Community Mental Health Australia Position Statement - Workforce and the community managed mental health sector

Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak community mental health organisations. CMHA, through its state and territory bodies, has a direct link and contact to mental health organisations delivering services at the community level. CMHA provides a unified voice for approximately 800 community-based, non-government organisations who work with mental health consumers and carers across the nation and who are members of, or affiliated with, the various coalition members.

The organisations represented through CMHA are:

- Mental Health Coalition of South Australia
- Mental Health Community Coalition of the ACT
- Mental Health Coordinating Council NSW
- Mental Health Council of Tasmania
- Northern Territory Mental Health Coalition
- Psychiatric Disability Services of Victoria (VICSERV)
- Queensland Alliance for Mental Health Ltd
- Western Australian Association for Mental Health

CMHA promotes the recovery of people living with a mental health condition so that they are contributing citizens and included in all of the economic and social aspects of their community. The organisation presents a united and representative voice for the community managed mental health sector who work every day on mental health issues and have the expertise through a specialised workforce, including a peer workforce and lived experience.

CMHA advocates for and promotes evidence-based, good practice and capacity building for community based mental health services, and collaborates with consumers and carers through a lived experience partnership. CMHA does this at the national level, and at the state and local level.

CMHA is concerned that the future of the community managed mental health workforce is being compromised by a range of reforms, including transitioning to the National Disability Insurance Scheme (NDIS), integrating the Primary Health Networks (PHNs) and delivery of the Fifth National Mental Health and Suicide Prevention Plan. In order for the reforms to achieve their aims including choice for consumers, coordinated care and service delivery, and people receiving the support they need at the stage they need it, the workforce must be enabled and supported. The objectives of the reforms will not be possible without a qualified and quality workforce to deliver them.

Why the sector is important

Community-based rehabilitation is strongly aligned with recovery-oriented practice. The workforce that delivers this practice is important as it integrates with clinical services in vital ways, and offers a distinct set of interventions that develop skills and capacities to assist people to build lives in their communities of choice.[1]

[1] Victorian Department Health and Human Services (2015), Components of Effective Mental Healthcare -Treatment, community based rehabilitation and disability support, Discussion Paper, 2015. Victorian Government, Victoria.

Room 1.06, Level 1, Griffin Centre
20 Genge Street, Canberra City ACT 2601
t: (02) 6249 7756 f: (02) 6249 7801
e: abresnan@cmha.org.au w: www.cmha.org.au

Community-based rehabilitation is a defined intervention designed to target the specific problems that arise when people have a severe and enduring mental illness. Practice must occur in an overall recovery framework that supports the personal journey of recovering.[2]

In addition to core recovery capability, the workforce requires:

- a sound understanding of mental illness and the impact of mental health problems on activities and participation;
- an understanding of evidence-based approaches to assisting people build skills, find employment, maintain a home and build social networks;
- sound understanding of rehabilitation models and related skills;
- a commitment to working with and including families; and
- an advanced understanding of recovery processes.[3]

Mental health reforms and workforce implications

Loss of psychosocial rehabilitation

Community managed mental health organisations within the community managed mental health sector prioritise community-based rehabilitation to support individuals to recover, and through this the sector has developed a workforce that is appropriately qualified and skilled to deliver these services and a culture that reflects the appropriate standards. This is particularly difficult in rural and remote communities including Aboriginal mental health workers.

The NDIS pricing creates several challenges for the support of people with psychosocial disability, the quality of supports available, and meeting Occupational Health and Safety obligations to staff. These include:

- A significant decrease in the level of salary providers can to afford to pay staff.
- Difficulty in being able to afford time for essentials such as supervision, training, development, collaboration and innovation, and routine administration.
- Workplace health and safety concerns when providers unable to fund two support workers – i.e. staff working in isolation and in uncontrolled environments such as people's homes, etc.
- Providers shifting to a more casualised workforce and the impact this has on being able to provide a consistent worker for individuals who seek this.
- An inability to retain the highly the highly skilled workforce employed currently and who have experience working with complex clients.
- Accommodating different levels of complexity and reflecting the costs of providing reasonable and necessary levels of care.

