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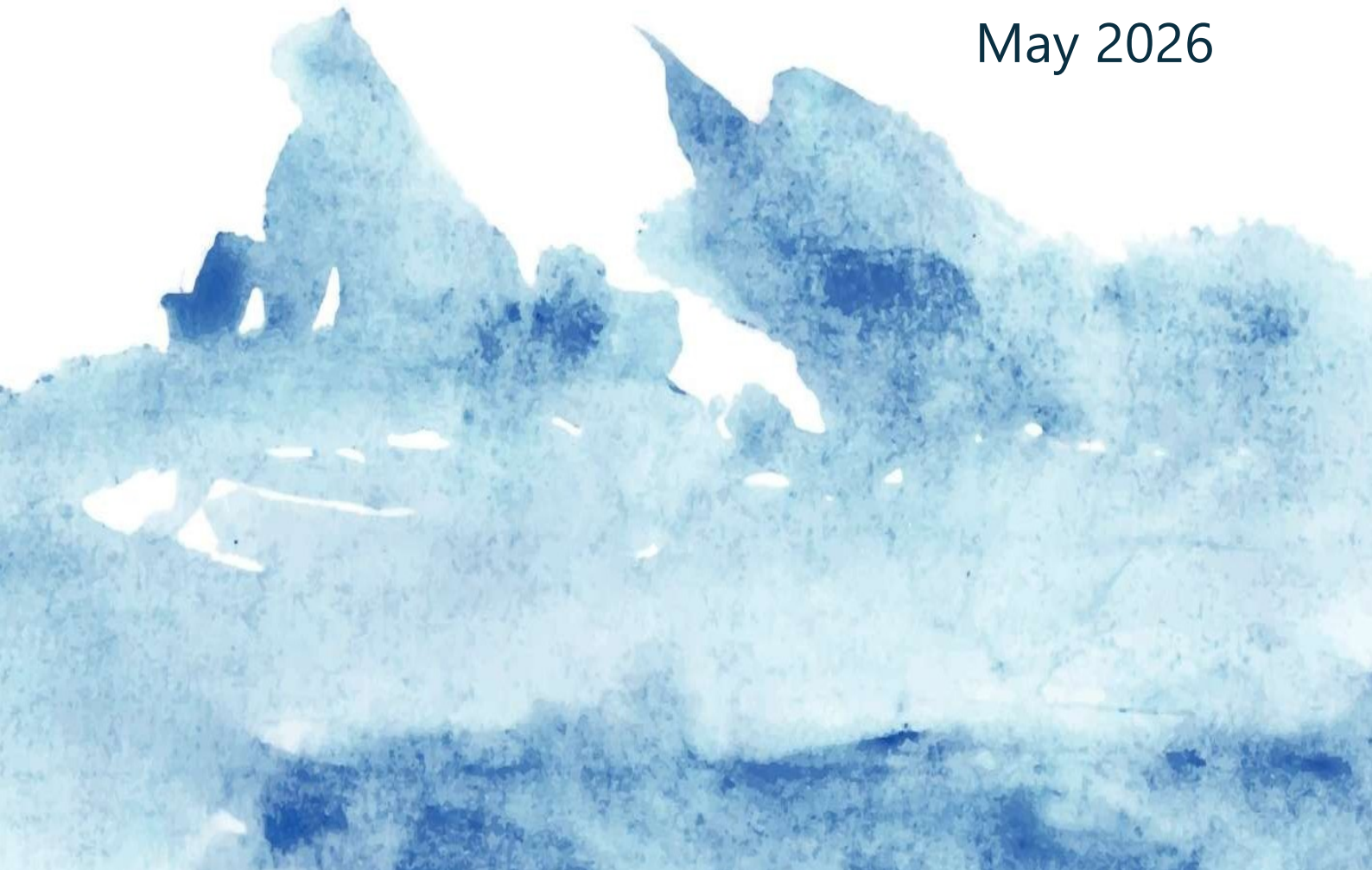
Community Managed Organisations Mental Health Workforce in Western Australia: Final Report

May 2026



Report preparation

This report was prepared by Human Capital Alliance (International) Pty Ltd (HCA) for the Western Australian Association for Mental Health (WAAMH) to report on the findings from the 2025 Community Managed Organisations Mental Health Workforce Survey.

Acknowledgements

HCA acknowledge this country as belonging to Aboriginal and Torres Strait Islander peoples of Australia. We acknowledge all people who have personal experience of mental illness. The voice of people with lived experience is essential in the development of our work.

HCA would like to thank key officers of those organisations that participated in the Reference Group for the 2025 Community Mental Health Workforce Survey Project. This included representatives from:

- AHA
- Amity Health
- Holyoake
- Pathways
- Relationships Australia
- Richmind
- Ruah
- St Barts
- Youth Focus

Suggested Citation

Ridoutt, L., Curry, R., Harvey, T., Prince, S. and Penter, C. (2026) Community Managed Organisations Mental Health Workforce in Western Australia. Western Australian Association for Mental Health

CONTENTS

Acronym / abbreviation	Meaning
ABS	Australian Bureau of Statistics
ACCO	Aboriginal Community Controlled Organisation
ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
ACT	Australian Capital Territory
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and Linguistically Diverse
CMO	Community Managed Organisation
CPI	Consumer Price Index
FTE	Full Time Equivalent
GP	General Practitioner
HR	Human Resources
HRIS	Human Resources Information System
IHACPA	Independent Health and Aged Care Pricing Authority
KPI	Key Performance Indicator
LGBTQIASB+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, Sistergirl and Brotherboy, plus other sexual orientations and gender identities
MHCC	Mental Health Coordinating Council (NSW)
MHMS	Ministry of Health and Medical Services (used in comparative references)
NBEDS	National Best Endeavours Data Set
NDIS	National Disability Insurance Scheme
NSW	New South Wales
OSR	Online Services Report (AIHW)
PHN	Primary Health Network

QAMH	Queensland Alliance for Mental Health
TAFE	Technical and Further Education
WA	Western Australia
WAAMH	Western Australian Association for Mental Health

1. Key findings / Executive summary

This report presents the findings of the 2025 Community Managed Organisations Mental Health Workforce Survey, commissioned by the Western Australian Association for Mental Health (WAAMH) and undertaken by Human Capital Alliance (HCA). The survey provides the most comprehensive and current picture available of the size, composition and challenges of the community managed mental health workforce in Western Australia.

A total of 52 organisations responded to the survey, representing a very strong response rate. Respondents included specialist mental health organisations as well as broader community service organisations delivering mental health programs across metropolitan, regional and, to a lesser extent, rural and remote areas.

Size and structure of the workforce

The community managed mental health sector in Western Australia employs an estimated total workforce of approximately 4,650 people, equating to around 2,960 full time equivalent positions when frontline workers, non-frontline staff and volunteers are combined.

Frontline care and support workers make up the largest share of the workforce, with an estimated headcount of 3,457 or 2,316 full time equivalent positions (78.3% of the total workforce). Six very large organisations (defined as employing over 100 frontline workers) employ just over half of all frontline workers, indicating a high concentration of workforce capacity in a small number of providers. Smaller (less than 20 frontline workers) and specialist organisations tend to employ fewer staff and may be more vulnerable to workforce disruption.

Non frontline support staff account for an estimated 848 workers or 578 full time equivalent positions (19.6% of the total workforce). Volunteers also form a small but important part of the workforce, particularly for some organisations, with an estimated 344 volunteers contributing the equivalent of just over 72 full time positions (2.1% of the total workforce).

Workforce profile

The workforce is predominantly female, with around 71 per cent of identified frontline workers being women. Most workers are mid-career, with the majority aged between 26 and 55 years. There are relatively few younger workers under 26 and a modest proportion of workers aged over 55.

Mental Health Support Workers are the largest occupational group, followed by counsellors or psychotherapists and designated lived experience peer workers. Registered clinical professions such as psychologists, social workers, nurses and psychiatrists make up a smaller proportion of the workforce. This mix reflects the psychosocial and recovery-oriented focus of much of the community managed mental health sector.

Qualification requirements vary by role. Many support roles require Certificate III or IV qualifications. In some cases, no formal qualification is required. Clinical leadership roles are more likely to require degree level qualifications.

Workforce diversity

Where data is available, the sector shows stronger representation of people with lived experience of mental ill health (39.4%), regardless of whether a role is a dedicated Lived Experience role, compared with other jurisdictions such as NSW and ACT where the proportion of the workforce with lived experience is 25.3%. The sector also shows a relatively higher representation of Aboriginal and Torres Strait Islander workers, people from culturally and linguistically diverse backgrounds, and people identifying as LGBTQIASB+ compared with other jurisdictions. Where data is available, WA CMOs report higher representation of Aboriginal and Torres Strait Islander workers (5.4%), CALD workers (22.9%), and LGBTQIASB+ workers (9.4%) compared with recent NSW and ACT surveys (2.5%, 7.3% and 7.6% respectively). However, many organisations do not routinely collect complete or reliable workforce diversity data, often prioritising privacy over systematic data collection. This limits the sector's ability to plan, monitor equity goals and demonstrate workforce strengths.

Employment conditions

Around 70 per cent of frontline workers are employed on permanent contracts, which is higher than reported in some other states. Much of the workforce is part time, reflected in a relatively low full time equivalent conversion factor.

Recruitment and retention

Vacancy rates are modest overall, with fewer than 5 per cent of frontline positions vacant at the time of the survey. However, there are significant recruitment challenges for specific roles, particularly Aboriginal Mental Health Workers, psychologists and some allied health professions.

The main reasons cited for recruitment and retention difficulties are structural rather than organisational. These include limited ability to offer competitive salaries compared with other sectors, particularly the public mental health system and private practice, lack of affordable housing for workers who need to relocate, and funding models that rely on short term contracts or contract rollovers without additional funding or indexation. These factors undermine job security and make long term workforce planning difficult.

Retention challenges reflect similar issues. Three quarters of organisations identified uncompetitive pay and conditions as the primary reason workers leave the sector, alongside insecure funding arrangements and housing pressures in regional areas.

Future demand

Most respondents expect demand for community based mental health services to increase over the next five years. Organisations anticipate more complex client presentations and increased service use linked to improved mental health literacy and reduced stigma. Both these factors are likely to drive future demand for a higher skilled (more professionalised) workforce.

Priority solutions

Organisations identified a clear set of high priority solutions. These include:

- longer term, multi-year funding contracts
- fair and consistent indexation of funding to keep pace with wages and costs
- funding that supports competitive salaries
- explicit investment in workforce development, supervision and training.

Other priorities include strategies to grow and support the First Nations mental health workforce, creation of clearer career pathways, and improved support for lived experience workers.

Overall conclusion

The community managed mental health workforce in Western Australia is sizeable, committed and central to service delivery across the state. It has strong foundations in psychosocial and lived experience practice, and relatively good workforce stability compared with some jurisdictions.

However, increasing service demand, growing consumer complexity and ongoing funding and labour market pressures present significant risks. Without coordinated action on funding stability, workforce capability and data quality, the gap between community needs and workforce capacity is likely to widen. Targeted, system level responses are required to support recruitment, retention and sustainable growth of this essential workforce.

2. Introduction

Past information on CMO sector mental health workforce

The community managed organisation (CMO) mental health sector has been increasingly accepted as a significant component of the total mental health workforce (see Australian Institute of Health and Welfare: https://www.aihw.gov.au/mental-health/topic-areas/community-based-services) although without full recognition. Data on the sector though is limited in terms of currency and comprehensiveness especially when compared to information available about the workforce providing public sector mental health services (Ridoutt and Cowles, 2019) and in spite of increased efforts within the sector itself over the last 5-10 years (Mental Health Coordinating Council (2023)). Seemingly sporadic prioritisation of this information at a State or Territory Government level has been a significant factor in the current inadequacy of information, compounded by the Commonwealth Government's intermittent efforts to collect data in this area (see below). This lack of consistent attention might reflect the fact that this part of the mental health system is understood to be a shared responsibility between State/Territories and Commonwealth. Variability in the way that the sector is defined and classified and the different methods that have been employed to collect information about the sector, has added to the data concerns. That the CMO sector mental health workforce is not explicitly identified in the National Mental Health Workforce Strategy 2022-23 is telling (Department of Health and Aged Care, 2022).

