Mental health in the health workforce

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Auckland University of Technology Associate Professor Dianne Wepa's research found that mental health in the health workforce is influenced by how workplace cultures either promote or hinder psychological safety

Mental health in the health workforce is shaped not only by registration processes but also by how everyday workplace cultures enable or undermine psychological safety. A different angle on recent discussions of regulatory barriers is to focus on "compassionate systems" that embed mental health support into the design of health services, rather than placing the responsibility solely on individual resilience. health+1

Reframing the problem

Health workers across professions report high rates of burnout, moral distress and intention to leave, driven by increasing demand, staff shortages and exposure to trauma and death. These pressures intensified during and after the COVID-19 pandemic, with surveys in multiple countries showing a substantial proportion of health workers experiencing symptoms of anxiety and depression, along with a rise in sick leave and early retirement. Instead of viewing these outcomes as personal weaknesses or isolated "stress management" failures, a compassionate systems lens treats them as predictable responses to structural and organisational conditions. ranzcp+3

From this perspective, the central question shifts from "How can individual clinicians be more resilient?" to "How can health systems reduce preventable harm to staff and build environments where wellbeing is an expected outcome of everyday work?" This reframe highlights that responsibility for mental health must be shared by policymakers, leaders, professional colleges, unions and service managers, rather than resting primarily on individual coping strategies. ranzcp+1

Compassionate systems in practice

A compassionate system is one where policies, leadership behaviours and team norms routinely prioritise psychological safety, inclusion and healing for staff and consumers. In practice, this means reducing chronic overload, ensuring fair access to leave, addressing bullying and discrimination and creating structures that allow staff to raise concerns without fear of reprisal.

Evidence from reviews of interventions suggests that organisational changes such as improving staffing levels, redesigning workflows and providing supportive supervision, deliver more sustainable mental health benefits than stand-alone individual self-care programmes. health+2

Health workers consistently report that feeling heard by leaders, being involved in decision-making and seeing timely action on safety and workload concerns reduce burnout and improve job satisfaction. For example, services that implemented regular, facilitated team debriefs and peer-support networks during crises reported better team cohesion and lower psychological distress than those relying on ad hoc, informal support.

Compassionate systems also recognise that different groups within the workforce experience risk differently, so strategies are tailored for junior doctors, nurses, allied health professionals, peer workers and managers. nami+4

Harassment, moral injury and culture

Workplace harassment, discrimination and moral injury are key drivers of poor mental health, particularly for women, racialised staff, migrants and overseas-trained professionals. Surveys of health workers show that those exposed to bullying, sexual harassment, or racism are significantly more likely to report symptoms of depression, anxiety and burnout than colleagues who do not experience these behaviours.

In mental health and emergency settings, occupational violence and threats from patients and families add further psychological hazards, especially when staff feel unsupported by organisational responses. cdc+4

Moral injury arises when workers feel unable to provide the quality of care they know is needed, often because of underfunding, bed shortages, or rigid policies that conflict with clinical judgment. Repeated experiences of turning people away, discharging them early, or working in environments that lack culturally safe options for Aboriginal, Torres Strait Islander, Māori and other Indigenous communities can erode professional identity and lead to deep emotional exhaustion.

For internationally trained clinicians and other marginalised groups, prolonged underemployment, repeated examination failures, or exclusion from leadership further compounds these risks, signalling that they are valued less than their peers. who+4

Building protective organisational structures

Moving from rhetoric to protection requires embedding mental health safeguards into core workforce infrastructure and governance. Key organisational strategies identified in labour market and workforce analyses include co-designed workload planning; clear role descriptions; mandatory anti-harassment policies with real enforcement; protected time for reflective practice and supervision; and access to confidential, stigma-free mental health and employee assistance services.

When hospital and community leaders adjust duty allocation, improve physical environments and provide structured supervision, levels of burnout, sick leave and intent to leave fall measurably. health+3

Psychosocial risk is now recognised in many jurisdictions as a core work health and safety obligation, requiring employers to identify, assess and control hazards such as excessive workload, low control, bullying and job insecurity. This legal shift reinforces the need for systematic action plans, regular staff surveys, transparent reporting and co-designed interventions rather than ad hoc wellness initiatives.

Importantly, protective structures must span the entire career pathway, including students, trainees, early-career clinicians and those in leadership roles, so that mental health support is integrated from entry to retirement. who+2

Policy levers and leadership responsibilities

Policy frameworks increasingly acknowledge that health worker mental health is a prerequisite for safe, high-quality care and system sustainability, not an optional extra. National and regional strategies highlight the importance of investing in the mental health workforce, improving supervision and career pathways and aligning funding models with workforce wellbeing and retention goals. Without such system-level action, simply training more staff will not resolve shortages, as workers continue to leave due to unmanageable workloads, unsafe cultures and limited progression opportunities. mentalhealthcommission+3

Leaders at every level play a crucial role in translating policy into practice. Practical actions include modelling respectful behaviour; responding quickly to reports of bullying or discrimination; involving staff in service redesign; and making wellbeing metrics as visible and important as financial and activity indicators. Targeted investments in rural, remote and community settings, as well as in peer and lived experience roles, can help distribute workload more equitably and ensure that the workforce reflects the communities it serves.

Leadership development programmes that emphasise emotional intelligence, trauma-informed supervision and collaborative decision making are increasingly identified as critical to building compassionate systems. nami+4

Future directions and research needs

Future research needs to evaluate system-level interventions longitudinally, examining not only individual outcomes, such as burnout and distress, but also workforce retention, patient safety and equity impacts. There is value in studying models that integrate organisational and clinical changes, such as trauma-informed workplaces, flexible rostering and culturally safe care teams, rather than evaluating single, isolated programmes. Health workers with lived experience of mental health challenges, including peer workers and those who have returned to practice after illness, should be involved in co-designing and evaluating these interventions. who+2

Nonetheless, current evidence is sufficient to support a shift from individualising distress to designing compassionate health systems where mental wellbeing is a core performance and equity indicator. This means measuring and reporting psychosocial risk, resourcing supervision and peer support and ensuring accountability for cultural change alongside clinical outcomes.

By embedding mental health protection into everyday structures and decisions, rather than treating it as a separate project, health systems can create environments where caring for others does not routinely come at the cost of workers' own mental health. mentalhealthcommission+3

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