Mental Health Australia

Submission to the Joint Standing Committee on the NDIS - Inquiry into NDIS Workforce

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Introduction

Workforce capability is the core of quality services that support choice and control for people with disability. This inquiry into the National Disability Insurance Scheme (NDIS) Workforce is a welcome examination of the challenges in developing a sustainable, appropriately qualified workforce to support the diverse needs of people with disability and carers wherever they live.

In this submission, Mental Health Australia, Community Mental Health Australia (CMHA) and Mental Illness Fellowship of Australia (MIFA) will outline the challenges facing the NDIS psychosocial disability workforce.

We call on the Joint Standing Committee on the NDIS to provide recommendations to support the viability of a quality psychosocial disability workforce into the future.

This inquiry is situated in a complex policy reform environment. The psychosocial disability workforce has been dealing with significant changes in the response to the COVID-19 pandemic, and is central to responding to the increasing mental health needs during this crisis. Several other reviews are simultaneously inquiring into the mental health system and will inform the funding and legislative arrangements for the national mental health workforce going forward. These include:

- establishment of the National Mental Health Workforce Taskforce
- development of Vision 2030 for Mental Health and Suicide Prevention and associated Roadmap for implementation (Roadmap expected to be submitted to Government in August 2020)
- the Productivity Commission inquiry into mental health (final report expected May 2020)
- review of the National Mental Health Policy (to be completed by early 2021)
- the Royal Commission into Victoria's Mental Health System (final report due October 2020).

There are also substantive inquiries underway into closely related service sectors with shared workforce, including the Royal Commission into Aged Care Quality and Safety, Royal Commission into the Violence, Abuse, Neglect and Exploitation of People with Disability, and the Primary Health Care Reform Taskforce.

At the same time, there are significant reforms underway to improve the experience of people with psychosocial disability engaging with the NDIS, which will be interrelated with workforce planning. These include implementation of recommendations from the Tune review of the NDIS Act and new NDIS Participant Service Guarantee, investigation into the impact of NDIS market settings on participants with a psychosocial disability (led by Victorian Department of Health and Human Services), implementation of the NDIA Psychosocial Disability Capability Framework, continued development and implementation of the Psychosocial Disability Stream, and implementation of a new *Psychosocial Recovery Coach* support item.

The Joint Standing Committee on the NDIS has a unique opportunity to contribute to this developing policy environment, by providing a national governance perspective and accountability to bring these various reviews together to support the necessary development of the NDIS workforce. We have outlined below the pressing issues for the Committee to address in relation to the psychosocial disability workforce, with consideration of this inquiry's Terms of Reference.

Understanding psychosocial disability

As expressed by the National Mental Health Consumer and Carer Forum, psychosocial disability refers to "disability associated with a person's psychosocial experience… as with other disabilities, a psychosocial disability associated with a mental health condition is the result of the complex interactions between limitations in activity (related to impairments associated with usually severe mental health conditions) and the environment in which people live". [1] Though psychosocial disability has not been well understood in the broader community, the impacts for an individual's daily functioning can be severe.

Supporting individuals to develop skills and resources to reduce the barriers and impacts of psychosocial disability, and pursue what they find to be meaningful in life, is the core work of psychosocial support services and an essential component of our disability support system. Recovery-oriented care, which promotes capacity building, development, and living a contributing life, is accepted best practice in mental health services.

While there is no one definition of recovery, it can be understood to mean "gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self."[2] This is what the NDIS – a disability *support* scheme – should support for people with psychosocial disability.

Unique approach to the psychosocial disability workforce

Psychosocial disability differs to other forms of disability in key ways, which means it requires a unique approach in NDIS policy and practices.

The uniqueness of psychosocial disability is that, rather than physical barriers, consumers primarily experience cognitive, social and motivational barriers to activities of daily living. These barriers can be addressed through a coaching approach that is personalised to the individual, builds on their strengths and maximises their potential to manage everyday life and participate in the community.

A psychosocial support worker requires a higher level of independent judgement and carries a significant responsibility and duty of care to the consumer, far higher than that expected of an attendant care worker.

Consumers with significant psychosocial disability impairments are frequently reluctant to engage with support systems. Psychosocial service providers can best use proactive outreach to engage a consumer, followed by a period of relationship building to establish trust. Only then can a psychosocial support worker work with a consumer to assess their needs, set goals, formulate a plan and coordinate supports.

This emphasis on engagement and capacity building means it is crucial that workers have psychosocial disability-specific skills, knowledge and experience and that they bring a high degree of sensitivity and empathy to the task of working with people experiencing psychosocial disability.

