ASU Submission

Inquiry into the accessibility and quality of mental health services in rural and remote Australia

Senate Standing Committees on Community Affairs

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1. Introduction

The Australian Services Union (ASU) is one of Australia's largest Unions, representing approximately 135,000 members.

The ASU was created in 1993. It brought together three large unions – the Federated Clerks Union, the Municipal Officers Association and the Municipal Employees Union, as well as a number of smaller organisations representing social welfare workers, information technology workers and transport employees.

Current ASU members work in a wide variety of industries and occupations because the Union's rules traditionally and primarily cover workers in the following industries and occupations:

- Social and community services, including mental health services
- Local government
- State government
- Transport, including passenger air and rail transport, road, rail and air freight transport
- Clerical and administrative employees in commerce and industry generally
- Call centres
- Electricity generation, transmission and distribution
- Water industry
- Higher education (Queensland and SA)

The ASU has members in every State and Territory of Australia, as well as in most regional centres as well.

2. Who we represent in disability services

The ASU is the largest union of workers in the social and community services sector, which includes workers in disability support services across the country. We are the major NDIS union in Queensland, New South Wales, ACT, and South Australia. We also represent public sector disability support workers in Queensland. We represent mental health workers in every state and territory of Australia.

The ASU's expertise in disability arises from representing the disability support workforce working in a range of different jobs roles including disability support work, community mental health services, Aboriginal services, care management and coordination, disability advocates, Local Area Coordinators, team leaders, and managers in disability providers.

3. The Inquiry

The ASU welcomes the opportunity to contribute to the Senate Standing Committee's inquiry into the accessibility and quality of mental health services in rural and remote Australia.

We do not intend to address all of the issues outlined in the Terms of Reference. We do however wish to respond to:

(c) the nature of the mental health workforce;

(d) the challenges of delivering mental health services in the regions;

Access to mental health services is an ongoing challenge for people living in rural and remote Australia due to a lack of or limited services available along with the recruitment and retention problems in the sector.

Our concerns in these regards are primarily as follows:

1. Gaps in mental health service provision that are arising as a consequence of NDIS eligibility rules;

2. Mental health support under the NDIS;

3. Impacts and uncertainty on the mental health workforce; and

4. Training and development of the NDIS workforce.

4. Community mental health services in rural, regional and remote areas

Australia's unique challenges of building social inclusion in a country with a relatively small population spread over a large landmass is well illustrated by issues facing community service workers in rural, regional and remote areas. Severe disadvantage in many Indigenous communities also poses particular challenges for the recruitment and retention of workers in remote areas.

These factors result in a lower population base to recruit workers, a lower skills base as people in these areas tend to have lower levels of relevant post-school education and higher unemployment and greater turnover of staff, who frequently travel long distances or relocate for employment in community services in rural, regional and remote areas.

Most community services report that workforce shortages in rural, regional and remote areas are a particular problem while the increased need for services to address social problems (including higher than average rates of unemployment and suicide) grows.

Currently, funding from a number of state and federal programs is used to support people experiencing a psychosocial disability, but this will be rolled into the NDIS. However not everyone who is currently receiving support from these programs will be able to access the NDIS, due to NDIS eligibility requirements.

Under the NDIS eligibility rules, people with a psychosocial disability related to a mental health issue, are eligible for support under the scheme as long as they meet the access requirements. Becoming a participant of the scheme will depend on a number of factors including a determination that your impairment is likely to be permanent.

The ASU is concerned people living with a psychosocial disability are not be eligible for NDIS funding, as their mental health issues are not "permanent". Most people experiencing mental health illnesses will not qualify as they live with a moderate and/or episodic mental illness and rely upon support programs that may not meet the eligibility criteria for the NDIS. A recent report found that up to 91% of people with a severe mental illness will not qualify for the NDIS and will require community health services to be met outside of the Scheme.[1]

This is of concern as those who do not qualify will need to rely on existing support services, however the funding for these very same support services are being subsumed into the NDIS. This situation is exacerbated due to the uncertainty around Commonwealth funded community mental health services such as PHaMS and PIR. Although the Commonwealth has made guarantees that people currently receiving services in these programs will have continuity of support even after the roll-out to the NDIS, there is no clarity about how this will actually operate in practice, nor what will happen to people who require support in the future. .

