Mental Health Australia

Mental health sector guidance on National Mental Health Workforce Strategy 2022-2032 implementation priorities

June 2025

Members of the National Mental Health Workforce Sector Advisory Group and Advisory Network offer the following guidance to the National Mental Health Workforce Working Group (Working Group) on priorities for the implementation of the National Mental Health Workforce Strategy 2022-23 (the Strategy). Members indicate the greatest resourcing for implementation should be focused on Pillar 3 (Support and retain) and Pillar 1 (Attract and train) in the short-term. Members also encourage Governments to prioritise actions to monitor, grow and retain the psychosocial and community mental health workforces. The Advisory Group and Network look forward to providing further advice to the Working Group as requested.

Members of the National Mental Health Workforce Sector Advisory Group and Advisory Network were invited to provide guidance on immediate priorities for implementation of the National Mental Health Workforce Strategy 2022-23 (the Strategy) via a short survey in May 2025. This paper outlines the results of this survey (n=53), and further feedback discussed at the inaugural Advisory Group meeting on 3 June, presenting mental health sector views on Strategy implementation priorities. The Advisory Group and Network include diverse sector representation, across all jurisdictions.

Key messages from Advisory Group and Network members to the Working Group emphasised the need to **strengthen and recognise the value of the peer workforce, the opportunities in engaging the non-clinical and community mental health workforce, and the importance of prioritising staff wellbeing**. There is recognition of the need for clinical and non-clinical mental health workforces to work together to provide the best possible care for people accessing services.

Members also emphasised the importance of the Strategy and **meaningful collaboration with the sector**:

> *"We urgently need to get this right. Across the country, services are under immense pressure and struggling to meet the growing demand for mental health care. This strategy cannot afford to be just another plan, it must drive bold, coordinated, and measurable improvements. The future of our workforce, and the wellbeing of our communities, depends on it. Good luck, we're counting on you."*

"Bold, visible action now will restore trust, retain workers, and prove this strategy is more than words on a page."

"The development of the Sector Advisory Group and the upcoming Advisory Network is a positive starting point, and we hope to see this collaboration continue genuinely."

Summary of implementation priorities

When asked about comparative prioritisation of the four pillars of the Strategy, the Advisory Group and Network indicated **the greatest resourcing for implementation should be focused on Pillar 3 (Support and retain) and Pillar 1 (Attract and train)** in the short-term.

The Advisory Group and Network were also asked to prioritise the most urgent short-term actions under each of the Strategy's Pillars. The Pillars are discussed below in order of their overall priority.

Pillar 3: Support and retain

Under Pillar 3, Advisory Group and Network members identified the most urgent short-term actions as:

1. Develop initiatives to **safeguard the wellbeing of the mental health workforce**
2. Develop **longer minimum service contract lengths** for commissioned mental health services, including in rural and remote areas

Members emphasised the need for a **systemic approach to improve working conditions and prevent workforce stress**, rather than focusing on individual coping strategies, to reduce workforce burnout. The equivalent burnout of family, cares and kin must also be considered.

Related short-term actions to "strengthen processes to consistently and regularly review workloads" and "review guidelines for supervision and specify support requirements for those in the mental health workforce" were also highly rated.

It was noted that **longer service contract lengths would address many of the retention issues that impact the sector**, where multiyear contracts are critical to retain staff and support service continuity. This is an immediate priority the Working Group should support.

Funding models must also include appropriate investment to support the wellbeing of the workforce, including funding for supervision, de-briefing and to ensure manageable client loads to prevent burn-out. In particular, First Nations organisations often deliver significant psychosocial support in order to maintain the wellbeing and retention of employees sharing their lived experience. Ongoing family, community and cultural demands on top of their paid work contribute to high levels of burn-out among this workforce. There are examples of Aboriginal and Torres Strait Islander organisations successfully supporting staff and reducing turnover that can be learned from, such as the Culture Care Connect program delivered by Aboriginal Community Controlled Health Organisations.

Pillar 1: Attract and train

Members indicated the most urgent short-term actions under Pillar 1 are:

1. **Address critical medical, nursing and allied workforce shortages** with an initial focus on psychiatry, psychology, mental health nursing, and other relevant allied health professions
2. **Examine innovative service delivery models that support increased engagement of the Lived Experience (Peer) and First Nations workforces** in different contexts

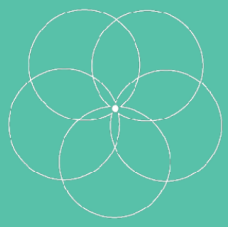
Addressing critical workforce shortages was rated as the stand-out priority action. Members emphasised the importance of **addressing the shortfall of community mental health workforces** (discussed further below) as part of this. Members highlighted the need for quality mental health education, training and placements in undergraduate curriculums as key to addressing workforce blocks. The Strategy action to "prioritise access to training for the mental health workforce through increased subsidies and use of placements and traineeships" was also highly prioritised and would contribute to this.