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

[2] Department of Health (2010). *Principles of recovery oriented mental health practice*. Retrieved from https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-nongov-toc~mental-pubs-i-nongov-pri

These differences are reflected in NDIS service data. NDIS psychosocial support providers have the highest proportion of clients with complex behaviour needs compared to other service providers (34.4% compared to 16.7%).[3] Further, participants with psychosocial disability and acquired brain injury are the only cohorts to identify goals relating to "Social and Community Activities" more frequently than goals relating to "Daily Life".[4] These trends emphasise the unique needs of the psychosocial disability cohort, and the required skills of the psychosocial workforce in capability building and recovery-oriented care.

Impact of transition to the NDIS on the psychosocial disability workforce

Transitioning psychosocial support services to the NDIS has had a significant impact on this experienced, specialised workforce.

As outlined by MIFA, "transitioning staff has been difficult with the unrealistic cost pressures under the NDIS. This has resulted in many redundancies and resignations, and consequently, a major loss of institutional memory and organisational stability, and an increase in human resources and recruitment costs".[5] This high turnover of staff is damaging for continuity and quality of care, where a trusted relationship between a consumer and staff is fundamental to engagement and recovery.

Overall, employment in the disability support sector has become more casualised with transition to the NDIS. As reported at the PHN and Mental Health Australia forum in 2019, casualisation of the psychosocial workforce increased significantly in transition to the NDIS. Full-time support workers now only make up around 33% of support workers employed by specialist mental health NDIS service providers.[6]

Fulltime workers are particularly important in psychosocial disability, as such employment stability supports continuity of care and building of ongoing trusted relationships between a worker and NDIS participant. This rapport and therapeutic relationship is vital to the effectiveness of recovery-oriented care.

[3] AbleInsight (2019). *Sector Summary Report: National Disability Service Providers Benchmarking Survey – Collection 3 (2017/18)*

[4] COAG Disability Reform Council (December 2019). *Quarterly Report.* p42. Retrieved from https://www.ndis.gov.au/about-us/publications/quarterly-reports

[5] Mental Illness Fellowship of Australia (2018), *Submission to the Joint Standing Committee on the NDIS: Market Readiness,* page 3

[6] AbleInsight (2019). *Sector Summary Report: National Disability Service Providers Benchmarking Survey – Collection 3 (2017/18)*

Current NDIS psychosocial disability workforce

The workforce who provide services to people with psychosocial disability through the NDIS is broad, including specialist mental health staff, general disability support staff, therapeutic professionals, and allied health from a range of backgrounds. NDIS participants with psychosocial disability rely on plan managers more than any other disability cohort (51%), and have the lowest rates of self-management (5%).[7] This highlights the importance of care coordination and other support staff for this cohort, including Local Area Coordinators (LACs) and staff employed through Information, Linkages and Capacity (ILC) building grants.

In this submission, we will focus primarily on the specialist psychosocial support workforce as the core workfirce. Currently, psychosocial support staff are employed by:

- specialised mental health psychosocial service providers
- general disability service providers
- other arrangements such as sole traders not formally part of other organisations or structures.

It is not possible to present the distribution of the psychosocial workforce across these types of employers, as there is a lack of data on this workforce. Prior to the NDIS, the NGO community mental health workforce was not included in national minimum mental health datasets, and as such there remains a gap in mental health workforce data. While the NDIS has supported some workforce research (which includes data on the psychosocial disability workforce),[8] this data is neither detailed nor current enough to inform psychosocial disability workforce development and planning. All levels of government should work with the NDIA to define the broad-based community mental health workforce, including the NDIS psychosocial disability workforce, and establish a method of appropriate data collection to monitor the required expansion of this workforce.

This is particularly imperative given the heightened need for community psychosocial support to assist people through the ongoing impacts of environmental disasters and the COVID-19 pandemic. These crisis events are impacting all Australian communities, and highlighting the already inadequate access to psychosocial support workers.

> **Recommendation 1**: Governments should work together with the NDIA and NGO providers to define the broad-based community mental health workforce, including the NDIS psychosocial disability workforce, and establish ongoing data collection to monitor required growth in this workforce.

[7] https://www.ndis.gov.au/about-us/publications/quarterly-reports December 2019 | COAG Disability Reform Council Quarterly Report p30

[8] AbleInsight (2019) *Sector Summary Report: National Disability Service Providers Benchmarking Survey – Collection 3 (2017-18)*

Future NDIS psychosocial disability workforce

We must take an innovative, collaborative approach to develop and sustain the workforce needed to support Australians living with psychosocial disability. Moving forward, we need a recovery-oriented, trauma informed, culturally responsive, and diverse workforce available to support people wherever they live.

As at 31 December 2019, there were 30,806 active NDIS participants with a primary psychosocial disability (and over 51,000 active participants with any psychosocial disability).[9] This is just under half of the 64,000 people with primary psychosocial disability expected to be eligible for the NDIS.[10] This gives an indication of the level by which the workforce needs to increase to meet demand.

The NDIS presents a tremendous opportunity to move beyond defining the workforce by strict, distinct professional roles, and instead mapping the workforce by skills and capabilities. A central question in designing the future NDIS workforce should be: how can we build the workforce for the services that people want?

