



PARTICIPATION
in Education

CHANGE AHEAD

by Sue Harrison

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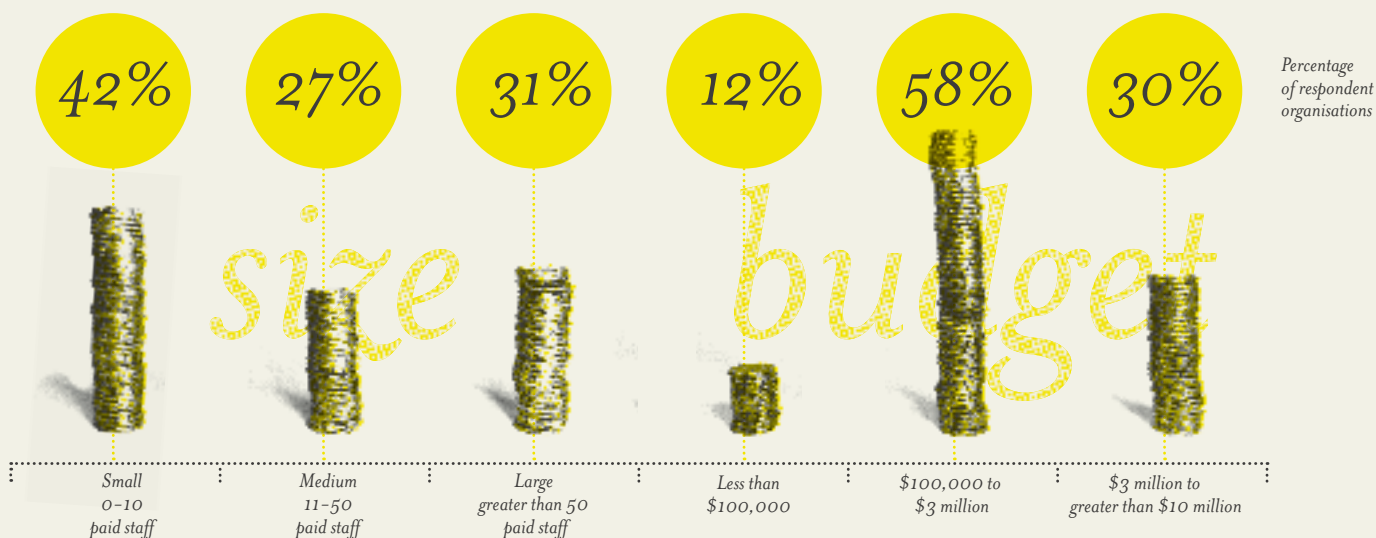
The mental health workforce is as wide and as varied as the people that it supports. When many people think about the mental health workforce, they envisage those working with people who are extremely unwell, and accessing hospital-based treatment and care.

In addition to these, the mental health non-governmental organisation sector, known as the community-managed mental health (CMMH) sector, also supports people with mental health issues in the community. These services provide flexible, cost-effective community-based support that is essential to recovery, early intervention and prevention. Services include a mix of psychosocial rehabilitation and support services, such as housing support, individual support, day programs, prevocational training, residential services, outreach and respite care. Service differences have arisen around Australia from past funding decisions, community need and the availability of generic support services.

The National Health Workforce Planning and Research Collaboration (2011) conducted the Landscape Study of the CMMH workforce in 2009-10, asking organisations about their characteristics and the services they offer. There were 268 valid responses from around 34% of the sector. The study estimated that between 4,950 and 9,989 paid employees worked for the responding organisations, which can be extrapolated to an estimate of between around 15,000 and 27,000 paid employees work for CMMH organisations around the country.

These organisations vary in size and budget, as shown in this table:

TABLE 01



An interesting finding regarded the range of funding sources for the responding organisations, with 28% having only one source of funding. Given the rate of change in mental health policy and subsequent funding distributions, this is risky for these organisations. Of the CMMH organisations with only one funding source, half were from their state or territory health department or other state-run department.

Government involvement

So why does receiving just state/territory-based funding expose organisations to significant change? Since 2006, as a result of the Council of Australian Governments' (COAG) National Action Plan for Mental Health, the role for the Commonwealth Government in community mental health funding has increased. The Plan outlined programs that are funded nationally, and provided by CMMH organisations, including:

- Day to Day Living.
- Personal Helpers and Mentors (PHaMs).
- Mental Health Respite and Carer Support.
- Family Mental Health Support Services.

