Submission of the Health Services Union

Productivity Commission Inquiry

'The social and economic benefits of improving mental health'

5 April 2019

About the Health Services Union

The Health Services Union (**HSU**) is a growing member-based union with over 85,000 members working across the health and community services sectors in every state and territory.

Our members work in aged care, disability services, community health, mental health, first response, alcohol and other drugs, hospitals and private practices.

HSU members are health professionals, social workers, paramedics, disability support workers, aged care workers, personal and community care workers, physiotherapists, occupational therapists, diagnosticians, nurses, scientists, technicians, clerical and administrative staff, doctors, medical librarians and support staff.

We are committed to advancing and protecting the wages and conditions, rights and entitlements of our members through campaigning, education and workplace activism. The HSU also provides a range of services and support to assist members with many aspects of working and family life.

We are a driving force to make Australia a better place. We work to ensure the rights of not just our members, but all working Australians, are protected. Our work and advocacy are in recognition of the inextricable link between accessible, quality and safe healthcare and meaningful social and economic participation. A valued health workforce is central to delivery of outcomes.

HSU National is the trading name for the Health Services Union, a trade union registered under the *Fair Work (Registered Organisations) Act 2009*.

Introduction

The HSU has some 10,000 members working in the mental health sector. Our members in the sector work in roles including social worker, psychologist, psychiatric nurse, occupational therapist, mental health clinician, peer support worker, alcohol and other drug (**AOD**) support worker, and clinical supervisor for education and training. In addition to those with direct involvement, we have members working in health professions that require them to interact on a regular, if not daily basis, with people experiencing mental ill-health. This includes paramedics, administration officers, aged care workers, disability workers and allied health professionals. Our members are employed in not-for-profit, privately owned and public organisations.

HSU members in the mental health sector report experiencing mental ill-health themselves as a result of their work, which by its nature is physically, emotionally and mentally demanding, and often involves high and repeated exposure to trauma. The HSU and its members are therefore expertly placed to make this submission and its recommendations to the Productivity Commission's *Inquiry into the Social and Economic Benefits of Improving Mental Health* (**the Inquiry**).

The HSU and its members welcome the opportunity to contribute to the Inquiry. We recognise the ability for such undertakings to give a voice to some of society's most vulnerable members and affect meaningful and wide-reaching change. We are, however, cognisant that this Inquiry follows a long list of similar reviews across the political spectrum. We urge the Inquiry to support the recommendations made in this submission and aide Government(s) to act immediately on implementation.

This submission has been prepared based on the first-hand experiences of our members, using semi-structured interviews. Evidence has also been collected from conversations with HSU Organisers and Officials. Anecdotal evidence contained herein is supported by various other resources including existing literature, submissions and reports on the mental health sector.

While the submission has been prepared by HSU National, it is made on behalf of our branches[1] and HSU members Australia-wide. The HSU also makes this submission in recognition of all those with lived experience, caring for a family member or friend with a lived experience, or working within a related sector or field, in the hope that it will deliver positive outcomes for all.

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[1] New South Wales, Tasmania, Victoria and Western Australia have the highest concentration of HSU members working within the mental health sector. NSW and Tasmania have the highest concentration for first responder workers.

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'We're dealing with human beings. They have clever thoughts, deep feelings and inspirational ideas that can shape us all. We must build a human focused service that lets them do just that'

<div align="right">Senior Mental Health Social Worker, Western Australia.</div>

Summary of recommendations

These recommendations support the Inquiry in its stated goal 'to make recommendations to improve population mental health so as to realise higher social and economic participation and contribution benefits over the long term.'[2]

Recommendation 1:

Substantially increase and better direct funding to reflect mental ill-health's contribution to the burden of disease by:

a) urgently funding an updated burden of disease study to be carried out, the last having been done in 2011. Findings from the updated study should be used to immediately inform funding and policy decision-making.

b) increasing funding to preventative and community mental health services. This funding must not be based on any reduction in the funding of acute mental health services.

c) providing funding to develop more community mental health well-being hubs to provide holistic care, including referrals to housing, income support, employment and other medical services. Such environments must be designed and funded to provide 'step down' modelling, where consumers can enter the system at any level, depending on their needs at any given time.

d) ending cyclical or project-based funding models. Award permanent funding to effective service providers.

Recommendation 2:

Develop a contemporary national strategy for mental health which:

a) must be signed up to by states through the Council of Australian Governments.

b) mandates states to engage in the required collaboration and preparation, including contributing to resourcing.

c) requires the Australian Bureau of Statistics be funded to carry out an updated National Survey of Mental Health and Wellbeing (National Survey), the last having been done in 2007. The

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[2]Australian Government Productivity Commission, *The Social and Economic Benefits of Improving Mental Health*, Issues Paper, January 2019, p. 2.

