Mental Health Workforce Solutions

TOWARDS A STRATEGY FOR COMMUNITY-MANAGED MENTAL HEALTH IN NSW, 2024

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Acknowledgements

Mental Health Coordinating Council (MHCC) acknowledges the Traditional Owners of the lands on which we work, learn and live.

We value people with lived experience of mental health conditions and are informed by their insights and expertise in our work.

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Citation

Mental Health Coordinating Council, 2024, *Mental Health Workforce Solutions: Towards a strategy for community-managed mental health in NSW* Authors: Henderson C, Sam K, Tadros E, Mental Health Coordinating Council, Sydney, Australia.

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1 INTRODUCTION

Following the publication of Mental Health Coordinating Council (MHCC)'s third **Mental Health CMO Workforce Profile Survey Report**, it is timely to provide a position paper that identifies our recommendations for Workforce Solutions in NSW that should inform advocacy moving forward. This paper represents analysis based on our survey findings as well as contemporary national and state literature, strategic planning, and policy documents relevant to the community-managed mental health sector.

The objective of this paper is to focus specifically on the mental health workforce that provides a range of clinical and psychosocial support services in the community, separate from public services, and highlight the challenges for Community-Managed Organisations (CMOs) and the sector on multiple fronts, including transitions and care coordination across service contexts. There is some overlap evident in the ten identified focus areas under which we have provided specific recommendations for workforce solutions to current difficulties experienced by the sector. To assist future strategic planning, these areas loosely cover the challenges, listed as follows:

1. Workforce recruitment, retention, and growth
2. Career promotion and pathways
3. Training and education
4. Conditions, remuneration and equity
5. Systemic challenges and opportunities
6. Funding issues
7. Contestable funding arrangements and issues
8. Role of government – including bilateral agreements
9. Standards, regulations and guidelines and quality improvement
10. Data gathering and evaluation

MHCC thanks all our members who contributed to discussions and shared their experience and expertise about the CMO workforce in NSW. We also acknowledge the contributions of other interested stakeholders and authors of the literature referenced in this paper.

MHCC invites further comment on this paper. The workforce is an evolving area and in a dynamic environment, we welcome ongoing feedback to guide our ongoing advocacy endeavours.

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BACKGROUND

In New South Wales (NSW) and nationally, the mental health workforce in CMOs has increasingly been recognised as a significant component of the entire mental health workforce. While access to information about the size and composition of the CMO workforce has improved in recent years, not least because of work undertaken by the sector itself (WAAMH, 2017; MHCC, Ridoutt and Cowles, 2019; Ridoutt, 2021; QAMH, 2021; MHCC, Ridoutt, et al, 2023), there remain deficits in the data picture at state, territory, and national levels.

Data on the sector is particularly limited when compared to the information available about the workforce providing public mental health services. Variability in the way that the sector is defined and classified, the different methods that have been employed to collect information about the sector, along with limited and sporadic prioritisation of this information at a State or Territory level, have all been significant contributors to the current scarcity of information. The most recent national assessment of the CMO mental health workforce was a survey of the mental health non-government organisation workforce conducted in 2009-2010 by the National Health Workforce Planning and Research Collaboration (NHWPRC).

There had been an expectation that the Mental Health Non-Government Organisation Establishments National Best Endeavours Data Set (MH NGOE NBEDS), which was implemented as a trial in Western Australia and Queensland, would ultimately provide quality national-level workforce data. This has yet to be realised. It was into this data deficit environment that MHCC initiated their first employer workforce survey in 2019, the 'Mental Health Workforce Survey Profile and Report' (Ridoutt & Cowles, 2019). The process was repeated in 2021 with the results published in that same year (Ridoutt, 2021). The Survey and resulting Report gathered information about CMO organisations delivering mental health services in NSW to better understand and support future planning decisions about the workforce.

MHCC repeated the employer workforce survey for the third time in 2023. This has enabled us to review data trends about the community-managed mental health workforce in NSW over a six-year period. This initiative provides useful information, enabling services to construct appropriate workforce planning and development strategies. The analysis in the Mental Health Workforce Profile details the findings from the 2023 Workforce Survey.

Together with the information gathered from its own survey findings, further consultation and through a process of scoping the available literature, MHCC has identified a series of focus areas under which to discuss the strategies necessary to bring about systemic change for the CMO workforce, enhance its sustainability and better meet the needs of people living with mental health conditions requiring community-based services in the future.

Whilst the National Mental Health Workforce Strategy 2022-2032 is an important document that outlines many similar points that we highlight in this document, it does not specifically address issues for the community-managed mental health sector and is unclear about where the CMO workforce sits in the broader picture of mental health service delivery. It frequently emphasises issues for the Lived Experience (Peer) Workforce but does not talk about the various contexts in which they work.

We note that there was an earlier NSW Strategic Framework and Workforce Plan for Mental Health 2018-2022: A Framework and Workforce Plan for NSW Health Services. Following the Framework's conclusion in June 2022, it was replaced by actions under Living Well in Focus 2020-2024, the Strategic Framework for Suicide Prevention in NSW 2018–2023, and the Bilateral Mental Health and Suicide Prevention Agreement 2021-22 – 2025-26. A progress report was delivered in 2019, but as we understand it, an evaluation was not undertaken.