This could mean building a transdisciplinary workforce where people have skills across multiple areas, and create possibilities for greater person-centred, interconnected care that can address determinants of mental health, physical health, social and emotional wellbeing.

The future workforce will also be shaped by greater incorporation of technology, with opportunities to provide more integrated care through use of digital devices and data systems.[11] This brings both challenges and opportunities, as can already be seen by changes in response to the COVID-19 pandemic. These changes have seen a welcome increase to service access online, where face to face delivery could not occur, but also highlight the widening of the digital divide in access to IT and skills for vulnerable population groups to utilise this technology.

Improving psychosocial support through the NDIS

To build, maintain, and improve the NDIS psychosocial disability workforce, the skills and capacity required to deliver quality support services need to be better defined.

Psychosocial support work requires skills in:

- forming stronger working alliances with participants
- working effectively with family and carers of participants
- acknowledging and addressing participants' fears and barriers
- providing effective social skills training
- applying the principles of several psychological interventions to a wide range of problems
- understanding and appropriately responding to the impact of trauma, social determinants, and the episodic nature of many mental health issues
- directly supporting and advocating for participants in their engagement within other settings.

[9] National Disability Insurance Agency (2020) *Participant data.* Retrieved from https://data.ndis.gov.au/explore-data/participant-data

[10] Productivity Commission (2019). *Mental Health: Draft Report*, Canberra. Page 431

[11] Australian Academy of Technology and Engineering (2020). *A new prescription: Preparing for a healthcare transformation*, Melbourne

Research shows the demonstration of these skills by employment services staff is associated with better employment outcomes for people with psychosocial disability.[12] The NDIS psychosocial disability workforce must be appropriately supported to develop and maintain such proficiency, in order to support better outcomes for NDIS participants, and greater independence from government services.

More broadly, staff interacting with NDIS participants with psychosocial disability should be:

- able to deal sensitively and patiently with people experiencing serious mental health issues, as well as with their families and carers
- knowledgeable about the impact of mental illness and psychosocial disability, recovery models, and about local service providers' capacities and capabilities (including any gaps in supply)
- skilled in active listening and guiding constructive conversations
- patient, persistent and proactive in maintaining contact and progressing processes
- available for face-to-face contact, especially when conducting assessments and planning processes
- alert to opportunities to reinforce and contribute to an individual's capabilities and self-confidence
- willing and enabled to work with peer workers wherever possible and appropriate.

Obtaining high outcomes requires staff with high levels of behaviour change competency, with social and practical intelligence. As outlined below, the current NDIS level of remuneration generally does not allow for, attract, or retain many people with such high-level skills.

The introduction of the Psychosocial Recovery Coach line item is a very welcome reform anticipated to go some way in enabling greater psychosocial recovery-oriented services through the NDIS. Prior to the disruption of the current pandemic, the Psychosocial Recovery Coach support item was anticipated to be introduced from 1 July 2020. The role will involve two streams relating to learned and lived experience. There was also early indication pricing for this item would be above core pricing, recognising the complexity of skills and experience required for the role. However, this item is still being developed and final details are yet to be confirmed.

Beyond the introduction of the Psychosocial Recovery Coach item, there will need to be broader changes to support holistic quality care for people with psychosocial disability.

There is a need to adapt the expectations and understandings of the type of NDIA supports provided by psychosocial services, towards a greater understanding of how recovery-oriented services function, and an understanding of the capacity building and case management role required for people with psychosocial disability. These adjustments also relate to the core price and the balance of core to capacity building elements in a person's plan.

Many psychosocial support providers believe alternative models of funding are required for psychosocial disability to allow for recovery-oriented support, proper wrap around case management, risk and incident management.[13] Funding needs to account for variations in support provision and the integrated nature of support provision (as opposed to separation into discrete tasks by different levels of workers).

[12] King, J. and Waghorn, G. (2018) *How higher performing employment specialists engage and support job-seekers with psychiatric disabilities*. Journal of Rehabilitation volume 84, No 2, pp 48-56

[13] Mental Illness Fellowship of Australia (2018), *Submission to the Joint Standing Committee on the NDIS: Market Readiness,* Page 6

Flexibility in individualised funding for psychosocial support and group supports could be provided through alternative funding arrangements such as subscriptions, memberships, bulk buying of support incidences in advance, full 'course' fees, and/or much more lenient cancellation policies.

There is significant evidence that many people with significant psychosocial disability do not undertake help-seeking behaviour and remain invisible to services whose intake is premised upon people (or their family or carers) first undertaking such help-seeking behaviour. There is a need then to increase specialist services and workforce to connect with and support people with psychosocial disability who are disconnected or facing barriers to apply for and implement NDIS plans. Proactive outreach and longer periods of active engagement to develop participant readiness is often needed prior to an individual's assessment for NDIS eligibility. Organisations and workforce having connections with the community and psychosocial expertise is crucial to achieve this.