The Human Capital Alliance report on the community managed mental health sector encapsulates the wider workforce difficulties and remuneration issues for the retention of this skilled and qualified workforce, particularly under the NDIS:

- having to back away from minimum workforce qualification standard since services cannot afford to pay the salaries required to attract and retain that level of worker;
- having a 95% direct service provision model with little margin for non-direct service work;

[2] Ibid
[3] Ibid

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- a pricing structure that makes very little allowance for induction, training, development, collaboration, and innovation, and routine administration;
- no detail on how the Information, Linkages and Capacity Building (ILC) is going to be implemented so no ability to plan for it or estimate income (for services) from it;
- losing very experienced, qualified and dedicated staff in the near to medium term future;
- many roles becoming more administrative and less recovery/support/ case management focussed – exacerbating the loss of valuable staff; and
- workforce instability due to the need to employ people on a casual basis.[4]

This project identified tensions between minimum qualifications and/or the skills required to undertake NDIS psychosocial disability services. An outcome of the impact of this on the recruitment practices of providers was likely to be individuals being employed with skills that may be adequate for most of the time undertaking 'core' support work, but unsuitable for consumers mental health issues to be properly understood.[5] The report recommended that the Federal Government develop quality assurance processes specifically for psychosocial support services as part of the NDIS Quality and Safeguarding Framework.[6] CMHA included in the 2017-18 Federal Pre-Budget Submission the need for the development of these quality assurance processes, in consultation and partnership with the community managed mental health sector.[7]

Working with the PHNs

Funding for a number of federally funded mental health programs has transferred to the responsibility of the PHNs, to be included in a flexible mental health funding pool from which PHNs will commission services based on regional planning and needs assessments, including joint planning with state, territory or local area health services. They are also required to undertake a stepped care approach to providing services. The guidance documents developed to assist the PHNs on the implementation of the reforms, and which outline the expectations of them, includes the directive that PHNs cannot commission psychosocial services. It states they can promote links to broader services, recognising these services are vital, but they are not within their scope.[8]

The PHN's will continue to be a significant commissioner of mental health services and will have an impact on the workforce that is developed and engaged to deliver these services. A restriction on commissioning psychosocial services has the potential to impact the viability of the community mental workforce with the major source of federal funding being directed focused on clinical and not community based support.

Investment in psychosocial mental health services is vital in all areas, particularly in rural and regional areas where less services are available and hospital can be the only option for people. A report from the

[4] Human Capital Alliance (2015) Final Report: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Project, October 2015.
[5] Ibid
[6] Ibid
[7] Community Mental Health Australia 2017-18 Federal Pre-Budget Submission, http://www.treasury.gov.au/~/media/Treasury/Consultations%20and%20Reviews/Consultations/2016/2017%20Pre Budget%20submissions/Submissions/PDF/Community%20Mental%20Health%20Australia.ashx
[8] Primary Mental Health Care Services for People with Severe Mental Illness. PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance. Department of Health Australian Government.

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Australian Institute of Health and Welfare (AIHW) *Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013-14*[9] examined local-level variations in populations across the 31 PHNs and smaller local areas. The report showed that people living in regional areas were more likely to be hospitalised for a mental health condition or intentional harm. This demonstrates further the need for PHNs across all areas, but particularly in rural, regional and remote areas, to commission the services that their needs assessments and planning identify, to stop people living with a mental illness from having the acute system as their only option, and building the community-based workforce to deliver the services that are needed.

CMHA supports the approach of providing regionally planned and based services, however, psychosocial services should be included in the services the PHNs are able to commission from their flexible mental health funding pool. The services they are able to commission should be as is reflected in their joint planning with state, territory or local area health services, and the planning and needs assessment work they have undertaken.