SOLUTION DIRECTIONS

1. Workforce recruitment, retention and growth

As outlined in Mental Health Workforce Profile Report: Community-Managed Organisations, MHCC 2023, MHCC identified the workforce under eleven service delivery categories (p.15) including both clinical and non-clinical roles. By far the largest category represented by members completing the survey are mental health support workers who comprise 37.5% of the total respondents. Persons with lived experience in both peer and non-peer direct care roles currently sits at 19.2%, and people with lived experience as a carer in both peer and non-peer roles is at 6.1%. However, the National Workforce Strategy 2022-2032 does not identify roles that are non-peer roles but concentrates on lived experience peers and First Nations workers in a broader service context.

To ensure a sustainable CMO sector, and to be able to recruit, retain and grow its workforce, both peer and non-peer workers must feel valued and equitably resourced. Too often this large group of essential mental health workers are not included in reform processes, strategic planning, research endeavours and cross-sectoral recognition. This requires a shift in thinking about the contribution the CMO sector plays in keeping people well in the community, reducing the burden on public service costs and enabling people living with mental health challenges to maximise their independence.

The sector should not serve merely as a training ground for better-remunerated employment in the public sector but should offer diverse and rewarding career opportunities for a future in the sector that provides training and includes the support and supervision essential to grow this workforce, and to avoid the potential for burnout of its leaders and direct service delivery workers.

Health and social care services, including those delivered in the community, can be work environments that present a greater incidence of psychosocial risks. Services must be supported to design programs and systemically manage psychosocial risks (SafeWork NSW, p.13).[1]

There is a well-recognised shortage of Lived Experience (Peer) Workers and one way to encourage their greater participation, growth and retention in the workforce is to enhance pathways that promote career development and improve structures to support their ongoing supervision and mentoring.

Extensive scholarship and subsidised programs to assist peers' access to training opportunities could be enhanced by providing multiple entry points (including Certificate II, and higher-level qualifications such as Certificate IV, Bachelor and postgraduate qualifications) and providing the broadest opportunity possible for prospective workers and improving the affordability of training programs (p. 26).[2]

Addressing the shortage of the First Nations workforce by increasing the representation of First Nations people within the mental health sector could be assisted by establishing higher-paid specialist roles. The National Workforce Strategy (p.26)[3] identifies opportunities that include:

- clearly defining career pathways
- providing appropriate support for career progression
- offering mental health traineeships or training programs
- enabling a culturally safe work environment
- promoting inclusion in multi-disciplinary teams and recognising and valuing the broad array of skills, including cultural knowledge, that Aboriginal and Torres Strait Islander workers bring to their positions

These opportunities are equally applicable across service contexts and highly relevant to increasing the number of First Nations workers in the community-managed mental health sector.

Availability of locally based education and training programs to improve access to entry level training is a vital consideration, as are addressing barriers such as needing to spend time away from community and the costs of travel and overnight accommodation (p.26).[4]

Developing a culturally safe, diverse, and inclusive mental health workforce requires several actions including:

- recruitment of staff from diverse backgrounds across all levels and within peer workforces
- developing place-based workforces
- training of all staff on Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, and healing in practices
- LGBTIAQ+ awareness training and other specialist needs training such as neurodiversity awareness (p.5). [5]

Funding and scope to deliver service models that recognise the increasing complexity in populations presenting for mental health care are driven by an ageing population, increases in chronic disease as well as multi and coexisting conditions and growing social and cultural diversity.[6] (Cleary, A, Thomas, N, and Boyle, F, 2020, A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health review and enquires. University of Queensland, p.16)

Building a sustainable mental health workforce relies on a training agenda that starts early and provides positive exposure to the range of roles in mental health which continues through a person's career pathway to ensure the workforce is retained. Particular attention needs to be paid to areas of greatest need, including for example, in rural and remote locations (p.5).[7]

2. Career promotion and pathways

Working in the CMO sector must be communicated as an equally important contributor to mental health as public services. People who work in the CMO sector often say that they love the culture, philosophy of practice and commitment that their colleagues demonstrate. However, 'passion-tax' is insufficient to sustain employment in the sector.

To attract more people into the sector, governments need to provide the wherewithal to create positive perceptions of working in the sector, and this includes improving the pre-service and post-graduate placement opportunities and broad-based experience of students and trainees (NMHWS, 2022-32, p.28).[8]

Planning for a sustainable workforce must be a key objective. This can only be achieved by ensuring financial security of CMOs. CMO workers frequently undertake roles that would offer 20-30% more remuneration in the public sector. Assertive efforts must be initiated to retain workers longer in the sector through:

- certainty about the level and the continuity of funding of services
- contracts ensuring greater security of employment for workers across the sector (contract periods extended for 5 years)
- clarity on both the requirement for regular indexation and the level of indexation as appropriate for human services contracts
- ensuring career pathways provide interesting and challenging roles and competitive salaries (vis-à-vis the public sector)
- providing non-graduate career entry workers with greater and more structured career development support [9]
- contract indexation to be included in the contract terms, specifying the frequency and calculation of the indexation figure to be applied
- indexation in line with the increase in wage costs, possibly based on the Wages Price index (WPI) for Health Care and Social assistance or reasonable alternative rather than just CPI.[10] [11]

These changes will contribute to a sustainable workforce in terms of planning, recruitment, retention, and growth. This is especially important as workforce shortages have been impacted by changes to the Fair Work Legislation that effectively removed the use of fixed-term contracts (of more than two years) for service delivery in our sector.