National Survey should have a focus on the current effectiveness of the 1992 National Mental Health Strategy (National Strategy) and its subsequent plans and policies, and the interrelation with implementation and individual outcomes. The National Survey must also examine what a contemporary National Strategy requires. Funding must guarantee a National Survey is carried out every 5-years following.

d) ensures comprehensive research into the non-registered mental health workforce is carried out, with a focus on work health and safety incidents and patterns, role classifications, remuneration and hours worked, regional and remote workforce supply, gender characteristics.

e) reinstates funding to the ABS to conduct a wholesale review of the Australian and New Zealand Standard Classification of Occupations, to ensure the collection of aggregate data on the mental health workforce.

f) ensures that bipartisan commitment be given to any long-term national mental health plan, quantified with length of commitment (10, 20 years).

Recommendation 3:

The federal and state governments commit to designing, funding and building redesigned therapeutic environments. The redesign will include establishing Psychiatric Intensive Care Units within existing hospital emergency departments and building new infrastructure for integrated service wellbeing and recovery centres. Input must be sought from people with lived experiences and services must be multidisciplinary, integrated, and focused on prevention and early intervention. The funding model for the wellbeing and recovery centres should be based on the GP Super Clinic Programme and be committed to by both levels of government for a long-term tenure (20 years).

Recommendation 4:

Improve workforce education and training by:

a) re-introducing a mental health major into relevant undergraduate degrees, in particular nursing, at all Australian Universities.

b) ensuring provision of clinical supervision programmes be harmonised between states to ensure supply of a consistent and quality national mental health workforce.

c) providing funding for all tertiary education providers, both in the VET and higher-education sectors, to develop and implement, in consultation with mental health workers and people with lived experience, clinical supervision programmes.

Recommendation 5:

Improve staffing levels and workforce support and development by:

a) requiring employers to work in consultation with workers, worker representatives and people with lived experience to determine staffing level requirements and discipline mixes across mental health services.

b) providing funding to employ additional staff as workplace educators and mentors, particularly in community mental health settings.

c) introducing mandatory employer requirements for and contributions to mentoring, professional development and continued education programmes for workers. Employers must demonstrate the ongoing provision of workforce education programmes.

d) putting in place state government arrangements that give employers extra funding on the basis that they have an Enterprise Agreement with the relevant union(s) covering their employees.

The HSU will speak to its areas of expertise in mental health service delivery, predominantly through the invaluable lens of workers in the sector and those in interacting health industries. As the myriad reviews, commissions, inquiries and studies into Australia's mental health system demonstrate, the systemic issues are complex and require a multi-faceted, coordinated and long-term plan. At the centre of any proposal for change must be the person; those living with mental illness, mental health problems or mental ill-health, and the many others that commit their lives to supporting them.

System structures and framework

The Australian mental health system has been built on reactive policy and systems. It is not equipped to provide effective prevention, early-intervention, community-based or multi-disciplinary services. Effective preventative and holistic treatment of a person's mental ill-health, illness or disorder requires sufficient and stable funding for services that accommodate individual needs. The system requires a well-resourced, national strategy. Yet currently the system is operating in 'crisis mode'.

The HSU summarises the issues for the mental health system's structure and framework as:

- inadequate funding, particularly in person-centred community care;
- unstable, 'cyclical' funding models;
- lack of national strategy, policy continuity and harmonisation;
- lack of reliable research and data; and
- partisanship, leading to the 'politicisation' of mental health policy.

Inadequate funding

Funding provisions for mental health does not adequately reflect the prevalence of illnesses and disorders. Despite being responsible for an estimated 12.1% of the total burden of disease in Australia, only 7.4% of government health expenditure is spent on mental health-related services.[3] The economic cost to Australia of mental health is high and rising; an estimated $70 billion per annum, or 4% of gross domestic product, was attributed to lost productivity and job turnover, alongside costs accrued at the intersections with the justice, housing, disability, employment and income support systems.[4]

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[3] Australian Institute of Health and Welfare, *Mental health services: In brief 2018*, September 2018, p. 3.
[4] National Mental Health Commission, *Monitoring mental health and suicide prevention reform*, national report, 2018, p. 34.

Recommendation: The Federal Government provide funding for an updated burden of disease study to be carried out, the last having been done in 2011. Findings from the updated study should be used to immediately inform funding and policy decision-making.

Recommendation: Substantially increase funding to reflect the burden of disease. In particular, increase funding to preventative and community mental health services. This funding must not be based on any reduction in the funding of acute mental health services.

Holistic, community-based services

Gaps in funding are found to be most severe in community mental health services, which are critical to psychosocial support and recovery. Absence of community-based treatment increases the likelihood of consumer interaction with acute care, placing unsustainable pressure on hospital emergency departments and in turn diverting scarce funds to acute, expensive, reactive treatment. Therapeutic environments that provide whole-of-person care centred in community and catering to individual needs, help keep relationships intact, maintain safe housing, manage physical health and comobordities, retain meaningful employment, and remain connected to the community.

Ensuring accessibility (affordability and availability) to a full-suite of local services is particularly pertinent for high-risk populations[5], including remote and regional Australia, Aboriginal and Torres Strait Islander peoples, older Australians, culturally and linguistically diverse groups, and the LGBTQI community. At present, there is a correlation between accessibility and geography; service shortages are more common in rural and remote areas, particularly for specialist care such as youth mental health or substance abuse treatment.[6]

Recommendation: Provide funding to develop more community mental health well-being hubs to provide holistic care, including referrals to housing, income support, employment and other medical services. Such environments must be designed and funded to provide 'step down' modelling, where consumers can enter the system at any level, depending on their needs at any given time (See also *Redesigned Therapeutic Environments*, pp. 14-15).

