Mental Health Recovery – Philosophy into Practice

A workforce development guide

2008
The Mental Health Coordinating Council (MHCC) is the peak body for community mental health organisations in New South Wales.

Membership is primarily comprised of not-for-profit community organisations whose business or activity is wholly or in part related to the promotion or delivery of services for the well-being and recovery of people with mental health problems and organisations that support carers and families of people with a mental health problem.

MHCC:

- Advocates for policy development and legislative reform
- Represents sector views to government and the broader community and health sector through consultation with consumers, carers, and other stakeholders
- Builds sector capacity through partnerships, collaboration, and workforce development
- Facilitates change through policy initiatives and projects
- Informs the sector on strategic directions in community mental health and disseminates information
- Researches, publishes and reports on current directions in community mental health and wider mental health and related areas
- Provides accredited training in recovery-oriented practice, traineeships and a range of educational products through its Learning and Development Unit
- Supports and encourages its member organisations to deliver recovery-oriented services and work in collaboration with consumers, carers, other organisations and the community
Acknowledgements

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The recovery philosophy provides people with mental health problems access to a set of principles by which to help them conceptualise and manage the individual and unique effects of that experience. The recovery principles also provide a set of mechanisms by which others including family and friends and those people employed within the mental health treatment and support system can frame and determine the nature of the assistance they provide.

Community mental health support services frequently use the term ‘recovery-orientation’ to articulate support for the application of recovery principles in their everyday work practices. The reason for development of this guide is to explore just what the specific components of ‘recovery-orientation’ are; to articulate what it means to operate in a ‘recovery-oriented’ way both in terms of support to the service user but also as a way to ensure the workforce providing that support operates from a culture that embeds the recovery principles in its own human resource operations.

The terms ‘recovery’ and ‘recovery-orientation’ have too often been applied loosely with scant understanding by individuals and services of its far reaching implications for how we understand, support and assist people with mental health problems. This guide articulates the components of effective recovery-based practice; it brings the rhetoric of ‘recovery’ to practical application. It promotes a recovery-oriented framework in which service users, carers, volunteers and employees are all supported to negotiate their individual paths; to contribute and achieve goals in an environment of respect and compassion.

Jenna Bateman
Chief Executive Officer
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**Key**

Throughout the guide you will see the symbols below at various points in the text. Each of the workforce pathways is accompanied by a portfolio of practical resources, for example, templates and checklists, and useful readings and websites. The symbols indicate that the reader is directed to the on-line version of the document - available on the MHCC website www.mhcc.org.au - to access the relevant practical resources. These resources are designed to assist managers to get a better understanding of certain workforce practices and provide a means of beginning to put into practice strategies to move the workforce and the organisation towards achieving a recovery-oriented service system. They can be downloaded, printed and adapted to be used in the most appropriate and meaningful way for the workforce and organisation.

- This symbol indicates that there is an accompanying template/checklist/resource sheet for managers to use/adapt for the workforce/organisation.

- This symbol indicates that there is a recommended reading or web-site listed in the resource section. These generally provide further information and better understanding of a particular workforce practice or provide valuable and user-friendly links and resources.

- This symbol indicates a workplace example or good practice example from one of the MHCC member organisations. These examples have been put together by staff from each of these organisations and speak in reference to a specific workforce development pathway. They aim to give readers an idea of how the workforce development pathway has been applied in practical terms in a community mental health organisation.

**Acronyms**

- **AMS** Aboriginal Medical Service
- **AQF** Australian Qualifications Framework
- **AQTF** Australian Quality Training Framework
- **ATSI** Aboriginal and Torres Strait Islander
- **CALD** Culturally and Linguistically Diverse
- **EAP** Employee Assistance Program
- **KM** Knowledge Management
- **LDP** Leadership Development Program
- **MHCC** Mental Health Coordinating Council
- **NGO** Non-Government Organisation
- **NTIS** National Training Information Service
- **RCOM** Routine Consumer Outcome Monitoring
- **RPL** Recognised Prior Learning
- **RTO** Registered Training Organisation
- **VET** Vocational Education Training
**Executive Summary**

This workforce development guide is the Mental Health Coordinating Council's response to an identified need for a coordinated and strategic approach to the growth of the community-based mental health sector. The guide is fundamentally structured towards a whole-of-systems approach which will assist community organisations to embody the principles of a recovery-oriented organisation and work effectively, and in collaboration with consumers and carers, to achieve these outcomes in practical terms.

The guide is structured according to the nine key workforce pathways that organisations must consider in working towards becoming, or sustaining, a recovery-oriented organisation. This guide recognises that fundamental to achieving each pathway is the mental health support workforce that the organisation relies on to implement its vision and service objectives. The vision for recovery-oriented organisations incorporates a workforce that is compassionate, collaborative, skilled and diverse. This is what makes this guide unique - it is about creating a recovery-oriented organisation through workforce development, in partnership with consumers and carers.

The guide is organised according to the following pathways. At the start of each chapter is a box which indicates the 'learning outcomes' for the specific workforce development pathway; managers may want to use this as a 'checklist' or starting point for the organisation, in partnership with staff, consumers, carers and other stakeholders. In addition, accompanying each pathway there are practical resources, including templates and checklists, and useful references to assist managers in this workforce development process.

**Workforce Development Pathway 1 - Organisational Culture and Values**
A recovery-oriented service requires organisations to have clear values and beliefs which inform the organisational culture, including participation and leadership. This forms the base of any systemic framework.

**Workforce Development Pathway 2 - Effective Partnerships and Collaboration**
A recovery-oriented service ensures a broad range of responses and shared resources and knowledge through partnerships with consumers, carers, other teams, agencies, sectors and government.

**Workforce Development Pathway 3 - Knowledge Management**
A recovery-oriented service requires open, shared knowledge management.

**Workforce Development Pathway 4 - Recruitment and Retention**
A recovery-oriented service requires the recruitment of staff with the appropriate values, attitudes and knowledge to support recovery processes, and retention through support for staff.

**Workforce Development Pathway 5 - Consumer Workers and Carer Workers**
A recovery-oriented service values lived experience and focuses on recruiting and supporting Consumer Workers and Carer Workers.

**Workforce Development Pathway 6 - Becoming a Culturally Competent Workforce**
A recovery-oriented service has a culturally competent and diverse workforce.

**Workforce Development Pathway 7 - Professional Development**
A recovery-oriented service gives staff the opportunity to increase and enhance knowledge, engage in reflective practice and to make progress in their careers.

**Workforce Development Pathway 8 - Supervision, Mentoring and Coaching**
A recovery-oriented service allows the opportunity for staff to explore and learn directly from the wisdom and experience of others.

**Workforce Development Pathway 9 - Evaluation and Performance Management**
A recovery-oriented service assesses the effectiveness of staff and services provided through indicators that are relevant and meaningful to consumers and carers.
Diagram 1 - Workforce development pathways to a recovery-oriented organisation

THE COMMUNITY

Other Services

1. Organisational Culture & Values
2. Effective Partnerships & Collaboration
3. Knowledge Management
4. Recruitment & Retention
5. Consumer Workers & Carer Workers
6. Becoming a Culturally Competent Workforce
7. Professional Development
8. Supervision, Mentoring & Coaching
9. Evaluation & Routine Consumer Outcome Monitoring

Recovery Based Organisation

Consumers & Carers
Introduction

The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

Aims and objectives of the guide

The aims and objectives of the guide are to:

- Improve overall effectiveness of services and outcomes for consumers and carers
- Promote ‘people centred’ organisations for staff, consumers, carers and stakeholders
- Promote staff development (personal and professional) that is firmly grounded within a recovery framework
- Strengthen staff development strategies used by managers to create a sustainable, modern, informed, and diverse workforce
- Promote professional and personal well-being of staff to enhance retention

Who is this guide for?

The word Manager is used throughout the guide to apply to any person in a managerial or senior role who is responsible for leading a team of staff in a community mental health setting, for example, Team Leader, Manager or Chief Executive Officer.

Managers are in the best position to assess the organisational and staff needs and set the strategic vision for workforce development within the organisation. In setting this vision, managers fundamentally need to include a genuine consultation framework in planning professional and personal development pathways which involves key stakeholders, consumers, carers and staff.

Traditionally, staff development processes have often focused only on permanent employees, and the extended workforce - such as part-time, casual, volunteer, and contract workforce - have been excluded even though they may have skills and knowledge important to the organisation’s goals. This guide suggests that workforce development is most effective when the full workforce is included and enabled.

The guide does not seek to be exhaustive or directive, instead it provides strategies that can assist an organisation to find a ‘best fit’ for the agency’s staff development needs, depending on its size, resources and culture.

The guide is unique as it sets personal and professional development firmly within a recovery framework to move the community mental health support workforce, both current and future, towards empowering, recovery-oriented service systems.

It is acknowledged that smaller organisations and rural and remote (rural) organisations may face specific challenges and barriers to some aspects of workforce development. Collaboration and working in partnership with other service providers will assist greatly with this. These smaller or rural organisations are still able to position themselves within a recovery-oriented framework and work in partnership with consumers and carers, for example, demonstrate a positive culture, structure and leadership which forms the foundation of any recovery-oriented organisation. The workforce pathways provided can be seen as benchmarks to aspire to. All mental health services have the capacity to support recovery and to work in partnership with consumers and carers.

This guide calls into practice a view of organisations as ‘people-centred’ - for staff, consumers, carers and stakeholders. It places great value on the individuality of people, and the importance of respecting and accommodating differences in people. An organisation can stand or fall as a direct result of the skills, attitudes, commitment and cohesion of the staff. The vision for recovery-oriented organisations incorporates a workforce that is compassionate, collaborative, skilled and diverse. If managers value and promote enhanced professional and personal well-being this will lead to
greater staff retention in the community mental health sector and positive changes to service
delivery and recovery outcomes. People-centred services also support individual’s to define their
own personal situation and recovery journey.

Who is the workforce that this guide is relevant to?

The community mental health support workforce consists of a range of skill sets. Some position
titles include, but are not limited to, social workers, mental health workers, psychologists,
occupational therapists, registered nurses, drug and alcohol workers, youth workers, community
service workers, mental health support workers, project officers, trainers/assessors, psychiatrists,
volunteers, administrative and management staff - who may or may not have the lived experience
of mental health problems. The consumer and carer workforces also include advocates,
consultants, representatives, peer support workers, volunteers, and trainers - and all of the above.

This guide refers to Community Mental Health Support Workers as the generic term for people
working in organisations supporting people with mental health problems. This terminology is in
line with recovery concepts, and the role of the Mental Health Worker to support people with a
mental health problem. It reflects the paradigm shift to working in partnership with consumers and
carers, and enables consumers to experience their individual recovery journey in a less rigid or
predetermined, and more organic way.

Research and development method for the guide

Of particular relevance in exploring how ‘recovery-orientation’ may translate across the community
support sector, was the 2006 MHCC Training Needs Analysis which investigated the training needs
of staff, both paid and voluntary, in NGOs providing services to clients with mental health problems.

The findings highlight a diverse workforce providing services from a range of disciplines and
frameworks. The premise of this guide is that the various skill sets employed within community
sector organisations have specific contributions to make but require an overarching philosophy or
set of values to create a shared language and cohesive objectives.

The following table highlights the key survey findings, according to current workforce qualifications,
current and future training needs, use of traineeships, size of the sector and funding sources of
member agencies.

An Industry Reference Group has informed and guided this project.

The guide has been assembled from both research-informed writing and consensus opinion
through consultation with the Industry Reference Group and a number of managers.

All efforts have been made to ensure information in this guide is accurate at the time of publication.
<table>
<thead>
<tr>
<th>Survey Area</th>
<th>Key Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qualifications</strong></td>
<td>Managers are highly qualified:</td>
</tr>
<tr>
<td></td>
<td>• 96% had a tertiary qualification</td>
</tr>
<tr>
<td></td>
<td>• 54% had a university level qualification</td>
</tr>
<tr>
<td></td>
<td>• 60% attended training in the last year</td>
</tr>
<tr>
<td></td>
<td>• Average of 14 years industry experience</td>
</tr>
<tr>
<td></td>
<td>Staff are less qualified:</td>
</tr>
<tr>
<td></td>
<td>• 70% had tertiary qualifications</td>
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<tr>
<td></td>
<td>• 68% were not mental health specific</td>
</tr>
<tr>
<td></td>
<td>• 5% have a Certificate IV in Mental Health</td>
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<tr>
<td></td>
<td>• 50% attended training in the last year</td>
</tr>
<tr>
<td></td>
<td>• Years of experience was not explored</td>
</tr>
<tr>
<td><strong>Training</strong></td>
<td>• Most agencies undertook training in the last 12 months</td>
</tr>
<tr>
<td></td>
<td>• Most training was non-recognised introductory level short courses</td>
</tr>
<tr>
<td></td>
<td>• Larger agencies had a greater capacity than smaller ones to train staff</td>
</tr>
<tr>
<td></td>
<td>• High demand for training in mental health over the next 12 months</td>
</tr>
<tr>
<td></td>
<td>• Most agencies face barriers to training including time, cost and backfill</td>
</tr>
<tr>
<td><strong>Traineeships</strong></td>
<td>• 22% of agencies currently making use of traineeships (eg, community services, disability)</td>
</tr>
<tr>
<td></td>
<td>• 67% interested in utilising mental health traineeships if available</td>
</tr>
<tr>
<td><strong>Size of Sector</strong></td>
<td>• 2,500 – 3,000 FTE total staff</td>
</tr>
<tr>
<td></td>
<td>• 1,500 – 2,000 FTE direct care staff</td>
</tr>
<tr>
<td></td>
<td>• 44% of members used volunteers</td>
</tr>
<tr>
<td><strong>Funding Sources</strong></td>
<td>• 54% NSW Health (or Area Health Service)</td>
</tr>
<tr>
<td></td>
<td>• 30% DADHC</td>
</tr>
<tr>
<td></td>
<td>• 22% FaCHSIA</td>
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<tr>
<td></td>
<td>• 22% private</td>
</tr>
<tr>
<td></td>
<td>• 14% DOCS</td>
</tr>
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<td></td>
<td>• 8% DEWR</td>
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</tbody>
</table>
Making the shift towards recovery-oriented services

What is recovery?

It is of some concern that there is currently no consensual Australian definition of recovery. Recovery in relation to mental illness is defined as the following according to American Psychologist, William Anthony:

“Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with the limitations caused by mental health problems. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”

Recovery in a broad sense is about finding a way to get back on track after experiencing illness. Recovery from the consequences of mental health problems can sometimes be more difficult than recovering from actually being unwell. Issues such as discrimination, loss of self esteem, and limitations to social, housing and employment opportunities, can all be very real barriers to recovery. Viewing recovery as a normal human process ‘demystifies’ the process of recovery from mental health problems and puts people in a better position to support someone in their recovery journey.

Service providers need to reflect the principles of recovery in order to enhance the individual’s recovery journey. This is at an organisational as well as individual level, for example, the culture of the organisation, and the individual’s frame of reference and understanding.

The principles of recovery include, but are not limited to:

• Hope and faith
• Meaning, purpose and direction
• Equality and respect
• Empowerment and self-determination
• Social inclusion and connectedness

Descriptions of recovery can become easily conceptually confused. Recovery can be seen through different lenses depending on individual and organisational agendas. The definition of recovery challenges what it means to be a service delivery organisation, a Mental Health Support Worker, a person who uses the services or a family member, and how we judge effective services and support.
In the community mental health setting recovery can be seen as:

• **An experience**

This conveys the personal and unique journey in recovery from mental health problems. Whilst the individual defines their recovery journey, recovery is not an isolated experience. It occurs within a context where relationships are of utmost importance - family, friends, and service providers can share the recovery experience.

• **A philosophy or set of values**

Recovery is fundamentally about a set of values which promote hope, self-determination, inclusiveness, acceptance, and compassion. These values all lead to choice and control for people with the lived experience of a mental health problem.

• **An individual practice**

This refers to how the worker applies their understanding of recovery and recovery principles into action, and how it guides the way in which services and service providers work in partnership with consumers, carers, families and the community.

• **A service system**

The principles and practices of recovery have broader implications for organisations (culture, structure and leadership), communities, and the wider sector. Recovery provides an opportunity to work together to provide a range of services for consumers and carers, and to ensure better outcomes for consumers and carers.

Managers and the workforce need to have a grasp of what recovery means when viewed through the above ‘lenses’ to fully understand the recovery philosophy and its implications for service planning and delivery. The nine workforce development pathways described within this guide are the key to practical application of recovery principles through workforce practices.

**How is recovery related to workforce development and recovery-oriented service systems?**

To ensure that the concept of recovery is put into action requires a significant paradigm shift: First and foremost, managers need to **embody the vision for a recovery-oriented service and ‘stay true’ to the meaning of recovery**. For managers to do this successfully will require organisational change, changes in anticipated outcomes, changes in power relationships and changes in the way staff are recruited, supported and developed. The workforce, in partnership with consumers and carers, is critical to moving towards converting the philosophy of recovery into reality.

The recovery vision and recovery principles must be incorporated into all aspects of staff development, service planning and delivery. Recovery competencies should be closely linked to staff performance management and reflected in service delivery. This can be achieved through a continuous process of sharing knowledge and information between Mental Health Support Workers, consumers and carers. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

This is the niche interest of this guide. The manager leads the workforce - Mental Health Support Worker, Consumer Worker, Carer Worker - to work effectively together and in partnership with consumers and carers for best recovery-oriented outcomes and to move the organisation forward within a recovery-oriented framework.

This is a future vision and destination for community mental health organisations and the challenge is how we get there. The role of this guide is to show that through committed and fulfilling professional and personal development of staff, managers can create a mental health support workforce, and as a result organisations, that incorporate the principles of recovery into practice and work in collaboration with consumers and carers at all times.
Guiding principles, practices & attitudes of recovery-oriented workforce development

- **Journey of recovery** – Supporting each individual’s journey of recovery. Service providers, consumers and carers working as partners to support recovery processes. Recovery concepts are genuinely incorporated into practice and there is a shared understanding of recovery-oriented systems.

- **Consumer and carer participation** - Engaging consumers and carers in an ongoing, respectful and genuine way in all areas of service delivery and planning.

- **Cultural competence** - Valuing cultural diversity, ensuring staff are in a position to work with culturally diverse people and employees from culturally and linguistically diverse (CALD) backgrounds & Aboriginal and Torres Strait Islander (ATSI) people, and respecting and responding to the individual needs of people that is sensitive to their age, gender, sexuality, spirituality, nationality, and religious background. This includes using preferred language and terminology at all times.

- **Reflective practice** - Committing to and engaging in continuous reflective practice to ensure personal growth, good practice and innovation. This should happen at all levels of the organisation and service delivery, and form a strong component of supervision practices.

- **Evidence-based practice** - Committing to keeping up to date with research findings, pursuing evidence-based practice within each organisation and following what is good practice in community mental health. This requires systems and structures that encourage flexibility to embrace new and improved work practices.

- **Working together in collaboration** - Sharing resources and knowledge through partnerships and collaborations, which will strengthen the community mental health sector and wider community sector. Building relationships with consumers, carers, communities and service providers.

- **Evaluation and measuring outcomes** - Constantly reviewing and looking to improve services. Ensuring that organisations are accountable for their outcomes. Committing to becoming a ‘learning organisation’ and continuous quality improvement.

- **Capacity building** - Building capable teams and strengthening services to respond to the needs of consumers and carers by ensuring staff is appropriately skilled and the organisation has an infrastructure that supports personal and professional growth and development.

- **Strong leadership** - Strong, committed, inspiring and forward-thinking leadership. Good leaders (Board members, CEO’s, Managers) enable staff to apply the organisation’s principles and values to their service delivery; enable staff to perform at their highest potential; enable consumer and carer participation; and enable successful partnerships, all of which help to create sustainable organisations where ideas and innovation can thrive.

- **Social inclusion** - Valuing the individuality and competencies of all groups from all backgrounds. Ensuring that the rights, views and values of all individuals are respected in service delivery and policy making. To commit to addressing discrimination and discriminatory attitudes towards people with mental health issues.

- **Transparency and trust** - Working honestly and openly with all people. To be responsive to the needs and views of consumers, carers and the whole workforce.
A recovery-oriented service requires organisations to have clear values and beliefs which inform the organisational culture, including participation and leadership. This forms the base of any systemic framework.

The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system. At the centre of this is a culture, structure and leadership - or organisational identity - which supports and allows for effective organisational and staff development within a recovery framework. Organisational development broadly refers to the activities that strengthen the ability of an organisation to build and advance its infrastructure and capabilities to achieve its objectives. The principles of recovery that accompany workforce development need to be incorporated into organisational structures and systems so that the practices remain in place irrespective of management or staff changes.
Culture

The starting and defining points of recovery-oriented service systems are people’s fundamental beliefs about mental illness and the purpose and values of services. The organisation’s purpose or mission grows from a vision. Clear purpose, values, beliefs and attitudes determine the rest of the recovery-oriented framework. Managers need to regularly clarify the core values and mission of the organisation and workforce so that they are not buried. Organisational culture is thus about identifying who you are, what you do, and why.

Community mental health organisations need to develop and promote the organisation as an attractive workplace through good leadership, a healthy workplace culture and clear organisational values. Organisations must be increasingly dynamic and flexible in their approach as new programs and funding streams are trialed and established. In this sense, organisational development is most successful when organisations reassess and reset their aspirations, strategy and vision, when there is effective management that is committed to building capacity throughout all levels of the organisation, and finally, when managers demonstrate patience in the process.

An organisation’s readiness to ensure that genuine consumer and carer participation becomes part of the organisational culture and practice is critical to working towards becoming a recovery-oriented organisation. Whilst consumer and carer participation must always be supported from the top down, it is also built from the bottom up. It is for this reason that an organisational framework that incorporates and supports these principles is essential. This is about how we conceptualise our stakeholders.

Organisational development means staff have the resources, both emotional and skill-based, that they need in order to reframe their thinking and embrace recovery-oriented practices.

Organisational ethics will be influenced by the organisation’s mission statement. This plants a seed which gives rise to a shared set of beliefs that influence the organisational culture. This organic perspective of organisational ethics allows managers to understand its importance in all workforce development strategies, for example, recruitment, professional development, supervision and cultural competency. Following from this, the values which give meaning to the organisation’s mission have implications for how the organisation should behave. The mission and the values combined create the ethical tone for the organisation, and any training, recruitment or codes of ethics can nurture this tone, but they cannot change it. The ethical climate thus begins deep within the organisation at its mission and values. However, it is not enough to simply have an inspiring mission statement to ensure ethical behaviour - honest and open internal communication, rewards for ethical behaviour, and a genuine desire within the organisation to ‘walk the talk’ are needed to ensure the workforce operates with integrity within an ethical organisational environment. This is also a crucial part of converting the philosophy of recovery into practice. Ethical integration occurs when the organisational aspirations, legal and ethical environment, ethical leadership and organisational culture are all working in a congruent and inter-dependent way.