The most recent *national* assessment of the CMO mental health workforce was a survey of the mental health non-government organisation workforce conducted in 2009-2010 by National Health Workforce Planning and Research Collaboration (NHWPRC) (National Health Workforce Planning and Research Collaboration, 2011). Since then, efforts have been made by several State and Territory peak bodies for CMOs to understand better the size, composition and direction of the CMO mental health workforce (for example, Penter, et al., 2017; Ridoutt and Cowles, 2019; Ridoutt, 2021; QAMH, 2021; Ridoutt, et al., 2023). There remain though, as noted above, deficits in the data picture with patchy data coverage in some States and Territories and even more so at the national level.

A proposed annual data collection by the Australian Institute of Health and Welfare (AIHW, 2015) the Mental health non-government organisation establishments National Best Endeavours Data Set (MH NGOE NBEDS)[1], has been trial implemented in Western Australia and Queensland in recent years. This would ultimately provide quality national level workforce data and is widely supported by the CMO sector (Mental Health Coordinating Council, 2019), but the project has not progressed. It is possible that the broader scope efforts (across all sectors) to capture mental health activity for activity-based funding purposes being promoted by the Independent Health and Aged Care Pricing Authority (IHACPA, 2025) has reduced impetus on the MH NGOE NBEDS front.

[1] https://meteor.aihw.gov.au/content/494729

Method overview

A workforce survey was developed specific to the Western Australian context although it borrowed significantly from survey tools used previously in NSW and the ACT. The survey tool was co-designed with a selected group of WAAMH stakeholders (large and small CMOs). As much as possible the survey tool design was consistent with those previously used in NSW and ACT so as to optimise consistency of data collection between surveys and therefore allow as much comparison between jurisdictions as possible. The survey consisted of a total of 32 questions (see **Appendix A** to review the survey format).

The survey was administered to a database of relevant CMOs developed by WAAMH (n = 55). The database was composed mainly of WAAMH membership but also included other non-member CMOs identified by WAAMH, who, although not specialist mental health services, were likely to be providing some mental health services as part of their service mix.

A total of 52 organisations responded to the survey and completed at least some of the questions (primarily the organisational details). Traditionally response rate is determined as the number of respondents from the database or sampling framework of the survey. Of the CMOs on the database, 8 did not respond, thus the response rate would be 85%. **This is a very high response rate**, and much higher than surveys undertaken in NSW and ACT (Ridoutt, et al., 2023). The number of total survey respondents was enhanced by five CMOs not on the database and who 'volunteered' their information after finding out about the survey through promotional activities (e.g., newsletters, forums, etc.).

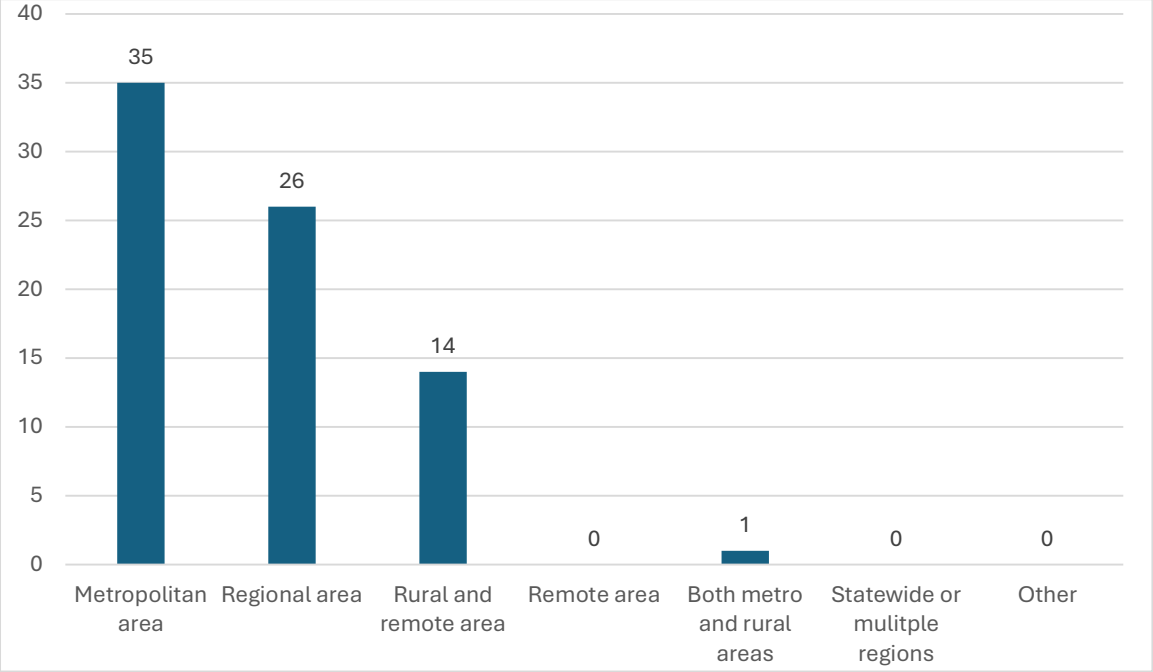
While the overall response rate was high, the rate to individual survey questions varied from all 52 responding to the organisation questions and to the key question on frontline[2] care workforce headcount. 34 organisations (65.4%, n = 52) completed the entire survey which is consistent with the response to similar previous surveys (see for instance Ridoutt, et al., 2023).

A particular challenge to attaining a complete response to the CMO workforce, especially to questions on workforce composition, is limitations of the data collected on employees. Most of the survey respondent organisations (69%, n = 48) indicated that they have no human resources information system (HRIS) and so their responses are either estimates (38%) or from payroll data (31%).

The responding organisations were distributed all over WA but mostly concentrated in Perth and the larger regional areas (88.5%, n = 52; see Figure 1). Some of the larger organisations provide services in Metropolitan, Regional and Rural / Remote areas.

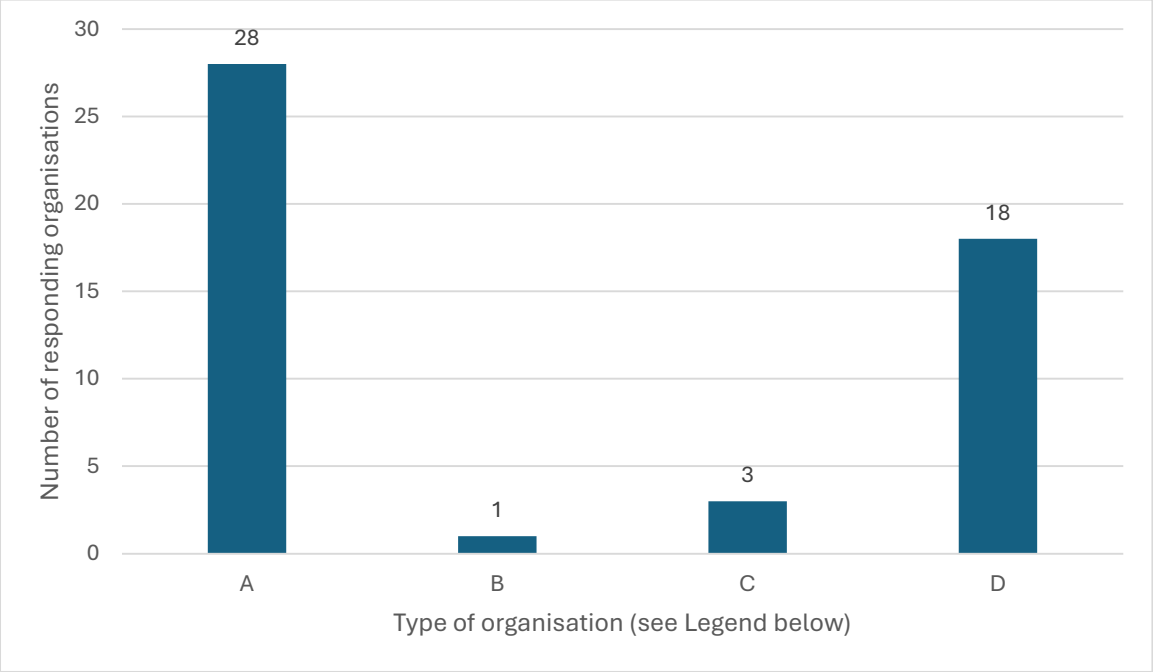
[2] The term 'frontline worker' was defined in the survey as "… those workers working directly with consumers to provide services and support".

Figure 1: Distribution of geographic areas in which organisations provide mental health services in WA (n = 52)



Just over one third of the responding organisations defined themselves as a specialist mental health organisation (36%; n = 50, See Figure 2) with the rest being broader purpose CMOs offering a range of services. This level of specialisation within the CMO population in WA compares with 24% in NSW (Ridoutt, et al., 2023) and the same (24%) in the ACT (Ridoutt, Curry, Prince, Dobson and Lawrence, 2023). Perusal of the list of specialist mental health organisations in WA by knowledgeable stakeholders however suggests some may have incorrectly self-defined (the category descriptions offered could have caused doubt) and therefore the actual proportion of specialist mental health CMOs in WA is much more akin to NSW and ACT.

Figure 2: Distribution of survey respondents by type of organisation (n = 50)



Key to Types of Organisations:

A = Community services organisation including mental health. Offers a range of services (e.g. aged care, alcohol and other drugs, child protection, disability, family and domestic violence, housing and/or homelessness), including mental health programs.

B = Organisation providing general support, not specific mental health programs. Delivers support that may be therapeutic in nature (e.g. relationship counselling, employment counselling) but does not run dedicated mental health programs.

C = Organisation that offers general health services. Delivers health and wellness services to the general population or specific vulnerable populations (e.g., First Nations, CALD, LGBTQIA+)

D = Specialist mental health organisation. Provides psychosocial and/or clinical mental health services. This may include organisations delivering NDIS funded services for people with a psychosocial disability.

The respondent organisations range in size from very small (1-10 frontline care workers) to very large (greater than 100 frontline care workers; See Table 1) with comparatively even distribution over the different organisational sizes.

Table 1: Size of organisations who offer mental health services in WA

Size of organisation (Frontline care worker numbers)	Frequency	Proportion of total responding organisations (%)
Very small (1-10)	16	30.8
Small (11-20)	9	17.3
Medium (21-50)	9	17.3
Large (51-100)	6	11.5
Very Large (100+)	12	23.1
	52	100

Broader Community services organisations that also offer mental health services are comparatively evenly distributed across different sized organisations (See Table 2). Mental health specialist organisations tend to be smaller in size.

Table 2: Distribution of Organisation Types by Size of Frontline Workforce

Size of organisation	Types of Organisations (See Figure 2 for key to organization types) N / (%)			
	A	B	C	D
Very small (1-10)	7 (25.0)		3 (100.0)	6 (33.3)
Small (11-20)	7 (25.0)			2 (11.1)
Medium (21-50)	3 (10.7)			4 (22.2)
Large (51-100)	5 (17.9)			1 (0.6)
Very Large (100+)	6 (21.4)	1 (100.0)		5 (27.8)
Total Number	28	1	3	18
% (n=50)				

3. Survey Findings

Workforce size

Frontline Care Workers

The number of frontline care workers currently working for the 52 survey respondent organisations is 3082. Very large organisations (23.1% of the total organizations, n = 48) account for 72% of the total frontline care workforce. Just the six largest organisations account for just over 50% of all frontline care workers employed.

