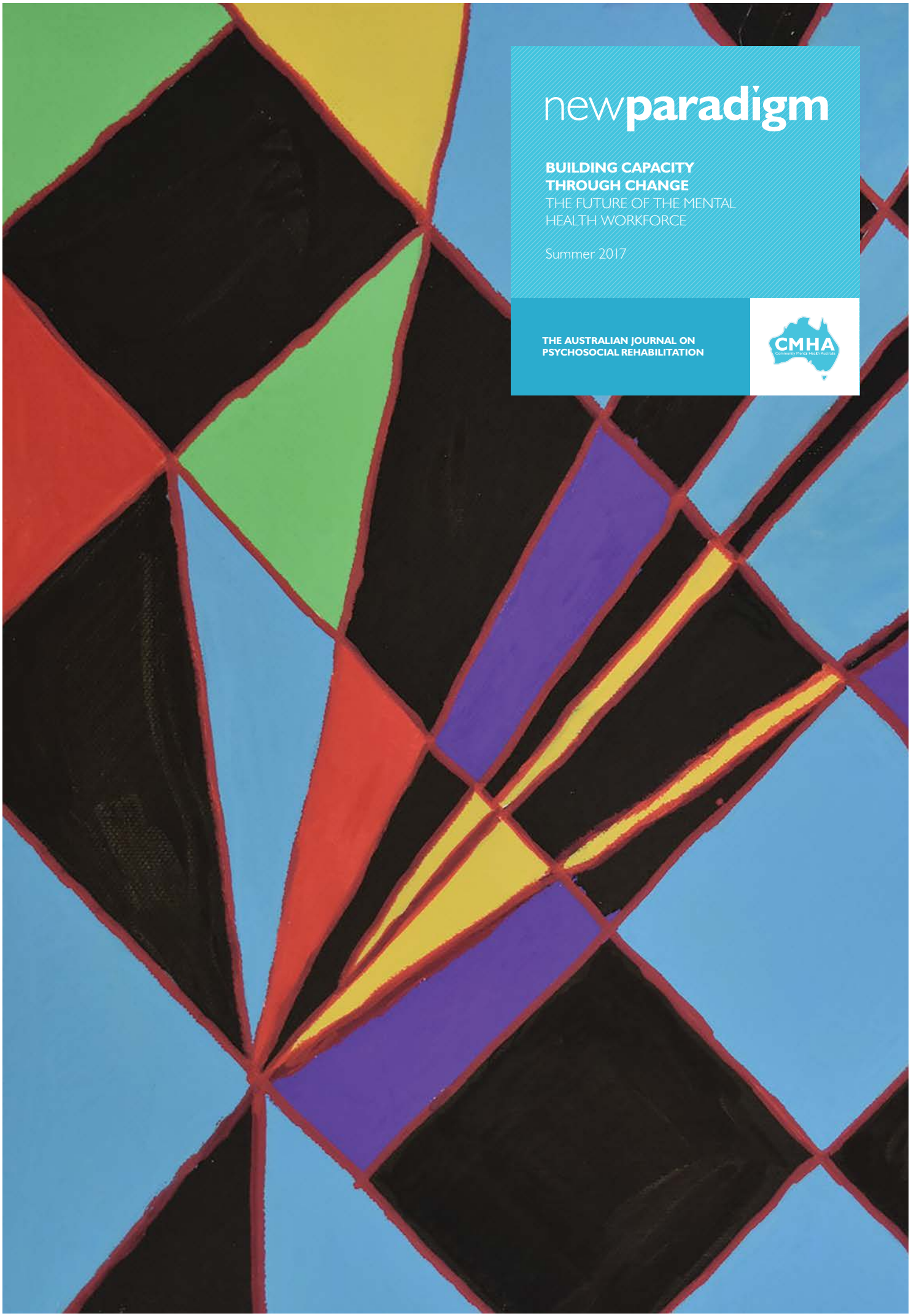

newparadigm

BUILDING CAPACITY THROUGH CHANGE

THE FUTURE OF THE MENTAL HEALTH WORKFORCE

Summer 2017

THE AUSTRALIAN JOURNAL ON PSYCHOSOCIAL REHABILITATION

CONTENTS

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- Brief articles should be approximately 500 words
- Letters to the editor should be under 300 words
- All articles should state:
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  - » the author(s) name
  - » the author(s) position or preferred title
  - » an email address for correspondence
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EDITORIAL

Welcome to the new look *newparadigm*.

Debra Parnell is the Interim CEO at VICSERV

We are very pleased to be presenting *newparadigm* under the banner of Community Mental Health Australia (CMHA), increasing our capacity to represent issues from across Australia, and to broaden our reach into new and expanding networks.

To mark this milestone in the Journal's development, it seemed appropriate to focus on an issue which is strategically significant for the mental health community, and holds challenges, and opportunities, that may have long term impacts across the sector.

As NDIS is implemented and evolves, the current skilled mental health workforce is shifting, developing, and potentially being lost along with along with it. This edition reflects the extent that the National Disability Insurance Scheme (NDIS) is driving change, thinking and activity for mental health organisations and their workforce. But it is not the only matter of relevance for the mental health sector – the growth of the peer workforce is an exciting development that is yet to be fully realised, in a range of contexts and settings, and workforce development and capacity remains an important consideration across the reform environment.

We open the edition with an introduction by Elizabeth Crowther, President of CMHA, who outlines the significance of this collaboration approach to *newparadigm* and the important steps CMHA are taking to fulfill its role at the national level.

In line with this, a second piece under the CMHA banner, outlines the issues it has identified in collaboration with its member organisations, on the transition to NDIS for mental health organisations, workers and consumers. It is based on a CMHA position statement, in which the need for a national mental health workforce strategy is identified as key to supporting and maintaining a robust and effective mental health workforce.

Tina Smith, Senior Policy Advisor with the Mental Health Coordinating Council (MHCC) provides an overview of a key piece of research conducted under the banner of CMHA and led by MHCC. The *Mental Health Workforce Scoping Project* provides valuable insight, recommendations and guidance on workforce issues across a range of health/mental health and disability/social care reforms underway in Australia. Future funding opportunities under the Workforce Innovation Fund may provide the means to continue the discussion about NDIS workforce and its needs within a mental health context.

We are delighted to present a thought provoking article by Sebastian Rosenberg, whereby he provides a valuable overview of the history of the mental health policy environment. He takes a positive approach to the opportunities and challenges facing community mental health, endeavouring to chart a positive course to a situation where community mental health is the main domain of care – as was first described in early mental health plans and policies. This article provides an important backdrop for much of the discussion that will ensue about workforce and the future role of community managed mental health.

We have delved into the experiences of organisations in two states that have already begun transitioning to the NDIS – Flourish Australia in NSW and Neami National in Victoria. These two very different experiences indicate the extent of the challenges, and the opportunities, for organisations in transitioning, developing and maintaining their workforces.

With the impacts of the implementation of NDIS being so significant in Victoria (as a result of the State Government's commitment to rolling most of its community mental health programs into NDIS) we have highlighted some of the workforce developments in that state. John Katsourakis outlines some of the significant work being done to meet the disruptions of the NDIS, and Andrew Fleming, Executive Officer of the Community Services and Health Industry Advisory Group, discusses some of the training initiatives underway, including the establishment of a new Office of the Victorian Skills Commissioner, that will tackle some of the workforce issues that are emerging.

In the interest of broader mental health workforce and workplace issues, we move away from the immediate issues posed by the NDIS, to also consider mental health practice developments:

- The National Mental Health Consumer and Carer Forum provide valuable discussion on 'reasonable adjustments' and challenges the community mental health sector to model good practice in responding to the needs of employees with mental illness; and
- Jenny Branton, Executive Officer of Mental Health Carers Australia, discusses a practical guide developed for working with carers of people with a mental illness, and how its adoption could change practice

Finally our ***vox pop*** in this edition asks the State and Territory community mental health peaks to reflect on the workforce priorities, challenges and opportunities for the workforce across Australia.

I hope you enjoy this landmark edition of *new****paradigm***, and that you find the information and ideas presented through these articles, thought provoking and valuable.

I would like to thank the contributors who have made this a very interesting and stimulating edition of *new****paradigm*** and to the new Journal Editorial Group, with representatives from CMHA and each State and Territory member organisation, who have endeavored to reflect the issues and interests of the mental health sector across the country. Finally I thank the VICSERV team for their valuable assistance in the production process.

BUILDING CAPACITY THROUGH CHANGE

The future of the mental health workforce

*new**paradigm*** – reflecting the changes in community managed mental health

Elizabeth Crowther is President of Community Mental Health Australia

This first edition of *new**paradigm*** under the Community Mental Health Australia (CMHA) banner marks the growing need, capacity and determination of the community managed mental health (CMMH) sector in Australia to influence change at a national level.

It not only represents the strengthening voice and goals of the CMHA but a new chapter for *new**paradigm*** in its widely-respected role of encouraging discussion and information sharing on mental health issues, research, policy and service provision in Victoria and beyond.

As many readers will know, changes within the community managed mental health (CMMH) sector have been ongoing for many years and prompted state and territory peak bodies to establish informal working relationships to understand developments in each jurisdiction.

As this process developed, this informal group wanted to advocate for the sector and be able to influence state, territory and Commonwealth developments in mental health.

However, as a non-incorporated group, we were dependent on others to deliver our messages. Mental Health Australia became an important ally during this period and remains an important partner in our national advocacy. Additionally there were opportunities for pieces of work through tender processes that clearly fitted within the remit of the group – however we were constrained from undertaking these activities because of our legal status.

From this need Community Mental Health Australia was incorporated in 2013. Each state and territory agreed to contribute financially and with expertise to establish this organisation. A Board was formed, consisting of the State and Territory Presidents, and an Executive Leadership Group (ELG) which was made up of jurisdiction CEOs.

The aims of the organisation are to:

- improve access to and quality of mental health services and supports available for people with mental illnesses by representation
- support the development of the community managed sector
- develop policy and undertake advocacy at a national level.

In order to support this development each state and territory organisation has committed to take on an organisational role. This has enabled organisational growth, the establishment of policies, financial accountability and growth. We have also continued to develop our advocacy and policy agenda, having input into national developments including the National Disability Insurance Scheme (NDIS).

As a result of this collaborative approach, CMHA has been awarded funding and has built a national voice. We have now appointed our first Executive Director – Amanda Bresnan – who has already met with key national figures to put forward our issues and solutions.

As our successes have grown, so too have our communication needs.

*new**paradigm*** has a long and valued history as a journal both in Victoria and nationally. It is a key communication platform for the CMMH sector and more broadly in the mental health sector, where it has a national reach.

We are delighted that VICSERV has agreed to partner with CMHA in the production of the journal, a joint venture that will more effectively and efficiently advance our common interests in CMMH development by pooling resources, ideas and reach of readership.

We are delighted that VICSERV has agreed to partner with CMHA in the production of the journal, a joint venture that will more effectively and efficiently advance our common interests in CMMH development by pooling resources, ideas and reach of readership.

This collaboration will see *new**paradigm*** extend its reach and reflect more comprehensively national issues in mental health and developments across states and territories.

Under the collaborative production arrangement each edition will strive to represent Australia-wide mental health issues and involve contributors from across Australia, with the content determined by a Journal Editorial Group (JEG), which will comprise a representative from each peak community mental health organisation and CMHA.

The role of the JEG will include:

- Informing the direction of *new**paradigm*** through identification of issues of interest to Community Managed Mental Health Services (CMMHS) and their stakeholders – this may include policy and practice issues and trends which could impact aims or activities.
- Informing the development of articles for publication through identification of potential themes, articles, topics and contributors.

I am proud to present this first edition of the *new**paradigm*** under the CMHA collaborative banner and hope you will find much of interest to read in this and future editions.

Challenges and opportunities for community mental health in Australia

Sebastian Rosenberg is a Senior Lecturer at the Brain and Mind Centre, University of Sydney

It is a critical and exciting moment for the community mental health sector in Australia. Shifts in policy and funding are creating more flexibility in the system.

These changes, across Primary Health Networks (PHNs) and the National Disability Insurance Scheme (NDIS) pose challenges for the sector. Old style, ongoing or long term contracts for service provision between government funders and non-government service providers are becoming relics.

At the same time, new models of professional, efficient care are emerging in the sector. Anachronistic and unhelpful dichotomies between the clinical and non-clinical aspects of contemporary mental health care are being blown away.

How can the sector understand these shifts and take best advantage of new opportunities? This article aims to review this environment and chart a positive course – a course that will lead to a situation first articulated decades ago as part of original mental health plans and policies. This is a place where community mental health is the main domain of care, not an afterthought or add-on.

Background

There is probably a perception in the community that resources for mental health have increased recently. The data suggests otherwise. Despite recent high profile appointments, commissions and media campaigns of various sorts, the mental health share of the overall health budget has actually declined in the past five years.
This is shown below in Table 1.

Table 1: *Health and mental health spending*

Year	Health spending ($millions)[a]	Mental health spending ($millions)[b]	Mental health %
2009 – 10	130,582	7,014	5.4%
2010 – 11	139,826	7,439	5.3%
2011 – 12	148,304	7,684	5.2%
2012 – 13	150,000	7,808	5.2%
2013 – 14	154,633	8,011	5.2%

a. Australian Institute of Health and Welfare, Health expenditure Australia 2013–14, total health spending in constant prices, p.6.
b. Australian Institute of Health and Welfare, Mental Health Services in Australia, Expenditure by source of funding constant prices.

While there has undoubtedly been growth in mental health funding, especially in relation to federal spending on the Better Access Program, spending on mental health has simply failed to keep up with the overall growth in spending in health.

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While there has undoubtedly been growth in mental health funding, especially in relation to federal spending on the Better Access Program, spending on mental health has simply failed to keep up with the overall growth in spending in health. Medicare data indicates the Federal Government is investing around $15 million each week on Better Access, which aims to improve community access to mental health professionals and team-based mental health care. This spending has apparently lifted the rate of access to care from 35 per cent in 2007 (Australian Bureau of Statistics, 2008) to 46 per cent in 2014 (Whiteford HA, et al, 2014).

In relation to state and territory spending, it is also pertinent to look where spending growth has occurred. This is shown in Table 2 below.

Table 2: *States and Territories, Areas of mental health spending, annual change (%) 2009–10 to 2013–14*

Area of mental health service expenditure	% Change
Public specialist psychiatric hospitals	-2.4
Specialised psychiatric units or wards in public acute hospitals	3.5
Community mental health care services	0.4
Residential mental health services	2.2
Grants to non-government-organisations	3.0
Other indirect expenditure	1.2
Total state/territory expenditure	**1.3**

The main area of spending increase has been public acute hospital services. Grants to non-government organisations (NGO) have also increased but from a very low base. At the start of the National Mental Health Strategy in 1992, these grants accounted for $2.21 of the $108.88 (2 per cent) spent on mental health per capita in Australia by the state and territory jurisdictions. By 2013–14, the NGO share of the per capita figure was $15.52 out of a total of $210.59 (7.4 per cent). By contrast, in 1992 public hospital mental health spending accounted for just over 20 per cent of per capita spending. By 2013–14, it was one third of per capita spending in the states and territories (Department of Health, 2013).

A further complication here is that what is reported as 'community' mental health services in fact includes hospital outpatient/ambulatory services.