Organisational integrity refers to when an organisation or community achieves its aspirations in harmony with its environment. Organisations that inspire and that people admire are those with clear purpose, vision and values, an internal drive towards progress, continuity of leadership and positive culture. Organisational ethics and integrity provide the domain in which the workforce is able to achieve a shared vision that is in accordance with a core purpose and values and organisational culture.
The hallmark of an adaptive culture is willingness on the part of organisational members to accept change and take on the challenge of introducing and implementing new strategies. The distinctive characteristic of an unhealthy culture is the presence of cultural traits that are in conflict with or contradict the values of the organisation. These have an adverse effect on the work place environment and performance. This extends to:

- Hostility to change and general scepticism of people who show initiative and innovation for change
- Internal politics which rule decision-making and create issues around power
- An aversion to looking outside the organisation for examples of good practice or new ideas

A positive culture embraces and demonstrates the philosophies of recovery - it is an adaptive culture.

The language of recovery is widely used, but this is not enough to ensure that the core principles of recovery are being implemented. The key is ensuring that services are genuinely rather than rhetorically recovery-oriented. Organisations need to be clear on their definition of recovery, for example ‘recovery from’ or ‘recovery in’ mental illness. The term ‘recovery’ has been interpreted differently, and in some organisations continues to be interpreted very differently from how consumers do. The definition of recovery adopted will dictate the type of services being provided. For example, a workforce that sees recovery as a measurement of symptom reduction versus social and emotional well-being, will strongly influence the ‘look’ of the services and support provided. Viewing recovery as solely about ‘symptom reduction’ rather than seeing this as one
possible part of a broader understanding of well-being as defined by consumers has negative implications for the kind of support organisations can provide. The consumer understanding and articulation of recovery has profound implications for service users, service providers, families and communities. A positive culture that reflects and demonstrates the principles of recovery means individuals will feel supported as they attempt to develop new meaning and purpose as they move beyond the effects of mental health problems.

Social inclusion is about being able to participate and contribute to social life - in economic, social, psychological, and political terms. Social inclusion captures the collective or social responsibility, as well as personal responsibility, for recovery. A cultural change within organisations to develop more ‘people-centred’ work practices will promote the principles of inclusiveness. This includes recognising the personal experience of mental health issues amongst employees and building a workplace conducive to well-being. This is important to ensuring the mental health and well-being of the whole workforce. This will benefit all staff, including those in Consumer and Carer Worker roles, and will have a positive flow-on effect on service users. Inclusiveness enables consumer and carers to feel connected to the organisation or services which are provided, the people they are engaged with, and the community. Their lived experience is valued and their differences - cultural, religious, gender, sexuality or any other - are honoured.

Structure

An organisation must have as part of their core infrastructure:

- Strategic Business Plan(s)
- Policies and Procedures manual - Recovery principles should underpin policy and procedure, e.g. self-directed care, self-management and recovery planning are prioritised
- Allocated and secured funding for workforce development (budget) – Includes funding to ensure adequate consumer and carer participation and employment opportunities for consumers and carers, CALD and ATSI communities
- Board of Management - Which includes consumer and/or carer representatives, CALD and ATSI representatives as is appropriate for the organisation

The core infrastructure of an organisation forms the foundations for any workforce development initiatives.

Understanding the process of change

Organisational change can be understood as a three-stage process that occurs over time:

Stage 1: Unfreezing
Stage 2: Changing
Stage 3: Confirming /Supporting

This process will become important as managers, staff, consumers and carers work in partnership towards creating a recovery-oriented organisation.
Stage 1 - Unfreezing

This is about investing time at the beginning of an organisational change program to prepare and support workers to embrace change and innovation. This will help to minimise any reluctance to change and move the workforce/organisation forward if they are ‘stuck’ in their way of doing things. Workers need to understand how change will benefit them, that the change is connected to organisational goals, and that it is necessary (i.e. not change for the sake of change). Managers need to:

- Acknowledge current work practices
- Support workers’ readiness for change
- Provide sufficient organisational resources for change
- Provide education/training/professional development
- Manage uncertainty associated with change

Stage 2 - Changing

This stage addresses the transition from old to new work practices, procedures or behaviours. Managers need to invest time and effort to trial new work practices to allow workers a trial period for ‘testing out’ and exploring the required change(s). This will allow workers to build confidence in their ability to implement change. It is important that trial periods are constructed in such a way that they do not add stress or frustration to existing workloads. Monitoring and evaluation of organisational change is vital to track progress over time and to deem the success of the program. Managers need to support workers to change their behaviour. This can be achieved through education and training, supervision, positive feedback and rewards/recognition for participating in organisational change. Motivation and capacity to change will be heavily influenced by the level of managerial support, both emotional and practical, during organisational change.
Stage 3 - Confirming/Supporting

‘New’ practices are integrated into standard work practice and become the ‘norm’. Continued support, monitoring and evaluation will help workers change their behaviour and sustain these changes.

**Strategies for effective organisational change**

There are four steps managers can take to set the foundations for successful organisational change. These are evidence-based strategies:

1) Effective communication
2) Using appropriate change agents, i.e. ‘champions’ of the organisational change program
3) Providing opportunities for joint-planning and participatory decision-making
4) Providing organisational resources and support at all levels

**Change Management**

The management of every organisational change requires its own strategy tailored to the organisational context and the nature of the change. The models below for change management are drawn from broader organisational research, and whilst they are designed for other sectors, they allow managers to see the holistic approach required to understand change, resistance to change and how to work through this resistance. By taking a whole-of-systems approach, managers are in a stronger position to support change and move the workforce towards achieving a recovery-oriented service system.

The three models below demonstrate that it is not enough to realise that change is needed. It is a collective process that requires several areas to be working well and in synchrony to overcome resistance to change. An organisation’s capacity to respond to and incorporate change depends on its organisational structure and systems and its culture. Readiness or openness to change encompasses attitudes of employees, training and approach of leaders, level of motivation for all organisation members as well as the actual physical resources of the organisation.

These models allow managers to isolate the areas which are adversely affecting the change process, and develop specific strategies to overcome resistance to change. Both the what (i.e. the nature of the change) and the how (i.e. implementation or the process of change) of change are inextricably linked by both the needs within the organisation and by those who utilise the new practice. The ‘fit’ between the new practice and the system into which it is being introduced will influence adoption and ‘buy-in’ of new practices.

1) Gleicher’s Formula - This formula for change illustrates that the combination of organisational dissatisfaction (D), vision for the future (V) and the possibility of immediate, tactical action (F) must be stronger than the resistance (R) within the organisation in order for meaningful changes to occur. Because of the multiplication of D, V and F, if any one of them is low then the product will be low and not capable of overcoming R.

\[ D \times V \times F > R \]

2) The ADKAR model for change management describes five required building blocks for change to be realised successfully on an individual level. The building blocks of the ADKAR Model include:

- Awareness – of why the change is needed
- Desire – to support and participate in the change
- Knowledge – of how to change
- Ability – to implement new skills and behaviours
- Reinforcement – to sustain the change
Strategy, structure and systems are classified as ‘hard elements’ - these are easier to define and management can directly influence them. Skills, staff and style (leadership) are classified as ‘soft elements’ - these can be more difficult to describe, and are less tangible and more influenced by culture. However, these soft elements are as important as the hard elements if the organisation is going to be successful. By placing shared values in the centre of the model shows that the organisation’s values are crucial for the successful development of all other areas. At the centre of all recovery-oriented organisations is a positive culture that genuinely believes recovery is possible for everybody.

**Leadership**

Leadership and governance is crucial to enable the workforce and the organisation to move closer to the future vision of recovery-oriented service systems. Leaders must embody this vision and culture, and Board of Management have a responsibility to demonstrate good governance and leadership. “Capable leadership is imperative to ensuring that an organisation knows the directions in which it is headed, has the structures and processes required to organise its activities and importantly, leaders influence others to create action.” Thus, the Board communicates and demonstrates this information to management and delegates key tasks to management.

The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system. However, without strong leadership which communicates this vision and establishes the legitimacy for it, it is much harder to secure the commitment and energy of staff, and get all pieces into place and working well. Board members and managers have a key role in nurturing. They have a responsibility to enable and ensure all employees understand and implement the organisation’s values and principles, select new employees that will mesh well with the culture, and reward those who display desired cultural behaviours.
**Board responsibilities**

The Board is there to provide sound governance, not management. There are six critical areas of Board responsibilities in guiding an organisation:

1) **Legal and Financial Accountability**
   - Finalise and approve the annual budget
   - Review programming and budgets
   - Conduct annual audit of organisation’s financial statements (usually external contractor)
   - Ethical and wise financial management
   - Risk management

2) **Strategic Vision and Objectives**
   - Define the organisation’s demographics or constituency
   - Describe its mission
   - Set its values and ethical guidelines
   - Determine long-term goals
   - Safeguard the mission and vision
   - Select and appoint a Chief Executive Officer (includes annual review)

3) **Fundraising**
   - Assisting the CEO or Development Officer to identify potential grants or corporate sponsors
   - Providing input into or developing fundraising plans
   - Chairing or being a member of the fundraising committee
   - Organising a fundraising event
   - Personally approaching key sponsorship targets
   - Hosting a fundraiser
   - Making a personal contribution
   - Helping to thank sponsors, donors and others supporters where appropriate
   - Laying the groundwork with heads of government, philanthropic foundations and corporations for further support from these sectors

4) **Advocacy**
   - To the community - build public awareness and reach new and broader audiences, e.g. community, media and government relations
   - For the community - provide a voice for important segments of the organisation’s constituency, e.g. stakeholder views

5) **Self-evaluation**
   - Boards need to regularly engage in self-evaluation to ensure they remain representative, responsive and effective
6) Meetings

- Hold regular meetings, providing a forum where:
  - Board members are regularly brought together to focus on their roles and responsibilities, identify problems and plan for the future
  - Members are encouraged and motivated
  - Ideas are shared and discussed and then discarded, improved or implemented
  - Tasks are allocated and reported on
  - Regular updates about relevant issues are provided
  - Members can get to know each other, professionally and personally
- Hold other meetings such as Annual General Meeting, Committee Meetings, Retreats, & Extraordinary Meetings (where urgent decisions need to be made)

The eight principles of leadership in mental health systems and programs

1. Leaders communicate a shared vision
2. Leaders centralise by mission and decentralise by operations
3. Leaders create an organisational structure and culture that identifies and tries to live by key values
4. Leaders create an organisational structure and culture that empowers their employees and themselves
5. Leaders ensure that their employees are trained and supported to translate vision into reality, that is, the application of knowledge to achieve organisational and personal goals
6. Leaders relate constructively to employees
7. Leaders access and use information to make change a constant ingredient of their organisation
8. Leaders build their organisation around exemplary performers
Kaiyu Konnect is a psychosocial recovery program providing social interaction opportunities, skill development, and support services to adults with a mental health problem / psychiatric disability. Our organisation believes that people living with a mental health problem still have the capacity to be active members within their community and to continue to acquire skills and experience personal growth.

Kaiyu values include:

- Assisting those most in need
- Providing innovative programs
- Empowering participants
- Openness and accountability
- Working in partnership with other relevant service providers to promote optimum opportunities for our participants
- Education about mental health problems to improve community acceptance and inclusion

Community Inclusion/Support Workers form the central relationship through which Kaiyu participants are encouraged in developing individualised service plans and goals. Kaiyu employees and volunteers then provide assistance to identify, explore, and connect with programs and community resources capable of promoting the participants' goals.

The ability to provide the best quality service requires a belief that our participants have much to contribute to the community. Support workers and volunteers need to demonstrate empathy and to establish rapport with participants and other team members. Kaiyu management encourages and supports ongoing professional development and learning opportunities for staff and volunteers, providing regular supervision, mentoring, and training. All participants, staff and volunteers are educated in, and expected to maintain, a code of behaviour that is respectful, confidential and non-discriminatory. Training in Occupational Health and Safety, Rights and Responsibilities, procedures for complaints and grievances, along with education about the Disability Service Act and National Mental Health Standards are included in orientation and education within the organisation to ensure best practice and service delivery. Evaluation of Kaiyu Konnect programs, and satisfaction with staff and volunteer performance, is conducted through regular surveys and individual reviews. Outcomes of evaluations are forwarded to the management committee to ensure that feedback is part of the continuous quality cycle for improvement.
A recovery-oriented service ensures a broad range of service responses and shared resources and knowledge through their partnerships with consumers, carers, other teams, agencies, sectors and government.

What will you get out of this chapter?
- The mutual benefits of partnerships and collaboration
- Important things to consider in setting up partnerships
- How to create successful partnerships
- How to network
- Examples of good practice in partnerships and networking

The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system. Collaborative recovery involves building relationships and partnerships between organisations, consumers, carers, families, workers and other stakeholders. While there is a diverse range of services in the community mental health sector, the philosophies and values that characterise these organisations are often common across the sector. Community Mental Health Support Workers are often dealing with the same things and the same kind of issues as workers in other sectors, such as drug and alcohol or housing services. Collaboration with other organisations, consumers and carers is important to learn from a breadth of experience and expertise that managers may not ordinarily have access to. By forming partnerships with other organisations managers are not only strengthening the organisation, but also their connectedness to the wider community and sector. It is about thinking of the organisation and staff in relation to other services and people.

When working within a recovery framework it is important that organisations guarantee full and equal participation of people accessing the services (where desired), so that they have opportunity to be involved in all aspects of service planning, delivery and evaluation. Consumer and carer participation is about enhancing relationships between consumers, carers and service providers. This is achieved through sharing information and skills, learning from each other and using available resources to improve the mental health services and the system for everyone who works and participates in it.65

The task of the Mental Health Support Worker is to facilitate recovery - they do not hold the key to recovery, the individual does.66 Whereas consumers and carers were once expected to passively receive ‘expert’ interventions, in a recovery-oriented organisation they are active agents and leaders in their own recovery.67 The workforce is no longer expected to be ‘on top’;
they need to be ‘on tap’. This partnership, or collaboration, informs recovery-oriented service delivery. Recovery emphasises the need for a community mental health system in which all parties - organisations, stakeholders, consumers, carers, workers - take responsibility for the mental health of the community and provide services in a coordinated and collaborative way.

Challenges to successful collaboration:

- Competition with other organisations for funding, resources and staff
- Fragmentation of the sector and many organisations working in isolation
- NGO funding stream is often not conducive to networking, i.e. funding is allocated for service provision only
- Time constraints
- Divergence of practice perspectives and organisational objectives
- Distrust between organisations and lack of goodwill to work together
- Lack of understanding of perspectives and practices
- Different levels of experience in collaborative efforts and professional training in staff
- Power differentials between consumers, carers and service providers
- Role strain

Successful partnerships are constructed at two levels - the organisational level and the individuals representing that organisation. At an organisational level, it is important that there are structures and support in place to allow for collaboration to occur. However, it is often the individuals who become the ‘champions’ for partnerships and the change agent for the organisation. Individuals selected to be involved in the collaborative process need to be self-reflective, flexible in their thinking and able to see other ways of operating.

Some benefits of successful partnerships and collaborative relationships

- Shared resources
- Shared expertise
- Recovery becomes everyone’s ‘business’
- Professional development - unexpected learning can take place
- Promotion of recovery-oriented practices
- Working together towards common goals
- Raising the profile of your organisation or a particular issue
- Providing benchmarking for service delivery, research practices or workplace practices
- It can be a fun and innovative process
- Meeting new, interesting, like-minded people
- Chance to see something in a new light
- Shared learning
- ‘Two heads are better than one’ approach to tackling complex issues
- Better community engagement
- More coordinated and streamlined services
- Simplifying the consumer’s path through the community mental health and other sectors
- Identify people showing early signs of mental health problems
- Better advocacy
- Less delineation between organisations and sectors, i.e. working cooperatively
- Joint funding for projects or initiatives
- Fostered social connectedness
- Less duplication of programs/services
What is important in establishing partnerships and collaborative relationships?

The same principles and skills it takes to develop working relationships with consumers, carers and staff apply for establishing effective partnerships. Managers and Community Mental Health Support Workers already have these necessary skills and are using them as part of core business. This places them in an ideal position to initiate partnerships with a range of stakeholders. It is about approaching organisations, consumers and carers in an open and transparent way to work towards a shared vision. Partnerships do not just happen, they are built.

The following are important in effective partnerships:

- An emotional connection between stakeholders with the social purpose, i.e. commitment to be involved in joint venture
- Key staff involved in the collaborative process need to be compatible - allowing for a ‘getting to know you’ period to build understanding and trust
- Staff are motivated and enthused about the partnership
- Management is committed to the partnership and support staff in the partnership
- Congruency of mission and strategies
- Shared values and philosophies, or at least, complementary rather than opposing values and philosophies
- Mutual respect between agencies, consumers and carers
- Compatibility of core services/clients/issues
- Commitment to resolve differences by both parties and readiness to change
- Capacity building within the organisation (training/skills development) to allow for successful adoption of strategies and a true sharing of resources
- Equal participation at all levels in decision-making, i.e. inclusiveness
- Shared ownership and accountability - including power and knowledge
- Good leadership, which includes a clear division of roles
- Financial management, i.e. adequate and stable funding and budget control
- Clear goals, agreed upon action plans and responsibilities
- Continuous evaluation and reporting to assist with and improve upon future collaborations. Organisations are ‘learning organisations’
- Ongoing, repeated communication, that evolves with the relationship and development of systems of work – honest and open communication

It is important to be clear on the organisation’s values and objectives before establishing partnerships to ensure there is a good fit of values. Managers and staff can reflect on the words below (and add to this list), to create a clear picture or profile of the organisation’s priorities, goals, and approach to any/all of the listed areas.

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Self-identity</th>
<th>Self-determination</th>
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<tbody>
<tr>
<td>Hope</td>
<td>Symptom management</td>
<td>Best practice/quality</td>
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<td>Spirituality</td>
<td>Stigma</td>
<td>Growth</td>
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<td>Community</td>
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<td>Relationships</td>
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<td>Family</td>
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<td>Well-being</td>
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<td>Empowerment</td>
<td>Social inclusion</td>
<td>Change</td>
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<td>Connection</td>
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How do I network?

Firstly, identify the available networks. These may include:

- Membership of professional associations
- Peak bodies
- Interagency meetings
- Other community health services
- Government agencies including Area Health Services/NSW Health
- Consumer advisory group within the organisation or link to independent consumer networks
- Carer advisory group within the organisation or link to independent carer networks

Examples of good practice in effective partnerships and establishing collaborations:

- Make available training calendars, meeting schedules, agendas of meetings, events, forums or conferences across the sector in the staff room or email notices
- Encourage staff to attend and present at conferences. Distribute discussion papers/contacts if staff are interested in finding out more
- Invite other services/organisations/consumers/carers to your agency
- Encourage staff to visit other organisations to see how they do things and what could be learned from them
- Encourage staff to participate in on-line discussion groups or forums - promote web sites with useful information and links to other services. This is a feasible option for rural organisations
- Instigate inter-agency meetings if they do not already exist
- Promote research projects that your agency is undertaking or invite other organisations/consumers/carers to become involved
- Plan morning/afternoon tea as an opportunity for staff to meet face-to-face with people they have regular phone/email contact from other organisations
- Have a joint planning day with relevant stakeholders, peak bodies, consumer, carers and staff to participate in workforce development strategic planning
- Invite a staff member/consumer/carer with expertise to give an in-house training in a particular area
- Pool resources to buy a training package and conduct joint training days/programs - this is a feasible option for rural organisations
- Create a pool of external supervisors/mentors within the sector who can be accessed on an as needs basis
- Establish a group supervision program across organisations - this could be a selected group of people from a similar organisation to your own or a group from across sectors to encourage further networking and learning. Plan to meet quarterly for exchange of ideas and discussion. This is a feasible option for rural organisations
- Engage with an organisation in a staff rotation/swap for a designated timeframe
- Research and list the existing services within your area, including contact details - make this information available to all staff, consumers, and carers, and encourage staff to contact relevant organisations and introduce themselves
- Create a database of organisations that are appropriate for within/cross-sector collaboration - that is, organisations with similar or complementary philosophies and services
- Cross promotion of projects - involve organisations/consumers/carers across the sector in individual research projects or pool resources to conduct research in partnership
- Examine existing services or projects within your organisation and commit to creating a collaborative relationship with respect to one of these areas - there will be some programs that naturally suggest themselves to networking or cross-sector collaboration - it is about harnessing these
Building partnerships and relationships with Aboriginal Elders and Communities

Some ideas to build partnerships:

- Having Aboriginal person(s) or Elder(s) in an advisory group and as a Board member
- Promoting your organisation and services within interagency meetings - it should not always be Aboriginal people who have to seek out the existing services
- Conducting activity days (consider splitting male and female groups) – enable the Aboriginal community to decide on the activity/day etc. which gives them ownership of the idea
- Targeting young Aboriginal kids at school - this is about showing them the possibilities within community care
- Mentoring on Boards - an Aboriginal Board member would mentor a non-Aboriginal Board member, and vice versa, and they could ‘sit in’ on each other’s Board meetings
- Developing a sound business plan with Aboriginal people and communities, possibly in a workshop setting, that has clear benchmarks and targets

Workplace example - NSW Health Family and Carer Mental Health Program - NGO Link Up

The NGO Link Up was initiated in December 2006 and is attended by the NGO agencies of the Family and Carer Mental Health Program (Uniting Care Mental Health, ARAFMI, Carer Assist and Carers NSW). It was initiated as a forum for networking and resource sharing and to ensure state-wide consistency of the NGO side of the Family and Carer Mental Health Program. We meet monthly and this rotates across agencies. We have all found it an extremely helpful forum to share common issues/challenges and brainstorm solutions to take back to our individual agencies for further discussion/approval. It has resulted in all parties coming to the table with a shared vision of ensuring that no matter where a family/carer lives in the state that they will have the same level of access and high quality of service, regardless of geography, culture and socio-economic status. We have found that we often think now not only in terms of how something will affect our individual agency, but the other NGO partners to the program also - this has resulted in us initiating joint professional development opportunities for program staff, discussing using common reporting formats (to make data collection easier for MHDAO), etc.
A recovery-oriented service requires open, shared knowledge management.

What will you get out of this chapter?

- An understanding of the stages of the knowledge management process
- An understanding of the ways to share information
- The importance of knowledge management
- The principles of a learning organisation in community mental health
- How to conduct a knowledge audit

Why does knowledge need to be ‘managed’?