Table 3: Distribution of Frontline Care Workers Across Organisation Sizes (n = 48)

Size of organisation	Number of frontline care staff (head count)	% of Total workforce
Very small (1-10)	61	1.9
Small (11-20)	125	3.1
Medium (21-50)	344	11.3
Large (51-100)	361	11.8
Very Large (100+)	2191	71.8
	3082	99.9

The above figure of 3082 is not the actual number of frontline care workers employed by CMOs in WA since the survey was not a census. To get a total estimate of the current workforce the above figure must be extrapolated by adding:

1) an estimate for organisations that did not respond to the survey. WAAMH officers categorised non-responding organisations in terms of organisational size based on anecdotal information and a review of organisation websites. Using this categorisation and the average frontline care worker numbers for each category (based on survey respondents, see Table 4 below), it is estimated that at least 183 extra frontline care workers are currently employed in the sector (in non-respondent CMOs).

Table 4: Average Number of Frontline Care Workers by Organisation Size

Size of organisation	Average Number of frontline care workers (head count)
Very small (1-10)	4

Small (11-20)	16
Medium (21-50)	38
Large (51-100)	60
Very Large (100+)	182

2) an estimate of frontline care workers employed in Aboriginal Community Controlled Health Services (ACCHS). No Aboriginal Community Controlled Health Organization (ACCHO) services in WA were respondent to the survey. Most provide a wellbeing / mental health service. According to the Australian Institute of Health and Welfare's (AIHW) annual report on ACCHO services activity based on information collected through two data collections – the Online Services Report (OSR) and the National Key Performance Indicators (nKPI) – there were 128.9 FTE 'Social and Emotional Wellbeing' frontline care workers employed in WA ACCHOs. This is estimated to translate into a head count of 192 frontline care workers.

We estimate the total CMO frontline care workforce head count in WA therefore to be 3,457.

The full-time equivalent (FTE) of frontline care workers from the 52 survey respondents is 2071.2. This provides an average FTE conversion factor of 0.67 (derived from the calculation FTE [2071.2]/ Head count [3,082]). The FTE conversion factor varies between organisation size as shown in Table 5, although apart from very small organisations, the level of part-time employment is quite similar.

Table 5: Estimated FTE Conversion Factors by Organisation Size (n = 52)

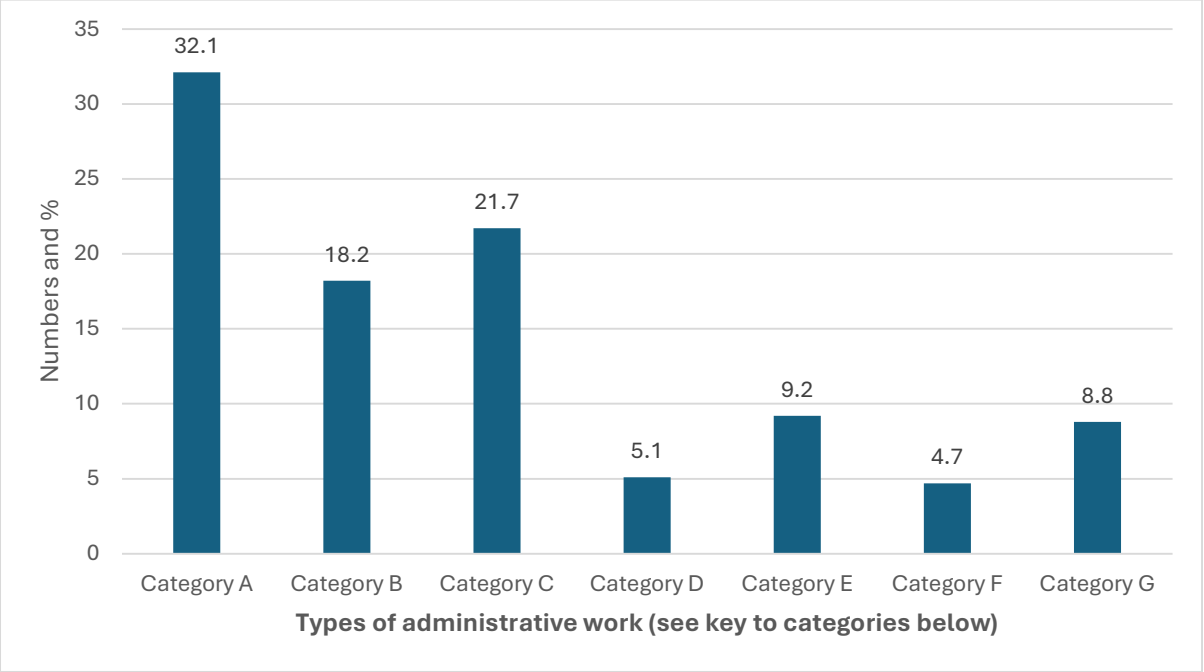
Size of organization	Estimated FTE Conversion Factor
Very small (1-10)	0.59
Small (11-20)	0.71
Medium (21-50)	0.67
Large (51-100)	0.70
Very Large (100+)	0.67

The total FTE of the frontline mental health workforce in the WA CMO sector is estimated to be 2,316.2.

Non-Frontline Workers

The total number of administrative support workers in responding organisations (n = 38) is 719. The administrative workforce is distributed across seven major types of administrative work as shown in Figure 3.

Figure 3: Distribution (%) of administrative workforce by type of work (n = 38)



Key to worker types

A = Corporate Services or Business Management
B = Receptionists and other front of house staff
C = Administrative support staff (e.g. communication and marketing)
D = Technical support staff (including IT)
E = Human Resources Management, Training and Workforce Development
F = Quality and Compliance
G = Other types of non-frontline worker

We can extrapolate an estimated number of administrative support workers from responding organisations to a total number in two ways.

The first is to use the number of respondents to the administrative worker question (n = 38) divided by the number who responded to the frontline care worker question (n = 52), an extrapolation factor of 1.4. Thus, the estimated total administrative support workforce of the respondent organisation population is 719 x 1.4 = 1007.

Since the respondents to the full survey is slightly biased towards larger organisations (see Table 1), an alternative means of extrapolating is to observe the response to the frontline care worker question of those who responded to the administrative support worker question. For the 38 that have completed the administrative support worker question the total number of frontline care workers is 2528, providing an extrapolation factor of 3082 / 2528 = 1.2. If this is applied, then the estimated total administrative support workforce of the total respondent organisation population is 719 x 1.2 = 863. Our preference has been to adopt the second of these two methods of extrapolation.

If we assume that the non-frontline workforce is employed in the same way as the frontline workforce, then the workforce head count translates into 578.1 FTE (863 x 0.67 = 578.1).

Volunteers

Of 37 organisations who responded to the survey question about employment of volunteers (71%, n = 52), just under half (17 of 37 or 46%) include volunteer staffing within their mental health workforces. Employment of volunteers is disproportionately done by larger organisations (41% of organisations employing volunteers are 'Very Large'), although the volunteer proportion of the larger organisations is quite small. On the other hand, some of the smaller organisations are quite reliant on volunteer labour with a high proportion of their workforce being unpaid.

The total number of volunteers employed by the 37 CMOs that responded to the volunteer employment question was 199 volunteer employees. This amounted to an additional 8% of workers (by head count) and 2.5% by FTE. If the results for the 37 respondents to this question in the survey is extrapolated to the entire estimated workforce, it is calculated the total number of volunteers on the CMO mental health workforce would be 344 or 72.1 FTE.

The most common roles of volunteer employees in the WA community mental health sector were non-frontline roles, as follows:

- Non-frontline consumer support roles such as catering, transport and social inclusion
- Board membership, governance and management roles
- Consumer capacity building (e.g. tutoring, digital skills)
- Fundraising and events
- Administration and IT.

However, frontline care roles were also reported, such as individual counselling, group work and home visits. To undertake these roles, around half of organisations engaging volunteers report providing minimum training for these employees.

Total workforce size

The total estimated size of the WA CMO mental health workforce (including frontline, non-frontline and volunteers) extrapolated from the survey responses is 4,659 or 2,956.5 FTE (see Table 6). This compares with the latest estimate of the NSW workforce size of 5,576 (Ridoutt, L., et al., 2023) or 3,520.5 FTE.

Table 6: Estimated Total Workforce Size of the WA CMO Mental Health Sector

Type of worker	Head count	FTE
Frontline or Direct workforce	3,457	2,316.2
Non-Frontline workforce	848	578.1
SUB-TOTAL	4,305	2,884.4
Volunteers	344	72.1
TOTAL	4,649	2,956.5

Workforce Gender Distribution

Not all organisations record the gender of their workforce. Only 37 of the 52 survey respondents responded to the question on the gender of their frontline workforce, of which only 28 or 75.7% (n = 37) record the gender of their mental health employee.

From a total of 1,485 workers thus identified, 1,050 (70.7%) were female, 413 (27.8%) male, and 22 (1.5%) identified themselves as another gender identity. From these indicative figures it can be seen that the WA CMO mental health workforce is strongly feminised, a finding which is similar to the community sector mental health workforce for NSW and ACT, found to be approximately 73% and 61% respectively from the latest surveys in those jurisdictions (Ridoutt, et al., 2023).

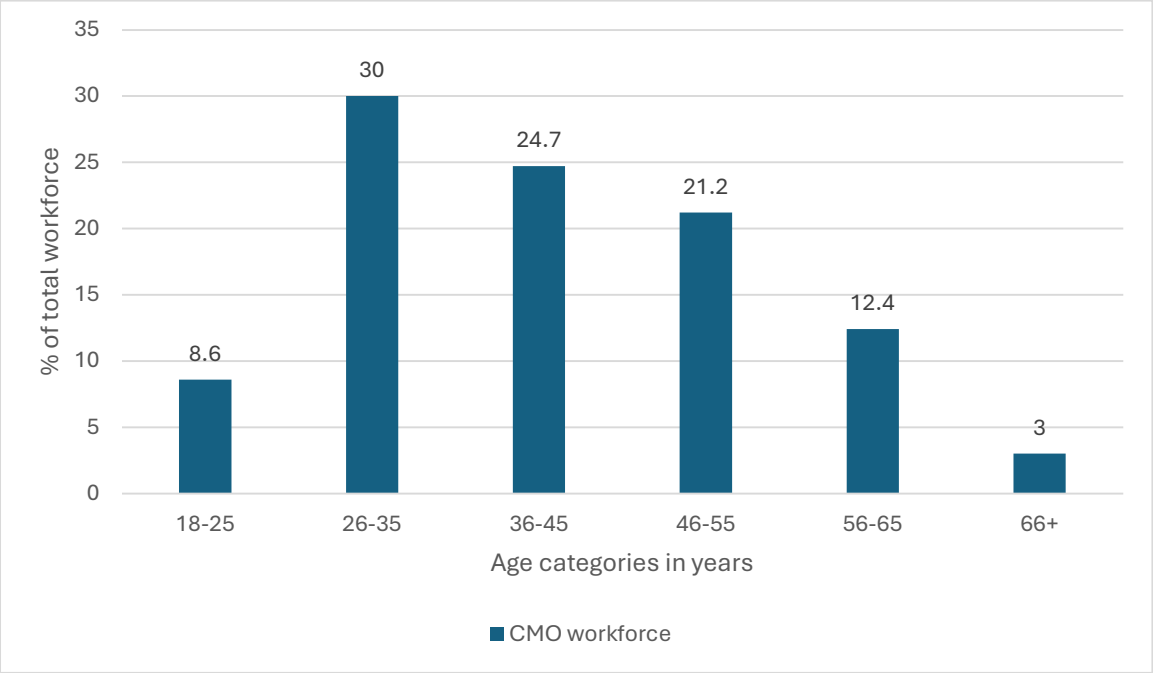
Age distribution

Only 34 of the 52 respondent organisations were able to describe the age distribution of their frontline care mental health workforce. Of the 1653 frontline workers whose age was identified (just over half (54%) of the total surveyed, see Figure 4) workforce, it was revealed that the 26–35-year age category was the most frequent at 30.0%. Overall, approximately 62% of the workforce was under the age of 46, while just over three quarters (75.9%) of the workforce were aged between 26 and 55 years, but only 255 (15.4%) were older than 55 years and just 8.6% were younger than 26. This is neither an elderly nor particularly young workforce profile[3]. Compared to the total Australian workforce, the WA CMO workforce has a significantly lower proportion of under 25 workers, a greater proportion of 26-35 and a slightly higher proportion of persons older than 46. Recent surveys of the CMO sector in NSW has demonstrated a trend to younger people being recruited to work in mental health,

[3] ABS (2026) Labour Force Australia. https://www.abs.gov.au/statistics/labour/employment-and-unemployment/labour-force-australia-detailed/latest-release

with 70% of workers under age 46 in 2023 compared to 64% two years earlier in 2021 (Ridoutt, L., et al., 2023). This is higher than WA's workforce.