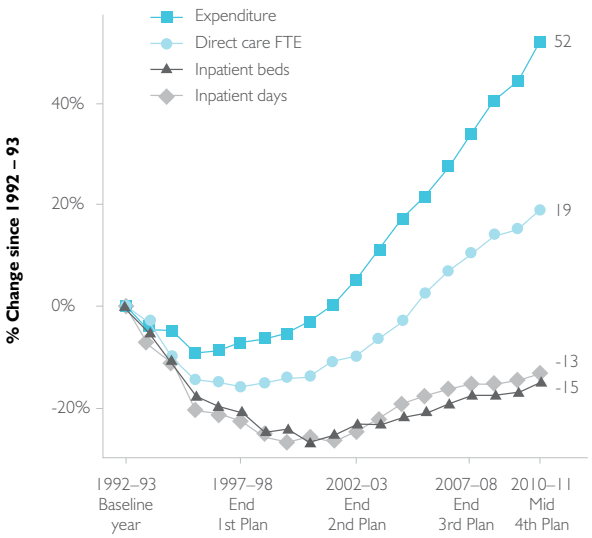
Service 'preference'

It is not possible (for me anyway) to separate the genuine 'community' mental health services provided by jurisdictional mental health services from those services provided at hospital outpatient clinics. While Table 2 indicates no real growth in spending on community mental health services, there has been an extraordinary growth in services.

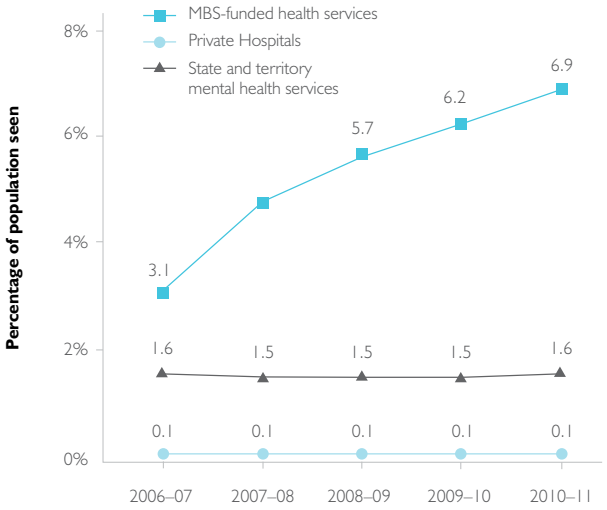
The 6.6 million 'service contacts' in 2009–10 had grown to 8.7 million by 2013–14 (Australian Institute of Health and Welfare, 2016a). The most frequently recorded type of community mental health care service contact was with an individual patient (as opposed to occurring in a group session) and a duration of 5–15 minutes. I think it is very likely that the great majority of supposed 'community' service contacts are in fact hospital outpatient services and phone calls. This would accentuate further state and territory preference for directing spending towards hospital rather than other services.

There is in fact very little evidence to support this clear preference (Thornicroft G & Tansella M, 2003). Rather than hospitals as the locus of care in the mental health system, contemporary thinking suggests a balanced approach, where community is the main location of care and support with hospital services provided as back-up, only when necessary. An unpublished national survey of ward managers indicated 43 per cent of all psychiatric inpatient beds in public hospitals were occupied by people who would be better off in other settings, if there were any services to which they could go.

Pic 1: *Expenditure and FTE*



Pic 2: *Access rates*



Pic 1, taken from the 2013 National Mental Health Report, shows that while spending has increased by 52 per cent and full time equivalent staffing in hospitals by 19 per cent since 1992–3, the number of beds and inpatient days has actually declined. This probably explains why state and territory mental health services have failed to lift their rate of access to care, as shown in Pic 2.

Australia's over-dependence on hospital-based care is expensive and inefficient. But shifting this has proven problematic. In April 2015 the National Mental Health Commission called for the staged redirection of hospital growth funds towards community-based services (Corderoy A, 2015). In an environment where the Commission's report had been leaked rather than presented, the Federal Government chose not to respond to the report with the sole exception of confirming that no such transfer of funds would occur.

This was of course not how things were supposed to end up. Years of mental health plans and policies, both federal and state, in fact emphasised the centrality of community mental health, going back right to the start.

An integrated program should ensure continuity of care and a balanced mix of community and inpatient services

National Mental Health Policy 1992

Despite these repeated commitments, across five national mental health plans, two national policies, one roadmap, one national action plan, one national review and two report cards as well as countless state and territory plans, mental health in Australia remains massively underfunded with spending heavily skewed towards hospital-based care. Against this backdrop, and with some notable exceptions, community mental health has struggled to emerge as more than a peripheral element of Australia's mental health service landscape.

Australia's over-dependence on hospital-based care is expensive and inefficient. But shifting this has proven problematic.

The issue here is that nobody 'owns' community mental health – governance is unclear.

Key challenges

Into this historical context now arrive a set of new challenges confronting the sector.

Primary Health Networks

The Federal Government has recently chosen to drastically reduce its role in mental health services, instead pursuing a devolved model of governance with responsibility shifted to 31 Primary Health Networks (PHNs). These PHNs now have responsibility for planning and commissioning of primary mental health care services, including programs like Better Access and Access to Allied Psychological Services (ATAPS), as well as Indigenous and suicide prevention services. The relationship between the PHNs and the community mental health sector is evolving, as PHNs attempt to discharge their obligation to prepare regional mental health plans.

Governance

Different levels of government have historically been responsible for different areas of mental health. While federal governments have been responsible for primary care, the states and territories have managed tertiary care.

One of the curious characteristics of mental health in Australia has been the inability to assert or define the role of secondary care. Secondary care has traditionally been seen as the place a person goes if their mental health problem cannot be managed in primary care. Access to secondary care was traditionally predicated on referral from primary care, typically the GP.

Particularly in the 1980s, led by pioneers like Professor Alan Rosen, Australia developed a range of acute and continuing care services, typically delivered in a community mental health centre or clinic with street frontage in a local neighbourhood (Rosen A, 2012). Premises were often shared between practitioners in co-located teams. From here it was possible to provide acute assessment and treatment in a community setting on a mobile basis at extended hours, seven days a week. Assertive outreach teams were set up, again operating every day, for people with ongoing or recurrent serious mental illness and associated disabilities.

These kinds of services also linked to GPs and made it practical and possible for people with mental illness to live in the community. These clinical community mental health centres are now rare, with the great majority of clinical mental health services strictly available on the campus of the hospital in either inpatient or outpatient settings, not on the high street.

To these secondary clinical services was also added, albeit in a most limited way, an array of psycho-social support services, commonly offered by non-government organisations, some of whom had been operating in Australia for decades. However, and as stated earlier, limited funding into the community mental health sector meant these services remained marginal – people were lucky if they got them.

The stunted history of secondary mental health care in Australia explains a lot of the gaps into which people now commonly fall. It is very difficult to obtain a mental health service between the general practitioner and the emergency department of a public hospital. Federal governments had begun to invest in these services over the past decade, with the Personal Helpers and Mentors, Partners in Recovery, Day to Day Living programs and so on. These investments will now be limited as these programs have been corralled for recipients of the National Disability Insurance Scheme (NDIS).

The issue here is that nobody 'owns' community mental health – governance is unclear. It is neither a federal nor state responsibility to grow non-hospital mental health service alternatives. It seems very unlikely the 5th National Mental Health Plan, due out shortly, will address this issue.

Packages of care and the NDIS

Governments seem more focused on arranging individualised packages of care than pursuing population health-type approaches to planning and funding in mental health.

Mechanisms like the NDIS are predicated on concepts like 'autonomy' and 'choice', permitting governments to absent themselves from their previous responsibility for service planning and delivery. Instead, responsibility is handed over to individuals and their 'brokers' to arrange care. Longer term contracts or block funding arrangements between governments and non-government service providers are becoming rare, which makes planning and workforce development in the community mental health sector impossible.

The full impact of the NDIS is still to be understood. There are concerns that the Scheme's focus on the most disabled (Tier 3) leaves huge numbers of people with mental illness at real risk of being unserviced (NDIS MI Way, interview). This is because the funding for the federal programs they used to access has been shifted to the NDIS and they find themselves no longer eligible for care. Mental health was a late-comer to the scheme and details about who will be eligible and how are yet to be resolved.

How also to fit the episodic nature of mental illness into insurance arrangements originally designed to meet the needs of people with permanent conditions? In a mental health context, terms like

'permanent' fit poorly with a concept like recovery. Evidence emerging from NDIS trial sites indicates that people's experience with the scheme varies considerably and depends a lot on the individual understanding of mental illness of the NDIS planners. There was also recent concern about the 'closure' of the Scheme to new participants in the Australian Capital Territory (ACT), with numbers well short of the expected level of participation by people with a mental illness.

Data

Community mental health services have struggled to demonstrate their impact due to a lack of data. There is lots of data in relation to hospital-based care, but very little for non-hospital care which can generate a fuller picture of the impact of mental illness on a person's life. Issues like housing, employment, education and social inclusion generally go unmeasured and unreported. Systems for community sector reporting have not been funded. This leaves the sector largely unable to demonstrate or report on the quality, efficiency or efficacy of care other than through specific, often one-off, self-funded research or surveys.

As an important side note, 2017 will mark a decade since the last National Survey of Mental Health and Wellbeing (carried out by the Australian Bureau of Statistics). I understand there are no current plans to replicate this survey, leaving Australia in danger of making uninformed policy and funding decisions.

Workforce

Surveys conducted in 2010 and 2011 (Australian Institute of Health and Welfare, 2016b) suggested that there were approximately 800 mental health NGOs in Australia with a total workforce in excess of 12,000 full-time equivalent employees. More than 40 per cent of the workforce had a bachelor degree or higher qualification in one of the health disciplines and 34 per cent had a certificate or diploma level qualification. More than 40 per cent of NGO organisations had been in operation for over 20 years.

As stated, changes like the NDIS have made it impossible to provide any certainty for staff working in the community mental health sector. Governments have also made it abundantly clear they wish to reduce the number of contracts they manage, sparking a round of mergers between NGOs. This process has tended to favour larger and more financially robust NGOs, with smaller, specialist NGOs opting to consider merging rather than extinction. All these changes mean that valuable and already-rare expertise in psycho-social rehabilitation is at risk.

At the same time, it is becoming clear that real demand and need for mental health services cannot be met by drawing on traditional health professional workforces alone (Reach Out, 2014). More innovative approaches to mental health workforce development are necessary, using paraprofessionals, peer workers and others.

Opportunities for the community mental health sector

Despite the significant challenges briefly set out above and the difficult historical context described, this has not prevented the emergence of a new and exciting range of services offered by the community mental health sector. Opportunities arise from this innovation.

First it is clear that the limitations of existing approaches to mental health care in Australia are well understood. Despite its restricted terms of reference, only really considering federal aspects of mental health care, the National Mental Health Commission's Review clearly showed the need to look beyond the Better Access Program as a cure-all.

Instead, it called for regional autonomy and flexibility, including concepts such as 'cashing out' of Medicare so as to offer new options for local people in the PHNs to respond to local mental health issues. PHNs are yet to fully embrace these opportunities but the authority to proceed is there. And with responsibility for care coordination and pursuing concepts such as 'medical homes', there is the prospect that PHNs will look to the community mental health sector to help them achieve their goals. There are also opportunities for the sector to press these issues in the course of construction of the 31 regional mental health plans. This local autonomy and greater flexibility should provide new opportunities for greater engagement by the community mental health sector.

While the fate of Activity Based Funding (ABF) remains somewhat in limbo nationally, including in relation to mental health, it should be clearly understood that a governing principle driving ABF is hospital avoidance. An old fashioned term not much used nowadays, hospital avoidance depends heavily on coordinated care between state-run hospital services and other services in the community. For example step up/step down services, several of which are run by community organisations, provide critical secondary mental health services. It is in the sector's interests to keep pressing for implementation of an ABF system that rewards investment in hospital avoidance.

The ABF approach also fits well with the concept of 'stepped care' as enunciated by former Health Minister Sussan Ley. As PHNs take up the challenge of conceptualising and implementing stepped care, it is vital the full extent of the consumer journey is understood. The steps extend from wellness through to acute care and back again in recovery. A stepped care model like this naturally runs through terrain where the community mental health sector has unparalleled expertise, particularly in creating the bridge between primary and tertiary mental health services.

For good or ill, the community mental health sector has been subject to considerable pressures. It has a flexibility and agility which means it can more quickly tailor and develop individualised services than can the public mental health system.

A related concept is Hospital in the Home (HITH) which offers individuals the opportunity to receive hospital level treatment delivered in their home, where clinically appropriate. HITH has a long history of application in mental health supported by solid evidence (Marks IM, et al, 1994) and is consistent with the approach of providing care in the community, closer to where individuals live. HITH is delivered by multidisciplinary teams including medical and nursing staff. People admitted into this program remain under the care of a treating hospital doctor.

It is worth noting that the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025 has set a target to shift approximately 20 per cent of its inpatient beds to HITH services by 2025. The trend towards HITH offers new opportunities for the community sector, particularly those that can offer services blending clinical and psycho-social support.

The PHNs also have a role in suicide prevention. Responsibility was shifted to the PHNs by the Federal Government partly in recognition of the failure of the LIFE (Living is for Everyone) framework to drive the suicide rate down. The National Commission has called for more localised approaches. Again, expertise in suicide prevention does not reside generally in the PHNs but in the community sector. This change provides new reason for engagement between the sector and the PHNs, as well as others. Addressing suicide requires holistic and coordinated care, not the traditional siloed approach.

And it is here that the community sector's strength can perhaps really emerge because of its willingness to evolve outside the traditional silos. For good or ill, the community mental health sector has been subject to considerable pressures. It has a flexibility and agility which means it can more quickly tailor and develop individualised services than can the public mental health system.

It is already doing so. There are numerous models of flexible mental health care offered by community sector organisations, incorporating both clinical and psycho-social aspects of care. These models span primary and secondary care, offering comprehensive services which address physical, mental and psycho-social needs. The sector is proving its capacity to effectively link and coordinate the different steps in stepped care, particularly for those people with complex needs. The type of services that have been built and are necessary to deliver solid community mental health support are shown below.

Elements of contemporary community mental health care

The Community Mental Health sector is a resource capable of bridging between primary and tertiary mental health, delivering recovery-focused services to people such as:

- Prevention and early intervention – short-term live-in or outreach support to prevent hospitalisation and after discharge.
- Centralised Intake and Assessment – to provide continuity of care across a range of services.
- Youth health clinics – offering multi-disciplinary care.
- NDIS Services – Coordinating supports under the National Disability Insurance Scheme.
- Individual outreach support – home and community outreach support to improve health, independence and wellbeing.
- Peer support – mentoring and connections through the lived experience, both in-vivo and online.
- Service coordination – expertise in managing different services and making sure people get all the support they need.
- Housing and Homelessness support – to help people find secure, affordable and safe housing.
- Helplines that provide information, guidance and referrals.
- Psychological counselling and therapy.
- Drug and alcohol counselling.
- Group activities that offer social connection and mutual support.
- Courses and workshops for skill building and helping people learn how to manage their health and wellbeing.
- Support for families and carers so they can have some respite from the demands of caring.

New players like PHNs and the NDIS are looking for guidance across a range of areas in which the community mental health sector is the expert.

The issue is that while the community mental health sector has built examples of these services, they are far from common. Step up/step down services represent one of the only community-based sub-acute mental health services available in Australia but the number of these services is probably less than a dozen.

