WAAMH

Western Australian Association for Mental Health

Workforce Development in Community Mental Health

Final Project Report

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This project was funded by the Mental Health Commission (MHC), to ensure input from the mental health sector informed the development of the Western Australian Mental Health, Alcohol and Other Drug Workforce Strategy. It does not necessarily reflect the views of the State Government or the MHC.

The Western Australian Association for Mental Health (WAAMH) is the peak body for the community mental health sector in Western Australia and exists to champion mental wellbeing, recovery and citizenship.

WAAMH recognises a continuum of supports - built on principles of human rights, recovery, co-production, personalisation and choice, social inclusion and cultural connection - are essential to the promotion, protection and restoration of mental wellbeing. WAAMH promotes, advocates for and further develops this network of supports.

WAAMH's membership comprises community managed organisations providing mental health services, programs or supports and people and families with lived experience of mental health issues and suicide, with whom WAAMH engages in genuine partnership. WAAMH also engages a wide network of collaborative relationships at a state and national level with individuals, organisations and community members which share its values and objectives.

Acknowledgements

WAAMH wishes to acknowledge the custodians of this land, the Aboriginal people of the many traditional nations and language groups of Western Australia.

We acknowledge the wisdom of Aboriginal Elders past, present and future and pay our respect to the Aboriginal communities of today.

Thank you

WAAMH thanks members of the Project Working Group and all stakeholders from the community managed mental health sector, Aboriginal Medical Services, the sectors beyond mental health that deliver mental health services, and consumers, carers and family members who participated in surveys and interviews for this project. Your insights, experience and contributions were invaluable to this work.

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5 July 2017

Mental Health Commission (Western Australia)
1 Nash Street
Perth WA 6000

Dear Commissioner,

We are pleased to present this Workforce Development in Community Mental Health Project Report in accordance with the contractual agreement between the Western Australian Association for Mental Health (WAAMH) and the Mental Health Commission (Western Australia).

The Report presents 37 recommendations to inform the development of and contribute to the *Drug and Alcohol and Mental Health Workforce Development Strategy* being developed by the Mental Health Commission in 2017.

The WAAMH team extends its thanks and appreciation to the staff of the Commission for their support during the period of work for this project. We also wish to acknowledge the stakeholders from the community managed mental health sector, Aboriginal Medical Services, the sectors beyond mental health that deliver mental health services, and consumers, carers and family members who contributed to this project.

Yours sincerely,

The WAAMH Project Team

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Project Officer

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Executive Manager of Programs

Abbreviations

ABS	Australian Bureau of Statistics
AHCWA	Aboriginal Health Council of WA
AMS	Aboriginal Medical Services
CaLD	Culturally and Linguistically Diverse
CEO	Chief Executive Officer
DCSP	Delivering Services in Partnership Policy
FTE	Full-time-equivalent
MHC	Mental Health Commission
NDIS	National Disability Insurance Scheme
NFP	Not-for-profit
NGO	Non-government organisation
NPAH	National Partnership Agreement Homelessness Services
PHaMs	Personal Helpers and Mentors Program
PHN	Primary Health Network
PIR	Partners in Recovery
SEWB	Social and Emotional Wellbeing
VET	Vocational Education and Training
WA	Western Australia(n)
WAAMH	Western Australian Association of Mental Health
WACOSS	Western Australia Council of Social Services
WAPHA	Western Australian Primary Health Alliance

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Executive Summary

Project background and purpose

The *Workforce Development in Community Mental Health Project* was commissioned by the Western Australian (WA) Mental Health Commission and undertaken by the WA Association for Mental Health (WAAMH) to identify future workforce development needs and issues in the community mental health sector (and sectors beyond mental health that deliver mental health services). WAAMH has previously engaged and published works and papers in the subject area of workforce. A list of those projects can be found in Appendix 9.

The Project will inform and contribute to the *Drug and Alcohol and Mental Health Workforce Development Strategy* being developed by the Mental Health Commission in 2017.

For this project, the community mental health sector workforce includes:

- Specialist mental health workers who work for community mental health organisations that provide community support and other services for people affected by mental health problems and mental illness.
- Generalist workers whose core function is not mental health but who work in the community sector with people with mental health issues in areas including youth, housing, disability, community and social services, women's health, health and medical, alcohol and other drug services, Aboriginal services and employment services.

Project methods

The methodology consisted of five separate but linked activities namely:

- **Review of documents and research:** A review of national and local policy, research and material relevant to workforce issues was undertaken.
- **Agency consultations:** Consultations, site visits and face-to face and telephone interviews were undertaken with 133 representatives from 73 non-government organisations (NGOs) in Kalgoorlie/Goldfields/Esperance/the Lands, Albany, Bunbury, Busselton, the Pilbara and the Perth metropolitan area.
- **Worker survey and agency survey:** Two online surveys were distributed, one for agency Chief Executive Officers (CEOs)/managers/co-ordinators and an individual worker survey for the general mental health workforce. 47 agencies completed the CEO/manager survey and 132 workers completed the general mental health workforce survey. A range of strategies were used to achieve a high survey response.

- **Survey for consumers, carers and family members:** An online and hard copy survey for service users (consumers, carers and family members) was distributed through agencies and carer, consumer and peer networks and was completed by 24 individuals.
- **Mapping of advertised jobs:** A mapping and analysis of all advertised mental health job roles and positions in the NGO sector in Western Australia (WA) was undertaken over an 8-week period. Information was collected about 100 advertised positions.

Chapter 2 describes drivers of change that set the context in which the community managed mental health workforce operates, including mental health reforms nationally and WA's 10-year plan to address systemic shortfalls in the State's mental health system. These reforms place a great emphasis upon the increasing role of the community mental health sector to provide treatment and supports that are based upon the core reform principles of personalisation, recovery, coproduction, peer work and outcomes.

However, the increasing role for the community mental health sector is occurring in a constricted fiscal environment, with additional funding uncertainty for many organisations with the roll out of individualised funding for the National Disability Insurance Scheme (NDIS). This focus and reliance upon the community mental health sector will result in a rapid future growth of the workforce, which needs to increase in size and diversify in skills to meet the demand for services.

Chapter 3 provides an overview of the community mental health sector in WA. The size, scope and role of the sector has increased significantly over the last decade. Commonwealth and State and Territory governments spend just under 7% of their budgets on the sector. There is a lack of comprehensive data about the sector and the workforce in WA. Estimating the size and scope of the workforce is difficult.

In 2014/15 the Mental Health Commission of WA reported a total of 1,013 full-time-equivalent (FTE) staff were engaged to provide state funded mental health services in 81 funded NGO agencies. Of these, 967 FTE were paid workers and 46 were unpaid/volunteer workers, with 795 FTE directly involved in service delivery.

The Mental Health Commission reported that a total of $74.8 million was expended on Commission funded services and 20,825 consumers received direct care services from NGO funded agencies through community treatment and community support.

A 2012 WAAMH project identified 104 agencies funded by State and Commonwealth governments who collectively delivered over 272 distinct programs and services. Of the 104 agencies, around 29% provided only mental health services and 71% of agencies provided mental health services along with other community based services.

The community mental health sector workforce is diverse, well qualified, highly skilled and experienced. The level of qualifications is high with most of the workforce holding a bachelor's degree or vocational qualification (primarily Certificate IV or III).

Chapter 4 summarises findings from consultations, agency interviews and surveys under seven key themes.

1. Funding, contracting and procurement
2. Training and skills development
3. Recruitment and retention
4. Remuneration, job insecurity, casualisation and workplace issues and stress
5. Aboriginal workforce
6. NDIS
7. The peer and lived experience workforce.

Participants in the consultations and survey respondents identified a wide range of issues and for ease of reporting findings are grouped into like clusters of information.

The first four themes were the highest priority workforce issues identified and are listed in priority order.

The needs of the rural and remote workforce emerged as a significant issue and issues are highlighted under each theme, rather than as a stand-alone issue.

Chapter 5 draws out the significant implications of project findings and provides an overview of the main opportunities, challenges and risks facing the community mental health sector.

38 recommendations are presented to address the opportunities, challenges and risks and the main findings. The recommendations propose change at four levels.

Policy and funding level These are policy and funding changes to address issues identified in the project.	**Sector and network level initiatives to strengthen the sector** These are initiatives that can be pursued at the sector or inter-agency level or by groups of agencies tackling issues they cannot do alone. These initiatives require collaboration, coordination and advocacy by the sector and government.
Good practice and support at the organisational, team and individual worker level These are initiatives that can be implemented at the agency level.	**Support for specialist workforces** These are initiatives to address the needs of particular workforces: • Rural and remote workforce • Generalist workforce • Peer and lived experience workforce • Aboriginal workforce • Small agency workforce

Recommendations

Recommendations are made on the understanding that there are either many bodies, agencies, sectors or stakeholders or combinations that could action, progress or support implementation of the recommendation. Any particular references that are made merely indicate a possible starting point.

Level 1: Policy and funding changes

Note: Any Mental Health Commission policy and action in the area of commissioning and contracting should not compromise or undermine workforce development goals, either intentionally or unintentionally.

Recommendation
1.1 In considering pricing levels submitted by agencies for contracts, the Mental Health Commission satisfy itself that the pricing incorporates an adequate provision and recognition of the cost of the provision of training, supervision and workforce development, so that appropriate pricing arrangements are reflected in contracts.

Recommendation
1.2 The Mental Health Commission to recognise that pricing levels submitted by agencies may vary and change according to the location and size of the agency being funded. When agencies lack economies of scale due to size, location or other factors, the price they submit may be higher, partially due to additional costs associated with workforce requirements.
1.3 Ensure funding models for the payment of services such as consumer- centred or individualised funding account for the full cost of the employment and workforce support required (i.e. staff development, training and supervision).
1.4 The Mental Health Commission should inform itself of remuneration pressures in the sector and in employment markets and their impact on the workforce, including being aware of/comparing relevant award and enterprise agreements used by the sector to like agreements in other sectors.
1.5 Funding agencies to enter into long-term funding agreements (suggested minimum three-year funding, although five-seven years as proposed by the Productivity Commission is preferable) to maximise productive work with less disruption to the workforce, service delivery and clients. It is imperative that funding is sufficient and that indexation of grants is standard practice. Agreements should have appropriate lead in times to allow for the establishment and recruitment of a suitable qualified and productive workforce.
1.6 Ensure that conditions in funding agreements which specify what a 'suitably qualified worker' is should have regard for the necessary skills and capabilities to perform the role safely and with due regard to client dignity, care and respect.
1.7 Investigate the case for a community mental health Industry/Workforce Development Fund, which broadly supports workforce development, including the provision of training, education and supervision and workforce development.

Recommendation
1.8 The Mental Health Commission to work with the sector to develop agreed workforce data standards/definitions and specifications to enable the collection of workforce data about the community mental health workforce in WA. This should provide accurate data about the size, scope, activities and needs of the community mental health workforce as it grows and changes to allow comparisons over time.[1]

Level 2: Sector and network level initiatives to strengthen the sector

These recommendations require action at the sector or inter-agency level or by groups of agencies tackling issues they cannot do alone and are built on a foundation of collaboration, coordination and advocacy involving peak bodies, the community mental health sector, the Mental Health Commission and other interested parties.

Recommendations
2.1 Support and develop sector wide initiatives to enhance the capability and capacity of the community mental health sector to work with people with dual diagnosis and other co-morbidities and to work across agency and sector boundaries (coordination and cross sectoral skills). This includes recognition of co-morbidities where they are present, assessment, referral pathways and capacity for collaboration and treatment for people with co-morbidities such as an intellectual disability and mental health and people with mental health issues and alcohol and other drug issues.
2.2 Support and assist the community mental health sector to undertake the necessary change management, cultural change and transformation of practice at an agency level so as to place recovery and trauma informed practice at the centre of client care and services.
2.3 Continue to support sector driven initiatives that maintain the Certificate IV as the recognised entry level training qualification and investigate and support a suite of programs that bridge the gap between Certificate IV and tertiary qualifications, specifically designed or experienced practitioners and which develop a workforce

[1] A suitable approach may mirror that of the Workforce Wizard developed by National Disability Services which collects data on a quarterly basis from participating non-government disability sector agencies. See National Disability Services. (Jul 2017). *Australian Disability Workforce Report*.

Recommendations
with higher level skills (one similar example is the Drug and Alcohol Sector Alcohol and Drug Volunteer Counsellors Program).
2.4 Ensure there are no barriers to accessing the Certificate IV or any other recognised entry level qualification (as determined from time to time).
2.5 Provide support for sector wide schemes that support or encourage the recruitment, retention, and movement of staff between services and agencies (such as portable long service leave schemes).
2.6 Continue to support and fund (via grants and other means) shared and collaborative training where multiple agencies partner and work together to share costs and provide joint training and development for the workforce, with a focus on regional areas where training is faced with accessibility barriers.
2.7 Engage with and participate in discussions, where they arise, to explore innovative approaches, including shared employment and staffing arrangements, creation of combined workforce pools, workforce exchange and collaborative service arrangements that enable workforce mobility and staff working or gaining experience across agencies and sectors.
2.8 Mental Health Commission consider supporting and funding the development of a knowledge and practice based exchange platform to facilitate the sharing of innovative workforce development policy and practice in the community mental health sector (and drug and alcohol sector). This project has identified innovative practice in areas such as remote supervision, work placements, collaborative training provision, shared employment and the employment of Aboriginal staff, and it would be beneficial to have a forum and structure through which this practice could be shared.