Figure 4: Proportion of frontline support workers in mental health in WA organisation operations by age (n= 34)



Workplace diversity

Capture of data by WA CMOs on workforce diversity measures is imperfect. Based on the responses of 36 of the survey respondents (69% of CMOs surveyed, n = 52) the most complete data collection is for Aboriginal and/or Torres Strait Islander status (78%, n = 36), Cultural and Linguistically Diverse (CALD) background (69%) and LGBTQIASB+ status (47%). Even data on 'Lived Experience of Mental Health' is poorly captured with only 22% of CMOs having accurate data on this worker characteristic and another 28% having data but data which is not well maintained and only related to the status of workers in designated lived experience positions. Many CMOs seem to value privacy above the capacity to monitor workforce diversity and prefer data from occasional self-report surveys than from routine data collection processes (for instance the HRIS).

With only 36 of 52 respondent organisations attempting to answer the question on workforce diversity, it may be inappropriate to make definitive statements about the level of workforce diversity in this sector. However, from those that were able to respond, there are some interesting observations.

Regarding frontline mental health staff with lived experience of mental health, 15 organisations advised they kept records of whether their staff identified that they have a lived experience. Of the 929 frontline mental health workers employed in these organisations, 336 had lived experience of mental health (39.4%). This suggests a sector that is well-engaged with

the importance and relevance of having significant numbers of people on staff with personal experience of the challenges of mental health conditions.

On the theme of indigeneity, 19 organisations advised that they record this attribute. Of the 1393 frontline mental health staff employed by these 19 organisations, 75 were noted to be of Aboriginal or Torres Strait Islander descent (5.4%). This proportion is lower than the per capita rate of Aboriginal & Torres Strait Islander people within the WA population (6%[4]). Given the relatively high rates of mental health conditions experienced within Aboriginal communities (AIHW, 2025), it can be argued that having a larger Indigenous presence within the workforce is important in service provision to Aboriginal clients. It is possible that the lower proportion employed by surveyed 'mainstream' CMOs is ameliorated to some extent by the Indigenous workforce employed by ACCHOs.

With regard to workforce with culturally and linguistically diverse (CALD) backgrounds, the 16 survey responders that record if their staff have CALD backgrounds employ 986 frontline mental health workers; of which 276 were noted to be from CALD backgrounds (22.9%), This proportion of CALD workforce is in rough alignment with the total number of mental health clients with CALD backgrounds accessing the mental health system (approximately 23%; Department of Health, WA, 2017) although CALD access to services is known to be much less than the English-speaking population (Department of Health, WA, unknown date).

For LGBTQIASB+ status, 15 of the survey respondent organisations that take a record for their workforce employ a total of 963 frontline mental health workers. Of these, 91 identify as being within the LGBTQIASB+ category (9.4%). This proportion of LGBTQIASB+ staffing is higher than for the total population at approximately 4.5% (Australian Bureau of Statistics, 2022) but may still be in rough alignment with the proportion of clients from LGBTQIASB+ communities given the prevalence of mental health issues in the LGBTQIASB+ population is significantly higher than for the total population (Central and Eastern Sydney PHN, 2025).

Compared to the NSW and ACT CMO mental health workforces, the WA CMO mental health frontline workforces have a greater proportion of Aboriginal and Torres Strait Islanders (5.4% vs 2.5%), a greater proportion of CALD background (22.9% vs 7.3%) and a greater proportion of persons identifying as LGBTQIASB+ (9.4% vs 7.6%).

Conditions of employment

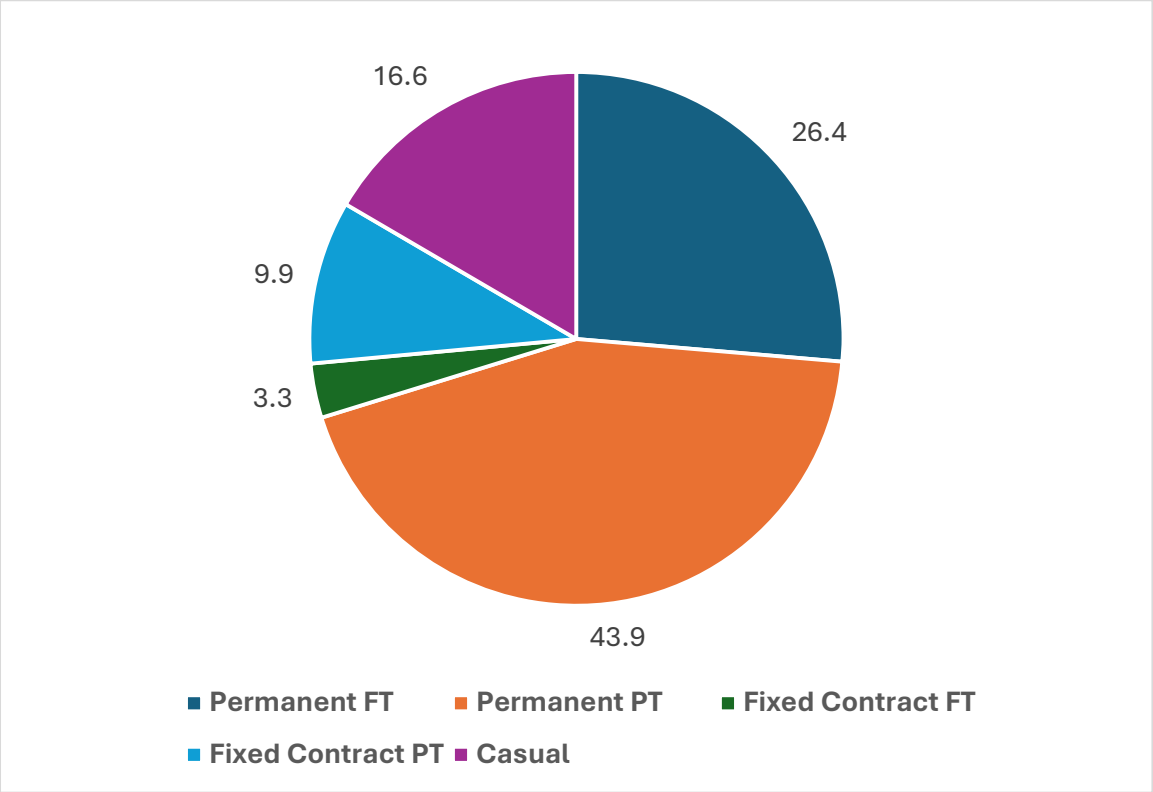
Only 34 of 52 surveyed organisations provided data on the employment type of their frontline mental health workforce; that is, 65.4% of survey respondent organisations. The 34 organisations that provided data employ a total of 1,817 frontline mental health workers (almost 60% of the respondent workforce). Over half of the workforce is employed part-time (see Figure 5), which was foreshadowed by the comparatively low FTE conversion factor (see page 16).

A majority of the workforce (70.03%) are employed on a permanent basis – 26.4% full-time permanent, and 43.9% part-time. Only 13.2% are on fixed term contract employment

[4] Australian Bureau of Statistics, *Western Australia: Aboriginal and Torres Strait Islander population summary*, 2021 Census.

conditions, which compares favourably with NSW where 24.4% are on fixed term contract arrangements. A similar proportion of the WA workforce is employed casually (16.6%) compared with NSW (15.2%, Ridoutt, et.al., 2023).

Figure 5: Distribution (%) of total CMO frontline mental health workforce by employment status (n = 34)

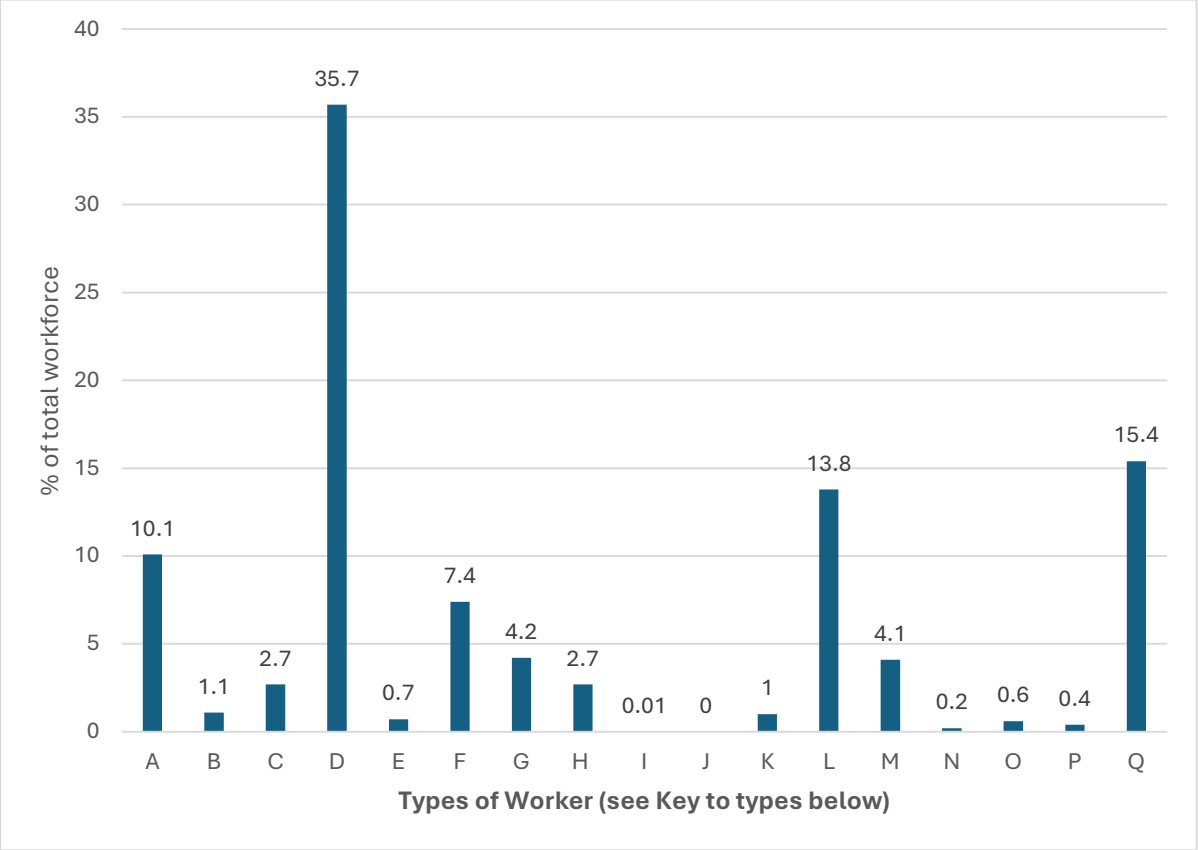


Distribution of the frontline workforce by worker category

A total of 34 organisations responded to the question on the composition of their workforce. These respondents employed 2262 frontline workers, that is 73.4% of the survey population's workforce. The largest component of the survey population workforce, over one third (35.7%) is Mental Health Support Workers, followed by Counsellor/Psychotherapist (13.7%) and Designated Peer Workers (10%). There was a large number of workers categorised as 'Other". This was because several organisations used their internal job titles to identify worker type rather than the more generic worker category labels used in the survey.