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[5] A Baciu & JM Sharfstein, 'Population Health: From clinic to community', *Journal of American Medical Association*, vol. 24, June 2016, pp. 2663-2664.
[6] Royal Australian and New Zealand College of Psychiatrists, 'Mental health in rural areas', website, viewed 18 March 2019.

Universal healthcare and funding stability

The HSU supports accessibility to health care. An individual's income should not be a determinant in their ability to access quality mental healthcare when they need it. This can only be achieved through provision of an adequately funded public health system. Private services should operate as a supplementary system, ensuring the focus remains on health outcomes not profit margins.

One HSU member described the current funding model as 'cyclical', describing how she has seen many effective public mental health services, or not-for-profit organisations receiving government funding, be shut down because 'an arbitrary time-limit was put on their worth'. Another member said it is time to:

'stop making services divert resources to filing funding applications. Make sure they (service providers) have the money they need to carry on with helping the people coming to them, and make sure their people (nurses, carers, social workers) aren't caught up behind a desk justifying why they need the money'

Recommendation: End cyclical and project-based funding models. Award permanent funding to effective service providers.

The lack of national strategy, policy continuity and harmonisation

Development of the 1992 National Mental Health Strategy (**the Strategy**) and its plans and policies were a monumental demonstration of collaboration between each state, territory and federal government. However, the implementation of the Strategy has not always occurred with the same cohesion. While shared responsibility arrangements between Commonwealth and the states can be effective, they also 'create scope for duplication and waste to occur, and regularly feature disputes over funding levels and cost-shifting between different levels of government.'[7] The result, nearly 30 years on, is a disjointed mental health system marked by an absence of targeted and responsive policy, national harmonisation and oversight.

Recommendation: A contemporary national strategy for mental health must be developed. The Commonwealth must mandate states to engage in the required collaboration and preparation, including contributing to resourcing.

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[7] A Biggs & L Cook, 'Health in Australia: a quick guide', *Parliament of Australia research paper series,* 31 August 2018, p. 3.

Recommendation: The new national strategy must be signed up to by states through the Council of Australian Governments (**COAG**).

Reliable research and data

Like the complexities impacting implementation of the Strategy, are the disparate ways in which states and mental health service providers and agencies (state, territory and Commonwealth) collect, monitor and share data on service provision and outcomes. The last substantive National Survey of Mental Health and Wellbeing (National Survey) was done in 2007, 10 years after the first National Survey was undertaken. The HSU is troubled that funding for a 2017 National Survey was cut by the Department of Health and has not been put in place again since. The 'lack of real outcome data not only impedes effective reporting, policy development and planning'[8] it also limits the extent in which decision-makers understand 'how people experience and recover from mental illness; what role any interaction with services plays; and the degree to which treatment results in returning to their homes, families, workplaces and the broader community.'[9]

HSU members report doing 'hours of paperwork', identifying a link between statistics derived from their paperwork and funding availability (albeit the data-funding linkages being 'patchy at best'). However, they also report a sense of the data 'going nowhere' and of 'systems that do not talk to each other' so the real benefits of that information, those that can support the delivery of efficient, holistic and individualised care, are not realised.

The mental health workforce is and needs to be diverse. HSU notes that the mental health workforce is most commonly identified as Australian Health Practitioner Regulation Agency (**AHPRA**) registered health professionals. In 2016, there were nearly 550,000 people that reported as registered health professionals. However, nearly 250,000 additional people reported as working in health industries. This included those in unregistered occupations including nursing support, personal and community care workers, medical receptionists, medical technicians, ambulance officers and paramedics[10], kitchen hands and commercial cleaners (hospitals). Most notably in the health professions "lumped together" are social workers, whose work forms an integral part of many mental health care plans. The exclusion of these critical occupations from formal research and data sets is reflective of an entrenched undervaluing of these roles, and the over-medicalisation of care for people with lived

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[8] DW Crosbie, 'Mental health policy – stumbling in the dark?', *The Medical Journal of Australia*, vol. 190, February 2009, pp. 43-45.
[9] Ibid.
[10]The AHPRA board for paramedicine was established in late-2017. Workforce data for 2018-2019 onward will include paramedics.

mental health experience. This has an adverse flow-on effect for related areas such as accurate workforce data and planning, work health and safety reporting, funding, and remuneration (see also *Remuneration*, pp. 20-21).

Recommendation: The Australian Bureau of Statistics (**ABS**) be funded to carry out an updated National Survey of Mental Health and Wellbeing (National Survey), the last having been done in 2007. The National Survey should have a focus on the current effectiveness of the 1992 National Mental Health Strategy (National Strategy) and its subsequent plans and policies, and the interrelation with implementation and individual outcomes. The National Survey must also examine what a contemporary National Strategy requires. Funding must guarantee a National Survey is carried out every 5-years following.

