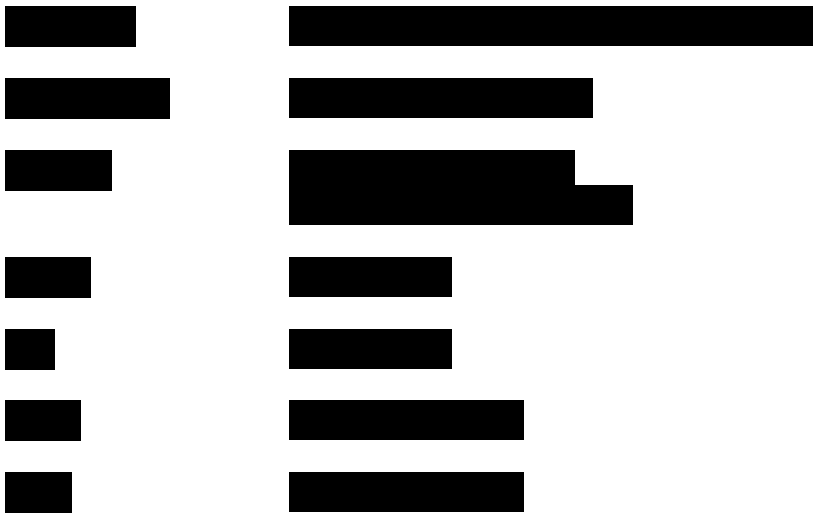
ASU Submission

Australian Government
Department of Health

National Mental Health Workforce Strategy
Consultation Draft



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1. The ASU

The Australian Services Union (ASU) is one of Australia's largest unions, representing approximately 135,000 members in the public and private sectors.

The ASU is the largest union of workers in the social, community and disability services sectors. Our members predominantly work in non-government, not-for-profit organisations that support people experiencing or at the risk of experiencing crisis, disadvantage, social dislocation, or marginalisation.

Of specific relevance to this consultation, the ASU represents workers in community mental health who work as: Community Support Workers, Community Mental Health Workers, Support Workers, Psychosocial Rehabilitation Workers, Lived Experience Mentors, Support Facilitators, Social Workers, and Case Managers.

The ASU commends the Australian Government on releasing the Development of the National Mental Health Workforce Strategy 2021-2031 for comment by stakeholders. The Workforce Strategy has been a long time in the making and extends ongoing work that has taken place to bolster the sector.

2. Recommendations

1. The primary type of employment offered to workers in the sector should be ongoing permanent employment, rather than short term contracts, to attract and retain an experienced workforce.
2. Remuneration should be fair and reflect the level of skills and experience required to perform the work to a high standard.
3. Training and professional development funding must be guaranteed under both mental health and NDIS systems to ensure ongoing skill development, career development and quality of services.
4. Short-term funding cycles and the resulting insecure funding environment are major barriers to rebuilding a stable, skilled, specialist mental health workforce. The replacement of short term funding cycles with ongoing funding should be a major priority. It should be a condition of funding contracts that employers provide their employees with permanent ongoing employment.
5. The attraction and retention challenges faced by the mental health sector are not issues of 'perception' that cannot simply be addressed by marketing campaigns about the attractiveness of the sector or by better exposure to the sector during education and training but are inextricably linked to the low wages and lack of secure work offered in the sector.

3. Aim

Unions should be recognised as stakeholders with a role to play in the mental healthcare workforce. As the representative of the workforce, the ASU is able to draw on the experience of our members employed in the mental health workforce. Our members hold a unique position: they not only support and care for the most vulnerable members of society, but are also advocates for their rights and aspirations. The ASU is committed to ongoing engagement and input with the Australian Government on the National Mental Health Workforce Strategy.

4. Objective One - Careers in mental health are, and are recognised as, attractive

The psychosocial sector clearly plays a valuable role in a strong, prevention-focused mental health system. Attracting and retaining the workforce within the psychosocial sector is important, given the relationship between a skilled mental health workforce and quality mental health services delivery.

