mhcc
mental health coordinating council

PO Box 668 Rozelle NSW 2039

T 02 9555 8388
F 02 9810 8145
E info@mhcc.com.au
W www.mhcc.org.au

ABN 59 279 168 647

9 November, 2012

Dr. Brendan Goodger
Research and Policy Manager
Community Services & Health Industry Skills Council Ltd.
Level 13, 1 Castlereagh Street
Sydney NSW 2000
P.O. Box H61
Australia Square NSW 1215
Email: brendan.goodger@cshisc.com.au

Re: Environmental Scan 2013 Submission

Dear Brendon,

The Mental Health Coordinating Council (MHCC) is the peak body representing community managed organisations (CMOs) working for mental health in NSW. We provide sector development and representation services to and on behalf of the more than 100 CMOs providing mental health services (MHS) in NSW that are our members. We also Chair the Community Mental Health Australia (CMHA) Workforce Development Working Group. CMHA is the alliance of all eight state and territory community sector mental health (MH) peak bodies and together we represent more than 800 CMOs delivering MHSs nationally. Please find attached MHCC's submission in response to the Community Services & Health Industry Skills Council (CSHISC) Environmental Scan 2013 consultation process.

MHCC is also a registered training organisation (RTO) specialising in community-based, recovery-oriented and trauma-informed MH training. For more information about the extensive range of workforce learning and development services that we provide to our members and others please visit: http://www.mhcc.org.au/learning-and-training/default.aspx).

We welcome you to your new role at the CSHISC. MHCC enjoys a much valued and productive working relationship with the CSHISC and took a sector leadership role around the 2006/08 review of the Certificate IV in Mental Health qualification in the Community Services Training Package (CSTP). This included activity to develop the Diploma in Community Services (Mental Health and/or Alcohol and Other Drugs) and MH related 'skill sets'. We went on to advocate for and take a leadership role in development of the recently endorsed Certificate IV in Mental Health Peer Work qualification. We are currently contributing to the review of the MH qualifications through participation in the CSHISC's Mental Health Subject Matter Expert Group (SMEG) and through representation to the Training Package Advisory Committee (TPAC). These representations are through the Manager of our RTO, Simone Montgomery.

MHCC also worked closely with the CSHISC during 2008/09 on the Mental Health Skills Articulation Project. The Services and Workforce component of that study has been very helpful in our representational work with funders and policy makers to better understand and value the contributions of CMOs delivering MHS, the workforce that delivers them, and also to better understand the importance of psychosocial rehabilitation and recovery support services and work roles.[1] I am attaching a recent journal publication that references this work and also speaks to the recent experiences and future directions of community sector MHSs and their workforce in Australia in which the Articulation Project is cited.[2]

[1] Community Services and Health Industry Skills Council. (CSHISC, 2009). *Mental Health Articulation Research Project Services and Workforce Study*. CSHISC: Surry Hills.
[2] Bateman, J. & Smith, T. (2011). *Taking Our Place: Community Managed Mental Health Services in Australia.* International Journal of Mental Health, 40(2), pp55-71.

You might also be interested to know that MHCC's Senior Policy Officer/Workforce Development (WFD), Tina Smith, is the community sector representative to the national Mental Health Workforce Advisory Committee (MHWAC) on behalf of CMHA. CMHA was formally launched, and the growing contributions of community managed MH sector and its' workforce recognised, on World Mental Health Day in Canberra in October and are further described in a recent promotional publication.[3]

You may be aware that the MHWAC is ceasing operations at the end of 2012 and responsibility for implementation of the 2011 National Mental Health Workforce Strategy and Plan (NMHWSP) will move to the new Mental Health Drug and Alcohol Principle Committee. Health Workforce Australia (HWA) will also become an increasingly important partner in MH WFD as they commence their Mental Health Workforce Reform Program with three projects: Mental Health Competencies; Mental Health Peer Workforce; and, Mental Health Workforce Study. A planned Assistants and Support Workers project is also of relevance to community sector WFD.

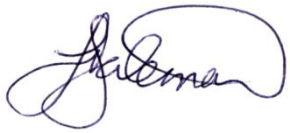
MHCC welcomes the opportunity to contribute to the 2013 Environmental Scan consultation process. In addition to the current shared activities being undertaken that have already been noted, MHCC is keen to see progress with regard to:

- Support in development of a national Community Sector Mental Health Workforce Development Plan (possibly through the Australian Workforce Productivity Agency/AWPA National Workforce Development Fund).
- A more evidence informed and embedded understanding of the competencies required for:
  - Effective care/service coordination across both training packages.
  - Ensuring that all human services, including health and community services, have the capability to be trauma informed and/or responsive.
  - Improving access to effective 'talking therapies' within the community sector (e.g., cognitive behavioural therapy, motivational interviewing, etc.).
  - Responding to people with co-existing MH and substance use issues.
- Development of higher level qualification/s in 'Health and Wellbeing Recovery Support' (e.g., Advanced Diploma, Graduate Certificate/Diploma). This action has been in the CSHISC quality improvement plan arising from the E-Scan for some years now.