In addition, the new programs of Partners in Recovery and DisabilityCare Australia, (formerly known as the NDIS) are being rolled out. At this stage, the interaction between these programs, and existing state and territory-based community mental health funding is not finalised, but everything points to these programs having a significant impact on how CMMH services will be funded and delivered.

The first stage of DisabilityCare Australia will be launched from July 2013 in four locations across the country:

- Hunter area, New South Wales.
- Barwon area, Victoria.
- South Australia (for children).
- Tasmania (for young people).
- In the ACT from July 2014.

At the time of writing, agreements for the full roll-out of the program have been made between the Commonwealth and all state/territory governments, with the exception of Western Australia. The scheme will be funded through the Commonwealth budget, an increase to the Medicare Levy, and financial and in-kind contributions from the states and territories.

In Victoria, CMMH services are watching the launch site of Barwon closely, in which existing mental health home-based outreach support, day program, and care coordination services will be provided as in-kind contributions as part of DisabilityCare Australia. Current consumers will be able to continue to receive services under the new program, but all new consumers may not meet the eligibility criteria.

Workforce challenges will be significant. Mental health services in Victoria are funded using an input-based block funding model. DisabilityCare Australia is funded on a consumer-based flexible funding model, with consumers able to purchase services of their choice to meet their needs. This provides much needed flexibility and choice to consumers, but sets challenges for service providers.

Organisations will be required to find ways to promote their services to consumers, provide these services at a high standard, and maintain cost efficiencies. With no guaranteed block funding, services will need innovative methods to maintain a well-trained and motivated workforce.

With less predictable income, service providers will still need to prioritise the training and education needs of their workforce. Highly developed skills in supporting recovery, care coordination, managing complexity, and collaboration with a myriad of other services, will become the core skills required of the CMMH workforce. It is generally accepted that the Certificate IV in Mental Health is the base-level qualification expected of this workforce, but service providers are questioning whether the qualification is adequate in this new environment. The critical thinking and analytical skills developed at diploma, degree, and even graduate diploma level are increasingly seen as required of the workforce in the highly complex community-managed mental health environment. There needs to be a significant investment in workforce training and education for existing and new staff to cater for future consumers.

What next?

Details of future funding arrangements for the CMMH sector are being developed but it is clear that the CMMH workforce faces challenges. These include a shift in traditional funding sources, a change in delivery of funding, and less predictable income and expenditure. Workforce development has not been at the forefront of these changes, but without a secure, well-trained workforce, services simply cannot be delivered.

Developing the workforce is crucial to cover:

- Desired characteristics of the CMMH workforce, including key skills and qualifications.
- Availability of training and education to existing and new workforce.
- Strategies for the recruitment and retention of a workforce that can meet the needs of consumers.

In conclusion, there is a significant challenge ahead. Development of the CMMH workforce to enable not just adequate, but best-practice service delivery, will require a significant investment. Many service providers are acutely aware of this need, and are working towards this goal with the limited resources at their disposal. But without a dedicated investment of funding, resources, and expertise at a policy and governmental level, there is a risk that workforce development will not keep up with the rate of change in service delivery, and consumers and carers will miss out.

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EDUCATIONAL SUCCESS

for People with Mental Illness

by Laura Collister

General Manager, Mental Illness Fellowship Victoria

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'The supported education course was a significant part of my recovery. Not only is it meaningful activity, including work, study, training and volunteering essential for self-esteem, finances and lifestyle, it is also important to make a contribution to society, keep a routine and do purposeful and enjoyable things. It has certainly been a pathway to social inclusion for me where I discovered a new world of possibility' (Ennals, Cartwright and Rinaudo: 2010, 2-16).
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Education is crucial for many people with a mental illness as a positive contributor to recovery and enabling them to gain employment. As a facilitator of recovery, participation in education gives individuals a socially valued role (Best, Still and Cameron: 2008, 65-68; Soydan: 2004, 227-248), builds self-esteem and overcomes some of the cognitive barriers that might result from mental illness (Rinaudo and Ennals: 2012, 114-120). Low levels of educational attainment have also been associated with poor employment outcomes (Waghorn, Still, Chant and Whiteford: 2004, 343-358).

It is reasonable to expect, then, that successful participation in education may have a powerful, positive effect on the lives of many people with a mental illness.

