NSW Health

Allied Health in Mental Health Workforce

Horizons Scanning and Scenario Generation Report 2020

NSW GOVERNMENT

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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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1 Introduction

The Allied Health Mental Health Workforce Project has been a collaboration between the Mental Health Branch and the Workforce Planning and Talent Development Branch of the Ministry of Health. This project supports the NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 to deliver holistic, person centred care. Growth of this workforce will increase access to allied health expertise to improve physical health care, functional recovery, emotional wellbeing, social participation and inclusion for people with a lived experience of mental illness. Ensuring the right workforce for the future is also a strategic priority of Living Well in Focus 2020-2024. I encourage you to explore the opportunities outlined in this report developed in collaboration with the allied health mental health workforce, people with a lived experience, families and carers and universities as a valuable resource for planning, delivering and evaluating services to drive improvements in health outcomes for the people of NSW.

David Pearce, Executive Director, Mental Health Branch, NSW Health

NSW Health recognises that mental health conditions are widespread and have a substantial social and economic impact on the people of NSW. Mental illnesses can cause distress and may affect a person's ability to function at work, in relationships and everyday tasks. The Allied Health Mental Health workforce provides treatment, develops strategies and supports lifestyle changes to overcome physical, psychological, social, occupational, communicative and environmental challenges that are integral to people with a lived experience of mental illness' quality of life and participation in society. This report marks the beginning of developing a further understanding of the Allied Health Mental Health workforce. An opportunity exists for Allied Health Mental Health Workforce to be better supported and utilised in the provision of patient centred, outcome focused and cost-efficient services to promote and optimise mental health and wellbeing for the NSW community.

Richard Griffiths, Executive Director, Workforce Planning & Talent Development, NSW Health

The Allied Health in Mental Health Horizons Scanning and Scenario Generation Workforce Project has been ground breaking, it is the first comprehensive look into the allied health professions working in NSW Health mental health services. The enthusiasm and engagement from allied health clinicians during the consultations, and the care, commitment and compassion observed that they have for people with lived experience of mental illness was inspiring. This report provides insight into challenges and opportunities for this workforce to work to the top of their scope of practice, enhancing the care and treatment they provide. The report also presents opportunities for Local Health District and Speciality Health Networks to support and grow their allied health workforce by strengthening allied health leadership, professional governance, education and training, and improving the experience of delivering care.

As Chief Allied Health Officer, this report is a timely reminder that our staff are our most important resource for delivering high quality health care which is of value and supports people with lived experience of mental illness to achieve the outcomes which matter to them.

Andrew Davison, Chief Allied Health Officer, NSW Health

2 Executive summary

The Allied Health in Mental Health (AHMH) Workforce Project Report is a strategic document that outlines the current context and opportunities for support and growth for the NSW Health AHMH workforce. The project is a collaboration between the Mental Health Branch (MHB) and the Workforce Planning and Talent Development (WPTD) Branch of the Ministry of Health (MoH) for a multidisciplinary workforce. It should be noted that the views expressed by stakeholders in the report are not necessarily those of the NSW Ministry of Health.

Consultation on the *NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022* identified an urgent need for increased access to allied health interventions. The potential statewide enhancement of community-based allied health expertise offers people with a lived experience of mental illness across NSW the opportunity to live well and longer through improved access to physical health care and support for their functional recovery.

Scope of AHMH workforce project

The allied health workforce in NSW Health is a diverse group of individual professions who work in a healthcare team to support a person's medical care. Allied health professionals provide services to enhance and maintain functions, emotional and physical wellbeing and social participation and inclusion within a range of settings including hospitals, community health, and in-home care. There is an emphasis on wellbeing, independence and health lifestyle through the provision of psychological, occupational, social, cognitive, communication and physical therapies.

NSW Health defines twenty-three professional groups as allied health professionals, the following fifteen groups working in mental health are in scope for this project:

- Art therapy
- Counselling
- Dietetics & Nutrition
- Diversional therapy
- Exercise Physiology
- Music therapy
- Occupational therapy
- Pharmacy
- Physiotherapy
- Podiatry
- Sexual Assault
- Social Work
- Speech Pathology
- Welfare
- Psychology

Key opportunities to grow and support the AHMH Workforce

Training and Research	Develop undergraduate AHMH profile and programs Develop innovative student placement models Develop a research culture to enhance outcomes and practice
Recruitment and Retention	Attract and support the future AHMH workforce Link AHMH to rural incentive opportunities Create university to new graduate pathways and roles Grow and support Aboriginal AHMH pathways Establish flexible workforce models Develop strategies to retain and increase opportunities for AHMH clinicians
Learning and Development	Develop capacity to work to discipline 'top of scope' Enhance AHMH education and educator roles Enhance technology to support the delivery of contemporary professional development opportunities Progress AHMH leadership opportunities, capacity and capabilities
Workforce Wellbeing	Implement workforce wellbeing strategies Enhance the profile of AHMH professions Strengthen clinical supervision and cultural mentoring Strengthen AHMH governance support structures

3 Overview

3.1 Purpose of the document

The purpose of this document is to better understand the NSW Health AHMH workforce as it currently exists and identify opportunities to support this workforce to deliver care that best meets the health needs of people with a lived experience of mental illness, their families and carers. This information is intended for use by the Local Health Districts and Speciality Health Networks (LHDs/SHNs) AHMH workforce and leaders, Mental Health Executives and Ministry of Health Branches and Pillar agencies to inform workforce planning strategies. These opportunities are not aligned with funding enhancements, but they provide a roadmap to achieve the strategic aim of growing and supporting the AHMH workforce.

3.2 Strategic alignment

The AHMH Workforce Project aligns with the following current NSW Health strategic priorities.

NSW Health Strategic Priorities 2019-20

NSW Health Strategic Priorities: Strategy 4 is to develop and support our People and Culture. Goals under this strategy that align with the AHMH workforce project include:

4.1 – Achieve a 'Fit for Purpose' workforce for now and the future

4.2 – Undertake whole system workforce analysis

NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022

This AHMH Workforce Project was established in response to a strategic priority to grow and support a skilled mental health allied health workforce by 2021, in line with forecast health service demand and delivery requirements.

This initiative delivers against three key objectives of the framework depicted in Figure 1 to deliver holistic care, improve the physical health care of consumers and increase community based options.

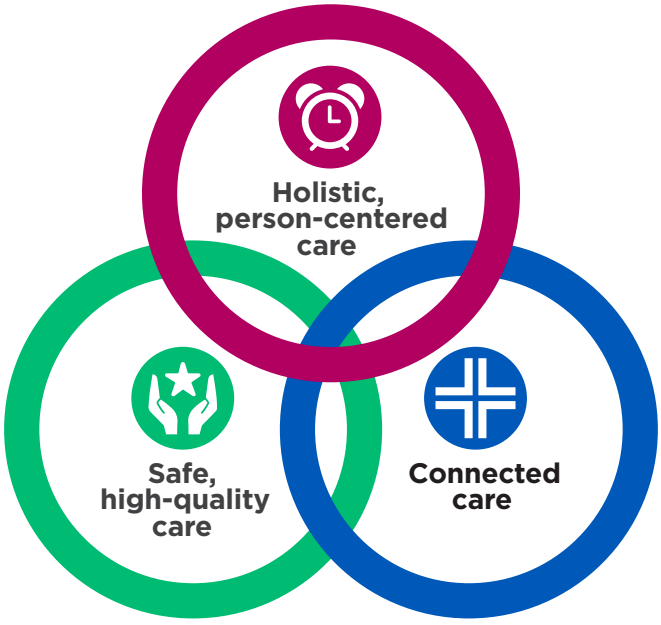


Figure 1: The three intersecting goals of the NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022

Strategic priorities within this framework relevant to the AHMH workforce project are depicted in Figure 2.

Figure 2: NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 strategic priorities aligned to AHMH workforce project

GOAL 1 Holistic, person-centred care	GOAL 2 Safe high-quality care	GOAL 3 Connected care
Strategy	**Strategy**	**Strategy**
2. Deliver holistic care 2.3 Grow and support the AHMH workforce **3. Improve the physical health care of people with a lived experience of mental illness** 3.2 Increase consumer access to the full range of available health interventions 3.2.1 Expand mental health consumer access to allied health expertise including exercise physiologists, physiotherapists, dietitians, speech pathologists, pharmacists, and occupational therapists **4. Increase community-based options** 4.2 Enhance mental health community support services 4.2.1 Strategic commissioning of a range of community support services under the Reform, Partnerships for Health and other initiatives 4.9.1 Increase the number of mental health practitioners engaged in management, leadership and talent development programs WP 2.1.1 – Scope development of a mental health attraction campaign that includes a focus on value-based recruiting	WP 4.10.1 Support more mental health staff to participate in clinical redesign, research, and improvement science education and practice 5.6 Ensure the workforce is capable and supported	9. Improve transitions 9.1 Implement guidance and service models that improve transitions 9.4 Improve person with a lived experience of mental illness access to NDIS services

The Health Professionals Workforce Plan 2012-2022

The AHMH Workforce Project also aligns with this framework that outlines strategies to ensure NSW trains, recruits and retains allied health professionals, doctors, nurses and midwives, oral health professionals as well as non-clinical professions to meet the future needs of the community.

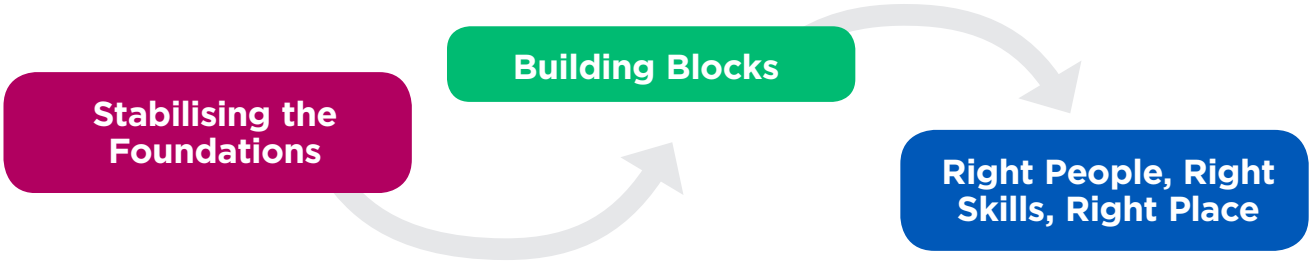


Figure 2: Strategic priorities of the framework

The cornerstone of this framework is *Stabilising the Foundations* – setting the scene for effective workforce planning and acknowledging that the challenges will be met by multi-faceted solutions. On this cornerstone rests the *Building Blocks* for the health professional workforce – providing the culture and working environment in the health system to enable a flourishing workforce. The foundations and building blocks provide the platform to realise the vision: *Right People, Right Skills, Right Place*.

These three key components have been utilised in the AHMH workforce report to frame the opportunities suggested, with the aim of growing and supporting the AHMH workforce. As this report is not a workforce plan, the components have been interpreted as opportunities to stabilise and build the AHMH workforce and promote the best use of AHMH skills to support people with a lived experience of mental illness.

3.3 Horizons scanning and scenario generation methodology

The Workforce Planning Methodology applied by NSW Health consists of three phases, depicted in Figure 3. The AHMH workforce project has utilised the Horizons Scanning and Scenario Generation (HSSG) components of this approach.

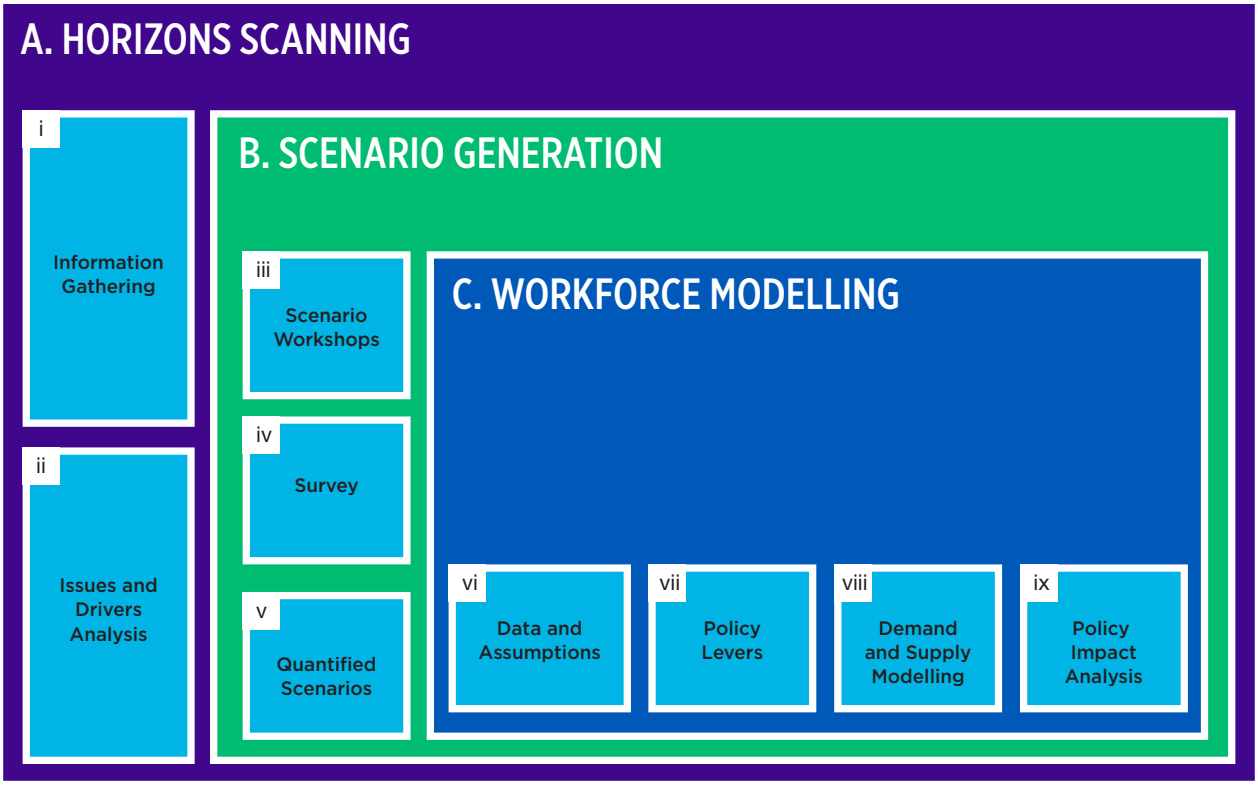


Figure 3: NSW Ministry of Health workforce planning methodology

Horizons Scanning. The first step in the planning process is to understand the current context, as well as supply and demand drivers impacting the workforce and provision of care. The process of information gathering and analysis to achieve this understanding is referred to as Horizons Scanning.

Scenario Generation. In the next phase broad consultation is undertaken with stakeholders internal and external to NSW Health, including people with a lived experience of mental illness. Further understanding is developed through data analysis and potential scenarios for the future AHMH workforce are co-produced. This process is referred to as Scenario Generation.

Workforce Modelling. The third stage in the methodology is Workforce Modelling. Modelling accounts for data and assumptions, policy levers, demand and supply, and policy impact analysis. The AHMH Workforce report provides the information necessary for this next stage which may be completed at a statewide level or by workforce planning units in LHD/SHNs.

To date HSSG has been undertaken for fourteen allied health professions by the Ministry of Health (MoH) to inform workforce planning. The AHMH workforce project is unique in its scope in that it is a collaboration between MHB and WPTD for a multidisciplinary allied health workforce. The collaboration is a first for workforce planning within the MoH and aims to support LHD/SHNs with implementation opportunities within the mental health system.

The AHMH workforce project has approached consultation with unique vigour. The focus has been on making the process and outcomes meaningful for AHMH, MH executives and local workforce planners, people with a lived experience of mental illness, and Aboriginal workforce stakeholders. The inclusion of broad inputs from these stakeholders through consultation in workshops, surveys, and interviews has enabled sharper development of the suggested opportunities.