Indexation at a level that keeps track of the increase in wage cost will mean it is possible to maintain services as per the planned model of service delivery, and therefore provide continuity of service to the community. Long-term financial clarity will assist CMOs in planning for more significant investments like IT systems, resources and training which would attract and retain its workforce.

3. Training and education

Training and education are areas of concern that present an overlap in terms of actions and outcomes, and across multiple areas that require attention. Nevertheless, MHCC reiterate that to effectively address the mental health CMO workforce shortage, there is opportunity to increase supply through increasing access to practice mentoring and supervision as well as quality placements and traineeships.

CMOs must be supported and funded to increase numbers of mental health training placements, and this requires senior staff to have the time to support such placements. In the current circumstances, many organisations do not have the capacity to take on students and ensure a positive and valuable experience that will result in recruitment down the track. Such opportunities are vital in championing the sector as a great place to work and demonstrate that the sector can provide real career pathways.

Appropriate and responsive education, training and professional development are essential to the ongoing improvement and sustainability of the CMO mental health workforce. Supporting early career workers through mentorship and structured on-the-job supervision is required, and capacity for senior workers to deliver this early career support should be appropriately planned and resourced. Cross-discipline mentorship is a potentially useful approach for building transdisciplinary perspectives and understandings about mental health services. Similarly, access to cultural mentors as a support for mental health workers could help build inclusive and equitable service provision.

There needs to be ongoing review alongside mechanisms for the development and provision of training programs and education that respond to emerging technologies and research findings and evolving health systems, that are accessible and inclusive for culturally diverse workers and those living in rural and remote areas (p.33).[12]

Training and education must reflect the most contemporary evidence-based practice. The sector must be funded to research and design training and professional development that responds to a dynamic service delivery and reform environment. Furthermore, people with lived experience must be embedded in the co-design and delivery of training programs for the workforce.

Greater consistency in education and training standards to upskill the entire CMO workforce will provide confidence in the level of skills held by workers from across the entire sector (p. 26).[13]

Training in the CMO sector must also reflect trauma-informed recovery-oriented practice principles that are consistent throughout organisational and governance structures and processes as well as in direct service delivery. This practice approach culture must be clear and cohesive across the sector, ensuring continuity of care and best outcomes for those accessing services as well as within the workforce.

Organisations that consistently provide training and external practice supervision and resources for staff, and those that ensure that staff efforts are recognised, seem to fare best despite funding issues.

It is challenging to sustain resources in the current economic environment, and governments need to recognise the value in supporting training, education, practice supervision and mentoring, as well resourcing staff back-fill whilst training occurs.

Training grants for the CMO sector are thin on the ground compared to public mental health and alcohol and other drug (AOD) sectors, and rarely ongoing. Often leadership, innovation and advocacy develop from grassroots practice in the CMO mental health sector.

Trauma-informed recovery-oriented practice, co-design and supported decision-making are good examples of practice that the sector has led in the progression towards acceptance and integration into national standards and generalised acknowledgement as evidence-based best practice approaches. Solutions to workforce issues in the future will need to include consistent access to education and training to ensure that Australians receive the mental health community-based services that meet their needs into the future.

Micro-credentialing is a training model that allows students to undertake study in buildable blocks which can be easier to complete than a full-length qualification and provide more flexibility for employers.

The development of micro-credentials needs to be supported by employers to ensure the skills developed align to key areas of need, with services having access to viable funding arrangements for their staff to engage in education and training activities while on the job (NMHWS 2022-32 p.30).[14] The availability of shorter programs to address barriers around length, cost and accessibility of training should be supported and this should include increased access to, and use of, continuing professional development across all career levels.

Improve health literacy of the CMO Workforce through the Health Literacy Initiative (Mental Health Commission of NSW)[15] and provide scholarships for related training and professional development activities in this context.

MHCC receives funding for scholarship places in Certificate IV Mental Health Peer Work from NSW Ministry of Health and the Mental Health Commission of NSW as well as Smart & Skilled under Federal arrangements. The two programs are funded differently, and our analysis shows that neither of these grants meet the actual costs of developing and delivering the training.

Improving digital skills for the workforce must be supported so that services can provide better access and equity to service users and understand how they can be provided ethically. MHCC has developed a Digital Service Delivery Guide to highlight issues that may arise from delivering a range of digital services in a community-based setting. The Guide supports best-practice and keeps people at the centre of safe, ethical and effective service delivery. [16]

Include supported decision-making as a core skill and competency for the CMO workforce. Supported decision-making (SDM) is a process of assisting a person to make their own decisions so that they can develop and pursue their own goals, make life choices, and exercise more control over things important to them. Access to SDM maximises a person's autonomy and independence and minimises the need for substitute decision-making and coercive practice.

