

## **Submission to the Productivity Commission's Inquiry into Mental Health**

Although there are many areas of the mental health system which need improvement, this submission will focus on; the mental health workforce and issues relating to uses of the mental health system. It is written following my observations and experience of working in the mental health community support services program (MCHSS) which is a non-clinical community mental health outreach as an accredited social worker in the Outer Eastern suburbs of Melbourne.

### **Mental Health Workforce**

There are three main issues with the mental health workforce which I will be focusing on; the de-skilling of the mental health workforce, negative impacts of short-term funding contracts on maintaining an experienced and skilled mental health workforce and the lack of training in mental health for employees in community services organisations.

#### **1. The deskilling of the mental health workforce.**

Deskilling of the mental health workforce is no more evident than in non-clinical community mental health. Roles that are traditionally social worker roles have been opened up to other lesser qualified disciplines which have resulted in the de-skilling of the workforce and positions being referred to as being social work however may not be held by social workers, this devalues the social work profession and under mind's the qualifications of social workers. This has been a negative outcome of neoliberalism, as organisations have chosen to employ staff with lesser qualifications at a lower cost or none at all, relying solely on a person's experience.

The benefits of the expertise of social works to clients in non-clinical community mental health services are:

- Social workers work holistically with people viewing them in their context, they are skilled at working with working with complex client's as they have excellent resources and are able to link people to other appropriate services such as housing supports, legal supports, AOD services, emergency and material aid and financial supports, which have good outcomes for clients.
- Social workers have skills in counselling, benefiting people to establish and maintain good mental health and their overall wellbeing which lessens the burden hospitals. This can also maintain therapeutic care in between counselling treatment sessions. Keeping clients engaged with strategies they have learned in therapy. Providing this type of continuity of care requires collaboration between clinical and non-clinical professionals.
- Social work support, also bridges the gap left by limitations to clinical care such as outreach support and community engagement. Having the flexibility to initially provide needed support and advocacy for someone accessing services.

## **2. Lack of training in mental health for staff in organisations who provide community care services (such as in-home support services under the NDIS or Aged care) to people with mental health concerns.**

I spent over 10 years in the home and community care program which is now a service delivery model for the NDIS. I spent time in positions as a support worker and a service coordinator, during that experience and my certificate training there was no training on mental health even though clients often had presenting mental health concerns, some even with severe mental health diagnosis. There is a separate certificate for training in mental health which is a required qualification for working specifically with people who have a mental health diagnosis such as in the area of community rehabilitation. The impact of the lack of training of staff is further stigmatises and increases disengagement of services by those with mental health concerns due to the staff lacking in basic skills and knowledge in mental health as well as a lack of understanding of mental health and its impacts on a person. Stigmatisation occurs when a client's difficult behaviour places alerts on file causing assumptions to be made from workers that the client is difficult to work with due to past behaviour.

Lack of trained and experienced mental health workers providing individualised support in the community which has been an outcome of the rollout of the NDIS. Much of the clients in the MHCSS program who transitioned to the NDIS where in a sense not better off as they lost the specific mental health support, they received from experienced mental health workers (1). The roll out of the NDIS has also caused the loss of valuable experienced mental health community support workers whose positions under the NDIS have been de-skilled and under paid. These skilled workers have had to find other positions or accept a lesser wage.

## **3. Impacts on the mental health workforce from short term funding contracts.**

The following are some of the consequences and impacts of short-term funding contracts have had on the mental health workforce and services that I have observed when working in MHCSS which is now defunded.

- Short term contracts cause workforce and service destabilisation as well as disruptions to programs which are having positive outcomes for clients. Loss of skilled workers who are forced to look elsewhere for employment.
- The ever-shifting extreme focus between either clinical or non-clinical community care approaches has yet to successfully meet a harmonizing place in between the two, as both are equally beneficial to the care and recovery of people with mental health concerns.
- Open market tenders which can push out smaller organisations which end up not surviving. Tenders having too many parties involved, for example a third party brokering the funding causing complications and lengthy delays into implementation which is disruptive to clients and workers.

- Having constant changes to programs, processes and system due to short term funding contracts causes unnecessary disruption to service delivery and continuation of care essentially setting people back in their recovery.