Recommendation: The ABS and/or Australian Government's Institute of Health and Welfare carry out comprehensive research into the non-registered mental health workforce in order to capture accurate sector specific data. This should include but not be limited to work health and safety incidents and patterns, role classifications, remuneration and hours worked, regional and remote workforce supply, gender characteristics.

Recommendation: Reinstate funding to the ABS to conduct a wholesale review of the Australian and New Zealand Standard Classification of Occupations (**ANZSCO**), to ensure the collection of aggregate data on the mental health workforce. Robust workforce data that reflects the full and diverse nature of mental health occupations will improve funding levels and allocation efficiency.

Partisanship

Exacerbating the absence of continuity is what our members describe as the "politicisation" of mental health policy. This also impacts stability of funding. One member, a mental health nurse in the public system, provided this description:

'I have worked in Victoria, New South Wales and Western Australia under [state government of] each persuasion. It is clear to me that it's [mental health] a political football. Things will be changed just to be seen to be doing something; to make a point of difference to the enemy. Where's my client in that approach?'

At a Mental Health Victoria-hosted discussion forum, held 12 March 2019, a number of stakeholder representatives expressed similar concerns regarding partisanship at both Commonwealth and state levels of government.[11] The HSU shares these concerns and the adverse impact this can have on funding arrangements, accessibility, care continuity, provision of community-based services, and the perpetuation of stigma and discrimination.

Recommendation: Bipartisan commitment be given to any long-term national mental health plan, quantified with length of commitment (10, 20 years).

Prevention, intervention, integration: Housing, income support, social services and the justice system

Effective person-centric treatment requires people experiencing mental illness to have early access to more and better co-ordinated services, both clinical and non-clinical. Services must be funded and designed to allow for a disentangling of the complex relationships between mental health issues and suicidality, substance abuse, physical conditions and the common risk factors underlying each (comorbidities)[12]; and the interrelation of other socio-economic issues such as housing stability, income support, social services, and the criminal and justice systems. HSU officials and members describe services as 'so thinly stretched they cannot examine the root cause of any given issue.' One member, a community social worker, provides the following description:

*'A client will present to a GP (general practitioner or ED (emergency department) or someone like me for whatever issue is worst that day. Maybe it's a physical ailment, maybe they're in psychosis, maybe they have nowhere to sleep. An assessment will be done on that **one issue alone**, in that moment. Then they're cut loose again. This doesn't prevent a damned thing.'*

Efficient resourcing: improving community service models

According to one HSU official, who has worked in the mental health sector directly, the current care models are plagued by 'allocation inefficiencies' and 'missed opportunities for integration of services.' Cuts are being made to preventative, holistic community mental health in order to 'prop up' bed shortages in acute care. Referrals to related and much-needed services such as public housing

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[11] Mental Health Victoria consultation session, Productivity Commission Inquiry into Mental Health, workshop notes, March 2019.

[12] KM Scott et al. 'Association of Mental Disorders with Subsequent Chronic Physical Conditions: World Mental Health Surveys From 17 Countries', *Psychiatry*, vol. 73, February 2016, pp. 150-158.

providers, income supports and financial counselling, domestic violence services, legal aid, and employment services are not always available or available in a timely manner.

HSU members have provided the following accounts:

'My client (an older male experiencing mental illness) had spoken with 95 Centrelink call-centre consultants to try and sort out his payments. 95 different people. How can we expect people suffering to navigate this on their own? I found him (after an attempted suicide) just in time. It's what tipped him over the edge, that pressure of dealing with the bureaucracy. If he'd had access to social housing supports and someone who could help with Centrelink sooner, he wouldn't have deteriorated and tried to commit suicide.'

Community Social Worker

'She keeps going in and out of emergency (with methamphetamine abuse). The cops will be waiting for her once she's done there. Then it's off to do some time with them. And let me tell you, that's not rehab. Got nothing to do with what she actually needs. She's back on the streets next. I do wonder if she'd been sent to me or someone like me first, way back at the start (nearly a decade), if we'd still be here now.'

Alcohol and Other Drug officer

Redesigned therapeutic environments

Psychiatric Intensive Care Units/Acute clinics

The HSU advocates for the creation of more Psychiatric Intensive Care Units (PICUs) and acute clinic facilities, to provide specialised services to those with known or developing acute mental disorders. The environments will:

- provide for specific staffing profiles and training
- prevent and/or better manage violent behaviours as they emerge and/or occur
- be co-designed with people with lived experience
- involve a 'step-down' model whereby consumers can enter the system at any level, depending on the acuity of their illness at any given time.