SDM that safely supports dignity of risk, whilst demonstrating a duty of care, is consistent with a trauma-informed recovery-oriented practice approach. It should be a part of ongoing professional development for CMO workers as well as the workforce across the broader mental health and human services system.

4. Conditions, remuneration, equity

In the Victorian Department of Health's (2023) paper 'Our workforce, our future: A capability framework for the mental health and wellbeing workforce' they write:

> *If we wish to provide a recovery-oriented, compassionate experience for consumers, carers, families and supporters, and [where diversity is welcomed, (MHCC inclusion)] we need to do the same thing for our workforce.* (p.16).[17]

MHCC concur with this sentiment. Workers need to reflect the communities they serve. Working environments must be ones in which employees feel safe, respected, and valued for the expertise they bring to their work.

> *We need to foster workplace cultures that enable the workforce to build their knowledge, skills and collaborative ways of working with each other as well as with consumers, families, carers and supporters.* (p.16).[18]

Addressing issues that negatively impact on retention of the mental health workforce will require a focused effort in the areas of mental health worker wellbeing, worker conditions and worker satisfaction – i.e., fostering positive workplace cultures and the provision of supervisory support, feedback, rewards and recognition to improve positive employee outcomes (p. 35).[19]

To improve lasting motivation and retention of employees in the sector there is a need for greater financial security, including remuneration and job security, which matches the conditions in similar public service roles.

Awards for Peer Workers is an area that requires further discussion. There are mixed perspectives on whether lived experience workers should be remunerated under a different award than non-peers. The topic is presently under review with unions, but as things stand, peer workers in public services tend to be employed under the Health Education Officer or Health Service Manager awards, and in CMOs peer workers are typically under the SCHADS award with the level determined by their qualifications, experience, and expertise.

Consultation with the workforce must continue to bring clarity to the conditions offered to people working in these roles. At this point in time, MHCC does not have a clear view on consensus, but what we would urge is that decisions about conditions for peer workers in the CMO sector be based on alignment with conditions and levels of remuneration applicable in public service contexts.

NSW Health, South-Eastern NSW, Lived Experience Peer Framework (p. 54)[20] provides recommendations that outline elements that MHCC suggest represent broader consensus:

1. Equitable remuneration and resourcing
2. Positions that are full-time with provision for part-time and job share arrangements
3. Employment entitlements and workplace conditions meet legislative requirements and are:
    - Remunerated according to a relevant and appropriate award e.g., Health Education Officers, Health Service Managers, SCHADS, Administrative Officers.
    - Previous lived experience roles, contributions and volunteering recognised including non-formal training and experience (e.g., Intentional Peer Support) and related/or unrelated formal qualifications.
    - Training undertaken during employment recognised and appropriately remunerated.
    - Lived Experience (Peer) Workers have access to business resources including computers/laptops, desks, phones, business cards etc.

5. Systemic challenges and opportunities

As the composition of the mental health workforce continues to change, diversified and sustainable partnerships and collaborations become increasingly important. Respectful, mutually beneficial, and sustainable partnerships and collaborations across all areas of the mental health workforce are necessary to maintain and enhance the ongoing quality and continuity of service delivery.

Working relationships across service providers can be improved through innovative models of care where possible (e.g., co-location of services), and strengthening processes such as joint training, information sharing through communities of practice, interagency meetings, shared data collection, and evaluation and joint case conferencing, to ensure the successful implementation of models of care (p.33).[21]

It is also vital that services engage in continuous quality improvement activities, including championing best-practice within a trauma-informed recovery-oriented framework; as well as creating avenues for effective service integration through networking, collaboration, and coordination.

6. Funding issues

Funding cycles should be lengthened to a minimum of 5 years to ensure sustainability, continuity of care, and worker retention (p.2).[22] The Productivity Commission's Mental Health Inquiry Report, the House of Representatives Select Committee's Final Report,[23] and the Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders all recommended that funding transition to five-yearly cycles.

The Productivity Commission also found that short funding cycles create extreme uncertainty and inefficiency for providers, which in turn can negatively affect people accessing services, staff wellbeing and retention.

It recommended that:

> "Australian and State and Territory Governments should extend the funding cycle length for psychosocial supports from a one-year term to a minimum of five years and ensure that the outcome for each subsequent funding cycle is known by providers at least six months prior to the end of the previous cycle."

It also stated that:

> "The Australian Government should require Primary Health Networks to establish longer-term contracts when commissioning psychosocial services, in line with the longer funding cycles that were generally introduced for Primary Health Networks." (p.49).[24]

This work continues through the NSW CMO and PHN Working Group of which MHCC is an active contributor. We recognise the NSW Government election commitment for Secure Jobs and Funding Certainty, which is a work in progress that we advocate needs to be fast-forwarded.

The relationship between contract length, sustainable service delivery and workforce attraction/retention is interconnected. Without longer funding cycles, CMOs will continue to be plagued by high staff turnover, a lack of permanent employees and an inability to execute longer-term planning and sustain workforce development. Without sustainability, organisations are unable to invest in continuous improvement including risk management, governance structures and staff training and development.