A 2011 Council of Australian Governments (COAG) agreement in fact allocated some $1.6 billion towards new sub-acute beds, to be shared between rehabilitation, palliative care, mental health, geriatric evaluation and management and psycho-geriatric services in both hospitals and the community (Council of Australian Governments, 2011).

The fact this investment now looks like a one-off rather than continuing has elicited criticism (Poulos C, 2013). From a mental health point of view, there has never been any accounting for how its share of funding under this agreement was managed by the states and territories. Again, it is likely that several of them took the opportunity to build hospital-based overflow wards for which there is little or no evidence rather than invest in evidence-based community alternatives.

Conclusion

While the reform environment in mental health is as complex as it has ever been, there are some new opportunities which have arisen for the community mental health sector. They are driven by policies which support stepped care, individualised funding and more effective coordination and titration of services – the right service at the right time in the right place. New players like PHNs and the NDIS are looking for guidance across a range of areas in which the community mental health sector is the expert. There is also some recognition that the existing overwhelming preference towards hospital-based mental health care is a failed strategy. Alternatives to hospitalisation, reducing unnecessary hospital admission and hospital avoidance are becoming increasingly important concepts.

This year will mark 25 years since the first national mental health policy was launched in Australia. While some things have changed, rates of access to care remain too low, service quality is highly variable (and often terrible) and the system as a whole remains unaccountable. With funding shortfalls and unclear governance it is possible to suggest that mental health reform in Australia has stalled.

The most recent set of federal reforms seem designed to try to address this stall, offering the prospect of more regionally focused, flexible and individualised approaches. The community mental health sector is well-placed to capitalise on these trends, having already shown itself to be resilient and adaptable, capable of delivering holistic and recovery-focused mental health care. These are vital attributes on which the future of Australian mental health reform depends.

What is also key here is the sector's capacity to draw not only on its experience and expertise but on its wellspring of compassion and empathy. Perhaps a distinguishing feature of many community mental health services is their enduring interest in the health and welfare of their clients, embarking on relationships rather than occasions of service. This is both good care and a competitive edge.

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NDIS and its impact on the psychosocial disability workforce

Elizabeth Crowther is President of Community Mental Health Australia

State and territory community mental health organisation peak bodies are involved in the implementation and roll-out of the National Disability Insurance Scheme (NDIS) and have a strong understanding through their members of the impacts for service providers, consumers and carers.

This article outlines key lessons and issues emerging from a number of relevant studies and reports about the transition to the NDIS and its impact on participants, others with mental health issues, and the mental health sector.

It is important that these insights, particularly those from the community mental health sector, which is delivering services as they transition, are incorporated and lead to changes which will ultimately improve the quality of service that is delivered to consumers.

Responding to psychosocial disability

A key issue for Community Mental Health Australia (CMHA) with the NDIS overall is how it will respond to people with psychosocial disability to assist individuals to both reduce the disabling impacts of their illness (community-based rehabilitation including intervention, prevention and promotion) and gain high quality disability support.

Community managed mental health service providers prioritise community-based rehabilitation to support individuals to recover. Specific quality aspects of their work relate to the National Standards for Mental Health Services (or in some states specific psychosocial rehabilitation and support service standards). The sector has developed a workforce that is appropriately qualified and skilled to deliver these services and a culture that reflects the appropriate standards.

A key question now is how to provide an appropriate workforce base within the NDIS pricing and practice structure which, by comparison, references disability standards and is designed primarily to deliver disability support.

There seems to be a misunderstanding within the NDIS pricing structure over what constitutes psychosocial disability support and what constitutes psychosocial rehabilitation, with the skills and knowledge required to deliver these supports being different. The NDIS pricing structure is able to fund disability support but is unclear about its reach into more complex supports.

This creates a potential imbalance in the provision of mental health support which should deliver a balanced system of clinical treatment, community-based rehabilitation and disability support.

The 2015 *Developing the Workforce* report by CMHA, led by the Mental Health Coordinating Council (MHCC) in New South Wales, on the impact of the NDIS on the mental health workforce, noted that:

> It is important to acknowledge an overall perspective from the study that many service providers consider the NDIS to be a 'challenging' environment, with pricing constraints and perceived rigidity in the Catalogue of Supports (now the National Disability Insurance Agency/NDIA Price Guide) seemingly making it difficult if not impossible to remain faithful to a recovery model and to deploy and manage the workforce in a preferred manner.

A key question now is how to provide an appropriate workforce base within the NDIS pricing and practice structure which, by comparison, references disability standards and is designed primarily to deliver disability support.

The NDIS pricing does not officially set mental health sector workers' wages, however it does have a significant influence over wages that mental health organisations are able to pay their employees. Some stakeholders noted in the report that pricing was not sufficient to purchase a suitably skilled workforce that engaged in complex 'cognitive behavioural interventions' as well as direct personal care. Many survey respondents expressed a fear that quality is being compromised by insufficiently skilled workers being asked to perform higher level work.

(The *Developing the Workforce* report was commissioned and funded by the NDIS Sector Development Fund as part of an NDIS Capacity Building Project delivered by Mental Health Australia – see more detailed findings from the work in this edition by the MHCC on p26)

A report by VICSERV on the NDIS Barwon trial (2015) concluded that the NDIS wasn't effectively delivering rehabilitation focused services that, alongside disability support services, are important parts of the continuum of care for people living with a mental illness. The Victorian sector has urged the federal and state and territory governments to ensure both receive secure and ongoing funding.

In order to maintain and support the community mental health sector workforce and ensure the current quality of service continues through the transition to the NDIS, it is vital that the NDIS Quality and Safeguarding Framework develops quality assurance processes specifically for psychosocial services. These should include continuous improvement processes and be developed in consultation and partnership with the community mental health sector.

Need for a 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 managed 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.

A workforce strategy should support both the mental health workforce and primary health workers, especially GPs, to prepare for mental health reforms, including the NDIS. The inclusion of the community managed mental health workforce is crucial.

It should also provide particular assistance to the consumer and carer peer workforce (both paid and volunteer), including to prepare for the NDIS and build the capacity of the workforce to assist consumers and carers to access the Scheme productively. It should focus on key areas of need, including peer worker, Aboriginal and Torres Strait Islander, rural and remote and early childhood workforces.

The lack of a comprehensive national mental health workforce strategy to develop, support and maintain the mental health workforce has been a significant policy gap and means reforms which have a significant impact in the workforce have no guiding policy to account for these issues.

Funding appropriate community managed mental health services

A range of highly successful community managed mental health services will no longer be funded in various jurisdictions as the NDIS moves to full implementation. These services are primarily focused on community-based rehabilitation and their disappearance means that people will no longer have access to services that help them to reduce the disabling impacts of their mental illness.

The lack of a comprehensive national mental health workforce strategy to develop, support and maintain the mental health workforce has been a significant policy gap and means reforms which have a significant impact in the workforce have no guiding policy to account for these issues.

Mental health and the crucial concept of psychosocial rehabilitation cannot be simply made to fit a system which is focused on disability support.

This could have a number of consequences for the NDIS such as the potential for people to enter the Scheme with higher levels of disability over time.

Mental health and the crucial concept of psychosocial rehabilitation cannot be simply made to fit a system which is focused on disability support. We must ensure that mental health services are funded accurately through an appropriate mechanism. Not doing so may result in failure to deliver psychosocial services to people who should have received them and place additional pressure on the health and social services system.

Lending support to this position is work undertaken by the University of Melbourne and Mind Australia exploring effective evidence-based psychosocial intervention in the NDIS (Hayes L et al, 2016). This literature review points to a range of issues related to achieving long term outcomes for NDIS participants with psychosocial disability, reducing their long term reliance on the NDIS and reducing its long term costs. The work was presented to the Independent Advisory Council of the National Disability Insurance Agency Board.

Recognising differences between the states and territories

A key issue with the NDIS is that differences are occurring between states and territories.

There is a general guarantee in the bilateral agreements between the Federal Government and the states and territories for continuity of support to people who are transitioning from existing services to the NDIS. However, this guarantee is being impacted at different levels with states and territories and federally funded programs such as Partners in Recovery (PIR), the Day to Day Living (D2DL) program, and Personal Help and Mentors (PHaMs) transitioning to the NDIS.

Some states, such as Victoria, are ceasing to fund state-based psychosocial services or services that assist people with psychosocial disability, such as funding for transport related services. This situation is also partly due to NDIS transitioning occurring at different stages in different places.

The real risks to consumers, carers and services providers are that some services may cease once the NDIS reaches full implementation, that incomplete information makes it difficult for services and service recipients to plan, and that there is significant uncertainty for workers regarding future demand for their skills and knowledge.

There are estimates that only about 20 per cent of people already in federally funded psychosocial support programs will be eligible for similar supports under the NDIS. This obviously creates significant gaps which states, territories and the Federal Government must fill through a process of genuine collaboration.

The central issue, as noted earlier, is that the NDIS is not a mental health system and cannot replace it, so both disability and psychosocial rehabilitation and recovery services must be part of a continuum of support for people living with a mental illness. CMHA remains committed to the NDIS and the benefits that it can bring to the lives of people living with mental health issues. However, it is vital that governments work in partnership with our sector to resolve the concerns and issues that have emerged.

The experiences from the NDIS trial sites has demonstrated that support is required to transition the mental health sector, in particular the community mental health sector, to be ready and able to maintain services and support people within the NDIS. VICSERV's Barwon trial report (2015) recommended that, before full roll-out commenced, there needed to be better communication with all stakeholders, and support for organisational readiness at 12 months prior to the shift to a new model of care.

States and territories are at different stages of transition, timeframes, and terms of bi-lateral agreements. There are regional variations in terms of the type of targeted support required, population differences, and issues of distance for regional, rural and remote areas. Regionally based collective workforce development directions to identify innovations, in addition to national and/or state/territory-based approaches, are likely to derive a greater benefit from and also be more cost-effective.

A key issue is therefore facilitating transition for service providers and organisations. Communities of Practice (CoP) are an effective mechanism and have been successfully undertaken by CMHA member peaks in New South Wales and Western Australia. Lessons from these can inform the design of future CoPs.

As states and territories are operating under different timeframes and terms of bilateral agreements, support should be structured regionally rather than as a single national or single state and territory process.

Moving forward

The community mental health sector knows the make-up of its community and understand the needs expressed by consumers in their communities. The sector's skills, knowledge and experience should be utilised and built on through the NDIS reform process.

To this end, the CMHA recommends the following actions:

1. It is vital that governments work in partnership with community managed mental health service providers to develop solutions to the number of concerns and issues that have emerged.
2. To ensure a continuum of care for people living with a mental illness, the state, territory and federal governments must ensure secure and ongoing funding for both the NDIS and rehabilitation focused services.
3. State, territory and federal governments must take responsibility for and work together in genuine collaboration to ensure that people ineligible for the NDIS continue to receive appropriate services.
4. Mental health cannot simply be made to fit a system which is focused on disability support when psychosocial rehabilitation is a very different concept. To ensure provision of adequate supports, and to avoid placing additional pressure on the health and social services system, an appropriate mechanism to fund mental health services must be identified.
5. A National Mental Health Workforce Strategy that includes the community mental health sector, the mental health peer workforce, and the primary health workforce must be developed to support and maintain a robust and effective mental health workforce.
6. The NDIS pricing structure must consider the level of skill and qualification required across the mental health workforce spectrum, including pricing for complex supports.
7. There is a significant concern in the community managed mental health sector that quality is being compromised by asking insufficiently skilled workers to perform work that requires higher level capabilities. In order to maintain and support the community mental health sector workforce and ensure the current quality of service continues through the transition to the NDIS, it is vital that the NDIS Quality and Safeguarding Framework develops quality assurance processes specifically for psychosocial services.
8. States and territories are at different stages of transition, timeframes, and terms of bi-lateral agreements. There are regional variations in terms of the type of targeted support required, population differences, and issues of distance for regional, rural and remote areas. Regionally based collective workforce development directions to identify innovations, in addition to national and/or state/territory-based approaches, are likely to derive a greater benefit from and also be more cost-effective.

This article is based on a CMHA position statement – NDIS and Psychosocial Disability – which highlights the impacts of the National Disability Insurance Scheme on the psychosocial disability workforce.

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Transformation not transition: adjusting to the NDIS in Victoria

Glen Tobias is Victorian State Manager of Neami National and Me Well

Victoria is in a very different position to other states when it comes to the National Disability Insurance Scheme (NDIS), having already committed to rolling the majority of its non-government organisation (NGO) mental health services into the Scheme. This effectively means the NDIS is the only option for most people with mental health issues who require psychosocial support in Victoria.

In contrast, New South Wales has maintained (and increased) its NGO mental health funding and the NDIS is available as an additional support to people with psychosocial needs.

This creates a very different environment and unique challenges for the community managed mental health sector in Victoria. Most of what is currently block funded by the Victorian Department of Health and Human Services (DHHS) will cease to exist and some, but not all, existing services will be replaced by NDIS funded supports. Therefore, existing providers in Victoria don't just have to ramp up for NDIS service provision. They also need to 'ramp down' current services as consumers move across to the NDIS.

This has been termed the transition from block funding to client-directed funding but I believe that there is a fundamental flaw in perceiving this as a *transition* – it actually requires a paradigm shift both in thinking and in service provision. Organisations that think they can *transition* to the NDIS in Victoria are putting themselves at risk.

Lessons from the Barwon trial site

Most people in the mental health sector know by now about the failure of Pathways, the main provider of mental health recovery services and psychosocial support in the Barwon NDIS trial area. Its story should serve as a lesson to all services considering transitioning to provide NDIS supports. To my knowledge, Pathways is the first organisation to become financially unviable in an NDIS environment and failing to take note and learn from their experience would be a critical oversight.

While services in Barwon were always going to do it hard, being as they were the guinea pigs in the trial site, there is every likelihood that many more services will also fail to survive the enormous changes required to thrive in an NDIS environment.

Transition thinking is a mistake. Existing organisations that only know block funding will need to *transform*.

Pathways is an example of a block funded organisation that attempted, but failed, to transition successfully to NDIS service provision. When Neami acquired the service from the administrators we found a number of aspects of the service that had not been set up to suit an NDIS environment. In examining these aspects it became clear that many of the problems arose from an incomplete transition in both the organisation's thinking and practice.

It appeared that Pathways was reluctantly trying to transition. In doing so it had retained a number of systems, processes and practices that were familiar and had served them well under a block funded environment but had now become a millstone around their neck. Many other services will face this legacy problem as they try to transition to an NDIS environment. Services will be trying to undo up to 30 years of accumulated practice wisdom and systems that will no longer serve them well in this new environment.

Transformation rather than transition

Transition thinking is a mistake. Existing organisations that only know block funding will need to *transform*. In comparison, new organisations entering the NDIS space are being much more competitive and successful as they are not constrained by having to change anything.

Organisations that are best placed to achieve the transformation required are those that have a track record of innovation and a history of successful organisational change. They will be clear why they are moving into the NDIS space, not doing it just because they cannot think what else to do. They will have a vision and a model for NDIS provision. They will invest heavily in new infrastructure and systems and will take responsibility for their own transformation. They will collaborate with the National Disability Insurance Agency (NDIA) and seek solutions not create conflict: NDIA staff are under just as much pressure as we are. They will also have or recruit people with the required experience and skills – leadership, innovation, entrepreneurialism, business skills, customer relations and marketing.