The importance and value of peer workers as a part of the mental health workforce

A recovery approach is at the centre of psychosocial approaches to addressing mental illness, and a vital part of this and the overall mental health workforce is the peer workforce. The following description encapsulates the important of peer workers:

> Peer work creates an environment for recovery where the intentional use of lived experience inspires hope, confidence and a sense of empowerment while working with people to build a meaningful life.[10]

The peer workforce has grown significantly in Australia, with community based organisations delivering programs across a range of service types, including family and carer support and education, viewing the peer workforce as an effective part of the existing workforce. Based on international evidence and identified sector need, the Community Services and Health Industry Skills Council (CSHISC) developed the Certificate IV in Mental Health Peer Work to meet the needs of this emerging workforce. Also acknowledged is the need for a skill set for peer workers who are in leadership, mentoring or senior roles.[11]

A report by the University of Melbourne and Mind Australia examining the effectiveness of early intervention strategies for people with psychosocial disability, found that Peer Support improved the recovery aspects of all interventions examined, which included the areas of employment, housing, education, networking and social skills, and health managements. It concluded that Mobile Support and Treatment Teams or Assertive Community Treatment (ACT)/Outreach, while not directly funded supports

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[9] Australian Institute of Health and Welfare 2016. *Healthy Communities: Hospitalisations for mental health conditions and intentional self-harm in 2013–14*. Cat. no. HSE 177. Canberra: AIHW.

[10] Victorian Government (2015) Components of effective mental healthcare: Treatment, community-based rehabilitation and disability support. Draft Discussion Paper – December 2015. Victorian Government: Melbourne

[11] Mental Health Peer Work Qualification Development Project, Mental Health Coordinating Council, http://www.mhcc.org.au/sector-development/workforce-development/peer-work-qualification-project.aspx, Accessed 1 May 2017

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of the NDIS, could be adapted to assist in the engagement and coordination of supports for people who are reluctant to engage with mental health services.[12]

National mental health workforce strategy

A key piece of policy work that is required is an examination of the overall workforce in mental health, including the community mental health sector, to ensure there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of mental health reforms that are occurring.

The workforce strategy should provide particular assistance to the consumer and carer peer workforce (both paid and volunteer), including to prepare for the NDIS. This should build the capacity of this workforce to assist consumers and carers to access the scheme productively. Along with a strategy for peer workers, key areas of need such as the Aboriginal and Torres Strait Islander, rural and remote and early childhood workforce should be a focus and part of the strategy.

CMHA's 2017-18 Federal Pre-budget submission recommended a National Mental Health Workforce Strategy be undertaken to develop, support and maintain the mental health workforce. This should include the community mental health sector, the mental health peer workforce, and the primary health workforce[13]. The Implementation Plan for the Fifth National Mental Health and Suicide Prevention Plan includes the development of a Workforce Development Program to guide strategies to address future workforce supply requirements and assist with recruitment and retention of staff. The inclusion of the community mental health workforce in this Program will be vital, as the various reforms in mental health are having an impact on the workforce in community-managed mental health sector.

Addressing specific population groups

The workforce in rural and remote areas

With the community-managed mental health sector, there is concern about engagement with and access to, for example, the NDIS for those people who experience social and geographic isolation in rural and remote regions. Feedback from community mental health organisations is that these people are often hard to reach and generally not engaged with services due to lack of knowledge of the availability of services and supports. For many of these people experiencing mental health issues, access to appropriate and understandable information is challenging.

The Queensland Mental Health Commission's rural and remote action plan discussion paper makes the point that mental health professionals work with minimal specialist backup and other members of the community are often called on to provide support. Distance, difficulty retaining experienced staff and constraints on available resources were a part of the challenge. It was therefore important to engage and up-skill local service providers, as they have the trust of the community, and to engage key local

[12] Hayes, L Dr. et al, (2016) Effective, evidence-based psychosocial interventions suitable for early intervention in the National Disability Insurance Scheme (NDIS): promoting psychosocial functioning and recovery. The Centre for Mental Health, Melbourne School of Population and Global Health.