Extending the length of Commonwealth and state funding cycles to a minimum of five years and renewal processes to occur with adequate lead time will mitigate these problems (p. 30).[25] Mental health planning and funding arrangements should be reformed to remove existing distortions, clarify government responsibilities and support localised decision-making.

The true costs of service provision are not reflected in current contracts. Service delivery is directly impacted by costs of recruitment and onboarding, supervision, professional development, program evaluation, administration, compliance, accreditation, and other overheads (e.g., cyber security, increasing rent and utilities), none of which are adequately accounted for in resourcing decisions. For more information refer also to MHCC Not-for-Profit Development Blueprint Issues Paper (p.3). It is important that any significant changes to funding arrangements are informed by a realistic assessment of the cost of true service delivery (p. 30).[26]

Stability of funding is a major concern, both in administrative terms (such as timeliness of payments or gaps in funding), and in contractual negotiations. As a program nears the end of contractual funding with no finalised negotiation on renewal, the program will start to wind down. This then increases the cost to the organisation during renewal as it reinstates the workforce and program and inevitably creates disruption for those accessing the CMO services. Greater transparency and speed in processing contract extensions and renewals are necessary to ensure continuity of services and to maintain service provider confidence, and a sense of safety for those they support, including families and the community (p.2).[27]

> *"We have a highly skilled workforce with funding only until June 2024. We risk losing this skill set in the absence of secure funding."*
>
> (MHCC 2023, Workforce Profile: Survey Responses)[28]

> *"We need more certainty about funding around non-NDIS and non-clinical services, so we expand the psychosocial workforce with more certainty."*
>
> (MHCC, 2023)[29]

The ability of small organisations to comply with funding administration is more onerous than for larger organisations, which may employ or contract specialist staff to deal with funding matters. Significant resourcing may be necessary to meet compliance of multiple systems and is a requirement that can detract from the ability to provide direct services to the communities that organisations support (p.3).[30]

Contract funding Indexation is a vital consideration. In an environment of increasing demand and escalating costs, services receiving inadequate indexation, are finding it hard to maintain levels of service delivery due to the necessary cuts in staff. This problem has plagued the sector for years both at a state and Commonwealth level. Some organisations have experienced a sustainability and quality crisis, which inevitably impacts the safety and outcomes for consumers. Many of our members report they are drawing from reserves to subsidise government-funded programs which is also not sustainable in the long term.

Governments should explicitly consider whether their funding model to CMOs includes sufficient provision for organisations to maintain a level of professional development, practice supervision and training that safeguards ongoing quality and capacity-building.

This must take into account appropriate governance arrangements that support workforce practices to successfully accredit themselves against the best practice psychosocial support standards necessary to deliver quality services. Correspondingly, wage levels must be commensurate with the complexity of work undertaken (p. 48).[31]

7. Contestable funding arrangements and related issues

In most developed nations, there has been a shift from public services to a marketisation of public goods and services. This represents a significant reform process aiming to transform the way in which community-based human services, such as health are delivered and consumed. For services, this means developing the capacity to adapt and innovate in response to changing circumstances to achieve quality and safety. The availability of rigorous research to demonstrate whether a market approach and contestability is a coherent reform process is mostly absent from the literature.

Contestability operates on the premise that better procurement processes allow more providers to enter the market and compete for contracts, this is expected to create stimulus for greater efficiencies, innovation, and improved service delivery to consumers. There is limited understanding however, about how community-based providers morph and re-configure in response to the opportunities posed by contestability (Durham & Bains, 2015). [32]

In commissioning and contracting, government agencies must find a balance between keeping service providers 'on their toes' and allowing competition to operate in a disruptive or destructive way.

The Harper Review: Competition Policy Review, Final Report 2015 endorses the value of a diversity of providers in the delivery of human services, whilst also recognising the importance of maintaining some certainty and continuity for providers and services. In relation to the duration of service agreements, the report says that governments should 'specify contracts with duration periods that balance the need to afford providers some level of certainty without excluding potential competitors for extended periods of time' (p.250). They argue that governments should develop long-term agreements in areas of mental health which require significant investment, experimentation and/or long-term planning.[33]

The Harper Review emphasises that the application of competitive principles in the human services sector needs to be approached with some caution over time: *'Like any changes to public policy, implementing changes to human services needs to be well considered.*

"Human services have a lasting impact on people's lives and wellbeing, increasing the importance of 'getting it right' when designing and implementing policy changes." (p.250).[34]

It quotes the Productivity Commission Report:

"*Experience with market-based instruments in human services in Australia suggests that such mechanisms often require refinement over time to promote improved outcomes*." (In this context, the establishment of a market-based system for employment services in Australia is sometimes cited).

MHCC urges governments to develop adjustment policies so that the professional capability of the sector is not jeopardised by the introduction of competition policy (p.251).[35] Competition and contestability has certainly impacted the professional capabilities of the workforce in relation to the NDIS, but introducing a fee for service that poorly accommodates a level of salary for the CMO workforce and the provision of 'un-registered' providers cannot reasonably ensure quality service delivery.