### **Issues relating to users of mental health services**

#### **General issues for users with access to mental health services:**

Inflexibility of supports as seen with the emergence of clinical care models within the community such as Stepped Care and Headspace, who do not provide outreach services. By outreach I am referring to community visits and home visits to clients not clinicians out posted to a different location site where client's still come to the clinician rather than the clinician coming to them. Limited clinical outreach services pose a significant barrier for people with mental health concerns to access supports. Outreach services provide flexible service creating better access to those who can struggle to get out of the house or be mobile in the community.

Having worked in non-clinical community mental health outreach I have seen that providing this type of support increases engagement and social participation. A study of a multidisciplinary holistic outreach support model provides evidence that outreach services can decrease hospitalisation and lengthy stays in hospital (3). Not providing this care disadvantages people and results in poorer mental health outcomes. Research has also found that comprehensive outreach support has better outcomes for people with mental health concerns. An outreach support model including both case management and a therapeutic component to it, has been shown evidence which suggests it has beneficial outcomes for people with mental health concerns (2).

Fragmentation of the supports in a complex system with several NGO's being allocated funding due to open tendering, as well as funding from both state and federal governments which deliver similar programs for example state government funded MHCSS and federally funded PHaMs. Constant funding changes due to short term funding contracts by governments which create discontinuation and disruption of care, with individuals potentially falling through the gaps. This also gives programs not enough time to properly prove to be effective or not. The constant changes to services provided also causes many people with mental health concerns to have a health decline as they are having to deal with the stress from constant changes in workers and programs.

Lack of flexibility in community support services even more so since the introduction of the NDIS and trend towards clinical community service models. Flexibility of services is needed to promote social connections which research has shown to be a significant factor in improving mental health (4). I have personally witnessed the improvement it has on people with mental health concerns wellbeing from my experience in MHCSS.

Clients who were socially connected had improved mental health and wellbeing. Flexibility in this type of support which needs to meet the needs and challenges faced by people with mental health concerns. Drop in centres are an example of this, spaces where there are staff trained in mental health, and where people with mental health concerns feel safe. Working in MHCSS, social isolation was a common theme with client's whose common goal was to be able to participate in the community socially. One of the main focuses of the MHCSS program was to address this issue.

Lack of flexibility for agencies to assist people needing help when they walk in off the street in distress. Having social workers who are able to address people's concerns, who can link them to other supports and agencies to address issues which are affecting their mental health whether it be housing, family violence, parenting or legal support. A social worker who is accessible, provide information, short term interventions and referrals. This is particular need in my experience from working in a sub-rural area, where walk ins frequently occurred. Partly due to minimal services in in the local area. Many clinical services have outreach sites however, have limited availability for clients to access the services they need and require clients to come into the clinic.

#### **Issues relating specifically to the introduction of the NDIS:**

- Poor engagement from psychosocial participants due to not understanding the scheme and not having the capacity to do so (1).
- Often many people with mental health concerns lack informal supports to assist them to navigate a complex system of services which the NDIS has opened up for them. Many people with mental health concerns are socially isolated, have dysfunctional families or are disconnected from family, making it difficult to access supports or services which increase their wellbeing and participation in society.
- Some psychosocial participants who transferred from the MHCSS program in the early stages of the rollout for the NDIS in the Outer Eastern Suburbs of Melbourne were not approved support coordination making it difficult for them to implement their plan, thus having a negative impact on their recovery as a result of not having continuity of care. Mind the Gap report recognised this issue and recommended that support coordination be approved for all psychosocial participants for at least the first and second years in the scheme (1).
- Many Psychosocial NDIS participants are having difficulties finding available services which meet their needs due to the introduction to the NDIS which changed the disability and mental health service landscape.
- Group programs and supports previously provided through block funding not fitting in with NDIS model of care or struggling to continue with the NDIS model of service and prices that reduce sustainability due to overhead costs etc. For example, a block funded program in partnership with a

gym where client's had access to the gym and then a social meeting afterwards. The alternative under the NDIS would be a personal trainer facilitating exercise groups outside a gym with limited equipment. Having to have consistent numbers to cover overheads, proves to be another challenge as many people with mental health concerns can have periods of disengagement and also struggle to participate consistently due to the challenges, they face managing their mental health.

## References

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