
# ASU Submission

## Report - Mental Health

Productivity Commission Inquiry

**Submitter:** Linda White, Assistant National Secretary

**Organisation:** Australian Services Union

**Address:** 116 Queensberry Street
Carlton South, Victoria, 3053

**Phone:** 03 9342 1400

**Fax:** 03 9342 1499

**Date:** 23 January 2020

# Table of contents

# 1. Introduction

The Australian Services Union (ASU) is one of Australia's largest unions representing 135,000 members across a diverse range of industries. We are the union for non-government community and disability sector workers and this is the fastest growing area of our membership. These members work hard every day supporting people experiencing or at risk of experiencing crisis, disadvantage, social dislocation or marginalisation.

The ASU has members in every State and Territory of Australia, including in most regional centres.

# 2. Our Submission

The ASU welcomes the opportunity to comment on the Productivity Commission's Draft Report for mental health. The ASU made a submission to this inquiry on 4 April 2019 and attended the public hearing in Sydney on 25 November 2019. We were also invited to provide further input in Melbourne on 12 December and we thank the Productivity Commission for this opportunity.

The following submission intends to address several questions raised by the Productivity Commission during the hearings in Sydney and Melbourne. Should the Commission wish for the ASU to elaborate further on any of the issues we highlight below, we are happy to do so.

# 3. Overview of the mental health workforce in community mental health

## Profession

Chapter 11 of the Draft Report outlines many professions in the mental health sector but it does not recognise our members who work in community mental health.

Non-Government Community Mental Health is embedded in Mental Health Services as part of the stepped model of care. While NGO Community Mental Health is part of the Mental Health system, its services are distinct from, yet complement clinical mental health services. Where mental health clinicians' principal focus may be on symptom management and reduction, often through pharmacological interventions, Community Mental Health (CMH) services focus on supporting the recovery goals of consumers through various psychosocial approaches.

Our members work as Community Support Workers, and can also be known as: Community Mental Health Workers, Support Workers, Psychosocial Rehabilitation Workers, Lived Experience Mentors, Support Facilitators, Social Workers, Case Managers.

Community Support Workers assist clients with a mental health disability to provide a range of non-clinical psychosocial rehabilitation options including assistance with accessing and maintaining independent accommodation, developing independent living skills (including shopping, budgeting and family contact), accessing community activities and resources, advocacy, liaising with other systems and institutions (e.g. Public Trustee, Centrelink, Courts) and managing and maintaining their mental health and wellbeing.

Page 30 of the overview and Recommendations Draft Report talks about improving people's experience with services beyond the health system. Community Mental Health Workers are ideally placed to provide these largely psychosocial supports, advocacy and links and this work forms a core part of the support arrangements. We note that the NDIS doesn't have a model in place that can as effectively provide this service.

Support is planned and provided using an individualised, personalised and consultative approach with each client and appropriate relevant people such as family members, close friends, case managers and significant professionals. A client's personal recovery goals are determined by themselves and are not determined by the worker or the service provider.

Community mental health services focus on recovery and early intervention and operate on a strengths-based model. These services are able to provide step-up/step-down care in a flexible way to meet clients fluctuating needs. All work is guided by support and recovery plans within the recovery and collaborative model of care.

Many people with psychosocial disability have needs and impairments that change in severity and in nature over their lifetimes, sometimes changing very quickly. We recommend the importance of keeping diversity of services in the sector. For some programs eligibility is via a Government Services Key Worker, in others it may be a GP or allied health professional, in other cases eligibility is via self-referral.

Often the eligibility criteria for support is relatively low as services do not require clients to identify as having a disability, and some do not even require a formal diagnosis of mental illness in order to qualify for support. Community based Support Workers can also connect effectively with Hospital Accident and Emergency Departments. Government Mental Health Services teams triaging, look for non-medical supports such as Partners in Recovery, Personal Helpers and Mentors Programs and similar State funded programs such as GP Access to meet the needs of individuals in psychosocial distress.

Community Support Workers also receive referrals sometimes through GP's, and in many cases a client will self-refer, with some clients even just knocking on the office door. People who are supported by the community services industry can have complex needs which are often multi-faceted and require support from more than one program or support area, i.e. housing, alcohol and drugs, financial planning etc. Community Support Workers have the training, skills, flexibility and workplace support to work across multiple sectors with people experiencing multiple mental health, physical health and psychosocial issues. These positions are at risk with the loss of block funded programs or are being downgraded to lower award levels under NDIS funding, and in reality already some of these positions have been lost because of defunding and then they have not been replicated in the new funding model.