International psychiatric rehabilitation literature recognises this, for example, Mowbray, Collins, Bellay, Migivern, Bybee and Szilvagy (2005, 7-20) and Soydan (2004, 227-248), and yet apparently there are few descriptions or rigorous evaluations of programs designed to support people to enter into education in Australia. Equally, return-to-education programs do not seem to figure prominently in the national mental health landscape for reasons which are unclear.

Certainly, numerous barriers to educational achievement have been described by the international literature – barriers relating to symptoms of mental illness and its episodic nature, barriers relating to the inflexibility of course demands and to the overwhelming social demands of mainstream educational settings. Fear – and experienced – stigma in educational settings are other key barriers.

Mental health professionals also can sometimes stigmatise people with mental illness and this can prevent them from achieving their employment goals. The professionals might view getting, and keeping, a job as unrealistic and likely to exacerbate illness.

This factor may also possibly influence considerations of a return to learning, with mental health professionals unintentionally curtailing an individual's educational aspirations.

People with a mental illness, including low prevalence disorders, however can be successful in education. The literature describes several approaches, some that can be broadly thought of as supporting people to return to mainstream settings and others that create specific supported learning settings as a stepping-stone to the mainstream.

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Mainstream support
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Supporting students to return to mainstream settings has numerous advantages over a more sheltered approach. Mainstream settings are more highly valued, less stigmatised, offer numerous course options and enable students to move out of the mental health world into a mainstream student role. It has been suggested that approaches paralleling the Individual Placement and Support Model will be most effective in assisting people to return to mainstream study (Waghorn et al: 2004,

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343-358) and there has been some success in adopting this approach in Australia, particularly with young people (Kilacky, Jackson & M^cGorry: 2008, 114-120). This approach responds to individual preferences, rapidly engages the individual in mainstream education and provides on-site, ongoing support.

Demands of the mainstream setting can, however, be high and, perhaps in response to this, a self-contained classroom model has been developed. With this model, described by Best et al (2008) and implemented in New South Wales, students attended supported education classes in a self-contained classroom in a mainstream setting. Teaching was delivered by mainstream teachers and mental health professionals offered support. The program reported high rates of students completing the course. While this approach familiarises students with the mainstream setting and provides opportunities to socialise out of the classroom with the general student population, it is unlikely to provide enough – and varied – courses to respond to student preferences and may be experienced as stigmatising.

Tailored education program

Another approach, described by Ennals et al (2010) and delivered by Mental Illness Fellowship in Victoria, has an education program tailored to the needs of people with a mental illness. This approach, while requiring students to meet nationally recognised standards, has a very flexible pace of learning. The course runs for more weeks with fewer hours per day and range of teaching methods. In addition, it has individualised mental health support and volunteer tutoring. Although this approach has few of the advantages of a mainstream setting, it does enable a high degree of mental health support. For instance, Ben, a student in this program, described how:

'In the course I had two important learning streams. I was learning more about mental illness and how to manage it from others in the class and from the teacher... I was also re-learning the skills in literacy, goal setting and regaining hope for my future' (Rinaudo and Ennals: 2012, 99-104).

In this quote, Ben refers to the importance of peers in his return to learning. Both Ennals and Best acknowledge the importance of peer learning and support. Peers not only provide valuable insights into managing mental illness and recovery, but also practical problem solving and support in overcoming educational challenges. Peer support is also increasingly being recognised as a particularly effective enabler of recovery.

Recovery Colleges in the United Kingdom take this approach even further. As learning centres, they offer a curriculum incorporating traditional education, such as literacy and numeracy lessons, with recovery education. Peer learning is fundamental to the colleges, with all courses being co-designed and co-led by peers and teachers or professionals. The colleges are open to people with a mental illness, the community, staff and their family.

Recovery Colleges are relatively recent developments in the UK and are yet to be established in Australia. This combination of peer approaches and education may well offer a highly

effective model for some, but like the other sheltered settings, will be unlikely to have the range of opportunities for students as in a mainstream setting and may be stigmatising.

It is likely that different approaches will suit different individuals, at different times. Young people may well value a rapid return to mainstream education, while people who have been disengaged from education and struggling in their recovery journey may choose a more sheltered approach, which incorporates more chances to learn from peers and to learn about illness self-management and recovery.

As Australia builds a mental health system centred on recovery, it is essential the mental health community embraces the educational aspirations of the people it serves and develops models that enable choice and support success.

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