These and other industry needs and issues are elaborated upon in our submission.

Please don't hesitate to contact either myself or Tina Smith (tina@mhcc.org.au) should you have additional questions about our submission or any other activities being undertaken by MHCC or CMHA in the area of mental health WFD as a key strategy for both sector development and in achieving better outcomes for the many Australian affected by mental illness.

Sincerely,



Jenna Bateman
Chief Executive Officer
Mental Health Coordinating Council

[3] Community Mental Health Australia (2012). *Taking Our Place - Community Mental Health Australia: Working together to improve mental health in the community.* Sydney: CMHA. http://www.cmha.org.au/pdf/Taking-Our-Place.pdf

Mental Health Coordinating Council Submission to the Community Services and Health Industry Skills Council

ENVIRONMENTAL SCAN 2013
November 2012

The CSHISC Environmental Scan 2012 identified that:

> *Workforce changes are occurring in parallel to, and as part of, industry reform, with major change themes including a shift towards interdisciplinary practice and person-centred models of service, an increasing focus on service delivery within the community setting, an emphasis on client functional independence and increasing recognition of complex and multiple needs (p. 15).*

The key recommendations made for the continuous improvement of the mental health workforce training packages included:

> *Examination of potential for higher-level competency standards, qualifications or skill sets reflecting advanced practice and practice leadership, and,*
>
> *Examination of expansion of care-coordination roles and skills/practices to support increasingly complex needs, including trauma-informed care and talking therapies. Any development of training package content should be addressed in conjunction with broader community mental health workforce development objectives and identification of a unified body of evidence about psychosocial and recovery-oriented practice.*

The following discussions and recommendations support and add to these directions.

DEMAND

- *Is the demand for services in your industry changing?*
- *How have they changed in the past year?*
- *What do you believe is driving change? (NB: include observations on factors such as the economy, policy or demographics as well as local changes, if relevant).*
- *How has your organisation responded to these changes? (NB: please include positive actions you may have taken to limit any negative impacts resulting from changes).*
- *Do you have any observations / opinions on how these changes might affect regional, rural or remote areas?*

<u>Community Sector Mental Health Workforce Development Plan</u>
The non-government community managed mental health sector continues to grow, professionalise and require strengthened workforce and professional development pathway directions. Since 2006, the sector has around doubled in size through funding of $800M received under the COAG National Action Plan on Mental Health 2006/11. COAG national MH programs include:

FaHCSIA –Targeted Community Care (MH)
- Personal Helpers and Mentors Service/PHAMS
- Mental Health Respite – Carer Support
- Family Mental Health Support Services

DOHA
- Day to Day Living.

Community sector MHS have expanded in the absence of a commensurate sector WFD plan. A similar expansion is expected over the next five years to June 2016 through the government's current policy and funding directions for MH including:

- Expansions to the above programs - $288.6M
- Commencement of the Partners in Recovery (PIR) care/service coordination initiative - $459.5M
- Various programs being rolled-out through the COAG National Partnership Agreement Supporting National Mental Health Reform - $400M.

These directions mean that the demand for vocationally trained MH workers - both with (i.e., peer) and without (i.e., non-peer) lived experience of mental illness and recovery - continue to grow rapidly.

While the inaugural National Mental Health Workforce Strategy and Plan (NMHWSP)[4], [5] endorsed in late 2011 is inclusive of vocational education and training (VET) directions there is much additional work needing to be done in that space, including the development of a national community sector mental health WFD plan. Appendix 1 provides an overview of CMHAs most recent discussions about directions for such a plan, should the resources to develop it be forthcoming. MHCC met with the CSHISC during 2012 to discuss opportunities to pursue a community sector MH WFD plan arising through the AWPA National Workforce Development Fund.

HWA is considering the introduction of new 'assistant and support' VET qualified MH work roles to better address people's MH needs and the predicted shortfalls in medical, nursing and allied health workers through to 2025.[6] While this direction may be beneficial in acute service settings it does not necessarily recognise or contribute to the professional development of existing VET qualified MH workers, contribute to addressing the increasing recruitment and retention issues being experience by CMOs, or to better understanding and valuing psychosocial rehabilitation and recovery support practice.

MHCC proposes that consideration of the following activities would strengthen the CSTP and complement implementation of the strategies and activities of the NMHWSP:

- Service Coordination
- Trauma Informed Care and Practice
- Talking Therapies
- Co-existing Mental Health and Substance Use
- Higher Level Qualifications.

Service Coordination

Service users continue to present with increasingly diverse and complex health and social problems. Service providers increasingly have to coordinate person-centred and self-directed care with the client, involve their family/friends, and work with a large number of other health and community services and workers in public, private and community sector settings. In addition, the new Medicare Local organisations will now have to also be considered as they move into the MH space as a strategy to improve the primary care responses to people affected by mental illness.