## Workforce

In our experience the community mental health workforce is qualified, skilled and experienced to support the philosophy of recovery and to provide services that are recovery focused.

The workforce requires:

- a sound understanding of mental illness and the impact of mental health problems on activities and participation;
- an understanding of evidence-based approaches to assisting people build skills, find employment, maintain a home and build social networks;
- sound understanding of rehabilitation models and related skills;
- a commitment to working with and including families; and
- an advanced understanding of recovery processes.[1]

A recent joint survey by the ASU's Victorian & Tasmania Branch and Mental Health Victoria found that 32% of respondents hold Bachelors or Honours Degrees, and 29% of respondents hold Masters Degrees. Only 8% of respondents had a Cert IV or lower as their highest completed qualification.

Many workers had significant experience with 63% of respondents having worked in the mental health sector for five years or more, and 30% having worked in the sector for 10 years or more.

[1] Community Mental Health Australia, *Workforce and the community managed mental health sector* [online] Accessed at: https://cmha.org.au/wp-content/uploads/2018/01/CMHA-Workforce-Position-Statement.pdf

However employment security is a huge factor for many workers with 46% of respondents reporting they were engaged on fixed-term contracts, and 53% reported being on permanent contracts.

Whilst the above statistics are only from Victoria, we believe them to be representative of the community mental health wider workforce.

As the Draft Report highlights the community mental health sector is experiencing a period of significant uncertainty and change and this is having a major impact on the workforce. This is due to a number of Australian Government-funded community-based mental health programs (PHaMs, PIR, D2DL, MHR:CS) having been transferred to the NDIS. This is exacerbated by State Governments transferring a percentage of their funding to the NDIS. South Australia has seen a 25% cut to NGO Mental Health Services. Due to these program losses and funding cuts some Organisations are lowering their award levels when employing Community Mental Health Support Workers, or offering voluntary and targeted redundancies and is some cases underwriting the shortfall with their own funds.

Unfortunately with the loss of funding for the above programs, we have seen many of our members lose their jobs. For example, a South Australian NGO has recently reported losing 20 staff, having to drop their Support Worker and Coordinator numbers from 80 to 60 people. With this sudden loss of staff over a six month period this NGO has reported losing 190 years of workers experience.

The NPSM (National Psychosocial Support Measure) which was funded as a stop gap strategy because of the winding up of PIR and PHAMS has a fraction of the resources and is experiencing huge demand and long waiting lists. In Adelaide there is a current waiting list of 160 distressed people with a team of five workers. This will be replicated across the country.

For workers who have remained at their service provider, low levels of funding, changing funding and uncertainty about funding, has impacted workers ability to approach work in a confident, planned, professional and organised way.

Despite many of our members leaving the sector either through loss of funding of previous programs or due to uncertainty in the sector, we do not believe it is too late to reengage these workers if longer funding cycles are implemented and there is more funding certainty and security in the sector, along with higher levels of remuneration.

## Workforce Data

In both the Sydney and Melbourne hearings the Productivity Commission asked whether the ASU was aware of workforce data specific to the community mental health sector and in particular to Community Support Workers.

In our experience workforce data for this sub-set of employees is difficult to obtain as much of the data is piecemeal and inconsistent. It often comes from surveys and data collections that only cover part of the workforce and are often not comparable, i.e. the alcohol and drug sector or the homelessness sector.

Long ago the ABS abandoned detailed statistics of the Social & Community Services and Disability workforce which has hindered planning and understanding the nature of one of Australia's fastest growing group of workers.

In South Australia 25% of Community Support workers capacity has been lost as of 31-12-2019. By 30-06-2020 there will be no PHAMS or PIR workers.

A recent Industry Workforce Analysis for the Community Sector was published by Insight Consulting Australia for the ACT Long Service Leave Authority. This analysis provides data for: the number of

workers in the sector, positions, turnover rates, age, wages and more.[2] We thought the Commission may be interested in viewing this data to assist with profiling the community mental health workforce.

We believe there is a need to develop agreed workforce data standards and definitions to ensure better data is collected about the community mental health workforce so that the sector has accurate data about the size, scope, activities and needs of the workforce – including qualifications, training and supervision expectations. We recommend that the ABS should be charged with the responsibility of collecting the data for this sector.

## Funding

### Funding for mental health programs

During several recent inquiries[3] the ASU has voiced our belief that current funding for mental health is inadequate. Funding for mental health should be at least reflective of the burden of disease attributable to mental health problems to allow adequate service delivery.

The Draft Report outlines how federal funding for community mental health services, including the PHAMS, D2DL, and PIR Program are being phased out as part of the introduction of the NDIS.