There is some work being developed in this space, through ILC initiatives and the NDIS National Community Connectors program. MIFA's ILC program will provide information to people with psychosocial disability who are help-seeking, to link them into the NDIS. CMHA is developing an ILC project called Assisting Communities through Direct Connection to improve understanding of the unmet need in the community and support connection to services. These initiatives will provide information and models for how proactive outreach can be implemented, but further resources and workforce training will be needed to meet the level of need. It must be an ongoing priority to ensure a component of the psychosocial workforce has skills and resources to reach out and engage otherwise isolated people experiencing severe distress.

Culturally responsive, diverse workforce

We need to develop a psychosocial disability workforce able to respond to the diversity of the Australian population. NDIA data shows that people from culturally and linguistically diverse (CALD) backgrounds make up 8.4% (24,023) of participants in the Scheme, and are more likely to have a psychosocial disability as a primary disability than non-CALD participants (11% compared to 9%).[14] Aboriginal and Torres Strait Islander peoples have particular needs for culturally responsive services, with disproportionate experiences of mental health needs associated with the impacts of colonisation and complex social determinants of health.[15] People who identify as LGBTIQ+ also experience mental health issues at a disproportionate rate, and benefit from services that are culturally sensitive and aware to the particular experiences and needs of the LGBTIQ+ community.[16]

The National Practice Standards for the Mental Health Workforce (2002) include 'awareness of diversity'. In order to provide sound psychosocial and mental health care in a diverse society, the workforce must go beyond being culturally aware however, to being culturally

[14] National Disability Insurance Agency (30 June 2019), *Culturally and Linguistically Diverse participants*, Retrieved from https://data.ndis.gov.au/reports-and-analyses/culturally-and-linguistically-diverse-report

[15] National Aboriginal and Torres Strait Islander Leadership in Mental Health: *Gayaa Dhuwi (Proud Spirit) Declaration*. Retrieved from https://natsilmh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf; Marmot, M. (2011). *Social determinants and health of Indigenous Australians*. Medical Journal of Australia, vol 194, number 10, pp 512-3, Retrieved from https://staging.mja.com.au/system/files/issues/194_10_160511/mar10460_fm.pdf

[16] National LGBTI Health Alliance (2020). *Snapshot of Mental Health and Suicide Prevention Statistics for LGBTI People*. Retrieved from https://lgbtihealth.org.au/wp-content/uploads/2020/02/2020-Snapshot-of-Mental-Health-and-Suicide-Prevention-Statistics-for-LGBTI-People-LGBTI-Health-Alliance.pdf; National LGBTI Health Alliance (2017). *Submission to the Joint Standing Committee on the National Disability Insurance Scheme: development of mental health terms of reference*. Retrieved from https://lgbtihealth.org.au/wp-content/uploads/2017/02/LGBTI-Alliance-Submission-to-NDIS-FINAL.pdf;

responsive.[17] As stated in the National Mental Health Workforce Strategy (2011), ongoing cultural competency training (rather than brief awareness sessions) is the most appropriate strategy for building workforce capacity in this regard. Further, recruiting people with existing cultural competency and providing training in psychosocial recovery care is an effective approach to developing a diverse workforce that is able to engage with all mental health consumers and carers. For example, engagement and training of local people in remote Aboriginal communities through the Community Connectors program has been successful in increasing engagement with the NDIS in these communities.[18]

Increasing cultural responsiveness and diversity of the NDIS psychosocial workforce should be coordinated with the broader mental health workforce. We must develop an informed, skilled, flexible and reflective workforce in order to successfully improve access, choice and control, and recovery for all Australians living with psychosocial disability.

Workforce in light of disasters

The Australian workforce, economy, social and environmental landscape have been fundamentally altered by the 2019-20 bushfire crisis and response to the COVID-19 pandemic. There is the opportunity to shape the future mental health workforce in light of these changes and emerging needs. Some emerging trends are the need for the workforce to:

- provide a combination of face to face and digital (or telehealth) supports, including supporting participants to upskill in use of digital technologies
- understand and work with people with psychosocial disability in community (and family) contexts that are themselves under considerable stress and trauma.

As Australia transitions out of isolation restrictions in response to the COVID-19 pandemic, human services will be an important sector providing employment and economic activity, while supporting the wellbeing of citizens.

[17] Embrace Multicultural Mental Health (2019) *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery, key outcome area 4, workforce.*

[18] Ferdinand, A. (2019). *Understanding disability through the lens of Aboriginal and Torres Strait Islander people – challenges and opportunities*. Centre for Health Policy. Retrieved from https://www.lowitja.org.au/content/Document/PDF/NDIS_Evaluation_M_Kelaher_v2.pdf

Challenges to creating and sustaining the NDIS workforce

The majority of service providers are finding it difficult to recruit and retain an adequately skilled psychosocial workforce under the NDIS.[19] There are systemic reasons for this, centring around inadequacies in the NDIS funding model that restrict the capacity of NDIS providers to recruit, retain, and reimburse the necessary workforce to provide appropriate care for people with psychosocial disability.