In relation to the peer workforce, members discussed that the Strategy is missing a short-term **focus on strengthening the rural and remote peer workforce,** as well as how people with disabilities can be empowered to join the peer workforce. For example, in South Australia scholarship funding for the peer workforce has been successful in developing this workforce, but rural employers have not necessarily understood the value of the peer workforce, affecting employment opportunities.

The Strategy should also focus on **growing the youth peer workforce** and providing young people with access to quality lived experience training and development and clear career pathways to attract and retain them. While some members supported a peer work accreditation body with minimum training requirements, others cautioned against creating further financial and capability barriers to entry. Members noted the importance of mental health services supporting a human rights-focus, to both strengthen the culture of the workplace and service, and support growth of the peer workforce.

To support the development of basic mental health skills in broader health and social workforces as included in the Strategy, members suggest **investing in developing contemporary and well-rounded curricula** with a wider range of mental health skills and emphasising 'soft skills.' This would enable all health and social service graduates to respond helpfully to people experiencing mental distress and facilitate early intervention. Curricula must also cover intersectionality and cultural competence.

Finally, members noted the importance of increasing the profile and prestige of mental health work, and its importance to the community, to ensure that mental health is an attractive career path.



Pillar 2: Maximise, distribute and connect

For Pillar 2, members overwhelmingly ranked '*Supporting initiatives to **grow local mental health workforces, particularly in rural and remote settings**, including training and placement opportunities*' as the most urgent action.

Advisory Group and Network members emphasised **tailored strategies to grow the rural and regional workforce** are needed, including preferential entry, paid placements, local mentoring, support for people to train and work locally, and housing incentives for rural students and professionals. The Advisory Group stressed that different workforces will need different solutions. They also called for f**lexible place-based approaches that account for local service infrastructure, including investigating and strengthening the informal supports** that communities have developed. Members provided examples of strategies to grow the rural and regional workforce and would be pleased to provide further advice to the Working Group on this priority.

Members also raised significant priorities around **maximising and connecting the workforce**. Short-term Strategy actions around identifying where "core competencies, capabilities and skills can be shared" across disciplines and developing and refining "nationally consistent scopes of practice" were highly rated. Advisory Group and Network members suggested that services should receive **incentives for delivering multidisciplinary care**, and urged consideration of new models of care to better utilise the existing allied health workforce to their full scope of practice.

Members also discussed the importance of **improving workforce capability**, and will be pleased to support governments' development of a national mental health workforce capability framework as committed to by Ministers at their recent meeting.

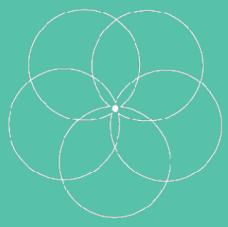
Members advised workforce **capability and service quality should be enhanced through stronger requirements for services to comply with cultural safety standards**, and implementing relevant workforce recommendations from existing inquiries such as those related to family domestic violence and child protection.

Members also raised opportunities to foster confidence, capability and commitment in the clinical workforce by supporting development of early career clinicians through creating structured, paid entry pathways into services before they move into tertiary-level clinical roles.

Pillar 4: Data, planning, evaluation and technology

Under Pillar 4, members highlighted one priority as the stand-out most pressing short-term action: '*Define what data is required, for what purpose, where data is currently held and **what additional collections are required to improve reliability, accessibility and comprehensiveness***.'

Members emphasised **gaps in data collection for key mental health professional groups** must be addressed to enable workforce and service planning – including for community-managed mental health workforce, peer workforce and social workers. This is critical to sit alongside data on clinical workforces.



Members also noted that **significant investment in technology, embedding data and evaluation roles, and ongoing staff training** is needed to ensure success of all Pillar 4 Strategy actions. Often these enablers are not included in funding agreements, which means services do not have the capacity or capability to prioritise these critical functions.

Advice on what is missing in the Strategy

Advisory Group and Network members further identified several **key workforce priorities they see as missing in the Strategy**.

Of particular concern is the **lack of inclusion of the community mental health and psychosocial workforces** in the Strategy. Members encourage implementation of the Strategy to include actions to monitor, grow and retain the psychosocial and community mental health workforces. The community mental health workforce is key to providing accessible mental health support, takes less time to train and stand up than clinical workforces and plays an important role alleviating pressure on and complementing clinical supports. However, the growth and retention of the community mental health workforce is not yet nationally monitored and supported. Strategic development of the community mental health and psychosocial workforces is needed, including the role of allied health professionals in psychosocial supports.

There are also opportunities to consider other workforce roles that aren't captured in the Strategy, including **mental health promotion and prevention and public health roles** designed to support mental health. Implementation efforts should also **consider how to connect to the informal workforce** – family, carers, community and people with lived experience stepping in to support each other, where formal workforces and service infrastructure are inadequate.

Members also stressed the need for implementation from a **life course lens** to address gaps in the Strategy, particularly around workforce supporting infants, children and older adults.

Conclusion

The Advisory Group and Network are pleased to provide this initial advice on prioritisation of Strategy actions, and would welcome the opportunity to provide further detailed consideration and advice to the Working Group on implementation of these priorities.