[1] Mind the Gap: The National Disability Insurance Scheme and psychosocial disability, The University of Sydney [online] Accessed at:: http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf

Community mental health and the NDIS do not provide like-for-like services. Community mental health services focus on recovery and early intervention and operate on a strengths-based model. These services are able to provide step-up/step-down care in a flexible way to meet clients fluctuating needs. These services do not require clients to identify as having a disability, and some do not even require a formal diagnosis of mental illness in order to qualify for support. Eligibility for the mental health support under the NDIS on the other hand is based on having a severe psychosocial disability that is expected to last a participant's lifetime, a criteria that does not fit easily with community mental health's focus on recovery. Many people with psychosocial disability have needs and impairments that change in severity and in nature over their lifetimes, sometimes changing very quickly.

We are particularly concerned at how the lack of funding for community mental health supports will play out in rural and remote areas of Australia. People with mental health issues living in rural and remote areas often face additional challenges that are distinctly different from those faced by people who live in metropolitan areas.

Recent research by Flinders University has revealed that not all NDIS participants have experienced improvements in their wellbeing since joining the NDIS, in fact participants with a mental health or psychosocial disability consistently reported lower levels of wellbeing than people with other types of disability.[2]

A further issue that is particularly emphasised in rural and remote areas is the lack of NDIS providers. Often no service providers existed at all or where they did exist, the market was such that consumers had no choice of provider. The University of Sydney recently found that organisations had decided not to provide services in rural and remote environments because they were unable to provide quality, safe service within the pricing structures.[3]

The lack of recognition of the extensive time involved in travel in rural and remote regions within NDIS pricing structures also greatly impacted on the ability to deliver financially viable service.[4]

As mental health services are more costly to run in rural and remote communities any shortfalls in funding is likely to impact more heavily on these services. It is therefore imperative that the NDIS is responsive to, and appropriate for, people with disability and their families and carers living in rural and remote areas.[5]

5. Mental health support under the NDIS

We are also concerned about the adequacy of funding for consumers who are eligible for NDIS funding. The delivery of quality outcomes for mental health service users is dependent on providers being able to invest in activities such as performance monitoring, quality assurance, continuous improvement and workforce training, development and planning.[6]

The NDIS has not been designed to accommodate and support the bulk of people who need mental health support. This is due to the fact the NDIS is a disability program and not a mental health program, and the needs of clients are very different.

Prices for some key NDIS supports are too low and do not include these critical activities and overlooks the diverse circumstances in which support is provided. Mental health support differs from other disability support in that it is primarily focussed on recovery.

[2] Evaluation of the NDIS, Final Report – February 2018, Flinders University [online] Accessed at: https://www.dss.gov.au/sites/default/files/documents/04_2018/ndis_evaluation_consolidated_report_april_2018.pdf
[3] Mind the Gap: The National Disability Insurance Scheme and psychosocial disability, The University of Sydney [online] Accessed at:: http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf
[4] Mind the Gap: The National Disability Insurance Scheme and psychosocial disability, The University of Sydney [online] Accessed at:: http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf
[5] Evaluation of the NDIS, Final Report – February 2018, Flinders University [online] Accessed at:: https://www.dss.gov.au/sites/default/files/documents/04_2018/ndis_evaluation_consolidated_report_april_2018.pdf
[6] Queensland Community Alliance submission to the Productivity Commission inquiry into Human Services [online] Accessed at: http://www.pc.gov.au/__data/assets/pdf_file/0013/214114/sub446-human-services-reform.pdf

Further, the nature of mental health issues means that a consumer's needs for support may vary widely over time. Consumers may have periods where they require intensive or crisis support, and other periods where they require less intensive support. The NDIS packages don't adequately take into account these fluctuating needs.