Level 3: Good practice and support at the organisational level

While these recommendations should be addressed at a sector or agency level, the Mental Health Commission can play a role and ensure it proactively develops and maintains knowledge of the challenges faced by the sector and its workforce in delivering the services it funds and support and take action to address those issues.

Recommendations
3.1 Develop and share good practice of managers and agencies who have created agency culture(s) and practice that reduce harms to the workforce caused by high staff turnover, worker stress and burnout, workload intensification and workplace health and safety issues.
3.2 Provide greater access to clinical and/or practice supervision, mentoring, peer support and professional development and training opportunities for all staff, including peer workers and lived experience workforce.
3.3 Increase clinical and/or practice supervision and mentoring skills in the community mental health sector.
3.4 Support the expansion of the use of evidence based online training and e-learning, telehealth, Skype-type services, online and e-mental health technologies.
3.5 See recommendation 2.8 (applicable in this section).

Level 4: Support for specialist workforces

Many sectors and workforces play a role in responding to people with mental health issues and ensuring access to quality services. There is a pressing need to ensure that these various workforces have equitable access to opportunities throughout the State and are supported to undertake training, workforce development and upskilling activities.

Recommendations are presented to address the needs of these identified workforces.

Recommendations
Rural and remote workforce
4.1 Improve rural and regional mental health outcomes by developing a detailed investment and capacity building plan for the rural and remote community mental health workforce. The plan should aim to build local community and workforce capacity and support region wide and locally driven collaborative and targeted recruitment, retention, training, supervision, learning and development strategies.
4.2 Develop regional specific approaches to workforce development that foster collaborative and innovative solutions to workforce development needs,

Recommendations
supported by a combination of government funding, Royalties for Regions funds, Lotterywest and in-kind contributions from local agencies.
4.3 Develop a rural and remote grants/funding/innovation program as part of the community mental health Industry Support Fund to support best practice and collaborative approaches to rural workforce development, including recruitment, retention, training, supervision and skills development.
4.4 Support the development of innovative models for clinical and /or practice supervision in rural and remote areas, that could include fly-in-fly out, shared employment of clinical and/or practice supervisors, remote supervision (including the use of skype and other technology, e-mental health technologies) and/or shared supervision across agencies.
4.5 Resource the coordination of localised training for mental health and other sector staff within the regions of WA.
4.6 Explore and develop incentives, including the availability of non-salary and other benefits, to attract, employ and retain workers in the community mental health sector in regional and remote areas, particularly those with higher level clinical skills.
4.6 Explore and develop incentives, including the availability of non-salary and other benefits, to attract, employ and retain workers in the community mental health sector in regional and remote areas, particularly those with higher level clinical skills.
Peer workforce
4.8 Develop, resource and implement a state-wide peer workforce strategy and provide incentives to progress cultural change and embed peer work and peer workers into all relevant services.
4.9 Increase the rates of recruitment and retention of peer workers and invest in the training and development of the peer and lived experience workforce.
Generalist workforce

Recommendations
4.10 Support the provision of accessible and appropriate training, supervision, mentoring, placement and professional development opportunities for the generalist workforce who provide services to people with mental health issues.
4.11 Explore the potential of, and support and promote opportunities for, workforce exchange placements and initiatives between agencies where generalist staff work in specialist community mental health services for a time limited period to develop and share skills and practice (some examples already exist).
Small agency workforce
4.12 As part of the proposed Industry Support Fund provide specific training and development support and funding for collaborative initiatives targeting smaller agencies in which barriers to equitable access have been identified.
Aboriginal workforce
4.13 Develop an Aboriginal community mental health workforce strategy to implement the key priority in the Mental Health Commission's 10 Year Plan to increase the Aboriginal workforce across the service spectrum.
For organisations funded to provide services primarily to an Aboriginal population
4.14 Support and provide increased government investment in culturally appropriate Aboriginal controlled programs and services provided by Aboriginal workers to enhance mental health and social and emotional wellbeing among Aboriginal people and Aboriginal communities.
4.15 Train, support and upskill staff in community controlled Aboriginal health services to develop and strengthen their capacity to work with Aboriginal people on mental health and social and emotional wellbeing issues.
For organisations providing services to a population which includes Aboriginal people
4.16 Train, support and upskill staff in in the community mental health sector and generalist staff working with Aboriginal people to improve their cultural competence and capability to work with Aboriginal people on social and emotional wellbeing and mental health issues.

Recommendations
4.17 Support community mental health agencies to embed cultural considerations in recruitment and retention policies and practices for Aboriginal staff. Specific considerations could include: a) Offering Aboriginal employees extended personal leave to attend to their cultural and family responsibilities; b) An acknowledgment of the concept of time differing to that of non-Aboriginal employees; c) Developing specific employment initiatives, such as Indigenous traineeships; and d) Consideration of appropriate ways to advertise positions, job description formats and interview processes.[2]
4.18 Embed cultural security training and development within organisations for staff and board members by incorporating cultural security training and supervision into staff induction processes[3] and provide training for existing staff.
4.19 Mental Health Commission consider supporting and funding the development of a knowledge and practice based exchange platform to facilitate the sharing of innovative workforce development policy and practice in the community mental health sector. This project has identified innovative practice in area such as remote supervision, work placements, collaborative training provision, shared employment and the employment of Aboriginal staff, and it would be beneficial to have a forum and structure through which this practice could be shared.

[2] Palmerston Association Inc. (2012, pp.12-13). *Aboriginal Cultural Security Guide for Human Service Organisations.* Perth.
[3] Palmerston Association Inc. (2012, pp.3). *Aboriginal Cultural Security Guide for Human Service Organisations.* Perth.

Chapter 1: Introduction

This report of the *Workforce Development in Community Mental Health Project* was commissioned by the WA Mental Health Commission and undertaken by WAAMH to identify future workforce development needs and issues in the community mental health sector, and sectors beyond mental health that deliver mental health services.

The Project will inform and contribute to the *Drug and Alcohol and Mental Health Workforce Development Strategy* being developed by the Mental Health Commission in 2017.

The workforce is the community mental health sector's most valuable resource. The capacity of the service system to implement change and meet the needs of people who use services depends on a skilled and experienced workforce.

Project purpose and scope

The overall purpose of the Project was to map the attributes, skills development and roles of people providing community mental health services, including people whose primary role may be different but who as a result of complex issues or co-occurring and co-morbid conditions are delivering what could be termed as mental health services, from the non-government community mental health sector including peer workers, consumers and carers.

The key objectives of the Project were to:

1. Identify drivers of change, challenges, trends and future workforce requirements for the community mental health sector.
2. Gather information about the roles, position titles, skills, selection criteria, attributes, and pathways to skills acquisition of people providing community mental health services in WA.
3. Map the main workforce development needs of the community mental health sector and other sectors beyond community mental health that deliver mental health services.
4. Identify potential measures to enhance and develop the community mental health sector workforce.
5. Identify opportunities and constraints for a workforce development strategy for the community mental health sector.

The Project used a broad approach to workforce development, recognising the importance of system wide, organisational and individual factors that impact on the ability of the community mental health sector workforce to respond effectively to mental health and related issues.

Project methods

A detailed and wide-ranging consultation and research process was undertaken to understand and identify future workforce development needs and issues.

Work commenced in January 2017 with project scoping, planning and document review. Consultations and survey development began in January 2017.

As well as agencies whose provide mental health services, the project sought to identify the needs and issues of agencies whose core function is not mental health. Many NGO's cannot be classified as exclusively providing 'mental health' services or support. They primarily cater to a wide range of inter-related issues and needs, such as housing, youth, women's health, disabilities, aged care, family and domestic violence, employment, family services, homelessness and social welfare, and respond to mental health issues within the context of addressing those issues.

A range of consultation opportunities were available for agencies and community groups.

Agency consultations

Regional consultations, site visits and face-to face and telephone interviews were undertaken with 133 representatives from 73 non-government agencies. This included peak bodies and agencies providing state-wide and regional services. Details are shown in the table below:

Site	**Number of agencies consulted**	**Number of respondents**
Albany/Great Southern	17	23
Bunbury/South West	9	20
Busselton/Lower Southwest	3	5
Kalgoorlie/Goldfields/Esperance/The Lands	11	28
Pilbara	5	5
Metropolitan area and state-wide area	16	40
Other regions	12	15
Total	73	133

In all sites, the sample included large and small agencies and specialist and generalist providers of mental health services. A full list of agencies consulted in each site is listed in Appendix 1.

Site visits included face-to-face consultations with the CEOs/directors and senior managers, and in some agencies, meetings and discussion with staff. In one case, consultation was undertaken at a Perth based meeting of CEOs from regionally based services around the state. The discussion questions for the consultations are listed in Appendix 2.

Surveys

Three online surveys were distributed, one for agency CEOs/managers/coordinators, an individual worker survey for the general mental health workforce, and one for consumers, carers and family members. 47 agencies completed the CEOs/manager's survey and 132 workers completed the general mental health workforce survey. A range of strategies were used to achieve a high survey response.

An online and hard copy survey for service users (consumers, carers and family members) was distributed through agencies and carer, consumer and peer networks and was completed by 24 individuals.

CEO/manager survey

Of the organisations represented in the survey, 76% have been in existence for 20+ years, 40% have an operating budget of >$5m but <$20m, 23% have a budget of >$1m but <$5m and 20% have a budget of >$20m.

72% provide mental health services/programs in addition to other services, 19% provide mental health support but no specific programs and 9% provide mental health services only.

79% of the 47 organisations operate in the metropolitan area, 64% in regional areas and centres, 32% in medium to small towns, 23% in remote areas and 6% in very remote areas.

The survey questions and a summary of the responses are provided in Appendix 3.

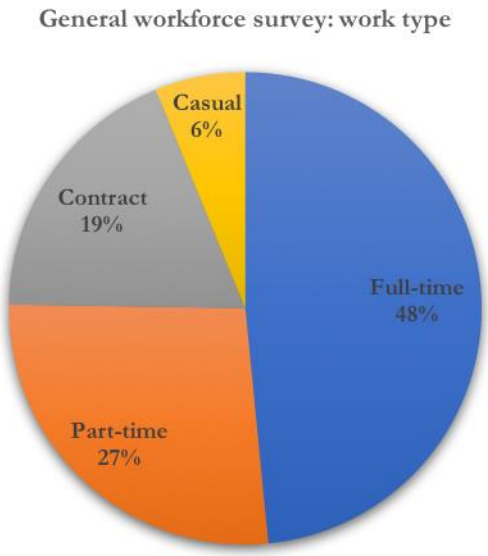
General workforce survey

There were 132 respondents to the general workforce survey. Not every respondent answered every question but over 100 responses were received for each of the questions.

80% of respondents are female. 90% are aged between 25 and 60, with 4% aged under 24.

51% of respondents have worked in the mental health sector between three and 10 years. 79% work for agencies that have been in existence for 20+ years.

88% are employed by one agency only, almost half are full-time (47%), a quarter are part-time (26%), one-fifth contract (18%) and 6% casual.



The survey questions and a summary of the responses are provided in Appendix 4.

Consumers, carers and family members survey

There were 24 respondents to the consumers, carers and family members survey.

71% of the respondents are female and 84% are aged 41-60. Almost a majority of the respondents (48%) have accessed services or support from non-government services for more than five years and 31% has accessed services or support for two to four years.

The survey questions and a summary of the responses are provided in Appendix 5.

Mapping of advertised jobs

A mapping and analysis of all advertised mental health job roles and positions in the community mental health sector in WA was undertaken over an eight-week period. Information was collected about 100 advertised positions. Of these, 83 were for advertisements for positions where the primary role of the position is to directly provide mental health services. A summary of these positions can be found in Appendix 6.

Project Working Group

A Project Working Group was established to assist with interpretation of project findings and to strategies around workforce issues, opportunities and constraints and the implications for the NGO

sector, as well as suggest actions to develop the community mental health workforce for inclusion in the Final Report.

The group had sector wide and cross sector representation and provided strategic advice and guidance to WAAMH about the findings of the Project. A list of the members of the Group can be found in Appendix 7.

Chapter 2: Project context

Drivers of change, challenges and trends

With the increased government focus on the importance of the community mental health sector in the provision of services in WA and the pending roll-out of individualised funding and the NDIS, the community mental health sector has embarked upon a period of rapid change that will provide both opportunities and challenges.

The drivers of change that set the context in which the community mental health sector operates include mental health reforms nationally and WA's 10-year plan to address the systemic shortfalls in the State's mental health system. These reforms place a great emphasis upon the increasing role of the community mental health sector to provide treatment and supports that are based upon the core reform principles of personalisation, coproduction, peer work and outcomes.