The inability under current funding levels to provide attractive salaries and professional development, which recognise the key skills and competencies of a recovery-oriented psychosocial disability workforce, is a fundamental barrier to the growth of this workforce.

Workforce requirements established under the Fifth National Mental Health and Suicide Prevention Plan, National Mental Health Workforce Strategy and industrial law contradict what is feasible under the NDIS.

We are concerned that quality and safety of NDIS psychosocial disability services will continue to be reduced, as in other sectors that have been forced to become reliant on inexperienced, underqualified staff due to inadequate funding.

Predominantly, the current NDIS workforce supporting people with psychosocial disability (and the organisations that employ, train, and support these workers) has been built up over the past decades through major investments in community managed mental health services from state and Commonwealth funded mental health programs (such as Personal Helpers and Mentors, Day to Day Living and Partners in Recovery). These programs have mostly ceased with transition to the NDIS.

Restrictions of NDIS funding model

Current pricing under the NDIS is reported to be unviable for psychosocial service providers. The Reasonable Cost Model (RCM)[20] fails to acknowledge the true costs of providing psychosocial disability support to individuals with serious mental illness. Many people with severe and complex mental illness are extremely vulnerable to self-harm, misuse of medication, mood instability and addiction to legal and illegal substances; and face poverty, challenges with tenancy, offending behavior and disengagement with services.

The current NDIS pricing structures do not adequately cover service delivery and quality assurance activities for this cohort. There are simple cost-drivers of service delivery that are not adequately accounted for in NDIS funding, as further outlined below. These cost-drivers are primarily:

- hourly rate that has to be enough to attract and retain people with required skills, experience and qualifications
- level of support for workers – supervision and professional development
- assumptions around appropriate 'billable' face to face hours
- overheads – allowing for investment in quality and improvement.

[19] In confidence - *Investigation into the impact of NDIS market settings on participants with a psychosocial disability: Preliminary project findings. Provider survey*.

[20] NDIA and NDS (2014), Final Report of Pricing Joint Working Group. Retrieved from https://www.ndis.gov.au/html/sites/default/files/documents/final_report_of_pricing_joint_working_group.pdf

Systemic barriers in NDIS policy and pricing which limit the development and maintenance of an appropriately skilled psychosocial workforce have been articulated previously by the sector,[21] and are reiterated again below:

- underestimation of core staff costs regarding skill, qualifications and pay
  - need a competitive salary that reflects the level of training and skills required to provide recovery-oriented psychosocial support
  - the original cost modelling indicated core supports would be provided by a worker classified at SCHCADS Level 2.[22] A higher level is required due to significant client complexity; and an increasingly mobile workforce with less opportunity for supervision. MIFA members report that prior to the NDIS, most staff were SCHADs Level 4, with some at Level 5. Furthermore, the modelling should be based on a casual rate, and allow for mandatory award level increases over time.
- inadequate provision for supervision, professional development and risk management
  - staff require time to engage in adequate supervision and critical incident debriefing and support. The requirements are higher for workers newly graduated or new to an organisation, and professional standards also require minimum supervision times for workers with certain qualifications which may be additional. With increasing complexity of support, staff require more time to participate in professional development and risk management activities, including incident reporting.
- lack of funding for rostering and staff travel time
  - significant planning and administration is required to effectively roster participants who are located near one another, especially in non-metropolitan and rural areas
- cancellations
  - greater flexibility is required when supporting people with psychosocial disability, as due to the nature of conditions, participants with psychosocial disability can often disengage completely and be un-contactable, or ask that appointments be changed or postponed to a day when they are feeling better able to benefit from the support. This requires additional rostering administration support, and impacts severely on the ratio of billable to non-billable hours
  - service providers are reporting the 10-day cancellation policy in response to COVID-19 assists with workforce and financial management, but participants are experiencing negative impacts – moving forward there needs to be a better balance of provider and participant needs
- overestimation of viable percentage of client-facing time
  - the expected percentage of client-facing time is highly unrealistic and reflects a lack of understanding of the type and complexity of psychosocial disability support provision

[21] Mental Illness Fellowship of Australia (2018), *Submission to the Joint Standing Committee on the NDIS: Market Readiness*; Community Mental Health Australia (2017). *Price Controls Review: Consultation on NDIS pricing arrangements discussion paper*.

[22] See Fair Work Ombudsman (2017) *Social, Community, Home Care and Disability Services Industry Award*

- unrealistic estimation of corporate overheads
  - the assumption that costs will reduce through gains in efficiency in the transition to the NDIS has not borne out in practice. There are several increased costs not accounted for under the NDIS, including administrative burden of line-item billing, changing intake staffing costs, and increased complexity of rostering. The overhead costs of meeting quality assurance and accreditation requirements prescribed by the National Mental Health Standards and new NDIS Quality and Safeguards auditing requirements are also not accounted for.