The skills required for effective service and care coordination (sometimes called case management - although this use of language reflects poor practice as it does not promote client self-directed care), including negotiating service provider role delineations, are complex and not optimally

[4] Mental Health Workforce Advisory Committee (2011a). *National Mental Health Workforce Strategy*. Melbourne: Department of Health. http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/3545C977B46C5809CA25770D00093C93/$File/MHWAC%20Workforce%20Strategy.pdf

[5] Mental Health Workforce Advisory Committee (2011b). *National Mental Health Workforce Plan*. Melbourne: Department of Health. http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/3545C977B46C5809CA25770D00093C93/$File/MHWAC%20Workforce%20Plan.pdf

[6] More information about HWA's Health Workforce 2025 initiative is available here: Health Workforce 2025 | Health Workforce Australia.

embedded in the Community Service and Health Training Packages. The Australian Government's policy directions are for coordinated and collaborative care and current workforce training does not support this (e.g., Fourth National Mental Health Plan - An Agenda for Collaborative Government Action in Mental Health 2009–2014, 2009). The NMHSWSP has identified service coordination WFD as a priority area.

Considerable work has been undertaken by MHCC during 2011/12 to better understand the skills required for effective service coordination including: a literature review and discussion paper; competency identification consultations with people affected by mental illness and service providers (to close a literature gap); and, mapping these findings against existing mental health and service coordination related vocational qualifications to identify gaps.[7] [8] These findings are being shared with the MH SMEG group and MHCC will be writing to the CSHISC about the findings and recommendations arising from this work. In summary, the MH qualifications in the CSTP have good coverage for service coordination which is being strengthened through the qualification review; however, the existing qualifications related to service coordination are problematic.[9] The need for a service coordination skill set to be developed has been identified. This would be particularly helpful in supporting implementation of the government's new $549.5M 'Partners in Recovery' initiative and the National Disability Insurance Scheme (NDIS) roll-out, but would also have implications for more broadly strengthening care coordination practice across a range of human service programs, settings and work roles given the increasing complexity of client presentations.

Trauma Informed Care and Practice (TICP)

The role that interpersonal trauma plays as an underlying cause of complex client presentations is increasingly recognised and understood (e.g., childhood abuse, violence, homelessness, immigration/refugee experiences, being diagnosed/living with a mental illness or substance use issue and/or traumatising experiences of MH/AOD services (including seclusion and restraint, and being involuntarily detained, etc.).[10] WFD toward achieving healing and TICP has gained traction in the USA, Canada, the UK and New Zealand as evidence-based practice and a cost effective approach to recovery-oriented health and community services delivery. We anticipate Australia pursuing similar directions over the next five years.

MHCC values the development of the Certificate IV in Mental Health Peer Work qualification that creates a foundational and core unit of competence related to TICP (CHCPW404A *Work effectively in trauma informed care*). The availability of the unit needs to be promoted across a range of qualifications, and possibly built upon through the development of higher level units of competence and a related 'skill set' for more advanced practitioners needing to build on the 'identify and/or respond' skill base to provide specific trauma responses to people affected by trauma .

'Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery' (Adult Survivors of Child Abuse, ASCA) were released in October 2012 following sign-off from Commonwealth Department of Health and Ageing.[11] The guidelines represent a first internationally providing the evidence-base needed to translate TICP research into practice. They establish a framework that responds to the national health challenge and set the standards in each of the following domains:

[8] Mental Health Coordinating Council (2012, draft). *Service Coordination Workforce Competencies: An investigation into service user and provider perspectives.* MHCC: Sydney.

[9] Information related to MHCC's *Service Coordination Strategy* can be accessed here: http://www.mhcc.org.au/projects-and-research/service-coordination-strategy-project.aspx.

[10] Information about the MHCC's partnership with Adults surviving Child Abuse (ASCA), the NSW Health Education Centre Against Violence (ECAV) and the Private Network of Mental Health Consumers and Carers to raise awareness about trauma informed care and practice (TICP), including establishment of the Australian TICP Network, can be found here: Trauma Informed Care and Practice.

[11] The TICP Practice Guidelines can be downloaded here: Adults Surviving Child Abuse

- `Practice Guidelines for Trauma-Informed Care and Service Delivery' are directed to all services with which people with trauma histories come into contact.

- `Practice Guidelines for Care and Treatment of People with Complex Trauma' are for the clinical context, and reflect growing insights into the role of trauma in the aetiology of mental illness and new possibilities for clinical treatment.

The purpose of the Guidelines is to inform a diverse audience about new ways of conceptualising and responding to trauma in clinical practice, and across health and human service settings. The Guidelines objective is to enable new possibilities for recovery for survivors of trauma and their children, as well as highlight the need for service and practitioner cultures and practice to be sensitive to the needs of complex trauma consumers, many of who are survivors of childhood abuse.

