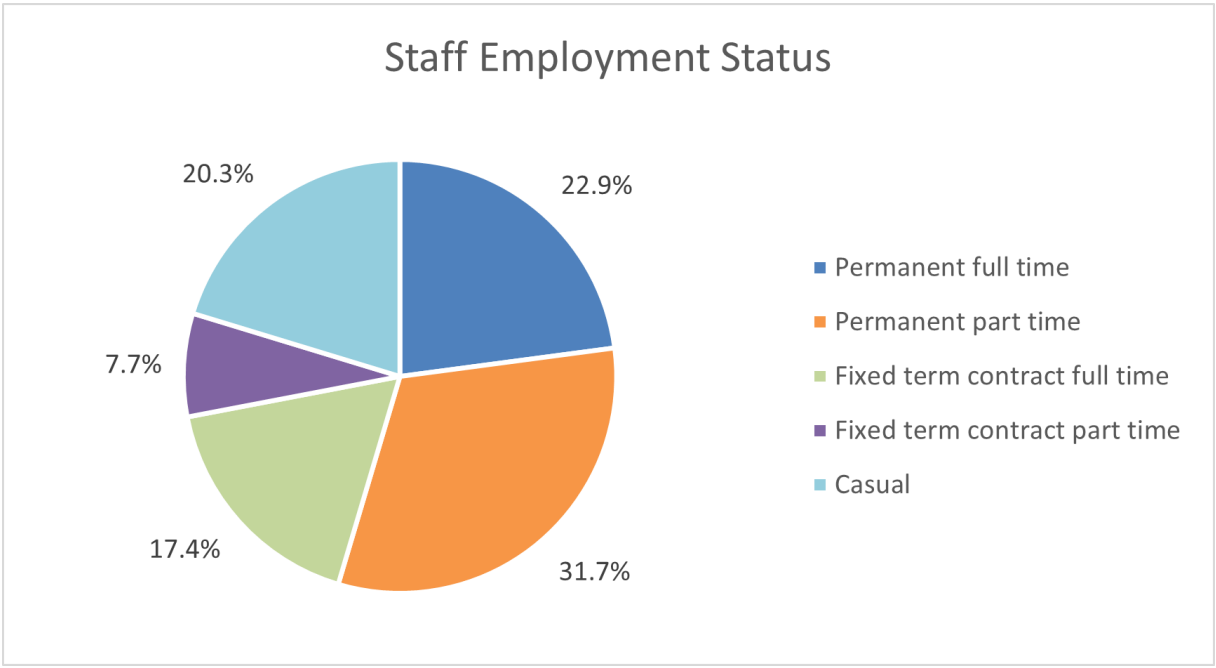
Figure 11: Concern for Worker Wellbeing [29 total responses]



Employment Status

Results show that just over half (54.6 per cent) of workers in Community Mental Health and Wellbeing Sector organisations which participated in this survey are employed on a permanent basis, with the rest of the workforce (45.4 per cent) employed on a temporary basis. This includes 20.3 per cent who are employed on a casual, hourly basis of renumeration. Of those employed permanently, the majority of these roles are part time rather than full time, with permanent part time workers making up the largest proportion of the workforce at 31.7 per cent. In total, the proportion of part time workers in the Queensland Community Mental Health and Wellbeing Sector – including those employed on a permanent part time, fixed term contract part time, and casual basis – is very high at approximately two thirds (59.7 per cent) of the total workforce.

Figure 12: Employment Status - All Workers [28 total responses]



This is comparable with high part time employment rates reported for Community Mental Health and Wellbeing Sector workforces in other jurisdictions. For example, the Mental Health Community Coalition ACT recently found 60.9 per cent of its Community Mental Health and Wellbeing workforce to be employed on a part time basis (including permanent, fixed term and casual workers) and a slightly higher proportion of workers (51 per cent) than Queensland employed in casual or temporary

(i.e. fixed term contract) employment[16]. In 2021, Mental Health Coordinating Council (MHCC) found 54 per cent of the Community Managed Organisation mental health sector workforce in New South Wales to be employed on a part time basis. In comparison, for the total Australian workforce in 2019, the part time employment figure was 32 per cent and 44.3 per cent for the Health Care and Social Assistance industry[17].

Volunteers

Thirteen organisations –46.4 per cent of respondents (n=28) – report that they use volunteers. This includes workers supporting direct service delivery but not being paid, including those in pro bono arrangements. By headcount, volunteers account for an additional 200 workers (6.5 per cent) within the Community Mental Health and Wellbeing workforce and make up a total of 28.2 FTE roles. In total, volunteers comprise 1.8 per cent of the FTE Community Mental Health and Wellbeing Sector workforce and 2.8 per cent of the FTE non-NDIS funded workforce. This is much lower than the FTE figures identified for the community managed mental health volunteer workforces in both the ACT (9.8 per cent) and NSW (8 per cent)[18].

Volunteers support the delivery of mental health services in Community Mental Health and Wellbeing Sector organisations in various ways. The most common way is through direct service delivery, with nearly a third of organisations which utilised volunteers (29.1 per cent), reporting that volunteers assist them in this way. For example, organisations reported that volunteers provide direct services such as co-facilitation of wellbeing mental health service groups, delivering specialist homelessness services, out-of-hours telephone support line assistance and performing duties as per a support coordinator or recovery coach while on student placement. The provision of administrative support is another key support that volunteers provide with 20.9 per cent of organisations reporting that they access administration support from volunteers. Other key volunteer tasks include board / advisory committee support, peer support, resource development and student placement or work experience.

