Strengthening the Social and Emotional Wellbeing, Mental Health, and Suicide Prevention Workforce

Gayaa Dhuwi (Proud Spirit) Australia and Indigenous Allied Health Australia acknowledge the traditional custodians of Country throughout Australia, and pay respects to all Elders, past, present, and future.

About Gayaa Dhuwi (Proud Spirit) Australia

Gayaa Dhuwi (Proud Spirit) Australia is the national leadership body for Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and suicide prevention. As a community-controlled organisation, it is governed and controlled by Aboriginal and Torres Strait Islander experts and peak bodies, working toward the highest attainable standard of social and emotional wellbeing, mental health, and suicide prevention outcomes for Aboriginal and Torres Strait Islander Peoples.

About Indigenous Allied Health Australia

Indigenous Allied Health Australia (IAHA) is a national, Aboriginal and Torres Strait Islander community controlled and member-based allied health workforce organisation. As leaders in Aboriginal and Torres Strait Islander education, training, and workforce development, IAHA support and elevate the Aboriginal and Torres Strait Islander allied health workforce to lead transformative change across health and wellbeing systems, grounded in Aboriginal and Torres Strait Islander ways of knowing, being and doing, for better health and social and emotional wellbeing.

Executive Summary

This position paper calls for urgent reform to recognise, invest in, and embed the Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, suicide prevention and postvention workforce, referred to collectively as the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce in this statement. This diverse workforce draws on cultural, clinical, and lived experience expertise and plays a critical role in delivering culturally safe and responsive, community-led care. It includes Ahpra-regulated, self-regulated and unregulated roles that support the maintenance of good wellbeing (prevention), early intervention, and recovery, yet continues to be excluded from national workforce data, planning, and commissioning systems.

Although national strategies acknowledge the importance of this workforce, structural enablers such as accreditation pathways, sustainable funding, and coordinated data collection across systems and providers remain lacking. This paper outlines recommendations to embed Aboriginal and Torres Strait Islander leadership and governance, invest in culturally safe and responsive workforce models, training and supervision, and integrate this workforce as a core

part of Australia's mental health system. Elevating and sustaining this workforce is essential to achieving equitable outcomes and a self-determined future where Aboriginal and Torres Strait Islander Peoples enjoy high levels of social and emotional wellbeing, no matter where they access services and support.

Background

Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, suicide prevention and postvention outcomes are grounded in holistic understandings of health that reflect the enduring strength, resilience, and cultural continuity of Aboriginal and Torres Strait Islander Peoples (Gee et al., 2014; Dudgeon et al., 2014). It is recognised that social and emotional wellbeing extends beyond clinical domains to include spiritual, cultural, and collective dimensions, firmly embedded in family, kinship, community, and connection to Country (Gee et al., 2014).

The Aboriginal and Torres Strait Islander social and emotional wellbeing workforce is central in building trust, supporting recovery, and embedding culture in care which has been increasingly acknowledged in national policy. The *National Mental Health Workforce Strategy 2022 to 2032* and the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021 to 2031* both call for greater structural support and visibility for this workforce within mainstream planning and reform efforts (Department of Health and Aged Care, 2021; 2022). Despite the significant contributions of the workforce, persistent gaps in formal recognition, funding structures, supported training pathways, and commissioning limit the workforce achieving its full potential. Elevating and embedding this workforce across systems is foundational to achieving a culturally safe, effective, and self-determined mental health system (Schultz, 2016; Tsey and Every, 2000; Bond et al., 2012).

Underinvestment in this workforce not only compromises health equity, but it also imposes avoidable social and economic costs. Higher rates of psychological distress, preventable hospitalisations, service disengagement, incarceration, and suicide are all linked to inadequate support for culturally responsive care (Kinchin and Doran, 2018). In contrast, strengthening this workforce delivers measurable returns, reducing acute demand, supporting early intervention, and building community led capacity for long term outcomes of high levels of social and emotional wellbeing (Dudgeon et al., 2017; Tsey et al., 2010). This is particularly true when it's embedded within a holistic model of care, operating across otherwise siloed sectors.

The Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Workforce

The Aboriginal and Torres Strait Islander social and emotional wellbeing workforce includes all people involved in the planning, delivery, and evaluation of culturally safe and holistic mental health care for Aboriginal and Torres Strait Islander peoples (Department of Health and Aged Care, 2022). This workforce spans public, private, not-for-profit and Aboriginal Community Controlled sectors and operates across a wide range of settings, including primary care, tertiary mental health, education, justice, housing, disability, child protection, aged care, and community services (Department of Health and Aged Care, 2022). It comprises Ahpra- and self-regulated and unregulated roles, including psychologists, psychiatrists, general practitioners,

nurses, social workers, occupational therapists, Aboriginal and Torres Strait Islander Mental Health workers and other allied health professionals, alongside Aboriginal and Torres Strait Islander Health Workers and Health Practitioners, social and emotional wellbeing workers, cultural mentors, traditional healers, Elders, peer support workers, and lived experience practitioners. The workforce functions through interdisciplinary and multidisciplinary teams and is shaped by the cultural, spiritual, and community determinants of health that are central to Aboriginal and Torres Strait Islander Peoples social and emotional wellbeing (Gee et al., 2014; Department of Health and Aged Care, 2022).

This workforce must be recognised not only for its diversity of roles, but also for the relational and cultural legitimacy it brings to mental health care. Grounded in holistic understandings of health, the social and emotional wellbeing workforce operates within a strengths-based framework that emphasises the interconnectedness of body, mind, spirit, culture, family, kinship, and Country (Gee et al., 2014; Dudgeon et al., 2014). Many of these roles are embedded within community and defined by trust, cultural authority, and lived experience, rather than clinical qualification alone (Schultz, 2016; Lynn, 2001). These relational dynamics are critical to workforce effectiveness, particularly in community-led and place-based models of care (Ware, 2013; Zubrzycki et al., 2017). A significant constraining factor is the internal policy architecture within organisations with throughput-driven KPIs and fee for service incentives, clinical governance that does not embed cultural governance, and workload/classification settings that fail to recognise the cultural labour and decision making authority. These settings displace time for community engagement, cultural supervision and relational care, limiting the workforce's ability to practice as intended. The *National Mental Health Workforce Strategy 2022–2032* supports this view, explicitly recognising the value of lived experience and the need for culturally safe service models (Department of Health and Aged Care, 2022).

While many roles within this workforce fall outside of standard accreditation and regulatory systems, evidence highlights their effectiveness in supporting early intervention, continuity of care, and long-term healing. This is the case particularly in Aboriginal Community Controlled settings (Tsey & Every, 2000; Bond et al., 2012; West et al., 2012). However, these contributions remain structurally unrecognised due to exclusion from data collection, workforce planning, and commissioning systems (Ware, 2013; Schultz & Cairney, 2017). These are the very structural levers the *National Mental Health Workforce Strategy 2022–2032* identifies as requiring reform to ensure equitable and sustainable workforce development (Department of Health and Aged Care, 2022). However, approaches to progressing this work often focus on the introduction of mandatory minimum qualifications and or additional regulatory requirements, which can be a barrier for some, including those with lived experiences.

To address this, both the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031* and the *National Mental Health Workforce Strategy 2022–2032* call for the integration of Aboriginal and Torres Strait Islander-led roles across all domains of the mental health system (Department of Health and Aged Care, 2021; Department of Health and Aged Care, 2022). This includes culturally safe education and training pathways, national and local planning that centres Aboriginal and Torres Strait Islander leadership, and commissioning mechanisms that reflect the true scope of the workforce. This workforce is not emerging, as it is well-established, effective, and essential, albeit underutilised. What is required is structural investment, national standardisation, and formal recognition to embed it fully within a system that has long relied on it, but is rarely resourced. Achieving nationally consistent recognition should not result in diluting existing strengths. Rather it should

elevate all roles to the highest standard already present in the sector, including scope of practice, remuneration, cultural authority, professional recognition, and conditions of employment. This ensures the workforce is strengthened, not constrained, and that Aboriginal and Torres Strait Islander-led models of care are fully valued. Doing so requires structural investment, policy integration, and reforms that secure these standards across the entire mental health system.

Structural Barriers Limiting Workforce Growth and Impact

Although its critical importance has been identified, the Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and suicide prevention workforce continues to be undermined by structural neglect. Rather than lacking in capacity, the workforce is constrained by fragmented systems, outdated regulatory frameworks, and narrow conceptions of what constitutes legitimate expertise. These systemic limitations prevent the workforce from being fully embedded, resourced, and sustained across all levels of mental health systems (Department of Health and Aged Care, 2022; Schultz, 2016).

It is important to note that workforce sustainability is not solely dependent on these overarching structural elements, but also on the social and emotional wellbeing of the individuals currently working within the system. High turnover resulting from stress and burnout impedes continuity of care, and by extension, damages the integrity and resilience of the workforce. Thus, strengthening the social and emotional wellbeing, mental health, and suicide prevention workforce requires the implantation of measures including comprehensive cultural safety standards that ensure the social and emotional wellbeing of individuals, in addition to the structural elements discussed below.