The Guidelines are designed to raise organisational awareness of the unaddressed trauma experienced by many Australians who access human and health services, and include principles for implementing policies and procedures. The Guidelines specifically target the mental health sector, given the context of the project and the critical need in that sector. However, the Guidelines advocate for trauma-informed principles and approaches to be introduced across the full spectrum of human services.

Tailoring the proposed Guidelines will enable their adoption across diverse service settings. While the Guidelines provide a framework for implementation, accredited workforce training and development is recommended to optimise the integration of trauma informed principles and practice into services and systems.

Talking Therapies

Vocational training related to the provision of psychological or 'talking therapies (e.g., motivational interviewing, solution focused therapies, cognitive behavioural therapy, dialectical behavioural therapy, etc.) will be also important for responding to increasingly complex client presentations – most notably co-existing anxiety, depression and substance use which affects a large number of Australians (National Survey of Mental Health and Wellbeing, 2007). A good model for vocational training that compliments the 'clinical' psychological therapy skills that are rarely developed in undergraduate university settings is the UK Improving Access to Psychological Therapies initiative (www.iapt.nhs.uk). New Zealand is currently modelling a similar approach (www.tepou.co.nz). The need for this area of work to be better understood and further developed was also identified by the CSHISC Mental Health Skills Articulation Project.

Co-existing Mental Health and Substance Use

The Diploma in Community Services (Mental Health and/or Alcohol and Other Drugs) is an important new qualification introduced in 2008 that will be reviewed as part of the MH SMEG activity currently underway. When the Diploma was developed some 'skills sets' related to MH and/or substance use were also developed that also need to be reviewed.

Higher Level Qualifications

Qualifications to be considered are an Advanced Diploma and/or Graduate Certificate/Diploma in 'Health and Wellbeing Recovery Support Work'. The need for higher level qualifications related to working with people with complex and diverse health and social problems has been identified by the CSHISC in previous E-Scans and continuous improvement plans (e.g., psychosocial rehabilitation and recovery support advanced practitioner - care and service coordination skills, TICP, talking therapies, coexisting mental health and substance use). Such qualifications would also be associated with the continuing need for leadership – including supervision, mentorship, research and development - in ensuring that psychosocial rehabilitation and recovery support skills of workers in a range of community, public and private work settings providing 'behavioural health' services are more greatly recognised and valued.

We now know that these workers do, and increasingly will, present with diverse qualifications and experience and include both peer and non-peer work roles. Many of psychosocial rehabilitation and support practitioners are currently unregulated health professionals working with particularly vulnerable and disadvantaged people. The proposed high level VET qualifications contribute to career and professional development pathways for vocationally trained MH workers and also provide a postgraduate 'clinical' vocational training pathway for university graduates.

MHCC believes that the above 'behavioural health' competencies sit at the interface between health and community service provision and their exploration would help to reduce the government/non-government, clinical/non-clinical and university/vocational structural silos that represent barriers to MH WFD identified by the CSHISC 'Mental Health Skills Articulation Project'. These discussions are also important to better understanding what competencies are required for achieving recovery oriented services provision (i.e., as opposed to psychosocial/psychiatric rehabilitation or traditional/medical model mental health care) at a variety of Australian Qualifications Framework levels and would aid the implementation of the National Mental Health Recovery-Oriented Practice and Service Delivery Framework currently under development.[12]

SUPPLY

- *What do you believe are the current and emerging occupational shortages?*
- *Are you aware of or do you see a need for new job roles emerging or required?*
- *Describe these new roles and how they meet client needs.*
- *Are workplace changes and job role changes addressed within your organisation?*
- *Are there barriers to this development?*
- *Do you have a workforce plan, and what is its long term projection (5 years, 10 years, 15 years...)?*
- *How do you see workforce development policies, strategies and funding supporting the community services and health industries growth and reform?*
- *What are your observations / opinions on how workforce development changes might affect regional, rural or remote areas?*

Mental health continues to be an area of growing workforce shortage – especially with regard to the skills required for community based, recovery oriented, trauma informed, socially inclusive and preventative approaches to service delivery (i.e., as opposed to medical model, hospital based and crisis driven approaches). While the NMHWFS/P is intended to address this situation it remains overly focused on university trained staff in public and private settings and is not sufficiently inclusive of either VET opportunities or community sector workplaces.

Both HWA and the NMHWFS/P have recognised the important contributions Peer Workers can make and planned peer WFD will be supported by the newly endorsed Certificate IV in Mental Health Peer Work qualification. A concern remains that these work roles will continue not to be well understood or supported by workplaces and these are reasons why two 'skill sets' - for Peer Worker 'managers' and 'leaders' – were also developed during the qualification development process. Strategies for helping workplaces in community, public and private settings to better understand and support these work roles will become increasingly important for mental health WFD in Australia. Ideally, this will include a greater awareness or Peer Work VET qualifications and their importance to both growing the workforce and recognising the skills of existing workers. The development of nationally recognised learning and assessment materials against the qualification will also be important as is ensuring skills portability.