However, the increasing role for the community mental health sector is occurring in a constricted fiscal environment, with additional funding uncertainty for many community managed organisations with the roll out of individualised funding for the NDIS. This focus and reliance upon the community mental health sector will result in a rapid future growth of the workforce, which needs to increase in size and diversify in skills to meet the demand for services.

Mental health reforms

At a national level, the community mental health sector is undergoing significant multiple reforms, all of which have significant workforce implications. They require the workforce to have the appropriate information, training and skills to manage the new arrangements and to develop new referral pathways and ways of working across agencies, disciplines and sector boundaries. The reforms will result a more diverse and expanded workforce, including emerging and growing workforces such as Aboriginal mental health workers, peer workers and the lived experience workforce.[4]

National Review of Mental Health Programmes and Services

The National Mental Health Commission released *Contributing lives, thriving communities. Report of the National Review of Mental Health Programmes and Services* in November 2014. The review makes recommendations to "…create a system to support the mental health and wellbeing of individuals in

[4] National Mental Health Commission. (2017). *The 2016 Report on Mental Health and Suicide Prevention*. Sydney: NHMC, Australian Government.

a way that enables them to live contributing lives and participate as fully as possible as members of thriving communities" [5] and are based upon:

1. Person centred design principles
2. A new system architecture
3. Shifting funding to more efficient and effective 'upstream' services and supports.

The implementation of reforms in response to the review is leading to change in the funding, planning, structure and delivery of mental health services across Australia to deliver a more person centred, locally based, recovery focused and stepped care approach to mental health and suicide prevention.

National Mental Health Workforce Strategy

In order to identify and adequately address workforce development needs in the community mental health sector strategies are being researched and implemented across Australia. This work is generally benchmarked against the 2011 National Mental Health Workforce Strategy.

> *The aim of the strategy is to develop and support a well-led, high performing and sustainable mental health workforce delivering quality, recovery-focused mental health services. The focus of this strategy and plan is the workforce, whose primary role involves early intervention, referral, treatment, care or support to people with a mental illness, in a mental health service or other health service environment, including non-government community mental health services.*[6]

The five overarching outcome areas of the national strategy are:

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 table in Appendix 8 details how the findings of this report relate to the workforce strategy outcomes, objectives and strategies of the national strategy.

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[5] National Mental Health Commission. (Nov 2014). *Contributing lives, thriving communities. Report of the National Review of Mental Health Programmes and Services. Summary*. Canberra: Australian Government.
[6] Mental Health Workforce Advisory Committee. (2011, p.1). *National Mental Health Workforce Strategy.* Melbourne: Victorian Government Department of Health on behalf of the Mental Health Workforce Advisory Committee.

Mental Health 2020 and the Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025

Mental Health 2020: Making it personal and everybody's business is the WA Mental Health Commission's strategic policy that sets out priority areas for action and provides a framework to address these issues.

Mental Health 2020[7] is underpinned by three key reform areas:

- Person centred supports and services
- Connected approaches
- Balanced investment.

Mental Health 2020 identifies a range of workforce issues and challenges:

- There are shortages of mental health workers due to attrition from an ageing workforce and shortages of trained generalist and specialist workers.
- Shortages are magnified in regional areas due to the difficulty of attracting experienced practitioners.
- Strategies are required for attraction, retention, training and professional development.
- The workforce must be responsive to diversity and complexity, including people of different ages, people from Aboriginal and Culturally and Linguistically Diverse (CaLD) backgrounds, people with disability, people living in rural and remote locations and other specific population groups.

In 2015 the WA Government released the *Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025* (the Plan). The Plan outlines the optimal mix and level of mental health services required to meet the needs of Western Australians over the next ten years, and includes a major increase in the role of community mental health organisations. It is predicted in the Plan that the percentage of community support services needs to double by 2025 in order to reach the optimal mix of services detailed in the Plan, from 8% in 2012-13 to 19% in 2025.[8]

While an increase in a focus upon recovery based care from community mental health support services is long overdue and obviously welcomed, an increase of this magnitude has significant workforce impacts that must be recognised and addressed.

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[7] Western Australian Mental Health Commission. (2015). *Mental Health 2020: Making it personal and everybody's business.* Perth: Government of Western Australia.
[8] Western Australian Mental Health Commission. (2015, p.21). *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.* Perth: Government of Western Australia.

The Plan acknowledges that the implementation of the reform directions of *Mental Health 2020* requires a well-trained, sustainable and quality workforce capable of understanding and meeting the needs of people with mental health issues and/or mental illness, their families, carers and communities.

Numerous priorities for workforce development across all sectors (public/private/community) are identified in the Plan[9]:

- Increase the number and appropriate mix of skilled workers.
- Expand and build the capacity and skill of the new and emerging workforce.
- Increase the capability across the specialist mental health sector to address complex problems and meet the needs of priority target groups.
- Implement a range of initiatives to improve the capability of mental health services to deliver evidence based prevention and recovery focused programs and services.
- Ensure staff have access to supervision and support to increase staff retention.
- Explore the need to set minimum qualification requirements across the sectors.
- Build capability across the broader health and human service sectors to appropriately prevent mental illness and meet the needs of people with mental health problems.
- Increase the Aboriginal workforce and implement strategies to build the cultural security of the mental health workforce.
- Increase the CaLD workforce and implement strategies to build the cultural awareness of the mental health workforce to ensure services are respectful of cultural diversity.
- Explore innovative options to increase the number and support the sustainability of an appropriately qualified and skilled regional workforce.
- Develop and strengthen partnerships with the tertiary education sector to introduce or increase mental health content into curricula for relevant courses.

This report aims to identify which of these priorities are relevant to the community mental health sector and provide recommendations on how to address them.

Individualised funding models and the NDIS

The introduction of individualised funding, where funding is directly allocated to consumers to make it possible for them to exercise greater choice and control over the services they require, has significant implications for the community mental health workforce.

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[9] Western Australian Mental Health Commission. (2015, p.161-162). *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025*. Perth: Government of Western Australia.

Common themes emerging from research into the impact of the NDIS and its pricing structure upon the workforce in Australian trial sites[10,11] and from the literature on consumer directed care internationally[12] include:

1. Change in the amount, nature and type of work being performed, and an increase in and changes to the skills requirements of the workforce.
2. Increase in casualization of the workforce, reduced hours, and less pay.
3. Increase in the size of the workforce.
4. Increased job stress.

The community mental health sector has identified many concerns about the impact of the current NDIS pricing structure on the workforce. Reports and submissions by Mental Health Australia and Community Mental Health Australia have argued that pricing constraints and rigidity in the catalogue of NDIS supports make it difficult to remain faithful to the recovery model and to manage and deploy the workforce in a preferred manner.[13] This includes forcing service providers to reduce the quality and range of services they provide, hiring less skilled and less qualified staff and increased casualisation of the workforce.[14,15] Service providers are also concerned about the recruitment and retention of appropriately qualified staff due to the low level of funding.[16]

Rural and remote service providers face many challenges with the move to individualised funding and market based approaches.

> *[They] often face small and fluctuating client demand, large geographic distances, high transport and staffing costs and clients with limited means.*[17]

There are greater risks and uncertainty for agencies under individualised funding models,[18] and individualised funding can and often does result in the shifting of risk from funders and employers to

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[10] Community Mental Health Australia. (2015, pp.5-6). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*. Sydney: Mental Health Coordinating Council.
[11] Cortis, N., Meagher, G., Chan, S., Davidson, B., and Fattore, T. (2013, pp.24-26). *Building an Industry of Choice: Service Quality, Workforce Capacity and Consumer-Centred Funding in Disability Care*. Final Report prepared for United Voice, Australian Services Union, and Health and Community Services Union, Social Policy Research Centre. Sydney: University of New South Wales.
[12] Skills IQ. (May 2017, p.11). *Workforce implications of consumer-directed care implementation in health and community services. Project report - phase one. An evaluation of skills and roles used in the Health and Community Services sector.*
[13] Community Mental Health Australia. (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*. Sydney: Mental Health Coordinating Council.
[14] See various MHA and CMHA submissions.
[15] Mental Health Coordinating Council of NSW. (2016). *Member Consultation Briefing Note: Community Managed Mental Health Sector Development Plan Strategy*.
[16] McDonald, F. (Aug 22, 2016). *New risks for disability care workers under the NDIS*. The Conversation.
[17] Carole Bain, general manager of country services with Silver Chain cited in Belardi, L. (Feb 2015). *Reform challenges for rural and remote Australia under the spotlight*. Australian Ageing Agenda.
[18] McDonald, F. (Aug 22, 2016). *New risks for disability care workers under the NDIS*. The Conversation : Browne, R. (Aug 8, 2016). *Poor conditions proposed for NDIS workers will undermine scheme*. Sydney Morning Herald : McDonald, F., and Charlesworth S. (2016). *Cash for care under the NDIS: Shaping care workers' working conditions?* Journal of Industrial Relations, Vol 58 (5) 2016,

workers.[19] This includes more flexible and fragmented working hours, less pay, and reduced working hours and reductions in working conditions, increasing the likelihood of workers being unable to get enough work to make an adequate living.[20,21]

Jobs are also becoming more casualised as a result of individualised funding. In the disability sector casualisation rates are around 40%.[22] A recent evaluation of the NDIS found:

> *Providers were reported to be offering contract or casual positions at lower wage rates of pay and skill levels. Some increased casualisation in the workforce was perceived to be leading to higher levels of turnover and churn in the sector and reducing the quality of services for people with disability.*[23]

The full scheme roll-out of the NDIS in WA commences from 1 July 2017. The scheme will roll out across the State over the next three years. A target of 6000 people with psychosocial disability accessing the NDIS in WA is in line with the Productivity Commission estimates.[24] The roll-out of the scheme will have a significant impact upon the workforce in the community mental health sector and the move to individualised funding of services is creating a high level of uncertainty within the sector.

These impacts pose many challenges and will need to be addressed in a workforce strategy for the community mental health sector in WA and will be explored in greater detail in the following chapters.

Other drivers of change, challenges, and trends

Fiscal environment

For many years the community mental health sector in WA has operated in a fiscal environment of needing to source additional funding in order to provide services, and this is likely to continue. This

pp 627-646 : Cortis, N., Meagher., G, Chan., S, Davidson, B., and Fattore, T. (Mar 2013). *Building an Industry of Choice: Service Quality, Workforce Capacity and Consumer-Centred Funding in Disability Care*. Social Policy Research Centre, SPRC Report 02/13. Sydney: University of New South Wales.

[19] Cortis, N, Meagher, G, Chan, S, Davidson B and Fattore, T (2013) *Building an Industry of Choice: Service Quality, Workforce Capacity and Consumer-Centred Funding in Disability Care*, Social Policy Research Centre, SPRC Report 02/13, March 2013, University of New South Wales, Sydney.

[20] McDonald, F. (Aug 22, 2016). *New risks for disability care workers under the NDIS*. The Conversation.

[21] McDonald, F., and Charlesworth S. (2016). *Cash for care under the NDIS: Shaping care workers' working conditions?* Journal of Industrial Relations, Vol 58 (5) 2016, pp 627-646.

[22] National Disability Services. (2016). *State of the Disability Sector Report 2016*. National Disability Services and the Centre for Applied Disability Research.

[23] National Institute of Labour Studies. (Sept 2016, p.47). *Evaluation of the NDIS Intermediate Report*.

[24] Western Australian Association for Mental Health. (Jan 2017). *Election Policy Platform and Pre-Budget Submission: Make Mental Health Count* - 2017. Perth.

adversely affects the ability of community mental health organisations to offer appropriate remuneration and to provide training and skills development.

Sebastian Rosenberg writes that mental health remains chronically underfunded in Australia and there has been a continued failure to invest in community mental health services. In 2014-15 mental health received around 5.25% of the overall health budget, while representing 12% of the total burden of disease. In 2004-5 mental health's share of overall health spending was 4.9% and funding levels have changed little since then.[25]

A 2011 survey of the community mental health sector in WA reported that 60% of the organisations surveyed needed to secure other funding to supplement the funding they receive for their community mental health services in order to sustain and add value to their services.