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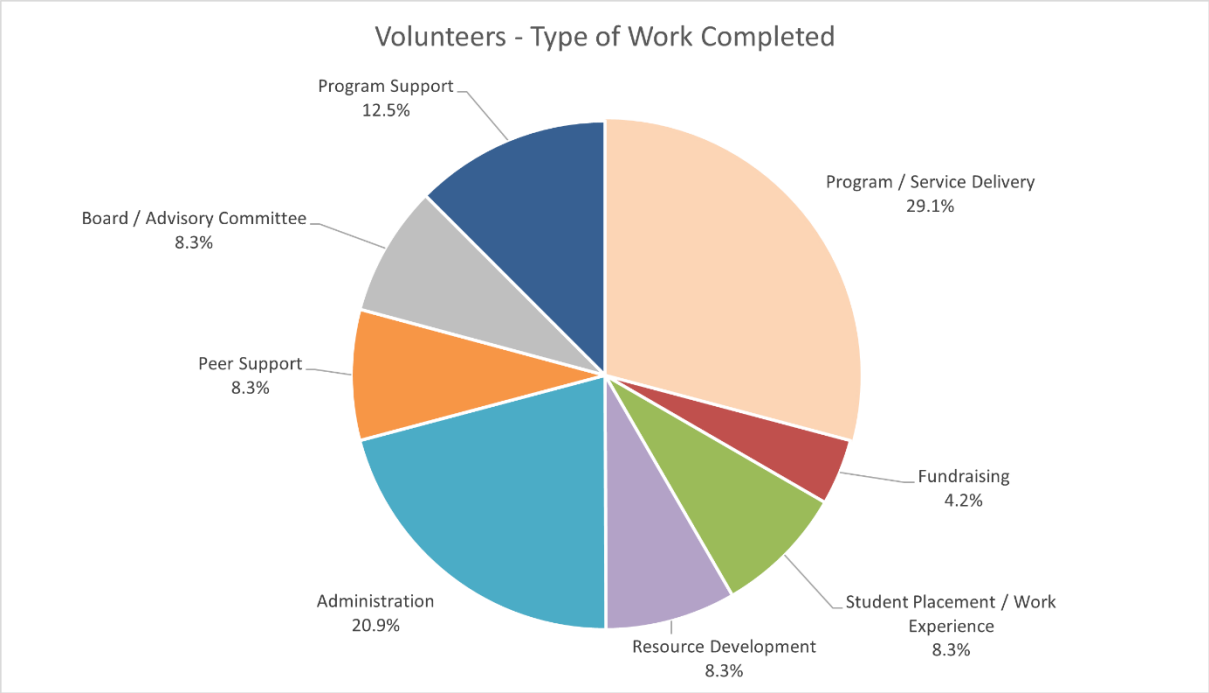
[16] Ridoutt, L., Curry, R., Prince, S., Dobson, C. and Lawrence, J. (2023). *ACT Community Managed Mental Health Workforce Profile 2023*. https://mhccact.org.au/wp-content/uploads/MHW-2023-Report-v03-WEB.pdf

[17] Ridoutt, L. and Mental Health Coordinating Council NSW. (2021). *Mental Health Workforce Profile: Community managed organisations mental health workforce report 2021 New South Wales*. MHCC_WorkforceSurvey_2021.pdf

[18] Ridoutt, L., Curry, R., Prince, S., Dobson, C. and Lawrence, J. (2023). *ACT Community Managed Mental Health Workforce Profile 2023*. https://mhccact.org.au/wp-content/uploads/MHW-2023-Report-v03-WEB.pdf

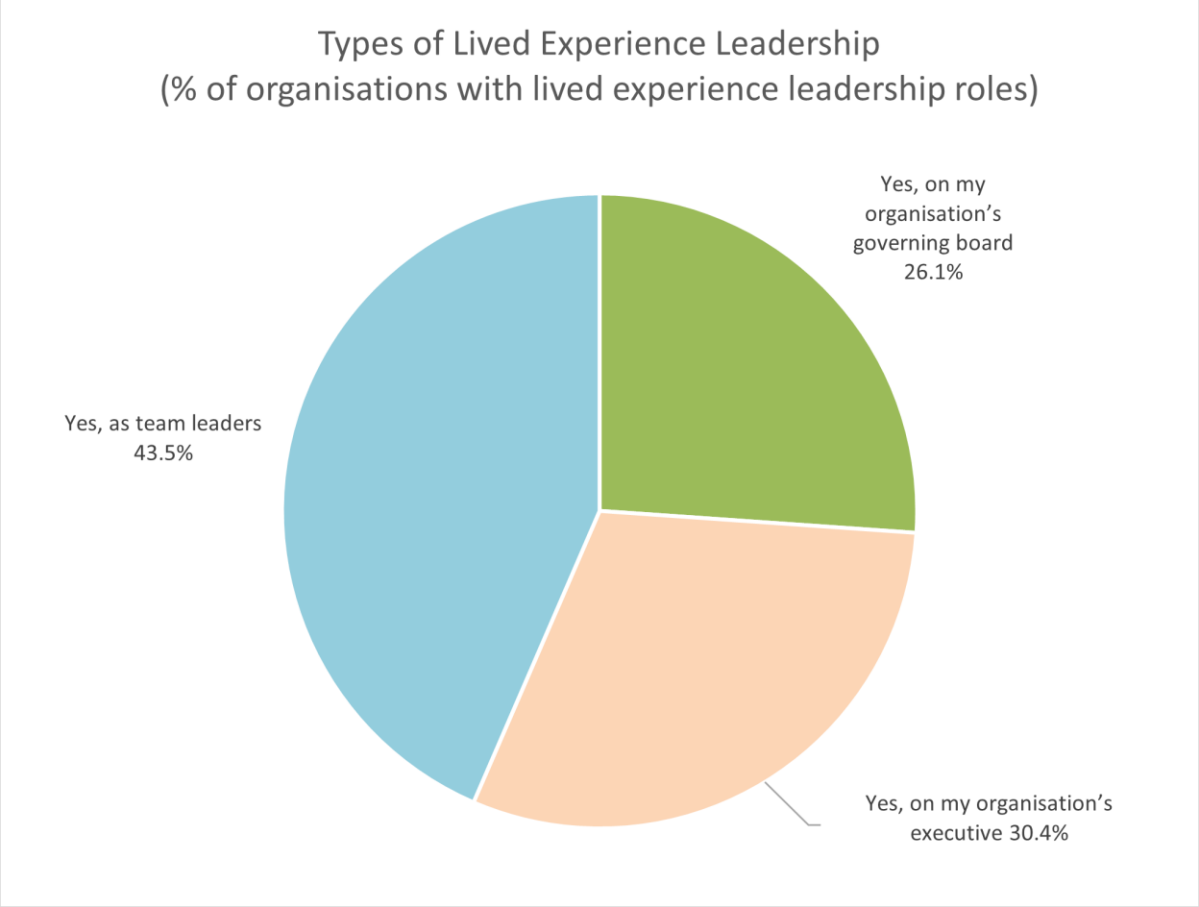
Figure 13: Volunteers - Type of Work Completed [13 total responses]