Contributions to be made by Peer Workers are important - both in addressing workforce shortages and in increasing recovery-oriented service provision and practice. However, whilst becoming better understood there is a risk that the other existing and potential contributions made by the

[12] More information about the National Mental Health Recovery Practice Framework is available here: Craze Lateral Solutions p/l - Mental Health Recovery Framework

community sector MH workforce are losing traction generated over the past six years through MHCC's involvement with both MHWAC and the CSHISC.

For the first time Australia has a nationally agreed baseline for beginning to understand supply issues and to build upon the qualifications and experience of the community sector MH workforce.[13] The 'Mental Health NGO Workforce Study' was designed to test a methodology to support workforce data collection and planning for the MH NGO sector.[14] However, in this process much was learnt about the sector and its current workforce. While acknowledging methodological and ongoing data collection and issues, the project confirmed the size of the sector to be about 800 organisations and its workforce was estimated to range between 15,000 to 26,000 employees (CMHA conservatively estimate this to be about 12,000 FTE). By way of comparison, the public MH service direct care FTE is about 21,000.[15] 42 % of responding organisations have been delivering services for more than 20 years. 43% of workers identified as having health qualifications — mostly in social work, psychology or nursing — and 34% of workers have a vocational qualification with the majority of these being at Certificate IV and Diploma levels.

The Workforce Scoping Study struggled to categorise the diversity of services being provided and the workforce delivering them. Development of a nationally recognised taxonomy of community sector MHS and processes for routine collection of a related minimum data set is being undertaken by the Mental Health Information Systems Subcommittee/MHISS in partnership with the Australian Institute of Health and Welfare (AIHW) and CMHA. However, the planned workforce data collection is minimal against sector development needs and is:

- Full-time equivalent paid staff
- Hours worked (voluntary/unpaid staff)
- Full-time equivalent staff - peer support workers (note: this should perhaps read 'peer workers' as support provision is just one of several peer work job roles).

This work is being built upon through consideration of a projected 'Associate Professionals' FTE arising through development of the national Mental Health Service Planning Framework (NMHSPF). This category is believed to consist of workers in any setting that are not doctors, nurses or allied health professionals working in public or private settings (i.e., the 'non-clinical' MH workforce). The NMHSPF FTE requirements for 'psychosocial disability rehabilitation and support services' (PDRSS) workers is also being informed by the NSW (MHCC) Sector Benchmarking Project which is making planning estimates of services/workers required per 100K of population against the direct service MHISS, AIHW & CMHA community sector MH service taxonomy.

Interestingly, the Workforce Scoping Study noted no major issues with regard to sector recruitment and retention. This finding in contrary to the views of our sector reporting increasing difficulties in recruiting skilled staff and retaining university qualified staff who gain early career vocational skills in the community sector and then move on to higher paid roles in public and private settings. The mismatch between remuneration for community sector compared to public MHSs workers continues to represent a considerable WFD challenge (i.e., resulting in recruitment/retention and professional development issues). However, we acknowledge that this is now being partially addressed through recent 'fair wage' decisions and planned equity increases (i.e., Equal Remuneration Order/ERO).

[13] National Health Workforce Planning and Research Collaboration (2011). *Mental Health Non-Government Organisation Workforce Study*. http://www.ahwo.gov.au/5FEFB2B7-ED6D-4281-9BB4-02F8C5E6686C/FinalDownload/DownloadId-3D32FE21FE67F469669D8BCB71156ABD/5FEFB2B7-ED6D-4281-9BB4-02F8C5E6686C/documents/Publications/2011/Mental%20Health%20NGO%20Workforce%20Project%20Final%20Report.pdf

[14] For an overview and summaries of learning please visit: Mental Health Non-Government Organisation Workforce Sector Project | Health Workforce Australia

[15] Australian Institute of Health and Welfare (AIHW, 2010). *Mental Health Services in Australia 2007-08*. Mental Health Services no. 12. Cat. no. HSE 88. Canberra: AIHW.

Training Packages

- *Do you believe the community services and health training packages support workforce development?*
- *How do you use the Community Services and Health packages in your work?*
- *Do the qualifications and competency standards help you or your organisation in up skilling your workforce or in your HR practices? (E.g. job descriptions, performance management and retention strategies)?*
- *What new / emerging job roles are not covered in the Community Services and Health Training Packages?*
- *What level of change is required in existing job roles to cater for integrated service delivery models and client focussed care?*
- *Do you use Training Package qualifications in your recruitment and advertising positions?*

MHCC greatly appreciates and values our engagement with the CSHISC around the current review of the Certificate IV in Mental Health and Diploma in Community Services (Mental Health and/or Alcohol and Other Drugs), including ensuring compliance to the 'streamling' of qualifications in the CSTP. Along with the introduction of the Certificate IV in Mental Health Peer Work and its' related skill sets, the community managed MH sector now has an emerging 'career ladder' for both peer and non-peer work roles that needs to continue to be further built upon.