It's not just the NDIA that is 'building a plane in the air'. So are services that are trying to transform from block funding to client-directed funding in the context of the biggest change to the sector ever, and within tight timelines.

Neami's approach

With the roll-out of the NDIS and the wind-down of federally funded programs – Partners in Recovery (PIR), the Day to Day Living (D2DL) program, and Personal Help and Mentors (PHaMs) – we are seeing a higher than usual turnover of staff, as would be expected in times of change. While this presents some problems in terms of continuity of service it also presents career opportunities for staff in the form of promotion and transfer possibilities.

The organisational structures and service delivery models required for the viable delivery of NDIS supports need to be fundamentally different to the models we have traditionally used to deliver block funded services. Neami has responded to this new environment and new requirements by setting up a new company – Mental Health and Wellbeing Australia (Me Well) – to operate in the client-directed funding environment of the NDIS. This requires a new business model, different work practices, a different workforce, and different business systems and infrastructure.

The organisational structures and service delivery models required for the viable delivery of NDIS supports need to be fundamentally different to the models we have traditionally used to deliver block funded services.

At the completion of the NDIS rollout we will have two companies designed for different purposes, each with very different funding arrangements, business systems, operations and staffing.

In Me Well we have a unique opportunity to use a new operating platform to evaluate new service delivery models under competitive market conditions in the Barwon region. This will allow us to more accurately evaluate how NDIS supports can be offered and delivered within NDIS funding parameters.

Culturally Neami has always had a can-do attitude and we are tackling the challenge with high energy, focusing not only on the risks but on the opportunities to innovate – and having fun during this time of change.

We expect that this new company, its organisational structure and its operating model will inform how we will deliver NDIS services in other locations.

While Neami National will remain strategically focused as a specialist mental health provider and Me Well will focus entirely as an NDIS provider there will be a necessary period of transition over the next three years while the NDIS is being rolled out. The ramp-up of Me Well will require the rollout of new systems and processes and recruitment and training of staff who can provide NDIS supports to transitioning and new consumers. A number of temporary arrangements will need to be put in place to achieve an effective transition for consumers and to ensure continuity of support for them.

However, at the completion of the NDIS rollout we will have two companies designed for different purposes, each with very different funding arrangements, business systems, operations and staffing.

Future plans

There are three main issues that are and will likely remain the focus for the next three years for Neami in Victoria:

1. Retain our existing workforce

   We are developing and implementing a number of strategies to retain our existing skilled and experienced workforce in the face of unprecedented change and uncertain times. We aim to retain the existing workforce for the following reasons:

   - we are committed to providing continuity of support to existing consumers so that they are assisted to transition to NDIS, and
   - new funding opportunities are beginning to arise through Primary Care Networks and government funding.

2. Recruit an NDIS workforce for Me Well

   We are focused on the timely recruitment of large numbers of staff to provide NDIS funded services to transitioning and new clients. This will be critical if transitioning clients are to have real choice of their service provider.

3. Be well positioned to capitalise on new funding opportunities

   In the midst of all this change it will be important to capitalise on new opportunities and to have the capacity to undertake and succeed in new ventures. Retention of our existing workforce will be critical to the success of new ventures.

New approaches to the workforce and workplace

Joanna Quilty is General Manager for NDIS at Flourish Australia

The adage 'our staff are our most important asset' is one that is frequently – and aptly – used by community managed organisations in relation to their work with vulnerable members of the community. Under the National Disability Insurance Scheme (NDIS) this adage takes on greater significance and resonance.

In a competitive marketplace, it is the frontline staff who embody 'brand' essence and who are crucial to attracting and retaining new business. They are the ones who connect, listen, and build relationships. It is the staff who provide the practical and emotional support, built on hope and empowerment, that is at the heart of recovery focused practice.

For the community managed mental health sector, the NDIS provides enormous opportunity to do more of what we do well. Embracing this opportunity will involve growing the workforce so that we have more staff reaching more people and supporting them to attain their goals and live participating lives.

However, along with opportunity, there is much uncertainty associated with the NDIS. This is not surprising given the scale and pace of the reform involved. A number of the most commonly voiced concerns about the NDIS relate to workforce issues: for example, that the NDIS will result in casualisation of the workforce, that it will mean lower wages and lower quality services, that it will be increasingly difficult for organisations to attract and retain high quality staff, and that workforce growth will not keep pace with funding growth.

It is true that there are many workforce challenges presented by the Scheme. However, our experience, as part of the Hunter trial site in New South Wales, suggests that none are insurmountable. Our process of embracing the challenge and trialling new approaches, then evaluating, learning and adapting, has proven successful in a changing and fluid environment.

Experiences from the Hunter trial site

When we commenced our involvement in the Hunter in 2013, approximately 17 per cent of our mental health services staff were based in the region. By the end of June 2016, that proportion had risen to 28 per cent, driven by the strong growth in the number of NDIS participants selecting Flourish Australia as their preferred provider. In fact, by the end of the trial, we were providing support services to 25 per cent of all people living with psychosocial disability who had obtained NDIS packages within the trial site.

The vast majority of the new staff employed by Flourish Australia to meet this demand are permanent staff members, with the proportion of the workforce that is casual remaining stable. These new staff have been employed under the same conditions and reflect the same mix of backgrounds, experience and pay levels as the rest of our workforce. In other words, the NDIS has not led to greater casualisation, lower rates of pay or a drop in the experience and qualifications that we expect of our staff.

We have needed to think carefully about matching the task to be performed with the skill level of the individual, and making the most of our experienced staff by focusing their efforts on the people whose circumstances are the most complex. This is good practice, whether in an NDIS environment or not.

Valuing lived experience

One of the outcomes of this workforce growth is the increase in the number of Flourish Australia employees with lived experience of mental health issues. In the Hunter, over the course of the trial, the proportion of staff who identify as having a lived experience of a mental health issue rose by approximately 13 per cent. The majority of this increase can be attributed to the seven-fold growth in the number of designated peer worker roles in the region over this period.

For Flourish Australia, the value we place on lived experience, and its role in informing day-to-day business and strategic direction, is a key point of difference and is central to our value proposition under the NDIS. This is reflected in our employment of people with lived experience at all levels of the organisation, the establishment of key roles as identified peer worker positions and the emphasis placed on a lived experience in recruitment and human resource processes. Approximately 50 per cent of our total workforce currently identify as having a lived experience. A significant contributor to this has been the opportunity for workforce expansion created by our early involvement in the NDIS.

As part of our commitment to valuing lived experience, Flourish Australia has created a peer support model which is embedded in our Recovery Action Framework and which leads the practice of peer work in Australia. For us, the value of peer work is unquestionable, and it sits well with the NDIS notions of choice and control and responsive, respectful service tailored to the needs and goals of the individual.

We have a commitment to growing our peer workforce to ensure people accessing our services can access a peer worker across our geographic footprint. Currently, approximately 25 per cent of our mental health services staff are peer workers, drawing purposefully on their own lived experience and recovery journey to support others. Our peer workers are fully integrated into local team structures, working alongside other mental health support workers as equals. They receive guidance, support and development to draw on their experience, manage their wellbeing and develop career paths.

The benefits of peer support are numerous, including reduced rates of hospitalisation, crisis and other service utilisation, better engagement with care, and higher levels of empowerment and hopefulness for recovery (Chinman et al, 2014). But it is more than this. As Associate Professor Julie Repper, an internationally recognised expert on peer support from the University of Nottingham's Faculty of Medicine and Health Sciences, says:

> 'Peers do not just change the experience of people using services. They also contribute to changes in the service as a whole. So long as the organisation is clear about their role, and all team members know what peers are employed to do, then peer workers can draw on their own experience to raise awareness of the limitations or drawbacks of current practice; they can challenge discriminating language and inhumane or 'othering' practices. This does make a difference' (Repper, 2016)

The strong workforce growth experienced as a result of our participation in the NDIS Hunter trial site has heightened our appreciation of making the right decisions during the recruitment process and making sure we select those who will truly embody our values and ethos.

Innovation in recruitment and practice

One innovative approach that we are trialling is the introduction of recruitment assessment centres. Rather than relying on the traditional written application and formal interview process alone, we are conducting assessment centres where a group of candidates come together for a day to participate in a variety of challenges and interactive scenarios designed to test their skills and capabilities in a 'live' setting. This provides an opportunity to observe interpersonal qualities, such as relationship building and teamwork, as well as the ability to put knowledge into practice and other attributes that fit well with the culture and values of Flourish Australia. While it is early days, there are indications that this approach is resulting in better recruitment.

The NDIS is also requiring us to rethink how we support our staff at the local level to maximise their contact and connection with the people they support. A key challenge is changing the focus from 'the office' as the locus where each day begins and ends, and where staff routinely return during the course of the day, to teams that are more mobile, autonomous and focused on being out in the field.

While the office is still important for providing staff support, connection and guidance, the NDIS is driving us to ensure that time spent there is purposeful and beneficial, not simply out of habit. In this environment, equipping staff with the right tools such as iPads, mobile phones and online resources is vital. Equally important is enabling staff to problem solve and feel confident to make their own decisions on the ground.

This is a significant shift from how many community managed organisations have traditionally operated under block grant funding arrangements. It is an approach that requires continual monitoring, fine tuning and adjustment in order to get the balance right. For Flourish Australia it is very much a work in progress.

There are certainly workforce challenges presented by the NDIS but they are perhaps not the ones we are commonly hearing about. They are challenges that require staff and managers to engage in a process of testing, refining and learning from new approaches together.

Quest for a new workplace culture

Our Hunter experience tells us that, in the main, staff are relishing the increased flexibility, autonomy and enhanced focus on face to face service delivery that the NDIS brings. And they are eager to be involved in discussions about other tools and strategies to increase mobility, face to face time and the sustainability of our NDIS approach.

Naturally, a more dispersed and mobile workforce brings challenges for managers in terms of providing the right information, tools and backup support to enable teams to get the job done. An example of this relates to the outreach support we provide in people's homes and the community. Our experience in coordinating flexible outreach services has highlighted that once a certain scale is reached, an effective automated scheduling system is vital. Time consuming manual, paper-based processes or face to face team meetings as the basis of allocating work aren't effective in a high volume, fast paced and changing environment. Rather, in this environment, modern and efficient back office systems are required.

Once again the feedback we are receiving from staff in the course of our testing of one such system is positive – they like the certainty of a portable electronic schedule provided in advance that seeks to organise their time in the most logical and efficient way possible, and gives them access to changes and updates in real time. They confirm that it is cutting down on the need for meetings, conversations and information exchange to work out what everyone is doing on a day to day basis.

In this context, managers need to change their approach and identify opportunities for continuous improvement in systems and processes in order to better facilitate excellent service provision. Over and above this, managers are needing to adopt a mindset that is less about dictating how and what needs to be done, and more about trusting staff and motivating and enabling them to do their best.

For Flourish Australia, this is pushing us in our quest for a workplace culture where staff are engaged, motivated and properly supported, and feel valued and empowered. A culture that not only benefits staff individually, but assists us as an organisation to recruit and retain the best. Ultimately this is what delivers great outcomes for the people we support.

There are certainly workforce challenges presented by the NDIS but they are perhaps not the ones we are commonly hearing about. They are challenges that require staff and managers to engage in a process of testing, refining and learning from new approaches together. And the opportunities and improvements that are arising as a result are plentiful.

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Developing the workforce: NDIS and the mental health workforce scoping project

Tina Smith is a Senior Policy Advisor/Sector Development for the Mental Health Coordinating Council (MHCC)

This article describes research undertaken by Community Mental Health Australia (CMHA) to scope the impact on the community managed mental health sector workforce of the National Disability Insurance Scheme (NDIS).

Among its findings and recommendations are the need to map the roles and skills of the workforce in the context of both NDIS implementation and other current mental health reforms.

It identifies complex tensions relating to the viability of NDIS services and supports pricing, with some stakeholders arguing that NDIS pricing is insufficient to purchase a suitably skilled workforce.

The article outlines opportunities to take forward key recommendations of the report, including through the NDIS Workforce Innovation Fund (Minister for Social Services, 2016). It reports also that some state and territory peak bodies have begun to explore the value of establishing a Professional Association to set standards for psychosocial rehabilitation and recovery support practitioners.

Background

The NDIS aims to provide funded disability support services for 64,000 Australians with psychosocial disability related to a mental health conditions by 2020. Achieving this will require growth of a skilled community sector mental health workforce. In that context, the NDIS and Mental Health Workforce Scoping Project (CMHA, 2015) explored NDIS workforce development experiences and needs of the community managed mental health sector.

Community-managed organisations (CMOs) provide a range of services for people affected by mental health conditions (CMHA, 2012). These include psychosocial rehabilitation and disability support services. The establishment of the NDIS has intensified the need to distinguish between these different categories of support and associated capabilities in an environment where psychosocial disability support and rehabilitation work roles are evolving (MHCC, 2016). Regardless, CMOs are the current NDIS psychosocial disability support services "market" and they report high organisational impacts related to NDIS implementation including limited sector/market support.

The scoping project was funded by the NDIS Sector Development Fund, administered by the Commonwealth Department of Social Services (DSS), through the 2013/16 Mental Health Australia (MHA) NDIS Capacity Building Project. MHA sub-contracted MHCC to undertake the project on behalf of CMHA. MHCC collaborated on the project with Human Capital Alliance (HCA), a management and research consultancy firm specialising in human and capital resources.

Many stakeholders reported the NDIS to be a challenging environment for CMOs and that it was proving difficult to stay faithful to recovery oriented practice.

The project methodology included:

- establishment of a Project Advisory Group (consumer, state/territory peak body, industry and stakeholder representatives)
- key informant interviews (to inform the approach and content of a sector survey)
- policy/literature scan (to identify policy and practices)
- audit of CMHA NDIS workforce development related activity
- sector survey (May/June 2015 – two year mark for NDIS implementation; n = 34)
- final project report including findings and recommendations.

Findings

The project explored NDIS workforce impacts and readiness of organisations that were either working in or preparing for the NDIS environment. Of the 34 organisations surveyed, 53 per cent (18) had NDIS experience. Quantitative and qualitative data about all organisations was gathered and analysed in the context of the early stages of NDIS implementation.

The project findings demonstrate a high workforce impact in the early stages of NDIS implementation (see Table 1 for a summary of key findings and recommendations).

Many stakeholders reported the NDIS to be a challenging environment for CMOs and that it was proving difficult to stay faithful to recovery oriented practice. It was evident that NDIS pricing for psychosocial disability support is lower than for other psychosocial rehabilitation and recovery support services. This and an identified trend of increasing casualisation in the workforce puts at risk the sector's Certificate IV (or equivalent and above) workforce minimum standard. Such trends threaten a reduction in workforce skills and qualifications and related impacts on service quality and safety (including emerging industrial issues).

Table 1: Summary of project findings (F) and recommendations (R)

F1 – The NDIS has affected the nature of work performed.

R1 – Undertake community mental health sector role mapping (i.e., skills, qualifications and pricing) and identify appropriate supports pricing.

F2 – Change in work has influenced a change in skill requirements.

R2 – Make Certificate IV Mental Health and Mental Health Peer Work qualification scholarships available.

R3 – Develop on-the-job pathways to the above qualifications.

F3 – Changes to employment and deployment of workers include growing casualisation.

R4 – Identify and promote good practice deployment of staff beyond casualisation.