There are significant risks with having an inadequately skilled workforce supporting participants with psychosocial disability – including mental health deterioration, increased avoidable hospitalisations, crises and suicide. If providers are not able to appropriately support people with psychosocial disability through the NDIS, these risks will simply be passed on to the already overwhelmed specialist mental health services.

> **Recommendation 2:** 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.

Rural and remote

There are additional barriers to growing the psychosocial disability support workforce in regional, rural and remote Australia. Particular strategies and incentives are required to improve the geographical distribution of the psychosocial disability workforce**.**

In addition to issues with pricing referred to above, regional, rural and remote area remuneration needs to increase to encourage the market in regional, rural and remote areas.

Particular cost pressures experienced in rural and remote areas, and provision of support to Aboriginal and Torres Strait Islander communities in remote areas, include:

- higher staff costs due to the need to attract and retain staff, while competing with similar higher-paying roles in government agencies and in mining industries
- significantly increased transport costs including vastly higher travel time and staff mileage cost (noting that in addition to distances required in these areas, some participants do not wish to access local workers due to confidentiality issues in small communities, and therefore request workers from further afield)
- the need for more specialised and trained staff who understand rural and remote needs, can work independently, and have cultural training where language and cultural differences exist
- additional corporate overheads associated with remote premises
- staff housing requirements.

Part of the solution to these challenges will be tapping into local workforces by training and supporting people from local communities rather than relying on existing workers to travel. Recruitment could initially be targeted to people with existing health and social services skills, and expanding from there.

Where there continue to be regions without enough providers to meet service demand, block-funding "Providers of Last Resort" may be necessary. Government could also consider hybrid models which include a block grant for basic infrastructure, with fee-for-service on top of this to promote accountability and participant choice-and-control.

> **Recommendation 3:** Ensure access to NDIS psychosocial services in regional, rural and remote Australia, through funding measures that realistically account for increased cost of service delivery in these areas, increasing recruitment of workforce from local areas, and considering block-funding and hybrid models.

Pre-employment training

Pre-employment training may be a useful strategy in developing and sustaining the quality workforce needed to support Australians living with psychosocial disability.

Pre-employment training for the psychosocial disability support workforce may support the rapid workforce growth that is needed, whilst nurturing the specific skills, knowledge and experience necessary for delivering high quality, psychosocial disability supports. Systematic and nationwide pre-employment training may support:

- necessary movement of workers into the sector from other fields and support retention of workers in the sector
- development of a transdisciplinary workforce where people have skills across multiple areas
- service providers to nurture the recovery-oriented, trauma informed, culturally responsive and diverse workforce needed to support people with psychosocial disability
- service providers to enhance quality and safety for consumers and workers alike, providing a safer work environment and a more capable workforce.[23]

There is evidence pre-employment training plays an important role in preparing workers for their field of employment.[24] This is particularly important in the psychosocial disability support sector, where a unique approach to support under the NDIS is required for people living with psychosocial disability. Supporting individuals with psychosocial disability to develop skills and resources to lead a meaningful and contributing life, whilst identifying and reducing barriers, are essential components of the recovery-oriented care that is considered best practice.

For new psychosocial disability support workers, pre-employment training can support swifter integration into support services, increase conceptual knowledge, increase self-esteem, improve interpersonal skills, and lead to greater levels of job success.[25] Pre-employment training could include supported education, volunteer experience, supported employment, and preservice.

[23] One of MIFA's Member organisations reported a 66% reduction in high-risk and moderate-risk cases of aggression after implementing pre-employment and employment training for staff.

[24] Wolf, J., Lawrence, L.H., Ryan, P.M. and Hoge, M.A., 2010. Emerging practices in employment of persons in recovery in the mental health workforce. American Journal of Psychiatric Rehabilitation, 13(3), pp.189-207 at p. 192.

[25] Wolf, J., Lawrence, L.H., Ryan, P.M. and Hoge, M.A., 2010. Emerging practices in employment of persons in recovery in the mental health workforce. American Journal of Psychiatric Rehabilitation, 13(3), pp.189-207 at p. 192.

There is strong evidence pre-employment training is vital for lived experience workers. Pre-employment training assists lived experience workers to be job ready, feel more confident and empowered, improve feelings of self-worth, and support personal recovery.[26] Preparation for psychosocial disability workforce employment may be a unique subset of employment preparation for individuals in recovery.

Prior to their employment, lived experience workers may have had little prior work experience or been out of the workforce for an extended period.27 Education during the hiring process could be a key point of transition for consumers who are well integrated with mental health support services and want to transition into paid employment as part of the lived experience workforce.[28]

[26] Wolf, J., Coba, C. and Cirella, M., 2001. Education as psychosocial rehabilitation: Supported education program partnerships with mental health and behavioral healthcare certificate programs. Psychiatric Rehabilitation Skills, 5(3), pp.455-476.