The non-peer MH skill sets also require review to ensure that they are meeting industry needs as these were somewhat hastily developed and agreed to in the final stages of the 2006/08 CHC02 review. For example, the 'assessment' unit in the MH skill set appears to be unnecessarily complex for non-MH workers. MHCC has developed, and forwarded to the CSHISC an alternative unit - 'Mental Health Skills for Non Mental Health Workers' - that was endorsed and that may be an appropriate substitute. It may also be useful across a range of qualifications to give health and community services workers foundational skills in MH. The co-existing MH and AOD skill set also requires the development of new units of competence that incorporate known evidence based practice in this area (i.e., it currently includes existing MH and AOD units but that does not equate to a skill set for effectively working with people with both problems).

MHCC anticipate that the process of developing Advanced Diploma and/or Graduate Certificate/Diploma qualifications in 'Health and Wellbeing Recovery Support' will result in a major improvement to the training package including strengthened career pathways, and will be timely for MH WFD within the CMO sector and embedding recovery oriented practice across a range of work settings. Graduate Certificate/Diploma qualifications will especially have appeal to university trained MH workers in both government and non-government work settings wanting to increase their recovery oriented service provision and psychosocial rehabilitation vocational skills.

Consideration of the proposed project based work in the following areas as previously discussed in this submission may lead to additional continuous improvements of the training package/s being identified:

- Service coordination
- Trauma informed care and practice
- Talking therapies
- Co-existing MH and substance use problems.

Training Quality

- *Do you have an opinion of what quality of delivery in training and assessment should include or be?*
- *What are your training concerns around quality?*
- *Do you consider on the job assessment important? What is the current status of on the job workplace assessment?*
- *Do you have any observations / opinions on how a regional, rural and remote setting may impact on the quality of training?*
- *Are technology / health informatics / e-health having an impact on existing roles?*

MHCC was audited by the Australian Skills Quality Authority in June and we were successful in obtaining another five years of registration in August. We don't think it appropriate for us to comment on the quality of MH training beyond MHCC's own RTO/WFD and learning function. Industry uptake of our qualifications and courses in NSW has been considerable. Since becoming an RTO in 2007 we have trained more than 5000 people and we score highly for both worker and workplace satisfaction with our services and products. It is notable that we are also delivering training services for existing workers beyond NSW. This would suggest issues for availability and/or quality of delivery and materials elsewhere. MHCC became an industry/enterprise RTO as a key strategic direction to develop the sector and its workforce. As a peak body, we are uniquely positioned to ensure the quality and currency of our learning and assessment materials and delivery strategies within a dynamic MH environment. Our trainers and assessors are sourced from within the sector, and include people with lived experience of mental illness and recovery, and their families and carers.

MHCC Learning and Development (LD) delivered high quality and affordable workforce professional development opportunities to the sector throughout 2011/12. This year we delivered a total of 76 trainings courses across numerous areas of interest as indicated below.

Course title	**Number of courses commenced 2011/12**
Certificate IV in Mental Health	7
Certificate IV in Training and Assessment	3
Diploma of Community Services(Alcohol, other drugs and mental health)	17
Advanced Diploma of Community Sector Management	6
Mental Health Connect	28
Professional Development Series	14
Total	**76**

A total of 368 days of training were delivered with 113 of these days in regional locations. 30.7% of all training conducted was offered in regional and interstate locations in NSW such as Wagga Wagga, Bourke, Orange, Kempsey, Wollongong, Melbourne, Adelaide and the Northern Territory. As indicated in the following chart, 57% of training days were based on organisational request and the remaining 42% were accessed through our public training calendar.

Based on the significant demand for in-house solutions for organisations the LD will continue to provide innovative and flexible delivery opportunities, particularly for regional and remote locations, as more courses and qualifications are delivered to meet both workforce and sector development needs.

It could be helpful to nationally track enrolments and completions of vocational MH qualifications and traineeships over time as a quality indicator, both for public (i.e., TAFE) and private RTOs. We believe that only four States have declared MH work traineeships despite this being an area of national skills shortage and that no peer work traineeships have yet been endorsed. Other incentives for undertaking vocational MH training need to be identified as the education and training budgets of mental health CMOs are often not included in performance and funding arrangements (e.g., scholarships, subsidies). The NSW Health funded MHCC Professional Development Scholarships Program provides a good model for how this could easily be scaled up nationally.