The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system. Knowledge management is about enabling knowledge creation and sharing of knowledge. Knowledge management involves enhancing relationships with consumers and carers so as to learn from their lived experience knowledge base. This is the knowledge base that principally informs recovery-oriented service delivery. Service providers need to recognise that the personal knowledge and expertise of consumers and carers is equal but different from their own service-provider knowledge base. Knowledge management in a recovery-oriented organisation is about synthesising ‘professional’ and ‘personal’ experience knowledge bases, ultimately fusing into a shared knowledge base. This involves a shift in attitudes as well as a shift in perspective of roles so that Mental Health Support Workers, Consumer Workers and Carer Workers become ‘partners’ with consumers, rather than the ‘experts’. It is about ‘going back to the basics’ and re-learning what we know and learning what we don’t know about recovery and recovery processes from consumers and carers. This will inform and guide the design and implementation of recovery-oriented services. It will also encourage individuals to become self-determining in their personal situation and journey and to know that their lived experience is valued.
Understanding that knowledge is a valuable resource is necessary, but not sufficient, for an organisation. This knowledge base needs to be deliberately managed through cultivating a learning culture and culture of exchange. This means staff at every level of the organisation systematically gather knowledge and share it with others in the organisation, consumers and carers, so as to achieve organisational goals and enhance service delivery. Managers need to stress the need to share information with the right people. This will be promoted if there is a culture that is trusting and open within and between organisations.

The kinds of activities and practices that will support organisational learning include:

- Forums in which conversations about purpose and practice can take place
- Strategic planning discussions/days
- Participation in policy-making
- Benchmarking and quality improvement
- Professional development
- Mentoring and action learning
- Innovation and evaluation
- Research practices
- Encouraging diversity in the workforce
- Reflective practice

**Action learning** takes place in a learning organisation. It is a workforce development technique through which individuals learn by doing. Through the process, “people increase their self-awareness and develop new knowledge, attitudes and behaviours as well as skills for making changes and redefining their roles and responsibilities within new or changing workplace contexts”. Action learning principles can also be tied in with reflective practice and linked to discussions about evidence-based practice and practice-based evidence. Action learning enables staff to build their own knowledge - this is a continuous process.

There are several stages in the knowledge management process, each of which requires different techniques to assist in its development. These are:

- Create
- Capture
- Share
- Revise

The knowledge milieu consists of four parts: people, process, content and technology. Managers need to have a balanced view of knowledge management - an over emphasis on technology issues at the expense of considering people, process and cultural issues could adversely affect technological advances. An example of this is the implementation of outcome monitoring without first engaging with staff and consumers about the benefits and context. This may result in poor uptake and decrease any potential value to the consumers and staff involved.
How to share information

One of the greatest challenges facing managers is the explosion of information and knowledge and how to disseminate this information to staff, consumers and carers in a meaningful and sustainable way. Also, the quality of information varies considerably and managers need to encourage staff to analyse and critique available research. There are several ways that managers can share this information with staff, consumers and carers by selecting the most valuable or key information. These include:

- Staff meetings or COIN (community of interest) teams that meet regularly
- Notice boards
- Emails
- Policy and Procedure updates
- Journal club
- Centralising research projects so that it is accessible to staff at all levels, and the validity, i.e. recency, of the work is checked
- Promote sharing of evidence-based practices across the community mental health sector and between sectors
- Story-telling or scenarios - this is one of the most powerful ways to convey knowledge
- Accessible file created where staff document interest pieces, case examples, examples of best practice, and other work related information

Managers need to be aware of the channels that exist to disseminate information so that the workforce is up-to-date with information. This will support decision making and improve services for consumers, carers and families. At the same time, managers should be mindful of information overload and select the most appropriate tools for sharing information for the organisation. These resources should match organisational goals and values.

With so much correspondence and information exchange happening electronically, managers need to have clear information management strategies. This will include policies that address management of emails, records-keeping policies, and responsible internet usage.

One of the most important goals of knowledge management is to identify accessible ways to manage information that staff bring to an organisation or develop during their employment. An example of this is maintaining files on a shared drive rather than on individual computers and reporting work progress during staff meetings. This ensures that when people leave the organisation the wealth of knowledge (both implicit and explicit) that they have is recorded and accessible. Succession planning involves a transfer of this knowledge base.

Managers need to develop a culture of continuous quality improvement in which information and knowledge is used to enhance recovery and service development. This extends to ensuring that robust, relevant and uniformly defined data is collected across the organisation regarding service delivery and workforce practices as well as data from consumers and carers. This allows for better workforce development planning, service quality and forecast planning. Decision-making and knowledge management will be relevant to the following groups, each with their own different need for information and knowledge:

- Consumers
- Carers
- Service providers
- Managers/team leaders
- Stakeholders/funding bodies
Conduct a knowledge audit for the organisation

Key questions that a knowledge audit could include:

- What knowledge does the staff/team need to acquire or develop?
- What are the ‘blocks’ to knowledge transfer and acquisition?
- How can knowledge be better shared and organised?
- What knowledge resources/tools are currently in use?
- What are the current and future benchmarks for knowledge use?

A knowledge audit can also assist managers to see what the most pressing needs are for research/project grants, e.g. knowledge gaps could suggest an area for research and development.

Workplace example – The NEAMI Leadership Development Program

The Neami Leadership Development Program (LDP) is an innovative program that structurally supports and guides the way in which Neami and its staff develop and grow in their capacity to manage information in an ever changing service environment.

Within the context of the LDP, knowledge management (KM) is defined as the systematic sharing of knowledge to achieve personal development and growth and organisational innovation and creativity. As such, KM at Neami is firmly embedded within principles of continuous improvement and the concept of Neami as a learning organisation. Both are ongoing tasks which require concerted staff effort and input across all organisation levels.

Learning organisations continuously adapt and change in response to both external and internal environments, with primary emphasis on directly improving outcomes for its service users. The LDP reflects the fact that a learning organisation needs to develop the capacity to create, acquire and transfer knowledge. Effective KM ensures those requiring information have ready access to it through people, information and other sources. When knowledge is managed effectively information is shared and good practices can be learnt and replicated.

As program participants, managers and senior practice staff work and study in a range of learning environments using a range of different formats including workshops, online learning, action learning sets and team learning. These opportunities enable participants to develop key leadership skills (e.g. creative problem solving, emotional intelligence, change management, sharing visions) while at the same time allowing staff to address important organisational questions through project work and action learning. Embedding these skills and a more inclusive and reflective leadership and learning style at management level has a positive ripple effect to all other levels of the organisation. In fact, it enables a better utilisation and incorporation of the diverse sets of skills, knowledge and capacities that exist at various levels throughout the whole organisation.
A recovery-oriented service requires the recruitment of staff with the appropriate values, attitudes and knowledge to support recovery processes, and retention through support for staff.

The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system. The development of recovery-oriented organisations emphasises the personal qualities of staff as much as formal qualifications, and seeks to cultivate the workers capacity for hope, compassion, acceptance, and other values and attitudes commensurate with recovery.83

The immediate focus for managers of community mental health organisations is to recruit and retain staff within the funding constraints of the sector and in an environment where other sectors/organisations may be able to offer higher remuneration and career mobility. As demand for community based mental health services increases, as is predicted in the future, employers will find it increasingly difficult to fill job positions if the pool of qualified and trained workers does not increase.

In many community mental health organisations, management is often frustrated with the costly and time consuming demands of recruitment. In particular, managers report difficulties attracting staff who reflect the demographic needs of people accessing services.84

What will you get out of this chapter?

- The keys to successful recruitment and retention
- Values and attitudes based recruitment processes
- What to include in a job description
- Orientation and induction processes
- Tips for succession planning
- Strategies to improve retention
- How to enhance worker well-being and reduce burnout
Organisations need to be innovative in their approach to recruitment and retention. Managers play an important role in influencing a worker’s commitment to an organisation. Retention strategies include offering greater flexibility in work arrangements, training, increased responsibility, supervision, and access to a wide variety of work roles and learning opportunities.

This section provides information on recruitment and retention strategies, orientation and induction processes, and job design. These areas are crucial to staff development, and lay the foundations for future workforce development strategies and areas for professional development.

What are good recruitment practices and procedures?

Recruitment is about defining a job role and finding a person and matching the two. How an organisation recruits is just as important as the employment opportunities it offers. Recruitment processes should be based on a thorough needs analysis of the organisation (see Workforce Development Pathway 7). Staff turnover is the perfect opportunity to review job descriptions to ensure that the position still reflects the needs as identified by the staff, consumers, carers and organisation. Recruitment is closely linked to organisational development as training, career guidance, and professional/personal development are all factors that attract staff to work in an organisation.

Recruitment consists of 5 steps:

1. **Define** - the role and the type of person you need to satisfactorily complete this work
2. **Attract** - a pool of qualified and interested applicants (both within and outside the organisation) to the role
3. **Assess** - information about your applicants so that you can make an informed decision about which applicants have the required capabilities for the job
4. **Select** - the best person for the role
5. **Appoint** - make an offer of employment

What are the advantages of good recruitment?

- Higher retention of staff
- Better outcomes for consumers and carers
- Staff that can work well both independently and as part of a team
- Staff that is interested in ongoing learning and professional development
- Staff that is always looking to improve productivity and what is considered good practice
- Staff that is able to deal with and respond to change
- Staff that can inspire and teach peers
- Staff that incorporate recovery principles into every aspect of practice

A values and attitudes driven approach to recruitment

The importance of values and attitudes in recruitment practices is about seeking people, and employing people, who can articulate a well-developed philosophical base that ‘fits’ with the organisation, for example, strengths-based and recovery-oriented frameworks. If you can recruit someone who can demonstrate values and attitudes that align with the organisation and behaviour that matches this, you are far more likely to be able to retain them.

There must be a pervading belief that every person who accesses the service is a whole and unique individual that has the capacity to recover. People who genuinely believe that recovery is possible for everyone will be better able to uphold hope, focus on the individual’s strengths, and provide better support. Further, people who genuinely believe that the lived experience of mental health problems contributes to the richness of a contemporary mental health knowledge base are better placed to deliver services within a recovery-oriented framework.
In recruitment practices, if these attitudes are sought after and upheld then the individual and the organisation are better placed to turn recovery principles into practice. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

If staff genuinely share recovery-oriented values and attitudes, it is possible to teach them anything because it is part of their own personal frame of reference. This can be referred to as the 'it' factor, that is, they ‘get’ the organisation’s goals and values. It is still important to consider ‘technical skills’ for the job role. It is, however, far easier to train someone in specific skills if they have a willingness and capacity to learn, than it is to teach attitudes and values which influence behaviour and the quality of service. This should be a fairly rigorous process, ascertained through scenario and problem-solving questions, reference checks and self-evaluations. A thorough orientation and induction program is also necessary to introduce new workers to the core values and attitudes of the organisation, and refresh existing staff.

Diagram 4 - The Iceberg Model of competency assessment

**Checklist for managers for hiring new staff member**

- Ensure up-to-date job description and key selection criteria
- Develop an employment advertisement
- Assess written applications for consideration
- Ensure appropriate selection process, e.g. interview panel and questions, reference checks
- Offer of employment
- Orientation and induction
- Evaluate the recruitment strategy to determine its efficacy
Develop a job description

- Clearly and concisely state what responsibilities and tasks the job entails
- Key qualifications of jobs, i.e. basic competency or skills required
- The personal attributes that underlie superior performance

It is not feasible to provide a ‘one size fits all’ job description for managers to use for all community mental health positions, as they are simply too varied. However, there are some key things which MUST be included in all job descriptions:

- Title of the position
- Department
- Reporting pathway
- Overall responsibility
- Key areas of responsibility
- Other positions (internal and external) the person will work closely with
- Terms and conditions of employment
- Expected performance outcomes/key performance indicators

The accuracy of the job description is likely to be improved by gathering information from different sources to get different perspectives on the knowledge, skills, and responsibilities of a position. This can be achieved through talking to people in the same or surrounding roles. Studies have shown that when prospective employees have a clear understanding of the job role through information provided by management and current workers, this leads to more successful recruitment and retention. Knowing the challenges and difficult nature of the work, i.e. having a realistic view of the job description, can help to avoid issues of stress and burnout.

Recruiting ATSI peoples, in both ATSI worker and other worker roles can be achieved through building networks with ATSI communities (word of mouth will be important). When recruiting ATSI peoples, it is very important to:

- Always include an ATSI person on the selection panel
- Allow flexibility within the position
- Ensure the individual understands the service your organisation provides and requirements of the position
- Ask ATSI communities to help write the job advertisement and position description (clear, everyday language)
- Consider options for on-the-job training

Managers need to review job descriptions to ensure that they respond to staff, consumer, carer or organisational changes, and also reflect the individuality of the advertised position. Job descriptions and advertisements should be interesting and creative, and managers can look to other organisations/on-line recruitment services for inspiration. It is important that community mental health support work and its workforce is well-promoted to increase and reshape public perception of the sector.

Offer of employment

The employment contract should always clearly state the required probationary period for workers, and the conditions of employment. One innovative idea is to create an employer recruitment calendar that clearly shows points of evaluation and review so that there is mutual understanding around this.

Orientation and induction

New recruits are often overloaded with information and existing staff are under time and work pressures, such that orientation and induction processes may not be prioritised. Organisations need to have the structure in place to ensure induction programs are followed. This includes a process of ‘checking in’ with new staff to ensure they have understood everything and are following
correct procedures. Effective orientation and induction helps new workers to understand their role and where they ‘fit’ within the organisation, and equips them with the tools they need to perform their work role.92 To assist with orientation and induction managers should have:

1) Induction manual - This would include:
   - Job description
   - Code of Conduct/Practice
   - An orientation/induction checklist
   - Organisation’s mission statement, values and philosophy, history
   - Strategic Plan & Annual Report
   - An up-to-date organisational chart (this should clearly outline all staff positions and clear career pathways and professional/personal development opportunities)
   - Policies and Procedure Manual
   - Orientation to the workplace, including OH & S issues (e.g. fire, security, emergency numbers)
   - Literature orientation, i.e. relevant resources/reading material
   - Agencies, networks, and partnerships
   - Information about supervision, staff meetings, mileage, leave forms

2) Mentoring/’buddy’ system

New workers are paired with an experienced worker from the same area to ‘show them the ropes’.93 Alternatively, a more formal mentoring system can be established in which new workers are matched with a more qualified and experienced mentor who will provide ongoing support and professional guidance.

This orientation period may also include an orientation to the Certificate IV in Mental Health Work (non-clinical), or particular modules, which may have been deemed a condition of employment. This qualification has been voluntarily agreed to by MHCC member organisations as the minimum standard for work in the community mental health sector in NSW.

Succession planning

The success of the organisation’s growth and sustainability depends on identifying and targeting suitable successors into key roles. A holistic view of succession planning looks at an individual’s career motivation, current competence, future capability, and “job ready fit” to work to a particular role.94 Strategic succession planning will simultaneously address recruitment, retention, and professional development strategies, as managers target the right people for the job. Succession planning also extends to supporting staff in transitioning between one job and another and how best to transfer information between staff and employers in new and old jobs.

Working towards best practice in succession planning:
   - Identify positions that are critical to the overall success of the organisation
   - Identify talent gaps
   - Succession planning systems should be viewed developmentally rather than focused on replacing staff, that is, it is a continuous process
   - Succession planning systems are constantly reviewed and evaluated, and respond to changes in the organisation
   - Current staff should be involved in the process
   - A range of strategies such as mentoring, training, and job rotation can be used to assist with smooth transitions between job roles
Managers should consider targeting the following groups in the recruitment process and provide incentives to attract other staff such as –

- **Consumer Workers and Carer Workers**  
  (see Workforce Development Pathway 5)

- **High school students** - with the ageing of the current workforce it will be increasingly important to appeal to young people, both to promote community mental health as a viable career option and also to offer part-time or casual work in low level roles for short periods of time

- **University students** - recruitment of university students in part-time and semester break employment in lower level roles whilst they are studying. Undergraduate placements/internships could help to increase awareness of and interest in community mental health careers. Attract graduates with the opportunity to gain skills, experience and exposure to various service types through placement rotations in community based organisations over a 12 month period; provide one year of full-time employment with opportunities to apply to move to permanent positions at the end of the year

- **Return-to-work** for women due to the often part-time nature of community mental health support work

- **Career change** - for people considering a career change from professions which are about ‘making money’ to one where they can be ‘making a difference’

- **Unemployed/underemployed** - opportunities to attract under-represented groups in the employment market, such as, middle-aged men and people who speak a language other than English at home

- **Mature age workers** - promoting the value of life skills and experience in the mental health field may attract older workers, who want to, or need to, work beyond retirement age

- Better engagement with people with **higher education backgrounds** and better ‘use’ of their specific skills and expertise, e.g. Psychiatrists, Psychologists, Occupational Therapists, Nurses, and General Practitioners. Thinking of innovative and attractive ways that they can contribute in a community mental health setting, e.g. professional development activities, rotations, part-time or contract work, in-services

- **Volunteers**
Strategies to improve retention

Different demographics will need different strategies for retention. Managers will need to be targeted in how they appeal to different groups’ needs and sensibilities. Ask the experts - ask the current and prospective employees what they would find fulfilling and satisfying, i.e. reasons to apply for a job and reasons to stay in a job.

Some retention strategies include:

- Greater flexibility in work arrangements
- Training/professional development opportunities
- Increased responsibility
- Access to regular supervision
- Access to a wide variety of tasks - interesting and challenging work
- Recognition for good work
- Encourage and support workers to balance work and family life
- Maintain good working relationships
- Provide workers with realistic expectations about the nature of the work, opportunities for professional development and career pathways
- Career Break schemes - e.g. take a break of one year away with deferred salary
- Study assistance programs
- Conduct exit interviews and use feedback for service quality improvement
- Demonstrating concern for the professional and personal well-being of staff with regard to work/life balance

Managers need to be mindful that some turnover is desirable and can in fact lead to organisational improvements. For example, turnover can be functional when poor performers, people not well suited to job roles and people who create conflict leave. New recruits can result in new ideas and increased enthusiasm, and they can also bring in new skills and higher levels of energy, vision and competence.95

Enhancing worker well-being

Stress and burnout

Tied to the concept of retention is the phenomenon of stress and burnout. Stress and burnout have been linked with increased turnover, reduced job satisfaction and organisational commitment and lower performance effectiveness96. The workers within the community mental health sector are a wonderful source of experience and expertise. For this reason, preventing stress and burnout and addressing current levels of stress and burnout is a crucial workforce development issue for the community mental health sector. This involves managers being aware of workers’ personal and professional well-being, and providing opportunities for them to perform at their best level.

As part of staff development/retention strategies, managers can conduct sessions to raise awareness about stress and burnout and early warning signs. This could include a stress and burnout checklist to allow staff to identify their own symptoms, if any, and then identify strategies that may reduce these. There are other activities that can be used to promote personal and professional well-being and enhance retention. For example, team building activities that focus on work/life balance or an in-house survey with staff to gauge interest in the implementation of a workplace well-being program in the organisation.
The causes of stress and burnout are most likely to happen when there is an imbalance between demands and resources, i.e. high demands and low resources.\textsuperscript{97}

For workers\textsuperscript{98}:

- High workloads
- Role conflict and ambiguity
- Physical working environment
- Challenge of working in the health and human services sector

For managers\textsuperscript{99}:

- Lack of perceived reciprocity
- Lack of perceived competency as a manager
- Lack of rewards for performance
- Excessive workload
- Younger and less experienced managers at greater risk

Table 2 - Signs of stress and burnout

<table>
<thead>
<tr>
<th>Work performance</th>
<th>Physical symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declining / inconsistent performance</td>
<td>Nervous stumbling speech</td>
</tr>
<tr>
<td>Loss of enthusiasm</td>
<td>Sweating</td>
</tr>
<tr>
<td>Accidents / uncharacteristic mistakes</td>
<td>Tiredness / lethargy</td>
</tr>
<tr>
<td>Increased time at work</td>
<td>Frequent headaches</td>
</tr>
<tr>
<td>Lack of holiday planning / leave requests</td>
<td>Hand tremor</td>
</tr>
<tr>
<td>Indecision</td>
<td>Rapid weight loss or gain</td>
</tr>
<tr>
<td>Memory lapses</td>
<td>Upset stomach</td>
</tr>
<tr>
<td>Criticism of others</td>
<td>Lack of interest in appearance / hygiene</td>
</tr>
<tr>
<td>Lack of cooperation with others</td>
<td>Increased alcohol consumption / smoking</td>
</tr>
<tr>
<td></td>
<td>Out of character behaviours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Withdrawal behaviours</th>
<th>Emotional reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reluctance to give support to co-workers</td>
<td>Crying</td>
</tr>
<tr>
<td>Arriving late and / or leaving early</td>
<td>Irritability / moodiness</td>
</tr>
<tr>
<td>Extended lunch breaks</td>
<td>Over reactions to problems</td>
</tr>
<tr>
<td>Increased absenteeism</td>
<td>Temper outbursts</td>
</tr>
<tr>
<td>Reduced social interaction</td>
<td>Aggressive behaviour</td>
</tr>
<tr>
<td></td>
<td>Sudden mood swings</td>
</tr>
</tbody>
</table>
Strategies that address stress and burnout are most successful when they involve organisational strategies, that is, a workplace systems top-down approach, as well as equipping the individual worker with resources and/or coping skills\textsuperscript{101}. 