Concerns in relation to the lack of regulation and oversight of unregistered providers have been raised by MHCC to the NDIS Review Committee in its submission.[36] Some newly established businesses or individuals are offering services for which they do not have the capacity to ensure quality and safe services. Some unregistered providers employ casual workers who are untrained and unsupported and have little knowledge or understanding of people living with psychosocial disability and the challenges they might present on multiple levels. Support workers are often left to work out for themselves what they need to know and do.

Whilst unregistered providers are expected to practice under the NDIS Code of Conduct and conduct worker screening, there is little accountability. Often participants may select a service provider based on price alone. Unregistered providers characteristically can charge less than registered providers, as well as pay workers more as their costs are lower. This is adding to the workforce casualisation problem that has been identified in multiple consultations and submissions to the NDIS.

Registered providers ensure that workers are trained and supported, and therefore factor these costs into their pricing. Within the NDIS market, there are several companies operating as digital contractor marketplaces that do not provide the legal supports that a traditional employer would provide, such as quality and safety guarantees for either the worker or the NDIS participant. This enables them to operate with lower overheads and may leave both participants and the disability support workers who are offering services as sole traders exposed.

Unlike registered providers, unregistered providers may not get audited because they are unregistered and cannot be investigated by the NDIS Quality and Safeguards Commission (The Commission). An investigation may occur following a complaint or as part of planned reviews. In both cases, an audit will only commence if the Commission has sufficient evidence to act in relation to an unregistered NDIS provider.

Unregistered support workers can be employed as sole contractors (such as via online platforms), through an unregistered provider, or through direct employment. This category of supports is arguably the most controversial in discussions about registration given some of these supports involve personal care often delivered in domestic contexts.

Some groups have expressed concern that unregistered support workers might increase risk for participants and workers as they are less closely regulated. The argument has been made that this might increase the potential for abuse and exploitation of both participants and workers. Nevertheless, MHCC acknowledges that for some participants, using unregistered support workers equates to more flexible shift times, increased choice of workers, greater consistency with workers, and the ability to set worker wages.

Participants have reported that it meant they could move away from 'agency rule book' limitations, and they felt more empowered within the support interaction. Some participants describe feeling safer and better supported when they chose their own support workers through unregistered pathways, and sometimes in particular locations, unregistered providers are the only option.

'Thin markets' also contribute to provider decisions. A lack of providers, long waiting lists, or a lack of registered providers with the required expertise mean people often have no choice but to use unregistered providers.

The supply of support workers has also been affected by COVID-19 and related policy responses. Additionally, some people are leaving disability care to work in aged care. Using unregistered support workers helps increase the pool of available staff.

The view generally is that the ability to use unregistered providers is about exercising choice and control through the NDIS. The preservation of two kinds of providers in the disability service market is thought to afford NDIS participants the 'dignity of risk' in choosing freely between registered and unregistered providers. However, research indicates that both participants and providers may need support to navigate the unregistered provider space.

8. The role of Commonwealth Government in workforce capacity building including in bilateral agreements

At a Commonwealth Government level, a model should be approved for the appropriate calculation of indexation, which uses relevant data and responds to the impact of inflation on service and salary expenses (p.3).[37] Governments must recognise that investment in competency of the psychosocial disability workforce is an investment in recovery and reduced dependency by participants with psychosocial disability over time.

Reforms must be implemented to the NDIS funding model, which account for the core staff and administrative costs required for an appropriately skilled psychosocial disability workforce (p.12).[38]

The role of the Australian Government is to provide overarching strategic development and coordination of the mental health and disability workforce. Government has the unique position of being able to coordinate workforce development across differently funded care to support the sustainability of the sector. The Commonwealth Government should provide five (5) year funding agreement tenures for the CMO mental health services with an extension option (e.g., 5+5) (p.3).[39]

Acknowledging that the same staff delivering psychosocial supports are funded by the NDIS, PHNs and jurisdictional programs, the Government is responsible for market stewardship, and aligning the NDIS psychosocial workforce with broader national mental health workforce strategies such as the National Mental Health Workforce Strategy. (p.17).[40]

The integration and management of the Australian mental health workforce would benefit from the establishment of a national centre of evidence-based workforce development resembling that of Te Pou o te Whakaaro Nui in New Zealand that supports the mental health, substance use and disability sectors in that country. Such a cross-sectoral workforce planning and training initiative could be the driver of the types of workplace changes needed to meet future challenges in delivering a person-led mental health service system. This would include undertaking research, as well as developing and coordinating education and training for service providers, developing disaster response workforce strategies, and providing resources, tools, and support to improve service delivery (p. 17).[41]

9. Standards, regulations and guidelines and quality improvement

Nationally consistent and clear models of practice are key factors that enhance opportunities and capacity to use the entire mental health workforce to its full potential and maximise multidisciplinary practice. This requires a broader review of models of care and team structures, particularly in the context of the recent development and launch of the National Mental Health Standards for CMOs (ACSQHC, 2022).[42] This new set of standards truly reflects a trauma-informed recovery-oriented practice approach that is culturally safe, sustainable and fundamental to both an organisational and direct service delivery culture. Whilst not yet mandated, these standards serve as an important guide to assist the workforce in demonstrating evidence-based practice and service delivery outcomes, using agreed indicators and measurement tools (p.33).[43]

To meet the needs of CMO mental health workers at different stages of their career across the life course and in a range of service contexts, the workforce must have the opportunity to work to the full breadth and top of their scope of practice by adopting multidisciplinary ways of working. This requires collaboration within and between the mental health and other human services workforces.