R5 – Identify approaches that link worker skill and consumer need levels.

R6 – Identify good practice workforce innovations and facilitate their adaption.

F4 – Organisations need more resources to understand the future impact of NDIS on the workforce.

R7 – Develop an information pack describing workforce approaches responsive to fluctuations in demand.

F5 – Quality assurance/continuous improvement processes are being challenged.

R8 – Promote quality improvement approaches to community mental health workforce effectiveness.

F6 – Focus is needed to strengthen both workforce quality and quantity.

R9 – Pursue responsive and flexible approaches to workforce innovations.

R10 – Contribute to national mental health workforce planning through use of role mapping results (R1).

F7 – Need to identify good practice community sector mental health workforce development in the NDIS environment.

Key workforce findings raised by all organisations (CMHA 2015, Table 6, p48) are:

- low rates of pay
- casualisation of the workforce
- uncertainty and funding concerns for workforce quality and governance
- need for and constraints on staff training and professional development
- recruitment and retention of skilled staff
- need for new tools and infrastructure.

Key findings raised by organisations with NDIS experience are:

- 65 per cent identified changes to the work required
- 56 per cent had changed service delivery models
- 83 per cent have, or plan to have, Certificate IV minimum workforce standard
- 61 per cent had not adopted the above standard when recruiting for NDIS work.

Changes to the work required include an:

- increase in the total amount and type of work, and the types of skills required (not higher level skills)
- emerging pattern of division of labour for less skilled and more skilled workers.

The project prompted discussion about a workforce development pathway for psychosocial disability support and/or rehabilitation mental health workers tied to notions of orientation (core), induction (transition) and certification (capacity building) – milestones that are aligned to the Certificate IV in Mental Health. Figure 1 (adapted from CMHA, 2015, Figure 13, p60) illustrates this approach.

Key recommendations

Project recommendations 1 and 10 relate to the need to better understand psychosocial disability and rehabilitation support work roles including the skills and/or qualifications required to deliver them and are relevant to the workforce development pathway proposed above.

Recommendation 1 is to conduct research into the NDIS support services that consumers most need and identify the worker roles consistent with these needs. The NDIS Sector Development Fund (DSS) could facilitate this by extending work on the Design of Individual Supports Project by the National Disability Insurance Agency (NDIA)/ MHA (NDIA/MHA, 2015). In support of this direction, the Disability Reform Council's NDIS Integrated Market, Sector and Workforce Strategy proposes:

> '….. to ensure the NDIS meets the needs of participants with mental health issues, it will be necessary to engage the sector to define mental health support roles, related job design and training requirements and establish how these roles differ from, and overlap with, other disability support roles'.
>
> (Senior Officials Working Group for the Disability Reform Council, 2015, p. 21)

CMHA notes that the project scope would extend to fulfilling the following research elements:

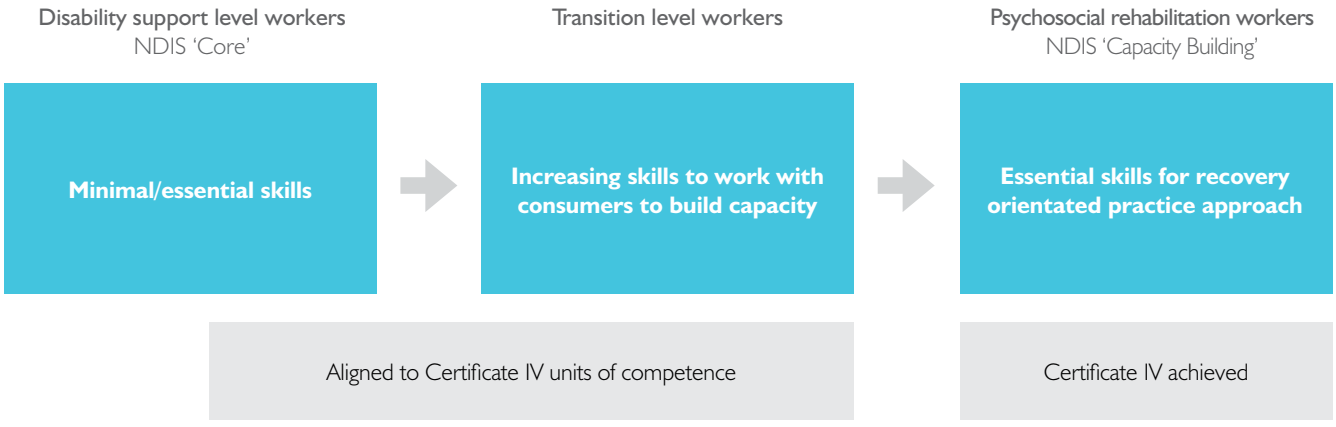
- mental health sector role mapping
- mental health sector skills and qualification requirements mapping
- identification of appropriate supports pricing.

Recommendation 10 is to undertake a national workforce planning project to gain a more precise understanding of the requirements for different types of workforce at different levels of training and qualification. Relative investment in different training models could then be reassessed.

The NDIS fit of Peer Work roles, including interface with the Certificate IV in Mental Health Peer Work, was not explored in this research. It did find that some organisations are growing their peer workforce as a deployment solution. However, this was not common practice.

The Federal Government is considering the findings and recommendations of the project and indicates that these will be part of policy and operational design of transition to the full NDIS.

Figure 1: *Workforce development pathway for workers delivering psychosocial support services under the NDIS*



Flexible workforce approaches beyond casualisation must be identified and contribute to good practice learning. NDIS providers must adopt customer based marketing and practice approaches including placing consumers at the heart of workforce development decision-making.

Discussion

The question about what good community sector mental health practice workforce development looks like in an NDIS environment requires further research. It is still too early to discern good practice even though some likely innovations (such as greater peer workforce deployment) are arising. Flexible workforce approaches beyond casualisation must be identified and contribute to good practice learning. NDIS providers must adopt customer based marketing and practice approaches including placing consumers at the heart of workforce development decision-making.

As noted earlier, the key tension of the project related to whether community managed mental health sector stakeholders would advocate to support a community sector mental health workforce standard at the Certificate IV and above level. The complex NDIS implementation environment and need for CMOs to manage their relationships with a range of government departments resulted in diverse views about the need for this standard. Some stakeholders supported moving away from qualifications against NDIS pricing arguably fixed at a low level (i.e., requiring organisations to hire less skilled and less qualified staff). Concerns about service delivery quality and safety, and risk, are at the centre of this tension.

Following the release of the final report of the project, CMHA and others have discussed next steps to advance its recommendations. This has at times proved challenging as different states and territories have different needs, preferences and resources. For example, NSW and Victoria are at different ends of the spectrum with regard to state governments growing or withdrawing from the provision of psychosocial disability and recovery support services in the current reform environments. In addition, the current NDIS implementation and mental health sector reform environment is evolving rapidly.

However, it is agreed that an integrated and coordinated mental health and disability support system must be able to deliver treatment, rehabilitation and support – especially for people most impaired, or at risk of becoming impaired, by their mental health condition. These people may need access to all three service types in varying combinations over time.

At full implementation of the NDIS, people with psychosocial disability who qualify for individual funding should be able to get their "reasonable and necessary" disability support needs met. However, with the defunding of all Federal and some state/territory mental health rehabilitation programs a significant number of people deemed ineligible for the NDIS will not have their needs met. A national integrated health and social care sector requires provision of psychosocial rehabilitation and disability support services, and growth of a workforce skilled and competent to deliver them; and states and territories need to contribute across the range of service types.

Some state/territory peak bodies argue that achieving clarity about the role, functions and costs of the psychosocial rehabilitation and disability support workforce will require the establishment of a Professional Association. While deliberations continue, the concept is that an association will set practice standards and strengthen recognition of psychosocial rehabilitation/recovery support practitioners through certification, registration, accreditation and/or other regulatory processes.

MHCC has been leading work to explore the merits of a Professional Association. This is because we view this direction as ensuring the continuing maturation of the community sector mental health workforce including reducing risks to quality and safety. A Professional Association will help to ensure continuous quality improvements, good practices in service delivery, and a growing research and development culture.

While there is no national direction for mental health workforce development, we need to accelerate discussion about NDIS markets, providers and pricing, and workforce needs within a mental health context.

The Australian National Audit Office (ANAO, 2016) recommends that the DSS produce and publish a disability care workforce action plan which includes specific actions, timeframes, accountabilities, and monitoring arrangements for implementation. ANAO advise that DSS has agreed to this recommendation and acknowledged the need to account for individual characteristics of cohort markets (e.g., psychosocial disability). The government has established an Interdepartmental Committee to consider ways of growing the 'care' workforce and this needs to include mental health specific representation. An efficient and sustainable CMO mental health workforce that can meet the needs of NDIS participants with mental health conditions will be a key to NDIS success.

The $5 million Workforce Innovation Fund (Minister for Social Services, 2016) provides an important initial opportunity to support market transition to the full Scheme as this relates to the needs of NDIS participants with psychosocial disability. Psychosocial disability support providers are a thin market in the context of NDIS implementation and exist within an under-resourced mental health sector. While there is no national direction for mental health workforce development, we need to accelerate discussion about NDIS markets, providers and pricing, and workforce needs within a mental health context.

CMHA commends this foundational mental health and NDIS workforce research as essential guidance on workforce issues across a range of health/mental health and disability/social care reforms underway in Australia. We look forward to contributing to opportunities to enhance national human service workforce growth and development.

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Transition, disruption and change: meeting the challenges of the NDIS in Victoria

John Katsourakis is Manager Education and Training at Psychiatric Disability Services of Victoria (VICSERV)

The advent of the National Disability Insurance Scheme (NDIS) heralds significant change for service providers delivering mental health services.

In Victoria, a major impact of the NDIS and overwhelming concern is focused on the potential loss of the skilled, knowledgeable and experienced community mental health workforce that currently operates across the state.

This article outlines some of the significant work being done in Victoria to meet the disruptions of the NDIS through the implementation by VICSERV of a Capability Framework across Mental Health Community Support Services, including a survey of current capabilities.

Workforce insights at a time of transition and disruption

The Victorian Department of Health and Human Services (DHHS) has developed a draft Organisational Capability Framework that sets out the performance expectations for organisations and workers in the mental health and alcohol and other drugs (AOD) sectors. It covers universal capabilities required to meet consumer needs and outcomes, irrespective of role, discipline or position in any organisation.

DHHS provided project funding to support VICSERV to implement the Capability Framework in partnership with its member organisations. Before conducting full implementation of the Capability Framework across Mental Health Community Support Services (MHCSS), VICSERV conducted a base-line survey to assess the existing capabilities of representative member organisations. The survey consisted of three sections:

- organisational capabilities
- individual capabilities
- leadership capabilities.

The survey results, whilst significant to the current MHCSS workforce, need to be viewed in the context of the forthcoming transition of most MHCSS services to the NDIS. The most recent update about the NDIS for the MHCSS (Department of Human Services, 2016) stated that the services that will transition to the NDIS will include:

- all individualised client support packages
- all adult residential rehabilitation services
- supported accommodation services (excluding three services with a homelessness focus).

These services account for approximately 60 per cent of the MHCSS workforce.

Demographics and qualifications

The demographics of the survey responses were similar to the 2010 VICSERV training needs analysis survey and the 2012 Victorian Psychiatric Disability and Rehabilitation Support Services workforce census report, with nearly 75 per cent of respondents being female and 60 per cent aged over 40 years.

The majority of the 513 respondents were from services based in metropolitan Melbourne and three-quarters had a job that involved direct client contact.

According to this survey's responses, the workforce is highly qualified with nearly two-thirds holding a graduate or postgraduate qualification. Ninety per cent indicated that they have a diploma or higher qualification.

According to this survey's responses, the workforce is highly qualified with nearly two-thirds holding a graduate or postgraduate qualification. Ninety per cent indicated that they have a diploma or higher qualification.

This is of potential concern given the preliminary workforce analysis of the NDIS, which identified that the support worker role requires only a foundational qualification of Certificate III in Individual Support. Consequently, a large number of the survey respondents would be over-skilled and over-qualified for the NDIS support worker role.

In addition, the foundational qualification of the Certificate III does not contain core or elective elements that address the current mental health and alcohol and drug workforce requirements.

Organisational capabilities

The survey responses showed that across most domains respondents were very positive about their organisation's capabilities, with 80 per cent or more stating that the capabilities were either 'highly evident' or 'somewhat evident'. Only in the domain of 'consumer driven' capability were respondents less certain. A greater focus on the growing peer workforce to help build this capability is recommended.

Respondents were also asked to rate what domains their organisation needed to develop. A weighted analysis was then conducted which revealed that 'consumer driven' followed by 'trauma informed' practice were the two domains that organisations need to develop further.

Individual capabilities

The survey indicates a workforce with a relatively high self-reported capability level. However, two capabilities ('transparency' and 'promotion of autonomy') were heavily weighted to the lowest proficiency (60 per cent and 65 per cent respectively). Again, a greater role for the growing peer workforce to help build these capabilities is recommended.

Leadership capabilities

More than one in four respondents were currently working in a leadership role, defined as:

- supporting and mentoring other staff
- influencing organisational culture, or
- being a leader in the sector.

The survey revealed that their leadership capabilities were, generally, in the medium to higher proficiency levels, particularly in the capabilities of 'managing self', 'working with others' and 'innovation and transformation'.

This was not the case in the 'resourcefulness' capability, where most respondents were in the lower proficiency levels. The 'setting directions' category also saw respondents scoring themselves in the lower proficiency levels with significant numbers stating they require further support and development to achieve these capabilities.

With the changing and evolving MHCSS, future workforce development programs will need to focus on leaders within the sector to ensure they have the necessary knowledge and skills to lead their teams and their organisations to provide the best care for consumers and families.

Implications for practice

There are obvious benefits to making the Victorian Government's Capability Framework available as a resource to the MHCSS workforce and the insights of the survey project may be valuable in considering broader implementation of the framework in the MHCSS sector. Analysis of survey responses from the representative organisations and discussion from the implementation project Steering Group have provided some suggested directions for implementation.

The Capability Framework is most useful when it can be used flexibly by organisations at any stage of development and is most likely to be used where it is able to be either fully or partially implemented depending on organisational need – including to support existing practice and systems already in place.

The Capability Framework is seen as relevant to the broader disability sector, and there would be value in DHHS sharing this work with the National Disability Insurance Agency for consideration as part of its NDIS Quality and Safeguarding Framework.

There is a clear need for ongoing support and investment in the areas of consumer driven and trauma informed practice to build capability in our workforce.

Consideration should be given to the potential role of the peer workforce in helping organisations improve capability in areas of consumer focus and transparency. To address this, some representative organisations have created peer-specific roles in intake, engagement and review processes. There is a need for ongoing support and investment in the Peer Workforce to support these types of roles into the future. The Certificate IV in Mental Health Peer Work (CHC43515) is the current qualification that provides well-rounded competency development for peer worker roles in clinical and community mental health and mental health disability support.

Further training and support is required for the current and developing leaders of teams and organisations. Continuing investment in VICSERV's *Community Managed Mental Health Leadership and Management Program* is recommended to further develop Victorian community leaders to tackle the challenges in the coming years.

Consideration should be given to the potential role of the peer workforce in helping organisations improve capability in areas of consumer focus and transparency.