[13] Community Mental Health Australia 2017-18 Federal Pre-Budget Submission, http://www.treasury.gov.au/~/media/Treasury/Consultations%20and%20Reviews/Consultations/2016/2017%20Pre Budget%20submissions/Submissions/PDF/Community%20Mental%20Health%20Australia.ashx

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community members and develop resources that make it easier for local service providers to access more people through property visits and community events.[14]

Aboriginal and Torres Strait Islander workforce

A central issue for the Aboriginal and Torres Strait Islander workforce is the need to build the numbers and capacity. Relevant to consider is the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP), which examines the evidence-base of what works in Indigenous community-led suicide prevention. The report identified that a common success factor in community-based interventions or responses to Indigenous suicide was development and implementation through Indigenous leadership and in partnership with Indigenous communities. The responses needed to address cultural and lived experience, and the right of Indigenous people to be involved in service design and delivery as mental health consumers. It also identified that the aim should be to employ community members, and that peer support was a feature of a number of successful programs.[15]

Understanding cultural relevant factors

A key issue for any scheme, organisation or body providing appropriate services is an understanding of not just mental health and psychosocial disability, but culturally relevant factors. For example, planners in the NDIS need to have an understanding of mental illness, coexisting conditions and psychosocial disability, and the impact these have on the entire planning process and future needs of the consumers/ participants. Many Aboriginal and Torres Strait Islander people will have elements of post-traumatic stress disorder (PTSD) due to their cultural background, therefore culturally relevant factors need be a significant consideration.

Outreach will be a significant consideration in addressing the challenges in engaging Aboriginal people with psychosocial disability, and there is currently no outreach component in the NDIS. This will also be the case for other vulnerable and disengaged populations including Culturally, and Linguistically Diverse (CALD) communities and people who are homeless.

Issues and actions

Below are issues and actions identified by CMHA, in order of priority. It is the position of CMHA that:

- The hourly rates included in the NDIS pricing structure must incorporate the level of skills and expertise required to provide support to individuals with psychosocial disability.
- Quality assurance processes specifically for psychosocial support services must be developed as part of the NDIS Quality and Safeguarding Framework. This must be developed in consultation and partnership with the community managed mental health sector.
- A key issue within the pricing structure of the NDIS is accommodating different levels of complexity and reflecting the costs of providing reasonable and necessary levels of care. The NDIS must make allowances for the cost of supporting people with more complex disability, which could be used to increase support when it is needed.

[14] Queensland Mental Health Commission (2016) Towards a Queensland rural and remote mental health and wellbeing action plan. Discussion Paper. March 2016.

[15] Dudgeon, P Professor et al., (2016). Solutions that work: what the evidence and our people tell us, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report. University of Western Australia: Crawley, WA

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- Psychosocial services should be included in the services the PHNs are able to commission from their flexible mental health funding pool. The PHN's will continue to be a significant commissioner of mental health services and will have an impact on the workforce that is developed and engaged to deliver these services.
- A recovery approach is at the centre of psychosocial approaches to addressing mental illness, and a vital part of the peer workforce.
- A key piece of policy work that is required is the development of a National Mental Health Workforce Strategy to ensure there is an informed and properly planned approach to developing, supporting and maintaining the workforce to deliver the range of mental health reforms that are occurring.
- A central issue for the Aboriginal and Torres Strait Islander workforce is the need to build the numbers and capacity. The responses needed to address cultural and lived experience, and the right of Indigenous people to be involved in service design and delivery as mental health consumers.
- A key issue for any scheme, organisation or body providing appropriate services is an understanding of not just mental health and psychosocial disability, but culturally relevant factors. Outreach will be a significant consideration in addressing the challenges in engaging vulnerable and disengaged populations including Aboriginal and Torres Strait Islander communities, Culturally, and Linguistically Diverse (CALD) communities and people who are homeless.

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