Key considerations relate to the scope of practice, coordination of care, workforce distribution, and opportunities to build a workforce that recognises and best utilises the skills and strengths of all workers. This requires that the CMO mental health sector workforce is considered as having an equally important role to play as other workers in public mental health services.

Actions necessary include:

- Developing and refining consistent scopes of practice across occupations and between jurisdictions that reflect the components of care and competencies required to deliver them, recognising discipline-specific contributions and multidisciplinary care.
- Reviewing regulatory arrangements to ensure the appropriate approach is in place to ensure consumer and carer safety, given each scope of practice.
- Establishing roles and career pathways that reflect effective use of multidisciplinary teams within consistent scopes of practice and enable workers to work to the top of their scope of practice.
- Creating incentives for service providers to use service delivery models that utilise the competencies of CMO workers to their full scope of practice.
- Strengthening coordinated care, collaboration and multidisciplinary ways of ensuring safe transitions when working within and between the mental health, wider health and social service workforces.

- Wrap-around service delivery models that adopt a person-centred and person-led approach where services reflect trauma-informed recovery-oriented practice principles and are 'wrapped around' the person, their family and carers.

- Service models that demonstrate the potential to improve health outcomes, particularly in regional, rural and remote areas, where service delivery coordination should be particularly responsive to local and diverse needs and strengthen the capacity in mental health support services.

- Building an integrated workforce across many parts of the service system to foster greater collaboration with other health and social services workforces, including age care, AOD and primary health care to minimise the possibility of people falling through gaps between multiple sectors and services.

A range of attitudinal, organisational and legislative barriers must be addressed to enable multidisciplinary teams to deliver integrated support and treatment. Investment in multidisciplinary teams supports improved mental health outcomes, utilises the workforce to its full scope, and facilitates sharing of knowledge and best-practice. These are opportunities to incentivise multidisciplinary teams and working with colleagues across disciplines.

10. Data gathering and evaluation

The use of data in workforce planning is key to enabling evidence-based, targeted, and appropriate responses to workforce quality improvement and needs identification. Data must be comprehensive, up to date, and integrated across all aspects of the mental health workforce lifecycle—from training through to service demand—to highlight workforce requirements and future opportunities. This will enable better understanding and planning on workforce opportunities, and can inform the design of targeted policy responses, such as addressing future workforce needs through interventions in the education and training sector (p. 44).[44]

To support workplace planning and projections, future data collection should be longitudinal, and undertaken regularly to gain a better insight into service (and therefore workforce) demand, as well as estimating supply (p. 9).[45] Services must be appropriately funded to collect, analyse, and report on data and outcomes.

Engagement and co-design with consumers, carers and service providers is crucial to ensure mental health services meet demographic needs and guide the development of the mental health workforce (p. 43).[46]

Monitoring and evaluation is essential to understanding how effective mental health workforce strategies are in providing high-quality services that provide positive mental health and psychosocial outcomes. Indicators on the quality, accessibility and sustainability of services and the intended outcomes should be collected, analysed, and reported on to ensure ongoing quality and improvement of the mental health workforce.

Following a partnership pilot project between NSW Health InforMH and MHCC, the YES-CMO Survey (Your Experience of Service- CMO) was implemented in 2021. The survey was originally designed to gather data from NSW funded programs HASI/CLS and Family and Carer Programs.

The primary purpose of YES-CMO data gathering is to support quality improvement. While it can inform organisations about how their teams are progressing in terms of meeting expectations and improving outcomes for the consumers and carers they support; its main objective is to support organisations longitudinally identify and track specific areas to address, to improve service delivery and build workforce capacity.

The YES-CMO aims to enhance operational areas that may support quality care. By supporting staff to continually look for opportunities to improve how they work with participants, it can help to build and sustain the workforce for the future.

InforMH has subsequently agreed to gather data from the CMO sector for other Commonwealth and NSW funded programs outside of the NDIS, the analysis of which is recorded separately to ensure MHCC can conduct its advocacy informed by specific funding streams.