General

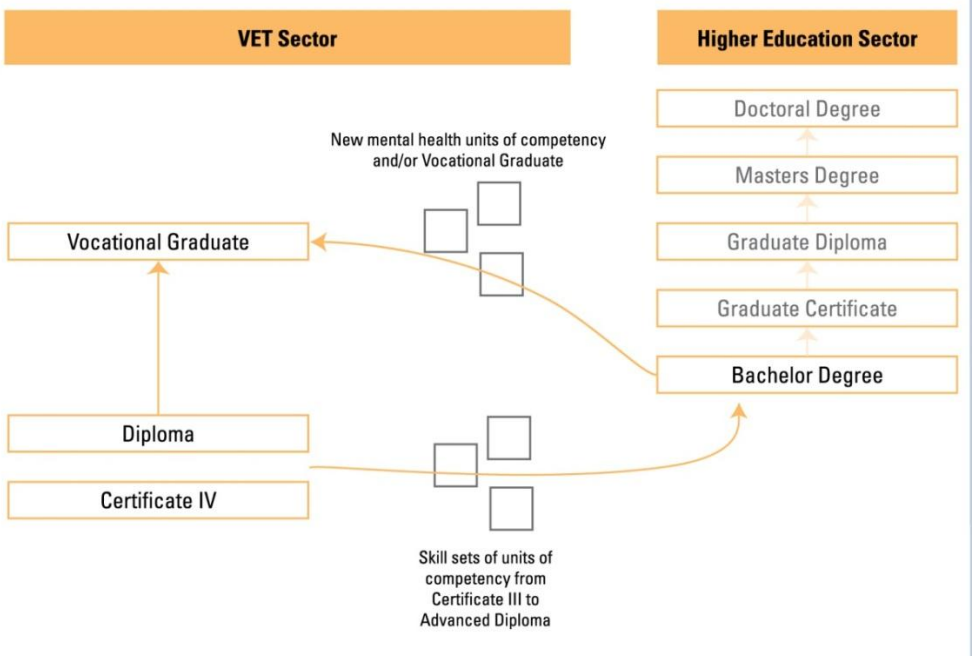
- *Did the recent Fair Work Australia's legislative decision have an impact on your industry?*
- *Do you believe there are pathway barriers between higher education and VET? If so how do you consider these barriers can be overcome?*
- *Do you think there are any implications for a 'demand driven' VET funding model?*
- *Do you consider leadership and management development important?*

The Fair Work Australia amended legislation has not yet had an impact on our industry as many organisations, especially the larger ones, are already paying above award wages to staff as a necessary recruitment/retention strategy or had established their own awards. This impact will likely change as salaries continue to increase and as NSW alterations to salary contributions remain unknown.

The articulation barriers between higher education and VET continue to be significant and outstanding recommendations of the Mental Health Skills Articulation Project need to be progressed (see Attachment 2).[16] The key outstanding recommendations relate to the greater valuing of psychosocial rehabilitation practice (i.e., recovery oriented service provision) including development of higher level MH qualifications as discussed throughout this submission. The following diagram from the Articulation Project illustrates how this would contribute to closing career pathway and articulation barriers.

[16] Community Services and Health Industry Skills Council (2009). *Mental Health Articulation Project Synthesis Report – Main Findings and Recommendations*.

Figure 4: New career pathways in mental health



However, considerable efforts would be necessary to assist universities to better recognise MH vocational qualifications and the psychosocial rehabilitation and recovery support MHSs provided by the community sector. One important strategy which could also address health workforce shortages involves greater utilisation of community sector work settings for undergraduate (i.e., 'clinical') training places. This is occurring in some community organisations and MHCC are currently developing a scoping paper and pilot project to be undertaken via the NSW Interdisciplinary Clinical Training Network (ICTN) in early 2013 and to look at opportunities for scaling up such initiatives nationally.

Demand driven VET funding models could help to drive some of the changes that MHCC believes necessary for the development of MH qualifications in the CSTP and their commencement/completion. However, this would depend on both Mental Health Work and Peer Work being added to various skills shortages lists of specialised occupations (i.e., in addition to the more traditional MH disciplines of psychiatry, nursing, psychology, social work and occupational therapy). For example, vocationally qualified MH job roles are not currently included on the AWPA Skilled Occupation List. More information about demand driven VET funding models would be required to have a clearer position. For example, if the policy agenda initially addressed the projected shortages of doctors, nurses and allied health professionals in MH then this might result in the introduction of, for example, assistant and support workers roles and the continuation of traditional medical model approaches to MHS delivery, and unintentionally result in recovery oriented service delivery and practice improvements losing traction.

We note that the AWPA (Skills Australia) 'Australian Workforce Futures' initiative[17] has considerable potential implications for peer WFD and CMO MH sector WFD. Unfortunately, mental illness as a psychiatric/psychosocial disability is not well understood in these directions. A key element is to develop workplaces/employers capable of supporting people with disabilities and this includes large numbers of Australians living with mental illness (i.e., psychosocial disabilities).[18] The growing understanding of mental illness as a disability and human rights issue will result in increased community sector employment support programs and increased need for specialised

[17] Australian Workforce Productivity Agency (2012). *Future Focus: Australia's skills and workforce development needs - a discussion paper.*

[18] National Mental Health Consumer & Carer Forum (NMHCCF, 2011). *Unravelling Psychosocial Disability: A Position Statement by the National Mental Health Consumer & Carer Forum on Psychosocial Disability Associated with Mental Health Conditions.* Canberra: NMHCCF.

training/WFD related to best practise provision of these services (e.g., Individual Placement and Support, social enterprise approaches, consumer operated services and programs). There will be a related increase in demand for skills related to supervising and making reasonable adjustments for employees with mental illness across all work settings.