Standardised Training and Accreditation

The Aboriginal and Torres Strait Islander social and emotional wellbeing workforce consists of diverse roles, including social and emotional wellbeing workers, cultural mentors, traditional healers, Elders, and lived experience practitioners. These roles remain excluded from national training, regulation, and accreditation systems. These roles, while essential to culturally safe care, do not align with the regulatory models built around Western professional frameworks (Ware, 2013; Schultz & Cairney, 2017). The *National Mental Health Workforce Strategy 2022–2032* recognises this issue, calling for fit-for-purpose competency frameworks and recognition processes that reflect the cultural, relational, and community-led nature of these roles, providing choice for people in accessing support (Department of Health and Aged Care, 2022). These include equipping the workforce with the skills required to maintain cultural authority, apply trauma aware and healing informed approaches, practice self-care, manage professional boundaries, navigate complex service systems, and work effectively within multidisciplinary teams within the community. While poorly designed regulatory requirements can create barriers to entry for experienced community practitioners, well-designed training, support and clear scopes of practice can strengthen capability, safeguard wellbeing, and ensure these roles are valued and integrated across the mental health system.

Without formal frameworks that reflect Aboriginal and Torres Strait Islander knowledges and ways of working, the legitimacy of these roles continues to be undervalued in policy, workforce planning and modelling, clinical governance, enterprise, and commissioning structures (Bond et

al., 2012; Tsey & Every, 2000). Moreover, the absence of national consistency in role definitions, training, and support leads to fragmentation, role ambiguity, and vulnerability to funding cuts (Zubrzycki et al., 2017; Lynn, 2001). The lack of accreditation also limits workforce mobility and self-determination, blocks access to clinical and cultural supervision, and hampers efforts to build a structured career pipeline.

Pathways to Professional Roles

There are limited structural pathways to support Aboriginal and Torres Strait Islander people to transition from informal or community-based roles into regulated professions such as psychology, social work, or mental health nursing (Lynn, 2001). Those who attempt to pursue formal qualifications often face institutional racism, cultural unsafety, financial hardship, and a lack of flexible, community-based education models (Dudgeon et al., 2014). Additional barriers such as mandatory police checks, working with children checks, and similar screening processes can also disproportionately affect Aboriginal and Torres Strait Islander applicants due to the ongoing impacts of colonisation, systemic bias, and over-representation in the justice system, further limiting access to professional pathways.

While the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031* promotes culturally safe education and training pathways, implementation has been inconsistent (Department of Health and Aged Care, 2021). Recognition of prior learning, flexible entry points, and tailored support programs are rarely embedded as standard practice across tertiary institutions (Schultz, 2016). As a result, skilled community workers are too often held in stagnant roles without the support needed to transition, specialise, or advance. The opportunity cost is significant, both for individuals, families and communities, and for a system in desperate need of culturally safe professionals.

Strengthening Inclusion in Workforce Planning

Despite decades of demonstrated impact, roles such as social and emotional wellbeing workers, cultural brokers, and traditional healers remain absent from national and jurisdictional workforce classifications, health data systems, and strategic workforce planning efforts (Ware, 2013; Schultz & Cairney, 2017). This lack of structural visibility creates a cascading effect: roles that are not named cannot be costed, evaluated, or funded sustainably, limiting mobility of the workforce.

The *National Mental Health Workforce Strategy 2022–2032* calls for improved data systems to reflect the true scope of the workforce (Department of Health and Aged Care, 2022). However, this has yet to translate into a coordinated effort to quantify and integrate Aboriginal and Torres Strait Islander specific roles into national planning, particularly those outside of regulated professions. The continued lack of inclusion of social and emotional wellbeing roles from health workforce datasets contributes to an underestimation of workforce and community need and perpetuates underinvestment. Until these roles are structurally recognised through inclusion in national workforce datasets, standard funding formulas, and formal commissioning guidance, they will continue to be sidelined from long-term workforce planning and reform.

Commissioning Models Undervalue the Social and Emotional Wellbeing Workforce

Approaches to service commissioning and funding models continue to prioritise regulated, biomedical roles over community-based, culturally grounded workforces. This reflects broader systemic bias towards Western clinical models of care and professional roles, and fails to account for the relational, preventative, and restorative strengths of the social and emotional wellbeing workforce (Dudgeon et al., 2014; West et al., 2012).