Currently, emergency departments must attempt to treat acute or chronically ill consumers in environments where there are staff shortages, inadequately trained staff or an inappropriate mix of skills across staff, all while tending to the diverse needs of others accessing acute care. The result can

be violence, disorder, trauma and injury; experienced by staff and consumers alike. PICUs/acute clinics will reduce these risks. These facilities should be established within existing hospital infrastructure, allowing for immediate triage to the appropriate care facility. See Figure 1 below.
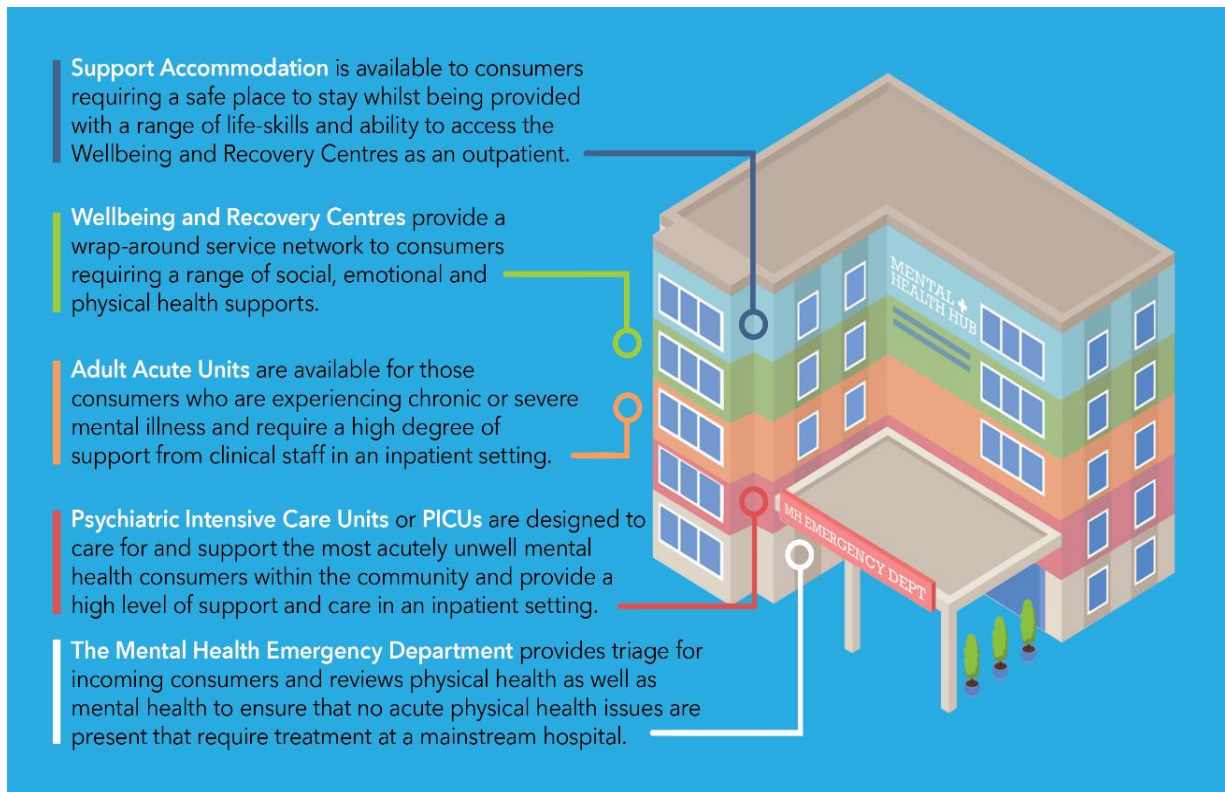

Support Accommodation is available to consumers requiring a safe place to stay whilst being provided with a range of life-skills and ability to access the Wellbeing and Recovery Centres as an outpatient.

Wellbeing and Recovery Centres provide a wrap-around service network to consumers requiring a range of social, emotional and physical health supports.

Adult Acute Units are available for those consumers who are experiencing chronic or severe mental illness and require a high degree of support from clinical staff in an inpatient setting.

Psychiatric Intensive Care Units or **PICUs** are designed to care for and support the most acutely unwell mental health consumers within the community and provide a high level of support and care in an inpatient setting.

The Mental Health Emergency Department provides triage for incoming consumers and reviews physical health as well as mental health to ensure that no acute physical health issues are present that require treatment at a mainstream hospital.

Figure 1. Example of additional PICU/acute facilities, with wrap-around recovery and well-being services.

Wellbeing and Recovery Hubs

The HSU believes many acute mental health service environments are designed inappropriately. A key problem with current acute service environments is the inappropriate placement of consumers with physically and/or sexually violent behaviours alongside other mentally unwell consumers. The behaviours of this small minority negatively impact on the recovery pathway for the majority of clients. Many current services are not environments that suit the needs of the consumer, rather they are a medicalised hospital model in most cases. Too often this critique of acute therapeutic environments is used as justification to remove funding from acute services and redirect it to community mental health services. However, this is a two-dimensional response which ignores the reality that a small but significant proportion of the mentally unwell population need acute services as part of their recovery.

The HSU advocates for the funding and development of wellbeing and recovery hubs. Such centres will promote overall health and wellbeing through a wraparound service provision model.[13] They will form an integral component of the 'step-down' model from acute therapeutic environments, as well critical early intervention and prevention care. Consumers can access the hub either as an in-patient or outpatient when needing support with mental and physical health issues, co-morbidity, housing, financial counselling, criminal justice and family violence (see Figure 2 below).