[27] Wolf, J., Lawrence, L.H., Ryan, P.M. and Hoge, M.A., 2010. Emerging practices in employment of persons in recovery in the mental health workforce. American Journal of Psychiatric Rehabilitation, 13(3), pp.189-207, at p. 192.

[28] Gates, L.B. and Akabas, S.H., 2007. Developing strategies to integrate peer providers into the staff of mental health agencies. Administration and Policy in Mental Health and Mental Health Services Research, 34(3), pp.293-306.

Lived experience workforce

Connecting with people with lived experience of mental health challenges, who have also undertaken training in providing mental health support, can often be very helpful for people with psychosocial disability in their recovery journey.

People who have journeyed through a similar experience and found ways to live well with mental illness embody hope, and are able to relate and connect to other people living with psychosocial disability in a unique way. There is growing evidence for the effectiveness of trained lived experience workforce (often called peer workers),[29] and momentum for increasing the peer workforce in Australian mental health services.

There are particular challenges in continuing to develop the mental health peer workforce, including role definition, cultural changes and career development. While people with lived experience of mental health issues have always been part of the mental health workforce, the modern peer worker is a particular identified position based around this expertise. Though well-established in some mental health service areas, integration of the peer workforce across the mental health system will require shifts in professional culture and ways of working together.

The peer workforce has also historically faced barriers of a lack of career pathways, with peer workers employed in entry-level face to face service provision roles, with no scope for ongoing professional development or increasing responsibility.

There is significant work underway to develop and promote the peer workforce across mental health services. Under the Fifth National Mental Health and Suicide Prevention Plan, the Australian Mental Health Commission is leading the development of Peer Workforce Development Guidelines by 2021. As outlined by the Commission, "this project will help support the peer workforce through providing formalised guidance for governments, employers and the peer workforce about support structures required to sustain and grow the workforce."[30]

Though there are existing jurisdictional and organisational guidelines, the national guidelines are intended to support consistency across Australia, and progress the professionalisation of the peer workforce.

The NDIS offers particular opportunities for the growth of the peer workforce. Peer workers are likely to be more familiar with disability support needs of people with mental illnesses and are able to identify ways to meet these needs outside the mental health sector and in dealing with everyday life in the community.

In providing these services they use their unique skills and experience to provide a conduit between mental health services and disability supports. They are also uniquely placed to provide pathways between generic disability services and people with a psychosocial disability.[31]

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[29] Health Workforce Australia (2014a), Mental Health Peer Workforce Literature Scan http://www.hwa.gov.au/sites/default/files/HWA_Mental%20health%20Peer%20Workforce%20Literatur e%20scan_LR.pdf, accessed April 2015

[30] National Mental Health Commission. *Peer Workforce Development Guidelines*. https://www.mentalhealthcommission.gov.au/Mental-health-Reform/Mental-Health-Peer-Work-Development-and-Promotion/Peer-Workforce-Development-Guidelines

[31] National Mental Health Consumer and Carer Forum (2001). *Unravelling Psychosocial Disability, Position Statement,* Retrieved from https://nmhccf.org.au/sites/default/files/docs/nmhccf_psychosocial_disability_booklet_web_version_27oct11.pdf

The NDIA should provide strategic support to expand the inclusion of the mental health peer workforce in the NDIS. The possibility of a lived experience stream in the Psychosocial Recovery Coach item is one important opportunity.

Further work could be around providing training for peer workers to ensure comprehensive knowledge and understanding of the NDIS and local service systems, including health and welfare.

> **Recommendation 4:** Invest in training and development of the mental health peer workforce, in collaboration with initiatives outside of the NDIS, to continue to expand this essential workforce.

National policy changes

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 sectors – acknowledging it is the same staff who deliver psychosocial supports funded by the NDIS, PHNs and jurisdictional programs.

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.

The integration and management of the Australian mental health workforce would benefit from the establishment of a national centre of evidence based workforce development similar to that of Te Pou o te Whakaaro Nui in New Zealand that supports the mental health, addiction 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, developing and coordinating education and training for service providers, as well as developing disaster response workforce strategies, and providing resources, tools and support to improve service delivery

In light of the myriad issues outlined above, and in particular the impact of NDIS pricing on the psychosocial disability workforce, Mental Health Australia, CMHA and MIFA reiterate the call by National Disability Services for governments and the NDIA to "fund and assist the development of an industry plan, led by the non-government sector".[32] The plan should be informed by input from people with disability, their families and carers, service providers, peak bodies, professional bodies, and governments. The plan should also include actions, timeframes, accountabilities, and monitoring arrangements. The proposed NDIS industry plan should include specific actions relating to development of the psychosocial disability workforce, including actions relating to maximising the use of the peer workforce. The plan will also need to take into account broader mental health workforce strategies, identified in the Fifth National Mental Health and Suicide Prevention Plan. This approach will ensure due consideration is given to flow on effects between sections of the mental health workforce.[33]