To the extent possible, workers categorised as 'other' were redistributed to worker categories specified in the survey, but this was limited by lack of information about the job titles provided. One new worker category was added post-analysis of the survey data, 'Community engagement officer', and some more of the 'other' classified workers could have been recategorised to this category if more details had been available.

Figure 6: Distribution of the CMO mental health workforce by type of worker



Key to types of workers

A = Designated Lived Experience (Peer) Worker

B = Designated Family/Significant Other Peer Worker

C = Recovery Coach or Mentor

D = Mental Health Support Worker

E = Rehabilitation Worker

F = Support Coordinator

G = Clinical leader

H = Nurse

I = Psychiatrist

J = Other Medical Practitioner (e.g., GP)

K = Psychologist

L = Counsellor/Psychotherapist

M = Social Worker

N = Occupational therapist

O = Other Allied Health Professional

P = Community engagement officer

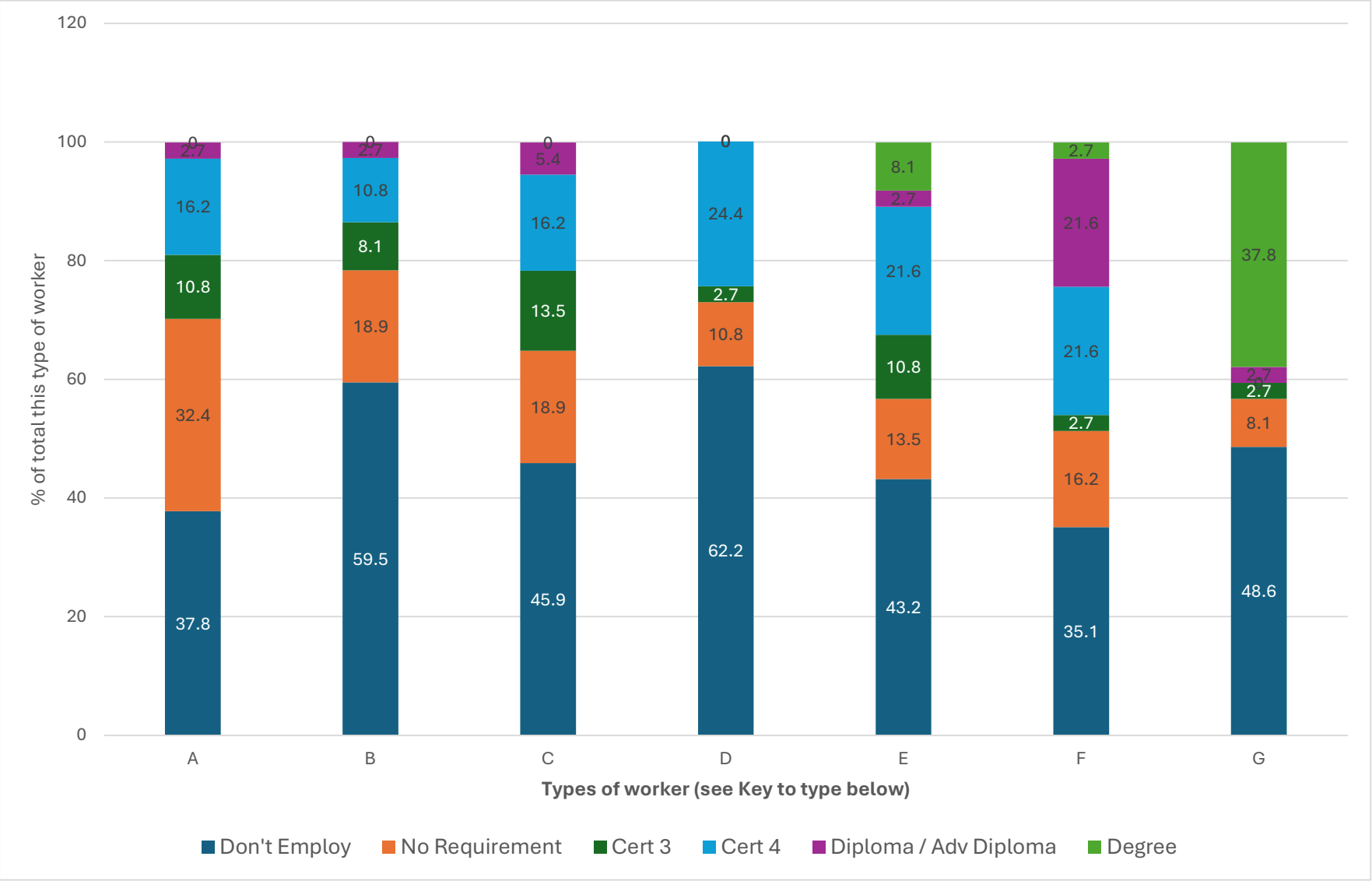
Q = Other

Minimum qualifications of selected types of workers

Apart from professional categories of worker, for which a degree or more qualification is required to be registered, the qualification requirements for other types of workers are more flexible (see Figure 7).

For instance, of those survey respondents to the relevant survey question (n = 37) who employ the most employed type of worker – a Mental Health Support Worker (n = 21, 57% of the respondents) – a quarter (23.8%) require no qualifications and over half (57.1%) require a Certificate 3 or 4 (see Figure 7). Just under one fifth (19%) require a Diploma or Degree for employment. For most worker categories at most organisations the highest qualification requirement of respondent organisations is a Certificate 4. The only exception is the Clinical Leader role for which a degree is indicated as required by nearly three quarters (73.7%) of the 19 organisations who employ this type of worker.

Figure 7: Qualification requirements for selected categories of employed workers (n = 37)



Key to worker types

A = Designated Lived Experience (Peer) Worker

B = Designated Family/Significant Other Peer Worker

C = Aboriginal Mental Health Workers

D = Recovery Coach or Mentor

E = Mental Health Support or Rehabilitation Worker

F = Support Coordinator

G = Clinical Leader

Perspectives on current workforce adequacy

Current vacancies

Two thirds of respondent organisations (n=39) reported they had had vacant frontline mental health positions in the past six months. A total of 117 vacancies were reported (n=26), which provides a vacancy rate of 4.6% of the total headcount of the organisations that responded to this question. An estimated vacancy rate of less than 5% is not generally considered to be a source of concern and largely accounted for by natural turnover. Of the total vacancies, 28% (n = 117) could be described as difficult to fill positions – 'difficult to fill' being defined as positions that are vacant for three months or more. This translates to a difficult to fill vacancy rate of 1.3%, which was found to be quite localised.

Recruitment issues

The most difficult to fill vacancies are for Aboriginal Health Workers (AHW), where 14 of 15 organisations (or 93%) employing AHWs reported significant difficulty (i.e. very or extremely difficult to fill) recruiting to this category (see Table 7). The next most difficult to fill category is psychologists, where 75% of organisations with psychology positions reported significant difficulty in recruiting. Then followed 'other allied health professionals' where six of 12 organisations employing AHPs reported significant difficulties, and then counsellors/psychotherapists where seven of 18 organisations (39%) noted significant problems.

Table 7: Proportion of CMOs employing mental health worker types reporting difficulty filling positions by level of difficulty (n = 37)

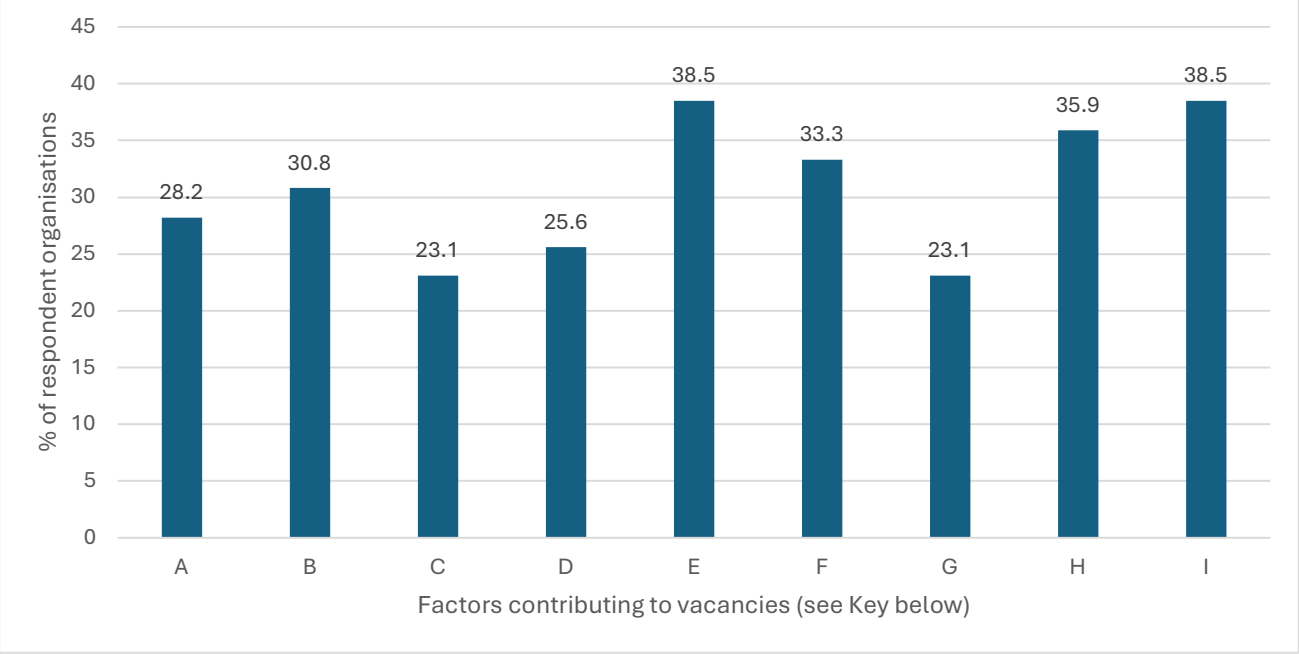
Type of Worker	Not difficult	Somewhat difficult	Moderately difficult	Very difficult	Extremely difficult	Number of organisations responding
Designated Lived Experience (Peer) Worker	13.6	45.5	22.7	18.2	0	22
Aboriginal Mental Health Workers	0	0	6.7	53.3	40.0	15
Mental Health Support or Rehabilitation Worker	4.5	50.0	36.4	4.5	4.5	22
Support Coordinator	10.5	36.8	26.3	21.1	5.3	19
Nurse	8.3	25.0	33.3	25.0	25.0	12
Psychologist	8.3	0	25.0	33.3	41.7	12
Counsellor / Psychotherapist	5.6	16.7	38.9	33.3	5.6	18
Other Allied Health Professional	16.7	25.0	8.3	41.7	8.3	12

While the calculations in Table 7 are based on low respondent numbers, there appears to be clear challenges in recruiting to professional roles in the sector, including and especially recruiting trained AHWs and psychologists, but also to counsellors and other allied health professionals. On the other hand, recruitment to worker positions where the qualification requirements are less restrictive (see Figure 7) such as lived experience peer worker positions and mental health support workers is relatively straight forward.