Lived experience workforce

Fifty per cent of organisations (n=28) participating in this survey reported that they have a dedicated role for lived experience leadership. Of these, the most common roles were as Team Leaders (43.5 percent of responses), followed by executive positions (30.4 per cent) and as lived experience leadership on governing boards (26.1 per cent).

Figure 14: Types of Lived Experience Leadership Roles [14 total responses]



Forty-six per cent of organisations report that they are actively seeking to expand the lived experience workforce, while a further 39 per cent plan to do so in the future. 18 per cent of organisations have no current plans to increase the lived experience workforce (see Figure 16).

Figure 15: Plans to Grow the Lived Experience Workforce [28 total responses]

When recruiting for the lived experience workforce, employers report that they are looking for:

- Lived experience of recovery
- Familiarity with suicide prevention and safety planning
- Familiarity with recovery oriented practice / framework
- Certificate IV in Mental Health Peer Work or Certificate IV Mental Health
- Specific skills or experience, for example group facilitation, counselling and psychotherapy skills, YMHFA training delivery, gardening or music
- Values alignment with the employer
- Soft skills, including personal maturity, emotional resilience, a good level of insight and self management
- The same qualifications as other staff members.

Employers also provided comments and ideas for building the lived experience workforce. Having a clear pathway for professional developmental for people with lived experience as well as supportive internal structures and systems were a common theme for organisations. Two respondents put

forward the conflicting view that there should not be a distinctive role for Lived Experience (Peer Workers). For example:

“Don't have separate jobs that are for peer workers - stop using the term peer workers. Employ people based on their qualifications who also have lived experience. Support staff to utilise this experience in a way that they are comfortable with. Provide a flexible, supportive work environment to assist staff with lived experience.” - Community Mental Health and Wellbeing organisation

“Peer workers and mental health workers should do the same work.” - Community Mental Health and Wellbeing organisation

For others it was more important to recognise and draw on the existing lived and learned experience within Community Mental Health and Wellbeing organisations and make it safe for people to share their experiences, while some organisations highlighted the need for inclusivity:

"Most of our staff are drawn to this area BECAUSE they have lived experience. All of our team have significant lived experience but also have professional qualifications to allow them to provide ongoing supports to their clients.” - Community Mental Health and Wellbeing organisation

"Acknowledgement of lived experience who are not in identified roles - 70 per cent of one program staff have a lived experience, but are not in identified roles. We could easily change existing roles to identified roles in many cases. Recognition of lived experiences without fear of limiting career progression/pigeonholing into identified-lived-experience roles would encourage staff to acknowledge their lived experience without the stigma/othering/risk it would currently entail. Internship or traineeship for people to gain both formal and on-the job experience. Increasing opportunities for peer mentoring, internships/traineeships with enough time allocated for supervision." - Community Mental Health and Wellbeing organisation

“It is important to recognise that a lived experience workforce can come with a variety of skills and qualifications and so all of what they have to offer needs to be valued, not just their lived experience. Lived experience knowledge should be given equal weight to professional knowledge.” - Community Mental Health and Wellbeing organisation

“Inclusive governance is important. People with a lived experience must be part of the decision-making process at every level. They must input their own experience

of recovery and add to the collective wisdom of lived experience. Co-design is just one option - consumers can lead programs themselves." - Community Mental Health and Wellbeing organisation

"I think it starts with having a worldview which says we all share similar challenges and strengths rather than an attitude of "us" (the provider) and "them" (the clients). Rather, we all have a wide experience of facing life with ups and downs - many of us could be the worker or the client over our life course. It is about mutual respect and authentic connection." - Community Mental Health and Wellbeing organisation