Further, mental health support work is complex. Entry level employees in mental health tend to perform work that aligns with level 3 or 4 in the SCHADS Award. This includes monitoring risk and supporting client safety, and employing evidence based practice models to support recovery in a holistic way, but NDIS pricing assumes support workers are employed at level 2.3 of the SCHADS Award. This classification will not attract and retain skilled and experienced mental health workers. NDIS direct mental health support pricing means it is not financially viable for service providers to offer sufficient professional supervision and training.

If mental health support workers are not sufficiently skilled and supported to perform the complex work required, worker burnout, high staff turnover and adverse client outcomes can be anticipated. Many people accessing mental health support services have experience of relationship based trauma. Research into trauma-informed care shows trusting and consistent professional support relationships are an important foundation for recovery oriented work. While consistency cannot be guaranteed even under the best service models, a pricing structure which actively undermines stability in the mental health workforce should be avoided.

Many service providers are already, under the guise of 'preparing for the NDIS' using less staff, lower classified staff, and staff working fewer hours in order to reduce their costs. We are seeing reductions in service levels.

Despite an NDIS loading bonus of 20-25% to rural and remote services many providers are warning they may be forced to shut down services if the NDIS pricing levels do not change. The problem of 'thin service markets' is an identified problem in the NDIS landscape. A central aim of the NDIS is to improve participant choice and control over the support they receive, however the current pricing structure may lead to fewer service providers, offering a lower level of service. To remain viable services must find a way to operate within the confines of NDIS pricing. [7]

6. Impacts and uncertainty on the workforce

As a consequence of both the absence of guaranteed funding for existing community mental health services, and the inadequacy of the NDIS funding for mental health supports, there is significant uncertainty among providers and workers as to the future of the community mental health workforce.

The provision of mental health services depends on the existence on an adequate, accessible and sufficiently skilled workforce. Our members working in the mental health services sector hold a unique position in which they not only support and care for the most vulnerable members of society, but they are also key advocates for their rights and aspirations to fully participate in society.

Workforce issues including high turnover, high burn out rate and stress levels and the inability to attract suitably qualified staff to the non-government mental health sector are well documented.[8]

Particular challenges relate to rural mental health workers due to the lack of geographical pay parity, lack of access to professional development opportunities and role ambiguity and role conflict which can be especially problematic for Indigenous and CALD workers who have responsibilities to their

[7] Disability service providers warn NDIS pricing could force them to shut down, The Guardian [online] Accessed at: https://www.theguardian.com/australia-news/2017/sep/02/disability-service-providers-warn-ndis-pricing-could-force-them-to-shut-down
[8] Parliamentary Inquiry into workforce participation by people with a mental illness [online] Accessed at: http://www.parliament.vic.gov.au/images/stories/committees/fcdc/inquiries/57th/iwppmi/Submissions/S008_Geelong_Trades_Hall.pdf

own communities and to their clients. Mental health services may lack the professional and organisational supports to work between cultural world views. [9]

Workers' ability to approach work in a confident, planned, professional and organised way is undermined by a culture of constant change. Already mental health service organisations are increasingly opting for part-time, casual and less qualified staff to keep costs to a minimum in order to win contracts and stay in business.

It is acknowledged widely in the sector that the disability workforce will need to double by 2020 to meet the increased demand for services under the NDIS. There needs to be consideration for how the NDIS will attract specialist mental health workers to the sector and how it will retain the current skilled and experienced workforce, especially in remote communities.

The ASU believes the NDIS pricing model needs to properly reflect the real cost of quality mental health support, including:

- Appropriate wages and conditions for the workforce and that reflects the complexity of the work they perform
- Secure jobs, not just short term casual work
- Career paths for mental health workers
- Team approaches and good quality supervision, including clinical supervision
- Specific mental health service provisions such as: case management, training, debriefing, documentation of care plans, etc.
- Stability of the workforce to ensure consistency for people experiencing psychosocial disability

As the mental health sector continues to transform we cannot ignore the views and voices of the workforce. Creating a safe, secure and sustainable sector that promotes consultation and collaboration between workers, rehabilitation and psychosocial support services, all the while trying to meet the unique needs of individuals and families will provide a strong foundation for the growth and development of our industry.