Organisational strategies to address stress and burnout are\textsuperscript{102}:

1) **Provide and support professional development strategies**, for example:
   - Flexible learning options
   - Grants/scholarships for professional development opportunities
   - A range of in-house and external professional development activities

2) **Ensure fair and adequate remuneration and other awards**, for example:
   - Compensation in the form of flexible working conditions, such as Flexi-Time arrangements and job sharing
   - Provide acknowledgement and recognition, both public and private
   - Opportunities to act in higher duties
   - Opportunities to work on preferred activities
   - Attendance at workshops/conferences

3) **Promote and support career development**, for example:
   - Provide continuous opportunities for learning and skill development
   - Provide challenging projects
   - Mentoring - opportunity to become a mentor to more junior staff
   - Training that provides transferable as well as specific skills
   - Networking opportunities
   - Allowing job rotation or internal transfers
   - Paying for workers’ membership of professional associations

4) **Promote a positive image of the community mental health sector**, for example:
   - Promote the success and value of programs within your service
   - Managers need to receive training on identifying and responding to signs of stress and burnout, both within themselves and staff. As the ‘face’ of the organisation it is important that managers realise the role they have in promoting a positive workplace culture

5) **Address organisational issues**, for example:
   - Job/service redesign - to address excessive workload pressures (a collaborative exercise between workers and managers)
   - Supervision and mentoring
Happiness at Work…

According to the Happiness at Work Index\textsuperscript{103}, the voluntary and not-for-profit sector contains both the largest proportion of happy people and the largest proportion of unhappy staff. This dichotomy could be due to the challenging but rewarding nature of working in that industry but also the tendency for lack of career development and frequently poor financial reward.\textsuperscript{104} Happiness at work is important to consider in promoting personal and professional well-being, thus enhancing retention of the community mental health workforce. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

<table>
<thead>
<tr>
<th>The top ten factors that make us HAPPY at work</th>
<th>Do we have this in our organisation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Friendly, supportive colleagues</td>
<td>□</td>
</tr>
<tr>
<td>• Enjoyable work</td>
<td>□</td>
</tr>
<tr>
<td>• Good boss or line manager</td>
<td>□</td>
</tr>
<tr>
<td>• Varied work</td>
<td>□</td>
</tr>
<tr>
<td>• Belief that we’re doing something worthwhile</td>
<td>□</td>
</tr>
<tr>
<td>• Feeling that what we do makes a difference</td>
<td>□</td>
</tr>
<tr>
<td>• Being part of a successful team</td>
<td>□</td>
</tr>
<tr>
<td>• Recognition for our achievements</td>
<td>□</td>
</tr>
<tr>
<td>• Competitive salary</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The top ten factors that make us UNHAPPY at work</th>
<th>Do we have this in our organisation?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Lack of communication from the top</td>
<td>□</td>
</tr>
<tr>
<td>• Uncompetitive salary</td>
<td>□</td>
</tr>
<tr>
<td>• No recognition for achievements</td>
<td>□</td>
</tr>
<tr>
<td>• Poor boss/line manager</td>
<td>□</td>
</tr>
<tr>
<td>• Little personal development</td>
<td>□</td>
</tr>
<tr>
<td>• Ideas being ignored</td>
<td>□</td>
</tr>
<tr>
<td>• Lack of opportunity for good performers</td>
<td>□</td>
</tr>
<tr>
<td>• Lack of benefits</td>
<td>□</td>
</tr>
<tr>
<td>• Work not enjoyable</td>
<td>□</td>
</tr>
<tr>
<td>• Not feeling that what I am doing makes a difference</td>
<td>□</td>
</tr>
</tbody>
</table>
**Tips to encourage good working relationships**

- Foster communication and working relationships across the organisation giving employees opportunities to share ideas and experiences.
- Encourage face-to-face communication where appropriate so that colleagues have more worthwhile discussions than email alone allows.
- Encourage a culture where people can express feelings.
- Learn to listen effectively and without judging, this will help you understand your colleagues better.
- Ensure no staff member is working in isolation but feels supported and involved in the organisation.
- Treat all team members with respect and be aware of cultural sensitivities.
- Provide opportunities for socialising outside of work, e.g. family days. This will help employees relate to each other and may help with conflict resolution in the workplace.
- Put positive working relationships at the heart of your organisational culture by including it as a guiding value.

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**Workplace example - On Track Community Programs Inc Young Person Mentoring Program**

On Track has actively sought to employ and support younger people in our workforce as a strategy to address predicted workplace shortages due to the ageing population of our workforce. This trend will have implications not only for On Track, but the community as a whole. It is encouraging to work with dedicated young people who are community minded, have a sense of social justice and have a strong desire to develop their careers in mental health and disability services.

When a young person (under 25 years) is employed by On Track they are assigned a more experienced mentor who oversees their progress and provides them with internal supervision. Young workers involved in the program are encouraged to pursue their area of interest such as tender applications, policy and procedure development or management and are supported to take on special projects within their designated area. This mentoring program acts as both a recruitment strategy, i.e. it attracts young people to the organisation, and also a retention strategy, i.e. young people are supported and provided with opportunities for personal and professional development.

On Track has already benefited from the Young Person Mentoring Program through the successful development and implementation of ‘Crossing the Bridge’ - a project aimed at high school kids with young mental health consumers and young workers talking to them about the risks of drug and alcohol abuse and the link with mental health problems.

Another project that was initiated by a young staff member, and developed and implemented through the mentoring program, was the Cancer Council Grant for Tobacco Use Cessation. This young staff member attended a NSW MHCC NGO Mental Health Conference and was then inspired to apply for funds through the Cancer Council. The On Track project provides staff and consumer training in smoking cessation and the provision of Nicotine Replacement Therapy (NRT).
Workforce Development Pathway 5 – Consumer Workers and Carer Workers

A recovery-oriented service values lived experience and focuses on recruiting and supporting Consumer Workers and Carer Workers.

What will you get out of this section?

- An understanding of the value of employing Consumer Workers and Carer Workers
- An understanding of remuneration and reimbursement guidelines
- An understanding of and appreciation for the specific contribution and value Consumer Workers and Carer Workers bring to an organisation
- The specific needs for Consumer Workers and Carer Workers
- Clear job descriptions for each of the job roles

From a recovery perspective the impact the hope of others can have on an individual who has given up cannot be underestimated. Hearing from people who have shared similar experiences and recovery journeys can facilitate recovery. From a staff development perspective, staff contact with consumers who have recovered from a mental health problem will help to reduce discrimination towards mental illness. Consumer Workers and Carer Workers provide hope and a role-model of recovery in action to both those employed within the workforce, and those using the service. All organisations can benefit from having Consumer Workers and Carer Workers. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

As discussed throughout this guide, consumers and carers should be encouraged to participate in service planning, delivery and reform. Participation, however, is a separate process to promoting and maintaining identified consumer and carer positions within the community mental health workforce. To have a Consumer or Carer Worker does not necessarily mean you have consumer and carer participation. Whilst it is acknowledged that there may be a great many Mental Health Support Workers with the lived experience of a mental health problem or Mental Health Support Workers in a caring role who choose to not disclose, this chapter is about an organisational commitment to build an identified consumer and carer workforce.

Just as it is acknowledged that consumers and carers are distinct groups with unique needs, they will also form different workforces which will bring a range of benefits to the community mental health sector and service users.

Following discussion on remuneration and reimbursement, this chapter will be divided into two sections: 1) Consumer Workers, 2) Carer Workers.
It provides options for managers/organisations in building consumer and carer workforces. This can mean incorporating paid roles into the workforce, or establishing a ‘pool’ of appropriate and diverse consumers and carers who the organisation can connect with on an ‘as needs basis’.

Remuneration and reimbursement

The information below is provided to allow managers to realise that it is possible to have Consumer and Carer Workers who are contracted for a specific project, committee or area of work, just as it is possible to have them as part of the paid staff. In fact, creating a ‘bank’ of Consumer and Carer Workers who cover a range of backgrounds and experience can be very valuable, and allows organisations to draw on the most appropriate people for particular tasks/work. The key for employers ‘contracting’ Consumer and Carer Workers is to provide adequate remuneration, or reimbursement at the very least, for their expertise and contribution.

There are several reasons for remuneration/reimbursement:

- It shows that the organisation values that person’s skills and lived experience
- It prevents exclusion of consumer and carer representatives who would otherwise be unable to be involved due to financial constraints
- It improves motivation to do good, consistent work
- It addresses power imbalances and places consumers and carers on an ‘equal footing’ to all other staff
- It enables consumers and carers to participate in research and evaluation

The National Consumer and Carer Forum in its document “Consumer and Carer Participation Policy – A Framework for the Mental Health Sector” has a set of ‘best practice principles’ for consumer participation, which include a principle on remuneration, as follows:


Consumers and carers will be remunerated for representative duties.

Unless otherwise agreed by consumers and carers, they will receive payment for their representative participation and reimbursement of expenses (e.g. travel and meals) incurred during their recognised active participation in externally organised mental health activities and processes that affect their lives. Consumers and carers should not be required to bear the costs of participation and representation expenses.

Reimbursement for such engagement will be negotiated between consumers and carers and the organisation on a paid or volunteer, part-time or full-time basis. It is important that all conditions regarding payment and expenses for representation be established upfront.

In the absence of established rates of pay, remuneration should follow the rates and conditions for holders of part-time public office positions set by the Australian Government Remuneration Tribunal, the independent statutory authority established under the Remuneration Tribunal Act 1973 (CWTW). Should funding be insufficient to meet these costs, rates for consumer and carer participation should be negotiated with their organisation, or in the case of independent consumer or carer consultants with the individual concerned.

Remuneration should also take into account the amount of time it may take to prepare for a meeting. This preparation time is often extensive, particularly when considering the amount of paperwork and material expected to be read prior to high-level meetings. There is often minimal recognition of such preparation time for consumers and carers, which may often involve taking time out of their daily business or using outside-work hours to prepare.’ (NCCF. 2004).

The Australian Government Remuneration Tribunal outlines remuneration for part-time public office positions and in the absence of existing standards or organisational policies for rates of pay for consumer and carer participation, this is generally accepted as best practice for remuneration for consumer and carer participation (as per the Mental Health Council of Australia guidelines). This recognises that consumers and carers have an expertise and valued knowledge, as do any other ‘experts’ that may be involved in council, committees or consultation. [www.remtribunal.gov.au]
Consumer Workers

This section is about supporting the development of an identified, paid consumer workforce. If one of our guiding practices is to deliver consumer-centred services and respond to consumer’s changing needs, then the acquired expertise from people who are living with a mental health problem is an invaluable asset to our workforce. It deserves to be recognised, nurtured and cultivated. This knowledge and skill, hard won, will provide a truly inclusive and vibrant component of the mental health workforce.\(^{110}\)

Some key points about the importance of language

The term ‘consumer’ is used to refer to anyone who uses, or has used a mental health service - a person with lived experience of a mental health problem. This is the preferred terminology in the Australian Mental Health Consumer Movement.\(^{111}\) The term ‘consumer’ captures the rights and expectations of the individual and the need for regulations and standards to ensure that this group is not misrepresented. It is a personal choice for an individual to use the term ‘consumer’. The term ‘consumer’ can show an individual’s commitment to help others through their own lived experience of a mental health problem and a personal commitment to their own recovery. It is up to the individual to choose if/when they cease to identify as a consumer. If a person with the lived experience of a mental health problem does not want to be referred to as a consumer, then the service provider can consult with them as to the preferred language, e.g. client, member, service user, survivor. Preferred terminology is person first language, i.e. the person is placed first, rather than any other characteristics or attributes relating to illness or disability.

From a consumer perspective, the phrase ‘case management’ also carries negative connotations and is in conflict with the principles and intent of recovery. It suggests a patronising and patriarchal approach. In recovery, consumers are in the ‘driver’s seat’ - consumers are not ‘cases’ and they do not need ‘managing’. Care/service coordination, support and key workers are all preferred terminology in this instance. Language always needs to be sensitive to the individual person.

Who is the consumer workforce?

Some paid consumer roles include:

- Peer support worker
- Independent consumer advocate
- Independent consumer representative
- Consumer trainer/assessor
- Mentor

The consumer workforce may also include volunteers.

It is important that roles and position titles reflect the job being undertaken. Thus, rather than adopting a role to a title, the title should be given based on the roles and responsibilities of the worker. It is imperative that prior to the assigning of a title, a position description and selection criteria be developed. This includes core competencies and guidelines which clearly set out day-to-day tasks and responsibilities. This also applies to Carer Workers.

There is a broad interpretation of what each of these consumer roles mean and a need for clarification of vocational roles. There is no ‘one size fits all’ approach to job descriptions and related qualifications. However, the essential and desirable criteria outlined are core components of any Consumer Worker’s position description, and will ensure that the Consumer Worker is able to undertake their specific role with integrity. This applies equally to Carer Worker roles.

As with recruitment strategies for all staff, some flexibility may be required with job descriptions provided if the organisation is looking to access a broad ‘pool’ of Consumer/Carer Workers who represent the population, e.g. oral/written communication may not be appropriate as an essential criteria for someone from a non-English speaking/CALD/ATSI background.
What is reasonable adjustment?

From a consumer perspective, it is derogatory to assume that a Consumer Worker, by virtue of the fact that they have the lived experience of a mental health problem, will need special considerations in the workplace, for example, extra supervision. Reasonable adjustment is a provision in the Disability Discrimination Act which applies to people with disability, their associates and carers. Whilst accommodations for a physical disability are clear, and perhaps more ‘tangible’ than for a mental health problem, the same principles of reasonable adjustment apply for Consumer Workers. Consumer Workers have the same legal right to reasonable adjustment as any person with a disability, and the same accountability to expectations placed by the organisation on all other employees. It is the responsibility of the manager to ensure reasonable expectations and responsibilities are implemented for Consumer Workers. All organisational policies, such as staff privacy and confidentiality, apply to Consumer Workers also, no more and no less than any other employee.

Reasonable adjustment is about flexibility which is mutually agreed between employer and the Consumer Worker in accordance with both legislative requirements and workplace policy/procedure. Flexible and supportive workplace practices should apply to all staff. It should be made known to all staff how the organisation can support them if they are experiencing difficulties within their job, for example, staff who identify as consumers can request support be provided by an external support person, in addition to that provided by their line manager. If choice is power, then to be able to plan and negotiate reasonable adjustment options not only enhances recovery but effectively ensures the organisation is able to continue to provide the service it is funded for and provide a supportive environment for all staff.

Consumer Workers, as with all staff, need to be provided with adequate, ongoing, specialist training and support to undertake their job role. This ensures they are not set up in a position where they are likely to fail. The same applies for Carer Workers. It is unethical and irresponsible to expect workers to conduct their roles if inadequately trained, and there are a number of courses available for Peer Support Workers and Consumer Advocates.

Managers may wish to review the organisation’s current Code of Conduct/Practice policies to ensure Consumer Workers are able to uphold this with full integrity. For example, many Consumer Workers have friends who may be accessing the service (as indeed may Carer workers and Mental Health Support Workers). Whilst they should not be expected to give up their friendships because they become employed within the organisation as a Consumer Worker, relationships of any description between consumers who access the organisation’s service and Consumer Workers require careful consideration to ensure there is not a misuse or abuse of ‘power’ within the relationship.

Possible reasonable adjustment can include, but not limited to:

- Job restructuring - reduced responsibilities/modified duties within the position for the period only in which the Consumer Worker needs this type of support
- Part-time or modified work schedules - flexible work hours, which ensures the Consumer Worker undertakes the overall weekly hours they are employed to work
- Leave, which could include leave without pay, for a specified period
- Modified workplace policies
- Job reassignment
- Access to external support and/or supervision from experienced Consumer Workers

Whilst managers have a responsibility to provide duty of care to all staff, they are not in the role of health practitioner providing a clinical response if/when a worker becomes unwell. Management need to clearly understand their focus is that of the ‘employer’ of the Consumer Worker. To facilitate a clinical role towards Consumer Workers might also interfere with the privacy and confidentiality of the Consumer Worker.
‘How can I best meet your needs?’

The key question for managers to ask any staff disclosing they have a mental health problem is, ‘How can I best meet your needs?’ This can extend to asking if the individual intends to inform any other staff of his/her mental health issues, and how to make adjustments to the workplace so that they can fulfil the core requirements of the job. There is no reason for managers to know the details of diagnosis or medications unless the individual chooses to disclose this information. In a consumer designated or peer identified role, self-disclosure as a person living with a mental health problem is automatic, but disclosure of mental health problems in mental health/support/clerical or other worker role is at the full discretion of the individual. An open door policy with staff will allow individuals to provide information at their own pace.

Managers need to be flexible and responsive to all staff’s needs. The behaviour and attitudes of an organisation’s management is known to ‘flow’ down to all levels of staff and influence the culture of the organisation. For example, management that provides mentoring and support promotes the transfer of this approach and sensitivity to all staff in their interactions with each other. Education and promotion of non-discriminatory practice does demonstrate sensitivity but it needs to be seen and maintained as part of an organisation’s culture in order to retain Consumer Workers. For example, whilst there are many reasons why Consumer Workers resign, it can be the case that they resign if they become unwell rather than be seen to let down the team/organisation, and managers need to be sensitive to the rationale behind their resignation. This may include considering the reason for the resignation, providing unpaid leave, or reducing duties to avoid losing competent and worthwhile staff. Knowing staff well and looking for signs that staff may be finding it difficult to fulfil the core requirements of the job will also help staff retention.

Affirmative action

Managers may consider affirmative action policies to promote the inclusion of Consumer Workers or workers who happen to identify as consumers, and further developing the consumer workforce. A person with the relevant experience and qualifications is given priority for the advertised position if, in addition, they have the lived experience of a mental health problem. This lived experience alone is not sufficient to successfully perform a job role; it is something they bring to the role. The core abilities and training required for the position are the same for anybody in a Mental Health Support Worker role.

Committing to responsive and compassionate management

The nature of mental illness is such that there may be times when Consumer Workers become unwell. If management adopts a responsive approach to the well-being of employees then they can accommodate and manage episodes of unwellness in the consumer workforce, just as they would if any staff member experienced a time of specific health or social need. Clear guidelines (i.e. policies and procedures) must be in place to know when and how to respond to a worker who appears to becoming unwell - functionality at work being the key. This can be done in advance in collaboration with staff, but ultimately the manager needs to assert authority when it becomes clear that the worker’s capacity to work safely and effectively is at risk.

Importantly, managers need to work with other staff in educating them on mental health issues in the workplace, including respecting boundaries, changes in behaviour, conflict of interest, how the organisation will cope with prolonged absences, complaints mechanisms, and non-discriminatory practices. This will help break down any preconceived ideas about staff that identify as consumers, for example, looking at any behaviour as symptomatic of their mental health problem(s). Some managers reported that staff ‘read into’ any behaviour change (e.g. irritability, tiredness, sadness) as a ‘sign’ that the staff person who has disclosed a mental health problem is becoming unwell. As with any member of staff, behaviour changes may or may not indicate a mental health problem, and it is the managers’ role to educate staff on mental health issues and well-being in the workplace. Staff within the organisation need to receive training about consumer designated roles.
Job descriptions

The following job descriptions are for paid Consumer Worker roles, although the same roles can occur in a casual or consulting capacity, with the appropriate remuneration.

Peer Support Worker:

Essential criteria

• Lived experience of a mental health problem
• An approachable and non-judgemental manner and attitude
• Genuine commitment to supporting people with mental health issues or problems
• Demonstrated knowledge of recovery and recovery pathways
• Demonstrated knowledge of the core precepts, principles and philosophies of the Australian Mental Health Consumer Movement
• Practical experience of working with consumers
• Ability and willingness to develop relationships with and network across community and mental health organisations, the wider health and disability sector, carers and families
• Excellent communication and active listening skills
• Demonstrated capacity to relate with dignity and respect, and as a unique person rather than as a ‘person with a mental health problem’
• Proven commitment to the principles and practice of EEO, Ethical Conduct, Cultural Competence, etc.
• Good organisational and administration skills
• Commitment to ongoing professional development
• Good computer skills

Desirable criteria

• Relevant Peer Support Worker qualifications and experience (Note - there are no nationally recognised qualifications at this time)
• Ability to respect and relate to a range of people from CALD backgrounds, including ATSI communities
• Understanding of a human rights focus
• Practical knowledge of local services
• Current drivers licence
• Knowledge of relevant legislation
• Ability to critically reflect on one’s own practice and performance

Peer Support Worker Job Description Example 1:

• Work collaboratively with consumers accessing the organisation’s services
• Provide practical support to consumers
• Provide peer support, relevant information and referral as required
• Liaise with consumers, community organisation and health workers at all levels
• Inform, encourage and support consumers to access other services provided by the organisation
• Provide written reports as required
• Participate in all practice supervision sessions as determined by the line manager
• Refer all consumer advocacy issues to relevant advocacy organisations and supports
• Uphold the consumers’ rights focus at all times
• Identify own ongoing education and training needs and participate on a regular basis in any education and training opportunities provided
• Conform to organisation’s policies and procedures and any reasonable directions from management

Consumer Advocate

The goal of advocacy is the ‘empowering of people to formulate, voice and achieve individual needs and wants’. Consumer Advocates have had a very positive influence on staff attitudes in many services when they are treated as an integral part of the team and their recommendations to enhance service quality are listened to and acted upon.

One approach to advocacy is for the Board to employ an independent Consumer Advocate who then reports directly to the Board, avoiding any issues that may arise due to conflict of interest. The Board will need to be accessible and available to give support to the Consumer Advocate.

Essential criteria

• Personal experience of mental health problem
• Communicate effectively orally and/or in writing
• Commitment to work with mental health service providers, community organisations and the wider disability sector
• Demonstrated knowledge of human rights
• Understanding of consumers’ rights and responsibilities
• Active listening skills
• Demonstrated capacity to be empathetic
• Proven commitment to the principles and practice of EEO, Ethical Conduct, Cultural Competence, etc.

Desirable criteria

• Ability to respect and relate to a range of people from CALD backgrounds, including ATSI communities
• Consumer Advocacy course/training Certification(s)
• Ability to critically reflect on one’s own practice and performance

Consumer Advocate Job Description Example 1:

• Train, support, educate and/or resource, i.e. enable consumers to speak on their own behalf (Self Advocacy)
• Advocate for policy reforms surrounding systemic issues of concern that have or may have an unwanted impact on consumers receiving or trying to receive a service (Systemic Advocacy)
• Provide Individual Consumer Advocacy to a consumer if and when they are unable to advocate on their own behalf, for whatever reason, when they give consent for you to do so
• Promote and uphold rights of consumers in the service, without fear or favour
• Refer consumers to a more appropriate service if circumstances requires a different form of advocacy or an advocate with more capacity to act
• Write timely reports whilst maintaining confidentiality at all times. Only share confidential information with media, staff, consumers, etc. with permission of management
Consumer Representative

This role involves a process of nomination/voting by the group of people to be represented, that is, it is an elected role.

Essential criteria

• Personal experience of mental health problem
• Capacity to attend and actively participate in regular committee meetings, forums and workshops
• Demonstrated knowledge & understanding of the core precepts, principles and philosophies of the Australian Mental Health Consumer Movement, including consumer participation and partnership
• Demonstrated knowledge and understanding of human rights and the rights and responsibilities of consumers accessing services
• Demonstrated written and/or verbal communication skills, e.g. record-keeping at committee meetings
• Ability to use negotiation skills when liaising with relevant parties, including consumers, other agencies and community services
• Ability to be empathetic, and provide appropriate support and information to consumers
• Proven commitment to the principles and practice of EEO, Ethical Conduct, Cultural Competence, etc.

Desirable criteria

• The ability to respect and relate to a range of people from different CALD backgrounds, including ATSI communities
• Relevant Consumer Representation training/course Certification(s)
• Basic computer skills
• Ability to critically reflect on one’s own practice and performance

Consumer Representative Job Description Example 1:

To do the following:

• Uphold the rights and interests of consumers, service users and potential service users
• Provide consumers’ feedback and input to relevant committees
• Uphold the right of consumers to be heard at relevant committees and present their ideas, issues and concerns to be tabled and discussed
• Report the activities of the committee to consumers
• Ensure accountability to consumers
• Ensure the committee acknowledges consumer concerns
• Provide information about any relevant issues affecting consumers
Consumer Trainer/Assessor

Essential criteria

- Demonstrated understanding of working with mental health services, including the NGO sector
- Excellent oral and written communication skills
- Good computer skills
- Demonstrated knowledge/experience of recovery-oriented approaches to mental health work
- Demonstrated knowledge & understanding of the core precepts, principles & philosophies of the Australian Mental Health Consumer Movement
- Flexible work practices
- Certificate IV in Training & Assessment or Assessment & Workplace Training (in order to work for an RTO)

Desirable criteria

- Personal experience of mental health problem
- Current drivers license
- The ability to respect and relate to a range of people from different CALD backgrounds, including ATSI communities
- Community services training & assessment experience
- Ability to critically reflect on one’s own practice and performance

Mentor

This is someone who the Consumer Worker can look to for guidance and inspiration to in a professional and personal capacity.