Even when social and emotional wellbeing programs are funded, they are often tied to short-term project cycles or fragmented across multiple funding streams, making workforce sustainability nearly impossible (Bond et al., 2012). The *National Mental Health Workforce Strategy 2022–2032* identifies the need for commissioning reform that enables flexible, place-based, and culturally safe service models (Department of Health and Aged Care, 2022). However, commissioning reform must be paired with organisational governance that enables the workforce to practise as intended. This includes appointing social and emotional wellbeing roles on secure classifications with clear scopes of practice; embedding cultural governance within clinical governance (e.g., co-chaired committees and dual cultural and clinical supervision); defining decision rights and delegated authority in care planning and case conferencing; establishing direct reporting lines to Aboriginal and Torres Strait Islander leadership; and recognising cultural work, supervision, and community engagement time in workloads and enterprise agreements. Evidence shows these governance settings improve service quality and retention (Lovett et al., 2018). Without formal recognition, robust data, nationally consistent training standards, and these governance conditions the social and emotional wellbeing workforce will continue to be undervalued and unrecognised, treated as peripheral supports within Western systems, rather than essential components of core service delivery for all Australians.

Recommendations

To strengthen and embed the Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and suicide prevention workforce, Gayaa Dhuwi (Proud Spirit) Australia and Indigenous Allied Health Australia, jointly call for:

1. Formal and consistent recognition of the Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, suicide prevention and postvention workforce in all national and jurisdictional strategy, policy and regulatory frameworks.
2. Strategic, joint funding commitments from the Commonwealth and jurisdictions to progress Aboriginal and Torres Strait Islander-led pathways for training, accreditation, and clinical and cultural supervision across community, lived experience, and professional roles. This should occur through the application of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021 to 2031 in social and emotional wellbeing and mental health.
3. Collection and public reporting of disaggregated workforce data, including unregulated and culturally defined roles, underpinned by Commonwealth leadership and existing agencies with responsibilities for workforce and data collection. This should occur in the context of understanding the unused or underutilised capability within the system and opportunities to
4. Collaborative, long-term, and place-based commissioning of social and emotional wellbeing services by governments, underpinned by blended funding (core block funding

for capacity and cultural governance, activity payments, and targeted outcome payments) across portfolios, rather than solely fee-for-service, biomedically driven funding models.

5. Resourcing Aboriginal and Torres Strait Islander leadership and organisations to develop the knowledge and formal evidence base in support of the return on investment for and viability of locally designed, interdisciplinary teams that centre cultural knowledge and cultural determinants, lived experience, and community authority as essential to the skill and service mix required to meet the needs of communities.
6. Aboriginal and Torres Strait Islander workforce governance to be embedded and enabled in all workforce planning, funding, implementation, and evaluation processes, including through the meaningful implementation of reforms by partners under the National Agreement on Closing the Gap, and recognition of the value and expertise of Aboriginal and Torres Strait Islander organisations including Gayaa Dhuwi (Proud Spirit) Australia and Indigenous Allied Health Australia.

Conclusion

The Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and suicide prevention workforce is foundational to achieving a culturally safe, effective, equitable and sustainable mental health system (Department of Health and Aged Care, 2022; Schultz, 2016). It brings together lived experience, cultural knowledge, clinical expertise, and community leadership. This is an asset that remains undervalued and underutilised within the mental health system (Zubrzycki et al., 2017; Dudgeon et al., 2014). There is clear evidence of its impact, however structural gaps in recognition, investment, and policy integration persist, limiting the potential of this workforce to lead meaningful and community driven change (Gee et al., 2014; Tsey and Every, 2000).

By addressing these systemic barriers through national standardisation, commissioning reform, sustained Aboriginal and Torres Strait Islander governance, and cultural safety standards for workers, governments can unlock the full strength of this workforce (Department of Health and Aged Care, 2021; Bond et al., 2012). The transformation of Australia's mental health system will not occur without this investment, investment which will be returned many times over. Independent modelling has shown that well designed mental health and suicide prevention reforms deliver returns that significantly exceed costs, through reduced hospitalisations, avoided crisis interventions, increased workforce participation, and associated taxation revenue, alongside measurable gains in life expectancy and quality of life (Productivity Commission, 2020; Kinchin and Doran, 2018). Strengthening this workforce is critical step toward realising the highest attainable standards of social and emotional wellbeing, mental health, and suicide prevention outcomes for Aboriginal and Torres Strait Islander Peoples (Dudgeon et al., 2017; Kinchin and Doran, 2018; Gayaa Dhuwi (Proud Spirit) Australia, 2015).

The expertise of Aboriginal and Torres Strait Islander organisations such as Gayaa Dhuwi (Proud Spirit) Australia and Indigenous Allied Health Australia, as well as the voices of the workforce itself, can support meaningful progress to elevate the social and emotional wellbeing workforce now and into the future.

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