Leadership and management development are vitally important to ongoing MH sector reform and WFD with the 'soft' skills associated with leadership (i.e., emotional intelligence) being equally important to the 'hard' skills of management. MHCC's 'Leadership in Action'/LIA (Advanced Diploma in Community Sector Management) course is aligned with Daniel Goleman's emotional intelligence theory and provides a variety of useful and practical tools to increase effectiveness as a manager and enhance leadership skills. MHCC also offers an LIA course for Aboriginal Managers that is tailored to meet the learning styles of Indigenous groups, with culturally appropriate content. This has been extremely well received. 'Clinical' leadership development had been identified as a key priority for implementation of the NMHWS/P and this must extend beyond workers with university qualifications providing treatment services in public and private settings.

The CSHISC's continuing advocacy and support on behalf of, and in partnership with, the CMO MH sector is greatly appreciated. MHCC looks forward to continuing to work with the CSHISC to strengthen the capacity of the health and community sector in working with people affected by mental health problems.

For more information about this submission please contact
Tina Smith – MHCC Senior Policy Officer/WFD
and CMHA representative to the national Mental Health Workforce Advisory Council.
Ph (02) 9555 8388 Ext 111, Mobile 0432 052 684, Email: tina@mhcc.org.au.

CMHA Activities and Recommendations for Community Sector Mental Health Workforce Development

The Community Mental Health Australia (CMHA) Workforce Development (WFD) Working Group has identified the following activities towards increasing community managed MH sector capacity in the area of WFD should resources become available to undertake this activity:

- Project to create a national Community Sector MH WFD Plan (given that the national MH WFD plan is insufficiently inclusive of our sectors specific needs)
- Recruit someone to coordinate WFD activity nationally via CMHA
- Scope existing WFD activities (i.e., roles and projects) within the peaks and their member organisations that we might advocate to see scaled up nationally
- Funds for each state/territory peak to contribute to the national scoping
- Activities to be inclusive of specific issues for consumer and carer (i.e., peer) workforce development
- Create a register of relevant MH VET training programs
- Sector recruitment strategy including promotion of traineeships (Cert IV MH and Cert IV Peer Work) and progressing MH 'VET in Schools' (i.e., sector recruitment strategies).

Objective 1.2 of the CMHA Strategic Plan is to 'Build a skilled and competent workforce' as follows:

1.2.1 Identify priority national workforce development requirements for the sector and establish a Mental Health NGO workforce development action plan aligned to the National Mental Health Workforce Strategy and Plan.

1.2.2 Identify coalition members best placed to lead on, and support the implementation of the Mental Health NGO workforce development action plan.

1.2.3 Establish 'Mental Health NGO centres of excellence in workforce development' and implement the Mental Health NGO sector workforce development plan.

Recommendations

- That CMHA pursue resources from the Commonwealth government to support our capacity to pursue WDF directions.

- That CMHA use this WFD illustration to highlight the need for a community managed mental health sector specific representational body, including sector development funding in the areas of:

    - WFD and learning
    - Data collection and outcome monitoring
    - Quality improvement
    - Coordinated and integrated service delivery.

Summary and Recommendations
Arising from the CSHISC Mental Health Articulation Project

Articulation is just one of a range of measures needed to improve skills in the mental health sector. If the policy objective of a high quality, integrated community mental health service is to be achieved there is an urgent need to address the following:

- A low cost model will never deliver a high quality service. Workforce development needs to be better integrated into service agreements through the funding for training, backfilling positions and the recognition of qualification and experienced gained in rates of pay.
- Inequalities in pay and development opportunities between government and NFP service need to be addressed; otherwise, articulation strategies will not have traction.
- A coherent, cross-sector workforce development strategy for the community mental health sector (government and NFP) needs to be established.
- Funding the systematic research and evaluation is required to create a unified body of psychosocial rehabilitation (PSR) practice to improve service quality and allow the development of an evidence-based workforce development strategy.
- In the community mental health sector, consideration could be given to the establishment of a minimum qualification of Certificate IV in mental health to provide a baseline for skills growth if funding and industrial arrangements are also addressed to ensure labour supply to the sector is not adversely affected.

Community Services and Health Industry Skills Council will identify new mental health national competency standards for development as part of the continuous improvement of Training Packages. The aim of new national competency standards will include:

- A review of the qualifications and competency standards in the CHC08 Community Services Training Package and their capacity to address potential skill gaps identified in the mental health articulation project (e.g. psycho-social rehabilitation); including potential for Vocational Graduate level components.
- Addressing skills gaps identified by VET and university-trained workers.
- Building on recommendations from the CHC02 Review.
- Provision of a skills framework to address and/or reduce fragmentation across different employer profiles.
- Provision of new skills driven by client and community mental health needs rather than available occupational frameworks; and
- Provision of new options for job redesign to better support service delivery.