With regard to difficulties encountered **in recruiting frontline** mental health workers (see Figure 8), the main factors contributing to vacancies for frontline mental health workers identified by organisations (n=39) most commonly cited (at least a third of responding organisations) were:

- Unable to offer competitive salaries with local competing non-aligned industries or sectors (for instance the mining sector) – cited by 38.5% or organisations
- Lack of available/affordable housing for preferred candidates who would need to relocate to take up the position – 38.5%
- Limited ability to offer competitive salaries and conditions – 35.9%
- Length of service agreements and funding models limiting the ability to offer permanent or long-term employment contracts – 33.3%

Figure 8: Relative prevalence of factors contributing to vacancies (n = 39)



Key to main factors contributing to vacancies

A = Insufficient number of workers with relevant qualifications

B = Insufficient workers with relevant length of experience despite having relevant qualifications

C = Difficult to attract workers to the CMO mental health sector

D = Candidates not willing to relocate to rural, regional and remote areas
E = Lack of available or affordable housing for preferred candidates who would need to relocate to take up the position
F = Length of service agreements and funding models limit the ability to offer permanent or long-term employment contracts
G = Frequent re-tendering of service agreements (despite meeting Program KPIs) so can't guarantee continued employment
H = Limited ability to offer competitive salaries and conditions relative to employers of similar roles (e.g. public sector employers, private practice, or sole operator)
I = Unable to offer competitive salaries with local competing non-aligned industries or sectors (e.g. mining, agriculture, tourism)

Some other reasons offered for difficulty recruiting included:

- Poor quality of applicants with only surface level knowledge of the industry and requirements of roles
- Childcare issues – specifically after school and holiday care
- Senior roles such as Clinical Lead are challenging to fill
- Finding qualified candidates in regional areas (we do not have the means to pay for relocation or housing)

Retention issues

When considering the main difficulties **in retaining frontline** mental health workers, many reasons given are similar to the main challenges noted with recruitment in the first instance (see Table 8). Far and away the main reason cited by respondents (76.5%, n=34) is the limited ability to offer competitive salaries and conditions relative to employers of similar roles (e.g. public sector employers, private practice, or sole operator). Other priority issues include:

- Length of service agreements and funding models limit the ability to offer permanent or long-term employment contracts – 44.1%
- Program funding normally being re-tendered preventing the ability to guarantee continued employment – 35.3%

Table 8: Main factors contributing to difficulty in retaining workers (n=34)

Factors contributing to difficulty in retaining workers	Number (n = 34)	% of total respondents
Difficult to retain workers in the CMO mental health sector	7	20.6%
Candidates not willing to stay in rural, regional and remote areas	7	20.6%

Factors contributing to difficulty in retaining workers	Number (n = 34)	% of total respondents
Lack of available or affordable housing for workers	9	26.5%
Length of service agreements and funding models limit the ability to offer permanent or long-term employment contracts	15	44.1%
Program funding normally being re-tendered (despite meeting KPIs) so can't guarantee continued employment	12	35.3%
Limited ability to offer competitive salaries and conditions relative to employers of similar roles (e.g. public sector employers, private practice, or sole operator)	26	76.5%

Other challenges to mental health worker retention were noted to be:

- Training and skill set – lots of unskilled/inexperienced workers
- General psychosocial burden of working in the industry, particularly where working alongside colleagues who also have significant lived experience
- Working with the youth cohort traditionally attracts early- to mid-career clinicians who will seek progression and diversification of opportunities outside the organisation
- Challenging work can create burn out

Perspectives on workforce demand in the sector in WA

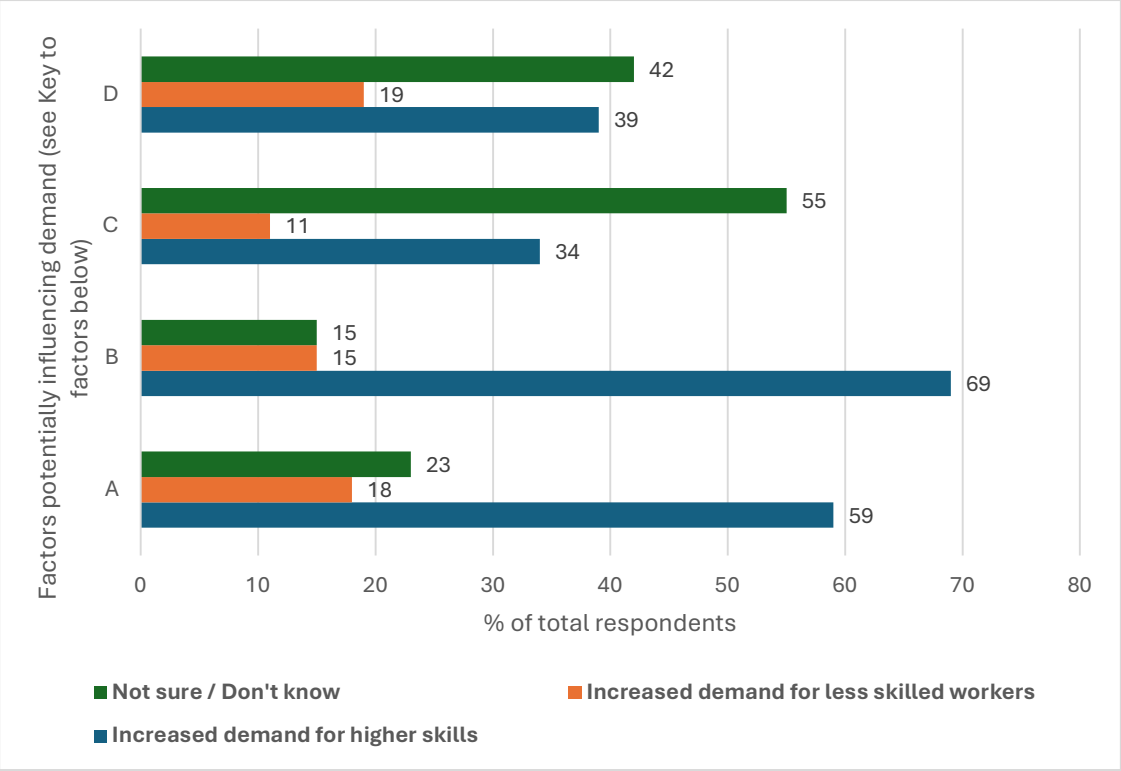
Just over two thirds (36 of 52) of survey participants provided viable responses to the question on factors that are likely to influence demand (need) for frontline mental health workforce in their organisations over the next five years. From the four listed factors in the survey, significant proportions of respondents felt that each of the factors would result in increased demand for staff with higher skills and experience in the sector (see Figure 9). From the responses though two factors stand out:

- Increasing complexity of presentations due to multiple co-occurring issues and/or multiple unmet needs. Over two thirds of respondents (69%) believed this factor would increase demand for **higher skilled and more experienced staff** in coming years.
- Increased number of presentations for mental health support resulting from improved mental health literacy and reduced stigma associated with help seeking. Over half (59%) of respondents felt this factor would **increase the need for higher skilled staff** in the sector.

These two factors represent a perspective that the number of clients to be given care in the future will increase and their presentation will be more complex. Regarding the other factors, commissioning priorities for Commonwealth and State Governments and service costings by commissioning bodies to determine price for commissioned services, most respondents (55.2% for the former factor and 41.7% for the latter factor) were uncertain how these factors would influence demand for mental health workers, skilled or

otherwise. Commissioning or contracting of services are a key driver of workforce demand and provides the means by which organisations increase or change their service delivery capacity which in turn informs the workforces they recruit to deliver contracted services. In combination, the aggregate intent of commissioning decisions provide the signal to the sector for the kinds of workforces it needs to plan for over time.

Figure 9: Factors that will have an influence over the next five years on the demand (need) for mental health workforce in the WA CMO Sector (n = 36)



Key to factors potentially influencing workforce demand

A = Increasing number of presentations for mental health support resulting from improved mental health literacy and reduced stigma associated with help seeking

B = Increasing complexity of presentations due to multiple co-occurring issues and/or multiple unmet needs

C = Commissioning priorities for Commonwealth and State Governments articulated through stated policy intents such as published strategic policy documents

D = Service costings by commissioning bodies to determine price for commissioned services (i.e. models designed and costed to reflect

appropriate staffing to deliver contracted outcomes at expected quality)

When considering all four factors presented, considerably more respondents felt that the associated demands for future workforce will be heavily in favour of high skilled and professional mental health workers ahead of less skilled staff (mirroring a broader view, e.g., Ridoutt, et al., 2023), although both will be required. The factors most strongly influencing this demand for a higher skilled workforce are the increasing complexity of mental health presentations and growing overall presentations associated with improved health literacy and reduced mental health stigma in the community.

A range of further factors were suggested by respondents as being possible influences on mental health worker demand in coming years, including:

- Significant growth in the rate of mental ill-health in young people
- Increased socioeconomic challenges pushing people out of the private system and into public sector community health and the not-for-profit sector.

Suggested human resource solutions

Nearly all of the workforce recruitment and retention solutions presented in the survey for the community mental health sector in WA were seen as medium to high priority by respondent organisations (see Table 10). The favoured solutions, identified by a significant majority of respondents as high to very high priority, were seen to be:

- Sufficient funding that mirrors competitive salaries across the mental health service sector (83.7%)
- Equitable indexation of funding that responds to inflation on services and salaries (77.1%)
- On-going five-year contracts for commissioned services based on performance achievement (75%)
- Contracts that include specific funding for workforce capacity building and sustainability, including training, practice supervision, mentoring (72.2%).

Table 10: Suggested human resource planning, development & management solutions (n=36)

Possible HR solutions	Level of Priority (n = 36)				
	Very low priority	Low priority	Medium priority	High priority	Very high priority
On-going five-year contracts for commissioned services based on performance achievement	1 (2.8%)	1 (2.8%)	7 (19.4%)	14 (38.9%)	13 (36.1%)
Contracts that include specific funding for workforce capacity building and	1 (2.7%)	1 (2.7%)	8 (22.2%)	12 (33.3%)	14 (38.9%)

Possible HR solutions	Level of Priority (n = 36)				
	Very low priority	Low priority	Medium priority	High priority	Very high priority
sustainability, including training, practice supervision, mentoring, etc.)					
Equitable indexation of funding that responds to inflation on services and salaries for CMOs	2 (5.6%)	0	6 (17.1%)	13 (37.1%)	14 (40%)
Sufficient funding that mirrors competitive salaries across at least the mental health service sector	0	0	6 (16.2)	15 (40.5%)	16 (43.2%)
Attractive career pathways that incentivise workforce sustainability	2 (5.6%)	4 (11.1%)	8 (22.9%)	16 (45.7%)	5 (14.3%)
Recognition that the lived experience workforce requires enhanced funding to cover greater supervision and other 'guard rail' support	0	7 (19.4%)	10 (27%)	11 (29.7%)	9 (24.3%)
Funding that provides for a sustainable workforce number to provide adequate back-fill capacity	1 (2.8%)	1 (2.8%)	10 (28.6%)	12 (34.3%)	11 (31.4%)
Strategies to support growth and sustainability of First Nations mental health workers	1 (2.8%)	2(5.6%)	13 (37.1%)	9 (25.7%)	10 (28.6%)
Standards and training that reflect trauma informed recovery-oriented practice	2 (5.6%)	1 (2.8)	9 (25.7%)	11 (31.4%)	12 (34.3%)

It appears that the major problems perceived by community mental health organisations for their frontline mental health workforces centre around funding stability to support competitive salaries in the marketplace, longer term employment contracts and resources for workforce capacity building. The solutions are likewise perceived to be centred around a strategic injection of funds to the sector to support workforce planning, development and support to meet the changing needs of the community. A range of additional solutions for workforce challenges were proffered by respondents, including:

- Enhanced investment in paid placements
- Accessible housing in regional environments to support NFP staff
- Training/support/resources for vicarious trauma, specifically for those with designated lived experience peer support roles.

Further thoughts on Mental Health Workforce

The final question in the workforce survey calling for additional comments produced some worthwhile observations and creative ideas. Of note is that many comments point to the need for focus on staff training and support:

- Enhanced and funded organisational investment in training and development
- Increased student placements and fostering of early career clinicians
- Mandated external professional supervision with reimbursement offered by the organisation
- Internal mentorship programs between senior & junior staff – especially for filling the gap for mid-level Aboriginal and Torres Strait Islander employees
- On-going training to stay aligned to KPIs and cultural competence

One organization described an active initiative where it has:

> *"…… developed an ongoing relationship with our local TAFE where we provide student placements for the Cert IV in Mental Health – this can then lead to permanent employment."*

Another respondent spoke of the need for mental health programs that are:

> *"….. community led and governed, flexible to changing community need. This requires flexible funding models that trust community mental health organisations to use their expertise and the communities' expertise to guide the service to be effective and efficient."*

4. Discussion

Overview

The survey findings suggest a sizeable community managed mental health workforce in WA estimated at 4,659 or 2,956.5 FTE (including frontline, non-frontline and volunteer workers)[5]. This compares with the latest estimate of the NSW workforce size of 5,576 (Ridoutt, et al., 2023) or 3,520.5 FTE. Very large organisations account for the majority of frontline staff, with just six organisations (12%) employing a little over half of all frontline workers.