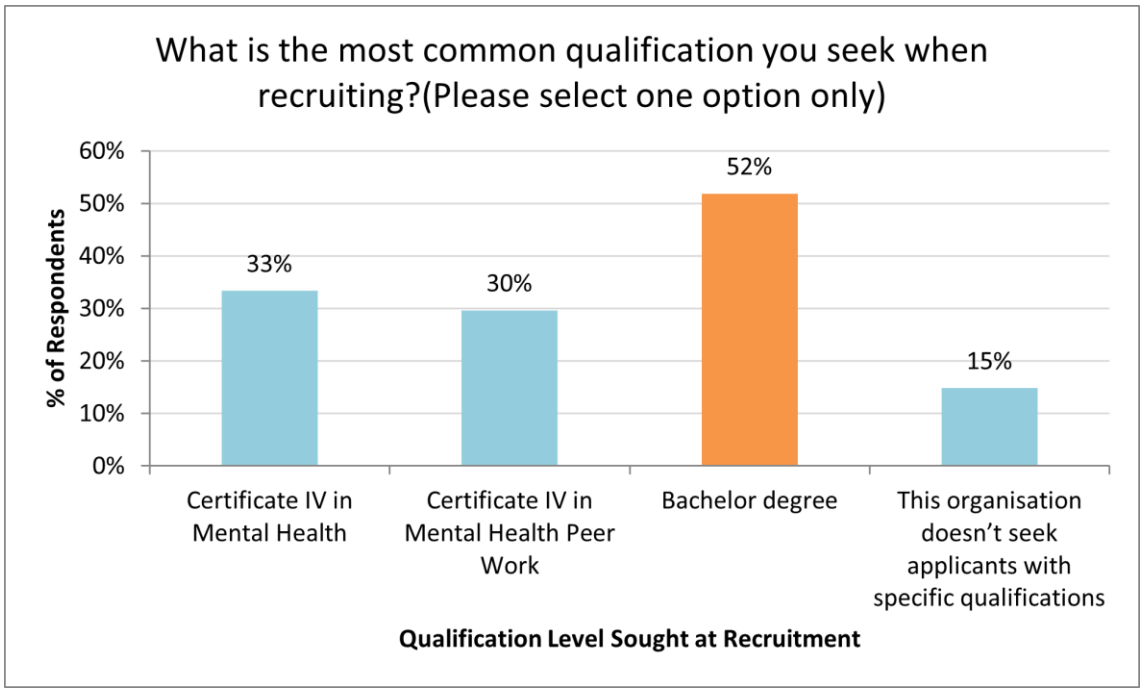
One respondent also highlighted the importance of external factors in supporting the growth of a lived experience workforce:

"It is important that structures and systems internal to organisations but also external are all able to be flexible and shift to be more accessible and inclusive of diversity, otherwise it will lack meaning and purpose to properly develop lived experience workforces if systems don't support it. For example, we can do lots of meaningful and considered work and alter practices and processes to ensure we are integrating and supporting a diverse workforce but when we have imposed requirements on us, it won't be overly effective. An example of this would be National Standards for MH Services (against which we are accredited), which are aimed at mainstream MH and don't offer the flexibility required to have clinical governance that is developed by consumers and those directly impacted by the service delivery." - Community Mental Health and Wellbeing organisation

Qualification level

More than half of organisations (52 per cent) participating in this particular survey question report that they are seeking Bachelor's degree when recruiting, making it the most commonly sought-after qualification. Nonetheless – when considered together – most organisations seek Certificate IV level qualifications via either the Certificate IV in Mental Health or Certificate IV in Mental Health Peer Work, with a total of 63 per cent of organisations most commonly seeking these qualifications. Fifteen per cent of organisations stated that they don't seek any specific qualifications when recruiting. These results regarding qualification level should be interpreted with caution however, as some organisations have selected more than one answer, perhaps due to varying qualification requirements for different roles. Therefore, QAMH cautions that – as organisations have responded differently to this question – these results may not be a valid representation of the sector.

*Figure 16: Qualifications Sought when Recruiting [25 total responses] *Note, results may not be valid*