3.4 AHMH workforce project process

To complete comprehensive workforce planning, it is necessary to understand the current and future challenges and drivers for the AHMH workforce. This project engaged in background research and stakeholder consultation to inform the development of evidence-based opportunities. Through the process depicted in Figure 4 key stakeholders were identified including frontline staff and senior leaders, universities, Aboriginal workforce leaders, people with a lived experience of mental illness and carers whose perspectives were incorporated into project outcomes. Detailed information about the AHMH workforce project processes and outcomes can be found in section five of this report.

Figure 4: Process undertaken in AHMH workforce project

4 Planning for the future AHMH workforce

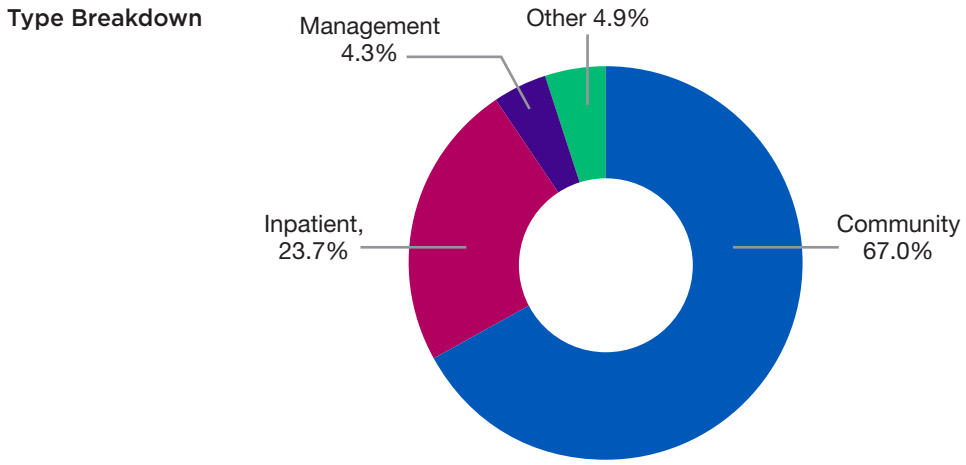
4.1 AHMH workforce profile

A data verification process was undertaken to form a statewide, high level view of discipline spread and workplace setting for the NSW AHMH workforce represented in Figures 5 to 8.

An analysis of the AHMH workforce by profession identifies the largest workforces as social work (35.9%), psychology (34.0%) and occupational therapy (20.5%). Physical health focused workforces of exercise physiology, speech pathology, pharmacy, physiotherapy and dietetics combined represent 2.7% of the total NSW Health AHMH workforce.

Physical health care

The *NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022* promotes the growth and support of both the established and emerging AHMH professions including dietitians, exercise physiologists, physiotherapists, pharmacists and speech pathologists. As a part of the multidisciplinary team, these professions can support the physical health needs of people with a lived experience of mental illness to not only improve physical health outcomes, but also reduce the risk of early mortality by addressing modifiable health risks.



**Other*: *defined by LHD/SHNs as AHMH who undertake research and academic positions, intake/acute positions that work across settings, drug and alcohol clinician positions, strategic leads on state-wide programs such as National Disability Insurance Scheme (NDIS), Perinatal infant mental health service (PIMHS), Intellectual disability and mental health (IDMH), family services clinicians and housing and transcultural liaison consultants*

Figure 5: AHMH statewide dispersion by setting (Source: 2019/2020 AHMH LHD/SHN data verification process)

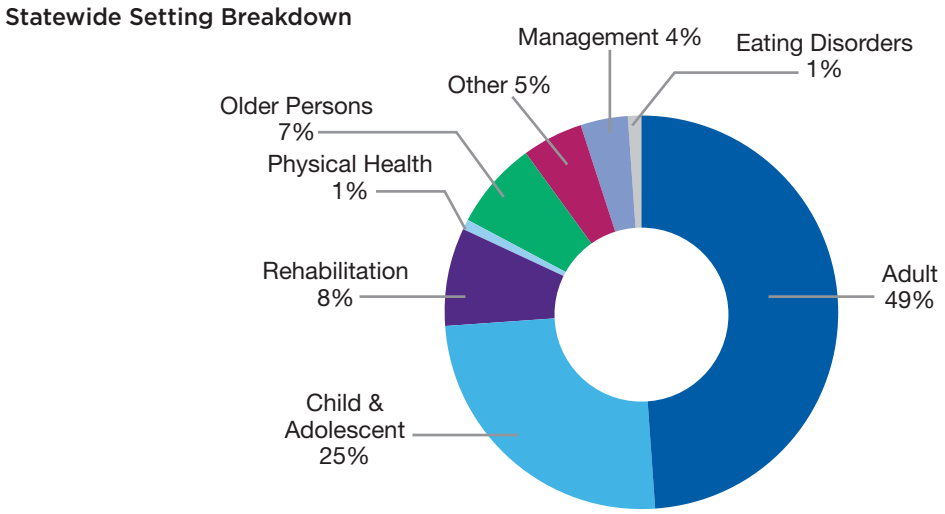


Figure 6: Setting breakdown by care setting (Source: 2019/2020 AHMH LHD/SHN data verification process)

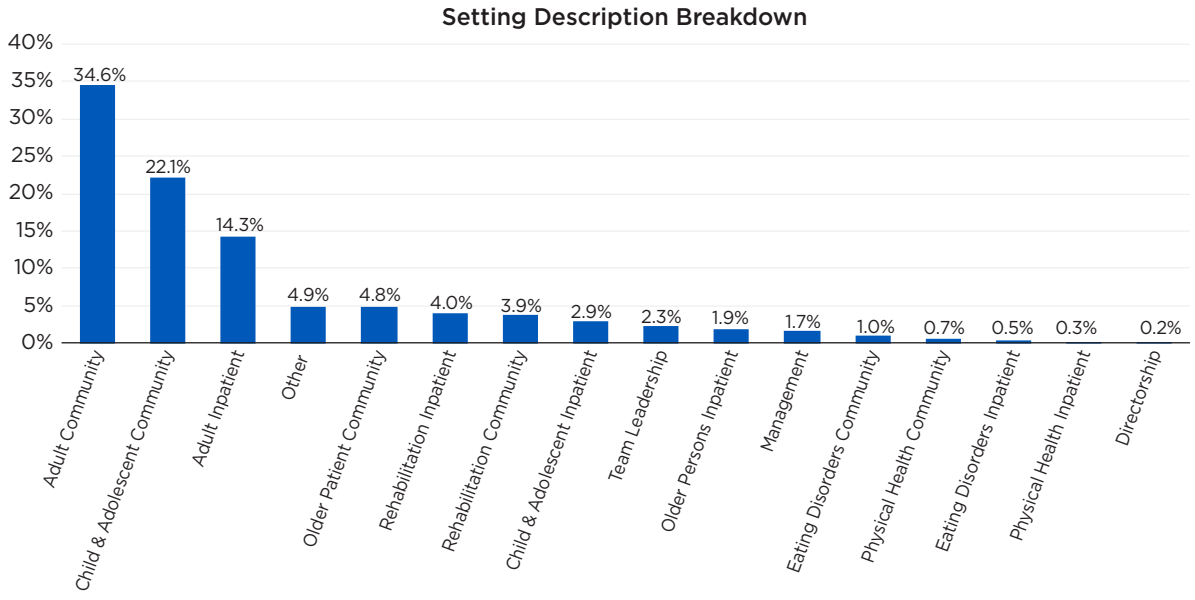


Figure 7: Further setting description breakdown (Source: 2019/2020 AHMH LHD/SHN data verification process)

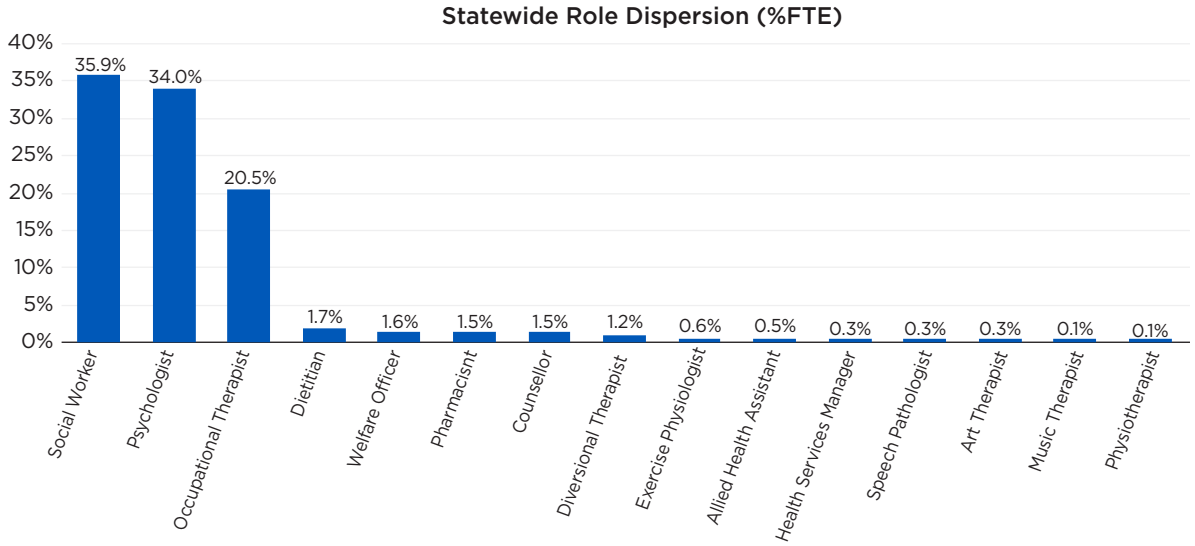


Figure 8: Allied Health dispersion by profession (Source: 2019/2020 AHMH LHD/SHN data verification process)

4.2 Vision for the AHMH workforce

For the purpose of this project a shared vision for the NSW Health AHMH workforce was defined by both the AHMH workshop delegates and NSW Health executive leaders. The vision provides a foundation to discuss the current workforce and to guide future workforce priorities.

AHMH Workshop delegates

Support the growth of a flexible and diverse AHMH workforce that feels valued, well-resourced, and supported in the delivery of high-quality care.

Figure 9: Wordcloud view of Scenario generation workshop delegates vision for the AHMH workforce (Mentimeter voting results)

Executive leaders

- Stronger alignment for AHMH as health professionals and professional alignment with allied health
- allied health, nursing, medicine, and Aboriginal health all have clear and respected roles
- An educated community who know when, how and where to access AHMH supports
- AHMH viewed as an essential part of the solution to changing workplace culture (e.g. institutional models) and workforce shortages
- AHMH having a greater role in community teams and leading community integration for mental health
- Pathways for Aboriginal people and workforce into AHMH with sufficient cultural mentoring
- A priority of the Fifth National Mental Health and Suicide Prevention Plan is to improve the physical health and reduce early mortality for mental health people with a lived experience of mental illness
- Using technology and working to discipline top of scope.

4.3 Key AHMH workforce principles

The following key principles to guide workforce planning were suggested by the Chief Allied Health Officer and validated by delegates at the Scenario Generation workshop. Delegates anticipate that these principles will guide services as they work toward the future vision for AHMH.

- AHMH are independent professionals with each profession defining their own scopes of practice in line with NSW Health policy and guidelines.
- All AHMH should be working to the top of scope and supported to do so; enabling the right care provided by the right clinician.
- AHMH should be closely aligned with their professional department within their LHD/SHN; to support the delivery of safe, quality, and value-based care.

- The role of individual professions and their identity should be supported within the multidisciplinary team. This includes having clear role delineations and an understanding that while all professions may share some common skills, each profession also has unique clinical skills which enhance recovery and the care people with a lived experience of mental illness receive.
- Models of care in the community and inpatient settings are well-defined by the multidisciplinary team. This includes clearly articulated therapeutic inputs by individual multidisciplinary team members during the different phases of care.
- Senior AHMH are valued members of an LHD/SHNs mental health service leadership team, in inpatient and community settings. They contribute to the planning and providing of care during all phases of the persons recovery journey.
- AHMH are flexible and adaptable in their roles and skills to meet the needs of the service and to ensure the best holistic recovery for people with a lived experience of mental illness.

4.4 Summary of demand and supply drivers for AHMH workforce

The literature and consultations identified several drivers influencing demand and supply for the AHMH workforce in the NSW public health system, for now and in the future. These are depicted in Figure 10.

DEMAND DRIVERS

Statewide policy	Changing needs and service context
• People with a lived experience of mental illness need access to the full range of allied health interventions to promote physical health improvements and functional recovery • Improved community-based access to dietitians, exercise physiologists, speech pathologists, physiotherapists, pharmacists and occupational therapists • To ensure that all "bio-psycho-socio-cultural" components of intervention and care are delivered all mental health units have a multidisciplinary team with the skills to deliver a therapeutic program and environment on an extended-hours basis	• Increasing complexity in presentations to mental health services (MHS) • Increasing number of young people/adults presenting to emergency departments • Growing number of older people with dementia • AHMH services are not visible, accessible and affordable • A preference to access services closer to home

SUPPLY DRIVERS

Training and Research	Recruitment and Retention	Learning and Development	Workforce Wellbeing
Undergraduate AH degrees offer contemporary, relevant MH education to prepare workforce. Opportunities for increased MH placements for all AHMH professions. Collaborative relationships. AHMH research role capacity.	Enhancements to AHMH workforce. Reducing the stigma of working in MHS. Engaging in discipline specific top of scope work. Opportunities for career progression and development	AHMH governance structures. Access to learning pathways to support interdisciplinary and discipline specific development. Holistic models of care supported by the MDT. Pathways to develop leadership and management capacity of AHMH.	Addressing vicarious trauma, burnout and promoting self- care. Autonomy, acknowledgment, engaging in regular and skilled supervision. Sound professional identity. AHMH support structures.

Statewide policy	Technology and system enablers
• Grow and support the AHMH workforce • Grow the Aboriginal and Torres Strait Islander workforce • Improve access to allied health professions through working across physical and mental health settings, partnering with CMOs, PHNs and other community-based organisations	• Co-design and Co-production • Models of care- restorative, social and emotional wellbeing • Sector relationships and workplace culture • Data and evidence to support workforce planning • IT infrastructure and tools • Industrial relations – level of advocacy

Governance

Figure 10: Demand and supply drivers for the AHMH workforce

Demand drivers

The main drivers influencing demand are statewide policy and changing needs of people with a lived experience of mental illness. There is growing recognition that people with a lived experience need access to the full range of allied health professionals to support multiple aspects of their wellbeing and may require services across multiple disciplines.

Increased access includes to the multidisciplinary team on an extended hours basis to include weekends and after hours in mental health inpatient units. A perception that AHMH services are less visible and accessible also impacts on demand for the AHMH workforce.

Supply Drivers

The main factors affecting supply of the AHMH workforce are grouped under the four key theme areas for this project of training and research, recruitment and retention, learning and development and workforce wellbeing. Statewide policy is another main driver influencing supply. The Framework commits to improving access to AHMH services, to support and grow the existing and emerging AHMH workforce and increase the number of mental health practitioners engaged in management, leadership and talent development programs. The NSW Public Sector Aboriginal Employment Strategy (2013 – 2023) commits to increasing the number of Aboriginal and Torres Strait Islander workforce. Technology and system enablers are supply factors that both support and challenge the policy commitments as the strength of these enablers varies across NSW, particularly in rural and remote areas.

4.5 Opportunities to grow and support the AHMH workforce

AHMH delegates participated in a scenario generation activity where they co-produced opportunities under the following four key theme areas developed from the HSSG processes:

- **Training and Research**: Activities by universities to prepare the AHMH workforce for a role within mental health services and engaging in and supporting AHMH research
- **Recruitment and Retention**: Activities to attract the future AHMH workforce and keep the current workforce engaged and committed
- **Learning and Development**: Activities that strengthen the AHMH workforce and provide opportunities for progression
- **Workforce Wellbeing**: Activities which enable AHMH workforce to feel supported and valued, work top of scope, and maintain their professional identity.

A summary of workforce opportunities is presented on the following page with the strategic alignment. A further breakdown for each theme area of opportunities that includes possible actions and suggested leads is provided following this summary to support the development of a targeted AHMH workforce plan.