Essential criteria

- Personal experience of mental health problem
- Demonstrated capacity to be a mentor
- Practical experience of developing a trusting and mutual relationship with mentee
- Excellent communication and active listening skills
- Approachable and acceptable manner and attitude
- Demonstrated ability to support consumers to develop their talents and skills
- Commitment to recovery and peer support core precepts, principles and philosophies
- Ability to provide respectful, constructive and meaningful feedback to the mentee
- Ability to support the mentee to further develop positive work practices and systems
- Knowledge of the boundaries and limitations of the role as mentor, including confidentiality principles
Desirable criteria

• The ability to respect and relate to a range of people from different CALD backgrounds, including ATSI communities
• Demonstrated knowledge and practical implementation of the core precepts, principles and philosophies of the Australian Mental Health Consumer Movement
• Demonstrated knowledge of all relevant legislation, i.e. Privacy Act, Anti-Discrimination Act, Mental Health Act, etc.
• Ability to critically reflect on one’s own practice and performance

Consumer Mentor Job description Example 1:

• Develop positive and mutual relations for the enhancement of self esteem mentoring and personal development
• Meet individually with person once a month (or as agreed)
• Be a sounding board for mentee’s ideas, needs or concerns
• Develop a relationship built on trust and mutual respect
• Provide positive and non-judgemental feedback
• Support the mentee to develop creative solutions to issues and concerns that require to be addressed
• Support the mentee to develop an individual work plan which best meets the needs of their employed role
The Consumer Activity Network (Mental Health) Inc. is the only independent, fully consumer run organisation in NSW and is based at Brookvale, Northern Beaches Sydney. CAN (Mental Health) also manages and runs Pitane Recovery Centre, the first and only consumer run recovery centre in metropolitan Sydney.

The organisation provides peer support services and recovery activities for mental health consumers locally, state-wide and nationally. For example: Phone Connections, a national telephone peer support line for consumers across Australia; Hospital to Home which provides practical assistance and peer support to consumers within the first 28 days of discharge from 2 Sydney psychiatric inpatient units; hosting the NSW Mental Health Consumer of the Year Awards to acknowledge and celebrate the achievements of consumers and their contributions to Australian society.

CAN’s vision is: “We CAN - We CARE - The Future is in Our Hands”. Pitane’s core philosophy is “Hopes and Dreams Can Come True.” Both the vision and philosophy underpin all peer support services, recovery activities and special events hosted. The organisation encourages and enables consumers to get out there and have a go, with the core ethos being: “If you don’t have a go, then how will you know?”

The core precepts, principles and philosophies of recovery, consumer participation and social inclusion provide the impetus which firmly places the organisation at the forefront of developing and implementing innovative consumer run services and recovery activities. The organisation’s commitment to these core precepts strongly highlights mental health consumers can run their own show, make their own decisions, have full control over their lifestyles of choice, and utilise their many talents and skills to achieve their hopes and dreams.

Some of the organisation’s activities hosted are:

- Women’s Coffee Club at a local community café.
- Social activities, i.e. visiting art galleries, going to the movies, walks etc.
- Special luncheons with international consumer guests.
- Hosting conferences.
- Providing consumer advocacy training.
- Hosting Self Esteem courses, working with the media workshops etc.
- WRAP (Wellness Recovery Action Plan) Groups

The partnerships and linkages CAN (Mental Health) Inc. and Pitane Recovery Centre have fostered highlight that “Recovery is about action. Action is about Recovery”.

Workplace example -
Consumer Activity Network (CAN) Mental Health Inc.
Carer and Family Workers

This section is about supporting the development of a **paid carer workforce**. A carer, as defined for the purpose of this guide, is a person whose life is affected by virtue of a family or close relationship and caring role with a consumer, or person with a lived experience of a mental health problem.\(^{116}\) This role is generally unpaid and involves a significant level of support and sacrifice. There can be prolonged periods of emotional and physical strain at the same time as great personal and family growth, for example, families may be drawn closer together and provide each other with solace and support.

One of the guiding principles for Carer Workers in mental health is the close working relationship they have with consumers of the services, in addition to carers and families. Perhaps the best way to view Carer Worker roles is as promoting ‘family-inclusive practice’.

Whilst it is important to promote carer identified roles, feedback from managers and others is that it may not always be feasible or realistic to recruit people with lived experience of being a carer. Instead, it may be more appropriate and valuable to the sector, consumers, and carers, to seek Carer Workers who are able to demonstrate ‘family-inclusive’ approaches to support and care. This means involving family members and significant others from the individual’s social environment to participate and engage in services, as well as support the individual’s recovery journey.\(^{117}\) Together with the unique set of relationships between Carer Workers, consumers, carers and families, this family-inclusive approach is an invaluable asset to the workforce. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

Many carers of workforce age face difficulties in balancing work and care responsibilities. To assist carers who want to participate in the workforce they require\(^{118}\):

- Affordable, quality alternative care arrangements for older people and people with disabilities
- Carer friendly workplace policies to assist carers in balancing work and care responsibilities
- Affirmative action programs to assist carers to re-enter the workforce

The mutual benefits of having a balanced working relationship with employees who have caring responsibilities are\(^{118}\):

- The organisation attracts and retains qualified, committed staff
- There is lower absenteeism and sick leave
- Improved staff morale and performance
- Increased profitability
- Increased flexibility of staffing arrangements to meet the needs of consumers or the organisation
- The working carer is better able to juggle paid employment with unpaid caring, feels supported and knows their rights in the workplace
- Public image of the organisation as a supportive working environment is improved

Work can be a protective factor for well-being of Carer Workers - something that provides an important focus in their lives and ‘time out’ for them. The decision to maintain work is a personal decision for the Carer Worker, but one that can be very empowering and provide the carer with a professional identity. Support from management is an integral part of this process.\(^{119}\) Managers need to utilise the options that exist for Carer Workers so that they can meet the needs of carers who are looking for permanent, casual or contract work. Not all carers will be looking for full-time paid work, just as not all carers will want only casual work.
Some key points about the importance of language

The distinction between carer and family member needs to be understood, as it is important to recognise that there will be different relationships that exist within a family. Not all carers will identify themselves as such, and may see themselves more in a family role. Many carers would argue that caring is not a choice, but a situation they find themselves in, whereas other carers will identify strongly as carers by choice. Preferred terminology will need to be discussed with the organisation/service provider as part of the orientation to the services.

Who is the carer workforce?

The carer workforce is not as developed as the consumer workforce in terms of clear positions and roles. At this stage, the paid carer workforce consists of:

- Carer Advocate
- Carer Representative

Another role that has been proposed as a possible direction for the carer workforce is:

- Carer Support Worker

The focus in all Carer Worker roles is frequently around enhancing quality outcomes for consumers, as well as carer-focused activities. This is very important because at no time should a Carer Worker lose sight of consumer rights or lived experience. Consulting with consumers and family is important at all times - a hand-in-hand relationship. Family-inclusive practice (see text box at the end of this chapter) should be promoted across all job roles so that it becomes part of the culture of the organisation.

Carer Support Workers are in a unique position to liaise and build relationships with consumers, carers, family and service providers. As people with the personal experience of being in a caring role for someone with a mental health problem, they can assist promotion of positive family relations and keeping the family together. Consumer and carer’s quality of life will reflect the quality of these relationships. Carer Support Workers see the family as an important ‘unit’ and are in a position to support, educate and advocate for families from the early stages of mental health problems onwards. This holistic approach to recovery goes beyond a mere focus on the consumer by incorporating the social context and relationships which support the consumer. This perspective is critical to the Carer Support Worker role. They are also in a position to ‘link’ carers and families to other services and support networks. This is where Carer Support Worker roles ‘fit’ within an organisation and how they can contribute in a unique way to recovery-oriented services. Carer Support Workers can provide ‘hands-on’ or frontline support to consumers, carers and their families. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

What are the specific needs for Carer Workers?

Usually employees are able to provide care and assistance outside normal working hours, except there will be times when they are required to provide more assistance and support - such is the nature of mental health problems. This is when carer responsibilities may impact the employee’s work responsibilities and it is during these times that it becomes particularly important that community mental health organisations have created ‘carer friendly’ workplaces that offer flexible opportunities for workforce participation and re-entry into the workforce for carers. Clear, accessible policies and procedures need to be established which outline to all staff how the organisation can support them, if they are experiencing difficulties within their job.
What is reasonable adjustment?

Reasonable adjustment is about flexibility mutually agreed between employer and the Carer Worker in accordance with both legislative requirements and workplace policy/procedure. Flexible and supportive workplace practices should apply to all staff. It should be made known to all staff how the organisation can support them if they are experiencing difficulties within their job, for example, staff who identify as carers can request additional support be provided by an external support person to that provided by their line manager. If choice is power, then to be able to plan and negotiate reasonable adjustment options not only enhances recovery but effectively ensures the organisation is able to continue to provide the service it is funded for and create a supportive environment for all staff.

Carer Workers, as with all staff, need to be provided with adequate, ongoing, specialist training and support to undertake their job role. This ensures they are not set up in a position where they are likely to fail. It is unethical and irresponsible to expect workers to conduct their roles if inadequately trained and there are numerous courses available for carer identified roles.

‘How can I best meet your needs?’

Similar to Consumer Workers, managers will achieve best results if they discuss flexible working arrangements and reasonable adjustment with Carer Workers. Carer Workers will be in the best position to advise managers of what they would find most helpful in order to be able to fulfil their core work responsibilities. This also enables Carer Workers to feel they have some control over their lives and autonomy over their workload. This is something that many carers feel they have lost during the course of their caring role, the nature of which is unique to each individual; cultural and family influences posing different demands on carers, particularly young carers. A flexible approach to work practices will have the most benefit to both the employer and Carer Worker.

All organisational policies apply to Carer Workers, no more and no less than any other employee. Managers need to be aware of their responsibility and obligation to employees with caring responsibilities under the Anti-Discrimination (Carers’ Responsibilities) Act 2000 (NSW). There are many practical strategies that can be used to assist employees balance their work and care responsibilities:

- Implement flexible work arrangements, such as Flexi-Time, part time work, job-sharing, flexible rostering, flexible start and finish time, and Time-In-Lieu
- Implement leave provisions such as paid family, personal or carers’ leave, allow flexible use of recreation leave and offer unpaid leave for single days or block periods
- Job sharing
- Allow working from home on a temporary or long-term basis
- Inform supervisors of employees’ entitlements and options, and encourage them to promote flexibility
- Provide information on community services that can assist carers and the person they support. This could be done through an identified contact person, a lunchtime seminar, staff newsletters and/or a bulletin board
- Arrange access to free or subsidised counselling services
- Ensure that carers have access to a telephone so that they can check that all is well at home

Affirmative action

The same principles for Consumer Workers apply here also. See page 50.

Committing to responsive and compassionate management

As with all staff, Carer Workers are expected to fulfil the core requirements of the job. When carer responsibilities affect employees’ functionality at work, managers will need to carefully consider with staff members the most appropriate short and long term plans. This will ensure that the organisation is able to continue to provide the service it is funded for and create a supportive environment for all staff.
Job descriptions

The following job descriptions are for paid Carer Worker roles, although the same roles can occur in a casual or consulting capacity, with appropriate remuneration.

**Carer Advocate**

**Essential criteria**
- Understanding of, and ability to demonstrate ‘family-inclusive practice’
- Knowledge of local mental health services in the area, or willingness to acquire such knowledge
- Communicate effectively orally and/or in writing
- Commitment to work with mental health service providers, community organisations the wider disability sector, consumers, carers and families
- Understanding of carers’ rights and responsibilities
- Understanding of consumers’ rights and responsibilities
- Active listening skills
- Demonstrated capacity to be empathetic
- Proven commitment to the principles and practice of EEO, Ethical Conduct, Cultural Competence, etc.

**Desirable criteria**
- Personal experience as a carer or family member of a person with a mental health issue(s) or mental health problem
- The ability to respect and relate to a range of people from different CALD backgrounds, including ATSI communities
- Carer Advocacy course/training Certification(s) (Note - there are currently no nationally recognised qualifications for this job role)
- Ability to critically reflect on one’s own practice and performance

**Carer Advocate Job Description Example 1**
- Train, support, educate and/or resource, i.e. enable carers to speak up their own behalf (Self Advocacy)
- Advocate for policy reform surrounding systemic issues of concern that have or may have an unwanted impact on carers and consumers (Systemic Advocacy)
- Provide Individual Advocacy service to a carer if and when they are unable to advocate on their own behalf, for whatever reason, when they give consent for you to do so
- Promote and uphold rights of carers in the service, without fear or favour
- Refer carers to a more appropriate service if circumstances require a different form of advocacy or an advocate with more capacity to act
- Write timely reports whilst maintaining confidentiality at all times. Only share confidential information with media, staff, consumers, etc. with permission of management

**Carer Representative**

**Essential criteria**
- Understanding of, and ability to demonstrate ‘family-inclusive practice’
- Ability to attend and participate in regular committee meetings, forums and workshops
- Strong interest in carer participation
Demonstrated written and/or verbal communication skills, e.g. record-keeping at committee meetings
Ability to use negotiation skills when liaising with relevant parties, including carers, consumers, other agencies and community services
Ability to be empathetic, and provide appropriate support and information to carers
Proven commitment to the principles and practice of EEO, Ethical Conduct, Cultural Competence, etc.
Knowledge of carers’ and consumers’ rights and responsibilities

Desirable criteria

Personal experience as a carer or family member of a person with a mental health issue(s) or mental health problem
The ability to respect and relate to a range of people from different CALD backgrounds, including ATSI communities
Relevant Carer Representation training/course Certification(s)
Basic computer skills
Ability to critically reflect on one’s own practice and performance

Carer Representative Job Description Example 1

The Carer Representative can reasonably be expected to do the following:

Uphold the rights and interests of carers, young carers, Carer Workers, and consumers;
Provide carers’ feedback and input to relevant committees;
Uphold the right of carers to be heard at relevant committees and present their ideas, issues and concerns to be tabled and discussed;
Ensure the committee acknowledges carer concerns;
Report the activities of the committee to carers;
Ensure accountability to carers; and,
Provide information about any relevant issues affecting carers.

Carer Support Worker

The Carer Support Worker role is not a counselling role. As it is a relatively new type of role, Carer Support Workers may be required to spend some time orienting other staff to their role and how they are able to assist/support staff, consumers and carers. This will help to build trust and break down any barriers which may exist between staff, for example, staff may feel threatened by this new type of role.

Essential criteria

Understanding of, and ability to demonstrate ‘family-inclusive practice’
An understanding of issues and concerns for carers of people who have mental health issues/access mental health services
Knowledge of carer’s and consumer’s rights and responsibilities
An approachable and non-judgemental manner and attitude
Genuine commitment to supporting carers and families, and people with mental health problems
Demonstrated knowledge of recovery, recovery pathways and respite services
Practical experience of working with carers, consumers and families
Ability and willingness to develop relationships with and network across community
and mental health organisations, the wider health and disability sector, consumers and families

- Proven commitment to the principles and practice of EEO, Ethical Conduct, Cultural Competence, etc.
- Excellent communication and active listening skills
- Good organisational and administration skills
- Commitment to professional development
- Good computer skills

Desirable criteria

- Personal lived experience as a carer/family member of a person with a mental health issue(s) or a mental health problem
- Relevant Carer Support Worker Certification(s)
- The ability to respect and relate to a range of people from different CALD backgrounds, including ATSI communities
- Practical knowledge of local services
- Current driving licence
- Ability to critically reflect on one’s own practice and performance

Carer Support Worker Job Description Example 1

- Work collaboratively with carers, consumers and families accessing the organisation’s services
- Provide practical support to carers and families
- Provide peer support, relevant information and referral as required
- Liaise with carers, consumers, community organisations and health workers at all levels
- Inform, encourage and support carers and families to access other services/respite provided by the organisation
- Participate in all practice supervision sessions as determined by the line manager
- Refer all carer advocacy issues to relevant advocacy organisations and support services
- Uphold carer and consumer rights at all times
- Identify own ongoing education and training needs, and participate on a regular basis in education and training opportunities provided
- Conform to organisation’s policies and procedures and any reasonable directions from management
- Advocate on behalf of carers as required, e.g. accompany carers to talk to health staff to put forward their concerns, assisting carers to make a complaint about the service or the service the person they care for is receiving, providing information, providing support and understanding
- Maintain carer and consumer confidentiality at all times
**Workplace example for Carer Advocate Role - Carer Assist - Well Ways Program**

Carer Assist works in partnership with families and carers using the Well Ways mental illness education program. This program is owned by the Mental Illness Fellowship of Victoria and is used by Carer Assist under licence. Carer Assist has run 58 programs since June 2003, involving 568 participants from all over NSW.

It is a group based, peer-to-peer family education program which has two main objectives – the delivery of up-to-date information about mental illnesses, medication, the mental health system and carer support systems; and the provision of support for families, including guiding participants as they examine some of the complex emotional and practical issues in loving and caring for someone with a mental health problem, and the development of ongoing support mechanisms.

Research conducted affirms families of people with a mental health problem are more socially isolated than their peers. Well Ways attempts to decrease this isolation by utilising a peer-to-peer model of education delivery, complemented by the establishment of a well-informed social network. Community development and mentoring / peer principles are essential in guiding the structure of the program.

Well Ways is delivered by two trained facilitators who have undergone training and accreditation with the Mental Illness Fellowship of Victoria. The two facilitators may be carers, or a combination of a carer and a Carer Advocate. The program is conducted over a 12 month period in three phases. An initial engagement phase occurs, where potential participants are connected with Carer Assist and are assessed for their suitability for joining Well Ways. The second phase is the development phase, an intensive, structured eight session component which aims to increase participant’s knowledge of mental illness, develop social networks, and develop problem solving skills. The third phase is a consolidation phase, which is designed to further develop skills in some important areas. A workshop is presented every two months on a particular topic and provides a formal structure for the group to stay connected. Groups are encouraged to remain in social contact between sessions to strengthen and create sustainable support networks. Leadership of the group is driven by carers who emerge from the process as natural leaders.

Carers who are identified as potential co-facilitators are also identified during this process and are offered training to become facilitators. To date, 12 carers have chosen to become co-facilitators in the program. Several support groups emerging from the Well Ways program have developed into sustainable and invaluable support groups, driven by proactive carers, servicing the community and expanding their initial membership.
The Family-Inclusive Practice Training is provided to workers working with consumers and/or their families and carers. The intended outcome of this training is to provide the foundations for support workers to work with families and carers of people with mental health problems, by raising awareness of family and carer needs, and provide education and the knowledge base to work with families and carers of people with mental health problems. The principles which underlay the family-inclusive practice training are: whole-of-family approach, holistic approach, Carer Life Course Framework and the Recovery Model. The assumption is that the relationship with the family and/or carer may influence the consumer’s recovery journey and a positive relationship between consumer and family/carer will hopefully result in benefits for both consumer and their families and carers.

The training course is 4 hours and is designed to engage workers in collaborative learning relevant to their work practice.

Family-inclusive Practice training aims:
1. To educate workers about the role of families and carers of people with mental health problems and their needs.
2. Explore worker’s attitudes, knowledge and experience in working with families and carers of people with mental health problems.
3. To provide knowledge and understanding of family-inclusive practice and the benefits of this approach to consumers and their families and carers.
4. To explore ways of integrating family-inclusive practice in the workplace by considering professional, departmental and organisational context.
5. To identify barriers to family-inclusive practice in the workplace and explore ways of addressing these.
6. To explore ways for support workers to transfer knowledge gained from the training into practice.
7. Provide an opportunity for support workers to critically reflect on their own practice in relation to working with families and carers of people with mental health problems.
Workforce Development Pathway 6 – Becoming a Culturally Competent Workforce

A recovery-oriented service has a culturally competent and diverse workforce.

What will you get out of this chapter?

- A broader understanding of culture and cultural competency
- How to encourage and support cultural competency in your workforce
- Strategies to promote and work towards achieving cultural competency
- How to measure cultural competence at an individual and organisational level
- Specific considerations for working with Aboriginal and Torres Strait Islander People

A connection to one’s own culture is a key to recovery. Recovery-oriented practices give positive value to cultural, religious, sexual and other forms of diversity as sources of identity and belonging. Recovery-oriented service provision requires an understanding of an individual in their cultural context and a willingness to provide flexible services which respect individual and family cultural identities. If the workforce is cognisant of this, and applies this in practice in partnership with consumers and carers, they are truly working towards achieving a recovery-oriented service system. In the same way that the concept of recovery has been used, there has been a focus on conceptualising cultural competence at the expense of operationalising, or putting into practice, initiatives and standards of practice. This chapter assists managers to take practical steps towards building a culturally competent workforce. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

What is cultural competence?

Cultural competence is an ability to understand, communicate with and effectively interact with people across cultures. It combines behaviours, attitudes and policies and requires that these are coordinated at a systems and individual level so that the system or individual is able to work effectively in cross-cultural situations.

Cultural needs and sensitivity, and the principles and philosophy of cultural competence, come into play in all areas of staff development. Cultural competence requires multi-level strategies and both a ‘top-down’ and ‘bottom-up’ approach to change management strategies. Community mental health support work is about accounting for the individuality of all consumers, carers and workers, from all backgrounds and circumstances. This extends to realising that individuals are starting from different points on their recovery journeys. It is not possible or appropriate to provide a ‘one size fits all’ answer for managers on how to include and respect all individuals - it is much more enmeshed with everyday practices and policies.
Cultural competence is something you work towards. There is not an end point where you can claim you are ‘culturally competent’ - it is an ongoing, reflective process that is ever changing in response to the changing needs of the individual. Culture is not fixed and static. It is constantly changing and responding to external and internal environments and circumstances.

At the **systems level**

“Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and well-being by integrating culture into the delivery of health services.”

At the **individual level**

Cultural competence is “the ability to identify and challenge one’s cultural assumptions, one’s values and beliefs. It is about developing empathy and connected knowledge, the ability to see the world through another’s eyes, or, at the very least, to recognise that others may view the world through different colour lenses.”

Cultural competence requires a shift in perspective from regarding ‘culture’ as solely reflecting nationality, to being an all-encompassing, dynamic, complex construct. This includes sub cultures, cultures within cultures, organisational culture, etc. It is about recognising all beings as cultural and promoting self-awareness, rather than always referring to cultures as ‘other than’ or distinct from Anglo-Australian cultures.

The definition of culturally and linguistically diverse (CALD) groups extends to recognising a person’s age, gender, sexuality, religion, spirituality and linguistic background as part of their cultural identity. In addition, Aboriginal and Torres Strait Islander (ATSI) communities will have culturally-specific needs.