'Attractiveness' isn't simply a matter of perception, it's about the actual jobs in the industry. Workers with skills follow the money and conditions. Vacancies will not be filled if the wages and conditions on offer are worse than those offered in other sectors.

Priority Area 1.1 and Action 1.1.1 need to be clear about what needs to change to make mental health an attractive career.

In deciding whether a job is attractive, a worker will have an eye not just on the current wage, but also on where the job is likely to take them in the foreseeable future. While wages contribute to attractiveness of an industry or role there are other important factors that impact attractiveness. These include:

- training and skills development;
- the non-financial attractions of the job, including: flexible work hours, job security, opportunities for overtime at the choice of the worker, access to supervision, whether there is a culture of long hours of unpaid work and whether work is expected in unsociable hours.
- the prospect of advancement in terms of career development and progression. This is a particularly acute issue for those in the lived experience workforce, where these opportunities are rare; and
- funding security, which ties in with job security.

The attractiveness of the sector is severely limited by its funding arrangements. The NDIS pricing model and other pricing arrangements need to properly reflect the real cost of quality mental health support, including:

- appropriate wages and conditions for the workforce and that reflects the complexity of the work they perform;
- secure jobs, not just short term casual work;
- career paths for mental health workers;
- team approaches and good quality supervision, including clinical supervision;
- specific mental health service provisions such as: case management, training, debriefing, and documentation of care plans; and
- stability of the workforce to ensure consistency for people experiencing psychosocial disability.

Funding arrangements constrain wage growth and professional development

A survey conducted by the ASU of mental health workers found that 47% of respondents reported they were looking to leave the mental health sector within the next five years. The main reason they indicated they intended to leave was the change to funding (such as the NDIS), with many citing they are able to get better pay and conditions working elsewhere.

Significant growth in sectors such as family violence, disability and aged care mean competition for workers is fierce. Until funding is set by reference to the classifications of skilled professionals, the industry will be unable to retain and most importantly attract experienced skilled mental health workers that are able to engage in the complex cognitive behavioural interventions required by mental health clients.

Work in community managed mental health is remunerated poorly when compared with comparable roles in the clinical sector.[1] Agencies are unable to offer higher wages and non-cash incentives are used to attract and retain staff due to funding constraints. ASU members have made it clear that fair remuneration matters. The sector cannot assume that this workforce will accept substandard pay and conditions because they value they find in their work.

Particular issues arise at the intersection between funding, Award rates and wages. Many mental health workers are only paid minimum Equal Remuneration Order ('**ERO**') rates under the Social, Community, Home Care and Disability Services Award (SCHADS) because funding is tied directly to those rates of pay. These rates are intended to be a minimum safety net, not the actual rates that prevail in the industry.

In particular, the introduction of the National Disability Insurance Scheme (NDIS) has entrenched minimum rates of pay as the standard for wages in the sector. This is because employers cannot charge participants more than the National Disability Insurance Agency price-cap, which is calculated based on minimum wage rate assumptions.

Additionally, the assumptions underpinning funding for wages in the NDIS are often wrong. For example, entry level employees in mental health tend to perform work that aligns with level 3 or 4 in the SCHADS Award, but NDIS pricing assumes support workers are employed at level 2.3 of the SCHADS Award.

Funding provided often does not match the full costs of service delivery and workforce development is not always included as a component of service funding. For example, NDIS direct mental health support pricing does not account for the significant professional development and training required to by the sector. The inadequate funding means it is not financially viable for service providers to offer sufficient professional supervision and training.

The low remuneration on offer for mental health workers under the NDIS mean that many skilled and experienced psychosocial workers would not consider a role in the NDIS at all. Our survey showed that many highly qualified and skilled ASU members have left the NDIS workforce in recent years.