Developing leaders equipped for disruptive change

Community Managed Mental Health (CMMH) services are currently undergoing a period of significant change. In response, VICSERV's *CMMH Leadership and Management Program* aims to develop effective, adaptive and resilient leaders who will work together to tackle complex challenges and ensure a progressive, dynamic sector. This program has been developed and delivered in partnership with Leadership Victoria with funding support from the Victorian DHHS.

Leadership involves the actions of individuals to engage, inspire and develop staff, teams and organisations to thrive in environments of disruption and change. Services in community, disability, aging and health (including mental health) have faced significant leadership challenges over recent times and the changes are continuing. They include the shift towards a greater focus on consumer control and choice (and the resulting system and policy changes), and the implementation of the NDIS, which will have a significant impact on a service's workforce, cash flow and bottom line.

Leaders need to meet these challenges head on, they need to take ownership of their internal reactions, be able to communicate with staff effectively, and maintain relationships with their consumers, carers and families to ensure the smoothest transition to the new environment.

The *CMMH Leadership and Management Program* has equipped leaders with energy, enthusiasm and capacity to: develop a clear vision and strategic direction, undertake change management, lead results-driven services and adopt a collaborative approach for improved client outcomes. Leaders can now apply this knowledge both within their own organisation and between organisations, regardless of the move to a competitive operating environment such as the NDIS.

Program participants have been very active in their learning and application back into their workplace through Community Leadership Action Networks which have worked on:

- more collaboration across sectors/agencies
- growth of the peer workforce
- challenging inequality
- networking and collaborative practice
- recovery orientated practice within the NDIS
- managing and supporting people through change
- exploring how to support participants to understand the NDIS and empower them to build capacity around choice and control to achieve their goals
- exploring how rural communities optimise mental health and seek and accept support when necessary (Rural Lives Matter).

Through this program and our NDIS engagement activities, VICSERV has been able to develop leaders to be more informed and resilient in such disruptive times.

Leadership is now not just the responsibility of the Board, CEOs and Management teams. To survive, leadership needs to be demonstrated by all levels of an organisation. Each organisation needs to encourage this leadership behaviour so that the impact of this disruption is managed well and an organisation not only survives, but thrives in this new and evolving world.

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VICSERV's CMMH Leadership and Management Program aims to develop effective, adaptive and resilient leaders who will work together to tackle complex challenges and ensure a progressive, dynamic sector.

Mental health skills and training in 2017 – what you need to know

Andrew Fleming is the Executive Officer of the Community Services and Health Industry Advisory Group

As well as significant change in policy and practice in mental health, there is significant reform underway in skills and training.

This article looks at issues arising at both the national level and in Victoria and point further to the urgent need for a national mental health workforce strategy.

The main qualifications for the specialist mental health workforce in Australia are the:

- Certificate IV in Mental Health Peer Work
- Certificate IV in Mental Health, and
- Diploma of Mental Health.

These qualifications are included in the national Community Services Training Package and are therefore generally subsidised by state governments.

National reform and issues

In 2014 the Council of Australian Governments (COAG) Industry and Skills Council agreed to six objectives for reform of the vocational education and training (VET) system. One of these is 'a national system of streamlined industry defined qualifications that is able to respond flexibly to major national and state priorities and emerging areas of skills needs'.

Work continues nationally on the structures that deliver National Training Package qualifications. However it will come as no surprise that reform has come along slowly and the system in 2016 was described by some as 'sclerotic' in terms of getting work done on a range of qualifications.

This work, therefore, is generally viewed as a longer term option for influencing mental health training.

Another important national element was the long overdue review in late 2016 of VET FEE HELP arrangements to prevent unscrupulous operators exploiting the scheme. It saw the eleventh hour passage of legislation in December to enable the implementation on 1 January 2017 of a new system, 'VET Student Loans'. This limits loans to the Diploma, Advanced Diploma, Graduate Certificate, Graduate Diploma levels. It has an Approved Course List, and course allocation to one of three loan cap bands of $5,000, $10,000 and $15,000, which will apply irrespective of whether the course is being delivered face to face, online, or by mixed delivery modes. With no other adjustments to the market, enrolment numbers will drop. Clearly, students wishing to study the Certificate IV mental health training will no longer be eligible for loans. Therefore, students EITHER get a subsidised place which may still have some fees in addition, OR pay full fee; with no opportunity to set the cost of either option against a student loan.

Training issues and directions in Victoria

The National Disability Insurance Agency has published a *Victorian Market Position Statement* that attempts to project future workforce demand in Victoria, where state psychosocial services funding is being shifted into the NDIS.

The numbers show the need for a 76 per cent increase in Full Time Equivalent (FTE) workers by the time the Scheme is fully rolled out in 2019. On the face of it, this would indicate a great pressure on the training system for mental health qualified workers. However, NDIS workforce issues contain many unknowns.

In Victoria, there has been a significant policy shift with the implementation of Skills First, an overhaul of the TAFE system in the state. The Victorian Government is promising it will deliver a "new approach to training" which will set a high benchmark for training quality and support the courses that are most likely to lead to employment. This has led to the publication of Regional Jobs and Training Needs reports to help align the level of funding for training to more closely match area requirements. Here, the focus on training quality is predominantly government subsidised training, not the fee for service training outside of the TAFE system.

In addition, a new office of the Victorian Skills Commissioner was created in 2015 to engage industry with training system issues and coordinate skills and training work underway in many areas of government. Some of that work in 2016 included:

- Setting up 10 Industry Advisory Groups, including Community Services and Health, with Sector Advisory Groups to be appointed in the near future.
- Reviewing and significantly culling the Funded Course List (the qualifications the government will subsidise) and introducing a new process, with Industry Advisory Group consultation, where qualifications can only be added to the list after a business case for government subsidy is established.
- Establishing Regional Taskforces to deal with unique skill needs of Victoria's regions, and Industry Taskforces such as for the NDIS and Family Violence services.

Funding and the future

There are presently three new programs of funds that should be closely examined by all mental health providers to see if they can help with opening up new pathways for the skilled workforce of the future. They are:

- The Workforce Training Innovation Fund ($40 million per year): to foster partnerships between industry and training providers to drive innovation in qualifications and approaches to the delivery of training and curricula.
- The Regional Skills Fund ($34 million): a targeted, placebased regional skills grants program driven by industry in partnership with the tertiary sector, working to build local capacity, resilience and support jobs creation.
- The Regional and Specialist Training Fund ($30 million in 2017): to address industry and community demand for training which existing training does not meet, with a focus on localised employer needs in regional areas (Regional), or specialised occupations of economic significance to Victoria (Specialist).

It is here that the need for a national workforce strategy becomes critical. These new mechanisms and funding provisions open up industry engagement avenues for the mental health field to review and influence training system issues. However it is a workforce strategy that will help focus these discussions.

Providing 'reasonable adjustments' in the workplace: a right not a privilege

By the **National Mental Health Consumer and Carer Forum**

The principles of respect for diversity and flexibility are at the heart of ensuring that everyone in a workplace is treated equitably, according to their needs, within the boundaries of the job they are employed to do.

The community managed sector as a whole can provide leadership in good workplace practices by respecting and valuing all forms of diversity and by creating and sustaining an environment where everyone can achieve their potential.

This article challenges the sector, especially community managed mental health organisations, to model the principles of equity and productive diversity and flexibility through their own practices and work relationships in the provision of what are known as "reasonable adjustments" for employees with mental illness.

Demonstrating an understanding of reasonable adjustments and a need for greater creativity and adaptability to ensure that the consumers and carers are provided with the workplace supports they need will not only serve as an exemplar to other employers but will ultimately also ensure the sustainability of the organisations themselves.

There are, and will continue to be, great strains on the workforce in the sector and significant competition for workers from other sectors. Community managed organisations will increasingly be unable to afford to lose good, skilled, experienced staff because of a failure to find ways to accommodate their needs in the workplace.

Rights to and benefits of work

The right to work and the right to "just and favourable conditions of work" are human rights recognised in Articles 6 and 7 of the International Covenant on Economic, Social and Cultural Rights and Article 27 of the United Nations Convention on the Rights of Persons with Disabilities (2006). Work is also a major determinant for good mental health and for recovery from mental health problems. It is thus inextricably linked with the human right to the highest attainable standard of mental health (Amnesty International, 2013, p3).

It is well recognised that people with a mental illness are among the most socially and economically marginalised members of the community. They experience high levels of unemployment and non-participation in the labour force. Unemployment has a number of negative effects including the loss of purpose, structure, roles, status and sense of identity. Employment enables social inclusion in the wider community and is an important way that people with a mental illness can meaningfully participate (Waghorn & Lloyd, 2005, p1). Income generated by employment also improves quality of life.

The Federal Government has been working to reform the welfare system to move people off the Disability Support Pension (DSP) and into work. There is a general acknowledgement that many people affected by mental illness are keen to work and, with the right supports, may find suitable jobs. Research shows that between 80 and 90 per cent of people with severe mental illness such as schizophrenia and bipolar disorder are unemployed and many are on a DSP. But despite this, they report their consistent number-one ambition is to get a job (Killackey, 2014).

Community managed organisations will increasingly be unable to afford to lose good, skilled, experienced staff because of a failure to find ways to accommodate their needs in the workplace.

Another issue that cannot be ignored is that it is easier to discriminate against people generally perceived as not "fully functional" in an environment where job-seekers are many and jobs, especially unskilled roles, are few. A 2002 explanation by the World Health Organisation (WHO) and International Labour Organisation (ILO) of the context in which people with mental ill-health are competing for jobs is as true now as it was then:

> "Obtaining competitively paid employment for a person with a background of serious mental illness remains a challenge at the best of times. It is even more difficult in periods of high unemployment when the availability of non-disabled workers is plentiful. Globalization, technological development and changes in the organization of work are having an impact worldwide. In the manufacturing sector of OECD countries, the employment of unskilled labourers has fallen by 20 per cent and there is a definitive trend towards the hiring of highly-skilled workers. We are forced to acknowledge that important changes have taken place in the very nature and organization of work: the free-market economy which predominates is often accompanied by downsizing of human resources and increased loss of job security." (Harnois & Gabriel, 2002).

Providing 'reasonable adjustments'

Getting a job is one thing, keeping a job is another and one of the main issues around job sustainability for people with mental health issues is the provision of "reasonable adjustments".

The workplace today is a very different one from that of even 20 years ago, particularly with the implementation of flexible work practices. Nowadays, technology has given the workplace the freedom to shape the work environment to fit individual needs and work styles to help both organisations and their staff. Flexibility comes in many different forms, including alternative scheduling, condensed work weeks, job-sharing, part-time work, telecommuting and freelancing. Some jobs and some workers are better suited to particular types of flexible arrangements, such as for staff members with young children, those caring for aging parents, and those recovering from physical illness or surgery.

The Commonwealth *Disability Discrimination Act 1992* requires employers to make reasonable adjustments also to support people with disability, including a mental health condition, provided the person is able to fulfil the inherent or core requirements of the job (that is, the fundamental requirements of the job that cannot be changed or altered).

The Australian Human Rights Commission (2010, p49-50) notes that a failure to make reasonable adjustments for a worker with disability, including a worker with mental illness, 'may constitute direct or indirect discrimination.' The Commission provides the following examples:

- not allowing someone with depression to work part-time where this arrangement has been sought as an adjustment for the worker's mental illness may be direct discrimination
- requiring a worker with mental illness to meet a general policy to start work at 7am, when the effect of their medication means they are not alert in the early morning, may constitute indirect discrimination.

However, there is an opt-out card. An employer can be deemed exempt if a "reasonable adjustment" involves an "unjustifiable hardship" for them to make. The Human Rights Commission further informs us that, in considering what an unjustifiable hardship is, it is necessary to take into account:

- the benefit or detriment to the employee
- any benefit or detriment to others affected by the adjustment
- the effect of the mental illness
- the cost of the adjustment and the employer's financial position, and
- the availability of financial or other assistance to the employer in making the adjustment.

There may be times when employers decide that an adjustment would involve unjustifiable hardship for the organisation before even fully considering what it would take to accomplish and whether there is support available to provide it. An employer and an employee can discuss the possibility of an alternate arrangement if the employer cannot provide the adjustment requested.

'Reasonable adjustments' for mental health

Reasonable adjustments are changes which can be made to a job to enable a worker to perform their duties more effectively in the workplace.

The majority of reasonable adjustment requirements pertain to physical disability and include making facilities used by employees readily accessible through the acquisition or modification of equipment or devices, the provision of readers or interpreters, etc. The kinds of accommodations needed for physical disability are very often technical and require a one-off adjustment. Those required for people with mental health issues tend to be ongoing and require attitudinal change on the part of the employer and co-workers who do not always understand the legislation and the reasonable adjustments required as they apply to psychosocial disability.

Reasonable adjustments for people with mental health issues are often quite simple and do not involve great expense. They go beyond flexibility although flexible working arrangements are certainly part of the whole picture and can include the ability to work from home (provided allocated tasks are met and core meetings and events attended), job-sharing, flexi-time, variable start and finish times, change in days worked, time off for medical appointments and "time-out" periods during the working day.

Real choice is empowering, and being part of the planning and negotiation of reasonable adjustment options promotes recovery.

Other accommodations can include changing some aspects of the job or work tasks, changing the work area (for example, moving a worker to a quieter work area), providing access to professional mentoring, coaching or on-the-job peer support, and making changes to supervision (for example, modifying the way instructions and feedback are given).

The Human Rights Commission (2010, pp17-18) provides detailed guidance and practical ways to accommodate workers with a mental illness, whether or not they are peer workers, stressing the need to:

1. Identify the 'inherent' (or 'core') requirements of the employee's job.
2. Assess the employee's skills and abilities.
3. Identify reasonable adjustments with the employee.
4. Check that the employee can meet the inherent or core requirements of the job when reasonable adjustments are made.

However, there are no checklists of reasonable adjustments which are set in concrete because people, workplaces and jobs differ and the best approach is to proceed on a case-by-case basis.

Nonetheless, it is critical to note that reasonable adjustments are not about diminishing the roles and responsibilities of any given position. Nor are they about creating a "dumbed-down" version of a job. Furthermore, any adjustments should be discussed with the employee at the outset of employment and reviewed on a regular basis. Care should also be taken to ensure that any adjustments do not lead to isolation from the workplace, colleagues and workplace support.

A right, not a privilege

The United Nations Convention on the Rights of Persons with Disabilities (2006) obliges its signatories, like Australia, to ensure participation of persons with disabilities in social, political and cultural life – and their equal right to work and gain a living.

Although reasonable adjustments obligations directly address systemic discrimination experienced by people with disability in the workplace, they are not universally accepted as "business as usual". They are often regarded as a privilege, not a necessity or a right, and often also seen as an unnecessary "bother" and a cost as opposed to an investment. Such views have implications not only for keeping a job but also for fair career progression. Consumer advocate Michael Burge has described lack of awareness about and failure to implement reasonable adjustments obligations as a breach of human rights and, potentially, "the biggest modern day systemic failure within Australian mental health with regards to consumer rights in the workplace."

Removing barriers for people with disability, including mental health issues, is fundamentally a human right and it is a mistake to assume that it is about such a small number of people that it is easily avoided.

However, it is important to remember in this context that around one in every five Australians, or more than three million Australians, experience a mental disorder of some kind. We are reminded by former Human Rights and Equal Opportunity Commission director David Mason that, "Disability (whether temporary or longer term) is a normal part of life." It makes sense, therefore, that making adjustments to accommodate disability should be a normal part of employing people (2007).