**What needs to happen?**

There is a need for strong leadership to commit and lead the workforce through the process of becoming culturally competent, through a clear framework and key performance indicators. It is unlikely change will be sustained without ‘diversity champions’ and senior support to create systemic change. Cultural competency at a management level affects the service culture of every organisation. The development of cultural competence is an interactive process between the Community Mental Health Support Worker, Consumer Worker, Carer Worker, manager, consumer, carer, and community.

Cultural competence requires that the workforce and the organisations have the capacity to:

1. Value diversity in all people
2. Conduct self assessment
3. Manage the dynamics of difference
4. Acquire and institutionalise cultural knowledge
5. Adapt to diversity and the cultural contexts of individuals and communities served

At an individual staff level, this is achieved through professional and personal development strategies. These strategies can be both attitudinal (values) and skill-based, and can include:

- Regular education and training (professional development) - where possible, integrating cultural competence training into mainstream courses for Community Mental Health Support Workers, Consumer Workers and Carer Workers, rather than it being provided in the form of ‘stand-alone’ or ‘one-off’ modules/workshops
- Supervision and mentoring
- Reflective practice
- Consumers, carers and people from CALD & ATSI backgrounds participate in the orientation of new staff members - this is an opportunity for the staff to learn about the organisation through the eyes of someone who uses the service
• Frequent in-service education with participation by consumers, carers and people from CALD & ATSI backgrounds
• Forums which bring together consumers, carers, Mental Health Support Workers, Consumer Workers, Carer Workers, community workers, and people from CALD & ATSI backgrounds, etc.
• Working with cultural brokers/mediators/consultants
• Training in working with interpreters/having access to face-to-face and phone-based interpreting services

At an organisational level, it refers to how managers build a positive culture that genuinely respects and responds to cultural differences. A comprehensive plan needs to be in place that addresses policies and guidelines, infrastructure, workforce development, evaluation and service delivery that support individuals and respects different cultures. This may also require managers to look at incorporating cultural competence principles and strategies into the following:

- Mission statements
- Policies and Procedures
- Staff recruitment and retention
- Data collection
- Staff orientation and induction
- Professional development opportunities
- Interpreting and translating processes
- Research tools
- Community partnerships
- Health promotion activities
- Complaints mechanisms
- Client satisfaction surveys
- Capacity building
- Action research involving consumer consultants
- Key performance indicators (KPI’s)
- Program work-plans

To encourage cultural diversity within the workplace managers may want to consider an affirmative action policy to address the difficulties people from CALD & ATSI backgrounds have in obtaining work. Also, traineeships could target new entrants to the sector.

Managers need to be aware that often staff reflects the views and attitudes of the community. Staff can still hold prejudices and discriminate against people even if they are employed in disability, aged care, mental health, etc. Managers should also not assume that people from CALD & ATSI backgrounds do not need cultural competency training. Managers need to show honesty and transparency about their core values, both personally and at an organisational level, and how these values can pan out in the organisation and impact on service delivery. This involves engaging workers in a process of critical thinking and reflective practice around their own values, and values training.

A possible ‘Plan of Action’

The following is a possible process for managers in considering cultural competence:

- **Conduct a cultural audit** - e.g. What is the current level of cultural competence and understanding within your organisation? How does staff rate their confidence in working with people from CALD & ATSI backgrounds? Which group(s) are you trying to access as service users?
- **Look at the training needs and governance structure within your organisation** - e.g. Diversity on the committee, policies and procedures to encourage recruitment of people from diverse cultural backgrounds, policies that reflect equity and social justice principles,
policies and practices that prevent discrimination

• **Ask about organisational change** - What structures are in place to allow for change to occur? What have you, as a leader, implemented before in your organisation/community to promote cultural competence?

• **Hold focus groups with consumers and carers** - Possibly administer a questionnaire to gauge important issues, and what a culturally competent organisation would look like to them

• **Networking** - What is the demographic of the group you are trying to connect with?

• The use of cultural brokers to access certain groups

• Do you have, or should you consider, an **affirmative action policy** to address the difficulties people from CALD & ATSI backgrounds have in obtaining work

• Devise a **Diversity Management Plan** for your organisation

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**Building a model of cultural competence**

**Principles of cultural competence**\(^\text{135}\):  
- Engaging consumers, carers and communities and sustaining reciprocal relationships
- Using leadership and accountability for sustained change
- Buildings on strengths - know the community, know what works
- A shared responsibility - creating partnerships and sustainability

**Strategies include**\(^\text{136}\):  

1) **Partnering with ethnic communities**
   - CALD & ATSI background consumers and carers on Boards of Management
   - Consumer and carer planning days
   - Consumers and carers on project/reference groups
   - Consumer advisory groups
   - Carer advisory groups
   - Focus groups
   - Informal get-togethers and printed materials

2) **Ongoing networks and relationships with CALD & ATSI background communities**, maintaining community demographic profiles and ensuring that services and delivery are responsive to community consultation findings

3) **Program design should support reciprocity and shared learning** through ongoing dialogue and exchange of information to encourage capacity building

4) **Evaluation processes** are established and findings are shared with the organisation and community

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**How to measure cultural competence**

Culture influences the life and behaviour of everyone, even if we are not consciously aware of it. It is always changing and complex because it will mean different things to different people. To be culturally competent requires an ongoing commitment to understanding others and a meaningful way to evaluate this.

At an organisational level cultural competence policies should be developed in partnership with consumers and carers and endorsed by management to provide clear direction to all staff of the organisation's expectations and emphasise its importance in the work staff undertake. A set of agreed **Standards of Practice** will further enhance staff understanding of cultural competence and serve as a practical guide to work performance that is uniformly applied across the organisation.
Key Performance Indicators on cultural competence should be included in an organisation’s Strategic Plan and can be used to regularly evaluate an organisation’s cultural competence, highlighting strengths and areas for improvement.

There are tools and checklists that exist for individuals to assess their level of cultural competence. These require great transparency on the behalf of the individual and the capacity and willingness to self-reflect. They can provide good baseline information for the individual, and can highlight areas that require further training, professional development or mentoring opportunities.

Aboriginal and Torres Strait Islander (ATSI) communities

Cultural competence should aim to meet the needs of ATSI communities and recognise ATSI health workers as a key component of the workforce. There are nine principles as outlined in the National Strategic Framework for Aboriginal and Torres Strait Islander Health\(^{137}\) that can be used by organisations to assist in the development of cultural competence and they are:

1. Cultural respect
2. A holistic approach - recognising that Aboriginal and Torres Strait Islander health must take in to account physical, spiritual, emotional and social well-being, community capacity and governance
3. Health sector responsibility
4. Community control of primary health care services
5. Working together
6. Localised decision-making
7. Promoting good health
8. Building the capacity of health services and communities
9. Accountability for health outcomes

To achieve these principles in practice the community mental health sector needs a compassionate, collaborative, diverse and skilled workforce so that it has the capacity to address the complex needs of ATSI communities. As such, specific recruitment and retention strategies are needed such as relevant training, professional development opportunities, regular supervision and sector support of both non-Indigenous and Indigenous Australian mental health staff working within Aboriginal services.

Some things to consider when working with ATSI communities include:

- ATSI people strongly identify with their cultural links to the region or “Country” from which they or their family/ancestors originate. Staff should endeavour to find this information out for all ATSI people they are working with. The boundaries of each ATSI Country or Nation are often loose and do not conform to state or suburban boundaries. Each has its own specific culture and it is a generalisation to say that there is one overall ATSI culture
- ‘Mental Health’ translates in ATSI communities as a person’s social, family, work, emotional, spiritual and physical well being
- A person’s kinship network (family) is extended and flexible and sharing resources amongst kin is considered the norm and part of a complex cultural system
- Mental Health Workers need to work in partnership with the Aboriginal Medical Service (AMS) & ATSI communities, particularly Elders and established local representative bodies, such as Community Working Parties, as they are in the best place to advise staff of the needs of their community
- AMS staff knows individuals and their kinship networks, e.g. who is grieving, unwell. They can provide an important link or introduction for mental health workers to individuals requiring support, which can assist in establishing trusting relationships
- ATSI communities do not like the term ‘consumer’ preferring ‘mental health survivor’
- Organisations need to be aware of the importance of attendance at funerals. Word will spread within the community that the organisation is a ‘good mob’
• When inviting ATSI Elders/communities to participate in a meeting or forum it is important to always provide a decent feed and transport. This will increase attendance and participation. Arrange chairs in a circle and conduct the meeting in an informal way allowing Elders/community representatives to lead the conversation. This will assist with communication and help build relationships. One idea is to start the meeting around the food table and then move to the chairs as the conversation unfolds.
• There is a need for ongoing communication with mainstream services, including notification of ‘at-risk’ people and communities, as a proactive strategy to prevent mental health problems from escalating to crisis point or psychosis.
• Mental Health Workers in mainstream services tend to work set shifts/regular hours, whereas AMS workers are on call 24/7 and can sometimes live in the communities in which they work, particularly in remote areas, and may have family connections to people they or their colleagues work with.
• Mental Health and Community Care Workers will need to follow-up appointments/activities with phone calls or visits to ensure the person(s) is still able to attend. It is ok to keep trying to call or to leave a ‘calling card’, but be mindful of a person’s level of literacy when choosing this approach.

Yarning about mental health
– A tool kit for culturally competent practice with ATSI communities

Essentially, yarning is about building rapport and getting to know each other better through telling stories and talking about an individual’s strengths and family connections. Through yarning with Aboriginal people, staff should have a better understanding of:
  • The issues facing the individual they work with;
  • The broader family/community context and specific cultural issues; and,
  • How best to recognise and respond to the individual’s mental health problems.

The Yarning about Mental Health method is about improving outcomes for ATSI people living with a mental health problem. It is a tool that can be used as part of staff development for people working with ATSI communities and as a part of a collaborative recovery approach to service delivery.

Stay Strong Talking Treatment

Staff can use the following topics as a guide to yarning with ATSI people about mental health.

Step 1 Family who keep a person strong
Step 2 Things that keep a person strong
Step 3 Problems that take a person’s strength away
Step 4 Goals for change and steps towards these goals
Step 5 Early signs of relapse and a crisis plan
Step 6 Discuss your risk assessment and the follow up to be undertaken, including the impact for the individual and/or their kin

Stay Strong Pictorial Treatment

The pictorial ‘Mental Health Stay Strong Care Plan Package’ is a brief motivational interviewing approach to care planning with ATSI people – from initial problem assessment through to goal setting and review. It is structured, sensitive and flexible to the needs of both people affected by mental health problems and mental health service providers.

Yarn about the following in conjunction with using the pictorial aid:
  • What keeps us strong?
  • What makes us sick?
  • What are we like when we are sick?
  • What gets us well again?
Chain Reaction Foundation is an organisation that works to create strong social inclusion both nationally and locally. It operates out of a philosophy that says - We greet you with great respect and with real affection, and ‘each one teach one.’ The Foundation has a small culturally diverse paid staff and a large team of volunteer specialist consultants and partners working at the national and local level in a pro-bono capacity. These men and women are drawn from diverse cultural faith, intellectual, and socio-economic backgrounds, and both agree to and practice the philosophical thought of greeting and working with each individual and client group in the spirit and manner suggested. The model of reciprocity is used in all our work - something in this for you and something in it for me. The Foundation believes in the practice of ‘each one teaching one’ - I will teach you something you don’t know, and you will teach me something I don’t know. The work is carried out in an atmosphere of equality and remarkable steps in personal and community development follows. Chain Reaction prioritises work with Australian Aborigine communities as members of our first nation. We recommend The Indigenous Cultural Awareness Programme (ICAT) to all organisations interested in promoting effective partnerships and collaboration in local communities.
What will you get out of this chapter?

- An understanding of what is professional development and why it is important
- How to conduct a learning and development needs analysis - individual, team and organisation
- Professional development strategies
- A practical & holistic way to conceptualise career pathways in this sector
- An understanding of the VET and higher education options for staff

Professional development should always be contextualised within a recovery-oriented framework. It plays an important role in enabling the workforce to promote recovery, develop recovery skills, and to convert the philosophy of recovery into reality, in partnership with consumers and carers. This chapter provides managers with the strategies and opportunities available to build basic skills and competencies in current and future Community Mental Health Support Workers, Consumer Workers and Carer Workers.

What is professional development?

Professional development has traditionally been thought of in terms of training and development. It is true that skills training and capacity building, by-products of professional development, lead to an increasingly sustainable and capable workforce. However, professional development is now seen to include a range of options which develop workers’ knowledge, skills and attitudes in order to ensure that they can work confidently and effectively, thus improving service provision. Professional development incorporates supervision and mentoring opportunities, on-the-job training, leadership training, and organisational structures to ensure the creation of a learning culture that embraces recovery principles and practices in the workplace.
Why is it important?

Professional development is a crucial part of staff development. Managers in the community mental health sector cite as one of their greatest needs access to appropriate and affordable training opportunities that has a community delivery focus and that allows people to learn in more flexible ways. It is important that managers work together with staff, consumers and carers to recognise current skills and knowledge, identify areas for development, and then help staff to incorporate recovery practices into professional development goals. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

The diversity of the community mental health support, consumer and carer workforce, in terms of the range of skills, experience and qualifications of its workers, is the greatest resource for this sector. However, one of the challenges for managers is to ensure that all current workers are properly qualified to deliver services, and future workers are provided with appropriate training. The introduction of a voluntary minimum standard qualification for community mental health work will ensure managers are clear on core skills needed for work in this sector. This will enable the transfer of skills across the sector which will strengthen the whole workforce. Clear entry points into community mental health work will also promote this sector and community mental health as a viable career option. This promotes a culture of professionalism across the sector and can help break-down the distinction between clinical and non-clinical services. Increased professionalism also supports workers to understand the value of skills training and continuing professional development. This becomes particularly important as Community Mental Health Support Workers, Consumer Workers and Carer Workers increasingly need to be trained in specialist skills in addition to the core skill base to meet the changing needs of consumers.1

The community mental health sector is a sector where on-the-job training and reflective practice plays a particularly important part in the transfer of skill. Managers should strive to promote and maintain a structure within the organisation that allows for this flexibility of learning.

Barriers to successful professional development:

- Training in the past has been ad-hoc with a ‘skills deficit’ focus
- At times the courses that staff express interest in attending are not relevant to their work or organisational goals/values
- Backlog or filling positions while people attend training
- Excessive/intensive workload
- Fragmented employment structures (i.e. a higher proportion of part-time, causal and contract workers)
- Training is seen as taking employees away from service delivery and direct service provision
- Difficulties knowing how to disseminate and implement this new information across the organisation once the training is complete
- High cost of training and courses
- Difficulty for geographically remote or rural organisations to access training

How to conduct a learning and development needs analysis in your organisation

Why is a needs analysis useful?

The first step for managers in addressing professional development is to undertake a thorough and accurate learning and development needs analysis within the organisation. This is a systematic assessment of the learning and development needs of the individual, team and organisation. This identifies gaps in existing knowledge and skills, and allows management to plan, in collaboration with all staff, the most appropriate and significant staff development strategies that will lead to better workplace practice. A learning and development needs analysis may uncover other areas for development, such as policies, procedures and paperwork used to support the provision of services. A needs analysis is not limited to identifying training needs only – it often...
has the indirect benefit of identifying areas in addition to learning needs for review and development. This is where a careful consideration of resources will assist in prioritising needs, and different strategies will be appropriate for different areas of need. It may be worthwhile to consider the use of an external consultant to assist throughout the needs analysis process.

**Step 1 - Conduct a learning and development needs analysis**

The learning and development needs analysis is designed to identify the skills and knowledge of the current workforce as well as identifying the anticipated competencies needed to meet future requirements. The learning and development needs analysis will provide information on the areas of greatest priority for further development.

As part of this learning and development needs analysis, managers need to ensure that all staff has up-to-date job descriptions (see Workforce Development Pathway 4). This is best done in collaboration with existing staff.

Once the job descriptions are clear, managers, together with staff, can then create an individual learning and development analysis, which provides information on the ‘match’ between actual skills of workers and skills required for current roles. This provides an opportunity to see in which areas individual staff may need or want further professional development. This will guide the kind of professional development strategies implemented by management. An individual needs analysis is also about aligning the current workforce’s skill set with the organisational goals and vision, and addressing possible career pathways for current workers. Involving consumers and carers in this process will also identify areas that they consider important to professional development to enhance service delivery and recovery outcomes.

**A team needs analysis** is distinct from an individual needs analysis. It is recognised that individual skills and competency alone does not secure team effectiveness and success. The team needs analysis should be conducted in a similar manner, however, beginning with a clear definition of the skills and knowledge required for their roles and duties. It may be useful to form a group of staff to ‘champion’ this team needs analysis in partnership with management.

**Organisational/agency learning and development needs analysis** involves a comprehensive study of the individual skill and knowledge base set against the organisation’s goals and values, and deliverable outcomes. It exposes organisational factors, such as resources available and support systems, which may help or hinder the transfer of new knowledge and skills or the implementation of professional development strategies. It outlines the current skills being used by the organisation, and any skill gaps which need attention.

The kind of information to be gathered in a learning and development needs analysis:

- Current skills and knowledge
- Actual job requirements
- Skills and knowledge to be learned on-the-job
- Skills and knowledge to be gained from professional development
- How successfully are roles being performed, i.e. job performance
- Areas that staff recognise they would like to improve or learn
- Career pathways
- Future requirements for staff and organisation and will the current skill and knowledge set address these needs
- Consumer and carer perspective
Step 2 - Set goals

The findings from the learning and development needs analysis will provide impetus to form goals and objectives for professional development. They will also form a clear picture of areas of potential growth in order to meet current needs and future demands. There may be areas that need to be strengthened or revised, or new skills and knowledge to be taught from the beginning.

Goals are most effective when they follow the SMARTER guideline, that is, they are specific, measurable, attainable, realistic, timely, evidence-based and reviewable. Goals should also be challenging and meet the needs of both the individual and the organisation so that everyone involved is motivated and committed to achieving the set goal(s). Goal development also allows managers and staff to together prioritise their needs, ensure that there is a common understanding of the goals, and define outcomes that will be used to evaluate the success of the professional development strategy.

Step 3 - Develop a learning and development plan

This step involves the coordination of individual, team and organisational needs into a cohesive plan that addresses the goals formulated in the previous step. Again, this is a collaborative process between managers and staff. The success of the learning and development strategies depends largely on how well you have planned implementation. To be covered during the planning stage:

- The resources - financial, expertise, facilities and other - required to implement changes
- How success will be measured and evaluated
- Target dates and behaviours
- Goals and objectives of professional development
- The people managing or overseeing the program
- The professional development needs of particular people, roles, teams, etc.

Step 4 - Identify and implement professional development strategies

External training can be both costly and impractical in community mental health organisations where time and staff are tightly resourced. Training is not sufficient on its own, and the extent to which new skills and knowledge are disseminated in the workplace depends on the structures and management in place that allow for transfer of skills.

Managers need to be innovative in their approach to professional development. There are a range of different, interesting, in-house professional development activities which can provide excellent opportunities for exchange of skills and knowledge, reflection, up-skilling, networking, and personal development. The most important thing is that managers need to assess the ‘best fit’ for the organisation and provide a range of options for the workforce.

Professional development strategies include:

- Study groups
- Supervision and mentoring
- Coaching
- Planning days
- Site visits
- Journal clubs
- Online discussion groups
- Cross-organisational exchanges
- Online learning
- Professional association membership
- Internships or placements

Step 5 - Evaluation

Evaluation is an important tool in any venture to measure success and make improvements to
future initiatives. In the case of learning and development strategies, a comprehensive evaluative process will ensure that the initiative has been effective in achieving its goals and the organisation and individuals have benefited in some way. It will also identify the areas to be improved upon in the future. There is no one way to conduct evaluation in your organisation as it will be determined by a range of organisational factors and the outcomes being measured. However, some things to consider about evaluation:

- What is it exactly you are trying to measure? What were the original goals?
- What would be the most appropriate way(s) of measuring outcomes, i.e. methodology? Consider size of organisation, culture, available resources
- Are you interested in short-term outcomes or long-term outcomes?
- What is a measure of the success of your learning and development strategies/needs analysis? How will you know if you have succeeded?
- Who is it important to involve in this evaluation process?
- What avenues exist for feedback?
- What are the individual/team/organisational outcomes?
- What can be improved upon in the future?

It is important in any initiative to have robust qualitative as well as quantitative information to help improve transfer of training into practice and implementation of new practices. There is a need to develop greater quantitative measures for evaluating the effectiveness of learning and development initiatives.

Career pathways - Professional and personal well-being

Clear career pathways, in the traditional sense of leading to increases in remuneration and job role/responsibility, are not always feasible in the community mental health sector. For this reason, this guide speaks in terms of the importance of ‘professional and personal well being’, which acknowledges other ways by which managers can increase worker well being and satisfaction. It does not wish to diminish the importance of career development, but is a shift of thinking to a more holistic view of professional goals and aspirations. It is about making frontline work in community mental health a legitimate and respected career choice.

If people are satisfied in their job, and feel ‘safe’ in their work environment, then career pathways become less of an issue. The process of reflective practice, both personal and organisational, is part of promoting well-being at work. If the organisation is mirroring the individual’s reflective practice, and vice versa, and each are responding to changing needs, then the worker is likely to feel greater congruency with their job role and professional goals, and more efficient.

Job satisfaction and worker well-being are very much tied in with how appreciated a worker feels, and if they are rewarded for their good work. If a frontline Mental Health Support Worker has shown excellence in support work, this is not to say they necessarily have the qualities to become a manager. A movement up the career ladder may in fact take them further away from using the skill-set where their talents lie, where they are happiest, and where they are most valuable to the organisation. Here it is about providing opportunities for professional and personal development.

Organisations need to think laterally in terms of career pathways for Mental Health Support Workers, Consumer Workers and Carer Workers. An example of this is creating senior titles, e.g. Senior Support Worker Role which recognise excellence and expertise in a particular area, or accepting movements across organisations as a sign of strengthening community health organisations. Encouraging a ‘sideways’ movement within an organisation that is clearly explained and outlined at the recruitment level allows Mental Health Support Workers, Consumer Workers and Carer Workers to see where they can move, and areas where they might want to become more skilled or set professional goals.

Providing opportunities to multi-skill staff enables lateral movements within the organisation, for example, staff can nominate to fill positions as they become vacant or if
someone is absent/un-well. By enabling staff to become multi-skilled and try working in different areas staff learn what they are good at and enjoy most.