The funding of psychosocial supports does not appear to be a priority in the report and the Federal Government's responsibility for this going forward is unclear. As mentioned previously the NPSM has been poorly funded to address the defunding of PIR and PHAMS.

The Draft Report outlines two options for structure reform in mental health, those being the Renovate model or the Rebuild Model. As mentioned in the public hearings, we believe there actually needs to be both.

Firstly in the interim period, and under the renovate model we would like to see funding extensions for PHAMS, D2DL, and PIR, rather than phasing these programs out (having capacity to meet new referrals and community demand). We are concerned that if these programs are not re-funded in the interim period we will lose workers and we will lose services and the needs of the community will not be met. We are also concerned that State Governments are neglecting their responsibilities for the health and welfare of people with mental health distress by cutting funding to their State psychosocial programs.

The Draft Report highlights a recent NDIS report that recommended that:

> … the Australian Government extend funding for PIR, PHaMs and D2DL programs until 30 June 2021 and make public by 30 June 2020 how it intends to deliver longer-term arrangements for existing program clients not eligible for the NDIS.[4] Unfortunately the Australian Government did not support this recommendation and as noted in the Draft Report "the current processes in place have led to poor consumer outcomes and mass uncertainty in the sector, even amongst professionals, and many consumers do not want to apply to transition"[5].

We would like to see the above recommendation included in the Final Report.

Additionally, when we look at whether to rebuild or renovate we have specific concerns relating to linking funding to existing medical funding. The Draft Report talks about funding allied services based on funding that already exists, and our concern is threefold.

Firstly, is the commitment to a medical model of psychosocial support, whereas we know that a lot of the people who work in psychosocial support in fact are professionals that don't come with a medical qualification such as Occupational therapy, Psychology, Nursing etc.

---

[2] Insight Consulting Australia, Industry Workforce Analysis: Community Sector [online] Accessed at: https://actleave.act.gov.au/wp-content/uploads/Community-Sector-Industry-Workforce-Analysis.pdf

[3] ASU Submission – Inquiry into the accessibility and quality of mental health services in rural and remote Australia & ASU Submission - Joint Standing Committee on the NDIS Inquiry into the provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition

[4] Productivity Commission Draft Report, Mental Health p.434

[5] Productivity Commission Draft Report, Mental Health p.437

Secondly, is that linking an already underfunded sector to funding for only medical professionals is going to exacerbate an inequity that already exists, so particularly in regional and remote communities or in communities where they don't have GPs who bulk bill, and when there is a high level of people with mental health issues that either can't or don't access allied professionals or GPs or other medical practitioners. It is often the psychosocial mental health support worker who makes the links happen between the client, the GP and the Mental Health System.

Thirdly, is because psychosocial support is aimed at recovery and is a strength based approach rather than a medical deficit approach, it means that many of the people who are already accessing services other than medical services won't be identified (e.g. Employment, legal, youth, health, family and financial assistance). So it's not so much a comment on whether we would prefer rebuild or renovate, but if there's a flawed funding model it's going to exacerbate an already underfunded system.

From our perspective, the longer it takes to rebuild the system, the more likely it will be that the sector will lose people who are already working. There are many who are being lost and moving to other areas like alcohol and other drugs who probably won't come back because there has been so much change and so much chaos. That's not exactly the system that people want to come back to if it's going to take another year or two.

The Draft Report is proposing that State and Territory Governments take on sole responsibility for commissioning psychosocial supports (DR 23.2).

This would have to come with caveats as there is too much inconsistency between States in their funding for community based mental health services and their financial dealings with the Federal Government. Our preferred model is via State funding overseen by COAG, rather than commissioning by PHNs. We support 5 year block funding for psychosocial support programs which will improve staff retention, quality of services and safeguards and financial efficiency.

### Funding for the longer contract terms

The ASU is concerned about the negative impact of current contracting arrangements on the 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.

In our experience, often workers and clients don't know which program they are actually being funded by. Funding linked to a recovery based model means it is not important for workers or clients to know how they are funded, what is important is the actual recovery itself.

The current short term funding cycles have adverse consequences for not only service providers but also the workforce. Short term contracts impede the development of stable relationships with clients whilst hindering service provision at the expense of outcomes for clients.

We support the Draft Reports recommendation to increase the funding cycle length for psychosocial supports from a one-year term to a minimum of five years.[6]

### Funding and the NDIS

Community mental health and the NDIS do not provide like-for-like services. As highlighted in the Draft Report only a small number of people who require psychosocial disability support are eligible for the NDIS.[7]

[6] Productivity Commission Draft Report, Mental Health p.68
[7] Productivity Commission Draft Report, Mental Health p.430

The NDIS has not been designed to accommodate and support the bulk of mental health sufferers. This is due to the fact the NDIS is a disability program and not a mental health program, and the needs of clients are very different.