> *The organisations reported expending considerable resources sourcing supplementary funding to support needs that are ongoing and cannot be met without additional funds.*[26]

A 2015 evaluation by the WA Department of Treasury of not-for-profit (NFP) organisations delivering community services on behalf of the State Government through contracts established under the Delivering Community Services in Partnership Policy (DCSP) found that in 2014-15, NFP organisations received 57% of their income through government contracts, and concluded:

> *Given the current constrained fiscal environment, the increased diversification of income sources may be required to overcome potential barriers to some organisations achieving long-term sustainability.*[27]

Also as part of the 2015 Treasury evaluation a sample of organisations were asked whether government was paying the organisations a 'fair and appropriate price' for the services contracted? While 45% of respondents were satisfied and 2% highly satisfied that the contract prices were fair, 28% of respondents viewed the contract price as unsatisfactory and 6% as highly unsatisfactory.[28]

Projected workforce growth, demand and supply

The health care and social assistance industries have created more new jobs in Australia than any other sector since 2000,[29] and the sector is set to grow even further with the reforms underway in

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[25] Rosenberg, S. (May 11, 2017). *Mental health funding in the 2017 budget is too little, unfair and lacks a coherent strategy*. The Conversation.
[26] Penter, C. & Gatter, B. (Mar, 2012, pp.ii-iii, 15). *A Project to Map the Community Mental Health Sector in Western Australia.* Perth: Western Australian Association for Mental Health.
[27] Department of Treasury. (Sept, 2016, p.3). *Sustainable Funding and Contracting with the Not-For-Profit Sector Initiative. 2015 Evaluation Report.* Perth: Government of Western Australia.
[28] Department of Treasury. (Sept, 2016, p.16). *Sustainable Funding and Contracting with the Not-For-Profit Sector Initiative. 2015 Evaluation Report.* Perth: Government of Western Australia.
[29] Spiers-Butcher, B. (Aug 1, 2016). *Reimaging NSW: how the care economy could help unclog our cities*. The Conversation.

disability, aged care, mental health, community services and the primary care industry. Australian Bureau of Statistics (ABS) data shows that in 2017 health and community services is now the single biggest employer nationally and in WA.[30]

The WA *Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025* envisages a 500% growth in the community mental health sector workforce to implement the plan.[31] This level of growth will occur in the context of similar increased workforce requirements in associated sectors, including aged care, areas of community services and health and the community mental health sector will therefore face increased competition for workers with similar skills and experience.

The NDIS is a key driver of change for the community mental health sector workforce. The full roll out of the NDIS will require significant growth in the workforce across all areas. In WA, an estimated 20,000 additional FTE workers will be required to fully implement the NDIS.[32]

Increasing demand for services drives demand for more workers, but also for a workforce with different skills and roles. This provides increased scope for support workers and care coordination and case management roles (particularly in individualised and consumer directed care models), greater emphasis on technological knowledge and skills, more roles for people with lived experience of mental health issues, heightened need for advanced clinical skills to work with clients with more high level and complex presenting issues (dual diagnosis, co morbidity, increasing case complexity and rising levels of drug and alcohol use) and cultural competence and related skills to work with a more diverse client base.[33]

A skills shortage already exists in key areas in the mental health sector. This relates to an undersupply of health workers in key areas, such as youth mental health,[34] socioeconomic and geographically disadvantaged areas, mental health nursing and clinical practitioners in rural and remote areas. The workforce's knowledge, skills, capabilities and practice need to be updated and continually improved.[35]

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[30] Australian Bureau of Statistics data cited in Greber, J. (Jun 23, 2017). *Health new backbone of workforce*. Australian Financial Review.
[31] This figure is based on projections contained in the 10 Year Plan.
[32] This figure was provided in a question from Finn, M. from Enable WA at WAAMH's Pre-Election Forum in Feb 2017.
[33] Community Services and Health Industry Skills Council. (2015). *2015 Environmental Scan, Building a Healthy Future: Skills, Planning and Enterprise*. Sydney: CS&HSIC, Community Services and Health Industry Skills Council.
[34] Freijser, L., and Brooks, P. (2013). *The Australian Health Workforce Institute Addressing Workforce Challenges for Youth Mental Health Reform*. Melbourne: Orygen Youth Health Research Centre, University of Melbourne and the Australian Health Workforce Institute.
[35] Mental Health Workforce Advisory Committee. (2011). *National Mental Health Workforce Strategy*. Melbourne: Victorian Government Department of Health on behalf of the Mental Health Workforce Advisory Committee.

Chapter 3: Profile of the community mental health workforce

This chapter profiles the community mental health sector in WA and combines publicly available information on the sector with findings from surveys undertaken for this project. For this project, the community mental health sector workforce includes:

- Specialist mental health workers who work for community mental health organisations that provide community support and other services for people affected by mental health problems and mental illness.
- Generalist workers who work with people with mental health issues in areas including youth, housing, disability, community and social services, women's health, health and medical, alcohol and other drug services, Aboriginal services and employment services.

The community mental health sector plays a critical role in supporting the mental health and wellbeing of West Australians. Services provided by the sector are fundamental to keeping people with complex mental health needs well, assisting them participate within their communities and lead contributing lives.[36] The sector is at the forefront of recovery oriented care and service delivery and provides a broad range of prevention, promotion, early intervention, rehabilitation, support, counselling and medical services. The sector has strong local networks and is actively involved in providing community based supports and services.

Size and scope of the sector and workforce in WA

In 2014-15 the Mental Health Commission reported that the size, scope and role of the community mental health sector had increased significantly over the last decade. In 2014-15 a total of 1,013 FTE staff were engaged to provide mental health services in 81 funded NGO agencies. Of these, 967 FTEs were paid workers and 46 were unpaid/volunteer workers, with 795 FTE directly involved in service delivery. A total of $74.8 million was expended on Commission funded services and 20,825 consumers received direct care services from NGO funded agencies through community treatment and community support. [37]

A Project undertaken by WAAMH in 2012 to map the community mental health sector in WA identified 104 agencies funded by State and Commonwealth governments who collectively delivered

[36] National Mental Health Commission. (2014). *Contributing Lives, Thriving Communities- Review of Mental Health Programmes and Services.*
[37] Western Australian Mental Health Commission. (2016). *Western Australia Mental Health Non-Government Organisation Establishment, In-Brief 2014/15.* Perth: Performance Monitoring and Evaluation Directorate, Mental Health Commission, Government of Western Australia.

over 272 distinct programs and services. Of the 104 agencies, around 29% provided only mental health services and 71% of agencies provided mental health services along with other community based services.[38]

In relation to the community mental health workforce, the mapping project found:

- 66% of organisations providing community mental health services had less than 10 staff and 40% of organisations had five staff or less.
- 78% of respondent organisations reported that all positions in their mental health services are occupied by people who meet required minimum qualifications.
- 22% of organisations reported that not all of their positions are filled with staff who meet required minimum qualifications.
- 31% of respondent organisations had at least one position designated as a peer support worker, or included lived experience of mental illness as a required or desirable selection criteria.
- Most of the 36% of agencies that employ at least one Aboriginal staff member in their community mental health service are in regional WA.

A training and workforce support analysis undertaken by WAAMH in 2013 estimated there were 3,867 full-time staff employed in responding agencies, with 1,112 being employed in providing mental health services. The largest 14 organisations employ a peer workforce of 102 people. This represents 11% of mental health workers.[39]

Specifics of the workforce

There is a paucity of data regarding the gender, age, numbers of staff in the peer and lived experience workforce, qualifications, and the employment status of workers in the community mental health sector in WA. National level data is therefore the most reliable information available at this time.

Gender

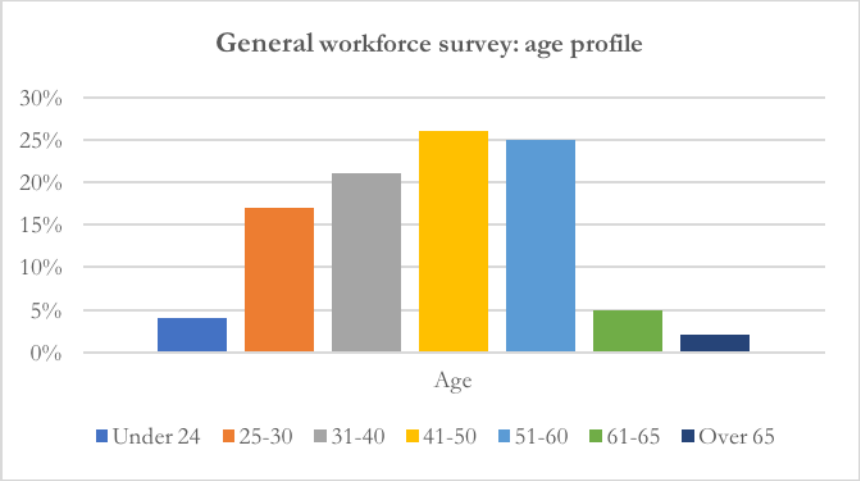
Like other community and social service jurisdictions, the community mental health sector in Australia is numerically dominated by women. In 2011, 87% of workers in community services occupations were women, a similar proportion as in 2006,[40] and in the disability sector 80% of the

[38] Penter, C., and Gatter, B. (2012.) *A Report of a Project to Map the Community Mental Health Sector in Western Australia*. Perth: Western Australian Association for Mental Health.
[39] Western Australian Association for Mental Health. (2013). *Training and Workforce Support Needs Analysis.* Perth.
[40] Australian Institute of Health and Welfare. (2013) *Chapter 9, Community Services Workforce* in *Australia's Welfare 2013; The 11th Biennial Welfare Report of the Australian Institute of Health and Welfare*. Canberra: Australian Institute of Health and Welfare, Australian Government.

workforce are women.[41] Of the respondents to the general workforce survey for this project 80% were female.

Ageing of the workforce

The community services and health sectors in Australia have an ageing workforce, with a high proportion of workers aged 45 years and over and recorded large increases in mature workers in recent years. In 2006, the sectors had a median age of 43 years, significantly higher than all other industries' median age of 39 and was the third oldest in Australia.[42] Of the respondents to the general workforce survey for this project 58% are aged 41 years or older.



The peer and lived experience workforce

Many organisations employ people with lived experience of mental health issues in paid and/or volunteer roles. These may be positions designated as peer worker, lived experience worker or recovery support worker where lived experience is a prerequisite for the role, or it may be where people bring their lived experience to the role, but that is not a requirement of the role or designated as such in the job title.

Peer workers are people who identify as having lived experience of mental ill-health and/or alcohol and other drug issues who are employed or volunteer in designated roles who use their common experience to support and inspire hope and recovery in others.[43]

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[41] McDonald, F., and Charlesworth S. (2016). *Cash for care under the NDIS: Shaping care workers' working conditions?* Journal of Industrial Relations, Vol 58 (5) 2016, pp 627-646
[42] Victorian Council of Social Service. (date unknown). *Recruitment and Retention in the Community Sector: A snap shot of current concerns, future trends and workforce strategies*. Melbourne.
[43] Western Australian Association for Mental Health. (Oct, 2014*). A Peer Work Strategic Framework for the Mental Health and Alcohol and Other Drug Sectors in WA*. Perth.

The 2012 WAAMH sector mapping project found that 31% of respondent organisations had at least one position designated as a peer support worker, or included lived experience of mental illness as a required or desirable selection criteria.

Qualifications

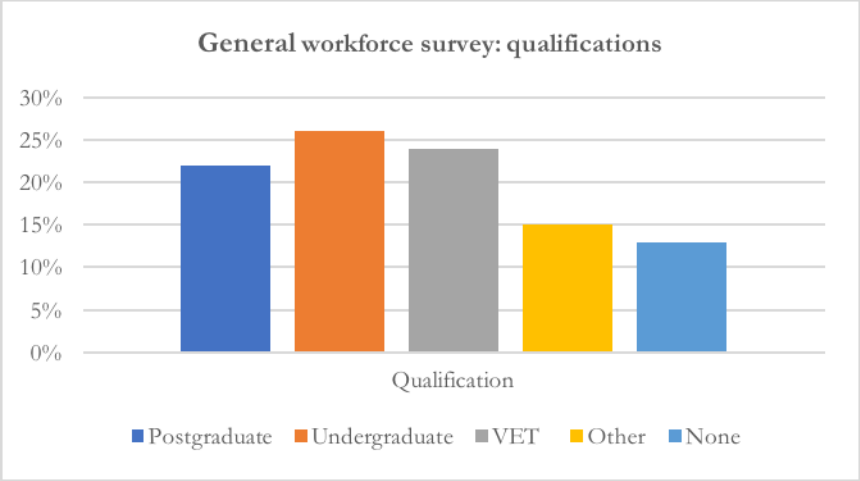
The community mental health workforce nationally is well qualified and the majority of staff have tertiary or vocational qualifications.

The 2011 National Mental Health Workforce NGO Scoping Project found that 43% of workers in community mental health organisations identified as having a bachelor degree or higher equivalent, mainly social work, psychology or nursing and 34% of workers had a vocational qualification, primarily Certificate IV and Diploma levels.[44]

The community mental health sector nationally has advocated for a voluntary minimum qualification. For psychosocial disability and recovery support work the minimum qualifications are Certificate IV in Mental Health or Certificate IV in Mental Health Peer Support Work or equivalent.[45] Over the last decade, the number of persons graduating with a Certificate IV qualification has grown rapidly, from 3263 in 2002 to 19,287 in 2012.[46]

Among the 132 respondents to the individual or general workforce survey conducted for this Project, there was an even spread of levels of primary qualification One quarter have an undergraduate qualification (26%), one quarter have a Vocational Education and Training (VET) Certificate, Diploma or Advanced Diploma (24%), one quarter have a postgraduate qualification (22%) and the remainder have other (15%) or no qualifications (13%). Of these qualifications 67% are in mental health.