The opportunities outlined are evidence-based strategies based on current research and broad consultation for LHD/SHNs to progress against the overarching strategy of growing and supporting the AHMH workforce. These opportunities are not aligned with funding enhancements, but they provide a roadmap to achieve the above strategy (2.3) of the NSW Strategic Framework and Workforce Plan for Mental Health 2018–2022.

The AHMH workforce project opportunites were developed prior to the 2020 COVID-19 pandemic. Since COVID 19, there has been an increased focus on providing services via telehealth by districts and networks. It is anticipated that this wider-scale adoption of telehealth, combined with the end of the five-year telehealth strategy period may provide a platform for more significant telehealth adoption and integration during the next strategy cycle impacting the way AHMH services are delivered.

Vision	Grow and support a skilled AHMH workforce to best support the health and wellbeing of people with a lived experience of mental illness		
NSW Strategic Framework and Workforce Plan for Mental Health: Goals	Goal 1 – Holistic, person-centred care		
	Goal 2 – Safe, high quality care		
	Goal 3 – Connected care		
Health Professionals Workforce Plan: Framework	Stabilising the foundations	Building blocks	Right people, right skills, right place
NSW Health Allied Health in Mental Health Workforce Opportunities	Training and Research	Develop undergraduate AHMH profile and programs Develop innovative student placement models Develop a research culture to enhance outcomes and practice	
	Recruitment and Retention	Attract and support the future AHMH workforce Link AHMH to rural incentive opportunities Create university to new graduate pathways and roles Grow and support Aboriginal AHMH pathways Establish flexible workforce models Develop strategies to retain and increase opportunities for AHMH clinicians	
	Learning and Development	Develop capacity to work to discipline 'top of scope' Enhance AHMH education and educator roles Invest in technology to support the delivery of contemporary professional development opportunities Progress AHMH leadership opportunities, capacity and capabilities	
	Workforce Wellbeing	Implement workforce wellbeing strategies Enhance the profile of AHMH professions Strengthen clinical supervision and cultural mentoring Strengthen AHMH governance structures	

Training and Research opportunities

Opportunities		Actions	Lead
1.	Develop undergraduate AHMH profile and programs.	**1.1** Collaborate with universities to embed mental health clinical skill content in all undergraduate allied health degrees and clinical placements.	Universities MoH LHD/SHNs
		1.2 Collaborate with universities to embed Aboriginal social and emotional wellbeing course content in all undergraduate allied health degrees and clinical placements.	Universities MoH LHD/SHNs
		1.3 Collaborate with universities to embed interprofessional practice skills in AHMH undergraduate course content including understanding all AHMH professions scope of practice.	Universities MoH LHD/SHNs
		1.4 Increase the role of people with a lived experience of mental illness and peer workers at universities co-designing, co-producing and delivering course content to enhance understanding of lived experience.	Universities MoH LHD/SHNs
		1.5 Utilise NSW Health AHMH as guest lecturers in AH university programs to promote the range of fulfilling opportunities that exist in mental health care.	Universities MoH LHD/SHNs
2.	Develop innovative student placement models.	**2.1** Offer integrated clinical placements with rotations through physical health and mental health, prioritising emerging AHMH professions.	LHD/SHNs
		2.2 Offer and support virtual student placements, prioritising rural and remote areas.	LHD/SHNs
		2.3 Deliver interprofessional practice student orientation and education programs.	LHD/SHNs
3.	Develop a research culture to enhance outcomes and practice	**3.1** Generate conjoint appointment roles, especially in emerging AHMH professions to grow profile in MH.	Universities LHD/SHNs
		3.2 Establish or develop AHMH research position/s with role scope to include guidance and support for AHMH clinicians to enhance research skills.	LHD/SHNs
		3.3 Support ongoing university relationships following completion of PhD or Masters to support AHMH clinicians to publish research.	LHD/SHNs Universities
		3.4 Prioritise support to build capacity for rural and remote research.	LHD/SHNs
		3.5 Develop research KPIs to demonstrate person with a lived experience of mental illness, cost/benefit and strategic aim outcomes.	LHD/SHNs
		3.7 Utilise experience-based co-design principles for research projects.	LHD/SHNs
		3.8 Review and update senior clinical position descriptions to include expectation of driving and supporting research initiatives and culture.	LHD/SHNs

Recruitment and Retention opportunities

Opportunities		Actions	Lead
4.	Attract and support the future AHMH workforce.	**4.1** Collaborate and engage with high schools and tertiary sector to promote AHMH as a career. **4.2** Develop recruitment strategies to identify and support final year AHMH undergraduates interested in roles in the NSW Health workforce. **4.3** Develop strategies to attract and support a culturally diverse AHMH workforce.	MoH LHD/SHNs LHD/SHNs
5.	Link AHMH to rural incentive opportunities	**5.1** Promote available rural incentive opportunities to undergraduate/ early career AH to work in rural/remote areas **5.2** Build on current social media campaigns to promote rural living lifestyle, featuring local staff to highlight benefits of living and working in a rural community.	MoH LHD/SHNs LHD/SHNs
6.	Create university to new graduate pathways and roles	**6.1** Re/establish protected 12-month new graduate positions. **6.2** Provide a comprehensive 12-month new graduate education program including mental health competencies, discipline specific clinical skills, interpersonal and professional practice skills, access to mentoring, and clinical supervision.	LHD/SHNs LHD/SHNs
7.	Grow and support Aboriginal AHMH pathways.	**7.1** Engage in cultural consultation in partnership with universities to learn how to attract and support Aboriginal students to AHMH roles. **7.2** Support flexible learning pathways for Aboriginal people to access AHMH degrees that include opportunities to study remotely and remain on country. **7.3** Establish targeted Aboriginal AHMH new graduate positions. **7.4** Support Aboriginal AHMH clinicians to link in with HETI/IAHA Aboriginal AH Network Group **7.5** Grow capacity of Aboriginal AH Cadetships to include psychology and have MH clinical placements.	Universities MoH LHD/SHNs Aboriginal workforce MoH LHD/SHNs LHD/SHNs MoH
8.	Establish flexible workforce models to support needs and increase recruitment opportunities.	**8.1** Support flexible workforce arrangements to enhance AHMH availability for people with a lived experience of mental illness after hours/weekends on inpatient units and community settings. **8.2** Establish 7 day a week AHMH inpatient and community based early intervention acute care response teams. **8.3** Establish a virtual workforce using technology to support people with a lived experience of mental illness in hard-to-recruit-to areas*	LHD/SHNs MoH MoH LHD/ SHNs MoH eHealth LHD/ SHNs
9.	Develop strategies to retain and increase opportunities for AHMH clinicians	**9.1** Provide opportunities for established AHMH to grow skills in a new area of practice through supported secondments within or across LHD/ HNs. **9.2** Develop education and development pathways for AHMH workforce streams. **9.3** Establish AHMH talent pools and utilise for secondments or consultation. **9.4** Increase the use of AH Assistants to support AHMH working to top of scope and increase person with a lived experience of mental illness access to supports. **9.5** AHMH leaders undertake comprehensive exit interviews to identify and address barriers to retention.	LHD/SHNs MoH LHD/ SHNs LHD/SHNs LHD/SHNs LHD/SHNs

Learning and development opportunities

Opportunities		Actions	Lead
10.	Develop capacity for AHMH to work to discipline 'top of scope'.	**10.1** Provide support and opportunities to increase understanding within other health professions (e.g. Medical and Nursing) of breadth of AHMH discipline specific interventions to facilitate top of scope practise.	LHD/SHNs MoH
		10.2 Fast tracking acceptance of AHMH top of scope practise culture in parallel with generic clinical tasks	LHD/SHNs
		10.3 Establish and communicate executive sponsorship of *Key principles for AHMH workforce* to inform future workforce planning.	LHD/SHNs MoH- Chief AH officer
11.	Enhance AHMH education and educator roles	**11.1** Seek opportunities to establish discipline specific and/or AHMH Educator roles based on local need.	MoH LHD/ SHNs
		11.2 Provide upskilling for emerging AHMH professional groups (e.g. exercise physiology, dietetics, speech pathology) through collaboration with peak bodies.	LHD/SHNs HETI Peak Bodies
		11.3 Develop strong collaborative relationships with universities to inform undergraduate education programs.	LHD/SHNs Universities
		11.4 Lead and deliver 12-month new graduate AHMH programs.	LHD/SHNs
		11.5 Establish AH new graduate rotational programs to include mental health for established and emerging AHMH professions**.**	LHD/SHNs HETI
		11.6 Collaborate with HETI on learning pathways to support AHMH new graduates and develop flexible and innovative education packages that are interactive and person with a lived experience of mental illness focused.	LHD/SHNs HETI
		11.7 Support HETI Workplace Learning Professional Development Program and other AHMH scholarships assisting AHMH to identify local indicated needs.	LHD/SHNs HETI
12.	Enhance technology to support the delivery of contemporary professional development opportunities.	**12.1** Invest in technology to support access to online capability, e.g. hardware support and appropriate network connections.	LHD/SHNs eHealth ACI
		12.2 Increase use of e-Learning opportunities for continual professional development e.g.- social media platforms whilst ensuring evidence-based practice principles are maintained.	HETI LHD/ SHNs
		12.3 Develop a statewide cluster learning package of AHMH training opportunities to support evidence-based discipline specific and interdisciplinary skill development, including My Health learning and external opportunities.	HETI LHD/ SHNs
		12.4 Utilise improved technology to increase access to videoconference clinical supervision for rural and remote AHMH clinicians.	LHD/SHNs eHealth ACI
13.	Progress AHMH leadership opportunities, capacity and capabilities	**13.1** Strengthen clinical lead roles to include operational management responsibilities and AHMH service improvements.	LHD/SHNs
		13.2 Develop opportunities for AHMH pathways (education, secondments and projects) into mental health operational management leadership positions	LHD/SHNs HETI
		13.3 Identify if any concerns about the relevant awards and liaise with MOH Workplace Relations about the need and feasibility of any changes to address the concerns.	MoH

Workforce wellbeing opportunities

Opportunities		Actions	Lead
14.	Implement workforce wellbeing strategies.	**14.1** Recognise and respond early to vicarious trauma and burnout.	LHD/SHNs AHMH
		14.2 Develop and promote My Health Learning module on vicarious trauma and burnout for MH workforce, including early warning signs, strategies and support options.	HETI
		14.3 Support flexible working arrangements where possible to enhance workplace culture and wellbeing.	LHD/SHNs
		14.4 Promote and support regular participation in workforce wellbeing activities e.g. Meditation-based Wellness & Compassion (MWAC) program at SLHD.	LHD/SHNs
		14.5 Promote use of the NSW Mental Health Commission the mental wellbeing impact assessment (MWIA)	LHD/SHNs
15.	Enhance the profile of AHMH professions.	**15.1** Develop AHMH profile page on NSW Health site using person with a lived experience of mental illness journey stories following involvement with each AHMH profession- established and emerging.	MoH
		15.2 Ensure visibility of AHMH innovation and achievements in LHD/HN innovation/quality awards.	LHD/SHNs
		15.3 Acknowledge and celebrate international allied health day annually with events and executive acknowledgment.	LHD/SHNs
		15.4 Develop an AHMH visual identity strategy to promote workforce capability and sense of belonging.	LHD/SHNs
16.	Strengthen clinical supervision	**16.1** Support AHMH access to clinical supervision appropriate to their profession, qualifications and level of experience.	LHD/SHNs
		16.2 Promote compliance with use of HETI The Superguide: *a handbook for supervising allied health professionals* to support experienced AHMH to develop skills to deliver clinical supervision.	LHD/SHNs
17.	Strengthen access to cultural mentoring.	**17.1** Support Aboriginal and Torres Strait Islander AHMH clinicians' access to regular cultural mentoring.	LHD/SHNs
		17.2 Increase access to local cultural support and education for non-Aboriginal and Torres Strait Islander AHMH clinicians.	LHD/SHNs
18.	Strengthen and grow AHMH governance support structures.	**18.1** Establish and/or strengthen discipline specific/AHMH reporting lines.	LHD/SHNs
		18.2 Grow the role of AHMH leadership roles to include operational management accountabilities for AHMH.	LHD/SHNs
		18.3 Strengthen the profile and accessibility of statewide Chairs of the NSW AH Advisory Groups for all AHMH professional groups.	MoH
		18.4 Enhance relationship and connection with Directors of AH.	LHD/SHNs
		18.5 Establish escalation pathway for AHMH priorities via AHMH leaders, Directors of Allied Health and NSW Health Chief Allied Health Officer.	MoH LHD/SHNs

5 Detailed AHMH workforce project processes and outcomes

5.1 Literature review

A literature review of published research articles and organisational reports, including unpublished reports and evaluations was undertaken to assist in establishing a broader context for the project . The review process considered current and future AHMH workforce risks, drivers, emerging issues, and opportunities. The search focused on literature published in the past ten years, prioritising Australian studies. Relevant literature from the UK, USA and Europe was also included for review.

The following databases were reviewed :Embase, Emcare Nursing & Allied Health Database, PreMEDLINE, PsycINFO, Cochrane Database of Systematic Reviews, Ovid MEDLINE and Google Scholar.

Review questions

1. What are the characteristics of the AHMH workforce and their scope of practice?
2. What is the range of evidence about AHMH workforce and community need for allied health services for informing policy development? Specifically considering issues around structures, staffing profile, governance, and clinical practice.

The search terms used were: Allied Health, mental health, health workforce, governance, education, recruitment, retention and patient experience. Following initial limited search results under Allied Health, key search terms were then expanded to include the range of AHMH disciplines as:

Occupational therap*y/ist, Psycholog*y/ist, Social work*/er, Diet*itian/etics, Physiotherap*y/ist, Pharmac*y/ist, Speech patholog*y/ist, Exercise Physiolog*y/ist

A summary of these key themes developed from the literature review was provided to interviewees and delegates at the Horizons Scanning workshop to test and validate the content.

Key themes identified from literature relating to the AHMH workforce included:

- Education
- Emerging models of care
- Recruitment and retention challenges (particularly in rural areas)
- Aboriginal workforce
- Professional identity
- Demonstrating outcomes
- Technology

These key themes represent a perspective compiled from the reviewed literature (white and grey papers) listed in the references. The full literature review and references can be found in Appendix 1.

Limitations

There is currently limited research relevant specifically to the AHMH workforce. Due to this an expansion of key search terms was undertaken and evidence was considered from both discipline specific mental health and broader allied health workforce research. There may be limitations in the evidence identified from the literature reviewed due to this.

The lack of specific research highlights the need for establishing AHMH specific research and evaluating workforce strategies within this group.

5.2 Universities consultation

The *Our Students, Our Future Allied Health Network Forum* was held on 31st October 2019 with attendance including Directors of Allied Health for LHD/SHNs, Allied Health Deans at NSW Universities and University of Canberra, Indigenous Allied Heath Australia (IAHA), HETI and MoH representatives including Aboriginal Workforce, the Chief Allied Health Officer and the Principal Allied Health Advisor.

Consultation on the AHMH Workforce Project was undertaken via a facilitated workshop at the forum. The following barriers, enablers, supports, and opportunities for enhanced collaboration between Universities and NSW Health to grow the AHMH workforce were identified.

Barriers to growing the AHMH workforce:

- Perceived stigma associated with working in mental health for allied health clinicians
- Perceived lack of clinical placements in the mental health setting
- Challenges in the provision of placement support and supervision for the emerging AHMH disciplines
- Lack of understanding of pathways from university to AHMH workforce
- Possible lack of understanding about generic role responsibilities, where an AHMH clinician's role may be perceived as a generalist role that is possibly unattractive to graduates
- Structure of some mental health services may not support work to a discipline's full scope of practice, or the scope of practice may be different to other clinical areas
- Possible role blurring in mental health and a lack of role identity possibility contributing to recruitment and retention challenges
- Governance structure in mental health may be different to other allied health services, with fewer opportunities to link with broader allied health networks.