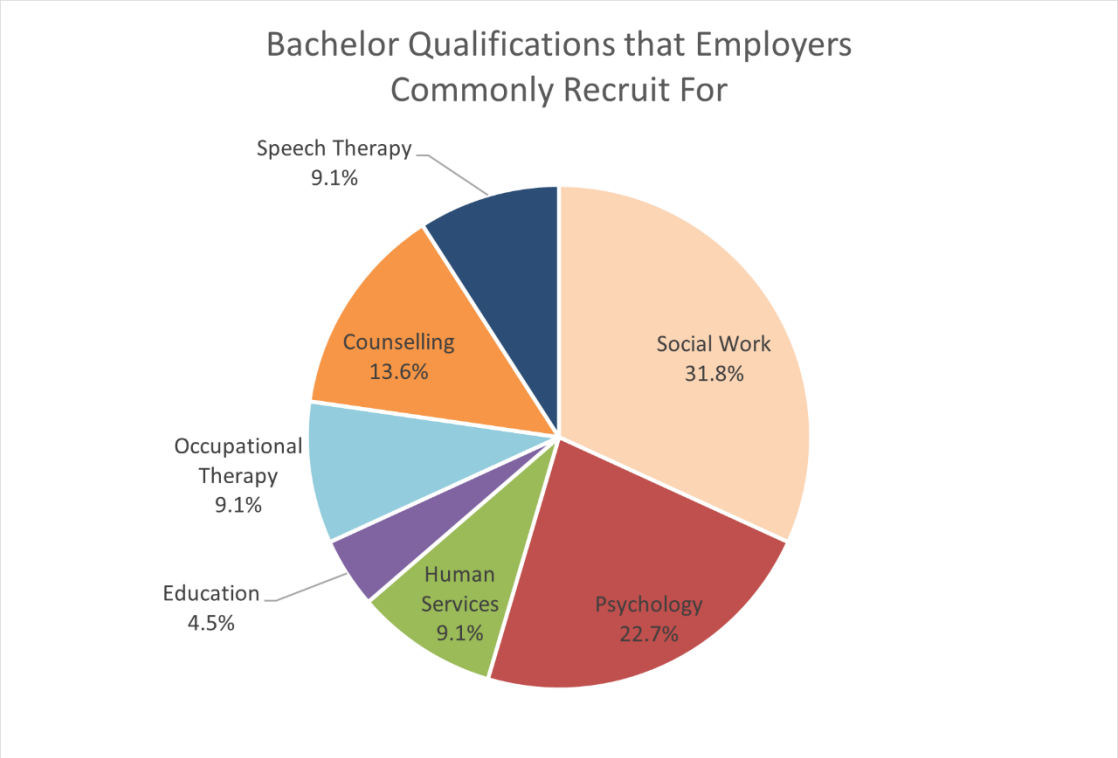


Bachelor's degree qualifications

For recruiters seeking bachelor's degree level qualifications, social work emerges as the clear front-runner and most commonly sought after degree qualification, with 31.8 per cent of organisations

seeking qualifications in this area. This is followed by psychology (22.7 per cent) and counselling (13.6 per cent). Figure 18 below shows other commonly sought qualifications at bachelor's degree level.

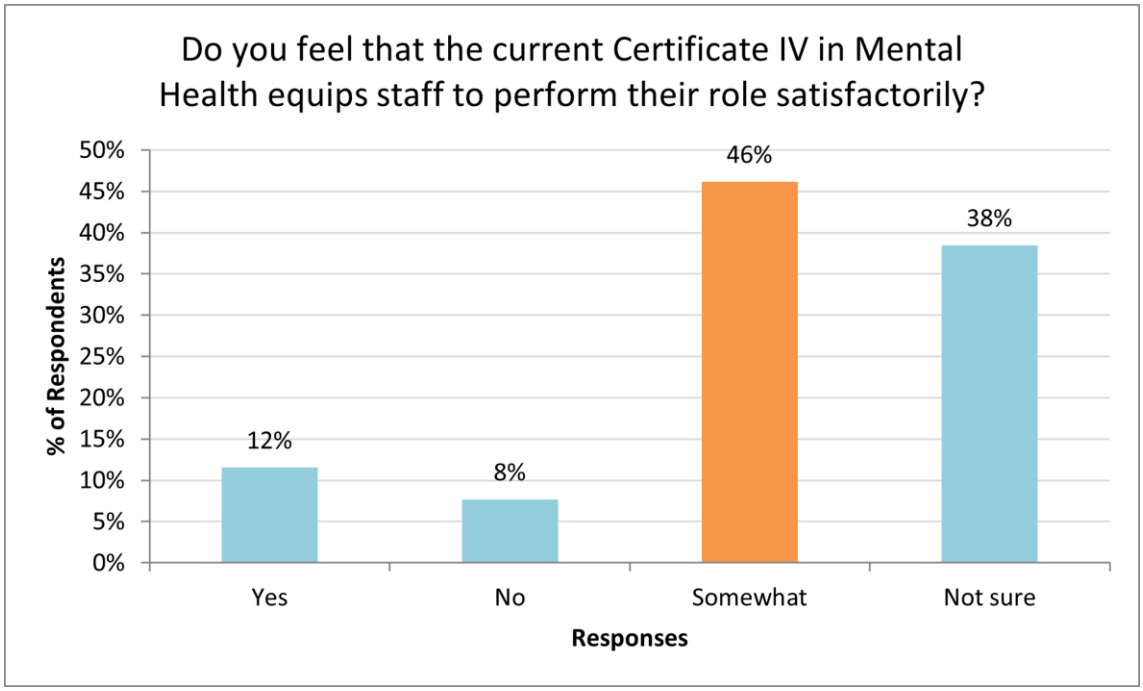
Figure 17: Bachelor's Degree Qualifications Sought at Recruitment [10 total responses]



Certificate IV in Mental Health and Mental Health Peer Work qualifications

Survey respondents held mixed views on the quality of the Certificate IV in Mental Health and Certificate IV in Mental Health Peer Work and to what extent these qualifications effectively equip workers for their role. The majority (46 per cent) of respondents felt that the Certificate IV in Mental Health was "somewhat" effective in equipping staff to perform their role satisfactorily while a further 38 per cent were "not sure". By way of explanation for holding this view, many organisations referred to the importance of values alignment, experience, aptitude and attitudinal factors related to the individual learner, in addition to the qualification itself.

Figure 18: Employer Views on Certificate IV in Mental Health [26 total responses]



In terms of the Certificate IV in Mental Health Peer Work, organisations were even less sure as to the effectiveness of the qualification, with the vast majority of respondents (46 per cent) selecting "not sure", and a further 23 per cent "somewhat". However, it is worth noting that nearly a fifth of respondents (19 per cent) do believe that the Mental Health Peer Work Qualification is an effective means of preparing staff for their role. When delving deeper, organisations who did not hold a positive view of the qualification cited experiences where individual students or staff with this qualification did not reflect appropriate values, attitudinal factors or understanding of the role, highlighting again the importance of individual qualities as well as the qualification itself. Positive reflections on the Certificate IV in Mental Health Peer Work included:

"It does depend on the role and what is required, however, if applicable level, the Cert IV provides a good level of applicable knowledge and skill." – Community Mental Health and Wellbeing Sector organisation