[44] National Health Workforce Planning and Research Collaboration. (2011). *Mental Health Non-Government Organisation Workforce Project: Final Report*. Adelaide.
[45] Community Mental Health Australia. (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*. Sydney: Mental Health Coordinating Council.
[46] Community Mental Health Australia. (2015). *Developing the Workforce: Community Managed Mental Health Sector National Disability Insurance Scheme Workforce Development Scoping Paper Project*. Sydney: Mental Health Coordinating Council.



Employment status

There is a paucity of data regarding the employment status of workers in the community mental health sector in WA. While information on the number of FTE positions is available, this is not broken down into numbers of workers employed permanently or on contract, full-time and part-time positions or in casual positions, and the numbers of hours worked by part-time and casual employees. Anecdotally, part-time work is common in the sector.

At the national level, part-time work is substantially more common in the community services sectors. In 2011, 57% of all community services workers worked part-time hours, a higher proportion than other occupations (34%).[47] In the disability sector, non-standard work is increasingly the norm for direct support workers, with over 55% of direct support workers are employed part-time and 31% employed as casuals.[48]

[47] McDonald, F., and Charlesworth S. (2016). Cash for care under the NDIS: Shaping care workers' working conditions? Journal of Industrial Relations, Vol 58 (5) 2016, pp 627-646.
[48] McDonald, F., and Charlesworth S. (2016). Cash for care under the NDIS: Shaping care workers' working conditions? Journal of Industrial Relations, Vol 58 (5) 2016, pp 627-646.

Chapter 4: Findings

This chapter summarises findings from consultations, agency interviews and surveys. Participants and survey respondents identified a wide range of issues and the findings are grouped into like clusters of information and presented under seven key themes. The first four themes are in priority order, based on which issues were the highest priority issues identified during the project.

1. Funding, contracting and procurement
2. Training and skills development
3. Recruitment and retention
4. Remuneration, job insecurity, casualisation and workplace issues and stress
5. Aboriginal workforce
6. NDIS
7. The peer and lived experience workforce.

The needs of the rural and remote workforce emerged as a significant issue and issues are highlighted under each theme, rather than as a stand-alone issue.

Theme 1: Funding, contracting and procurement

The most significant issue raised during the project is the impact of State and Commonwealth funding, contracting and procurement arrangements on the community mental health workforce and workforce development. There is significant concern about the negative impact current funding and contracting arrangements are having on the community mental health workforce.

Heightened levels of uncertainty and insecurity about funding and contracting arrangements in the current environment impact directly on the workforce. This includes the impact of the NDIS, the transfer of block funded programs like Personal Helpers and Mentors Program (PHaMS) and Partners in Recovery (PIR) to the NDIS, uncertainty around services funded through Commonwealth funded programs such as the National Partnership Agreement on Homelessness (NPAH), uncertainty around the WA Mental Health Commission funding and uncertainty around the role of the Primary Health Network (PHN) / WAPHA in funding mental health services.

Funding issues

Issues and concerns raised during the project include the types and models of funding (for example, individualised and competitive models), changes to the type of funding (change from block funding to individualised funding), delays in contract renegotiation, inadequate funding relative to client need, short term funding, short term roll-overs or sudden program cuts, lack of certainty and security in

funding, unfunded costs carried by agencies and the workforce, funding cutbacks and reductions and concerns about individualised funding models for people with mental health issues and psychosocial disabilities.

Funding, service procurement and contracting issues impact directly on the workforce in many ways:

- Uncertainty regarding the security or renewal of funding contracts has a direct impact on the workforce.
- Insecurity of funding, in the form of short term contracts or one-year extensions, presents significant workforce challenges and is a barrier to effective workforce planning and development. Staff lack security of employment and income and staff retention is a problem as staff are likely to move to positions that offer greater security of employment and income. Agencies invest in training staff, but due to the insecurity of funding that investment is lost when staff move to more secure and better paid positions.
- The limited funding allocated in contracts for workforce development, training and supervision, particularly in individualised funding models, has a negative effect on the workforce.
- Competitive funding processes have a direct impact on the workforce. They divert attention and resources, lead to fragmentation of services and a lack of understanding about who is doing what in areas of rapid change or reorganisation. They create uncertainty and insecurity for staff and clients as contracts, services and staff change regularly and new providers with limited local history or connections win contracts. Collaboration and cooperation is impaired as agencies become hesitant about sharing information with competitors.

These issues have been raised consistently by the community mental health sector[49] and the community services sector. In 2016 WACOSS summarised the funding concerns of community sector leaders as follows:

> *Cuts to service funding are likely to continue, and there remain many areas where a lack of clear policy direction, derailed 'federation' reform processes and lack of sector engagement continue to create uncertainty. We are likely to continue to see delays in contract re-negotiation, short-term roll-overs or sudden program cuts – further undermining the challenges with retaining skilled staff and an inability to invest into long-term service development and capacity building across the sector. For the first time since the DCSP reforms were instituted in WA we have seen a Mid-Year Budget Review in which front-line*

[49] Mental Health Australia. (Oct 2015). *Commissioning and Contracting for Better Mental Health Outcomes*.

community services have not been quarantined from the savings sought through departmental reviews and efficiency dividends.[50]

Another issue raised during consultations is that policy and service decisions made by public mental health and acute services have a significant impact on the community mental health workforce. For example, if public mental health services see less clients those clients often end up with community mental health services. This also manifests in a higher level of acuity or complexity of clients being seen in community mental health services where there is a capacity constraint in the public mental health and acute services.

Theme 2: Training and skills development

Issues of training and skills development are the second most important issue raised during the project.[51]

Training

82% of managers who completed the online survey indicated that there is insufficient funding for training. Inadequate funding for training in contracts was also raised as a significant issue in the face-to-face-consultations. The lack of funding for training and skills development in individualised funding models was also raised. A common question about individualised funding models, such as the NDIS was:

Where does funding for training and workforce development come from?

With block funding agencies can allocate a proportion of funds for training. However, this is more difficult in individualised funding models.

The cost of training was raised in the consultations and the online survey as a significant issue. In addition to the cost of the training courses themselves, agencies face a 'double cost' for training as the cost of lost service delivery time while staff are at training and the additional cost of backfilling for staff in service provision roles who attend training must also be accounted for.

Many agencies said the pressure to meet contractual service obligations and the service hours requirements specified in contracts creates a barrier to staff attending training. If agencies lack the

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[50] Western Australian Council of Social Service. (2016). *Community Sector Leaders Forum on Emerging Issues. Emerging issues summary list.* Perth.

[51] Concerns about funding for workforce training were also a consistent theme in the 2012 survey of the community mental health sector in Western Australia. See Penter, C. & Gatter, B. (Mar, 2012). *A Project to Map the Community Mental Health Sector in Western Australia.* Perth: Western Australian Association for Mental Health.

capacity to backfill for staff who attend training then staff are unable to attend training. The manager of one agency said:

> *Pressure to meet Mental Health Commission contracted hours limits capacity to put hours to training.*

Inadequate funding in contracts for training and the cost of training are felt more acutely by regional and remote workers and workers in smaller agencies. Most training is provided in the metropolitan area and regional and remote agencies face the additional costs of travel and accommodation for their staff. WACOSS notes:

> *Cost pressures on regional community service providers mean they have difficulties travelling to Perth or regional centres to access training. In some instances, the cost of accommodation and travel to Perth for professional development is prohibitive. Having the capacity for personal development and training...is essential for community service providers to remain sustainable.*[52]

Smaller agencies with smaller budgets, or with a single contract, struggle to budget for the costs associated with training and workforce development. At issue is not just the cost of training, but also the service delivery time that is lost and the workload pressures that result from staff being at training, rather than providing services. Staff attending training are unable to be replaced or relieved and work duties cannot be picked up by other staff. This affects agency capacity to provide services and meet service delivery targets. A staff member from a small agency said:

> *We are already time poor and there is only two of us.*

There is seen to be a lack of coordination and fragmentation of training, particularly in regional centres. The fragmented and competitive nature of training provision in regional areas means that multiple agencies may be involved in delivering training without any local needs assessment or concerted or coordinated planning.

Consultation participants emphasised the value of joint agency approaches to training and workforce development where workers from a range of roles and agencies are brought together for training and professional development under the banner of several agencies who share costs, planning and coordination. Examples were provided from rural and regional areas where agencies sourced funding for a collaborative shared training and development initiative which was used to fund experienced

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[52] Western Australian Council of Social Service. (Oct 2010). *Issues Paper – Excerpt. Companion to the WACOSS Pre-Budget Submission. Part Two – Issues and Funding Pressures in Regional WA. Accessibility and Sustainability of Community Services in Regional WA.* Perth.

external trainers and deliver a series of programs for workers, people with lived experience and the wider community over a week.

Entry level training is considered to be well catered for and of an adequate quality. However, there is seen to be a lack of more complex and in-depth training that provides deeper understanding and more in-depth skill development for staff in key areas such as dual diagnosis and co-morbidity and working with people with personality disorders, schizophrenia, and bi-polar disorders. This is particularly the case in rural and remote areas.

Training and professional development also featured strongly in the general workers' survey. 35% of respondents chose more training and development opportunities in their top three most influential factors encouraging them to stay in the sector, and 43% ranked opportunities for developing new skills in the top three most influential factors keeping workers in their roles. 55% indicated that whether or not professional development was agency funded had high influence upon their participation.

Co-occurring and co-morbidity issues

Clients are presenting with more complex, chronic and acute needs and challenging behaviours and staff must deal with increasingly complex and acute presentations. Co-morbidity issues are proving a major challenge for agencies and workers. This includes co-morbidity involving drug and alcohol and mental health issues and co-morbidity involving disability and mental health issues, including acquired brain injury and autism.

There is an urgent need for sector wide initiatives to enhance the capability and capacity of the community mental health sector to work with (and case manage) people with dual diagnosis and other co-morbidities and complex needs.

Recovery and trauma informed practice

Staff need to be equipped with skills and capacities in recovery oriented practice, trauma informed practice, co-design and self-direction and integrated, cross sector and joined-up ways of working.

Consumers surveyed as part of this project indicated that one of the two main areas where there could be greatest improvement in community mental health services is a focus on achieving the recovery goals of the individual consumer.

However, getting all staff on board with and skilled in recovery oriented practice is not achieved by once-off training courses, but takes time and resources. Often this is an organisational change matter, as much as an individual knowledge and skill matter. This requires an ongoing response, not just

once-off training and ongoing training, support and development is needed. But how do agencies fund and sustain this over time if funding is not available in core funding or individualised funding?

Supervision

Professional and clinical supervision is a critical issue for the community mental health workforce. This is the result of the increasing complexity of client need, the intensification of workloads and the emotional and psychological impact of the work in a resource constrained environment, all of which mean that workers face more demanding situations. Access to adequate supervision is vital to ensure staff can carry out their role to a high standard.

Managers and agencies face challenges providing adequate clinical and professional supervision in a resource constrained environment. Issues identified include the availability of regular supervision for staff, variable management and agency support for supervision, limited funding for supervision. questions about how supervision is to be funded under individualised funding models and providing supervision to staff in regional and remote areas.

In rural and remote areas, there may not be staff with the clinical skills and professional experience to provide supervision. Models and strategies are needed to provide and improve supervision remotely.

Another challenge in regional and remote areas is ensuring staff can pursue professional registration. In many regional and remote communities, there are few locally based clinicians and professionals who meet the standards for clinical registration processes.

Theme 3: Recruitment and retention

Issues of recruitment and retention are ongoing issues for the sector and were identified as a high priority issue during consultations and in surveys.

As stated in Chapter 2, the WA *Mental Health, Alcohol and Other Drug Services Plan 2015 – 2025* envisages a 500% growth in the community mental health sector workforce to implement the plan,[53] and in WA an estimated 20,000 additional full time equivalent workers will be required to fully implement the NDIS.[54] Based upon the feedback received from managers for this project the need for more mental health workers is already apparent.

Key recruitment and retention concerns that emerged from the face-to-face consultations and surveys undertaken for the project follow.

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[53] This figure is based on projections contained in the 10 Year Plan.
[54] This figure was provided in a question from Finn, M. from Enable WA at WAAMH's Pre-Election Forum in Feb 2017.

There are insufficient numbers of suitably qualified and experienced workers

Recruiting staff with the right mix of skills, experience and expertise remains a challenge. Agencies generally receive plenty of applicants but finding the right candidate, with the right mix of skills and capacities and fit with agency values, is often a challenge.

In the managers' survey 88% of respondents indicated there are mental health workforce shortages in their area and 53% had experienced difficulty recruiting mental health workers in the last 12 months. For half of the positions on offer it takes two to three months to fill those positions.

In the 2012 survey of the WA community mental health sector many organisations cited workforce shortages and competition with other organisations that had capacity to provide higher remuneration as major challenges for them in attracting and retaining qualified staff in all positions.[55]

As well as recruiting experienced (and often older) staff the sector also needs to recruit younger staff. This is an ongoing issue and as a result the workforce is ageing.