As part of review, managers should spend time with staff developing their professional and personal well-being - asking staff their training needs, looking ahead to where they see themselves in five/ten years time, and then helping them to achieve this. This symbolic gesture by management shows that they are taking the time to listen to the needs of the staff, getting to know staff, and helping them to achieve their goals. It is also about transparency - that is, acknowledging the constraints within which the organisation has to operate, but working together to come up with innovative and satisfying ways to support and foster personal and professional growth. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

**Increasing the professionalism of staff**

There is a strong need to increase specialist recovery-oriented, community-based mental health skills across the sector and ensure uptake of an acceptable voluntary minimum standard qualification and/or qualifications. It is important that organisations have the structures in place to allow for skill expansion so that workers remain within the organisation and committed to their job roles. The following information discusses qualifications and possible pathways in community mental health. In order to have coordinated, best practice services, managers need to look at the qualifications, or potential qualifications, of staff.

**Higher education**

There are a range of higher education courses available in areas such as, but not limited to, Social Work, Nursing, Psychology, Occupational Therapy, Applied Social Science, Behavioural Health Science, Counselling and Communication, Health Sciences, Management and Governance. Courses are available at the Bachelor, Masters, Doctorate, Graduate Certificate, Diploma or Graduate Diploma level. It is a case of contacting the relevant institution for further information and course outlines.

**Vocational education**

Vocational Education Training (VET) is vocational/skill-based, and as such, provides a wonderful opportunity for managers to sit down with their employees, and speak directly about their job roles and responsibilities to identify competencies they are already using and competencies they would like to develop. The focus is on the work they do, and supporting workers to do their job well. Managers can then recognise current competencies and suggest particular training for further development which may be vocationally based and part of the Australian Qualifications Framework (AQF).

**Australian Qualifications Framework**

The first agreed framework, called the Australian Qualifications Framework, (AQF) enables different training organisations throughout Australia to issue the same type of qualifications. The same rules apply throughout Australia. The AQF can be summarised as being:

<table>
<thead>
<tr>
<th>AQF Level</th>
<th>Relevant qualification</th>
</tr>
</thead>
<tbody>
<tr>
<td>AQF 1</td>
<td>Certificate I</td>
</tr>
<tr>
<td>AQF 2</td>
<td>Certificate II</td>
</tr>
<tr>
<td>AQF 3</td>
<td>Certificate III</td>
</tr>
<tr>
<td>AQF 4</td>
<td>Certificate IV</td>
</tr>
<tr>
<td>AQF 5</td>
<td>Diploma</td>
</tr>
<tr>
<td>AQF 6</td>
<td>Advanced Diploma</td>
</tr>
<tr>
<td>AQF 7+</td>
<td>Higher Education Qualifications</td>
</tr>
</tbody>
</table>
Australian Quality Training Framework

The second agreed framework called the Australian Quality Training Framework (AQTF) enables different assessors throughout Australia to accept the assessments of each other, because they follow the same rules and assess to the same standards. It also enables people to gain a qualification through the skills recognition assessment process.

National Training Packages

The third agreed framework, called National Training Packages, enables specific workplace competencies to be identified across all industries in Australia. This means that, in those industry areas where national workplace competencies have been identified, a participant can be assessed against them by a qualified assessor. The Community Services Training Package CHC02 is most relevant for the community mental health sector and includes the Certificate IV in Mental Health Work (non-clinical) CHC41102.

Outcomes can be decided by the worker, who, for example, can achieve a Statement of Attainment following successful completion of competence units or pursue a more formal qualification such as the Certificate IV in Mental Health Work.

The Certificate IV in Mental Health Work (non-clinical)

The Certificate IV in Mental Health Work has been agreed to by MHCC member organisations as the accepted voluntary minimum training standard for front line workers in community mental health services. There are a range of Registered Training Organisations (RTO’s) available to assist workers to complete the qualification through a variety of pathways including recognition of prior learning and course-based delivery. The National Training Information Service (NTIS) provides a list of RTO’s who currently offer the Certificate IV in Mental Health Work [www.ntis.gov.au]

Financial assistance for your organisation

Mental Health Work Traineeships are now available for health and community services in NSW. The State and Federal Government offer traineeship options to assist your workforce to become skilled and qualified to achieve the Certificate IV in Mental Health Work. Traineeships are a fantastic way of attracting new entrants to the sector by providing career and learning pathways that lead to a nationally recognised qualification. Existing workers may also be eligible for a Government incentive to complete the mental health qualification. To find out more about traineeships visit [http://www.australianapprenticeships.gov.au/] or [http://apprenticeship.det.nsw.edu.au]
How to complete the qualification

There will be varied pathways to achieve the Certificate IV in Mental Health Work depending on the RTO. The key concept is to allow for flexible practice. Some of the possible pathways are:

<table>
<thead>
<tr>
<th>Pathway</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Course pathway</strong></td>
<td>Most suited to someone with no qualification and little experience. This option includes training, assessment and workplace based projects.</td>
</tr>
<tr>
<td><strong>Blended Pathway - Recognition of Prior Learning (RPL) and Training</strong></td>
<td>Most suited to someone with some qualifications and experience who needs to attend some training. This option includes collection of evidence, training and assessment.</td>
</tr>
<tr>
<td><strong>Full RPL</strong></td>
<td>Most suited to an experienced worker who may have some qualification(s). This option includes collection of evidence, e.g. work documents and may also include completion of assessment tasks (individual units only).</td>
</tr>
</tbody>
</table>

Pathways to other VET qualifications in the Community Services Training Package (2002)

<table>
<thead>
<tr>
<th>Certificates</th>
<th>Diploma</th>
<th>Advanced Diploma</th>
</tr>
</thead>
</table>
| Certificate IV in Community Mental Health Work | Diploma of Community Services Management  
Diploma of Community Welfare work  
Diploma of Community Services (Case Management)  
Diploma of Community Services (Financial Counselling) | Advanced Diploma of Community Services Management  
Advanced Diploma of Community Services Work* |

*Please note that there are no prerequisite requirements for course entry except the Advanced Diploma of Community Services Work, which is based on work experience.

Education in Practice

The stories below are designed to illustrate how higher education and vocational education can be made relevant to the community mental health sector for people at various entry points in to the sector, and with a range of experience levels and professional goals.

**James** is 26 years old. He completed a TAFE course in Community Services 8 years ago, and recently undertook a traineeship to complete the Certificate IV in Mental Health, through a combination of RPL and coursework. He approached his manager because he wanted to pursue higher studies in mental health, and eventually child and adolescent psychology.

Where to from here?

James was able to enter directly into a Bachelor of Behavioural Health Science, which he completed whilst balancing part-time work. He is now eligible to enrol in a Master of Health Science (Child & Adolescent Health).

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1 Note that this training package is currently under review. The 2009 Community Services Training Package will include a new Diploma in Community Services Practice with a mental health and/or substance use specialisation as well as new “skill sets” for identifying and responding to people with mental health or substance use problems.
Carol is a Manager, with 30 plus years of sector experience. She has seen the changing face of mental health, and is working with more clients with Alcohol and Other Drug (AOD) issues. Carol wanted recognition for her managerial skills, but needed up-skilling in working with AOD client.

Where to from here?

Carol was able to complete the Certificate IV in Mental Health Work by full RPL, including an elective in working with consumers with mental health and AOD issues, and then go on to complete a Graduate Diploma in Health Management. Carol is now interested in pursuing health management studies at a Masters level, and she meets requirements to do this.

Sue is 34 years old, worked as a Community Mental Health Worker for 5 years, and has a background in nursing. She is currently working in a HASI program and wanted to receive a formal qualification.

Where to from here?

Sue was able to complete a Certificate IV in Mental Health Work, with the support of her workplace, through RPL.

Rob is 21 years old, he recently completed a university degree in Psychology. He has had some work experience in a private mental health organisation. He wants to gain further experience across a range of activities. He is attracted to the idea of receiving training whilst at work, as he wants to enter the workforce.

Where to from here?

Although Rob was uncertain about completing the Certificate IV in Mental Health Work, he recognised that he needed practical skills in mental health work. He was able to receive some RPL and completed the rest of the qualification through face to face training. He was able to incorporate training with learning-on-the-job.

Matt is 27 years old, from a CALD background, completed a Certificate III in Disability 8 years ago and is currently working with people from CALD backgrounds. He would like to increase his skills and knowledge in working with people from Aboriginal and Indigenous backgrounds.

Where to from here?

Matt was a good candidate/eligible for a traineeship - he completed the Certificate IV in Mental Health Work via full course attendance. In addition, his manager was able to find a short course on working with Aboriginal and Torres Strait Islander people which Matt completed.

Individual performance management

It is important that there are clear policies and procedures in place which address performance management issues, including the required probationary period for workers and the conditions of employment. In the event of poor performance or unacceptable behaviour, managers need to be clear on the disciplinary action to be taken. Disciplinary action is required by an employer to correct actions that are not in accordance with organisation policies or customs. It may occur as a response to any form of misconduct.

A good job description should cover agreed performance outcomes and planned professional goals for the individual worker. Performance standards and review needs to be built in to the policies and procedures manual of the organisation. A regular review process of job descriptions and roles should happen at least twice a year, and an individual appraisal should be conducted on an annual basis. Reflective practice engages workers in a kind of individual performance management through a continuous process of considering one’s own experience of applying knowledge to practice, and learning from experience.

A key question for managers to ask in developing a performance management program is - ‘Are your performance management processes compatible with the organisation’s vision and mission?’ That is, are the skills, attributes and demonstrated behaviours that you are ‘check-listing’ in individual staff appraisal in keeping with the organisation’s culture and goals?
There are several ways to assess and monitor staff performance. These include:

- Supervision and support processes;
- Probationary period and annual appraisal;
- Staff surveys;
- Training attendance rolls;
- Training Needs Analysis; and,
- Observation.

**Workplace example - New Horizons Enterprises Ltd**

New Horizons Enterprises Ltd is a not-for-profit, NGO providing a wide range of community support services. New Horizons Enterprises has been in operation since 1981 and have experienced massive growth particularly over the last five years. We currently support over 2000 people.

Due to organisational expansion across NSW we have appointed a Learning & Development Officer to assist with identifying training needs and to provide specific training opportunities to staff. Training needs are mapped through monthly supervision meetings, annual performance appraisals and/or via requests from staff and supervisors.

It is important to note that when implementing a professional/career development plan it should not only reflect the needs of staff, legislative and organisation requirements but also the changing needs of the people we support.

We are currently supporting 65 employees to gain formal qualifications. Of the 65 traineeships being managed, 80% are undertaking Certificate IV Mental Health Work, which we consider to be an entry level requirement.

New Horizons is proud to launch the Inaugural Mental Health Support Workers Conference ‘Building Resilience’. This initiative was spearheaded by our HASI (Housing Accommodation Support Initiative) State Manager. The aim of the conference is to provide “Frontline Support Workers’ with an opportunity to learn from sector leaders, network with one another, share their experiences and promote best practice.

New Horizons is also involved in a number of consumer research and development projects.

In summary, New Horizons aims to provide training that is not only linked to various roles but that hopefully enhances job satisfaction and increases industry skills and knowledge.
What will you get out of this chapter?

- A clear understanding of the difference between clinical supervision and line supervision
- A clear understanding of the role and importance of supervision, mentoring and coaching
- An understanding of reflective practice and its importance in supervision and support practices
- What is considered good practice in supervision, mentoring and coaching?
- The pros and cons of external versus internal supervision

Supervision and support practices, as part of workforce development, can be useful to assist with recruiting staff, retaining valuable staff, supporting and encouraging good practice, worker well-being, and engaging in reflective practice. Supervision allows staff to reflect on the core tenets of recovery and recovery-oriented services. The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system.

It seems that there is a hybrid kind of supervision that occurs in the community mental health sector. Possibly due to budget and time constraints, it often does not seem appropriate to consider the process of supervision, mentoring and coaching as happening distinctly, they are all closely linked. Managers should be clear on exactly what the organisation offers in terms of supervision and support, its purpose and goals.

Supervision and support needs will be different for different organisations but this can be easily understood by means of a needs analysis. The key is for managers to trial and evaluate different supervision and support programs to find the most appropriate model for the organisation. This could include promoting that there is a process in place for staff to access Employee Assistance Programs (EAP) on an as needs arise basis.
Definitions and terminology

What is supervision?
Supervision serves an educative and supportive function. It is an opportunity to raise professional issues and gain further expertise. Supervision allows an individual to learn from their own experiences in working with consumers, review and debrief approaches to recovery-oriented support practices, and ensure that service delivery is following best practice standards. The supervisor must have skills to facilitate regular and systematic supervision. Supervision can be facilitated by an individual, in a group setting or in a triad, with an additional facilitator, to suit the size and culture of the organisation. Group supervision may be a more feasible option for smaller or rural organisations.

What is clinical supervision?
In some community organisations, because of the staff employed, a clinical model of supervision is in place. Traditionally, the word ‘clinical’ has been associated with a medical model of treatment and care and one that does not ‘fit’ with recovery principles in the community mental health or ‘non-clinical’ setting. This clinical model focused on decompartmentalising or ‘breaking down’ a person’s symptoms, and treating them systematically. However, clinical services are now recognising the importance of looking at individuals holistically, taking into account context and other factors for their mental well-being, e.g. connectedness to other people, occupation and proper housing. As a result of mental health and other services attempting to work more closely and in partnership across all settings, the definitions of ‘clinical practice’ seems to be blurring. However, community mental health organisations, whether delivered in non-clinical or clinical settings, do share the following aspects of clinical practice - professional/trained staff working in partnership with consumers in a setting (be this a community mental health centre, the person’s home, etc.) according to knowledge and evidence-based practice, to provide recovery-oriented interventions and support for people living with a mental health problem.

What is line supervision?
This category of supervision includes operational supervision, which may be provided by a line manager. A line manager has a clear line of accountability. They are responsible for day-to-day management of workplace practices and service delivery, planning and monitoring workload, ensuring quality of work, ensuring health and safety, time management, motivating, administration and record-keeping.

What is managerial supervision?
This is a kind of professional supervision which is provided by a professional senior from the same discipline. Professional supervision from a manager/senior is about ensuring good governance is being followed and that the organisation is working in accordance with its goals and vision. Professional supervision could cover some/all of the following areas:

- The context of professional practice (systemic competence and role efficacy);
- The conceptualisation of strategy (conceptual competence and ethical judgement);
- The competent response to expressed client need (technical skills); and,
- Critical self-awareness (personal development).143

Management appraisal systems and supervision should run parallel to each other, although agendas for each can be identified and planned in either setting.

As the consumer and carer workforce grows it is important to consider different supervision and mentoring practices that are appropriate to different job roles. For example, a Consumer Advocate compared to a Peer Support Worker may require different supervision or support practices as part of their professional and personal development. Again, this is about finding the right ‘fit’ for the staff and organisation - if this happens, supervision practices can provide a wonderful opportunity for personal and professional development and positive service outcomes. Consumer Workers often receive supervision that is the same for Mental Health Support Workers. Mismanagement of staff in consumer and carer designated roles, where there may have been no supervision or problematic
supervision, has in some cases lead to role confusion and strain, conflict of interest, staff becoming unwell, and other negative consequences. The supervision needs of Consumer and Carer Workers is an area that needs to be explored further as there is no current evidence of what is most effective and appropriate practice.

Table 3 - Typical roles and responsibilities of line management supervisor versus supervisor

<table>
<thead>
<tr>
<th>Line management supervisor</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Resource Management (e.g. time/attendance, leave, disputes, performance)</td>
<td>Facilitate skills and knowledge acquisition, engage in reflective practice, ensure service delivery is following best practice &amp; recovery-oriented standards</td>
</tr>
<tr>
<td>Budget/resource issues</td>
<td>Educating (teaching, facilitating, conceptualising about professional issues, evidence-based interventions/best practice/recovery-oriented service systems)</td>
</tr>
<tr>
<td>Change management</td>
<td>Mentoring (e.g. monitoring, evaluating, promoting enhanced organisational skill)</td>
</tr>
<tr>
<td>Work allocation</td>
<td>Supporting (listening, understanding, reflecting)</td>
</tr>
<tr>
<td>Approving practice supervision agreements</td>
<td>Ethical issues</td>
</tr>
<tr>
<td>Code of Conduct issues</td>
<td>Code of Conduct issues</td>
</tr>
<tr>
<td>Client management</td>
<td>Negotiate content of supervision agreement with supervisee</td>
</tr>
</tbody>
</table>

What is mentoring?

Mentoring can be defined as either an informal or formal process and can be an important professional development tool for staff, including for managers. Informal mentoring develops on its own between the individual staff member and desired mentor, and formal mentoring involves allocation of a mentor. Both processes can be encouraged and supported by the work place. Mentoring can be provided by someone from within the organisation or an external person. This person may be engaged in the relevant field of practice or involved in a separate field. The mentor provides counsel, insight and guidance and acts as a sounding board for ideas and decisions that relate to the mentee’s career. A mentor can provide advice in professional development strategies, planning career goals, establishing contacts in the field of interest, feedback and exchange of ideas. The idea of a mentor is someone with qualities that appeal to the individual’s sensibilities and professional objectives, be they skills, expertise or shared vision. The individual is ‘taken under the wing’ of the mentor and helped to reach their career goals and make networks. This relationship can be ongoing and a point of reference throughout that individual’s career.

What is coaching?

Coaching is a method of improving individual or team performance through direction and instruction in order to learn a particular skill or work towards a set goal. It usually involves an external expert or coach who is bought in to work on a particular issue. This can be achieved through workshops, seminars and supervised practice. As applied in the mental health field, the key to coaching is the focus on one’s goals and vision.
Table 4 - Supervision and support strategies available to organisations

<table>
<thead>
<tr>
<th>Focus</th>
<th>Line Management</th>
<th>Supervision</th>
<th>Mentoring</th>
<th>Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus</td>
<td>Meet policies and procedures of the organisation</td>
<td>Build good practice in clinical skills; skill &amp; knowledge acquisition</td>
<td>Career development and psychological support</td>
<td>Learning specific issues and skills</td>
</tr>
<tr>
<td>Delivery</td>
<td>Clear delineation with job descriptions and organisational chart</td>
<td>Clear contract – can be internal or external supervisor</td>
<td>Supported by the organisation</td>
<td>Clear contract with outside expert</td>
</tr>
<tr>
<td>Target group</td>
<td>Individual</td>
<td>Can be done on individual or group basis</td>
<td>Primarily on an individual level but can be done as a group</td>
<td>Learning and progression for individual or team around issue</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Against agreed performance standards</td>
<td>Improved and current clinical practice; service delivery that follows best practice standards, increased insight/knowledge</td>
<td>Guidance on developing career path and making career forwarding choices</td>
<td>Improvement in specific skills required for role</td>
</tr>
</tbody>
</table>

Reflective practice

Reflective practice is a professional development technique that involves thoughtfully considering one’s own experiences in applying knowledge to practice while being coached by professionals in the discipline. It is a self-regulated and continuous process. It requires the individual to either:

a) ‘Reflect in action’ - This involves looking to our experiences, connecting with our feelings and individual frames of reference or understanding, or ‘thinking on our feet’, or

b) ‘Reflect on action’ - This involves ‘turning the mind back’ onto something to explore why we acted the way we did, e.g. writing about it, talking about it with a supervisor.

Reflective practice is a unique part of staff development and service delivery in the community mental health sector. It should be enmeshed in all organisational practices, e.g. supervision, evaluation, performance management, cultural competence, and forming partnerships. Reflective practice in supervision provides a unique opportunity for staff to be encouraged and supported to understand and incorporate the values and philosophies of the organisation, e.g. genuine consumer and carer participation, cultural sensitivity, recovery-oriented services and evidence-based practice.
Why is supervision important?

Much of the literature on supervision is from a clinical framework, e.g. drawn from the broader health and other fields, such as psychology, social work, psychiatric nursing or alcohol and other drug (AOD) settings, and as such there is little supervision material with a specific mental health focus. However, although community mental health staff are not always operating in a clinical environment there are many aspects of clinical supervision which will be shared with supervision as it happens in this sector.

The main objectives of supervision programs are to:

- To provide support to staff
- To give advice
- To allow the sharing of ideas and resources
- To ensure good practice as outlined in the current literature
- To ensure that workers maintain ethical boundaries
- To facilitate professional development
- To enhance staff communication and sense of cohesiveness
- To maximise staff morale and retention
- To maintain the highest possible standards for consumer outcomes

The benefits of supervision are:

- Organisations that support continuous learning
- Staff that feels supported
- Organisations that support professional and personal growth for staff
- Improved staff communication
- Increased confidence of staff
- Reduced burnout
- Increased job satisfaction
- Quality practice
- Ongoing reflective practice

The main challenges associated with supervision are:

- The cost of supervision
- Encouraging staff to participate
- Finding appropriately experienced supervisors
- Time constraints
- Competing demands on resources

If managers are clear on the process of supervision and their role within the process, then this will filter down the organisation to all workers. Supervision requires both a ‘bottoms up’ and a ‘top down’ approach - that is, it is the workers responsibility to approach the manager to seek access to supervision as part of staff development, just as it is the manager’s responsibility to ensure staff are accessing supervision at a required minimum level (that is, it becomes part of their performance plan), and the structures are in place to support this.
What is good practice in supervision?

The guidelines below are drawn from the AOD field. Whilst there may be some variations within the community mental health setting, it allows managers to be clear on the existing or future supervision program. Supervision should:

- Consist of a mix of individual and group supervision
- Be conducted in a one-on-one (individual supervision) setting at least monthly with sessions lasting between one and two hours
- Ideally employ a supervisor external to the agency, preferably one that has been chosen or agreed upon by the staff member(s) that are being supervised
- Involve a formal contract between the supervisor and the agency that is reviewed at least annually through evaluation and feedback from staff
- Be incorporated into staff work plans and performance agreements

There are several ways of recruiting a clinical supervisor:

- Advertising in a local paper
- Inter-agency networking - Approaching other community mental health organisations that may have access to or employ staff who could act as clinical supervisors
- Word of mouth

Table 5 - Internal versus external supervision - Pros and Cons

<table>
<thead>
<tr>
<th>Pros</th>
<th>External supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal supervision</td>
<td>External supervision</td>
</tr>
<tr>
<td>- Understands the organisation</td>
<td>- Brings new knowledge and experience to the organisation</td>
</tr>
<tr>
<td>- ‘Insider knowledge’, expertise or experience specific to your area of work</td>
<td>- ‘Outsider view’ of things</td>
</tr>
<tr>
<td>- Easily accessible</td>
<td>- Recruit from a wider pool of appropriate supervisors, and more opportunity to be selective in your final choice</td>
</tr>
<tr>
<td>- A person who is familiar to you and your needs</td>
<td>- Clear contracts and agreements set up</td>
</tr>
<tr>
<td>- Possibly shares similar interests/career goals</td>
<td>- May be less subjective in supervisory process</td>
</tr>
<tr>
<td>- Lower costs - resources needed for supervision readily available</td>
<td>- Workers may feel more comfortable speaking honestly and openly to them</td>
</tr>
<tr>
<td>- Easier to organise/set up</td>
<td>- Existing staff do not need training</td>
</tr>
<tr>
<td>- Opportunity for a staff member to increase their role/responsibility by taking on a supervisor position</td>
<td></td>
</tr>
</tbody>
</table>
Cons
- Conflict of interest could arise, due to role confusion
- May lack objectivity
- Staff feel less comfortable disclosing/sharing information for fear of being shamed or reprimanded
- Contracts/protocols more easily overlooked
- ‘Match’ between supervisor and worker may be less rigorous
- Time needed to train supervisors may take away from time spent on other tasks/service delivery

Cost
- ‘Remote’, i.e. contact is less frequent
- Professional values may not be congruent with the organisation’s values
- Significant orientation and induction needed to the organisation, its goals, objectives, staff members, structure, etc.