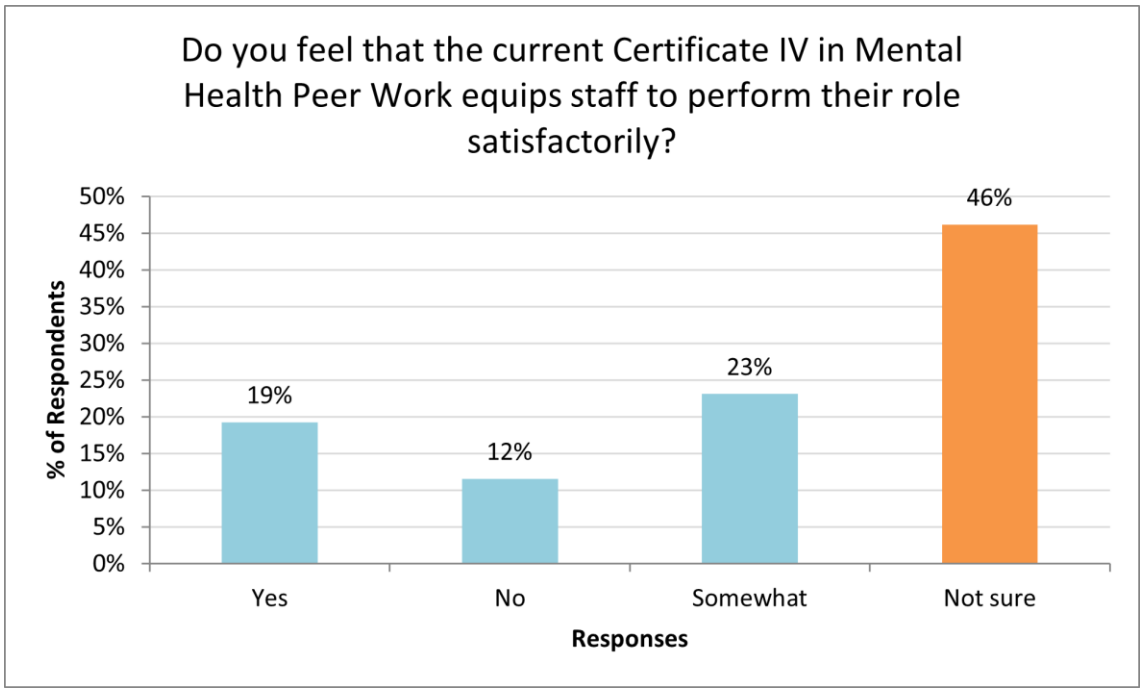
"When we have had staff with this qual, it has been a good foundation." – Community Mental Health and Wellbeing Sector organisation

However others noted that the qualification has areas for improvement, for example:

"Needs to be reviewed and updated to reflect new models of working and model that include multi-disciplinary teams etc." – Community Mental Health and Wellbeing Sector organisation

"It does not delve as deeply into effective lived experience sharing as IPS [Individual Placement and Support]*" – Community Mental Health and Wellbeing Sector organisation*

Figure 19: Employer Views on Certificate IV in Mental Health Peer Work [26 total responses]



Workforce training and development

Traineeships

Organisations held generally positive views about traineeships, with 74.1 per cent of respondents stating that they would consider employing a trainee under a new traineeship program if implemented in the future, with a further 18.5 per cent indicating that they would possibly consider employing a trainee. Approximately 81 per cent of respondents indicated that they would be interested in offering placement opportunities for students completing their Certificate IV in Mental Health or Mental Health Peer Work. Two employers noted that although they are interested in engaging with trainees, they aren't able to, due to a lack of opportunity for one employer, and due to the dual qualification model of the support provided within that specific organisation for the other.

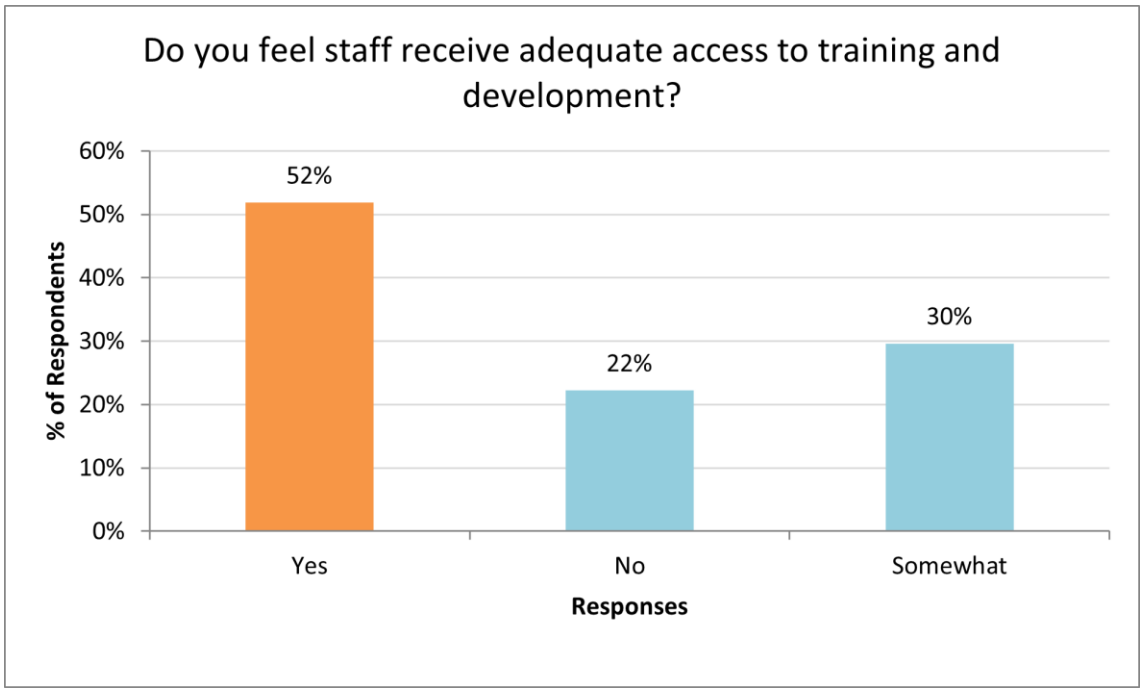
In terms of vocational qualifications – those delivered by Registered Training Organisations (RTOs) – suggestions for improvement include:

- More practical tools and exposure for learners
- Better exploration of continuation of learning pathways, bridging between packages of Community Services Cert III – diploma onwards into diploma. This system is currently poorly articulated and often without direct transfer, leading people to be disengaged from furthering their education
- Ensuring that industry currency is broad and appropriate for trainers. NDIS in particular has slipped under the radar of CHC package reviews, and while this is an ever changing beast is a major force in the community services staffing sector. The Cert III individual support has recently been updated, however translates poorly into any other CHC pathway.
- Higher scrutiny of trainers and ensure that students are work ready.
- More opportunities to engage with trainees in the mental health/social work sector, particularly in regional areas.

Staff access to training and development opportunities

Organisations within the Community Mental Health and Wellbeing Sector which responded to this survey were evenly split between those that felt that staff receive adequate access to training and development opportunities (52 per cent) and those that felt it could be improved (a total of 52 per cent selecting “no” or “somewhat”). Again, in this instance, these responses should be interpreted with caution as respondents may have selected more than one response. It is also worth considering that respondents may have answered the question “Does your organisation experience challenges in providing adequate access to training and development?” differently and with less of a positive take on what is happening in their organisation.

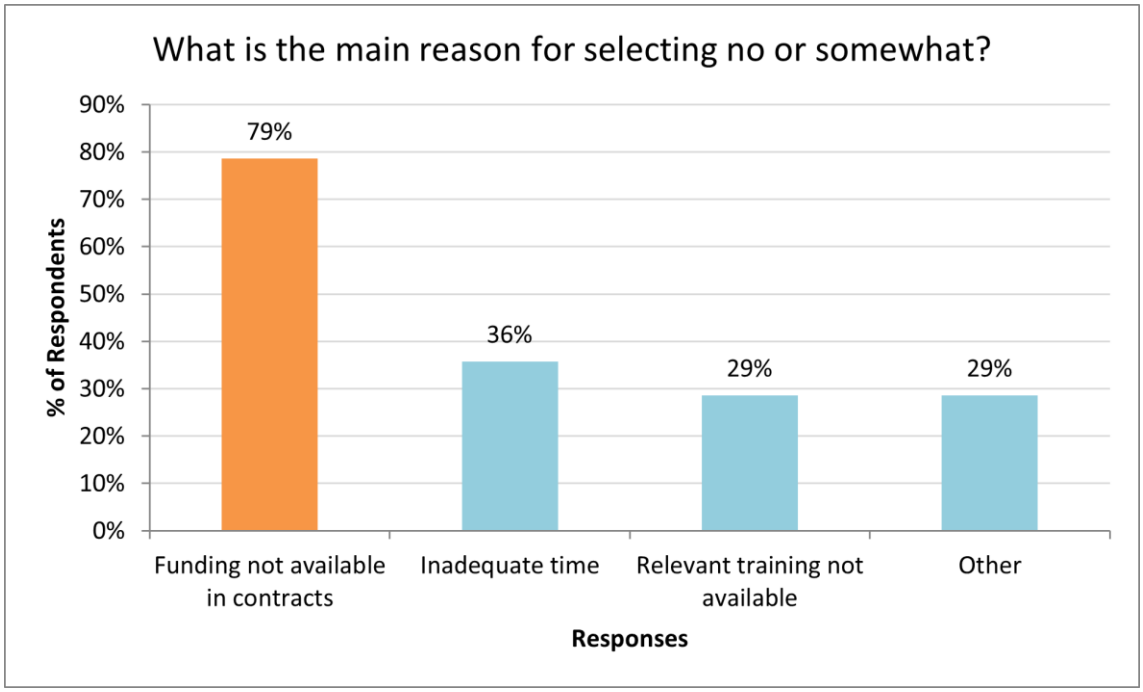
Figure 20: Staff Access to Training and Development [27 total responses]



Barriers to training

For organisations which selected “no” or “somewhat”, a lack of funding is cited as the main training barrier for 79 per cent, while a lack of time was an issue for 36 per cent (see Figure 22 below). Nearly a third (29 per cent) of organisations stated that the relevant training was not available for their workforce.

Figure 21: Barriers to Providing Staff Training [14 total responses]



Areas for future training and development

Organisations provided a wide range of ideas for future training and development areas that they would like to see made available to the sector. These include:

- Individual Placement and Support and stories for change
- External supervision
- Multicultural, LGBTQI, First Nation training
- Trauma informed leadership
- Core skills in assessment and counselling for lived experience workforce without degree qualifications
- Co-design skills development
- More specific carer based training
- Recovery Oriented Practice
- Trauma Informed Care
- Brief Therapy
- Child and youth mental health / relational youth work

- Supervision training
- More flexibility around subsidised training options for us an organisation to encourage staff development - the Training system seems very rigid and inflexible and doesn't always work for our staff/organisation requirements
- Better understanding of the interface between NDIS and QHealth / mainstream supports
- Reflective / developmental practice sessions on lived experience
- Supporting recovery under NDIS model
- Leadership and Management / Project Management / Peer Leadership
- Sector education for support workers to better understand mental health and identifying mental health issues
- Mental Health First Aid training (this needs to be at an affordable price and short enough to be accessible to smaller organisations)
- Vicarious trauma / resilience / self care
- Addressing mental health stigma and improving personal maturity
- Situational awareness / professional boundaries
- Dual Diagnosis (AoD)
- Co-morbidity (ASD is quite prevalent)
- Behaviour management, including responding to challenging behaviours, Positive Behaviour Support Plan (PBSP), medication management, mealtime management