Uncertainty and insecurity about funding acts as a barrier to retention and recruitment

Instability of funding and employment contracts means that only casual or contract work can be offered. Agencies with short term funding lose staff to other agencies and sectors where longer contracts and greater job security are available.

Underemployment for individuals engaged as casual or contract staff is inefficient and creates pressure on individuals to seek employment elsewhere.

Staff qualifications

While some agencies prefer to employ staff with tertiary qualifications, most agencies indicate that Certificate III and Certificate IV are the minimum entry level qualification for staff. However, in practice in some circumstances staff are employed without those qualifications. Some agencies employ staff for specific roles without qualifications, particularly in casual roles, and focus on skills, experience, and compatibility and fit with the agency and the client.

Managers who responded to the survey indicated that they overwhelmingly recruit workers with qualifications to provide mental health services and 82% of organisations have minimum qualification requirements. 86% employee people with tertiary qualifications, 71% employee people with qualifications such as a Certificate IV in mental health or peer work, and 24% employed workers who committed to gaining the relevant qualifications. 24% employ workers with no relevant formal

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[55] Penter, C. & Gatter, B. (Mar, 2012, pp.10, 32). *A Project to Map the Community Mental Health Sector in Western Australia*. Perth: Western Australian Association for Mental Health.

qualifications but relevant experience, attributes or 'soft skills'. 19% have experienced that there is an insufficient number of workers with the required qualifications. This is consistent with the results of the 2011 survey of the community mental health sector in WA when 22% of responding organisations reported that not all of their positions were filled with staff that met the required minimum qualifications[56].

Recruitment and retention is more difficult in rural and remote areas

A workforce with a sufficient number and an appropriate mix of health professionals[57,58] is integral to the sustainability of rural and remote services. However, recruiting staff with higher level clinical and professional skills (including social workers, psychologists, and mental health nurses) to work in regional areas is a problem in some locales, such as inland rural and remote locations. The cost of housing and access to education and health services are factors that impact on people's willingness to work in regional areas. WACOSS has stated:

> *A fundamental barrier to attracting and retaining workers is the lack of affordable housing in the regions…. The viability of the community services workforce in regional WA would be greatly enhanced if workers had access to subsidised housing, recognising their value to the community as key workers.*[59]

Workforce turnover is an issue in some regional areas. In some regional sites, a proportion of the workforce only stay a few years and this has a flow on effect for the mental health workforce, for example staff positions unfilled, established relationships are lost, inter-agency cooperation is disrupted, and it is harder to recruit.

Incentives are needed to attract people with tertiary qualifications, mental health experience and clinical skills to regional areas.

There is a limited pool of potential workers, particularly in rural and regional areas and employers are often in competition with each other to recruit staff. This can make it difficult and/or time consuming to fill positions. This places additional pressure on agencies and services and on the people who use services and support.

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[56] Penter, C. & Gatter, B. (Mar, 2012, pp.10, 32). *A Project to Map the Community Mental Health Sector in Western Australia*. Perth: Western Australian Association for Mental Health.
[57] Walkman, J. & Humphreys, J. (Jul 2012, pp.15) *Sustainable workforce and sustainable health systems for rural and remote Australia*. The Medical Journal of Australia, 1 Suppl 3.
[58] Onnes, L.L. (Aug 2016*). What is a sustainable remote health workforce? People, practice and place.* Rural and Remote Health 16: 3806.
[59] Western Australian Council of Social Service. (Oct 2010). *Issues Paper – Excerpt. Companion to the WACOSS Pre-Budget Submission. Part Two – Issues and Funding Pressures in Regional WA. Accessibility and Sustainability of Community Services in Regional WA*. Perth.

A more collaborative approach to recruitment at a regional and local level is needed to address the problems of recruitment.

For agencies who provide 24/7 services the pressure of filling rosters creates challenges for staff recruitment and retention and participation in workforce development activities, including training and supervision. Staff turnover is higher in rostered services.

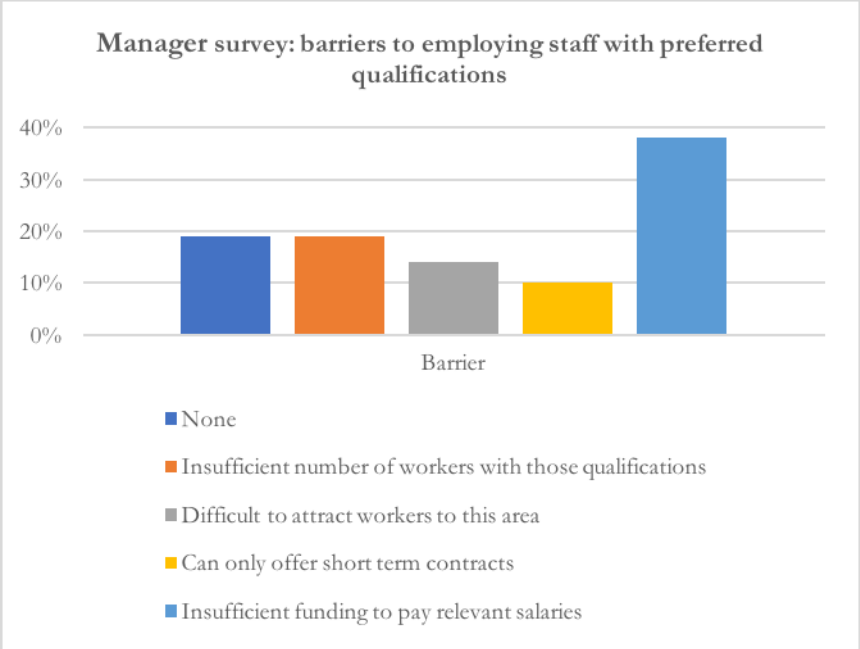
Theme 4: Remuneration, job insecurity, casualisation and workplace issues and workplace stress

Remuneration

Participants in consultations and the survey said that lower wages and remuneration received by staff in the community mental health sector, as compared to workers in the public mental health sector who perform similar roles, act as a barrier to recruiting and retaining workers. This is identified as a major reason for staff leaving the sector.

The majority of respondents to the workers' survey indicated they would like better remuneration (54% chose this in their top three factors that would encourage them to stay in the sector).

38% of managers who responded to the survey indicated that the major barrier to their organisation employing workers with the preferred qualifications is insufficient funding to pay relevant salaries.



These issues were acknowledged in the 2011 National Mental Health Workforce Strategy:

> *Remuneration levels (differences in remuneration within and between state/territory public services, and between the public and NGO sectors) are important factors in the attraction, retention, mobility and sustainability of the mental health workforce. These industrial issues apply to the whole health and community services workforce, and are not unique to the mental health workforce.*[60]

Casualisation

The number of casual staff in the sector is increasing and there is mounting concern about casualisation, although casualisation has benefits for agencies and consumers.

Some agencies are moving to staffing models heavily reliant on casual staff, particularly in sectors where funding is individualised, such as the NDIS, disability, aged care and mental health. The NDIS is a key driver of casualisation, largely the result of the individualised funding model and current pricing structures.

Some agencies have made a strategic decision to limit casual staff and retain full-time and permanent part-time positions as much as is possible. This is easier to do with block funding.

Non-salary benefits to attract and retain the workforce

Of the 83 position advertisements, 25 did not include any information about benefits of working for the organisation or within the sector generally.

Other than the standard salary packaging, benefits offered by some organisations across the sector include access to additional leave/leave loading, long service leave after five years, employee assistance programs, professional training and development opportunities, practice development sessions and supervisor mentoring, support to achieve formal qualifications, career progression opportunities, remote/district allowances including housing and electricity allowances, purchased leave and flexi time.

Workplace stress and burnout

Issues of workplace stress, burnout, workload intensification, demanding working conditions and the emotional and psychological difficulty of the work are concerns for managers and workers alike.

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[60] Mental Health Workforce Advisory Committee. (2011, p.13). *National Mental Health Workforce Strategy*. Melbourne: Victorian Government Department of Health on behalf of the Mental Health Workforce Advisory Committee.

Respondents to the workers' survey identified workload pressures, understaffing, stress, and burnout as the second highest workforce challenge.

Some issues mentioned were heavy workloads and high caseloads, poor work environments, poor morale and lack of employer support, stress and burnout, pressures resulting from understaffing and funding cuts, problems with management, bullying, intimidation and violence, lack of administrative and agency support, fear of redundancy, pressure to meet key performance indicators, excessive compliance and the impact of organisational restructuring.

Some of these issues were also raised by staff during interviews and consultations.

Several participants in interviews spoke about pressures on front line staff because of what they describe as a 'money culture' in their agency, that overrides or places pressures on the 'service culture'.

A significant number of respondents to the workers survey reported they were working hours in excess of their paid hours.

The community mental health sector experiences workplace pressures and stress not experienced by other sectors. Burnout and stress are common experiences for the mental health workforce due to:

- client pressures (including increasing numbers of clients with complex needs, complex presentations, role of drugs and alcohol, stigma, lack of community support)
- service pressures (paucity of community based services, lack of beds and services, difficulty of sharing the burden with acute service providers, less time to spend with clients, service cutbacks, lack of connect between public mental health, primary health, community mental health and other services) and
- increasing administrative and bureaucratic compliance (including paperwork, reporting requirements, regulatory compliance, risk management, complaints and agency demands).

A 2013 report on consumer centred funding in disability care found:

> *Nationally, the health and community services sector makes up around 10 percent of the Australian workforce yet it has the highest percentage of workers compensation claims for psychological distress, comprising 20 percent of claims.*[61]

[61] Cortis, N., Meagher, G., Chan, S., Davidson, B., and Fattore, T. (2013, p.27). *Building an Industry of Choice: Service Quality, Workforce Capacity and Consumer-Centred Funding in Disability Care.* Final Report prepared for United Voice, Australian Services Union, and Health and Community Services Union, Social Policy Research Centre. Sydney: University of New South Wales.

The same report raised concerns about individualised funding models:

> *In general, the evidence indicates that individualised funding schemes create a number of risks and uncertainties for workers. For those who are employed by organisations, there is evidence that organisations have passed many of the risks associated with increased flexibility onto workers, responding, for example, to increases in short notice requests with a casualised, on-call workforce, for whom there appear few offsetting benefits.*[62]

There is a need for better understanding about the extent of and impact on the community mental health workforce of changing working and employment conditions, more complex client needs, workload intensification pressures, work related stress and burnout on the capacity and health and wellbeing of the workforce.

Theme 5: NDIS

High levels of concern and anxiety about the NDIS and the implications for the community mental health workforce emerged during this project. The impact of the NDIS and the preparedness and readiness of the community mental health workforce for the NDIS and the challenge of adapting services and agency processes are significant concerns for the sector.[63]

These concerns were expressed by agencies and staff involved in the NDIS pilot sites, as well as agencies who have not been part of the trial sites.

Workforce impacts of the NDIS

A number of workforce impacts of the NDIS emerged during the project.

There is a consistent view that the flow on effects for the community mental health workforce have not been given adequate consideration. The CEO of one agency said "there is no regard for the workforce".

The NDIS is seen as a key driver of casualisation and this is a concern for many in the sector. Deskilling of the workforce is seen to be a result of the current model and pricing structure. Low pricing structures are a concern and make it more difficult to employ staff with the level of qualifications needed to work with many clients with mental health issues. This leads to a concern

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[62] Cortis, N., Meagher, G., Chan, S., Davidson, B., and Fattore, T. (2013, p.27). *Building an Industry of Choice: Service Quality, Workforce Capacity and Consumer-Centred Funding in Disability Care*. Final Report prepared for United Voice, Australian Services Union, and Health and Community Services Union, Social Policy Research Centre. Sydney: University of New South Wales.
[63] A NSW review of the readiness of the non-government sector for the NDIS undertaken by the Audit Office of New South Wales found that most NGO providers require additional and ongoing support to prepare and transition to the NDIS. New South Wales Audit Office. (2017). *Performance Audit- Building the readiness of the non-government sector for the NDIS*. New South Wales Auditor-General's Report to Parliament.

about the possible loss of a skilled, knowledgeable, and experienced workforce in the transition from block funding to individualised funding and the deskilling of the workforce as a result of the current model and pricing structure.

Agencies are concerned about whether the goal of achieving greater choice and control and flexibility for clients within the individualised funding model and current pricing structure can be achieved, whilst at the same time maintaining satisfactory employment conditions for the workforce.

General concerns about the NDIS impact on the workforce

Many general concerns were raised about the NDIS. These concerns relate to the impact of the NDIS upon people who currently receive services from the community mental health sector. These changes will also impact on the community mental health workforce.

One concern is that large numbers of people with psychosocial disabilities who previously received services through PHaMS and other programs will be ineligible for the NDIS.

There is concern about the lack of services and choice in rural and remote areas.