External supervision can be supplemented by internal practices, such as:
- Regular case review team meetings
- Peer supervision
- Interagency meetings
- Staff appraisals/peer review
- Internal and external training
- Regular line management supervision regarding policies, procedures and daily practice
- Reflective practice - personal and organisational

What should an agreement between supervisor and supervisee contain?
- Goals for supervision
- Expected outcomes of supervision
- Mutual obligations in the supervision process
- Structure of supervision
- Evaluation processes
- Limits of confidentiality
- Ethical issues
- Content of supervision

What is good practice in mentoring?
Managers are in a good position to act as mentors or to facilitate mentoring relationships within the workplace. Managers are in a position to recognise workers’ needs and offer opportunities to build on strengths and address weaknesses. They also work closely with staff and share similar goals and values. All of these reasons lend themselves to the spontaneous development of a mentoring relationship.
Background

The Supervision Program has been developed over the last 2 years, by Housing and Accommodation Support Initiative (HASI) management, in consultation with staff. As HASI is a relatively new service, the different components have evolved, according to the changing needs of HASI staff and management.

The initial program consisted of informal individual internal supervision with a Team Leader, and group-based external clinical supervision. However, as the service and its staff have developed, a more formalised supervision program was established, and more opportunities for professional development have been created through the implementation of a coaching program, and ‘Quarterly Recovery’ Workshops.

Structure

At present, the Supervision Program at HASI2 consists of 4 components, each with a specific purpose and goals:

1) Internal Supervision
   - Regular, fortnightly individual supervision with the Team Leader ensures staff are supported in all areas of their work (client issues, administration, current projects, management, collegial concerns, training and development, etc) thereby enhancing staff productivity and reducing burnout.

2) External Clinical Supervision
   - Monthly group clinical supervision provided by a qualified supervisor allows staff the opportunity to discuss client issues, ethical issues, to reflect on their work, and to monitor their self care.

3) Coaching
   - The coaching program provides experiential learning for staff, to improve their understanding of the client’s experience in recovering from mental health problems. This provides staff with an additional dimension to their intervention and interactions with clients, as well as speeding up their own personal and professional development.
   - The coaching program utilises the same framework of “Collaborative Recovery’ which is implemented with HASI clients. Therefore, in collaboration with the Service Manager, the staff member will clarify personal values, create a compelling personal vision, set meaningful and manageable goals, and determine specific action steps towards achieving those goals.
   - By applying the recovery process to themselves, staff can develop a better understanding of the processes and challenges which face HASI clients in improving their lives.

4) Quarterly Recovery Meetings
   - Quarterly Recovery Meetings are 1 day workshops, attended by all Outreach Service staff. The agenda is determined by the Service Manager and may include guest speakers, presentations by selected staff members, and activities designed to improve skills, and explore themes relating to mental health recovery.
   - Quarterly Recovery Meetings help to inspire, engage, and stimulate staff to consistently improve their practice, and help to maintain a consistent recovery philosophy across Aftercare services.
Challenges

The main challenges faced in implementing this program have concerned the time required to conduct the various activities, and weighing this against the immediate needs of clients. Both staff and management would agree however, that the various supervision and coaching activities ultimately support our clients by better preparing staff in terms of skills, knowledge, empathy, and personal well being.

The practical issues surrounding time management have been largely dealt with by utilising personal Outlook calendars available on Windows software. The Team Leaders have access to all staff calendars, and are responsible for sending notice of all supervision sessions, training courses, and workshops scheduled. Where possible, regular appointment times are kept to assist staff in maintaining structured work routines.

Management has been consistent and vocal in its commitment to all aspects of the Supervision Program, which has helped to send the message to staff that this program will continue indefinitely, and that staff are expected to participate as part of their role and responsibilities.

Benefits

The benefits of the Supervision Program have far outweighed the challenges faced in establishing it. In a recent staff survey, 90% of HASI2 staff reported strong job satisfaction, and 85% report strong organisational commitment. Furthermore, HASI2 scored 100% on questions concerning ‘Supervision’ (“My manager listens to what I have to say”, “My manager gives me help and support”). HASI2 also scored high on performance appraisal, personal relations, innovation, and career opportunities.

Staff has also expressed great appreciation for such a comprehensive Supervision Program, and particularly enjoy the supervision and coaching components of the program. Management note that the program helps to make staff feel valued, and in return, high morale fosters productivity and commitment.
A recovery-oriented service assesses the effectiveness of staff and services provided through indicators that are relevant and meaningful to consumers and carers.

The workforce, in partnership with consumers and carers, is at the heart of achieving a recovery-oriented service system. From a workforce development perspective, evaluation allows opportunities for improvement, strengthening teams, enhancing relationships with consumers and carers, reflection, goal-setting, and knowledge that the organisation is making a difference. Evaluation also serves as an important indicator that organisations, and the workforce, are delivering services from a recovery-oriented framework.

"Once upon a time there was a woodcutter who was working vigorously to cut down a tree in the forest using a saw that was growing increasingly blunt as he worked harder and harder to bring down the tree. One day a passer-by stopped and suggested that the man could be much more effective if he stopped and took the time to sharpen his saw. The woodcutter replied impatiently 'I don’t have time to sharpen my saw – I’m too busy sawing.'"
This short analogy illustrates an important point about evaluation. We are often so focused on delivering services and working at a busy pace that we do not take the time to stop, reflect and evaluate the effectiveness of our processes. The risk is that sometimes we are not offering the best available support and services to consumers and carers. This chapter hopes to illustrate the benefits to be found for organisations in finding the time to conduct proper evaluation processes. The objective is essentially to seed and sustain a reflective and responsive outcomes culture within community mental health organisations in service delivery and program development, as opposed to an outputs focused culture.

Why measure outcomes?

For consumers:

• To facilitate recovery
• Provides a point of feedback and dialogue to evaluate the services they receive\textsuperscript{155}

For Mental Health Support Workers:

• Informs treatment decisions\textsuperscript{156} and service delivery mode
• Helps evaluate the effectiveness of interventions and monitor consumer progress\textsuperscript{157}
• Uncovers unmet needs and changes in specific needs

For the mental health system:

• Guide policy and service development through the establishment of outcomes benchmarks\textsuperscript{158}
• Inform staff development and training needs\textsuperscript{159}
• Builds stronger relationships between service providers, consumers, carers and the community
• Helps organisations to plan and achieve initiatives for individual and community benefit
• Achieves a higher level of accountability

The process of evaluation allows us to do more of what is working and less of what is not working. Evaluation needs to be approached as a learning tool and part of what is considered good practice for everybody. It is a continuous process of asking questions, reflecting and reviewing, such that it becomes part of day-to-day service development practices.\textsuperscript{160}

A challenge for the community mental health sector is the ‘dissemination, implementation and sustained use of evidence-based mental health practices’.\textsuperscript{161} There has been a focus on establishing what is good practice and evidence-based practice. Now there is an emerging area of research on how to ensure that these practices are happening ‘on the ground’. Organisational influences on implementation - things such as the structure, culture or climate, internal processes and leadership need to be better researched and understood.

Evaluation might include staff, stakeholders, funding bodies, the local community, allied health professionals, community services, government organisations, Consumer Workers, Carer Workers, service users, carers and families - anybody that is affected by your initiative. Each of these groups will have different needs and desired outcomes. Managers should benchmark the organisation’s performance of particular activities and services against examples of good practice. This will provide some kind of yardstick for judging the effectiveness and efficiency of internal operations and setting performance standards for the organisation.\textsuperscript{162}

Evaluation can take place through:

• Staff/consumer/carer surveys
• Repeated needs analysis
• Focus groups
• Semi-structured interviews
• Outcome measurement
The AEIOU Model for Evaluation - taken from ‘Evaluation: A Guide for Good Practice’

A – Ask the right questions
E – Examine options and explore methods
I – Initiate actions and interpret answers
O – Options for Change
U – Undertake change for good practice

Things to consider when developing evaluation:

- What is the purpose of the evaluation and its priorities in terms of feedback?
- What are the constraints on the evaluation, e.g. cost, time, resources?
- What do we (staff, consumers, carers, management, stakeholders, community, etc.) hope to gain from the evaluation?
- What percentage of our time and budget are we prepared to commit to evaluation?
- Whose cooperation do we need during the evaluation process?
- How do we ensure that the evaluation reflects a balanced view of the (project/ service/ issue) and has value/meaning for consumers, carers and the community?
- What form(s) will the evaluation reporting take (at what point(s) is evaluation conducted, its content and structure)?
- Have we carefully considered any cultural and linguistic needs in the evaluative process?

Routine Consumer Outcome Monitoring (RCOM) - the ‘why’ and ‘how’

Evaluation needs to occur at an individual level with staff through performance management processes. It also needs to occur at a systems or organisational level, conducted by staff in collaboration with consumers and carers. An outcome measure is a tool to measure a change attributable to an intervention. A consumer intervenes in his/her own life and self care. An outcome measure gives us clear ideas about what to do and how it is co-produced (service & consumer).

Recovery cannot be easily deconstructed into measurable outcomes. One person’s journey to recovery will be vastly different to the next person, for example, a recovery outcome measure for one person might include something as seemingly simple as ‘I got out of bed today’. Routine consumer monitoring is the repeated use of an outcomes tool to monitor consumer health, recovery and well-being over a set time. We do this to know specifically about consumer’s needs, and whether they are being met, to improve our practice and services. Routine outcome monitoring should be relevant in terms of tracking and assisting individual recovery processes and evaluating the services consumers receive, not just focusing on assessing symptoms, functioning and service usage.

Involving consumers and carers in the evaluation process is essential - consumers and carers are the critical reference group. Managers need to train staff in how to do this sensitively and professionally so that involvement is voluntary and meaningful. This will strengthen relationships between staff, consumers and carers, and help to ‘map’ the consumer’s recovery journey. Routine consumer outcome measurement will also increase staff’s sense of competency and satisfaction with the work that they do, and highlight areas for further development. From a workforce and an organisational view, it provides staff and consumers with a structure which fosters discussion and better informs goal setting, monitors consumer outcomes and informs future service development. Collaborative development of goal-setting and individual service plans is part of the collaborative recovery process.
Examples of Tools:

- HONoS – Health of the Nation Outcomes Scale
- LSP – Life Skills Profile (16 or 32 item)
- K10 – Kessler 10 Symptom Scale
- GAF – Global Assessment of Functioning
- CAN – Camberwell Assessment of Need
- CANSAS – CAN Short Appraisal Schedule
- BASIS – Behaviour & Symptom Identification Scale (32 or 24 item)
- WHOQOL – World Health Organisation Quality of Life Scale for people with disabilities

Workplace example –
Implementation of data and outcome monitoring across Psychiatric Rehabilitation Association (PRA)

Since late 2007, PRA has implemented a rollout of Data and Outcome Monitoring Systems (DOMS) across all programs. This consisted of structured phases within a timeline since September 2007 to present.

- Internal policies on both the Outcome Monitoring System and Outcome Tools have been created and implemented throughout PRA. A Manager of the DOMS unit has been appointed. Current staffing consists of 2 part time DOMS Administration Assistants, and 2 part time Peer Support Workers to assist with completion of the CANSAS throughout our supported employment services.
- A database has been created, and a minimum data set of demographics for all consumers within the organisation is being entered and updated.
- Computers and technology upgrades have been provided to all sites.
- An information brochure has been created and is being dispersed throughout the organisation. This brochure is aimed at consumers, and will be provided to them on entry to each program to ensure they are informed re the process. It is a resource which can also be provided to family and carers if needed, and provides a practical means of disseminating information to consumers as required. In the future, PRA may investigate methods of translating the brochure into community languages.
- An instructional DVD has been created which shows positive, negative, and difficult CANSAS interviews. This has been used in all PRA training, and each site is provided with a copy for new staff to view.
- This DVD is also being used in MHCC’s “Mapping the Difference” outcome monitoring training, and has been requested for use by PRA's contracted trainers for use in training with Mental Health Certificate IV courses. Other NGO’s are also expressing interest in use of PRA’s CANSAS Training DVD in their own training, and PRA will be discussing possible use in the future.
- PRA contracted trainers to conduct training sessions across the organisation. This involved a wide variety of staff, not just those who have direct consumer contact, but also administration staff, business service staff and consumer advocates and representatives from each program. The training evaluations are being analysed, and a follow up training session for those requiring further information will be conducted.
- All training attendees received a “DOMS Kit”, created by PRA, comprising a folder with copies of electronic versions of CANSAS and monthly summary paperwork, brochures about Outcome Monitoring (“Support for Individual Recovery”), appointment cards to be given to consumer for follow up interview on Individual Goal Planning, laminated prompt/flip cards created by PRA for use with CANSAS summary, and copies of PRA policy and procedures on DOMS. This Kit will be able to be sold to other organisations interested in implementing a CANSAS needs assessment across their organisation.
Conclusion

In order to create recovery-oriented organisations we need to develop a clear picture of what they might look like. The future vision for community mental health organisations is one in which:

- Recovery is expected, both by people with the lived experience of a mental health problem, and their carers, families, and service providers;
- Consumers, carers, families and services work together in a supportive and respectful way to achieve goals as lead by consumers and carers;
- The workforce is compassionate, collaborative, skilled and diverse;
- Strong leadership provides clear vision and guidance, and demonstrates this vision and a positive attitude at all times;
- Organisations listen and respond to changes in the consumer and carer profile, community needs, cultural and other issues;
- The workforce and organisations engage in ongoing research and learning to achieve innovation and sustainability;
- The sector is an attractive, supportive and dynamic environment in which to work; it attracts a wider pool of workers, retains staff and promotes the inclusion of consumers, carers, CALD & ATSI communities in the workforce;
- The sector is professionalised and an acceptable voluntary minimum qualification is in place for Mental Health Support Workers, Consumer Workers and Carer Workers;
- The workforce and organisations regularly evaluate the services they provide, in partnership with consumers, carers and families, to ensure good practice standards.

This guide presents the nine key workforce pathways to achieving a recovery-oriented organisation.

If the workforce is clear on the destination picture of a recovery-oriented organisation they can start to create the pathways to get there. This is a process done in partnership between managers, consumers, carers, families, service providers, and the community.

All of the workforce pathways interact and influence each other and the ‘system’ in which they are operating. However, success of a genuine recovery-oriented service system is not possible without true collaboration with consumers and carers and attitudes and values at every level of an organisation that are commensurate with a recovery approach. These form the foundations for a recovery-oriented organisation, and enable the framework within this guide to be adopted in an organic and holistic way.
Glossary of Terms

Action learning
A process of ‘learning by doing’ or learning by putting research into action. It asks participants to reflect and review the action they have taken and the learning points that arise. It is a learning technique particularly suited to adults.

Affirmative action
An employment process designed to address the difficulties and discrimination people with a disability experience in finding work.

ATSI
A term used to refer to Australian and Torres Strait Islander communities.

Australian Qualifications Framework (AQF)
A nationally consistent set of qualifications for all post-compulsory education and training in Australia. It enables different training organisations throughout Australia to issue the same type of qualifications.

Australian Quality Training Framework (AQTF)
Provides the basis for a nationally consistent, high quality vocational education and training system for Australia. The AQTF consists of two parts: standards for Registered Training Organisations and standards for State and Territory Registering/ Course Accrediting Bodies. The AQTF enables different assessors throughout Australia to accept the assessments of each other, because they follow the same rules and assess to the same standards.

Burnout
The experience of long-term exhaustion and diminished interest, usually in the work context.

CALD
A term used to refer to culturally and linguistically diverse people/groups of people/communities.

Carer
A person, who at time of need, provides regular or intermittent support to someone who has a mental health problem. The carer may not necessarily be a family member or live full time with the cared for person, but is someone who has assumed the close, non-institutional caring role as a friend or advocate, and provides financial and/or emotional and/or practical support (ARAFMI 2005 as cited in the MHCC Social Inclusion paper).

Change management
A structured approach to moving individuals, teams, and organisations from a current state to a desired future state. It includes both organisational change management processes and individual change management models, which together are used to manage the people side of change.

Clinical supervision
A branch of supervision for staff who are engaged in client focused work, i.e. directly managing a caseload of clients. It provides an opportunity for case review and to discuss other professional issues in a structured way.

Coaching
A method of directing, instructing and training a person or group of people, with the aim to achieve some goal or develop specific skills.
**Code of Practice**
A Code of Practice provides practical guidance and advice on how to achieve a standard of practice within an organisation. A Code of Practice speaks broadly to standards of attitudes and behaviour which incorporates the key values and philosophies of the organisation. Code of Practice is the preferred terminology in this guide, and includes Code of Conduct standards, which traditionally focus on upholding roles and responsibilities, behavioural actions and interactions with staff, consumers, carers and ‘administrative’ standards, such as dress code. A Code of Practice is not a law but should be followed unless there is an alternative option which achieves the same or better outcome. Failure to follow Code of Practice is cause for disciplinary action as determined by the manager. Codes of Practice are developed through consultation with staff, consumers, carers and other stakeholders.

**Consumer**
A person with the lived experience of a mental health problem.

**Cultural competence**
An ability to understand, communicate with and effectively interact with people across cultures.

**Family-Inclusive Practice**
A model of support and care which recognises the context or social environment in which an individual exists, and the important role relationships with family members play in a person’s mental well-being. This approach supports the inclusion of family members in all aspects of service planning and delivery to improve recovery outcomes for consumers.

**Line management supervision**
Supervision provided by a line manager which includes a responsibility for day-to-day management of workplace practices and service delivery, planning and monitoring workload, ensuring quality of work, ensuring health and safety, time management, motivating, administration and record keeping.

**Mental health problem**
As a personalised term, that is, to refer to someone with a mental health problem, recognises the principles of recovery, and the value of community-based and psychosocial approaches. It reflects the thinking and ownership that is necessary for the person to take control and not see themselves as ‘sick’, but as having a ‘problem’ whereby they seek what they want rather than having only one (medical) option.

**Mental illness**
As a personalised term, that is, to refer to someone with a mental illness reflects a commitment to a ‘health’ or ‘medical model’ of service provision, and as ‘sick’, i.e. dependent and needing medical support.

**Mentoring**
A relationship between a more experienced mentor and a less experienced partner referred to as a protégé or mentee. It can be a formal or informal process. The mentor provides counsel, insight and guidance and acts as a sounding board for ideas and decisions that relate to the mentee’s career.

**Needs analysis**
The formal process of identifying learning and development gaps at an individual/team/organisation level and its related professional and personal development need(s).

**Organisational development**
Refers to the activities that strengthen the ability of an organisation to build and advance its infrastructure and capabilities to achieve its objectives, for example, structure, Boards of Management, leadership and culture.

**Performance management**
The process of assessing progress toward achieving predetermined goals. Performance appraisal is where individual performance is formally documented and feedback delivered.
**Personal development**
Tied with the concept of worker well-being and happiness at work. It involves feeling supported at work, doing fulfilling and challenging work, forming good relationships with colleagues, learning from one’s experiences, etc.

**Professional development**
In the context of this guide, professional development is about developing workers’ knowledge, skills and attitudes in order to ensure that they can work confidently and effectively - it is tied in with the concepts of lifelong learning or continuing education.

**Reasonable adjustment**
Reasonable adjustment (sometimes referred to as Reasonable Accommodation) is an active approach that requires employers, service providers, etc. to take steps to remove barriers from disabled people’s participation in the workplace, under the condition that this does not cause “undue hardship”, e.g. financial or physical burden (see Disability Discrimination Act 1992).

**Recovery**
In relation to mental illness, recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with the limitations caused by the illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.

**Recognition of Prior Learning (RPL)**
The acknowledgement of a person’s skills and knowledge acquired through previous training, work or life experience, which may be used to grant status or credit in a subject or module.

**Reflective practice**
A professional development technique that involves thoughtfully considering one’s own experiences in applying knowledge to practice while being coached by professionals in the discipline.

**Registered Training Organisation (RTO)**
An organisation registered by a state or territory recognition authority to deliver training and/or conduct assessments and issue nationally recognised qualifications in accordance with the Australian Quality Training Framework.

**Reimbursement**
The payment of out-of-pocket expenses incurred as a result of participation. These may include travel, stationary, telephone, postage, fundraising requites, accommodation, meals, childcare and carer costs (IAHS Resource Centre, 1998).

**Remuneration**
A payment for services rendered, and is intended to cover costs of travel, preparation, representative attendance at meetings and feedback to the representative consumer/carer group (IAHS Resource Centre, 1998).

**Routine Consumer Outcome Monitoring (RCOM)**
An evaluation process conducted in partnership between service provider and consumer to measure change(s) attributable to an intervention or service being provided.

**Rural/regional/remote**
According to the Rural Remote and Metropolitan Area (RRMA) Classification System, there are 3 rural classifications - large rural centres (population between 25,000-99,999); small rural centres (10,000-24,999) and other rural areas (less than 10,000). There are two remote classifications - Remote 1 (towns with more than 5,000) and Remote 2 (towns with less than 5,000).

**Social inclusion**
The ability to participate in and contribute to social life - in economic, social, psychological, and political terms.
**Stress**
Stress refers to psychological, e.g. anxiety, physical, e.g. high blood pressure and behavioural, e.g. poor sleeping, irritability responses to increased work-related demands and pressures over a discrete or short-term period.

**Succession planning**
The process of identifying and preparing suitable employees through mentoring and professional development to replace key staff if/when they leave the organisation.

**Traineeship**
A system of vocational training combining off-the-job training at an approved training provider with on-the-job training and practical work experience.

**Vocational Education Training (VET)**
Post-compulsory education and training, excluding degree and higher level programs delivered by higher education institutions, which provides people with occupational or work-related knowledge and skills. VET also includes programs which provide the basis for subsequent vocational programs.

**Workforce development**
A broad ‘umbrella’ term which describes a wide range of strategies, policies and programs, including organisational development, recruitment and retention, research and evaluation, training and development etc. It provides a holistic and dynamic approach to target issues at an individual, organisational and systems level. The goal of workforce development is to manage the size and composition of the workforce, retain and manage that workforce and skill that workforce. Workforce development is the hoped outcome of workforce planning.

**Workforce planning**
A process of achieving sustained organisational performance and accountability through the development of a capable workforce.
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