Onus on the workplace, not the worker

In a recent presentation to the NMHCC, Michael Burge (2016) said:

> "The turnover and retention of experienced Peer Workers has been a concern of mine for a few years now. Not to mention the lack of awareness some case managers have about reasonable adjustments and the impact it may have on their clients in the workforce across Australia."

Although the *Disability Discrimination Act 1992* is just and appropriate, it relies on people with mental health issues being aware of their employer's obligation to provide reasonable adjustments. This is not always the case. Workplaces should ensure that staff are aware of their rights. People with a lived experience of mental illness have a basic human right to both know and be aware of their employer's obligation to make reasonable adjustments to accommodate them in the workplace.

Nonetheless, people with mental health issues can be reluctant to raise any concerns – anxiety levels, self-stigma and fear of official processes (and potential backlash) often do not lend themselves to seeking justice. In a previous edition of *new**Paradigm***, consumer advocate Indigo Daya noted that:

> "Disability legislation requires reasonable adjustments in the workplace but in practice this does not always happen. Often consumer employees are not even aware of this option, or may fear that such a request may endanger their tenure. Employers can assist by being proactive, offering adjustments like flexible hours or quiet work areas, and being open to creative solutions." (Daya, 2012, p9)

In its submission to the Australian Human Rights Commission's Willing to Work consultation, the Mental Health Council of Tasmania (2015) also looked at the barriers created by workers compensation legislation, noting:

> 'Workers Compensation Acts across Australia include the aggravation, acceleration or recurrence of a pre-existing disease. For people with mental illness, this means that the employee would have to prove that he or she had suffered a compensable "injury", being the exacerbation of her pre-existing mental illness.

It quotes that insurance industry itself acknowledging that "workers compensation systems are not responding to mental health claims in an optimal way." (Insurance Council of Australia, 2015, p27).

Although reasonable adjustments are reasonable and fair accommodations for people with mental health issues in the workplace, it is also important to note that not all people with mental health issues require these accommodations. One source reminds us that:

> "From a consumer perspective, it is derogatory to assume that a Consumer Worker, by virtue of the fact that they have the lived experience of a mental health problem, will need special considerations in the workplace, for example, extra supervision." (MHCC, 2008, p49).

Again, any requirements for adjustments need to be made on a case-by-case basis with the person themselves. Real choice is empowering, and being part of the planning and negotiation of reasonable adjustment options promotes recovery.

The issue of the Consumer or Peer Worker is critical as sometimes these workers are left out of the usual accommodation provisions. The same source notes:

> "All organisational policies, such as staff privacy and confidentiality, apply to Consumer Workers also, no more and no less than any other employee. Reasonable adjustment is about flexibility which is mutually agreed between employer and the Consumer Worker in accordance with both legislative requirements and workplace policy/ procedure. Flexible and supportive workplace practices should apply to all staff." (MHCC, 2008)

In conclusion

One of the National Mental Health Consumer and Carer Forum's key messages to the Willing to Work Inquiry (NMHCCF, 2015, p5) was:

> "The accommodations needed for people with psychosocial disabilities require an attitudinal change on the part of the employer and co-workers. Many people have no idea what accommodations might be needed and there are employers who would feel this is an onerous issue and one which would impact on their decision to hire or retain an employee with a mental illness. The law decrees that such accommodations are made available while also ensuring that the cost of bringing about 'reasonable accommodations' should not be unreasonable or unbearable for the employer. However, part of the issue relates to misunderstanding of mental illness, especially regarding episodic versus permanent disability."

Worthy of note is research (Waghorn & Lloyd, 2005) which acknowledges Individual Placement and Support [IPS] as an essential method to place people with severe mental disorders into work. In 2011, leading academic Dr Geoff Waghorn authored a presentation advocating the IPS model to the Federal Government's Parliamentary Inquiry into Mental Health and Workforce Participation. In the 2014 Interim Report on Welfare Reform, authored by Patrick McClure, the IPS model is singled out as an innovative improvement to the current approach to assisting people with mental illness into sustainable employment. (Department of Social Services, 2015, p122). Dr Waghorn's work is based on the premise that any person with mental illness can work given the right support and job match. A system of ongoing support is also a good way to ensure that reasonable adjustments are provided in the workplace.

The National Mental Health Consumer and Carer Forum works to give mental health consumers and carers a united, national voice. For more information, go to **https://nmhccf.org.au/**

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Useful websites

Fair Work Ombudsman https://www.fairwork.gov.au/employee-entitlements/flexibility-in-the-workplace

The Federal Government can provide financial assistance for workplace modifications for employees with disabilities. See http://jobaccess.gov.au/content/employment-assistance-fund

Employer's guide to implementing a peer workforce: Reasonable adjustments, Mental Health Commission of New South Wales, http://peerworkhub.com.au/wp-content/uploads/2016/05/15-adjustments.pdf

Engaging with mental health carers: changing workplace practice

Jenny Branton is Executive Officer of Mental Health Carers Australia

This article provides an indication of how mental health practice can change through the adoption of a practical guide for working with carers of people with a mental illness, which recognises there are three partners – consumers, providers and carers – working together to support better mental health outcomes.

Underpinning laws and policies

National, state and territory legislation, standards and policy clearly articulate the obligation of mental health service providers to respect, engage and partner with carers.

The Statement for Australia's Carers, Carer Recognition Act 2010 states:

> "Carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers."

It adds:

> "Each public service agency is to take all practicable measures to ensure that its employees and agents have an awareness and understanding of the Statement for Australia's Carers."

Standard 7 of the 2010 National Mental Health Standards asserts:

> "The Mental Health Service recognises, respects, values and supports the importance of carers to the wellbeing, treatment and recovery of people with a mental illness."

Standard 2 of the 2012 National Safety and Quality Health Service Standards requires that:

> "Leaders of a health service organisation (should) implement systems to support partnering with patients, carers and other consumers to improve the safety and quality of care."

In 2013, the Federal Government committed to the adoption of a Recovery Framework for service delivery, where all staff, consumers and carers have the opportunity to participate as equal partners in the delivery of care for people with a mental illness.

Yet the experience of carers is that the policy does not generally translate to practice.

The National Mental Health Commission – in its report *A Contributing Life: the 2013 National Report Card on Mental Health and Suicide Prevention* and more recently in its 2014 *National Review of Mental Health Programmes and Services – Contributing Lives, Thriving Communities* – has identified the need to develop and implement a practical guide for the inclusion of families and support people in mental health services, to turn the policy into practice.

The Guide provides practical ways to engage with carers and continue to protect peoples' privacy and other rights.

Developing a practical guide

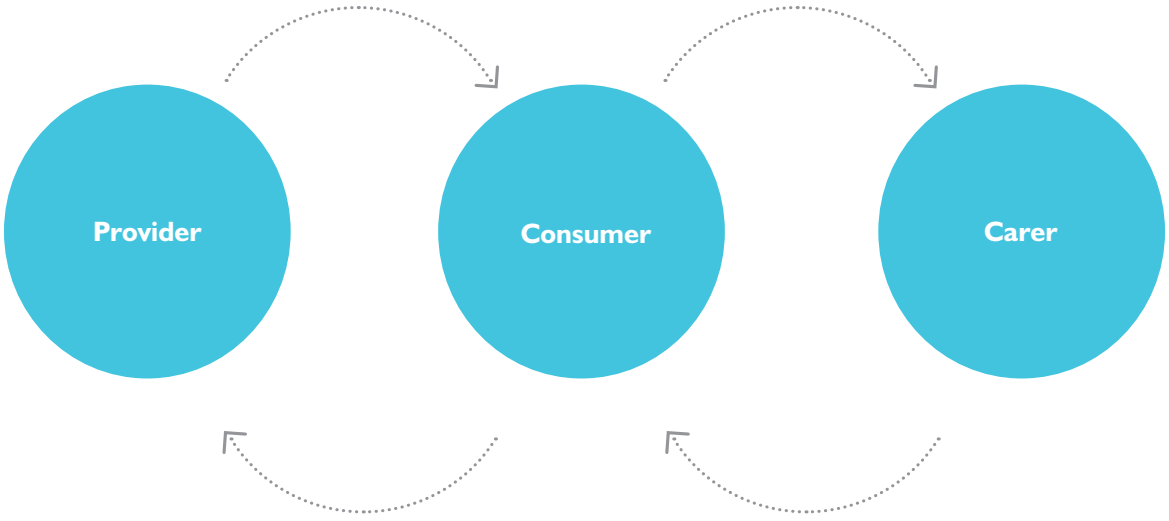
In 2015, a collaboration between Helping Minds, Mind Australia, Mental Health Australia, Mental Health Carers Australia and the Private Mental Health Consumer and Carer Network developed *A Practical guide for working with carers of people with a mental illness*.

Historically, the training of professional staff and the delivery of care to people in both the acute and recovery phases of a mental illness have been organised around an individual treatment model (Diagram 1). In many circumstances this can result in situations where carers are unable to contribute, receive information or to participate in the recovery process.

Consultation indicates that within community-based services, staff training in using a partnership approach to service delivery is limited. Many staff express concerns regarding issues such as confidentiality as a barrier to using a partnership approach.

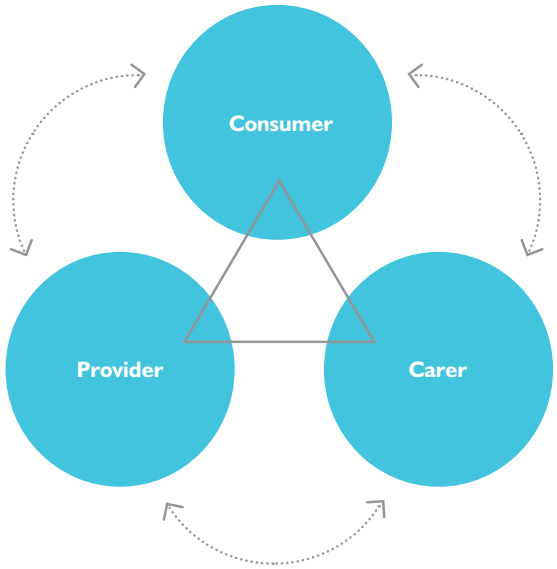
The Guide provides practical ways to engage with carers and continue to protect peoples' privacy and other rights. It is based on the UK Carers Trust model, the Triangle of Care (Diagram 2), an approach that encourages working in partnership with carers at all levels of care, from the individual to overall service planning.

Diagram 1: Individual treatment model



The Triangle of Care model was initially developed in the UK by carers and staff seeking to improve carer engagement in acute inpatient services. It has now been extended to cover all mental health services whether they be an inpatient, community team or specialist service. The model recognises there are three partners, consumers, providers and carers, working together to support the recovery process.

Diagram 2: Triangle of Care model



Canvassing the views of carers can be key to ensuring that any risk factors they are aware of are properly evaluated and acted upon. A number of enquiries into serious incidents have identified that failure to communicate with and listen to carers and families has been a significant contributory factor.

The Guide is based on six partnership standards that can be applied across all settings and incorporate age related, cultural and other needs. A number of individuals and organisations within Australia have already translated some or all of these standards into practice.

Each partnership standard is accompanied by an easy-to-use self-assessment tool with a traffic light system (red, orange, green) that can be used by both individual staff and organisations to assess current practice and determine areas for change. The Guide also includes practical examples for each standard of activities and approaches that individuals and organisations might undertake to improve their capacity to work in a partnership manner.

The Guide provides a practical framework that, if implemented will:

- meet the criteria contained in carers' rights legislation, quality and safety standards and state and territory mental health legislation
- demonstrate organisational commitment to working in partnership, and
- meet various requirements of the accreditation processes.

More importantly, implementing the Guide will improve the experience of providers, consumers and carers.

> "I cried when a staff member said 'Are you John's mother? How are you going?'"
>
> **A mother's comments during consultation when developing the Guide**

The way ahead

Mental Health Carers Australia is currently coordinating a project to explore approaches to implementing the Guide in different mental health related service delivery settings. Demonstration projects will be undertaken in several states and territories and the learning and tools to come from them will be documented and made available via a website for other organisations to use. The overarching objective of the demonstration projects is to show how the Guide can fundamentally change the culture and practice of specified mental health service providers in engaging with carers, so improving outcomes for consumers.

The Guide is designed as a tool organisations can use without the need for external facilitation. It can be implemented as a whole or broken down to the standards an organisation identifies as priorities. *A Practical guide for working with carers of people with a mental illness* can be downloaded for free from **mentalhealthcarersaustralia.org.au**.

Mental Health Carers Australia is a member based national organisation representing people who support or care for a person with a mental illness

The Six Partnerships Standards

1. Carers and the essential role they play are identified at first contact, or as soon as possible thereafter.
2. Staff are carer aware and trained in carer engagement strategies.
3. Policy and protocols regarding confidentiality and sharing of information are in place.
4. Defined staff positions are allocated for carers in all service settings.
5. A carer introduction to the service and staff is available, with a relevant range of information across the care settings.
6. A range of carer support services are available.

*new**paradigm***
VOX POP

Respondents:

Mental Health Coordinating Council (MHCC) New South Wales
Northern Territory Mental Health Coalition (NTMHC)
Western Australian Association for Mental Health (WAAMH)
Mental Health Coalition of South Australia (MHCSA)
Psychiatric Disability Services of Victoria (VICSERV)
Queensland Alliance for Mental Health (QAMH)
Mental Health Council Tasmania (MHCT)

Our Vox Pop outlines workforce priorities, challenges and opportunities for the community mental health sector workforce across Australia.

1. What are the biggest challenges and opportunities facing the community mental health sector's workforce over the next decade?

Mental Health Coordinating Council, New South Wales

The biggest challenge is that there is inadequate recognition of the range of services delivered by the non-government community mental health sector, its workforce or their professional development needs.

The sector has provided help to people affected by mental health conditions for over 100 years (pre-dating government community mental health services established in the 1980s) and yet its service delivery roles and functions are not well valued – let alone the workforce that delivers them. The skills of doctors and nurses will never be enough to meet the psychosocial supports needed to deliver acute and/or subacute treatment services – neither community or hospital based – and so alternative roles and functions in a range of work settings need to be recognised and expanded. That is particularly so in regard to the 'lived experience' workforce – both peer and non-peer (i.e., roles where lived experience of recovery from a mental health condition is either essential or desirable).

Northern Territory Mental Health Coalition

For the Northern Territory, the biggest challenge is a sustainable workforce. The Territory tends to have a mobile workforce, people coming from interstate and staying for just 2–3 years, especially in the mental health sector.

Western Australian Association for Mental Health

In many ways, the challenges facing the workforce are those faced by the sector. They include the impact of client centred funding and programs, intersection of work in complex cases with other sectors, and the uneven and inequitable spread of access and opportunity for clients to benefit from services. These matters get to the heart of sector viability and response to change, the location and holistic nature of services offered and thence to the workforce's ability to respond to casualisation, location of services, skills needed to work in complex scenarios across 'sector' boundaries, and learning to understand what a career in community mental health is or is becoming.

Locally, Western Australia's Mental Health Commission is developing a workforce strategy as part of its 10 year plan and has commissioned WAAMH to produce a report on needs. The Commission has also looked for input from the alcohol and other drug sector via their peak body (Western Australian Network of Alcohol and other Drug Agencies). We will work with them to report on the workforce challenges that arise in the co-occurring space.