The largest single worker group is Mental Health Support Workers, followed by Counsellors/Psychotherapists and Designated Peer Workers. Professional roles that require registration are a smaller share of the workforce at an estimated 26%. In the public sector mental health services registered professionals are predominant.

Outside of the regulated workforce, most roles are hired at Certificate III or IV, or with no formal qualification requirement (clinical leadership generally requires a degree). This skill mix is consistent with the psychosocial and recovery-oriented remit of the sector. In NSW, repeated workforce surveys have identified a slow but noticeable reshaping of the CMO mental health workforce with a shift to more

[5] Efforts to obtain a reliable estimate of the public sector or even the total WA mental health workforce size in order to compare the CMO mental health workforce proved difficult.

professional staffing (Ridoutt, et.al., 2023) in response to more complex presentations and commissioning expectations that require higher clinical capability.

The workforce is highly feminised and largely mid-career, with most workers aged 26 to 55. Diversity indicators suggest comparatively higher representation of Aboriginal and Torres Strait Islander workers, CALD workers and LGBTQIASB+ workers than reported in recent NSW and ACT surveys. However, many organisations do not routinely collect reliable diversity data in HR systems, particularly on lived experience outside designated peer roles. This constrains workforce planning and hampers monitoring of equity goals.

Roughly 70% of frontline positions reported were permanent, a stronger result than in some other jurisdictions (Ridoutt, et al., 2023). This would suggest some workforce stability for mental health workers in the community sector in WA despite the length of contracts being identified by some respondents as a factor in attraction and attention. However, this assumption is undermined to an extent by having almost a third of the workforce (29.8%) employed on a casual or fixed term basis. As well, the FTE conversion factor of 0.67 indicates substantial part-time employment. For service continuity, supervision, and career development, this has pros and cons. It enables flexibility and work–life balance but can fragment capability and increase the coordination burden, especially in regional services and for programs that rely on solo or small-team coverage (EmploymentPlus, 2025).

Vacancy rates reported are modest, but hard-to-fill roles cluster in the same places we see nationwide pressure: Aboriginal Health Workers, psychologists, and some allied health categories. The top drivers of vacancies and turnover are inability to offer competitive salaries, housing access and affordability for relocating staff, and funding arrangements that limit permanent or long-term contracts. These are structural conditions shaped by commissioning settings, indexation practices, and the WA cost environment, not just local HR practice. Addressing them is likely to require policy and funding levers as much as organisational strategies.

Workforce Policy implications

Four implications stand out:

1. Stability and parity in funding
   The sector's priorities are clear. Sustained contracts of at least five years, equitable indexation that keeps pace with wage and CPI pressures and doesn't erode the real value of contracts, and explicit provision for workforce capacity building are seen as high to very high priority solutions. These would directly reduce churn, support permanency, and improve competitiveness on salary and conditions relative to public and private sector employers.

2. Targeted strategies for hard-to-fill roles
   WA-specific initiatives for Aboriginal and Torres Strait Islander workforce growth and for professions in short supply are warranted. Options include paid student placements, bonded scholarships linked to community placements, funded supervision, and housing supports for rural and remote recruits. A more enticing career pathway would support better retention - Co-design with ACCHOs and community leaders is essential to progress in this area but building on work already done in the sphere (Bailey, et al., 2017). This is not a unique challenge to the community managed mental health sector so there may be value in cross-sector approaches that leverage what is working in successful organisations or in other sectors or settings. While it is understood

that there is to be a specific focus on ACCOs in the commissioning of community managed mental health services for ATSI people in Western Australia as part of a broader WA community sector commissioning strategy, it will still be necessary for non-ACCO providers to be responsive to the needs of ATSI people to ensure choice.

3. Building clinical and advanced practice capability within the psychosocial model
   To meet the rising complexity of presentations while maintaining recovery-oriented practice, services will need blended teams that combine peer, psychosocial and clinical skills, with funded practice supervision, mentoring, and trauma-informed training. This is consistent with respondents' calls for capacity-building line items in contracts.

4. Lift the quality and consistency of workforce data
   Many organisations lack HRIS infrastructure or do not maintain complete workforce data. For very small organisations this may not be an issue, but for organisations with at least 50 or more workers this is a deficit. A light-touch data improvement program could include standardised data fields, privacy-respecting collection of lived experience status beyond designated roles, and simple reporting dashboards aligned to WAAMH and funder needs. Over time, better data would enable more accurate workforce modelling and reduce reliance on estimates and extrapolations.

The National Mental Health Workforce Strategy 2022-2032, provides strong support for these implications to be pursued with its four strategic pillars. A summary of the four pillars and the strategies most relevant to the [WA] CMO mental health sector is provided below:

Strategic Pillar 1: Attract and Train

Priority areas relevant to the WA CMO workforce are to:

- Mobilise the broader social and emotional wellbeing and health workforce
- Promote mental health careers as an attractive career choice
- Develop and deliver recruitment and career pathways to attract a suitably skilled and diverse workforce
- Enhance training pathways, access to supervision, and support skills transfer

Strategic Pillar 2: Maximise, Distribute and Connect

Priority areas relevant to the WA CMO workforce are to:

- Address workforce supply in rural and remote areas
- Address workforce distribution across settings and between public, private and not-for-profit sectors.

Strategic Pillar 3: Support and Retain

Priority areas relevant to the WA CMO workforce are to:

- Support workplaces to create mentally healthy workplaces and adopt positive workplace cultures
- Increase access to, and use of, continuing professional development across all career stages
- Increase supervision and mentoring across all career stages, including current and emerging leaders
- Adopt funding models and arrangements that drive quality of care and promote retention.

Strategic Pillar 4: Data, Planning, Evaluation and Technology

Priority areas relevant to the WA CMO workforce are to:

- Use data to support workforce and service planning, including demand and surge management
- Improve data governance, quality, collection and utilisation, including addressing data gaps

In terms of workforce planning which might allow the CMO sector to 'get ahead' of the trends that will determine workforce demand, this is being hampered currently by CMO managers having to rely on intelligence they get from the incremental changes in commissioning policy. In other words, CMO managers are operating partially blind, and attempting to piece together a strategic workforce response from multiple and imprecise signals from commissioning agencies. A more strategic and whole of mental health services approach would be to develop (with all stakeholders) a vision of the future workforce from which appropriate strategies can be 'backcast' to find the best pathway forward (Rees, et al., 2025). Taken together, these actions would help the WA CMO mental health sector sustain its strengths in peer and psychosocial support while building the higher-skill capacity that services expect to need. They would also stabilise organisations through more predictable funding, strengthen recruitment and retention in regional WA, and improve the evidence base for ongoing workforce planning.

Regional considerations

Several constraints are amplified outside metro Perth. Employers report difficulty attracting candidates to regional and remote roles due to housing availability and affordability, limited relocation support, and fewer pathways for student placements and supervised practice. Any statewide workforce strategy will need a specific regional stream that bundles funded housing solutions, relocation packages, tele-supervision, and regional training pipelines developed with TAFE, universities and local providers. This is not unique to the community managed mental health sector however, and it is recommended that cross-sector and cross-government approaches to regional workforce challenges be pursued.

Data limitations

While the response rate for this survey was high, several data limitations should be noted when interpreting the findings. The survey was not designed as a census of the entire community managed mental health workforce in WA. Although WAAMH maintains a comprehensive database of relevant organisations, some providers did not respond and others outside the database participated through self-selection. Workforce size estimates therefore rely on extrapolation based on organisational size categories and reported averages and should be interpreted as indicative rather than precise.

While the overall response rate was high, data completeness varied across survey questions, some questions only being answered by close to half the surveyed population. Not all respondent organisations were able to provide information on workforce composition, employment type, age distribution or diversity characteristics. Many organisations reported limited workforce data infrastructure, with the majority relying on payroll data or estimates rather than a dedicated human resources information system. This constrains the consistency and granularity of workforce information available and limits the ability to draw definitive conclusions in some areas, especially for diversity indicators and employment arrangements.

In addition, the boundaries of the community managed mental health workforce are not always clear cut. Some organisations deliver mental health services alongside other community, health or social services, and workforce roles may span multiple program areas. There is also overlap between community managed services, Aboriginal Community Controlled Health Organisations and parts of the private sector, particularly for psychosocial and NDIS funded services. These factors introduce some uncertainty into workforce estimates and comparisons and reinforce the need to interpret results as representing the community managed mental health workforce broadly rather than as a tightly bounded population.

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Appendix A: Survey Tool

2025 Community Managed Organisation Mental Health Workforce Survey

Western Australian Association for Mental Health (WAAMH)

Thank you for taking time to be part of the 2025 Community Managed Organisation Mental Health Workforce Survey. This survey has been commissioned by the Western Australian Association for Mental Health (WAAMH).

You can come and go from this survey until you submit it and all work completed up until you leave each time will be saved. You will automatically resume on the saved (part completed) survey form so long as you use the same IP Address (the same computer and internet server).

Abbreviations

CMO	Community Managed Organisation operating on a not-for-profit basis
FTE	Full Time Equivalent
HRIS	Human Resource Information System
NDIS	National Disability Insurance Scheme
Frontline or Direct workers	These are workers in indirect roles that do not provide services and support. This includes administrative and reception staff, ITC support, cleaners, transport drivers, etc.
Designated Lived Experience (Peer) role	A role which makes lived experience expertise an essential requirement in addition to the relevant practices, skills and knowledge required for the role. This can refer to Consumer Lived Experience (Peer) worker roles or Family/Significant Other Lived Experience (Peer) roles. Covers a range of roles including frontline, leadership, advocacy, education, policy and research & evaluation roles
Paid worker	A person employed by the organisation who receives financial compensation for their work. This includes full-time, part-time,

	fixed-term contract, and casual staff, regardless of their role or employment type. Paid workers may be involved in direct service delivery, management, administration, or other support functions.
Unpaid worker / volunteer	An unpaid worker, freely dedicating time, skills, and energy to benefit others, a cause, or the community without financial gain
Allied Health Professional	University qualified health professionals or practitioners that are not part of the medical, dental or nursing professions. Examples include art or music therapists, nutritionists, counsellors and psychotherapists, dieticians, exercise physiologists, occupational therapists, physiotherapists or psychologists
Vacancy	A planned and budgeted staff position which is not filled

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2. Background information part 2

* 1. Please complete the following contact details.

This information is collected for the administration of the survey only and will not be included in the data or survey report.

Name of person completing the survey

Role of person completing the survey

Organisation

Email address

Phone number

* 2. Please indicate the geographic areas in which your organisation provides mental health services in Western Australia.

- [ ] Metropolitan area
- [ ] Regional area
- [ ] Rural and remote area
- [ ] Other (please specify)

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3. Details about your service provision

These questions will help us gain an understanding of the range of services provided by mental health CMOs in WA.

* 3. Which of the following definitions most closely describes your organisation's **operations in WA**? Select the one option that most closely reflects the services your organisation predominantly provides in Western Australia.

Specialist mental health organisation. ◯

Provides psychosocial and/or clinical mental health services. This may include organisations delivering NDIS-funded services for people with a psychosocial disability.

Community services organisation including mental health. ◯

Offers a range of services (e.g. aged care, alcohol and other drugs, child protection, disability, family and domestic violence, housing and/or homelessness), including mental health programs.