What our members say: *'I am currently employed as a Community Mental Health Practitioner. The last three years have been stressful at work, as we have seen the restructuring of adult residential services and recommissioning on mental health services with massive redundancies. The result has meant new staff are now placed on 6-month and 1-year renewable contracts, with provision for early termination. Job insecurity does impact on both staff and clients and it is hard to be fully productive when you are required to look for a new job. It is incredibly stressful applying for jobs in order to keep employment.*

In this time I have seen across the sector a huge erosion in employment conditions. Now EFT means effective full time, which could be anything from a new standard of 6.5 to 7.5 hours. All these reductions are designed to reduce staff costs and eliminate penalties and paid tea breaks. It means that anyone changing jobs is forced to have a decrease in pay, so going from 7.6 – less 7.2 and dropping hours and going down the employment band, can mean sacrificing up to $150.00 per week.'

[9] Labour dynamics and the non-government community services workforce in NSW, Social Policy Research Centre [online] Accessed at: https://melbourneinstitute.unimelb.edu.au/assets/documents/hilda-bibliography/other-publications/pre2010/Cortis_etal_NGO_LabourDynamics_SPRC.pdf

7. Training and development of the NDIS workforce

Greater choice and control for people with disability over the types of supports they want and need will mean that the NDIS mental health workforce needs to be supported to continuously develop new skills and qualifications relevant to diverse needs of individual clients.

However, there is currently no person-centred professional development plan for the NDIS workforce. Disability sector workers are highly skilled and passionate about what they do – but their capacity to have their skills recognised, to develop new skills and to attain relevant person-centred qualifications is severely limited.

Furthermore, continuing professional development, in-house training and induction, and access to study leave is limited and varies across providers. As the sector becomes more competitive with the entrance of large for-profits in the market, access to these supports by workers will be further diminished as providers drive to reduce costs and increase profits.

Accordingly, the ASU commissioned research by the Australia Institute Centre for Future Work to develop a portable training entitlement system for NDIS workers. We have **attached** a copy of the report.

We consider that a portable training entitlement system is essential to ensuring we build meaningful careers and skills in the workforce, allowing us to recruit and retain the employees needed to deliver the support the community needs.

8. Case Studies

Selectability in Queensland

Selectability was formed after the merger of Supported Options in Lifestyle and Access Services (SOLAS) and Mental Illness Fellowship North Queensland (MIFNQ) in March of 2017. There are still long-term employees who previously worked at SOLAS and MIFNQ, however there are a lot of new employees employed.

Selectability is a not-for-profit, community mental wellbeing and suicide prevention service supporting the people and communities in northern, central and western Queensland (including Townsville, Cairns, Ingham, Mackay, Palm Island, Charters Towers and Mt Isa). The focus is to assist individuals with their personal goals/ aspirations and to enjoy a good, well rounded life of their choice, through a holistic approach.

Selectability is funded from a variety of sources across state and federal government departments, including the NDIS.

In 2009 the Queensland Pay Equity decision was handed down (sometimes referred to as the Fisher rates). In 2010 many Queensland disability corporations moved to the National Fair Work System where a normal SCHADS pay guide rate applied. However for the transitional corporations, such as Selectability, the Fisher rates apply.

Prior to the introduction of the NDIS the transitional corporations received “block funding” to provide services. Selectability’s historical experience has been around $70 per hour however when the NDIS was rolled out the core support NDIS payment is $44 per hour which is a substantial reduction from the $70 per hour Selectability operated under

Essentially the Fisher rates create a two-tier community service sector where a large proportion of provers are on the modern award which is at its base level of 1.1 is 22% lower than the Fisher rates that apply, including Selectability.