Prices for some key NDIS supports are too low and do not include critical activities and overlook the diverse circumstances in which support is provided. The nature of mental health issues means that a consumer's needs for support may vary widely over time. Consumers may have periods where they require intensive or crisis support, and other periods where they require less intensive support. The NDIS packages don't adequately take into account these fluctuating needs.

In the public hearing we told the Commission that the NDIS has taken a very tailored individual response and made it much more rigid. It doesn't allow for a range of activities such as step-up/step-down crisis response and early intervention service that delivers safe and quality supports. This is because previous block funding included funding for client face to face meetings along with travel time, workplace training, supervision etc. where the NDIS does not provide for this.

Further, in the public hearings we highlighted how many workers in the NDIS stream are performing work at a lower level. This is due to the fact that entry level employees in mental health tend to perform work that aligns with level 3 or 4 in the SCHADS Award. This work includes monitoring risk and supporting client safety, and employing evidence based practice models to support recovery in a holistic way.

NDIS pricing assumes support workers are employed at level 2.3 of the SCHADS Award. This classification will not attract and retain skilled and experienced mental health workers. NDIS direct mental health support pricing means it is not financially viable for service providers to offer sufficient professional supervision and training.

Many service providers are already, under the guise of 'transitioning to the NDIS' using less staff, lower classified staff, and staff working fewer hours in order to reduce their costs. We are seeing reductions in service levels.

**Case Study – Me Well**
Recently Neami, a leading community mental health service provider, created a subsidiary called Me Well in order to provide NDIS services. Me Well will provide services where Neami would have previously as the NDIS rolls out.

Neami's justification is that the NDIS is too poorly paid and too risky to have it near the Neami brand. They want to make Neami a specialist, clinical mental health provider and have Me Well do what they see as the low-skilled work that the NDIS demands of mental health support. They plan for it to be award based and will have people on individual contracts.

Neami have said that there will be less supervision and training given to Direct Support Workers at Me Well (SCHCADS Level 2) than Neami would have previously provided. Support Coordinators will be paid slightly more than the current Support Worker role at Neami but will have a much larger case load and less time with each client, most of which will be back-of-house stuff not face-to-face.

If mental health support workers are not sufficiently skilled and supported to perform the complex work required, worker burnout, high staff turnover and adverse client outcomes can be anticipated.

Many people accessing mental health support services have experience of relationship based trauma. Research into trauma-informed care shows trusting and consistent professional support relationships are an important foundation for recovery oriented work. While consistency cannot be guaranteed even under the best service models, a pricing structure which actively undermines stability in the mental health workforce should be avoided.

### Funding and PHNs

Funding for a number of federally funded mental health programs has transferred to the responsibility of Primary Heath Networks (PHNs).

As the Draft Report outlines

> *"nationwide, there are 31 PHNs all commissioning psychosocial supports and each has another set of compliance and reporting requirements….. with different strategies, tender processes, reporting requirements and stakeholder complexities"*[8].

In our experience working with PHN's, client results are extremely variable due to different Board Members, Directors, Locations etc. There is also no consistency in the administration of funding.

The internal training and support offered to workers can vary from PHN to PHN and is usually based on the business owners or boards personal experience and beliefs along with the organisations purpose and strategy.

With PHN's being a significant commissioner of mental health services it would be useful if there was consistent internal training that workers receive in the psychosocial sector. It would also be useful if the compliance and reporting requirements were rationalised.

PHN's priority is allied health, not community based psychosocial services. They are not funding long term psychosocial programs and are not consulting with communities or organisations who want to co-design and provide psycho social recovery, and outreach services. Some PHN's do have a focus on recovery oriented, psychosocial programs however are still limited in their implementation of these due to funding (ie NPSM) being temporary rather than an ongoing investment in community based, preventative programs that sit outside of the NDIS.

### Other funding

The Draft Report asks whether the NDIS is working well for people with psychosocial disabilities.

Our members tell us the NDIS is working for a small percentage of people in mental health distress. For the majority, the NDIS does not connect well with the mental health system. It's not set up to respond to crisis or escalating of symptoms. It's generally not a specialist mental health service and isn't a like for like replacement funding or model wise for existing programs such as PHAMS or PIR.

Staffing profiles, award levels, funding, access to supportive teams and training are different to block funded specialist community based mental health services. Consequently clients with a mental health illness are not having all their needs met by NDIS such as problem solving, crisis management, and liaisons with clinical services.