Enablers to grow the AHMH workforce

- Enhanced mental health curriculum component in all Allied Health degrees, inclusive of interdisciplinary practice knowledge and skills
- Increased opportunities for clinical placements for all Allied health professions
- Innovative placement models such as interdisciplinary placements
- Increased access to mental health simulations for all Allied Health degrees

Supports required to grow the AHMH workforce

- Enhanced funding of post graduate grants/ scholarships
- Caring for students who may be triggered by lived experience; access to a program like the Employee Assistance Program (EAP) to help support wellbeing of students and allied health clinical placement supervisors

Opportunities for collaboration between Universities and NSW Health

- Collaboration could include discussion about how to make mental health more attractive for clinical placements and employment using innovative case studies
- Developing collaborative case studies with people with a lived experience of mental illness using co-design
- Collaborative review of allied health curriculum to enhance relevance.

There was strong agreement on the need for more collaboration with this viewed as a positive step to overcoming barriers to grow and support the AHMH workforce from the university level. Engagement in these opportunities may have a significant impact on supply drivers and support and growth factors for the AHMH workforce.

> 'Health and Education need to better understand how each party can support each other.'
>
> – Universities

5.3 Horizons Scanning and Scenario Generation Workshops

AHMH delegates were nominated from LHD/SHNs, HETI and the MoH to attend both the Horizons Scanning and Scenario Generation workshops. The purpose of these workshops was to engage delegates in activities to help further understand and test findings from research and consultations, and consider opportunities for the future AHMH workforce. The workshops encouraged consideration of the health needs of people with a lived experience of mental illness, and possible improvements to meet changes in demand and supply factors into the future. Information was gathered using tabletop exercises, Mentimeter questions (interactive presentation and poll tool) and group exercises.

The *Horizons Scanning* workshop held in December 2019 had seventy-two delegates attend including AHMH leaders, frontline clinicians, MoH representation from MHB, WPTD and the Chief Allied Health Officer and HETI stakeholders. The workshop began with exercises to better understand delegate views on the current context for the AHMH workforce and future workforce planning. Themes emerging from the literature were presented and validated. Delegate views on themes of recruitment and retention, learning and development, and education and research were also gathered through interactive group activities. Workshop delegates worked to identify demand and supply factors that impact on the AHMH workforce. From this information a demand and supply diagram was developed and tested with participants at the following Scenario Generation workshop.

The *Scenario Generation* workshop was held during the NSW bush fires crisis in early February 2020. Fifty-four delegates participated, with the majority of participants who attended the first workshop present.

The day included an overview of learnings to date about the AHMH workforce and its future direction, and how these learnings would work together with the *Health Professionals Workforce Plan*; *The Mental Health Strategic Framework and Workforce Plan* and guiding principles for the AHMH workforce in planning for the future. A key activity included a facilitated solution planning activity where *Opportunities to grow and support the AHMH workforce* were co-produced with delegates across four categories: Wellbeing and Support, Training and Research, Learning and Development and Recruitment and Retention.

A summary of the Horizons Scanning workshop themes identified by delegates through workshop activities can be found in Appendix 2.

Figure 11: AHMH workshop delegates test survey questions on as a continuum exercise

5.4 Leader and Executive Interviews

Seven key leaders in the NSW Health AHMH community were consulted to share their knowledge and expertise on key issues and potential opportunities. Participants included Directors of Allied Health in Mental Health, Aboriginal Workforce management, senior representatives from Indigenous Allied Health Australia (IAHA) and HETI, and a MHB Senior Policy Officer. Interviews were conducted by phone, lasting approximately 40 minutes with answers recorded and provided to those interviewed for validation. Throughout the interviews, participants were asked to validate key themes identified in literature as compared with their own experiences and their view about the future direction of the AHMH workforce.

Interviewees also provided advice for effective facilitation of the HSSG workshops. Findings from the interviews formed the basis for interactive activities, including the Mentimeter interactive experience in workshops.

Four key statewide Executives from NSW Health were also consulted to understand their perspectives on the strategic priorities and direction for the AHMH workforce. Interviews were conducted by phone with answers recorded and provided to those interviewed for validation. Executive staff included the NSW Chief Allied Health Officer, the Executive Director of the Workforce Planning & Talent Development branch, Director of Clinical Services and Programs Mental Health Branch, and a Senior Aboriginal Workforce Project Officer.

5.5 Aboriginal AHMH workforce

Consultation with Ministry of Health Aboriginal Workforce Unit and AHMH workforce survey results identified similar challenges to the rest of the AHMH workforce, with additional challenges outlined below where there are identified Aboriginal positions.

Aboriginal AHMH

There are minimal numbers of AHMH workforce who identify as Aboriginal or Torres Strait Islander. The *Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020*, and the *NSW Public Sector Aboriginal Employment Strategy 2019-2025* released in July 2019 re-set the Aboriginal workforce targets to 3%.

> '[A challenge is] a small, overworked Aboriginal workforce - where there are identified Aboriginal positions or someone has identified as Aboriginal, then the job becomes heavy. Because they become the broker between the service and the community at high personal cost, and yet, this is also where the value is.'
>
> Wendy Bryan-Clothier
> Aboriginal Workforce Unit
> Ministry of Health

Resourcing

Findings from interviews and workshops indicated that identified Aboriginal positions come with an increase in professional and personal workload. Employees are seen as community members who connect people with a lived experience of mental illness to services. Although this was the goal when configuring service delivery, consideration needs to be given to how the Aboriginal workforce can be supported. They are also more likely to be working with a higher risk population (e.g. trauma background), may be frequently approached after hours, and may also have less access to support in rural locations.

Models of Care

A review of current models of care is required to ensure appropriate services are provided, especially for Aboriginal people. The workforce needs to be supported with a mandatory use of enablers such as the *Aboriginal Health Impact Statement* and the *National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health* accreditation elements will guide appropriate service development. Relevant community-based models will ensure the AHMH workforce are meeting the needs for these population groups.

Workforce Development

Other methods that may enhance the development of the workforce include staff secondments across metropolitan and rural settings and providing clear pathways and courses for development and training. A focus on leadership development is recommended through identifying and allowing opportunities for staff to act in higher roles and receive coaching from other leaders.

These actions will lead to an enhancement in clinical capability, professional competence, and therefore, service outcomes for the Aboriginal workforce and population of NSW.

5.6 People with a lived experience of mental illness consultation

Consultation with people with a lived experience of mental illness occurred through a facilitated focus group. This provided a unique perspective on the healthcare system that can only come from asking people about their personal experiences. Nine people with a lived experience of mental illness from metropolitan and rural communities across NSW participated in the focus group by either attendance in person or via video or teleconference. The purpose was to understand their perspective on emerging models of care and the role of the AHMH workforce in supporting improved outcomes. Focus group participants also provided valuable input into the development of the survey.

The survey for people with a lived experience of mental illness was distributed via LHD/SHN networks to extend the opportunity to a larger group to gather their views on engaging with AHMH services and possible solutions for the future. Twenty people with a lived experience of mental illness responded to this survey with responses analysed and themed to inform the development of opportunities.

Focus group outcomes

Summary of insights:

- Increasing consumer awareness of available AHMH services
- Make care easier to access directly by consumers where appropriate (as opposed to always requiring a referral)
- Providing multidisciplinary care to consumers was very important to helping them with all aspects of their care
- Establish methods of staff accountability in providing positive experience of services
- Allowing the option for consumers to receive care in different ways e.g. the use of technology or telehealth services, would allow opportunities for more consumers' needs for services to be met.

Knowledge of available services

- A major barrier to using appropriate services was the lack of information about the services available.
- The main way participants were exposed to available services was following admission into hospital when a referral to AHMH services occurred. Participants reported being unaware that many AHMH services were an available option in their care.
- GPs appear to not have full knowledge of available AHMH options to support appropriate referrals to these services.
- People with a lived experience of mental illness found great benefit in accessing care from multiple AHMH services where available.

> 'When people start to find out they have a mental health service need – they don't know how to access services if they haven't been through hospital.'
>
> – Person with a lived experience of mental illness

Complexity

- Participants did not entirely agree with the complexity theme the AHMH workforce raised 'increasing number of young people in Emergency Departments'. They considered that youth can be a stressful time in a person's life, and that numbers could be increasing due to better awareness of mental health and a reduced stigma around mental illness.

Transitioning to the community

- People with a lived experience of mental illness reported that having relevant AHMH services organised prior to their return to the community allowed for a more successful transition back into their community.

Availability and accessibility of care

- Participants reported that it can be costly and difficult to access all the services they need.
- Participants reported at times having to travel great distances to receive relevant care and support.

Potential solutions suggested by focus group participants

- A proactive approach to care, including education for youth (whether they are experiencing a mental illness or not) – 'Try to catch it before it explodes'.
- Review of multidisciplinary approach to care that includes greater consideration for physical health issues.
- More community-based care, e.g. a 'step up and step down' program for people who are either entering or leaving hospital, with care arranged before or after hospital.
- Start links with AHMH services while still in hospital.
- Raise community awareness of AHMH services. including GP awareness of AHMH services and providing regular communication about current services available in local area.
- Co-design and co-production of all person with a lived experience of mental illness services happens, at the moment is regarded as 'a phrase that is tokenistic.'
- More awareness of peer support workers to help with service access – 'It's good to know you have a peer support worker who has been through it before.'
- Fewer administrative barriers to accessing services and programs.
- Consideration for the care needed for those experiencing climate-related disasters, e.g. droughts and fires.

> 'Rather than treating the symptoms, preventative action is crucial with support for those in difficult circumstances.'
>
> – Person with a lived experience of mental illness

Survey outcomes

Twenty people with a lived experience of mental illness responded to a survey asking for their experience with AHMH services in NSW Health Mental Health Services. Most people had received care for greater than 12 months (58%).

Awareness and access to services

When asked whether they were aware of AHMH services, the majority were aware of Psychology services (68%) however below 40% of respondents knew about other AHMH services. People were mostly referred to AHMH services following a hospital admission, followed by GP referral.

Respondents were least likely to seek out services on their own.

People were also asked about how access to services could be improved for rural and remote areas. They felt that increasing the number of clinicians would assist in meeting demand for services. The use of telehealth and online support, as well as mobile services was also suggested.

> 'Having someone that knows me, and my illness has helped me stay stable.'
>
> – Person with a lived experience of mental illness

Experience of care

Respondents reported both positive and negative experiences with accessing AHMH services. Positive experiences were due to favourable services received from knowledgeable staff. Unfavourable responses were due to service needs such as long wait lists, lack of options for appointment times and the condition of the facilities.

Respondents felt that AHMH services generally had a positive impact on their recovery journey (67%), due to the treatment and support received.

Receiving multidisciplinary care helped some people with improving all aspects of their life. Negative experiences were due to the perceived lack of knowledge and experience by staff, as well as long waiting lists.

When asked about how their experiences with accessing and receiving AHMH services be improved, respondents stated that more staff with greater appointment time selection and making it easier to see AHMH providers in the community would assist without the need to request a referral. Treatment plans that are tailored to individuals would help with making wellbeing improvements compared with generic models of care.

> 'The joint allied health teams helped me to live again.
>
> – Person with a lived experience of mental illness

Use of technology in care

When asked directly whether they would consider using technology in receiving care, most respondents indicated that they would consider it as part of their care. For those who indicated they were unsure of

whether they would accept care using technology, some of the reasons provided were due to concerns about technology literacy and access. Allowing people the option of receiving care through technology was suggested as an easier way to consider its use. Respondents recommended the appropriateness of the use of technology would need to be considered for individual cases as it may not be suitable for everyone.

5.7 AHMH Workforce survey

Following the Scenario Generation workshop in February 2020, a survey consisting of multiple choice and extended response questions was distributed via LHD/SHN Directors of Mental Health and Directors of Allied Health to the AHMH workforce. The survey provided the AHMH workforce the opportunity to share experiences and insights into providing care and provide suggestions for the future direction of the workforce. Five hundred and forty-nine (549) responses were received from the AHMH workforce, representing approximately 31% of the total AHMH workforce at the time. Responses underwent a detailed analysis of themes and were incorporated to inform the development of opportunities.

The AHMH workforce survey investigated the workforce's feelings about their current role and future of the AHMH workforce. The wealth of information gathered through the survey is highly valued and will be considered in relation to future workforce planning for AHMH.

The distribution and prevalence by number of responses within the main theme areas of this AHMH project and emerging sub-themes from the survey is depicted in Figure 12. A summary of the workforce survey outcomes can be found in Appendix 3 of this report.

A high level of responses related to the four key areas for opportunities in this report were received. In addition to these themes the following four key sub-themes emerged from responses with participants expressing if improvements occurred in these areas, AHMH workforce concerns could be potentially resolved.

- Management/Leadership opportunities and structures (14%)
- Acknowledgment/Understanding of the AHMH workforce (13%)
- Enhanced AHMH staffing to meet need (12%)
- Enhanced resources to support wellbeing (10%).

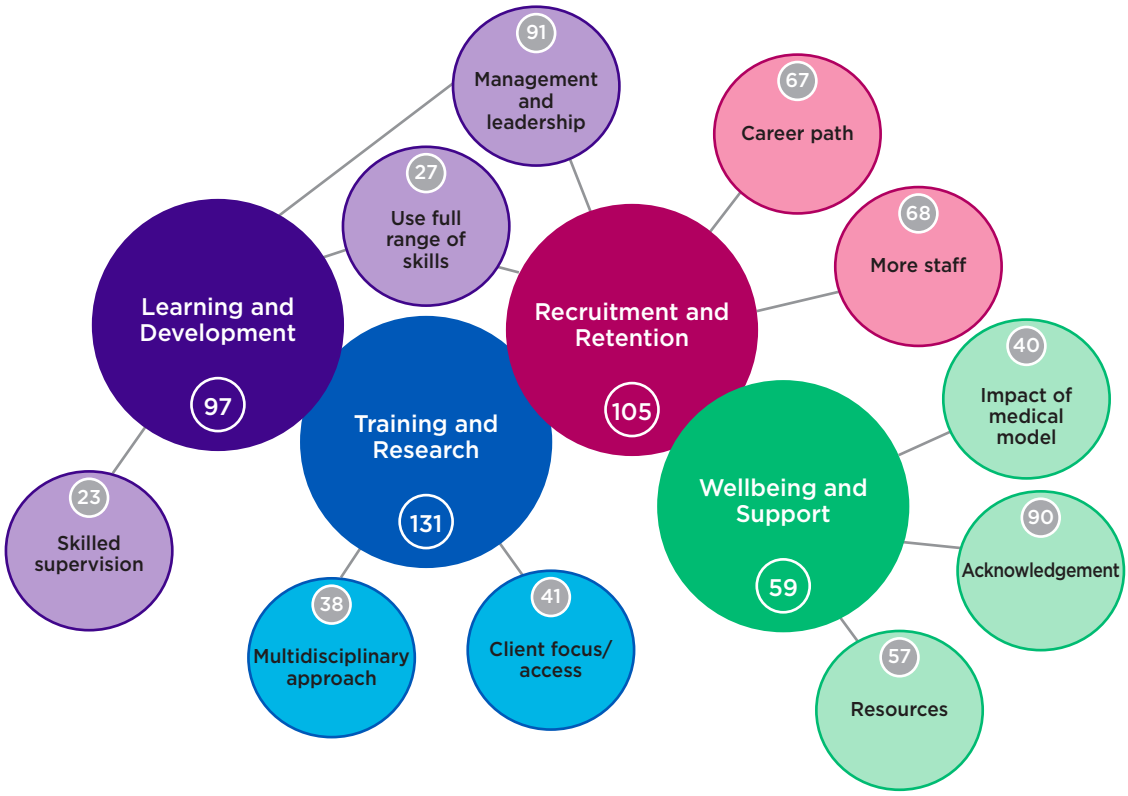


Figure 12: AHMH workforce survey key themes and sub-themes (number of responses)

Five further sub-themes emerged related to desired changes for the AHMH workforce. When grouped these account for 23% of total responses.

- Ability to use full range of skills/opportunities to specialise (7%)
- Advanced career path options (5%)
- Receiving and delivering skilled supervision (5%)
- Improvements to pay structures (3%)
- Flexibility in service delivery (2%).