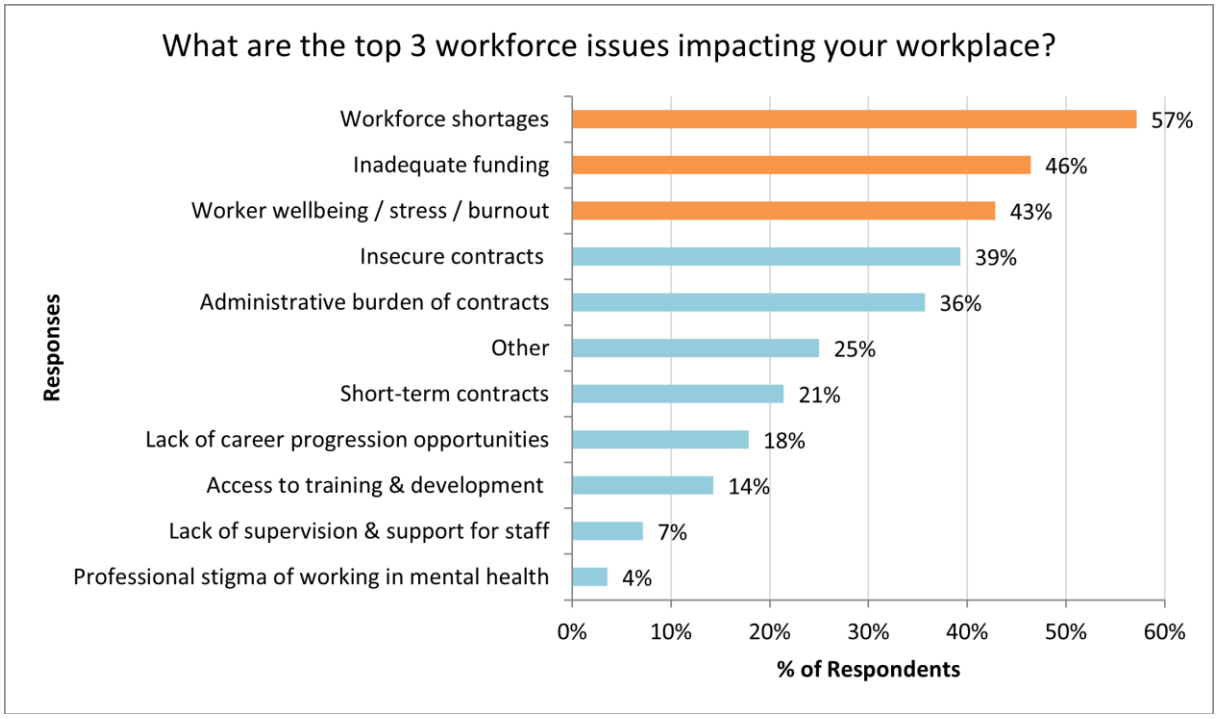
One organisation noted that it would be useful to have:

> *"More flexibility around subsidised training options for us an organisation to encourage staff development - the Training system seems very rigid and inflexible and doesn't always work for our staff/organisation requirements." – Community Mental Health and Wellbeing Sector organisation*

Top workforce concerns

The top workforce concern cited by Queensland Community Mental Health and Wellbeing organisations participating in this survey is workforce shortages, with 57 per cent citing this as a key workforce issue facing their organisation. Given the exceptionally high growth of the sector over the last financial year alone, this is hardly surprising. This is followed by "inadequate funding" (46 per cent) and "worker wellbeing / stress / burnout" (43 per cent). Difficulties managing contracts and the insecure nature of funding (including insecure contracts, administrative burden of managing contracts and short term contracts) are also highly represented.

Figure 22: Top Three Workforce Issues [28 total responses]



Appendix 1: Modified Monash Model[19]

Modified Monash Category (MMM 2019)	Description (including the Australian Statistical Geography Standard – Remoteness Area (2016)
MM1	**Metropolitan areas:** Major cities accounting for 70 per cent of Australia's population. All areas categorised ASGS-RA1.
MM2	**Regional centres:** Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are in, or within a 20km drive of a town with over 50,000 residents. For example: Ballarat, Mackay, Toowoomba, Kiama, Albury, Bunbury.
MM3	**Large rural towns:** Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM 2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents. For example: Dubbo, Lismore, Yeppoon, Busselton.
MM4	**Medium rural towns:** Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM 2 or MM 3, and are in, or within a 10km drive of a town with between 5,000 to 15,000 residents. For example: Port Augusta, Charters Towers, Moree.
MM5	**Small rural towns:** All remaining Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas. For example: Mount Buller, Moruya, Renmark, Condamine.
MM6	**Remote communities:** Remote mainland areas (ASGS-RA 4) AND remote islands less than 5kms offshore. For example: Cape Tribulation, Lightning Ridge, Alice Springs, Mallacoota, Port Hedland. Additionally, islands that have an MM 5 classification with a population of less than 1,000 without bridges to the mainland will now be classified as MM 6 for example: Bruny Island.
MM7	**Very remote communities:** Very remote areas (ASGS-RA 5). For example: Longreach, Coober Pedy, Thursday Island and all other remote island areas more than 5kms offshore.

[19] Australian Government Department of Health. (2020). *Modified Monash Model – Fact Sheet*. modified-monash-model-fact-sheet.pdf (health.gov.au)