> **Recommendation 5**: Recognising the role of government in workforce development and coordination across funding streams, providers and jurisdictions, the Australian Government should establish a National Centre for Mental Health Workforce Development

> **Recommendation 6**: The Australian Government should fund an NDIS industry plan, led by the NGO sector and complementary to other mental health workforce development plans, to strategically plan and coordinate development of the NDIS psychosocial workforce

[32] National Disability Services (2017). *How to Get the NDIS on Track*. Page 4

[33] Mental Health Australia (2018). *Submission to the Joint Standing Committee on the National Disability Insurance Scheme Inquiry into Market Readiness*

Relation to other sectors

As discussed above, the current NDIS pricing assumptions do not support favourable working conditions to enable highly skilled people to continue in psychosocial disability support roles. As such, the sector has lost long term psychosocial support workers who have moved to other health and community services with better working conditions.

As the system stands, there are ongoing interface issues between the NDIS and a range of other service systems including justice, housing, education, and transport. However, there currently is no effective or efficient mechanism to resolve these cross portfolio issues.

Further, given the interconnectedness of human and social services sectors, investment in development of the psychosocial workforce will lead to benefits in other areas too. It is not possible to separate complex interconnected human needs into independent industries with separate workforces. There is strong interconnection between the psychosocial workforce and other community services, disability services, allied health, education and child care, employers and those responsible for workplace health, defence services, crisis response services, justice, and aged care. The competencies (and associated training) of the NDIS psychosocial disability workforce should be understood as a sub-component of the set of competencies required by this broad range of the human services workforce. Investment in the ongoing development of best practice capacity building work through the psychosocial workforce will then inform best practice across many other human services.

> **Recommendation 7:** There is a role for the Council of Australian Governments (COAG) in monitoring, reporting and resolution of issues between the NDIS and other service systems. In mental health, this monitoring and reporting should cover service systems established through Primary Health Networks, and state- and territory-funded mental health services (clinical and non-clinical; acute and non-acute; residential and community based).

Conclusion

The NDIS psychosocial disability workforce is a unique component of our social security system. This specialised workforce has been depleted through transition to the NDIS, where funding constraints have restricted the ability of providers to employ skilled professionals with appropriate employment conditions. It is in the best interests of NDIS participants, and governments funding support services, to invest in a psychosocial workforce with appropriate capacity to support over time the capability and independence of NDIS participants with psychosocial disability.

Recommendations

1. Governments should work together with the NDIA and NGO providers to define the broad-based community mental health workforce, including the NDIS psychosocial disability workforce, and establish ongoing data collection to monitor required growth in this workforce.

2. 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.

3. Ensure access to NDIS psychosocial services in rural and remote Australia, through funding measures that realistically account for increased cost of service delivery in regional areas, increasing recruitment of workforce from local areas, and considering block-funding and hybrid models.

4. Invest in training and development of the mental health peer workforce, in collaboration with initiatives outside of the NDIS, to continue to expand this essential workforce.

5. Recognising the role of government in workforce development and coordination across funding streams, providers and jurisdictions, the Australian Government should establish a National Centre for Mental Health Workforce Development

6. The Australian Government should fund an NDIS industry plan, led by the NGO sector and complementary to other mental health workforce development plans, to strategically plan and coordinate development of the NDIS psychosocial workforce

7. There is a role for the Council of Australian Governments (COAG) in monitoring, reporting and resolution of issues between the NDIS and other service systems. In mental health, this monitoring and reporting should cover service systems established through Primary Health Networks, and state- and territory-funded mental health services (clinical and non-clinical; acute and non-acute; residential and community based).

Mental Health Australia, Community Mental Health Australia and Mental Illness Fellowship of Australia would be pleased to provide further evidence to support this inquiry, and invite the Committee to contact us if we can be of further assistance.

About Mental Health Australia

Mental Health Australia is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector and committed to achieving better mental health for all Australians. Mental Health Australia members include national organisations representing consumers, carers, special needs groups, clinical service providers, public and private mental health service providers, researchers and state/territory community mental health peak bodies.

About Community Mental Health Australia

Community Mental Health Australia (CMHA) is a coalition of the eight state and territory peak mental health organisations. Through them CMHA has a direct link and provides a unified voice for several hundred nongovernment organisations who work with mental health consumers and carers across the nation.

About the Mental Illness Fellowship of Australia

Mental Illness Fellowship of Australia (MIFA) is a federation of long-standing member organisations, established in 1986. Our members deliver specialist services for individuals living with severe mental ill-health and their carers, friends and families, out of nearly 60 ‘front doors’ in metropolitan and regional areas, to over 20,000 people each year. Our membership has a strong focus on building community, valuing peer support and lived experience, and supporting recovery.

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