Vital to the support and sustainability of the CMO mental health workforce is that robust and comprehensive data about their profile and practices are reported on by the sector. Interventions for building the CMO mental health sector's capacity to regularly collect and use data on their own workforce should be explored. MHCC ACT recommend that either the AIHW and/or ACT Government provide investment into ongoing mental health workforce data collection by the sector. By strengthening our understanding of the community-managed mental health workforce and prioritising its growth, we can improve workforce planning and create a more inclusive, person-centred, recovery-oriented and resilient mental health system that better supports the diverse needs of individuals and communities. (p. 36).[47]

What MHCC Member organisations told us

In MHCC's Workforce Survey Profile Report, our members reported several directions based on specific environmental factors, demonstrated by the following table:

Table 8: CMO perceptions (% of CMOs) on the direction of influence of different factors (n = 40)

Influencing factor	Direction of influence			
	Increase demand for skilled workers	Increase demand for less skilled workers	Reduce demand for skilled workers	Reduce demand for less skilled workers
Mental health reform at national and state level, e.g., Bilateral Agreement, Standards	86.11%	27.78%	0.00%	0.00%
Uncertainty in NDIS & other funding arrangements	63.64%	27.27%	21.21%	6.06%
Contestable tendering	69.70%	24.24%	21.21%	3.03%
PHN commissioning of mental health services	88.89%	19.44%	5.56%	0.00%
Funding levels to recruit the required number of staff	67.50%	22.50%	25.00%	2.50%

A search for human resource solutions

A newly introduced question to the MHCC Workforce Survey Profile 2023 asked respondents to consider and rate the importance of a range of possible solutions to CMO mental health workforce issues. A total of 41 CMOs answered this question.

Almost all the proposed solutions were rated by a majority (>50%) of CMO respondents as a high (or very high) priority to be advocated and actioned. Standout workforce solutions identified as being a high or very high priority are:

- Sufficient funding that mirrors competitive salaries across the service sector (90%)
- Contracts that include workforce capacity building and sustainability, e.g., training. practice supervision, mentoring, resources (88%)
- Attractive career pathways that incentivise workforce sustainability (85%)
- Standards that reflect trauma-informed recovery-oriented practice (80%)

The results are in Table 9 following:

Table 9: Perceived importance (by priority rating) of possible HR solutions to CMO mental health workforce issues by proportion of responding CMOs (n = 41)

Proposed workforce solutions	Level of priority allocated (% of CMOs)		
	Low & very low priority	Medium priority	High & very high priority
Rolling five-year funding contracts	12.2%	14.6%	73.2%
Contracts that include workforce capacity building and sustainability, e.g., training, practice supervision, mentoring, resources	4.9%	7.3%	87.8%
Equitable indexation that responds to inflation on services and salaries for CMOs	7.5%	15.0%	77.5%
Contractual obligations that reduce red tape and minimise administrative costs	4.9%	21.9%	73.2%
Consistent employment conditions and insurance requirements	12.2%	26.8%	60.9%
Sufficient funding that mirrors competitive salaries across the service sector	7.3%	2.4%	90.2%
Attractive career pathways that incentivise workforce sustainability	2.4%	12.2%5	85.4%
Support and resources for the lived experience workforce, creating employment pathways and workplace readiness	10.0%	17.5%	72.5%
Industrial protections for the lived experience workforce	12.5%	37.5%	50.0%
Funding that provides for a sustainable workforce with adequate back-fill	7.3%	19.5%	73.2%
Strategies to support growth and sustainability of First Nations mental health workers	2.50%	27.5%	70.0%
Rationalisation of standards and accreditation requirements	10.0%	47.5%	42.5%
Standards that reflect trauma-informed recovery-oriented practice	5.0%	15.0%	80.0%
Improved legislative clarity in relation to fixed term contract obligations	12.5%	15.0%	80.0%
Introduction of a pay roll levy in NSW to fund growth and sustainability of mental health CMOs	25.6%	25.6%	48.7%

What principles, actions and mechanisms have been identified to support an effective mental health workforce across Australia?

Developing holistic person-centred and person-led, trauma-informed recovery-oriented, strengths-based approach requires:

- Building knowledge around trauma-informed recovery-oriented mental health practice which acknowledges that each individual is an expert of their own life.
- Mechanisms including the person engaging with services, carer and staff feedback loops to build shared understandings of all stakeholder perspectives.
- Co-design processes embedded from project inception and delivered in a genuine and meaningful way by service providers who are adequately supported, trained and resourced to engage in these processes.

Developing culturally safe, diverse and inclusive mental health workforces requires:

- Recruitment of staff from diverse backgrounds across all levels and particularly within peer workforces.
- Developing place-based workforces.
- Training and professional development of all staff on Aboriginal and Torres Strait Islander perspectives of social and emotional wellbeing, mental health and healing in practice, LGBTQIA+ awareness training and other specialist needs training including about neurodiversity.

Developing a high-quality, sustainable, accessible and equitable workforce requires:

- Respectful, mutually beneficial and sustainable partnerships and collaborations across all areas of the mental health workforce and relevant human service sectors.
- Appropriate and responsive education, training, professional development and mentorship throughout all career stages.
- Continuous assessments of progress and outcomes through monitoring and evaluation and adapting and improving strategies where needed (p. 8).[48]

MHCC and its Members urge the NSW Government to provide funding to invest in the development of a **Community-Managed Mental Health Workforce Framework for Action 2024-2034.** This Framework must address principles, actions and mechanisms identified above and ensure that investment is available over the life of the framework to make real the ten solution points itemised in this position paper.

With the necessary NSW Government support and resources to develop a Framework and implement the Framework's actions, MHCC, and its Members express their willingness to assist the Government in what is clearly a matter of urgency, based on the evidence presented.

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