Currently Selectability is trying to declassify jobs to Level 1 in a bid to meet NDIS unit prices. There is the potential that should this uneven playing field not be remedied locally owned and community focused employers will be forced out of business.

Case Study - Selectability

Since the roll out of NDIS Kate* has been very unhappy in the workplace. She feels as though the new management are purely business based/ money focused, and has no knowledge or understanding of the mental health industry.

Kate feels the workplace culture has completely diminished, and there is no longer any recognition for the work staff are doing. Kate said the work has always been extremely busy but it reached a point where they no longer have time in the office to do important things like their communication notes. The organisation recognised that and tried to find a way for staff to have time in their rostered shifts to get that done, but the proposed solutions did not work.

A lot of staff were lost through Voluntary Redundancies as a result of NDIS. Kate believes that more money needs to be put into the mental health sector in terms of training - the industry is not understood, for example, staff experience aggressive behaviour from clients and no training is provided for handling this. There seems to be a lack of general understanding about these challenges in the role.

Kate is very worried about the new staff that are being employed that don't have the qualifications/ understanding of mental health (although, this is starting to be addressed more now there seems to be a little more awareness from management).

** Name has been changed for privacy*

South Australian Case Study:

Mount Gambier is 434kms away from Adelaide City. ASU members working at Provider A have had their work force cut by half. From 1 July 2018 due to the cuts in the PHaMS funding the work force will go from 4 workers to 1.8 FTE.

Provider A closed their books for referrals to the PHaMS program in April in anticipation of the reduced funding. Their current 60 clients have tested their ability to get an NDIS package, but only one has succeeded.

ASU members advise that the geographical region that they look after covers 63,000 people. They are the sole provider of psychosocial PHaMS program. They hold grave concerns for their ability to support current clients, let alone potential for new clients.

ASU members have advised that local GPs have concerns that community support will not be present, resulting in more people accessing the GP for mental health issues and putting strain on the medical sector.

NSW Case Study 1:

Amy* has worked at a regional mental health provider (Provider A) for 3 years. She is based in a Southern NSW border town. Her work is funded by PHaMS Employment and Respite programs. Prior to her employment, there were 2 staff members at the workplace, but there was a block of time where no one was in the role.

There is a noticeable lack of competition in this border town, as noticed by providers and staff in the region. Any new providers work primarily with low level clients.

Some of this may be connected to this NSW/Victorian border town. Provider B is a large provider based in Victoria that has services in the nearby Victorian border town. But they are prioritising their Victorian base before contemplating crossing the border.

Amy is restricted to only having a certain percentage of her clients in the Victorian border town. She is the only funded PHaMS Employment service between the NSW border town and Melbourne.

When she first started in her position, Amy did a good deal of promotional activity to build up her client base, but quickly had to stop this because Provider A wasn't expanding in the area to meet the needs of clients she was attracting.

PHaMS guidelines say that a normal caseload for a full time worker is 24 clients (12 high needs, 12 low needs). Amy currently works with 50 clients and has between 10-15 ready for Intake that she cannot service.

Provider A is currently restructuring due to funding pressures from the NDIS and changes to block funding. Amy's workplace has been slated for closure.

There is nowhere for non-NDIS mental health clients to go.

Other services in the area are going through a similar reduction in staff. Provider B used to have 12 staff, now has 2. Centacare used to have 5, now has 2.5.

An unexpected flow on effect from the lack of mental health services is that physical and intellectual disability services are taking up mental health clients. Physical and intellectual service providers in the area seem keen to expand their client base, but most services and staff will not have adequate training in mental health support.

The scarcity of services in the region means that support workers are forced to make a choice of who needs them more. Recently, Amy received a call from a client's parent, the client has finally received an NDIS package, but Amy is unable to service this client due to the heavy caseload she is carrying.

Clients who cannot receive the mental health support they need often become so unwell that they are admitted to hospital. When many clients are discharged from hospital they are not able to receive the mental health support they need to remain well and so the cycle repeats.