Organisation providing general support, not specific mental health programs. ◯

Delivers support that may be therapeutic in nature (e.g. relationship counselling, employment counselling), but does not run dedicated mental health programs.

Organisation that offers general health services. ◯

Delivers health and wellness services to the general population or specific vulnerable populations (e.g., First Nations, CALD, LGBTQIA+)

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4. Select the mental health services your organisation provides in WA. Please select all that apply.

- Counselling face-to-face
- Counselling and support – telephone and/or online
- Information and referral – telephone and/or online
- Intake, assessment, triage for referral to other services
- Group support activities - face-to-face and/or online
- Mutual support and self-help
- Staffed residential services, including refuges
- Personalised support, including support to accommodation/housing, education, employment,
- legal and other

- Care coordination
- Education, training and professional development
- Systemic reform and advocacy
- Mental health promotion and health literacy
- Mental illness prevention and early intervention
- Alcohol and other drugs services
- Trauma specific services
- Rehabilitation
- Clinical services
- Family and carer support
- Other, please provide details (text box)

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5. Details about your current employees

In this section we would like to understand the profile of the current workforce working in mental health services/programs in your organisation in WA.

This section relates to your workforce in more detail. Reminder: where exact data is unavailable, or cannot be obtained easily, please estimate.

* 5. Please provide the total number of paid staff currently employed i**n direct (frontline) mental health roles within your WA operations.**

Include full-time, part-time, and casual staff. Also include staff who work across roles (e.g. part-time manager and part-time direct support worker).

Number of staff (head count)

* 6. Considering the total number of staff provided above, what is the total Full Time Equivalent (FTE) for these employees? The FTE can be calculated by adding up hours worked per week by all workers and dividing by 38.

For workers with dual roles (say manager and direct support work, only include hours they work providing direct support.

FTE of staff

* 7. To help us interpret the data, is your response to the two questions above derived from:

- ◯ Payroll data
- ◯ Human Resource Information System (HRIS)
- ◯ Estimates

* 8. We now want to break down the figures by roles. Please indicate the total number currently employed by your organisation in WA **for each position listed**. The numbers in your response should add up to the

If you employ no workers in a particular category please respond with a '0'. If you leave it blank we will assume it is zero.

Designated Lived Experience (Peer) Worker	
Designated Family/Significant Other Peer Worker	
Recovery Coach or Mentor	
Mental Health Support Worker	
Rehabilitation Worker	
Support Coordinator	
Clinical leader	
Nurse	
Psychiatrist	
Other Medical Practitioner (e.g., GP)	
Psychologist	
Counsellor/Psychotherapist	
Social Worker	
Occupational therapist	
Other Allied Health Professional	
Other (number)	

9. If you provided a number for 'Other' roles, please specify what these roles are. This might include workers who provide a form of direct care support but also provide non-direct support like managers who do both administrative leadership and clinical leadership or bus drivers who support clients while travelling.

10. Please indicate the total FTE currently employed for each worker type by your organisation in WA (see definition provided earlier on how to calculate FTE). Only provide if this information is available.

Again, if you employ no workers in a particular category please respond with a '0'. If there is no response we will assume zero.

Designated Lived Experience (Peer) Worker	
Designated Family/Significant Other Peer Worker	
Recovery Coach or Mentor	
Mental Health Support Worker	
Rehabilitation Worker	
Support Coordinator	
Clinical leader	
Nurse	
Psychiatrist	
Other medical practitioner (e.g., GP)	
Psychologist	
Counsellor/Psychotherapist	
Social Worker	
Occupational therapist	
Other Allied Health Professional	
Other (please specify the number)	

* 11. Do you have minimum qualifications for these types of workers? Please tick one box for each row.

	Don't employ	No requirement	Certificate 3	Certificate 4	Diploma/Advanced diploma	Degree
Designated Lived Experience (Peer) Worker						
Designated Family/Significant Other Peer Worker						
Aboriginal Mental Health Workers						
Recovery Coach or Mentor						
Mental Health Support or Rehabilitation Worker						
Support Coordinator						
Clinical Leader						

* 12. To determine the employment type of your direct support mental health workers, please indicate the total number of employees for each of the below categories. **If you employ no workers in a particular category please respond with a '0'. If there is no response we will assume zero.**

Permanent, Full Time	
Permanent, Part Time	
Fixed contract, Full Time	
Fixed contract, Part Time	
Casual / Hourly remunerated	

* 13. Please indicate the total number of direct support workers in mental health in your WA organisation operations by age. **If you employ no workers in a particular category please respond with a '0'. If there is no response we will assume zero.**

18-25 years	
26-35 years	
36-45 years	
46-55 years	
56-65 years	
66+ years	

* 14. Please provide the number for each of the worker types below of all paid **indirect or non-frontline** workers employed by your organisation to support mental health programs in your WA operations. Include full time, part time and casual employees. **If there are no workers in a category please write '0'. If there is no response we will assume zero.**

Corporate Services or Business Management	
Receptionists and other front of house staff	
Administrative support staff (e.g. communication and marketing, finance, assets management)	
Technical support staff (including IT)	
Human Resources Management, Training and Workforce Development	
Quality and Compliance	
Other types of non-direct worker	

* 15. Does your organisation collect data on gender identity?

Yes ◯

No ◯

2025 Community Managed Organisation Mental Health Workforce Survey

6.

16. Returning to **direct support staff**, please provide the total number working in mental health in your organisation in WA who identify with the following gender categories.

Male

Female

Other gender identity (e.g. non-binary, bigender)

* 17. Does your organisation collect data on any of the following staff characteristics? Tick

the box most appropriate for each category

	Yes	Yes, but the data is not well maintained	No
Persons with lived mental health experience (including as a carer). This includes workers who are not in designated roles … and therefore must demonstrate lived experience as a requirement of filling the job			
Cultural background (including First Nations status)			
CALD			
LGBTQIASB+			

Would you like to comment on your response? (Textbox)

18. If you answered 'YES' in any form to Question 17, please provide the number of workers at your organisation who are...

If you indicated previously that your data on this aspect of your workers may be poor or is not well maintained, you can provide an estimate or not respond to the question.

Persons with lived experience of mental illness	
Aboriginal and Torres Strait Islander	
Culturally and linguistically diverse	
LGBTQIASB+	

2025 Community Managed Organisation Mental Health Workforce Survey

7. Details about your volunteer workforce

* 19. Do volunteers work in your organisation's operations in mental health programs in WA?

Yes ◯

No ◯

2025 Community Managed Organisation Mental Health Workforce Survey

8.

20. How many volunteers, by head count and FTE does your organisation have. *Reminder, estimates are okay where data is not available.*

Number of volunteers (head count)

FTE estimate for volunteer workforce

21. From the list below select all the areas of activity your volunteers perform in your WA operations. Select all that

apply.

- Consumer support service and non-direct support (e.g. catering, transport and social inclusion)
- Direct care (e.g. individual counselling, groups, home visits)
- Telephone crisis and support lines
- Outreach patrols
- Personal care (e.g. cleaning, food delivery)
- Consumer capacity building (e.g. tutoring, digital skills, etc.)
- Fundraising and events
- Systemic advocacy
- Individual advocacy
- Administration and IT
- Board membership, governance and management roles
- Practice supervision and mentoring
- Other (please specify

22. Does your organisation set minimum training or education requirements for your volunteers?

Yes ◯

No ◯

If you would like to provide more details, please comment here:

2025 Community Managed Organisation Mental Health Workforce Survey

9. Workforce shortages

This section explores current vacancy rates for mental health specific services and programs in your organisation's WA operations.

* 23. Does your organisation have any current and/or past vacancies in budgeted frontline mental health positions in your Western Australian operations?

Yes ◯

No ◯

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10.

24. If you answered YES to the previous question, how many current vacancies are there?

25. How long have the vacant positions identified in Question 24 been vacant? (Number of vacancies should add up to the number in Q24)

One month	
Two months	
Three to six months	
Six months or more	

26. Please indicate the **main factors** contributing to vacancies lying vacant for three or more months (that is **recruitment difficulty**). You can choose more than one factor.

- Insufficient number of workers with relevant qualifications
- Insufficient workers with relevant length of experience despite having relevant qualifications
- Difficult to attract workers to the CMO mental health sector
- Candidates not willing to relocate to rural, regionals and remote areas
- Lack of available or affordable housing for preferred candidates who would need to relocate to take up the position
- Length of service agreements and funding models limit the ability to offer permanent or long-term employment contracts
- Frequent re-tendering of service agreements (despite meeting Program KPIs) so can't guarantee continued employment
- Limited ability to offer competitive salaries and conditions relative to employers of similar roles (eg public sector employers, private practice, or sole operator)
- Unable to offer competitive salaries with local competing non-aligned industries or sectors (eg
- mining, agriculture, tourism)
- Other - please provide details of any other factors which you think impede recruitment

27. From a recruitment perspective, please rate your perceived level of difficulty in filling the following roles:

	Not difficult	Somewhat difficult	Moderately difficult	Very difficult	Extremely difficult	N/A
Peer worker						
Carer peer worker						
Mental Health Support or Rehabilitation Worker						
Support Coordinator						
Nurse						
Psychiatrist						
Psychologist						
Counsellor						
Other medical practitioner						
Other Allied Health Professional						
Other (please specify)						

26. Please indicate the **main factors** contributing to difficulty in **retaining workers** that you consider good for their job role. You can choose more than one factor.

- Difficult to retain workers in the CMO mental health sector
- Candidates not willing to stay in rural, regional and remote areas
- Lack of available or affordable housing for workers
- Length of service agreements and funding models limit the ability to offer permanent or long-term employment contracts
- Program funding normally being re-tendered (despite meeting KPIs) so can't guarantee continued employment
- Limited ability to offer competitive salaries and conditions relative to employers of similar roles (eg public sector employers, private practice, or sole operator)
- Other - please provide details of any other factors which you think impede worker retention

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11. Future workforce needs

In this section we are looking at what you believe will be future mental health workforce needs and what some of the solutions to these issues may look like.

* 29. From the following list, please select any of the factors you believe will have an influence over the next five years on the demand (need) for mental health workforce in your organisation in WA. (Please answer for each row).

	Increased demand for workers with higher skills and experience	**Increased demand for less skilled workers**	**Unsure / don't know**
Increasing number of presentations for mental health support resulting from improved mental health literacy and reduced stigma associated with help seeking			
Increasing complexity of presentations due to multiple co-occurring issues and/or multiple unmet needs			
Commissioning priorities for Commonwealth and State Governments articulated through stated policy intents such as published strategic policy documents			
Service costings by commissioning bodies to determine price for commissioned services (i.e. models designed and costed to reflect appropriate staffing to deliver contracted outcomes at expected quality)			

Please describe other factors which you believe could influence the workforce into the future

30. Below is a list of possible solutions to workforce recruitment and retention issues. Please rate the degree to which each solution would benefit your organisation's ability to attract and retain mental health workforce. You must respond to all factors

	Very low priority	Low priority	Medium priority	High priority	Very high priority
On-going five year contracts for commissioned services based on performance achievement					
Contracts that include specific funding for workforce capacity building and sustainability, e.g. training, practice supervision, mentoring, resources					
Equitable indexation of funding that responds to inflation on services and salaries for CMOs					
Sufficient funding that mirrors competitive salaries across at least the mental health sector					
Attractive career pathways that incentivise workforce sustainability					
Recognition that the lived experience workforce requires enhanced funding to cover greater supervision and other 'guard rail' support					
Funding that provides for a sustainable workforce number to provide adequate back-fill capacity					
Strategies to support growth and sustainability of First Nations mental health workers					
Standards and training that reflect trauma-informed recovery oriented practice					

Please comment on what other solutions would support your organisation to recruit and retain a mental health workforce.

31. Are there any initiatives in your organisation or elsewhere already producing positive workforce outcomes? Please comment.

32. Do you have further thoughts about current or future workforce issues and solutions for the community mental health sector in WA? Please comment.