Themes and sub-themes from the survey identify a strong desire among respondents for a shift in the way they work and how they are able to employ their skills, how their roles are perceived and understood by other professionals, and how their roles grow over the course of their career.

5.8 AHMH workforce strengths

Horizons Scanning workshop delegates participated in an interactive mentimeter activity to gain an understanding of their view of the current AHMH workforce strengths captured in Figure 13. The delegates felt the AHMH workforce is passionate and dedicated, with diverse skills and people that are creative, flexible, and collaborative, and take a holistic, patient-centred view. The AHMH workforce perceive they are adaptable and well placed to support the changing health care focus for people with a lived experience of mental illness, and that the current strategic focus aligns with the approach of and AHMH workforce.

5.9 AHMH workforce challenges

The challenges identified by delegates at the Horizons Scanning workshop were consistent with the findings in literature.

The key issues for the AHMH workforce as perceived by stakeholders were:

- Limited opportunities available for career development and progression
- An underdeveloped professional identity
- AHMH occupy positions with generic task responsibilities and limited opportunities to use discipline specific skills
- A perception that discipline specific skill sets are not well understood by the MDT
- A need for increased allied health leadership roles and reporting lines
- Challenges to growing the allied health workforce due to recruitment and retention difficulties (particularly in rural areas)
- A lack of Allied Health Educator positions
- Concerns around inconsistency and feeling of inequity compared to other professional groups
- Whether emerging models of care support restorative practices
- Ensuring there is a match between education and training, student placements, workforce support and the expectations of the workforce to meet needs of people with a lived experience of mental illness

Figure 13: Wordcloud view of Horizons Scanning workshop delegates view of the strengths of the AHMH workforce (Mentimeter voting results)

- Demonstrating outcomes through data and qualitative feedback from people with a lived experience of mental illness
- Lack of investment in technology (e.g. telehealth, internet access, portable devices, and social media).

Two additional issues are worth highlighting. The first issue was raised by people with a lived experience of mental illness, and the second issue was raised on behalf of an underrepresented Aboriginal workforce.

- Affordability and accessibility of AH services for people with a lived experience of mental illness
- A small Aboriginal workforce in high demand

Note that these workforce issues sit in the context of the broader health system, where recent changes for NDIS are creating specific opportunities and challenges for the sector (e.g. drain of workforce to NDIS, increased expectations of AHMH workforce).

Further information on workshop themes can be found in Appendix 2.

'The NDIS is creating opportunity for AHMH. We need to move away from building hospitals and move to a community base. This is the domain of AH, who have a role in community-based care, particularly for rural NSW, where AH and Aboriginal health have a critical role.'

– Richard Griffiths, Executive Director, Workforce Planning and Talent Development for NSW Health

5.10 AHMH Workforce – demand is changing

While changing needs for people with a lived experience of mental illness have been clearly identified as one of the factors influencing demand, this was a major focus throughout consultation discussions and worth examining in more detail. There are also important differences between how different factors were perceived and prioritised by workshop participants as compared to the focus group with people with a lived experience of mental illness. Demand is also influenced by changes in focus for national and state-wide strategic plans. The *Fifth National Mental Health and Suicide Prevention Plan* priority to improve the physical health of people living with mental illness and reduce early mortality is informing the development of physical health care guidelines enhancing access to AHMH care. *The Mental Health Safety and Quality in NSW: A plan to implement recommendations of the Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities* (2018) recommends the expansion of access to the multidisciplinary team on inpatient units after hours and on weekends to enhance bio-psycho-social-cultural care.

Complexity

Overwhelmingly, workshop participants felt increasing complexity was the most significant area of change for mental health people with a lived experience of mental illness. They identified several areas driving this complexity:

- Increased presentations from refugees and asylum seekers and people with trauma history
- Increased numbers of mental health people with a lived experience of mental illness due to increasing awareness and acceptance of mental health conditions
- Increased measurement of physical health parameters for people with a lived experience of mental illness means more is known about co-existing conditions and interventions incorporated into MH care plans
- The impact on physical health of medications
- This impact of technology changes and possible increasing disconnection in society
- Private services and NGOs funded to support low to moderate needs of people with a lived experience of mental illness only, with expectation NSW Health support high and complex needs
- Changes in environment (e.g. social media) have contributed to increased presentations from younger people with a lived experience of mental illness
- The impact of family breakdown, intergenerational issues, and perceived limited support options for carers
- Perception of limited time to adequately treat issues contributing to mental health can lead to return presentations and contribute to increased complexity.

People with a lived experience of mental illness from the focus group confirmed many of these areas and added two further areas:

- Difficulty navigating the system and recent changes with NDIS
- Climate disasters' effect on mental health, e.g. impact of bushfires on community members.

In response to this focus on complexity, NSW Chief Allied Health Officer put forward the question, 'Are people with a lived experience of mental illness changing, or is it the service system that is changing? And what does this mean for the services we provide and our workforce?'

Focus group participants responded, 'It's a bit of both… consumers are becoming more aware, but also, the system is changing how it is delivered.' They went on to describe how with stigma reducing in the community and awareness of mental health increasing there are now more people with a lived experience of mental illness accessing services. And with more research into mental health, there is increasing knowledge of what works, which affects how services are provided to people with a lived experience of mental illness

5.11 Workforce wellbeing – wellbeing and support

A high priority area for the AHMH workforce identified through project processes is wellbeing and support. In response to this identified need an additional category of 'workforce wellbeing' has been added to the AHMH workforce report categories in recognition of the impact of vicarious trauma and burnout on AHMH workforce, and the importance of developing and implementing opportunities to address this impact.

AHMH delegates at the Horizons Scanning workshop and respondents to the AHMH workforce survey strongly agreed with the themes identified in the literature around workforce wellbeing identifying the following impacts:

- Perceptions of under-resourcing and low staffing levels while demand and complexity are increasing
- Limited opportunities AHMH to advocate for allied health support needs due to concerns about current governance structures
- Limited workforce early intervention strategies within mental health services recognising the impact of vicarious trauma and burnout on AHMH. For example, EAP is available to access but typically only when at crisis point
- A motivation to deliver interventions that are person-centred, trauma-informed, evidence-based, and recovery-focussed and work to discipline 'top of scope' limited by feeling locked in to primarily delivering generic risk management and mitigation interventions

Appendixes

Appendix 1: Literature review report

Growing an Allied Health in Mental Health Workforce

> **Right People, Right Place, Right Skills**.
> Strategy 2.3 – Grow and support a skilled mental health allied health workforce in line with forecast health service demand and service delivery requirements.
>
> NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022

The need for growing the Allied Health in Mental Health (AHMH) workforce in response to the needs of people with a lived experience is documented in current strategic plans, professional body position statements and literature with proposed benefits to both person with a lived experience of mental illness health outcomes and health system sustainability (NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022; Australian Allied Health Leadership Forum position statement 2020- Mental Health; Lizarondo et al., 2016; Naccarella, 2015; Philip, 2015; Somerville et al., 2015). Allied Health (AH) are increasingly being viewed as integral to transforming health, with current research suggesting AH not only improve the quality of patient outcomes, but may have the potential to offer innovative solutions for sustainable future healthcare (Lizarondo et al., 2016; Philip, 2015).

While there are reports of strong evidence for AH in improving patient outcomes, minimising risk and harm from illness, improving health system efficiency and capacity to meet increased demand cost effectively, this remains poorly understood and largely invisible In the Australian health policy and reform environment (Australian Government Dept of Health, 2013). There are current calls for a shift in culture and health model to genuinely involve people with a lived experience of mental illness and make full use of all three pillars (AH, Medicine and Nursing) of patient care workforce (Lizarondo et al., 2016).

The Review of Australian Government Health Workforce Programs (2013) encourages service sector workforce planning looks at community needs for care. Also how AH skills can meet these needs as an alternative to a population based planning approach. This would provide meaningful information to assist not only with supply and demand for the different AH professional groups, also best practice models for service delivery including interdisciplinary care and the use of Allied Health Assistants. The challenge for AHMH when viewed as a whole workforce is a possibly paucity of evidence and outcome data for the effectiveness of some particular AH interventions, both as a collective and within some individual professions (Australian Government Dept of Health, 2013). With AH increasingly considered an essential part of a people with a lived experience of mental illness health care team and a focus on prevention, maintenance and function in the community it is essential that health outcomes for AHMH are better understood so they can be justified in a policy and reform environment.

The 2019 Henry Review of Health Services for Children, Young people & Families within the NSW Health System delivered recommendations acknowledging that demand for AHMH far exceeds supply. Recommendations include long term strategies to increase the AHMH workforce by allocating similar levels of funding as for other workforces in NSW Health. As well as collaboration with university faculties of health on AH curricula had a first 2000 days focus on physical, cognitive, social and emotional health of the population focus.

The Living Well Strategic Plan for Mental Health in NSW (2014) reform calls for care that is: person-centred and tailored, family and community focussed, recovery-oriented, trauma informed, provided in the least restrictive way, and delivered in partnership with people with lived experience and their families and carers, and with other

organisations. Under this reform inpatient and community-based mental health care are considered important and complementary parts of the health system.

The Reform aims to build and strengthen community-based care while seeking to improve and refine inpatient care, with current evidence in outcomes and strengthening the health system, the AHMH workforce and approach to care is well placed to support these reform aims.

The Allied Health workforce are increasingly being viewed as the "glue in the health system, with potential to ease the pressure off the health system and create system level resiliency" (Naccarella, 2015). The challenge for AHMH clinicians, managers and policy makers is being able to clearly demonstrate efficacy based on reliable data outcomes that inform funding arrangements to support the further growth of AHMH.

Increasing diversity in the AHMH workforce to support holistic care

> The most cost effective, cost efficient and sustainable treatment and management of mental illness is through integrated models of care. There is growing evidence for the need for reform across the mental health workforce and models of care. Non –traditional interventions such as diet modification and exercise therapy have a role in treating mental illness, not just physical co-morbidities.
>
> Australian Allied Health Leadership Forum position statement 2020 – Mental Health

Allied health professionals bring a wealth of contemporary, diverse and specialist skills that contribute an essential role to contemporary quality recovery focused service delivery within mental health services (Qld health, 2017).

The Health Education and Training Institute (HETI) define Allied health as:

- Tertiary qualified health professionals and hold relevant State or Territory registration, licence or accreditation to practice.
- Provide a range of therapeutic and diagnostic services in either the public or private health care sector.
- Apply their skills and knowledge to restore and maintain optimal physical, sensory, psychological, cognitive and social function.
- Use a range of complex professional clinical skills including communication, clinical reasoning, reflection and evidence-based practice skills.
- Are 'allied' or aligned to each other and other members of the health professional workforce, working together as part of a multidisciplinary team; to each other and other members of the health professional workforce, to their clients, the client's family, carers and community working across the health system.

Allied Health comprises of 22% of the NSW Health mental health clinical workforce (NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022). People with a lived experience of mental illness need access to the full range of AHMH to support their physical health, mental health and wellbeing. The NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 recommends as a workforce priority, enhancing access to the AHMH workforce. Particularly speech pathologists, dietitians, exercise physiologists, physiotherapists, occupational therapists and pharmacists in alignment with the three key objectives of the framework: to deliver holistic care, improve the physical health care of people with a lived experience of mental illness and increase community based options.

This statewide enhancement of allied health expertise "offers people with a lived experience of mental illness across NSW the opportunity to live well and longer through improved access to physical health care and support for their functional recovery" (NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022) and to address social participation and inclusion.

NSW Health has also committed that the National Equally Well Consensus Statement (2016). The consensus statement principles further demonstrate the demand for growing an AHMH workforce. A person centred holistic and inclusive approach, a focus on the mental, physical, social and emotional wellbeing of the individual, families, intervention and a continuous focus on recovery is encouraged. With integrated physical and mental health care people can be enabled to live healthy, contributing lives, both socially and economically.

An evidence based approach to increasing physical health supports is clearly justified and should be prioritised (Rosenbaum et al. 2016; Rosenbaum, Teasdale, Czosnek, Byron & Schuldt, 2017). Multiple systematic reviews and studies have identified positive effects with significant effect sizes for physical health interventions for mental health people with a lived experience of mental illness in support of the exercise physiology, physiotherapy and dietetics workforces (Rosenbaum, Tiedemann, Serringham, Curtis & Ward, 2014; Teasdale et al., 2015).

Current research for emerging AHMH workforce groups suggests that while integration within the multidisciplinary team has gained traction, the workforce faces challenges. With calls for education to increase capacity for culture change to accept physical health interventions as part of standard mental health care (Rosenbaum et al., 2017).

A lack of skills in specialised areas such as mental health on graduation for these professions is also highlighted as a challenge to grow the emerging AHMH workforces. To increase confidence in management of people with serious mental illness, address stigma and address health system barriers for this workforce a solution proposed by researchers is increased exposure to relevant mental health curricula at the university level for all AH degrees (Rosenbaum et al., 2017; Wheeler et al. 2012; Wheeler, Fowler & Hattingh, 2013; Andrew, Briffa, Waters, Lee & Fary, 2019).

Professional identity

> A holistic view of health encompasses an individual's mind, body and spirit. Different perspectives – including the patient's, family member/s, as well as those of health and medical professionals can provide important insight that can help improve a person's health and wellbeing. That is why being inclusive of these perspectives is an important part of interprofessional practice. When practitioners from a variety of professional backgrounds have the opportunity to contribute their expertise, knowledge and skills, the result is better outcomes that lead to better health for the individual.
>
> Overview of Interprofessional practice- Allied Health Education & Training Dept., QLD Health

Professional identity is a key factor in the functioning of interprofessional teams. Interprofessional practice represents the intersection of rights of people with a lived experience of mental illness to receive best available health care and recognition of the individual contribution of each profession (Grace et al., 2017).

Current workforce research for the traditional AHMH professions of social work, occupational therapy and psychology reports high engagement in generic work for AHMH may negatively impact professional identity and is linked to workforce wellbeing and recruitment and retention challenges. (Scanlen, Meredith & Poulsen, 2013; Scanlen, Devine & Watkins, 2019).

Strategies for maintaining the employed workforce include increasing workforce satisfaction and ability to work to top of scope and opportunities for professional development as much as increased salary (Stokes, Matthews, Grenyer & Crea, 2010).

Although discipline specific research reports role blurring negatively affects workforce retention and professional resilience, the intersection between interdisciplinary models of practice and AHMH generic worker roles has not been significantly explored in the literature across all disciplines, or for the AHMH workforce as a whole. There is encouragement to work form a common structure based on shared underpinning values, such as those aligned with Allied health and the capacity of a particular profession to support specific health care needs (Porter & Wilton, 2019). Limited research in to impacts of transdisciplinary tasks on professional identity for the AHMH workforce and potential implications for recruitment and retention identifies need for further understanding of how this impacts broader the AHMH workforce, and evaluation of strategies to address potential impacts.

Aboriginal Workforce

> Strengthening the Aboriginal workforce in the health system is seen as critical to improving services. A key priority is to build a NSW Health system and workforce that closes the gap in health outcomes between Aboriginal and non-Aboriginal people by providing a culturally safe and competent health service.
>
> NSW Aboriginal Health Plan (2013-2022); Good Health, Great Jobs: Aboriginal Workforce Strategic Framework (2016)

Headline statistics as of June 2016 report a 10% increase in the NSW Health Aboriginal Allied Health workforce in response to strategies such as the Allied Health cadetship program. The program aims to address three key areas of addressing growth in Aboriginal workforce by addressing health outcomes through closing the gap strategies to increase accessibility to mental health supports for Aboriginal people, the provision of a culturally appropriate service and strengthening partnership with universities to support attraction to AH degrees and transition to workforce. Despite the strong strategic directions across a number of frameworks (NSW Aboriginal Health Plan, 2013-2022; Good Health, Great Jobs: Aboriginal Workforce Strategic Framework, 2016; NSW Strategic Framework and Workforce Plan for Mental Health, 2018-2022) there is limited evidence and data in relation to experience, barriers, enablers and numbers in the Aboriginal AHMH workforce, where AH is identified as the current 23 professions recognised by NSW Health, as defined by NSW Treasury Codes.

The NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022 recommends improved access to the full range of allied health professionals, to support social and emotional wellbeing, physical health and address health risks that contribute to higher rates of mortality and morbidity for Aboriginal people. Both Aboriginal and non-Aboriginal AHMH Workforce, in collaboration with community, Aboriginal health liaison officers and Aboriginal medical centres are well placed to deliver holistic care, in the community and environment of choice for people with a lived experience of mental illness reflective of Values Based Healthcare approach that is a NSW Health priority.

Mental health services are focussed on service delivery that is culturally appropriate respecting the Aboriginal concept of mental health and wellbeing (NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022). Improvements in cultural safety for the Aboriginal workforce aim to assist with recruitment and retention challenges, while also enhancing cultural understanding and education for all workforce on the importance of Aboriginal workforce to health (NSW Aboriginal Health Plan, 2013-2022).

Along with strategic aims to increase representation of Aboriginal people in all health professions, innovative workplace strategies such as peer mentoring between Allied Health professionals and Aboriginal workforce may assist with strategic aims.

A study of this initiative reports outcomes in promotion of two way learning, increased visibility and understanding of AH as a mechanism to increase demand and workforce. Evaluation of this program recommended this may form part of a multi-strategy approach to the development of the Aboriginal health workforce (Browne, Thorpe, Tunny, Adams, & Palermo, 2013). Further evaluation of other strategies to grow and support the Aboriginal AHMH workforce specifically is needed to support these important strategic aims.

Supporting transitions from University

> There is a need to strengthen the congruence between skills of graduating students and the requirements of an ever changing health care delivery sectors as a mechanism for recruitment and retention.
>
> Newton-Scanlan et al. (2017)

Allied Health graduates are entering an increasingly complex and demanding workplace that requires a mix of clinical competencies and broader professional skills.

There is an expectation from employers that new staff will have the appropriate skills necessary to effectively work with patients and carers, within teams, be able to understand and apply evidence and contribute to the health organisation while being flexible, adaptive and able to work under pressure (Smith & Pilling, 2008).

The development of competency may be a stressful and anxious time for new graduates. Academic theory does not always inform clinical reasoning and treatment options. Allied Health professions face patients with varied presentations and characteristics such as demeanour, personality, attitude towards recovery and different social circumstances (Ladyshewsky, 2010).

University degrees provide discipline specific skills, but do not always equip new graduates to be team focussed, work ready clinicians able to independently work with increasing complexity in contemporary health care workplace (Smith & Pilling, 2008). In Australia a formal graduate year is common in nursing and medicine however structured programs to support student to professional transition in Allied Health are uncommon. A search for such programs identified no current NSW model facilitated by HETI. There are varying new graduate program models for broader Allied Health workforces, facilitated by different health services within Victoria, QLD, ACT and WA Health, with some similarities but no standardised content.

There are several qualitative research papers examining the experience of new graduate AH clinicians. This research considers mechanisms of support (enablers) from an organisational, personal and community perspective as a means to address potential challenges. New graduates need to demonstrate competence in the core technical skills of their discipline, as well as interpersonal and communication skills, negotiation, problem solving ability, capacity for reflective practice and professionalism (Croswell, & Beutel, 2011). Research on the graduate experience of early transition describes concerns, increased anxiety and common fears such as; fear of making a mistake, concern at not knowing something they should know, reluctance to seek help or burden more experienced busy staff, a system that may be under-resourced where support may not always be available and the stigma of being new (Morley, 2009; Smith & Pilling, 2007). A study by Gray et al. (2012) looked at areas where new graduate Occupational Therapists felt less competent and confident and identified role identity and articulation, written communication, teamwork, collaboration, evaluation and the use of evidence based practice.

For graduates to integrate successfully and become productive, contributing members of a professional team, they need to develop beyond the pure technical skills of their discipline and be supported to shift away from a focus on self that is instilled at university, to being an active member of an organisation (Hayhurst, 2011; Howe & Healey, 2012; Sole et al., 2012).

While current research queries the relevance of university curricula for the graduate allied health professional working in a public mental health role, a number of opportunities and innovations are proposed that may assist and support recruitment and retention in the Australian mental health workforce.

A study reviewing alignment between clinical priorities and coverage in university curriculum for mental health occupational therapists working in public mental health services in NSW (Newton-Scanlen et al, 2017) identified the area of mental health practice as complex and rapidly changing. This study explored educational priorities identified by the workforce, and level of coverage in university curricula. Topics considered to be essential priorities, but not given high level coverage included interdisciplinary tasks common in public mental health practice of risk assessment and management, self-care and resilience.

The findings are replicated in other studies that call for further discussions between clinicians and academics to support curriculum revisions and assist with employment (Rosenbaum et al., 2017; Wheeler et al. 2012; Wheeler, Fowler & Hattingh, 2013; Andrew, Briffa, Waters, Lee & Fary, 2019).

Innovative interprofessional education models are increasingly seen as necessary to prepare students for team based care and enhance person with a lived experience of mental illness outcomes (Olson, & Bialocerkowski, 2014; Beebe et al. 2017). Emerging professions in AHMH workforce have called for increased mental health specific content in all AH degrees as previously discussed and may benefit from this format of education to assist with growing this emerging workforce and addressing identified needs. Education programs are needed, particularly for emerging workforces to address mental health knowledge, attitudes, confidence and skills required to work effectively with people with a lived experience of mental illness and carers in mental health setting (Wheeler, Fowler & Hattingh, 2013).

With a current expectation for co-design and co-production to occur in mental health service planning and delivery, a 2018 study identified learnings from people with a lived experience of mental illness regarding priorities for recovery oriented curricula at the university level (Arblaster et al. 2018). This was found to be a mechanism for increasing relevance of service delivery and preparing students for collaborative work with people with a lived experience of mental illness. Mental Health reform emphasizes recovery, partnership work and prioritising person with a lived experience of mental illness needs over professionals, this study calls for the need for to develop capabilities for working in this way from the university as relevant skills for entering the workforce. There is a current acknowledgment of the strength of lived experience as a reliable source of evidence not only for models of care, also to inform workforce planning.

Professional Development

> With a changing staffing profiles trend, health service delivery and population needs, Allied health must engage in lifelong learning and draw from practice based experience and current evidence to remain competent to practice.
>
> The Governance Guide: a best practice governance framework for allied health education and training, HETI (2014)

A focus on local needs of the people with a lived experience of mental illness should drive the education and training agenda for the Allied Health workforce.

There is a risk this may be overlooked in preference of a model that prioritises an individual's learning goals so it is essential to ensure a health service is responsive to both the area population's care needs, and the education and training needs of its staff to deliver safe and high quality patient care (HETI, 2014).

Attention to barriers and enablers may assist organisations to engage effectively in AH workplace learning. Ultimately, better workplace learning should lead to improved patient, staff and organisational outcomes (Lloyd et al., 2014).

The Lloyd et al (2014) study identifies workplace learning as learning through participation at work and learning that is stimulated by workplace activities. It acknowledges that a large part of workplace learning occurs incidentally, without the employee being fully aware that learning is occurring. Regardless of the nature of workplace learning it can occur at the individual, team or department level, as well as at an organisational or system level. Identifying factors that restrict or facilitate workplace learning (barriers and enablers) may improve workplace learning by enabling more targeted education and training strategies. This study also reinforces the importance of having an organisation wide learning philosophy and supportive organisation wide infrastructure as key enablers.

In the study common barriers to workplace learning were reported as lack of time, a negative workplace culture, an absence of challenging work tasks, lack of expert support and advice, absence of expertise, opaque knowledge (remote to learner/tasks) and limitations of instructional media.

The role of an Allied Health Educator (AHE) in mental health services is being considered in workforce plans (NSW Health Professionals Workforce Plan 2012-2022). An AHE may provide advocacy and support for indicated learning needs in a growing diverse AHMH workforce. This aim is supported by the recent workplace learning study recommendations (Lloyd et al, 2014) that where AHE roles existed, the capability of allied health professionals to engage in workplace learning appeared to be greater than in those workplaces lacking these positions.

This was achieved by dedicated educators enhancing the capability to engage in workplace learning, teaching how to educate others, providing feedback and guidance on practice, synthesising literature, as well as through the development and delivery of tailored education programs.

Access to workplace learning and ongoing continuing professional development opportunities has strong links to workplace wellbeing, professional resilience and retention challenges in current Australian research (Newton-Scanlen, Still, Stewart & Croker, 2010; Conomos, Griffin and Baunin, 2013).

Workforce Wellbeing

> Poorer employee wellbeing, including high levels of burnout and low job satisfaction is associated with poorer person with a lived experience of mental illness outcomes and high staff turnover. Understanding factors for burnout and implementing protective factors can promote workforce wellbeing and enhance retention.
>
> (Newton – Scanlan & Still, 2013)

There is limited research on workplace strategies to support wellbeing for the AHMH workforce. There is currently limited data available on the incidence and clinical implications of challenges to workforce wellbeing such as burnout syndrome.

There is acknowledgment that mental health professionals have a high risk of developing burnout (Volpe et al. 2015, O'Connor, Muller Neff & Pitman, 2018).

Relevant studies identify job related intrinsic and extrinsic factors as an opportunity to contribute to development of interventions to increase wellbeing and decrease turnover intention.

These include access to clinical supervision, promoting a work/life balance, promoting supportive team environments and ability to use discipline specific skills that contribute to professional recognition and personal satisfaction (Newton Scanlan & Still, 2013; Saxby, Wilson & Newcomb, 2015)

A study of factors in the service delivery environment that may have a negative effect on job satisfaction identified team dynamics and team leader qualities.

There were considered important supports. Results from this study were encouraged to be used to inform leadership education in mental health services (Volpe et al. 2015).

A study of professional resilience identified risks to professional identity when negatively influenced in contexts dominated by biomedical models, there are expectations to work outside professional domains and use generic knowledge and a lack of validation of discipline specific practice (Ashby, Ryan, Gray & James, 2013). Professional resilience was found to be sustained by strategies that maintained participants' professional identity. These strategies included seeking 'good' supervision, establishing support networks and finding a job that allowed a match between valued knowledge and opportunities to use it in practice.

Researchers suggested further research is required into the role discipline-specific theories play in sustaining professional values and identity and that professional resilience may assist in the retention of the mental health workforce.

Current research deepens the understanding of factors contributing to workforce wellbeing and professional resilience for AHMH, but there is a need to trial and evaluate workforce wellbeing strategies to inform an evidence based approach to this potential workforce issue that impacts not only wellbeing, but workforce sustainability.

Supporting a Rural & Remote Workforce

> Objective 3.2: Develop evidence informed and scalable health workforce solutions that respond to local need and enhance access to care. Innovation to encourage deliberate team based and alternative service models including greater top of scope use of Allied health workforce for rural and remote communities in NSW.
>
> The NSW Rural Doctors Network's (RDN) 2019-22 Strategic Plan

Rural workforce shortages are a global phenomenon, Australia has unique rural health challenges in providing adequate services and addressing workforce shortages, with the most severe and protracted rural workforce shortages in public sector community mental health (Cosgrave, Maple & Hussein, 2018).

There has been significant research into the recruitment and retention of Allied Health clinicians to rural areas and attrition factors. This research informs possible enablers of support to attract and retain new graduates and other staff and to address barriers to retention. Campbell, McAllister and Eley (2012) undertook a literature review of the influence of motivation in rural and remote recruitment and retention. They identified 26 Australian articles and utilised motivation theory with intrinsic and extrinsic classifications to conceptualise the literature. Intrinsic factors are known to contribute to job satisfaction and come from within an individual. Extrinsic motivation incentives are provided by the job, are important in preventing job dissatisfaction and are linked with retention. Negative extrinsic factors listed included poor access to professional development, professional isolation, and insufficient supervision. Positive extrinsic factors included the rural lifestyle and diverse caseloads, with positive intrinsic factors being autonomy and community connectedness. Negative intrinsic factors included feeling overwhelmed and not valued. The authors concluded that positive intrinsic factors can mediate negative extrinsic factors and encouraged identifying ways at an organisational level, to nurture and develop these, as well as addressing negative extrinsic factors to assist with retention. Similarly, Kerane, Lincoln & Smith (2012) conducted a thematic analysis of focus group discussions examining factors for retention of Allied Health clinicians in rural NSW and identified five major themes; personal factors, workload and type of work, access to continuing professional development (CPD), impact of management and career progression.

In this study, pull factors included an attractive rural lifestyle, family in area or area of origin, low cost of living, personal engagement in community, advanced work role, broad variety of challenging clinical work and making a difference. Push factors were identified as unmanageable workload, lack of social opportunities, inadequate access to CPD, inappropriate service models and inequitably distributed service resources and failure to fill vacant positions. The strongest frustration and push factor was cited as lack of access to CPD.

Discipline specific research in psychology identifies challenges and opportunities for rural workforce, emphasising the high value placed on psychologists having skills applicable to issues confronting rural Australians, but a disparity in access to government incentives available to the medical and nursing workforce.

There is evidence for a *growing your own* medical workforce that may be applied to the rural AHMH workforce, including strategies such as quarantined places and support entry for rural students (Roufiel, Gulliver & Maybery, 2014).

Innovative recruitment and retention strategies include short term programs to orientate students to rural MH practice (Sutton, Patrick, Maybery & Eaton, 2015) and establishing rural MH Academic positions (Pierce at al. 2016) showing good short term effects, but requiring long term inputs to sustain for retention. A study of turnover intention for rural allied health professionals and nurses offers a holistic, whole of person approach to recruitment and retention (Cosgrove, Maple & Hussein, 2018). Described as a social process, in the initial *adjustment* stage turnover intention is most strongly influenced by professional experience related to the job role, workplace relationships and level of access to CPD, as well as personal dissatisfaction related to limited social connections.

Transitioning to the *having adapted* stage, personal satisfaction is a major influencer on turnover intention and dependent on life stage. This study recommends taking a whole or person approach in development of policies and strategies for attracting and maintaining a rural workforce.

The Centre for Allied Health Evidence (CAHE) (University of South Australia, 2007) conducted a literature review of the features of rural and remote practice to inform competencies for Allied Health clinicians working in this setting. While contextual and intrinsic factors are acknowledged to vary across locations, common features include treating a population with higher needs and a diverse health profile, providing services in multiple contexts, enhanced collaboration with team members and other agencies, greater involvement in health promotion, increased work with Aboriginal communities and people in a culturally safe way and the provision of a wide range of services across the continuum of care. For Allied Health clinicians working in a rural setting, it is important to be aware of health differentials, increased trends in poorer health and to understand the local health profile and how this impacts on service delivery. The WA Health Service developed Allied Health interdisciplinary competencies to assist with guiding the development of professional skills in a rural and remote context.

They classified competencies as Professional (administration and management tasks, supervision, time, information and workload management) and Clinical (quality and safety, care coordination management, healthcare prioritization, teamwork, understanding the scope of practice, translating evidence based practice in a rural context, quality improvement and evaluation).

This and other rural and remote research work has informed resources available on the Services for Rural and Remote Allied Health (SARRAH) online resource. Established in the 1997-1998 Federal Government Budget, SARRAH aims to support rural and remote Allied Health with appropriate resources and the identification of priority issues to government (Australian Government Dept of Health, 2013). These resources include links to supporting self-directed information to develop competency in professional and personal skills relevant to rural and remote practice including cultural safety skills, self-care, ethical practice and confidentiality and professional boundaries, professional isolation, social isolation and safety and survival skills.

The federal government's expansion of CRANAplus support to Allied Health clinicians working in rural and remote areas addresses common themes and concerns from literature of lack of supports experienced by rural health professionals, the psychological impact of working in this context and poorer access to relevant educational courses (Australian Government Dept of Health, 2013).

AHMH are trained to understand, address and support a holistic approach to health, in collaboration with medical interventions as part of a multidisciplinary team. It may be beneficial to focus on appropriate supports for attracting and retaining a rural AHMH workforce as identified in the literature to address rural and remote workforce challenges.