Redesigned therapeutic environments, particularly the Recovery and Wellbeing Hubs will require new infrastructure, and we submit should be developed under a model akin to the GP Super Clinics[14]. The benefits of following a similar programme include:

- Strengthening of a mental health focused Primary Health Network (PHN) responsive to local community needs
- Establishment of mental health PHNs in regional and remote areas
- Integrated multidisciplinary care
- Secure, long-term funding arrangements for infrastructure and services, agreed between Federal and State governments and based upon comprehensive selection criteria
- Lower rates of admission to hospital emergency departments
- Safer treatment and work environments
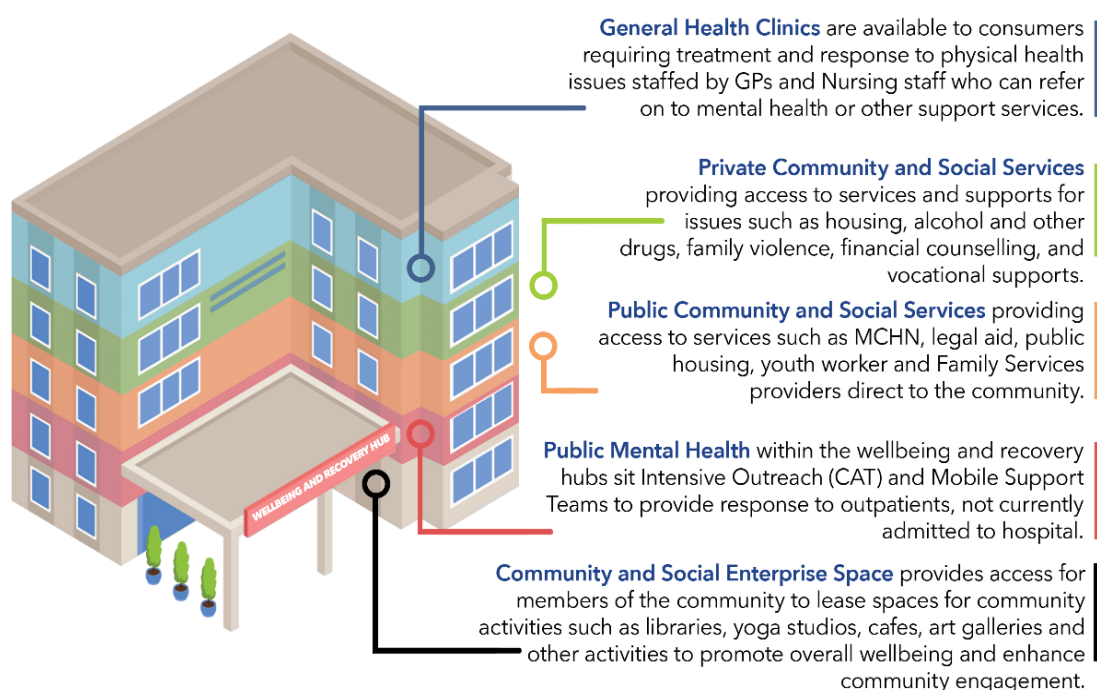- Supported workforce with improved wages and conditions; attraction and retention rates.

General Health Clinics are available to consumers requiring treatment and response to physical health issues staffed by GPs and Nursing staff who can refer on to mental health or other support services.

Private Community and Social Services providing access to services and supports for issues such as housing, alcohol and other drugs, family violence, financial counselling, and vocational supports.

Public Community and Social Services providing access to services such as MCHN, legal aid, public housing, youth worker and Family Services providers direct to the community.

Public Mental Health within the wellbeing and recovery hubs sit Intensive Outreach (CAT) and Mobile Support Teams to provide response to outpatients, not currently admitted to hospital.

Community and Social Enterprise Space provides access for members of the community to lease spaces for community activities such as libraries, yoga studios, cafes, art galleries and other activities to promote overall wellbeing and enhance community engagement.

Figure 2. Example of services provided for in a recovery and well-being hub.

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[13] Health and Community Services Union (Victoria), 'Better Mental Health for Victoria: Here's what we can do together to re-establish Victoria as Australia's leader in the sector', Issues Paper, 2019.
[14] Australian Government, Department of Health, *About the GP Super Clinics Programme*, website, 28 November 2013.

Recommendation: The federal and state governments commit to designing, funding and building redesigned therapeutic environments. Input must be sought from people with lived experiences and services must be multidisciplinary, integrated, and focused on prevention and early intervention. The funding model should be based on the GP Super Clinic Programme and be committed to by both levels of government for a long-term tenure (20 years).

The mental health workforce: Skilled, healthy and valued

The key issues facing the mental health workforce can be summarised as:

- Lack of specialist training and experience.
- Difficulty recruiting and retaining skilled workers.
- Staffing shortages and lack of skill mixes.
- High worker turnover due to stress and occupational violence.

The work undertaken day-in and day-out by the mental health workforce and those in related fields is emotionally, physically and mentally demanding. A skilled, healthy and valued workforce will improve outcomes for consumers, mental health and other sector workers, and society.