Short term funding cycles & Insecure work

Short term funding cycles for many mental health providers means short-term employment contracts are common. Many employers engage employees on fixed-term contracts tied to funding arrangements. This means employees have little certainty about their ongoing employment in the sector or what pay and conditions will apply to their job over the long term. This means skilled-workers are less likely to consider building a career in the mental health sector.

[1] Victoria Department of Health, Shaping the future: The Victorian mental health workforce strategy: final report [Available at:] https://trove.nla.gov.au/work/172920453?q&versionId=188494997

Longer-term funding cycles and contractual obligations on employers to provide permanent employment wherever possible will be vital for attracting and retaining experienced workers in future. We believe a minimum funding cycle of five years should be established, as per the Productivity Commissions recommendation in their 2020 Mental Health Inquiry Report[2].

Workforce planning should acknowledge and address the way funding models and sector instability undermine stability of employment in the sector, which in turn impacts on service quality for consumers.

Work environment

Skilled and experienced mental health workers know they need a supportive work environment in order to deliver high quality services. They will avoid roles where insufficient work resources or poor management structures constrain the quality of their work. ASU research shows that regular professional supervision, informal team support and quality managerial relationships offset the potential for stress and burnout. Supportive line managers and available professional supervision are also vital to mental health workers wellbeing along with workforce training and professional development.

Workforce training and professional development

Mental health workers require competency in a range of areas, including: mental illness presentations, alcohol and drug use, suicide intervention, trauma informed care, motivational interviewing, goal setting and monitoring, responding to family violence and family inclusive practice. These skills cannot be developed without adequate time and financial support allocated for professional development and training. There are risks to service quality if staff are conducting psychosocial work in the community without sufficient training or support.

ASU members often highlight the importance of training in improving the quality of service they could provide. On-the-job training and development is particularly important, given that many workers in the sector do not have university qualifications. For example, many peer workers rely on their lived experience. However, the quality and quantity of training in the sector currently varies widely. The lack of enforceable or regulated qualification and training standards means workers have inconsistent access to ongoing training and professional development opportunities, and consumers are supported by inconsistently trained staff.

5. Objective Three - The entire mental health workforce is utilised

We fully support the Priority Areas for Lived Experience (Peer) Workers & Psychosocial Support Workers.

The Strategy should also involve a clear plan to grow the psychosocial support workforce over time, to make clear it is a career path worth embarking on. Consideration should be given to immediate interim funding to boost existing mental health programs, such as the Early Intervention Psychosocial Support Response program in Victoria.

[2] Productivity Commission Inquiry Report, Mental Health [Available at:]
https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health-volume1.pdf

The psychosocial support workforce operates on model based on prevention, early intervention and recovery. This is based on a holistic view of a person and not just their symptoms. It is predicated on the belief that mental illness can be prevented and that people can eventually recover. The intention is to intervene in the early stages of mental illness to prevent or reduce the progress of mental illness and then to support the person to recover from the mental illness.

The recovery model of mental illness is very different from the concepts that underpin the NDIS. The purpose of NDIS supports is not to help a person with a disability 'recover', but to assist them to overcome the social barriers that prevent from fully engaging in life. To access the NDIS, a person with a disability must present evidence that their disability is 'permanent and significant'. This is obviously at odds with a mental health model based on recovery.

If appropriately funded, the psychosocial support workforce could be a person's first and last stop for treatment for their mental illness. The over-reliance on NDIS funding limits the capability of the psychosocial sector to implement the recovery model.

In the NDIS, individualised funding means there is little money for non-client-facing activity such as supervision, team building, and training. This means that employees working in block-funded programs receive more training, team building activities and supervision/debriefing than their colleagues in individually-funded programs. Without these activities, the psychosocial support workforce cannot achieve its full potential.

Our members report some experienced larger mental health organisations are opting out of the NDIS because the task-based disability support model does not align, philosophically, with the organisation's recovery- and strength-based, community engagement model.