## Violence against psychosocial workers

Safety for workers is a serious concern especially those working alone in the community. Safety is improved greatly when staff have access to training, supervision and collegiate support via teams. These workers are experts at establishing rapport and responding to consumers crises as they occur.

There is a common misconception about violence against psychosocial workers, however in our experience it is more likely that a client will be a victim rather than a perpetrator of violence. Workers are trained in de-escalation tactics and because this type of work is voluntary and not mandated – the risk is minimised.

[8] Productivity Commission Draft Report, Mental Health p.424

From our member's perspective, the biggest risk for workers is actually travelling and being in a car to visit a client. Many organisations have strict policies around isolated areas or working in a client's home and workers have the support of their managers and peers.

## Early intervention

We believe that the community psychosocial sector needs to be built up and not torn down. We further believe that the current system and structure almost guarantees that those with mental health challenges have nowhere to go until the mental health issues are so acute that they need the support of clinical services.

Early intervention and prevention programs aim to improve the health and wellbeing of clients before mental health problems worsen. They can also be incredibly cost effective by reducing the demand for, and the cost of, future healthcare interventions. There may also be benefits for society and the economy more widely. Early intervention and prevention is not only for children and young adults but also for all ages experiencing a relapse. Community support Workers are specialists in supporting a consumer through these crises without necessarily having to involve hospital or other clinical services.

The Draft Report supports this premise as it details how "psychosocial supports can be cost effective as they may reduce demand for more expensive interventions. In their absence, people's needs can easily escalate to costlier services".[9]

Ultimately we believe the way in which mental health is viewed and tackled needs to be reversed. We believe funding early intervention programs to be the upmost of importance, rather than waiting for a client to have a serious mental health diagnoses and for them to be referred to the clinical sector for treatment. It would be helpful if the Productivity Commission could undertake data collection or a cost benefit analysis that assists with confirming our view that early intervention is more cost effective than treatment in the clinical sector.

## Peer workers

The Draft Report discusses peer workers, but the examples provided are of a clinical nature. We would like to see community mental health peer workers also included in the Final Report.

A mental health peer worker is someone employed on the basis of their personal lived experience of mental illness and recovery (consumer peer worker), or their experience of supporting family or friends with mental illness (carer peer worker).[10]

Peer workers are important and valued workers of the mental health workforce as they often help to create an environment for recovery by using their own lived experience to inspire hope, confidence and a sense of empowerment whilst working with a client to help build a meaningful life.

In the NGO sector Peer Workers are seamlessly incorporated into teams and provide direct support services alongside Community Support Workers.

We therefore support the Productivity Commission's recommendations [11.4] in regards to strengthening the peer workforce, including peer workers who work in the community mental health sector.

[9] Productivity Commission Draft Report, Mental Health p.420

[10] Australian Government, Peer workforce role in mental health and suicide Prevention [online] Accessed at: https://www1.health.gov.au/internet/main/publishing.nsf/content/2126B045A8DA90FDCA257F6500018260/$File/PHN%20Guidance%20-%20Peer%20Workforce%20role%20in%20Mental%20Health%20and%20Suicide%20Prevention.pdf

# 4. Conclusion and Recommendations

As highlighted in the Draft Report many of the matters discussed in this submission must be acted on with some urgency due to the timeline of the transition to the NDIS.[11] We also want to see the Final Report include more information about the sector in which our members work.

Accordingly, the ASU makes the following recommendations to the Productivity Commission for inclusion in the report.

The Federal Government should:

1. Urgently commit to funding extensions for PHAMS, D2DL, and PIR, rather than phasing these programs out (including for new consumers) with capacity to take on new referrals so waiting lists don't keep growing. The underspend on the NDIS could fund this.

2. Prioritise the development of a comprehensive NDIS psychosocial stream which extends beyond the NDIS gateway. This should include a full suite of psychosocial support types in the NDIS price guide which are priced appropriately to support the specialised, trained and qualified psychosocial workforce. We recommend a preferred provider list with only mental health standard NGOs able to provide these specialist services. Relevant Mental Health Services standards are outlined in the Australian Government National Standards for Mental Health Services strategy report 2010.

3. Develop agreed workforce data standards and definitions to ensure better data is collected about the community mental health workforce. This would include qualifications, training and supervision expectations. Data collection on these workforce statistics should be undertaken by the ABS.

4. Undertake data collection or a cost benefit analysis that assists with confirming our view that early psychosocial supports with a relapse prevention and early intervention focus is more cost effective than treatment in the clinical sector.

[11] Productivity Commission Draft Report, Mental Health p.416