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Appendix 2: Horizons Scanning workshop themes

The following themes and related issues were identified by participants throughout the first workshop:

Universities/Students

- The need for better resourced and suitable student placements
- Increased education and experience in mental health
- Inclusion of experience/supervision for students as a mandatory requirement of studies
- Education/Professional Development/ Supervision
- A need for Allied Health Educators
- Pathways for career development and progression

Models of Care

- The need for a people with a lived experience of mental illness and carer perspective in designing models of care
- Models of Care between professions are generalised and vary, without a standardised reference for clinicians to refer to
- Call for better understanding by staff of the National Disability Insurance Scheme (NDIS) and its impact on role scope
- NDIS calls for a proactive approach to care whereas mental health services are perceived as reactive
- How mental health and drug and alcohol services can work together as care models are seen as differing from one another, need for dialogue on how to combine care methods

Governance

- Increased opportunities for consultation of allied health staff on policy changes
- Allied health inputs in to a broader contextual view for service development and delivery that includes considerations such as how AHMH can meet patient need and economic challenges
- Perceived challenges for AHMH to access senior management due to hierarchies and reporting lines

Recruitment and Retention

- Workforce flexibility (including part-time work, weekend and evening work) and access to development opportunities (such as education and supervisors)
- Available career pathways and opportunities for progression
- Opportunuties for AHMH to act in higher/ management positions limited due to lack of multi-classed senior positions
- Resourcing of allied health professionals is difficult, including the recruitment of staff and maintaining funding for positions if recruitment has not occurred

Aboriginal Workforce

- Supportive and innovative career pathways including support to attend university are needed including the availability of allied health specific cadetships
- Need for Aboriginal health liaison officers to support delivery of and access to AHMH care

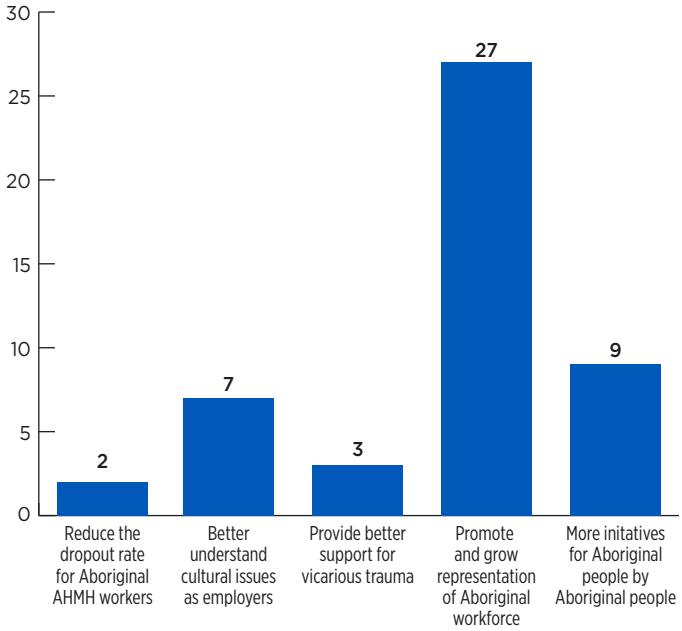

Figure 15: Participants voting for how to show further commitment to supporting the AHMH Aboriginal workforce (Mentimeter results)

Culture

- Experiences of a negative workforce culture have occurred for some AHMH
- Perception by AHMH of a power imbalance between professional backgrounds impacting opportunities to provide care

Professional Identity

- Feeling unfulfilled in roles due to perceived inability to apply their broad skills in generic roles
- A feeling of high workforce with large caseloads and perception the impact of this is not understood by management with limited supports available
- Limited allied health leadership structure in some LHD/SHNs
- Limited allied health leadership roles available resulting in perceived lack of career progression and opportunities to act in leadership roles
- Review of reporting lines and appropriateness of allied health positions reporting other disciplines, including nursing positions

Demonstrating Outcomes

- Limited opportunities to capture and analyse adequate data which therefore cannot be used to impact service provision
- Measurable discipline specific outcomes are required

Technology

- Greater investment in technology is needed, followed by adequate staff training
- Access to appropriate technology is not available in rural and regional areas
- A call for electronic medical records that integrate well

Changing health needs of people with a lived experience of mental illness

- Comorbidity and dual diagnoses for many people with a lived experience of mental illness, at times combined with medication use
- Perceptions that AHMH have an increased responsibility to holistically manage care leading to greater caseload work and the need for ongoing training to meet changing needs
- Limited time to adequately focus on in-depth treatment for each person with a lived experience of mental illness leading to repeat presentations
- Perception of greater workload and less funding due to NDIS introduction
- DSM-V increasing treatment categories for person with a lived experience of mental illness accessing services
- There is a need for an adaptable and flexible workforce to meet changes in people with a lived experience of mental illness needs.

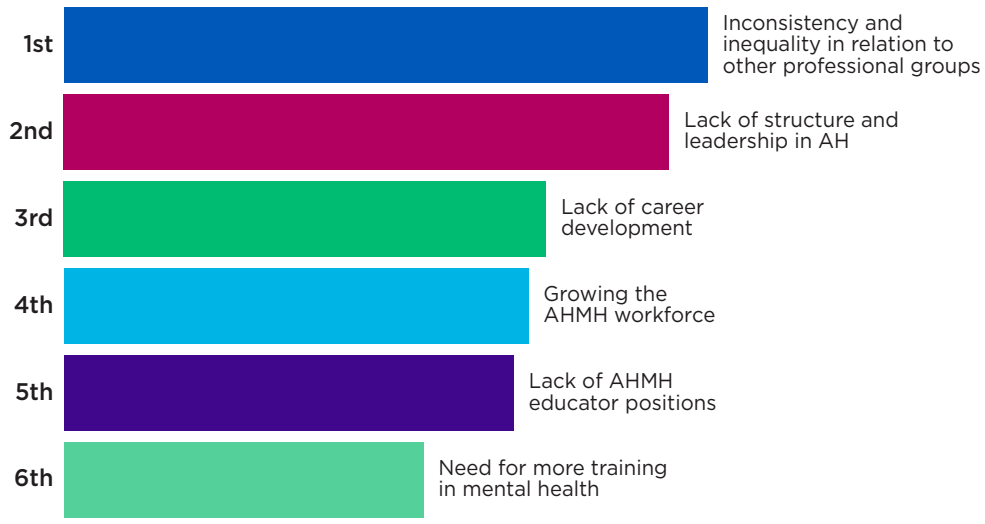

Figure 16: Participants' voting on which challenges are higher priority to understand more about (Mentimeter results)

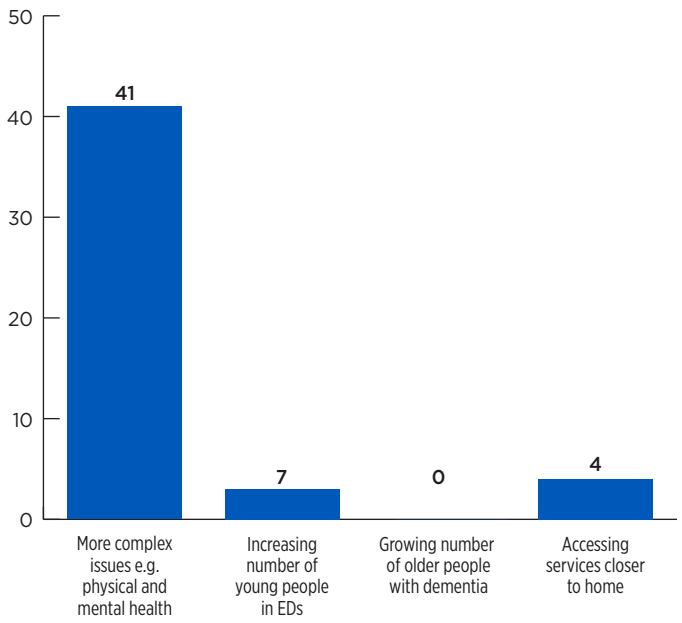

Figure 17: Participants' voting on what is changing for AHMH people with a lived experience of mental illness (Mentimeter results)

Workforce Planning

Participants were consulted regarding their thoughts on the future workforce planning for AHMH staff.

When asked whether they have previously engaged in previous workforce planning activities within their LHD/SHNs, a large number of participants indicated that they have either not been engaged or were minimally engaged. Engaging AHMH in activities that impact the provision of care is will enhance the quality of care provided.

To better plan for the future AHMH workforce, participants indicated the following data and KPIs would be significant in helping clinicians:

- Patients and caseload per AH clinician
- FTE numbers by position and grades
- Person with a lived experience of mental illness surveys
- Time allocated to educating, supervising and training staff and students
- Referral data
- Patient hospital stays that have included allied health intervention
- Incident reports
- Staff retention and turnover rates
- key performance indicators specific to roles
- Patient health outcome data.

Figure 18: Participants voting on how the future AHMH workforce might be strengthened from the presented list (Mentimeter results)

Ideas for workforce activities:

- Workforce pipeline – including secondments, talent pools
- Co-design – person with a lived experience of mental illness consultation in the development of models of care
- Education and training – the need for educator positions, ongoing staff education and training requirements, provide supervision for staff
- Models of care – holistic models of care required for people with a lived experience of mental illness, including close links with other disciplines
- Innovative thinking – sharing of ideas that work across LHD/SHNs
- Strategic links – better alignment between LHD/SHN strategic plans and AHMH workforce planning and development
- Technology – adequately resource staff, including those in rural and remote areas, provide staff with relevant emerging technologies to increase effectiveness in their roles
- Better collaboration with NGO and private sector.

Appendix 3: Workforce survey outcomes

The AHMH workforce survey investigated the workforce's feelings about their role and future. The survey contained nineteen questions. Six questions were open-ended and five of these were analysed in the report. Thirteen questions were multiple choice, yes/no, or otherwise objective questions.

Survey responses

The response rate to the survey was 31% (549 respondents from an overall workforce of 1,750). From these survey respondents:

- The vast majority are from the psychology, social work, or occupational therapy fields, followed by nutrition and dietetics, exercise physiology, and counselling
- 23% of respondents have been in their role for more than 10 years, 36% for 3-10 years, 28% for 1-3 years, and 14% for less than a year
- 3% (17 respondents) identified as Aboriginal or Torres Strait Islander
- There was a good response from all participating LHDs except for two
- 85% agreed that, 'Being identified as MH matters to me,' versus 79% agreeing that, 'Being identified as AH matters to me.'
- Approximately 58% felt they were able to use their full range of their skills and abilities in NSW, their service and in their current role
- Approximately 66% were hopeful for the future of the AHMH profession in NSW, their service, and in their current role.

The wealth of information gathered through the survey is highly valued and will be considered in relation to future workforce planning for AHMH.

Overall experience and challenges

The first open-ended question asked:

- What is your experience of delivering services to NSW people with a lived experience of mental illness? Feel free to express your views about any part of your experience. You can consider areas such as accessibility of your service for people with a lived experience of mental illness, information about your service, ability to meet person with a lived experience of mental illness demand for your service, training needs for you/ staff in general, etc.

Responses were coded to fifeteen themes, many of which echoed in the four subsequent open-ended question responses, with responses in most cases containing two to three themes. These themes began shaping into overall challenges experienced by the workforce. The themes are listed below in order from most to least common. Percentages are noted among the five themes common to more than 10% of responses:

- More resources/staff (33%)
- Hard to fully meet people with a lived experience of mental illness' needs (27%)
- Poor access to training (21%)
- MH role not understood/valued (17%)
- Issues with inequality/accessibility of services (16%)
- Needing team support
- Needing more time
- Too many administrative demands
- Degradation of service
- Need for true multidisciplinary approach/ collaboration
- Disparities in urban vs. regional
- Physical environment insufficient
- Poor access to supervision
- Indigenous staff/programs required.

Improvement opportunities

The other four open ended questions were analysed together for the purposes of this report. The questions were:

- What more could AHMH workforce do in NSW? This is your opportunity to describe what more could be done to make the most of AHMH workforce.
- What could be done to support you better in your role? This is your opportunity to describe what would assist you do your best work in your role.
- How can we promote a great future for AHMH workforce? This is your opportunity to describe what more can be done for the AHMH workforce.
- What would improve your satisfaction within your current role? This is your opportunity to voice what would assist you in enhancing your satisfaction in your role.

In a number of responses, respondents expressed satisfaction with their work, the support they receive, and their co-workers. However, given the nature of the questions, which invite suggestions for what more could be done to achieve certain objectives, the vast majority of responses provided ideas for addressing perceived challenges with the workplace as it currently stands.

Survey respondents provided their perceptions, feelings, and thoughts about the current state rather than any kind of objective description. From these perceptions, feelings, and thoughts came a general picture of an AHMH who really love their work and are proud of what they do but feel undervalued, misunderstood, and unacknowledged by their colleagues and management; this is also reflected in their pay. They are concerned and disappointed that their work is made to fit within the medical model. From a workforce perspective, the medical model is not equipped to value their contribution or support its equal integration within a multidisciplinary approach, and from a client-centred perspective, they do not feel it best serves clients. There is a risk of staff burnout due to high caseloads, significant administrative demands, insufficient resources and support, and insufficient staff numbers. There is also a lack of a clear career pathway, with no progression opportunities beyond senior clinician level. Survey respondents were dismayed that funding and opportunities for skilled supervision, training, and professional development were either unavailable, difficult to access, or not on par with that provided to medical professionals.

Respondents felt that AHMH's role and voice was not represented or advocated for within leadership and management. Respondents expressed a strong desire to be managed by other AHMH professionals, or to at least see AHMH represented within management. Respondents expressed their wish to be able to use their specialties or skillsets, rather than be treated as generalists. Respondents also expressed their wish that vacant roles be filled, that more full time work be made available, and that roles be provided with increased flexibility.

In analysing the workforce survey, responses were first coded (based on the presence of certain keywords) to one of four themes:

- Wellbeing and Support
- Recruitment and Retention
- Learning and Development
- Training and Research.

All responses were then read individually and coded to a set of sub-themes. The themes are listed below in order from most common to least common. The frequency of sub-theme occurrence across the 549 surveys' open-ended questions is listed in parentheses after sub-theme title:

- **Management/Leadership** (107) – Respondents expressed dissatisfaction with their current reporting line structure, the lack of AHMH managers, and/or their wish for a management/leadership career path within AHMH
- **Acknowledgment/Understanding** (99) – Respondents expressed the desire for acknowledgment by non-AHMH colleagues and/or greater understanding and appreciation by those colleagues for the work that AHMH do
- **More staff** (91) – Respondents expressed a desire for more AHMH staff, or for vacant positions to be proactively filled
- **Resources** (71) – Respondents expressed a desire for greater resources or funding of any kind (e.g. for carrying out day-to-day work or for the purposes of undertaking training)
- **Use full range of skills/specialties** (53) – Respondents wanted to be able to carry out their work using their full range of skills or the skills inherent in their particular specialty, rather than performing a limited range of skills or generalist skills
- **Client focus/access** (49) – Respondents described how they would like clients to be better served, or how they wished client access to services could be improved
- **Multidisciplinary approach** (47) – Respondents expressed a desire to work in a true multidisciplinary team or for closer adherence to a purer multidisciplinary model
- **Medical model** (40) – Respondents described frustration with or the limitations of carrying out AHMH work within what they perceived to be a medical model of care
- **Career path** (40) – Respondents reported a lack of a career path beyond a certain level, or expressed their wish for a clearer career path within AHMH
- **Skilled supervision** (37) – Respondents requested ready and frequent access to skilled supervision
- **Better pay** (21) – Respondents expressed the desire for better pay, pay commensurate with skill, and/or more accessible regrading

- **Too much case management/admin** (20) – Respondents expressed that they felt they were spending too much time on case management or administration and that their time would be more productively spent using their professional skills
- **Flexibility** (18) – Respondents expressed a desire for greater job flexibility, especially for working mothers
- **Occupational Therapists** (17) – Respondents specifically requested either more occupational therapy roles, more occupational therapist support, and/or the ability as an occupational therapist to use their specific skill set
- **Clear documentation/processes** (14) – Respondents expressed a desire for clearer documentation and processes to follow in carrying out roles
- **Equipment/Physical environment** (13) – Respondents identified a perceived lack of [quality] equipment for carrying out their role, and/or improvements that could be made to the physical environment in which they work or serve clients
- **Aboriginal** (3) – Respondents identified the perceived need for additional Aboriginal AHMH staff and/or closer networking between Aboriginal organisations.