Theme 6: Peer and lived experience workforce

Peer work has been provided by community organisations, consumer, family and carer led groups for decades. Peer work is now recognised as integral to quality service delivery.[64] Research shows that peer workers improve recovery for individuals,[65,66] and can significantly reduce hospital bed stays and rates of post support relapse.[67] The peer workforce is a critical and integral foundation of service delivery in mental health.[68]

A key issue identified during the Project is the need to increase the peer and lived experience workforce in community mental health organisations in WA.

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[64] Western Australian Association for Mental Health. (Oct, 2014*). A Peer Work Strategic Framework for the Mental Health and Alcohol and Other Drug Sectors in WA*. Perth.

[65] Repper J., and Carter T. (2011). *A review of the literature on peer support in mental health services. Journal of Mental Health*. 20(4):392-411 cited in Western Australian Mental Health Commission (2015, p.156). Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth: Western Australian Mental Health Commission.

[66]Rowe M., Bellamy C., Baranoski M., Wieland M., O'Connell M., and Benedict P. (2007). *Peer support group intervention to reduce substance use and criminality among persons with severe mental illness*. Psychiatric Services. 58(7) cited in Western Australian Mental Health Commission (2015, p.156). Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025. Perth: Western Australian Mental Health Commission.

[67] Lawn, S., Smith, A., and Hunter, K. (2008). *Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service*. Journal of Mental Health, 17(5), 498-508 cited in Community Mental Health Australia. (2012). Taking our Place. Working Together to Improve Mental Health in the Community.

[68] Western Australian Association for Mental Health. (Oct, 2014*). A Peer Work Strategic Framework for the Mental Health and Alcohol and Other Drug Sectors in WA*. Perth.

The 2012 WAAMH sector mapping project found that 31% of respondent organisations had at least one position designated as a peer support worker, or included lived experience of mental illness as a required or desirable selection criteria.

Of the 83 mental health job advertisements analysed over a two-month period, there were just two advertisements specifically for peer workers and five advertisements that referred to peer support. Nine advertisements referred to lived experience.

Consumers surveyed as part of this project indicated that one of the two main areas where there could be greatest improvement in community mental health services is providing access to peer support/peer workers.

Some key issues regarding the peer and lived experience workforce that emerged during the project are detailed below.

Peer workers and people with lived experience are critical to the sector

People with lived experience are a growing part of the workforce and work in a variety of roles. This is attributed to an increasing recognition of the value and benefit people with lived experience bring to services and the workforce. Many people with lived experience are employed in roles not designated as peer workers.

The demand and need for mental health services is unlikely to be met by drawing on traditional workforces alone. Innovative approaches using peer workers, lived experience workers and para-professionally qualified staff are necessary.

The sector needs support to employ the peer and lived experience workforce

There is concern that whilst the value and role of peer workers and the lived experience workforce is increasingly acknowledged by government and the sector, this has not been matched by the level of funding required to employ more peer workers and lived experience workforce and to train, support and supervise these workers. Increased funding is needed for the employment of peer workers and the lived experience workforce.

Greater clarity is needed about how agencies can develop the skills and provide supervision, training and support for peer workers. The development needs of peer workers and the lived experience workforce can be overlooked. A training and development framework and guidance about effective models and practice for the supervision of peer workers and the lived experience workforce are needed.

Preparation of peer workers is an issue for some agencies. Views differ about whether the Certificate IV in Mental Health or the Certificate IV in Peer Work is the preferred qualification.

Other workers in the sector need skills to work effectively with consumers, carers, and family members

Further development is needed of the skills and capacity of the community mental health workforce to work effectively with consumers, carers, family members and significant others.

Theme 7: Aboriginal workforce

For this Project, the Aboriginal mental health workforce includes Aboriginal workers employed in specialist mental health services and generalist NGOs, as well as social and emotional wellbeing (SEWB) workers and Aboriginal mental health and health workers employed in Aboriginal community controlled services, such as Aboriginal Medical Services (AMS).

The mental health workforce in Aboriginal community controlled health services

Aboriginal health workers in Aboriginal community controlled health services play a major role in addressing mental health and social and emotional wellbeing issues, but are often not seen as part of the community mental health workforce.

As part of the Project input was sought from the Aboriginal community controlled health sector. The Aboriginal Health Council of WA (AHCWA) convened discussions with 12 AMS CEOs and AHCWA staff. Email input was provided by managers and staff from three other AMS in regional and remote areas. In addition, a face-face meeting was held with managers in one AMS during a regional site visit.

Key workforce issues raised by the CEO's, managers and staff of AMS

Many Aboriginal people prefer to access AMS for mental health support and services. However, AMS are not currently funded adequately to employ specialist mental health workers and struggle to meet the level of demand for mental health support and services from Aboriginal people, including those with serious acute needs, as well as people with lower level mental health issues.

Many AMS have experienced and skilled staff working in SEWB services and if their resources were increased, and their skills expanded, they could provide an increased level of culturally appropriate support to Aboriginal people with mental health issues.

In rural and remote areas, there is a need for increased access to culturally appropriate psychological and higher level clinical services for Aboriginal people.

Funding is needed so AMS can employ more professionally trained staff to provide mental health support and services and develop links with acute services in a culturally appropriate way. Aboriginal health workers and staff working with mental health issues also require more training on mental health.

A key issue identified during the project is the pressing need to increase the Aboriginal workforce and the non-Aboriginal workforce's level of cultural competence. The 10 Year Plan notes:

> *The delivery of culturally secure services is the responsibility of staff working across the mental health, alcohol and other drug service system.*[69]

It should be noted that over a two-month period there was only one job advertisement where Aboriginality was a prerequisite out of the 83 advertisements for the WA community mental health sector, and only three other advertisements had awareness of Aboriginal culture and/or cultural security as a minimum requirement.

Other issues regarding the Aboriginal workforce that emerged during the project follow.

Aboriginal workers and consumers require holistic models

Aboriginal people embrace a holistic concept of health, which links mental and physical health within a broader concept of social and emotional wellbeing. Aboriginal workers prefer to work in a holistic way, rather than just focus on mental health issues in isolation. This has significant implications for the Aboriginal mental health workforce.

Aboriginal concepts of social and emotional wellbeing, mental health and cultural healing, combined with culturally competent clinical practice will make the greatest contribution to achieving highest possible standard of mental health outcomes for Aboriginal people.

Many Aboriginal people want access to services where mental health and social and emotional wellbeing are integrated into health service delivery. This requires a workforce that can deliver culturally and clinically informed mental health and social and emotional wellbeing responses integrated with culturally appropriate suicide prevention, health, housing and alcohol and other drug services.

There is limited funding for social and emotional wellbeing and mental health services for Indigenous clients in both the Aboriginal community controlled sector and specialist and generalist NGOs.

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[69] Western Australian Mental Health Commission. (2015, p.148). *Better Choices. Better Lives. Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025.* Perth: Government of Western Australia.

Recruiting and training Aboriginal workers can be a challenge

Retention of Aboriginal staff in the community mental health sector is a major challenge due to community and cultural demands on staff, the stigma associated with mental health, lack of job security and low levels of remuneration. A common issue for NGOs who employ Aboriginal staff is that they are lost to more secure and better paid positions in the public sector.

Some non-Aboriginal NGOs are developing models to recruit and train Aboriginal staff (for example Aboriginal traineeships).

Chapter 5: Discussion – implications of findings and recommendations

This chapter draws out the significant implications of project findings and presents recommendations to address barriers and develop the community mental health sector workforce.

The first section provides an overview of opportunities, challenges and risks facing the community mental health sector. This draws from material presented in Chapters 2 and 3.

The second part identifies recommendations to address the opportunities, challenges and risks and the main findings of the project presented in Chapter 4. The recommendations propose change at 4 levels.

Policy and funding level These are policy and funding changes to address issues identified in the project.	**Sector and network level initiatives to strengthen the sector** These are initiatives that can be pursued at the sector or inter-agency level or by groups of agencies tackling issues they cannot do alone. These initiatives require collaboration, coordination and advocacy by the sector and government.
Good practice and support at the organisational, team and individual worker level These are initiatives that can be implemented at the agency level.	**Support for specialist workforces** These are initiatives to address the needs of particular workforces: • Rural and remote workforce • Generalist workforce • Peer and lived experience workforce • Aboriginal workforce • Small agency workforce

5.1 Opportunities, challenges and risks for the community mental health workforce

It is a critical and exciting time for the community mental health sector. The increased focus on the importance of the community managed mental health sector, the pending roll-out of individualised funding and the NDIS and changes in policy, service delivery and funding that create more flexibility in the system present new opportunities, challenges and risks for the sector. The recommendations presented in Section 5.2 are designed to address many of these issues.

Some of the major opportunities and challenges that have emerged during this project include:

Mental health reforms nationally and in WA's 10-year plan aim to address systemic shortfalls and problems in the mental health system and place greater emphasis on the role of the community mental health sector in providing services, treatment and support based upon principles of personalisation, regional and local focus, coproduction, peer work and outcomes.

However, the community mental health sector is operating in a **severely constricted fiscal environment** and remains chronically under-funded. It is also experiencing major funding uncertainty and insecurity resulting from the impact of NDIS funding, the transfer of block funded programs like PHaMS and PIR to the NDIS, uncertainty around services funded through Commonwealth funded programs such as the NPAH, uncertainty around Mental Health Commission funding and uncertainty around the role of the PHN/WAPHA in funding mental health services.

Ongoing, secure and or long-term **funding contracts and block fundin**g arrangements are becoming less common, fundamentally transforming the community mental health workforce and creating greater risks and uncertainty for agencies and workers. 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 recruit and retain high quality staff. Recruitment and retention is affected by the lower wages, heavy workloads, stressful working environments and job insecurity due to short term and uncertain funding arrangements. 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.

The community mental health sector faces significant challenges in **attracting, recruiting and retaining workers**, across a range of roles and skills, who have the necessary experience, skill and background and are compatible with agency values and philosophy.

Low levels o**f remuneration** compared to similar positions in the public sector affect staff attraction and retention. Due to funding constraints and funding levels, agencies are unable to offer higher wages and non-cash incentives are used to attract and retain staff.

Despite being the biggest employer in the country, the health and community services sectors have the fifth lowest average weekly earnings out of 13 industry sectors measured by the ABS.

The community mental health sector **workforce is diverse, well qualified, highly skilled and experienced**. The level of qualifications is high with most of the workforce holding a bachelor's degree or vocational qualification (primarily Certificate IV or III).

Non-standard work, including part-time, contract and casual work, is increasingly the norm in the community mental health (and related) sectors. While there are benefits for agencies and the workforce in non-standard work, there is also mounting concern, particularly about increasing casualisation of the workforce.

Increased service demand presents challenges, opportunities and risks. Nationwide, demand for mental health services is expected to rise between 135% and 160% by 2027, which will require almost 9000 extra mental health professionals. In addition, the WA 10-year Mental Health Plan envisages a 500% growth in the community mental health sector workforce.

The full **roll out of the NDIS** will require significant growth in the workforce across all areas. The current estimates of the required NDIS workforce expansion is 70,000 workers over the next 3-5 years and in Western Australia, an estimated 20,000 additional FTE workers will be required.

This **level of growth** will occur in the context of similar increased workforce requirements in associated sectors, including aged care, community services and health. The community mental health sector will face increased competition for workers with similar skills and experience.

Increasing demand for services drives **demand for more workers** and for a workforce with different skills and roles. It is increasingly clear that this demand cannot be met by traditional workforces alone and there is growing need to support and develop other workforces, including the peer workforce (consumer and carer peer) and lived experience workforce, the generalist workforce, the rural and remote workforce and the Aboriginal workforce.

Workforce supply pressures and skills shortages exist in key areas, such as youth mental health, rural and remote workforce, socioeconomic and geographically disadvantaged areas, mental health nursing and experienced practice/clinical practitioners willing to work in rural and remote areas.

The distribution of the workforce is another issue, specifically the **under-representation of Aboriginal workers** in the community mental health sector. This is particularly important as mental

health and social and emotional wellbeing issues have a disproportionate impact on Aboriginal people and Aboriginal communities in Western Australia.

The findings of the project show that **rural and remote services** face specific workforce challenges in terms of recruitment, retention, training, skills development and supervision. A workforce with a sufficient number and an appropriate mix of staff is integral to the sustainability of rural and remote services. However, organisations providing services in regional areas face additional difficulties in attracting and retaining appropriately trained staff including:

- the cost of living;
- the additional cost of travel;
- remoteness;
- lack of available and affordable housing; and
- low remuneration for community service workers.

The community mental health sector is responding to **more and more people with co-morbidities and chronic conditions,** particularly people with co-occurring drug and alcohol and mental health issues and intellectual disability and mental health issues. Responding to these challenges requires a highly skilled and competent workforce that can work more collaboratively with the drug and alcohol sector and other sectors and agencies, such as disabilities, housing, health, education, child and family services and justice.