Other services, such as Provider C, get a bulk of the referrals from clients who cannot access NDIS packages. In the NSW Border town, Provider C has weeks and weeks' worth of waiting lists. This is a short term program that does not have the resources or capacity to properly address the needs of high level clients.

*** Name has been changed for privacy*

NSW Case Study 2:

Impact of changes in tendering of NSW Health – Housing and Accommodation Support Initiative (HASI) in regional NSW from Flourish Australia to Wellways.

Flourish Australia delivers frontline mental health services across NSW including PIR, PHaMs, HASI, outreach, in centre, assistance after hospitalisation to name a few. It is often the main, if not sole, provider of services in regional areas providing high reputation services with long term staff members and has an ethos for hiring peer workers.

Despite decades of experience and proven community impact Flourish, along with all other Mental Health sector providers, is forced to re-tender for funding for services which are their demonstrated core business. This leads to insecurity at an organisational funding level which more often than not is pushed through to the frontline workers through contracted employment, short term projects, or, ongoing projects without long term sustainability or security beyond the current funding cycle.

Although not strictly NDIS, the recent HASI tendering round in late 2017 resulted in Flourish losing the tender is some areas where it has delivered HASI for years and gaining the tenders in areas it was not currently operating.

In Central Western NSW, particularly Bathurst, Parkes and Cowra the HASI tender was awarded to Wellways, a Victorian organisation with no current service provision in these areas, nor history of delivering homelessness services.

Many Flourish members who were made redundant secured employment with Wellways but lost their accrued employment status, LSL, sick leave, annual leave and familiarity of process and infrastructure.

Under the new organisation, which was still procuring office space, computers, and vehicles, the members continued to support the transitioned clients and introduced newly employed Wellways managers to the nature of the HASI work they were now responsible for.

The disruption to workers' careers, reputations, long term security and day to day job performance was enormous and unnecessary. No consultation occurred with the sector to allow for transfer arrangements to be made between providers for continuity of employment for workers and service for clients, the tenders did not seem to be "lost" for any poor performance and seemed awarded arbitrarily, and, cynically perhaps, to increase the variety of providers in response to the opening of the market.

Whilst HASI is not NDIS it is an example of the affect that competitive tendering which is increasing for economic reasons, not improvement of quality. This does not necessarily provide greater choice and control for clients and does not value add to the jobs in community nor increase the career opportunities for workers in the community and disability sectors.

Some workers chose redundancy and did not pursue options with the new employer as they feared a repeat in another three year funding cycle. Some have exited altogether, taking their experience and knowledge with them.

The disruption to clients was stressful while they were prepared for being exited from the non successful service and clients and their families were at a loss to understand why, when some of the same workers were employed by the new organisation, there was a need to transfer at all.

The organisation's name carries meaning and weight in a community who know "Sheila who works at Flourish" and now don't know who to go to while the name of Wellways gets established.

The cost of paying out redundancies, and fitting out new offices, training, infrastructure etc. has burden on the organisations individually and the community collectively. When not-for-profits have to compete in an open market these expenses have effects on the long term sustainability of organisations and undermines the quality of service through squeezing wages and conditions.

Problems facing the Victorian mental health workforce

Mental health services in Victoria face a particularly uncertain future, the effects of which are likely to be much greater in rural and remote areas.

The Victorian government funds community mental health through the Mental Health Community Support Services (MHCSS). In 2014 the previous Victorian government made the decision to transfer this funding into the NDIS. This means that as the NDIS rolls out across the state funding community mental health services are being de-funded. This decision, and the failure to address the consequences of it, has led to a crisis in community mental health support in Victoria.

This situation is exacerbated due to the uncertainty around Commonwealth funded community mental health services such as PHaMS and PIR that has been outlined above.