Effectively increasing funding and accessibility can ensure more people's mental health is supported holistically and in the community, decreasing the need for more restrictive, expensive clinical and acute services.

Work should be done to establish what core capabilities are required for the provision of high quality psychosocial support, and funding provided to develop training programs to be made available to all workers in the sector.

The government should also introduce a staged process for the introduction of mandatory qualifications (social work or equivalent degree) for specialist psychosocial support staff, to ensure that the necessary expansion of these services does not result in a reduction in service quality. A process for the recognition of current competencies should be established for the existing workforce.

The Strategy should be strengthened to ensure that wages reflect the complexities of the employee's responsibilities and duties. Our members report there are large numbers of employers who deliberately under-classify positions by manipulating position descriptions to exploit ambiguity in the SCHDS Award classification structure. Employers create roles where tertiary qualifications are 'desirable' (as opposed to 'necessary') but only hire tertiary qualification employees. This is a significant cost-saving to employers, who gain the benefit of highly skilled and productive employees at a lower rate of pay. The simple solution to this problem is to require funders to prescribe minimum classification levels for each type of work covered by a funding contract.

6. Objective Four - The mental health workforce is appropriately skilled

We wholeheartedly agree it is important to ensure the broader mental health workforces have the knowledge and skills to support people experiencing mental distress. There is great value in the overlap of roles of psychosocial and community based mental health support.

Whether it be external stakeholders such as neighbourhood centres, psychologists, alcohol and drug services or diabetes clinics, physiotherapists and osteopaths. The potential enhancement of the allied health workforce and the ability to provide multi-faceted solutions and understanding will ensure quality service for mental health consumers. It is important to ensure people with mental health issues have access to safe and inclusive services across all domains.

Additionally, we believe the broader mental health workforces could be a source of new workers for the sector as overtime they will gain the knowledge, experience and tools to effectively treat mental illness and this may ignite a new career path.

A particular focus on workforce development and training is important to ensure that all workers have the skills and qualifications necessary to provide safe, effective, trauma informed and recovery-oriented care.

The Strategy acknowledges the importance of strengthening skills of the existing and future mental health workforce. It is important workers do not bear the brunt for costs associated with additional training and education required as part of their roles. Our members often cite costs for training and/or education as a barrier. The cost of training can include: course fees, any foregone income from reduced hours of work and time traveling to classes along with the direct cost of that travel.

We believe Priority Area 4.4 should be linked to Priority 5.4 as they are inter-related. We support both priorities.

In addition, the Strategy should be strengthened by making the standardisation of professional development a priority for the plan and developing a mechanism to recognise on-the-job training when moving between employers. Our members have told us that employers have rejected training delivered by a similar organisation or a perceived inferior training provider. This is wasteful and unfair to employees.

7. Objective Five - The mental health workforce is retained in the sector

Many of the priorities and actions listed under retention are also what makes a job attractive, i.e. employment conditions, supervision, professional development, career progression, employment security. The Strategy would be strengthened if these critical measures were clearly identified upfront in Priority One as attraction pieces as well.

Retention of the Mental Health workforce also requires a workforce plan that looks at the community sector as a whole. Any workforce attraction and retention proposal that operates solely at the expense of other parts of the sector (alcohol and other drug treatment, housing and homelessness, family violence etc.) is doomed to fail.

8. Conclusion

Attracting, developing and retaining a highly skilled, specialist psychosocial mental health workforce, including peer support workers, is an essential foundation for quality psychosocial service delivery.

ASU members value secure, well remunerated jobs and clear career paths and progression as ways of retaining and attracting a qualified workforce.

Employment contracts subject to funding agreements or contracts result in insecure employment, flexible and fragmented working hours, reduced working hours and reductions in working conditions. Uncertain and short-term funding impacts on the sector's ability to attract and retain high quality staff.

The ASU, along with our members, would welcome the opportunity to provide additional evidence to the Taskforce.