Beyond the four main themes, four sub-themes stood out as accounting for much of respondents' concern:

- Management/Leadership (a sub-theme in 14% of respondents answers)
- Acknowledgment/Understanding (13%)
- More staff (12%)
- Resources (10%).

If AHMH were to make improvements to these four main areas, they would go far in positively addressing the greater part of the workforce's concerns. In addition, beyond those four dominant sub-themes, sub-themes relating to desired changes in AHMH staff roles would account for an additional 23% of sub-themes across all responses, if taken together:

- Use full range of skills/Specialties (7%)
- Career path (5%)
- Skilled supervision (5%)
- Better pay (3%)
- Flexibility (2%).

Themes and sub-themes from the survey identify a strong desire among respondents for a shift in the way they work and how they are able to employ their skills, how their roles are perceived and understood by other professionals, and how their roles grow over the course of their career.

The first open ended question asked AHMH to describe their experiences delivering services to people with a lived experience of mental illness. Responses were coded to the following themes, distributed across responses as shown below:

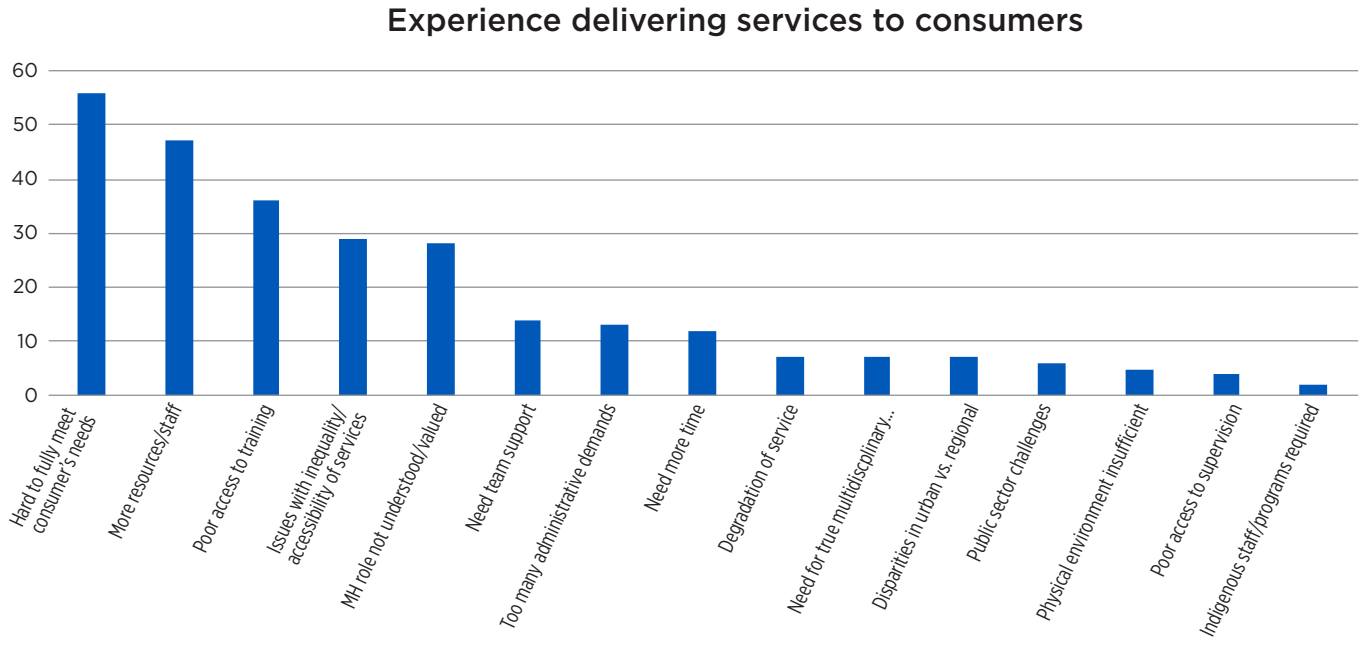

Figure 19: Experience delivering services to people with a lived experience of mental illness

The chart shows the various issues that respondents described as features of their work. The five main issues were:

- More resources/staff (an issue common to 33% of participants' responses)
- Hard to fully meet people with a lived experience of mental illness' needs (27%)
- Poor access to training (21%)
- MH role not understood/valued (17%)
- Issues with inequality/accessibility of services (16%).

All responses to the remaining four open ended questions (all essentially dealing with what changes and improvements could be made to improve AHMH workers' experience) were first coded to four overarching themes, based on the presence of key words: Training & Research; Recruitment & Retention; Learning & Development; Wellbeing & Support.

The distribution of responses across these themes is shown below:

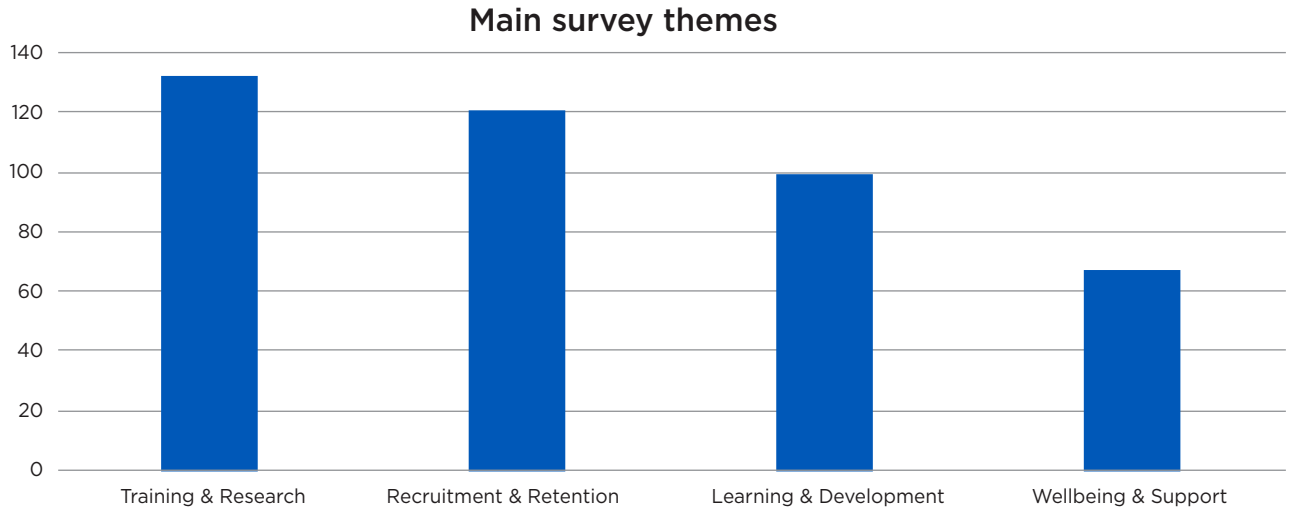

Figure 20: Main survey themes

All responses were then read individually and labelled with sub-themes. Virtually all responses have thus been coded either with at least one of the four overarching themes, one or two sub-themes, or in most cases, both one or two main themes and two sub-themes.

The distribution of sub-themes across survey responses is shown in the two graphs below. The main sub-themes were:

- Management/Leadership
- Acknowledgment/Understanding
- More staff
- Resources.

These four sub-themes account for approximately 50% of all sub-themed responses. Second tier sub-themes, accounting for approximately 35% of all sub-themed responses, were Use full range of skills, Client focus/access, Multidisciplinary teams, Medical model, Career path, and Skilled supervision. The remaining sub-themes accounted for approximately 15% of responses.

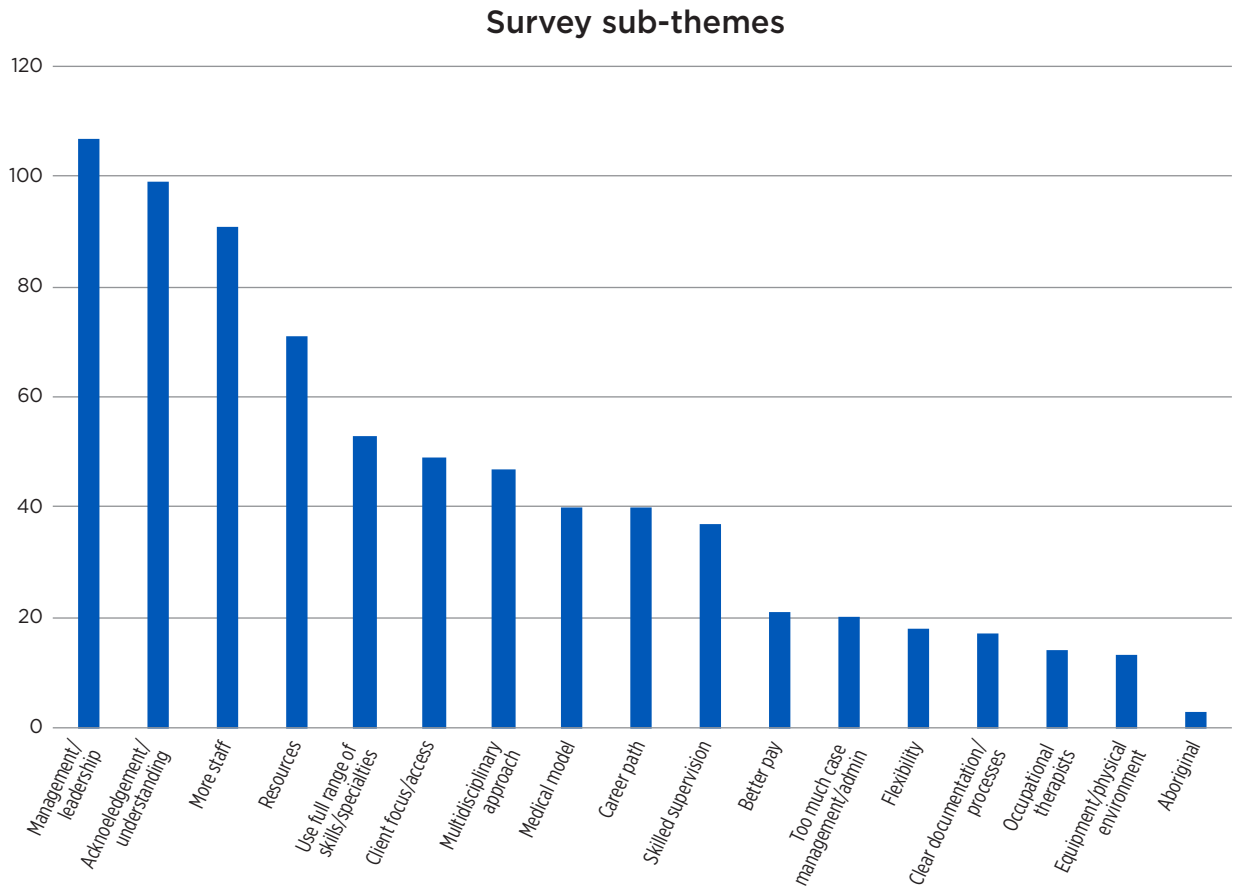

Figure 21: Survey sub-themes

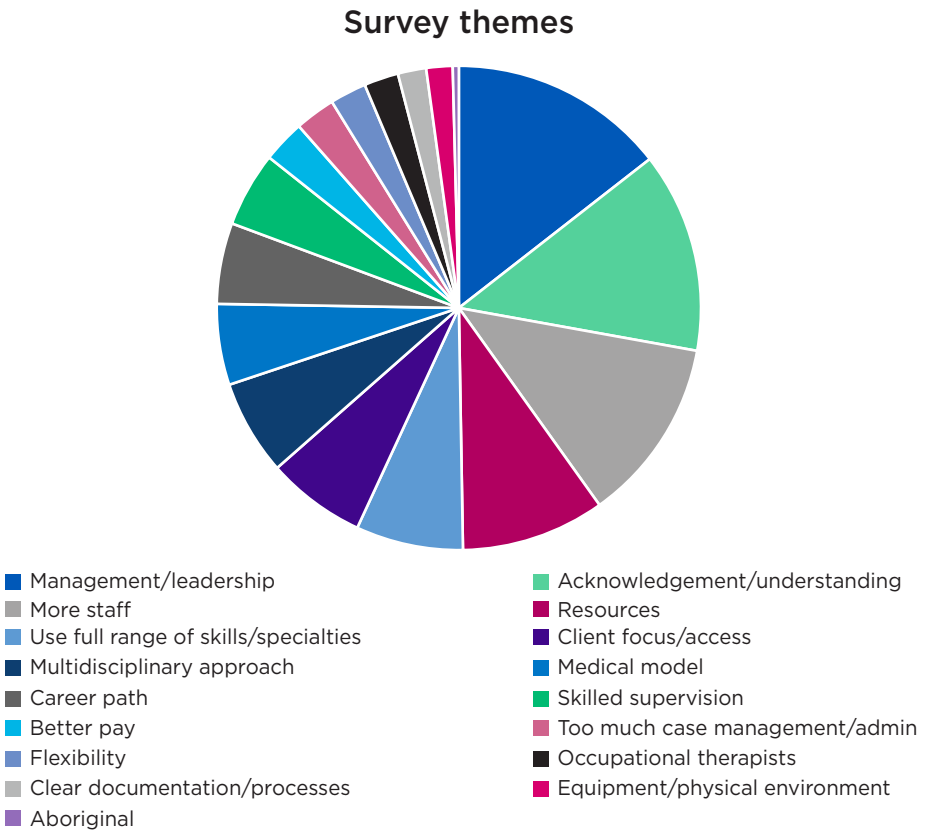

Figure 22: Survey themes

Appendix 4: Acknowledgment

We would like to thank the following individuals for their time and participation in this project.

Name	LHD/SHN
Chris Willcox	ACI/ HNELHD
Julie McFarlane	CCLHD
Jim Richards	FWLHD
Vanessa Smith	FWLHD
Maria Berarducci	HETI
Rhonda Loftus	HETI
Cath Wood	HNELHD
Donna Wright	HNELHD
Nadine Street	HNELHD
Maria Roberts	HNELHD
Pip Bowden	ISLHD
Christine Wowk	ISLHD
Nicole Nicholls	ISLHD
Jenny Cugaly	ISLHD
Alexandra Harman	ISLHD
Vindya Nanayakkara	JHFMHN
Kath Jones	JHFMHN
Andrew Kaw	JHFMHN
Erica Engelbrecht	MLHD
Faith Rogers	MLHD
Carl Gray	NBMLHD
Veronica Vella	NSLHD
Janice Plain	NSLHD
Peter Woollett	NSLHD
Andrea Worth	SCHN
Colleen Alford	SCHN
Sally Kyrios	SCHN
Daniella Kanareck	SESLHD
Shanti Gupta	SESLHD
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Stephanie Gill	SESLHD
Rishi Baldeo	SESLHD
Elise Tripodi	SESLHD
Oscar Lederman	SESLHD
Alison Tucker	SESLHD
Simon Tully	SLHD
Julie Bohan	SLHD
Lil Vrklevski	SLHD
Mary Woodward	SLHD
Helen Ryan	SLHD
Georgia Frydman	SLHD
Erikka Henessy	SLHD

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Tracy Bolton	SNSWLHD
Stephen Freeman	SVH
Hellen Francis	SVH
Brandy Murphy	SWSLHD
Andrew Grinsbergs	SWSLHD
Norma Albornoz	SWSLHD
Meg Thomas	SWSLHD
Danielle Leahey	WNSWLHD
Jenna West	WNSWLHD
Natalie Clarke	WNSWLHD
Danica Mackay	WSLHD
Stacey Williams	WSLHD
Nancy Zaki	WSLHD
Mayuri Parmar	WLHD
Wendy Bryan-Clothier	MoH
Charles Davison	MoH
Brian Shimadry	MoH
Andrew Davison	MoH
Celia Halliburton	MoH
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