Effect on the Victorian workforce

We do not have exact figures of the size of the community mental health workforce in Victoria, but the recent Mental Health Workforce Strategy report stated there are currently over 5000 clinical mental health professionals and an additional 1300 mental health community support services workers[10]. As a result of this de-funding the majority of these workers will be losing their jobs. Mental Health Victoria is the peak body for the mental health sector in Victoria. They recently polled their employer members and the seven that had responded as of reporting have stated they will be shedding 637 jobs between them over the next year.

This will be particularly challenging in rural and remote areas where there is neither the population or employment opportunities found in metropolitan areas that could more easily absorb these job losses.

The ASU Victoria & Tasmania Branch has partnered with Mental Health Victoria to run a longitudinal survey focused on the changes happening to the community mental health workforce in Victoria. The first round the Community Mental Health Workforce Survey closed on 11 May 2018 and we are currently in the process of analysing and reporting on the results.

Initial analysis shows a number of results that are relevant to this Committee's inquiry, particularly "(c) the nature of the mental health workforce". The survey was sent to community mental health workers across the state. The survey had 127 respondents from 18 different community mental health agencies so provides a good sample size from which to draw conclusions about the wider workforce.

- ***Education*** – 32% of respondents hold Bachelors or Honours Degrees, and 29% of respondents hold Masters Degrees. Only 8% of respondents had a Cert IV or lower as their highest completed qualification.

- ***Professional experience*** – 63% of respondents have worked in the mental health sector for five years or more, with 30% having worked in the sector for 10 years or more.

- ***Lived experience*** – 12% of respondents identify as having a psychosocial disability or a disability related to mental health. A majority of respondents (55%) report that they have a lived experience of mental health challenges.

- ***Employment security*** – 46% of respondents reported that they were engaged on fixed-term contracts, and 53% reported being on permanent contracts. Only one respondent reported that they were employed as a casual.

We are particularly concerned as to what these experienced specialist mental health workers plan to do after the NDIS finishes rolling out. In our survey we asked questions about what the respondent's current career intentions were, considering the changes occurring in their sector.

[10] Victorian Government, Victoria's 10-year mental health plan, Mental Health Workforce Strategy [online] Accessed at: file:///C:/Users/jmiles.ASU/Downloads/Mental%20health%20workforce%20strategy.pdf

90 of our respondents answered that they were currently working in MHCSS or Commonwealth funded roles that will lose funding due to the transition to the NDIS. Of these respondents:

- 6 people said that they were planning to work in another specialist mental health role.
- The most common response was “I don’t know” when asked about their plans, with 46 people selecting this option.
- The amount of respondents who answered they planned to work in the NDIS – 0.

We also asked whether the changes to the community mental health sector have made you more or less likely to continue working in mental health support. 80% of respondents said that it has made them less likely.

Although we do not have specific data from rural and remote areas, survey respondents were working in 13 out of the 16 Victorian NDIS areas. What is shown in these survey results is alarming and will have significant effects on the provision of mental health services across Victoria, not just in rural and remote areas. What is demonstrated from the results is that the existing community mental health workforce is experienced, educated and professional. But that this experience and professionalism that has taken Victoria decades to develop largely disappear after the transition to the NDIS, unless government comes up with a solution.

9. Conclusion

The funding uncertainty surrounding the mental health sector is compounding an already difficult situation with mental health services in rural and remote communities. We know that the funding uncertainty is having a significant impact on the community mental health workforce and we call on Federal and State Governments to clarify funding arrangements immediately. There is an urgent need to clarify what supports will be available to clients who do not qualify for support under the NDIS.

Failure to adjust the current NDIS pricing model for people experiencing a mental/psychosocial disability will have a significant impact on the delivery of quality outcomes for mental health service users in rural and remote Australia.

ASU members value secure, well remunerated jobs and clear career paths and progression as ways of retaining and attracting a qualified workforce for the NDIS to be a success. We call on the Government to implement a portable training entitlement system for NDIS workers, as outlined in the attached report.

Finally, the ASU, including frontline workers, wishes to appear before the Committee to give additional evidence and to represent our concerns more fully.