Education & training, skill acquisition and experience

There is a serious lack of mental health training in the national curriculum. Provision of mental health training for direct and related occupations, along with the return of specialist mental health majors in tertiary education, is the critical beginning point for reinvestment in a skilled, resilient, local workforce. HSU members trained prior to the axing of specialist education programs in the 1990s[15] are reporting intergenerational gaps in knowledge. As the older workforce enters retirement, young workers with less experience, often without the benefit of specialist mental health training, are expected to take on senior roles and responsibilities. The international mental health workforce that was imported with the intention to be a supplement is returning home and opportunities to recruit from overseas do not exist at the level they once did. The result of the substantial, long-term underinvestment in mental health education and training is driving a staffing crisis for the workforce and people needing mental health care.

Graduates from higher-education and vocational institutions must receive comprehensive clinical supervision upon entry into the workforce. Currently, this is not uniformly provided by institutions and

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[15] Commonwealth of Australia Senate 2006, *A national approach to mental health – from crisis to community*, final report, pp. 16.

varies state-to-state. An HSU member with 36 years' experience across the mental health system, first as a nurse and for the last 20 years as a mental health social worker in hospital and community settings in the UK, Europe and Australia, in both managerial and frontline service provision, who also holds a Masters in Social Work and has contributed to local university programs as a placement supervisor over the last decade', described the Australian graduate support system as follows:

'Placement supervision and specialist training depends on what state you live and/or study in. In NSW, you can get up to 3 years supervision and mentoring after you graduate. Support is incrementally decreased, but it's appropriate and available.

I had one woman come to me after she moved from Victoria to Western Australia upon graduation and she was shocked that there was no post-grad support for her. She wished she'd stayed in Melbourne.

In WA, we contacted universities ourselves to help them set up supervision programs. But there's no incentive, direction or funding for them.'

Minimum standards of clinical supervision must be harmonised across jurisdictions. The discrepancies compound the absence of specialist training in the national curriculum and present a barrier to peer-to-peer knowledge sharing.

Recommendation: Re-introduce a mental health major into relevant undergraduate degrees, in particular nursing, at all Australian universities.

Recommendation: The provision of clinical supervision programmes be harmonised between jurisdictions to ensure supply of a consistent and quality national mental health workforce.

Recommendation: Funding be provided for all tertiary education providers, both in the VET and higher-education sectors, to develop and implement, in consultation with mental health workers and people with lived experience, best-practice clinical supervision programmes.

Workforce support structures

The provision of workplace support structures is known to reduce work stress and burnout, foster a culture of safety (consumer and worker) and contribute to knowledge retention[16]. At present, Australia's mental health system does not provide adequate workplace support tailored to the specific needs of the sector. The HSU advocates for the following to be implemented across all services providing mental health care.

Workforce planning

HSU members report on significant staffing shortages. In Victoria, it is reported that there are currently 100 vacancies in nursing alone.[17] The reason for staffing supply issues is three-fold. Firstly, the lack of specialist training deters students from choosing a career in mental health. Secondly, cost-cutting measures by employers often look to reduce wage expenditure as a first point of call. This results in reduced staffing levels. Thirdly, the sector is subject to high-rates of staff turnover due to either stress, burnout and/or trauma or lack of ongoing workplace support, and often, both.

Staffing

The sector urgently needs increased numbers of staff across a mix of disciplines and services. Employers must commit to appropriate staffing levels and provide resources to ensure these can be provided consistently. Focus must be given to ensuring the availability of staff across clinical and non-clinical treatments. Employment of additional support staff, such as administration and Psychiatric Support Officers (PSOs), will reduce case management and administrative burdens for clinical staff while also ensuring safe discharge pathways and referrals to connecting services take place and are done in a timely manner. Increased numbers of staff qualified to work with specific social groups, such as Aboriginal and Torres Strait Islanders, older Australians, the LGBTQIA community, and culturally and linguistically diverse groups should also be employed.

Recommendation: Employers must work in consultation with workers, worker representatives and people with lived experience to determine staffing level requirements and discipline mixes across services.

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[16] HK Spence Laschinger & MP Leiter, 'The Impacts of Nursing Work Environments on Patient Outcomes and Safety', *Journal of Nursing Administration*, vol. 36, June 2006, p. 259.

[17] Health and Community Services Union (Victoria), 'Better Mental Health for Victoria: Here's what we can do together to re-establish Victoria as Australia's leader in the sector', Issues Paper, 2019.

Rostering

The recent Senate Inquiry into the mental health of first responders[18] outlined the impact of rostering on the wellbeing of these workers[19]. The report drew attention to the role rostering practices have in staff wellbeing and employment outcomes. Most notable was the Committee's commentary on:

- the detriment of prolonged shift-work on health and wellbeing
- the need for rotated rosters to reduce staff exposure to trauma and high-pressure situations
- the benefits of rostering to ensure mix of staff skill sets and experience
- the relationship between availability of money for, and amount spent on, staffing and an employer's ability to implement safe and effective rostering.