The **NDIS** is driving significant change for the community mental health sector workforce. The sector is concerned that pricing constraints and rigidity in the catalogue of NDIS supports make it difficult to remain faithful to the recovery model and to manage and deploy the workforce in a preferred manner. In addition, evidence emerging from research into the impact of the NDIS on the workforce highlights risks and opportunities including:

- Change in the amount, nature and type of work being performed, and changes to the skills requirements of the workforce.
- Concerns about the recruitment and retention of appropriately qualified staff and reductions in service quality due to the low funding levels.
- Increased casualisation of the workforce, reduced hours, and less pay for some staff.
- Increase in the size of the workforce.
- Increased job stress.

5.2 Recommendations

Not all recommendations require action by the Mental Health Commission to progress. Some initiatives are best progressed by peaks, agencies and bodies other than the Commission, although the Commission's initiative, endorsement or support may be necessary.

Recommendations are therefore made on the understanding that there are either many bodies, agencies, sectors or stakeholders or combinations that could action, progress or support implementation of the recommendation. Any particular references that are made merely indicate a possible starting point.

Level 1: Policy and funding changes

Project findings show that the community mental health sector is vulnerable in its ability to sustain and develop a workforce sufficiently equipped to deliver services to a growing cohort of clients with increasingly complex and challenging needs, in a resource constrained environment.

A major cause of this vulnerability, universally expressed by the people who participated in this project, is funding, contracting and procurement arrangements that do not provide for adequate levels of remuneration, employment security, training, and the development and upskilling of the community mental health workforce to achieve client outcomes.

Concern about levels of remuneration remains a significant issue for the sector and the workforce and the resultant impact on the recruitment and retention of staff.

Any Mental Health Commission policy and action in the area of commissioning and contracting should not compromise or undermine workforce development goals, either intentionally or unintentionally.

Recommendation
1.1 In considering pricing levels submitted by agencies for contracts, the Mental Health Commission satisfy itself that the pricing incorporates an adequate provision and recognition of the cost of the provision of training, supervision and workforce development, so that appropriate pricing arrangements are reflected in contracts.
1.2 The Mental Health Commission to recognise that pricing levels submitted by agencies may vary and change according to the location and size of the agency being funded. When agencies lack economies of scale due to size, location or other

Recommendation
factors, the price they submit may be higher, partially due to additional costs associated with workforce requirements.
1.3 Ensure funding models for the payment of services such as consumer centred or individualised funding account for the full cost of the employment and workforce support required (i.e. staff development, training and supervision).
1.4 The Mental Health Commission should inform itself of remuneration pressures in the sector and in employment markets and their impact on the workforce, including being aware of/comparing relevant award and enterprise agreements used by the sector to like agreements in other sectors.
1.5 Funding agencies to enter into long term funding agreements (suggested minimum three-year funding, although five-seven years as proposed by the Productivity Commission is preferable) to maximise productive work with less disruption to the workforce, service delivery and clients. It is imperative that funding is sufficient and that indexation of grants is standard practice. Agreements should have appropriate lead in times to allow for the establishment and recruitment of a suitable qualified and productive workforce.
1.6 Ensure that conditions in funding agreements which specify what a 'suitably qualified worker' is should have regard for the necessary skills and capabilities to perform the role safely and with due regard to client dignity, care and respect.
1.7 Investigate the case for a community mental health Industry/Workforce Development Fund, which broadly supports workforce development, including the provision of training, education and supervision and workforce development.
1.8 The Mental Health Commission to work with the sector to develop agreed workforce data standards/definitions and specifications to enable the collection of workforce data about the community mental health workforce in WA. This should provide accurate data about the size, scope, activities and needs of the community mental health workforce as it grows and changes to allow comparisons over time.[70]

[70] A suitable approach may mirror that of the Workforce Wizard developed by National Disability Services which collects data on a quarterly basis from participating non-government disability sector agencies. See National Disability Services. (Jul 2017). *Australian Disability Workforce Report*.

Level 2: Sector and network level initiatives to strengthen the sector

These recommendations require action at the sector or inter-agency level or by groups of agencies tackling issues they cannot do alone and are built on a foundation of collaboration, coordination and advocacy involving peak bodies, the community mental health sector, the Mental Health Commission and other interested parties.

Recommendations
2.1 Support and develop sector wide initiatives to enhance the capability and capacity of the community mental health sector to work with people with dual diagnosis and other co-morbidities and to work across agency and sector boundaries (coordination and cross sectoral skills). This includes recognition of co-morbidities where they are present, assessment, referral pathways and capacity for collaboration and treatment for people with co-morbidities such as an intellectual disability and mental health and people with mental health issues and alcohol and other drug issues.
2.2 Support and assist the community mental health sector to undertake the necessary change management, cultural change and transformation of practice at an agency level so as to place recovery and trauma informed practice at the centre of client care and services.
2.3 Continue to support sector driven initiatives that maintain the Certificate IV as the recognised entry level training qualification and investigate and support a suite of programs that bridge the gap between Certificate IV and tertiary qualifications, specifically designed or experienced practitioners and which develop a workforce with higher level skills (one similar example is the Drug and Alcohol Sector Alcohol and Drug Volunteer Counsellors Program).
2.4 Ensure there are no barriers to accessing the Certificate IV or any other recognised entry level qualification (as determined from time to time).
2.5 Provide support for sector wide schemes that support or encourage the recruitment, retention, and movement of staff between services and agencies (such as portable long service leave schemes).

Recommendations
2.6 Continue to support and fund (via grants and other means) shared and collaborative training where multiple agencies partner and work together to share costs and provide joint training and development for the workforce, with a focus on regional areas where training is faced with accessibility barriers.
2.7 Engage with and participate in discussions, where they arise, to explore innovative approaches, including shared employment and staffing arrangements, creation of combined workforce pools, workforce exchange and collaborative service arrangements that enable workforce mobility and staff working or gaining experience across agencies and sectors.
2.8 Mental Health Commission consider supporting and funding the development of a knowledge and practice based exchange platform to facilitate the sharing of innovative workforce development policy and practice in the community mental health sector (and drug and alcohol sector). This project has identified innovative practice in areas such as remote supervision, work placements, collaborative training provision, shared employment and the employment of Aboriginal staff, and it would be beneficial to have a forum and structure through which this practice could be shared.

Level 3: Good practice and support at the organisational level

The community mental health sector workforce experiences work related pressures and stress not experienced by other sectors. Burnout and stress are common experiences for the workforce due to client pressures, service pressures and a perceived increasing administrative and bureaucratic compliance impost. Agencies need to develop cultures of workforce wellbeing that promote the health of the workforce.

Another factor is the significant amount of change occurring across the sector that is causing considerable uncertainty, anxiety, workload intensification and stress for the workforce.

While these recommendations should be addressed at a sector or agency level, the Mental Health Commission can play a role and ensure it proactively develops and maintains knowledge of the challenges faced by the sector and its workforce in delivering the services it funds and support and take action to address those issues.

Recommendations
3.1 Develop and share good practice of managers and agencies who have created agency culture(s) and practice that reduce harms to the workforce caused by high staff turnover, worker stress and burnout, workload intensification and workplace health and safety issues.
3.2 Provide greater access to clinical and/or practice supervision, mentoring, peer support and professional development and training opportunities for all staff, including peer workers and lived experience workforce.
3.3 Increase clinical and/or practice supervision and mentoring skills in the community mental health sector.
3.4 Support the expansion of the use of evidence based online training and e-learning, telehealth, Skype-type services, online and e-mental health technologies.
3.5 See recommendation 2.8 (applicable in this section).

Level 4: Support for specialist workforces

Many sectors and workforces play a role in responding to people with mental health issues and ensuring access to quality services. There is a pressing need to ensure that these various workforces have equitable access to opportunities throughout the State and are supported to undertake training, workforce development and upskilling activities.

The findings of this project show that workforce recruitment, retention, training, skills development and supervision are particularly challenging for services in rural and remote areas. A workforce with a sufficient number and an appropriate mix of staff is integral to the sustainability of rural and remote services. However, organisations providing services in regional areas face additional difficulties in attracting and retaining appropriately trained staff including:

- the cost of living;
- the cost of travel;
- remoteness;
- lack of available and affordable housing; and
- low remuneration for community service workers.

The 10-year Plan recommends a dual strategy for the Aboriginal health workforce: increasing the number of Aboriginal mental health workers and increasing the cultural awareness of non-Aboriginal workers in mental health and general health workforce and thereby the cultural security of organisations. Recommendations are presented for both approaches.

Many generalist providers are often the first point of contact for people with mental health issues. Enhancing the confidence and capability of these generalist providers is critical. For smaller agencies, the costs associated with workforce development are prohibitive (especially for skills outside of the scope of the generalist services being provided).

Recommendations are presented to address the needs of these identified workforces.

Recommendations
Rural and remote workforce
4.1 Improve rural and regional mental health outcomes by developing a detailed investment and capacity building plan for the rural and remote community mental health workforce. The plan should aim to build local community and workforce capacity and support region-wide and locally driven collaborative and

Recommendations
targeted recruitment, retention, training, supervision, learning and development strategies.
4.2 Develop regional specific approaches to workforce development that foster collaborative and innovative solutions to workforce development needs, supported by a combination of government funding, Royalties for Regions funds, Lotterywest and in-kind contributions from local agencies.
4.3 Develop a rural and remote grants/funding/innovation program as part of the community mental health Industry Support Fund to support best practice and collaborative approaches to rural workforce development, including recruitment, retention, training, supervision and skills development.
4.4 Support the development of innovative models for clinical and /or practice supervision in rural and remote areas, that could include fly-in-fly out, shared employment of clinical and/or practice supervisors, remote supervision (including the use of skype and other technology, e-mental health technologies) and/or shared supervision across agencies.
4.5 Resource the coordination of localised training for mental health and other sector staff within the regions of WA.
4.6 Explore and develop incentives, including the availability of non-salary and other benefits, to attract, employ and retain workers in the community mental health sector in regional and remote areas, particularly those with higher level clinical skills.
4.7 Investigate identified areas of the state to determine whether surplus GHA housing exists and whether it can be made available to community mental health agencies as an incentive to attract more experienced practitioners to rural and regional areas.
Peer workforce
4.8 Develop, resource and implement a state-wide peer workforce strategy and provide incentives to progress cultural change and embed peer work and peer workers into all relevant services.

Recommendations
4.9 Increase the rates of recruitment and retention of peer workers and invest in the training and development of the peer and lived experience workforce.
Generalist workforce
4.10 Support the provision of accessible and appropriate training, supervision, mentoring, placement and professional development opportunities for the generalist workforce who provide services to people with mental health issues.
4.11 Explore the potential of, and support and promote opportunities for, workforce exchange placements and initiatives between agencies where generalist staff work in specialist community mental health services for a time limited period to develop and share skills and practice (some examples already exist).
Small agency workforce
4.12 As part of the proposed Industry Support Fund provide specific training and development support and funding for collaborative initiatives targeting smaller agencies in which barriers to equitable access have been identified.
Aboriginal workforce
4.13 Develop an Aboriginal community mental health workforce strategy to implement the key priority in the Mental Health Commission's 10 Year Plan to increase the Aboriginal workforce across the service spectrum.
For organisations funded to provide services primarily to an Aboriginal population
4.14 Support and provide increased government investment in culturally appropriate Aboriginal controlled programs and services provided by Aboriginal workers to enhance mental health and social and emotional wellbeing among Aboriginal people and Aboriginal communities.
4.15 Train, support and upskill staff in community controlled Aboriginal health services to develop and strengthen their capacity to work with Aboriginal people on mental health and social and emotional wellbeing issues.
For organisations providing services to a population which includes Aboriginal people

Recommendations
4.16 Train, support and upskill staff in in the community mental health sector and generalist staff working with Aboriginal people to improve their cultural competence and capability to work with Aboriginal people on social and emotional wellbeing and mental health issues.
4.17 Support community mental health agencies to embed cultural considerations in recruitment and retention policies and practices for Aboriginal staff. Specific considerations could include: e) Offering Aboriginal employees extended personal leave to attend to their cultural and family responsibilities; f) An acknowledgment of the concept of time differing to that of non-Aboriginal employees; g) Developing specific employment initiatives, such as Indigenous traineeships; and h) Consideration of appropriate ways to advertise positions, job description formats and interview processes.[71]
4.18 Embed cultural security training and development within organisations for staff and board members by incorporating cultural security training and supervision into staff induction processes[72] and provide training for existing staff.
4.19 Mental Health Commission consider supporting and funding the development of a knowledge and practice based exchange platform to facilitate the sharing of innovative workforce development policy and practice in the community mental health sector. This project has identified innovative practice in area such as remote supervision, work placements, collaborative training provision, shared employment and the employment of Aboriginal staff, and it would be beneficial to have a forum and structure through which this practice could be shared.

[71] Palmerston Association Inc. (2012, pp.12-13). *Aboriginal Cultural Security Guide for Human Service Organisations.* Perth.
[72] Palmerston Association Inc. (2012, pp.3). *Aboriginal Cultural Security Guide for Human Service Organisations.* Perth.

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