Mental Health Coalition of South Australia

People with mental illness have continually told us that they want more investment in supports that help people to thrive in the community. It makes economic as well as social sense to do this. In the last 10 years, SA has developed a growing body of evidence for effective services in the community managed mental health sector (CMMHS). Associated with this has been significant investment in workforce development including adoption of minimum qualifications (Certificate IV in Mental Health) for mental health workers in the CMMHS. A nascent lived experience workforce has emerged.

The next decade may see a de-emphasis on mental health-specific vocational qualifications and the National Standards for Mental Health Services in the CMMHS. The change from block funding to individualised funding will have major implications on the relationship between employers and workers. The growth of the lived experience workforce is also a huge opportunity in the new mental health environment as consumer choice becomes the norm rather than the exception.

To support our workforce may require a sector-wide approach rather than thinking organisationally. How can we support training for a workforce that works across multiple organisations if they need to? How can workers work across multiple organisations in ways that are manageable for worker, client and organisation? What systems and communication tools do we need? How does leadership development and succession planning work in a more flexible and mobile work setting?

VICSERV

The NDIS will change how mental health disability support and, potentially, mental health disability rehabilitation support will be delivered to meet the participant's specific needs. To adapt, the community mental health workforce will need to be more consumer focused and directed.

The community mental health sector is well-placed to respond if its skills and knowledge are utilised. Community organisations know the make-up of their community and understand the needs expressed by the consumers in their community. Moving forward, we need a workforce that can adapt to the changes in the make-up of communities.

Queensland Alliance for Mental Health

The National Disability Insurance Scheme (NDIS) is the biggest challenge affecting the community managed mental health sector with the scheme rolling out between 1 July 2016 and 30 June 2019. The NDIS has huge implications on the mental health workforce, bringing challenges such as:

- workforce supply, attraction and retention
- casualisation of the workforce
- recruiting and induction
- management and supervision, particularly, appropriate support for the peer workforce.

The NDIS brings opportunities such as:

- significant job and training opportunities
- workforce innovation
- resource pooling
- new service models and best practice methods
- peer workforce.

The implementation of the new Mental Health Act 2016, scheduled to take effect in March 2017, will present further challenges and opportunities over the next decade.

Mental Health Council Tasmania (MHCT)

In Tasmania a large area of concern is the difficulty in recruiting and retaining staff. The mental health sector has a rapidly aging workforce, there is very little career progression for employees, in many cases support workers are given marginal wages and benefits with limited access to relevant and effective training, and funding systems place large burdens on the workforce to meet high levels of demand with inadequate resources. It is particularly difficult to attract and retain mental health specialists even with generous incentive packages.

Because Tasmania is a highly regionalised state, with poor rural mental health services, the care of people with mental health disorders falls to others, including general practitioners, and community managed care organisations which are often ill-equipped to provide appropriate care for people with acute mental illness. When psychiatric services are available in rural areas, they are provided by outside consultants who visit the community infrequently and cannot offer sufficient contact needed for ongoing care. This also means that, on top of the added burden placed on the family members of people with mental illness living in rural areas, most of them are unable to access support or respite for themselves.

2. What developments have occurred in your state/territory in relation to mental health and its workforce as governments implement the NDIS? How does it differ to other reforms implemented?

Mental Health Coordinating Council, New South Wales

New South Wales does not currently have a mental health workforce strategy. The NSW Government Mental Health Strategic Plan 2014–2024 includes the development of a NSW Mental Health Workforce Plan, in consultation with the NSW Mental Health Commission, however progress on the strategy has been slow with some initial 2016 planning meetings but no clear direction or timeline. The NSW Ministry of Health has not had a framework for the delivery of community mental health services since 2012 which further complicates directions for workforce development. The NSW NDIS trial in the Hunter region demonstrated workforce impacts, including both challenges (for example, in recruiting sufficient skilled staff) and opportunities (such as peer workforce growth). The NSW Government must consider treatment, rehabilitation and support work roles and functions across a range of work settings in progressing the development of the Mental Health Workforce Plan. Assessing the impact of the NDIS on existing service streams and workforce skills will need to be factored in to future workforce planning to ensure the mix of services and skills are well targeted to achieve positive recovery outcomes for people with mental health conditions.

Northern Territory Mental Health Coalition

Roll-out of the NDIS for people living with psychosocial disability commenced on the 1st January 2017 in East Arnhem (Nhulunbuy). The Northern Territory is currently uncertain about the future of state-funded programs as the NDIS continues to roll out across the regions.

For the Northern Territory, the biggest challenge is a sustainable workforce. The Territory tends to have a mobile workforce, people coming from interstate and staying for just 2-3 years, especially in the mental health sector. However, professional development opportunities are rare and mostly offered in metropolitan areas, such as Darwin, Katherine and Alice Springs. High travel expenses then limit regular attendance by staff outside of those centres. Staff will also often move to the bigger centres to further their career opportunities putting regional mental health providers at a disadvantage.

With the NDIS payment schedule allowing higher invoicing for higher qualified staff service provision this will put regional mental health providers at a further disadvantage – already we are seeing permanent positions being made redundant or casual to allow more 'flexibility' under the NDIS. There has been a lot of confusion around the implementation of the NDIS and the uncertainty has been unsettling for both the service providers and their clients.

Western Australian Association for Mental Health

Western Australia does stand out, in respect of the NDIS, in that geographically limited trials and evaluations have been run to compare the national model of the NDIS and the State model.

Negotiations are currently underway between Western Australia and the Commonwealth as to how the NDIS will happen in WA. Consequently, large parts of the state have no experience of the NDIS model and sector organisations and their employees have yet to feel the impact. It would be fair to say that levels of concern in the workforce are high as there are few tangible steps to progress outside of the trials areas. This is then combined with the Primary Health Network (PHN) model in which psycho-social support does not feature and the community mental health sector workforce is thus more anxious about the future. At the state level, there is a high level of energy increasingly focusing on outcomes and impact – but the challenges here centre on how to define outcomes and accountabilities for cross-portfolio (government) and cross-sectoral (community) challenges.

Mental Health Coalition of South Australia

Roll-out of the NDIS for people living with psychosocial disability will commence in South Australia in July 2017. South Australia also has uncertainty about the future of state-funded programs as the NDIS rolls out. Concerns have been expressed about the capacity to maintain focus on services that meet the National Standards for Mental Health Services and with specialised training and professional development. There is also concern about ability to retain qualified staff at current remuneration levels as well as the capacity to retain permanent full or part-time employment for staff. At least one non-government organisation (NGO) has created a separate organisation to offer NDIS support where that workforce may work under different contractual arrangements to other mental health support staff. Others feel confident they can maintain current employment levels however these are more likely to fit into the "larger NGO" category. NGOs reliant on funding that has an uncertain future are finding it difficult to plan ahead.

The major difference is not about choice and control for consumers. The sector understands and supports that. The current challenge for this reform is about how jurisdictions balance the roll-out of the NDIS as a broad social initiative for people with disability without creating new and significant gaps in the mental health system that will disadvantage people with severe illness, regardless of whether they are eligible for NDIS or not. In this environment it is difficult to have an evidence-based conversation about the interface between disability and mental health that will lead to good outcomes for consumers and by association the community managed mental health sector.

VICSERV

An analysis of current issues experienced by consumers with psychosocial disability, their carers and their services in the NDIS trial area of Barwon highlights significant concern surrounding the loss of a skilled workforce, previously funded through the state-funded Mental Health Community Support Services (MHCSS).

The Victorian Government launched its 'Keeping our sector strong: Victoria's workforce plan' in October 2016. The Plan includes additional investments aimed at designing world-best education programs, training the future workforce, researching emerging opportunities and empowering not-for-profits to reorient to a global market. However, as the NDIS is rolled out across more regions in Victoria in 2017, significant catch up is needed to ensure that State Government reforms will lead and support the sector through the impacts of the NDIS, rather than lag behind.

Queensland Alliance for Mental Health (QAMH)

The mental health landscape in Queensland has undergone significant developments since the early 1990s. After a series of public inquiries into mental health services, all Australian governments adopted the 1992 National Mental Health Policy and a series of five-year National Mental Health Plans were established to implement what became known as the National Mental Health Strategy. Further inquiries in 2005 led to the establishment of the Queensland Plan for Mental Health 2007–2017.

The plan required a collaborative response from the mental health workforce and other agencies with growing recognition of a holistic approach to reducing the prevalence and impact on the mental health of individuals, their families, carers and communities. In 2013, the Queensland Mental Health Commission was established to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system. The workforce responded by strengthening relationships and collaborating with agencies, including housing, corrections, disability, police, child safety and emergency services.

The NDIS differs considerably from previous reforms as it moves away from 'block funding' programs to a 'fee for service' model. Earlier reforms had little effect on frontline workers. But now workforce models are changing. Frontline workers need to have an understanding of sales, customer service and the ability to work within financial constraints as well being able to adapt and customise service delivery in a person centred model.

Conversations are being held in the sector regarding formal qualifications and whether they are necessary. Some organisations are recruiting workers with no experience and no formal qualifications, with new staff undergoing customised organisational training only. For other organisations, formal qualifications are a pre-requisite. This brings opportunities for a diverse workforce.

Mental Health Council Tasmania (MHCT)

In its 10-year plan for mental health reform (Rethink Mental Health: Better Mental Health and Wellbeing – A Long-Term Plan for Mental Health in Tasmania 2015–25), the Tasmanian Government includes as a reform direction "Supporting and Developing Our Workforce." The stated goal is "to support and develop the workforce to meet the needs of an integrated mental health system and to improve the mental health and wellbeing of the Tasmanian community." The plan acknowledges that maintaining a sustainable, high quality workforce is a significant challenge in Tasmania across a range of settings, including hospitals, health care and community. To address this reform direction, the Tasmanian Government is committed to the following key actions:

1. Develop a joint workforce development strategy for the public mental health services and the private mental health sector including establishment of joint psychiatrist positions.
2. Develop opportunities for joint training to support an integrated mental health system including joint training for consumers, carers, public, private, primary health, and community sector.
3. Establish a peer workforce in public mental health services to complement the existing workforce.

3. What do you think should be the top priorities of a renewed National Mental Health Workforce Strategy?

Mental Health Coordinating Council New South Wales

Australia's National Mental Health Workforce Strategy/Plan (2011) identifies five priority outcome areas:

1. Developing, supporting and securing the current workforce.
2. Building capacity for workforce innovation and reform.
3. Building the supply of the mental health workforce.
4. Building the capacity of the general health and wellbeing workforce.
5. Data and monitoring and evaluation.

The direction for this strategy and its implementation plan appears to have been lost in the change of the Federal Government in 2013. Current national mental health reform directions do not include workforce considerations beyond, importantly, expanding the number of peer workers and nurse practitioners. This is not sufficient however to address the range of skills and work roles needed in a comprehensive mental health service system.

What are MHCC's top priorities? We want a renewed national strategy with the outcome areas above and inclusive of a greater focus on workers with vocational educational and training mental health qualifications to provide non-acute rehabilitation and support services.

Northern Territory Mental Health Coalition

- Address the need to include peer workers.
- Develop a sustainable and expanding workforce, especially in very remote communities.
- Identify and address the gaps in training for local Aboriginal and Torres Strait Islander people to deliver their own programs to their own people.

Western Australian Association for Mental Health

At first glance it would be easy to just say that the five priorities from the 2011 National Mental Health Workforce Strategy/Plan are still valid, applicable or just need to be done. But given the roll-out of the NDIS and introduction of Primary Health Networks, they should evolve.

Priorities 4 & 5 (building the capacity of the general health and wellbeing workforce, and data and monitoring and evaluation) should become standard operating procedure. They underpin high level direction changes.

This doesn't mean that they have been done and completed but a new 'top five' needs to include priorities for client and carer centred design of work and services (and thence the related skills, career pathways, role definitions, etc.). A specific recognition of the range and diversity

of the community mental health workforce, upon which so much of the effectiveness of the public workforce relies, needs to be a point of priority. This is important as the 2011 Strategy's focus on very specifically defined work roles lends itself most to the public-sector workforce and doesn't pay enough attention to very diverse and evolving roles in the community sector. This is especially a challenge for those community agencies and workers which deal with complex needs and tend not to have strictly defined 'sector' boundaries between skill and experience.

Mental Health Coalition of South Australia

1. Maintain a focus on the National Standards for Mental Health Services and a high quality and trained mental health psychosocial support workforce with Certificate IV in Mental Health or Peer Work as a minimum qualification.
2. Develop employment models that support the evolving environment and offer reasonable working conditions and remuneration for staff.
3. Understand the mental health roles in the community managed sector – develop a national map of roles, skills and reasonable remuneration that reflects the work undertaken.
4. Identify, monitor and document high performing workforce models and examples – especially through the eyes of consumers and carers.
5. Work collectively and openly across the mental health sector to ensure the workforce supports a stepped model of care and support that is centred in supporting consumers to thrive in their community.

VICSERV

1. Determine what a robust and responsive mental health system looks like and the workforce that will be needed to deliver it – identifying each of the elements. How does it compare to what we have now? What needs to change?
2. Identify the level of training and knowledge required to deliver supports within the high quality mental health system and develop national training and education standards at post graduate and undergraduate levels that will ensure graduates meet the levels required.
3. Implement employment models (for example, remuneration and other incentives) that will ensure the attraction and retention of a skilled workforce where it is needed.
4. Maintain innovation and investment to sustain a workforce of people skilled to work with participants with mental illness, including commitments to the consumer and carer peer workforce.
5. Monitor and review to ensure that the system continues to reflect the needs of the mental health sector.

Queensland Alliance for Mental Health

1. Retention.
2. Attraction.
3. Training and education for staff at all levels: board members, CEOs, managers, frontline and support staff.
4. Support; access to regular and effective supervision.
5. Effective management and leadership.

Mental Health Council Tasmania (MHCT)

1. It is critical that all sectors (public, private and NGO) jointly develop robust mental health and psychosocial support workforce planning to: identify and fill workforce gaps; provide the right training and support; provide clear projections for staff numbers and costs. Part of this work will involve state agencies and mental health services collecting information routinely on the workforce using a standardised data set in order to provide a unified picture of the mental health workforce.
2. Workforce planning for mental health across the entire care pathway must be developed to ensure that we have the comprehensive knowledge needed to identify how changes in skill mix could help improve delivery, retain staff and tackle high vacancy rates.
3. As public interest and awareness of mental health increases and stigma diminishes, many more people may consider a career in mental health and there is the potential to put in place an approach that encourages more young people to choose a career in mental health.
4. Protecting the mental health of the workforce is also vital. The adoption of good practice in the management of mental health in the workplace also helps to build perceptions of mental health services as places where people want to work.
5. A broader definition of workforce needs to be adopted for this planning process to include those people in other sectors who work with people with mental health issues. It is difficult to comprehend how undergraduate social work students, for example, are not provided with a more thorough grounding in mental health given that they will almost certainly encounter people with mental health disorders across the spectrum of their social work careers.
6. Education and training are critical to workforce development yet continuing education for all segments of the workforce tends to rely on single-session, didactic approaches. This approach has proven ineffective in changing workforce practice patterns and providing workers with confidence and job satisfaction. Additionally, the positive effects of training too often are impeded when the workplace fails to support or perhaps even hinders the use of newly learned skills. Each of these issues and others related to continuing education must be addressed in the context of a series of objectives and actions designed to strengthen workforce training and education.

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