The Committee was resolute that workforce planning, including resourcing, staffing levels, skills mix, and rostering improve workforce wellbeing and in turn, the quality and safety of care provided. The same principles apply to the majority of the mental health and related workforce, who are often employed in high-pressure, 24/7 operational environments such as hospitals, in-patient clinics and on-call community work.

The HSU notes that no formal Government response to the Senate Inquiry report has been released. The HSU supports the findings and recommendations contained within the report. In particular, the HSU urges this Inquiry to consider recommendations 4-7 and 12, and the preceding chapters to each, of the Senate Inquiry. These recognise the need for myriad workforce support structures in high-exposure occupations, which in the HSU's view includes first responders and extends to other workers in mental health.

Mentoring

HSU members report that resourcing pressures reduce their ability to engage in or offer professional development programs, such as mentoring. For new entrants to the mental health workforce, the inability to receive on-the-job guidance and education can be a deterrent to career development. For workers that experience work-related trauma, such as violence or suicide, not having a trusted colleague to debrief with or clear path to support, can cause them to develop their own mental ill-health and in many instances, leave the sector.

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[18] First responders include paramedics, police officers, firefighters and emergency service call-centre workers. For the purpose of this submission, we are referring to paramedics and emergency service call-centre workers under HDSU coverage.
[19] Commonwealth of Australia Senate 2019, *The people behind 000: mental health of our first responders*, report, pp. 12, 56-5.

An HSU member working in community services described how she watched the decline in availability of support programs for colleagues, particularly those that are 'out into the field.' She believes this has occurred because employers 'value watching their pennies more' and the introduction of 'centralised service management makes it harder for us (community workers) to build and tap into our network.'

Recommendation: Employ additional staff as workplace educators and mentors, particularly for community workers.

Recommendation: Introduce mandatory employer requirements for and contributions to mentoring, professional development and continued education programmes for workers.

Remuneration

Average wages across the mental health workforce do not adequately compensate for the nature of the work or the importance of these workers to improving wider social and economic outcomes. Particular issues arise at the intersection between funding, Award rates and wages. A prime example are disability support workers supporting consumers with psychosocial disability. The vast majority of these employees are paid minimum Award rates under the Social, Community, Home Care and Disability Services Award (SCHADS). The introduction of the National Disability Insurance Scheme (NDIS) has further entrenched minimum Award rates of pay as the standard for wages in the sector. This is because employers cannot charge participants more than the National Disability Insurance Agency price-cap, which is calculated based on Award wage rate assumptions. This cap coupled with the unique characteristics of the disability-mental health sector—a sector almost entirely reliant on government funding with minimal or limited co-contributions/co-payments by the service recipients—largely precludes bargaining above Award wage outcomes.

The introduction of the NDIS has also seen the liquidation of a number of State and Commonwealth programs and their funds redirected to the Scheme's costs. This has had particularly detrimental effects for both participants and workers in the mental health/psychosocial disability sector as the resourcing levels of these programs enabled the delivery of significantly higher rates of pay for skilled community mental health practitioners. For example, in Victoria, the Mental Health Community Support Services (MHCSS) program enabled funded service providers to offer SCHADS Award wages

at Levels 4 and 5 of the Award, whilst NDIS funding was capped on the assumption of Level 2 of the Award.

Low wages and their effect on workers impact the sector more broadly. When a worker feels underpaid and undervalued, they are less likely to engage with their work and are more likely to vacate the role or field.[20] HSU members report often feeling undervalued. Inadequate renumeration together with training, workforce planning, resourcing and support deficiencies, contribute to poor retention rates across the sector. Therefore, the ability to build a stable, quality and local workforce is jeopardised. Systemic shifts to the valuing and resourcing of mental health workers is required in order to address this multi-faceted issue.

Recommendation: The HSU calls for state governments to put in place arrangements that give employers extra funding on the basis that they have an Enterprise Agreement with the relevant union(s) covering their employees. Such arrangements would assist in ensuring that all Australian's have access to good quality mental health care via a valued, well-supported workforce and stable workforce.

Conclusion

Australia's mental health system is in crisis, having long operated as a series of disjointed and reactive services. Marred by an absence of contemporary national strategy; inadequate funding; gaps in research; and 'one-size-fits-all' service models, it is failing to improve individual care and outcomes. Urgent investment in person-centric, multidisciplinary and integrated services is required for care to be effective and with lasting impact. Funding must be provided to allow a redesign of therapeutic environments based on wrap-around community settings, along with dedicated and safe acute care clinics.

The HSU calls the Inquiry's immediate attention to the inextricable link between a well-trained and valued workforce and improved social and economic outcomes across the board. Meaningful mental health reform must include investment in the workforce. This should be provided to deliver specialist education and training, increased staffing levels across disciples, healthy rostering and fair remuneration. Failure to support the mental health workforce is a failure that extends to those accessing care, their families and communities.

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[20] J Shen, A Cox, A McBride 2014, 'Factors influencing turnover and retention of hospital consultants', *Health Services Management*, vol. 17, November 2014, p. 257.